2017

Addressing Needs of Intimate Partner Violence Survivors in the Emergency Department

Claudia F. Schenk
Walden University

Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral dissertation by

Claudia F. Schenk

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Dorothy Scotten, Committee Chairperson, Human Services Faculty
Dr. Scott Hershberger, Committee Member, Human Services Faculty
Dr. Gregory Hickman, University Reviewer, Human Services Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
2017

Abstract

Addressing Needs of Intimate Partner Violence Survivors in the Emergency Department

by

Claudia F. Schenk

MSW, University of Michigan, 1990

BA, Oakland University, 1988

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Human and Social Services

Walden University

August 2017

Abstract

Intimate partner violence is a global epidemic and public health concern, including in the United States. The purpose of this descriptive, exploratory, nonexperimental, quantitative study was to determine to what extent intimate partner violence survivors avail themselves of offered resources and interventions in health care settings. The general systems foundation was used for the study's theoretical foundation. The research questions ascertained the proportion of intimate partner violence survivors who accepted mental health, law enforcement, and community outreach resources; the level of comprehensive intervention they received; and the associations, if any, between types of services. Retrospective data were collected from121 medical records from an emergency department in the Midwest United States. Descriptive statistics were performed on collected medical record data and chi-square analyses were performed in an exploratory manner to determine associations between types and numbers of other services accepted. The outcomes indicated that the majority of participants accepted comprehensive intervention, social work or mental health intervention was the most frequently accepted service, and the majority of patients who accepted social work accepted other services. Anticipated social implications may include survivors receiving multi-disciplinary interventions sooner, increased efforts by health care providers to work collaboratively with community agencies, continued development of hospital policy and protocols, and opportunities for further research. Society may ultimately benefit from a decreased economic cost to society and a positive impact in growth and development of witnessing children.

Addressing Needs of Intimate Partner Violence Survivors in the Emergency Department

by

Claudia F. Schenk

MSW, University of Michigan, 1990

BA, Oakland University, 1988

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Human and Social Services

Walden University

August 2017

Table of Contents

List of Tables

List of Figures

Chapter 1: Introduction to the Study

Introduction

According to the World Health Organization, global and regional violence against women, leading to physical and emotional ill health, has reached epidemic proportions (Garcia-Moreno, Hegarty, Lucas d'Oliveira, Koziol-McLain, Colombini, & Feder, 2015). Violence against women from an intimate partner is also a global epidemic (Maddoux, McFarlane, Faan, & Liu, 2015). Intimate partner violence differs from other forms of violence because the physical and or psychological abusive behaviors by one or both partners occurs in an intimate relationship such as marriage, dating, family, friends, or cohabitation (Chapin, Coleman, & Varner, 2011). In the United States, intimate partner violence occurs at a rate of 3.6 per 1,000 people, with four of the five victims being women (Catalano, 2012; Futures Without Violence, 2014). This form of violence occurs across age groups, social classes, cultures, and ethnicities (Leppakoski & Paavilainen, 2013). Various disciplines have focused attention, intervention, and research on intimate partner violence (Catalano, 2012).

Legal, medical, and community coalitions have contributed discipline-specific perspectives, policies, interventions, and clinical practices to address components of intimate partner violence (Antle, Barbee, Yankeelow, & Bledsoe, 2010). However, specialists in each discipline typically only address a specific component of intimate partner violence identification and intervention in their work. The complex problem of intimate partner violence, especially the comprehensive nature of survivor needs, cannot be addressed in isolation (Bogeanu, 2012). Intimate partner violence survivors may

benefit from greater collaboration on the part of the specialists who provide for their legal, medical, community resource, and mental health needs (Cox et al., 2010). A systems approach is also successful in leading to changes in practice and policies in health care settings (Hamber, Rhodes, & Brown, 2015; Ritchie, Nelson, Wills, & Jones, 2013).

Researchers found evidence supports addressing intimate partner violence needs in health care settings, such as clinics, hospitals, and the emergency department (Auerbach & Mason, 2010). Survivors of intimate partner violence often seek services from medical-care providers, which offers a multitude of opportunities for research and intervention (Beynon, Gutmanis, Tutty, Wathen, & MacMillan, 2012; Ghandour, Campbell, & Lloyd, 2015). Qualitative and quantitative researchers conduct studies and research on relationship violence. Past qualitative researchers on intimate partner violence in medical-care settings identified and explored ways of eliminating barriers to relationship violence screening and intervention (Beynon et al., 2012); whereas, past quantitative researchers focused on compliance in screening, program planning, process, and policy (Chibber & Krishnan, 2011).

Despite increased research on intimate partner violence in health care settings, the issue of intimate partner violence remains (Catalano, 2012). Survivors presenting to health care settings often have unmet mental health or social work, legal, and community resource needs (Chapin et al., 2011; Todah & Walters, 2011). Campbell & Lewandowski (2011) identified unmet mental health issues of depression and anxiety. Antle et al. (2010) found survivors were in need of law enforcement resources through increased

safety support services such as mandatory reporting, personal protection orders, and alleged perpetrator arrest. Villagrana (2010) found survivors' unmet community resource needs included unsafe housing, unemployment, and lack of advocacy and support.

A gap persists in research and practice on exploring the possibility of introducing intervention and resources to survivors in health care settings to address unmet needs. In my study, I addressed this gap in the literature by exploring the possibility of introducing legal, mental health, and community-resource services to survivors in the emergency room. Specifically, I considered the likelihood of survivors making use of intervention and resources when offered in the emergency department. An increased understanding of the needs of survivors and the potential to address those needs in the emergency room may also offer opportunities for health care providers to coordinate services with community advocates and law enforcement.

Survivors' use of medical services provides opportunities for providing intervention and resources. When comparing relationship violence survivors to individuals who have not experienced intimate partner violence, survivors are more likely to use emergency room services (Colarossi, Breitbart & Betancourt, 2010). Due to the increased likelihood of survivors of intimate partner violence using health care services many opportunities occur for practice and research in hospital settings (Beynon et al., 2012; Bledsoe & Sar 2011; Colarossi et al., 2010; Power, Bahnisch & McCarthy, 2011). Coordinating these efforts in health care settings such as emergency departments may help providers proactively address the entirety of intimate partner violence survivors' legal, mental health, and community resource needs.

This chapter begins with definitions of intimate partner violence along with background information on this form of violence. I then present my problem statement, purpose, rationale, methodology, research questions and hypothesis, and theoretical foundation. Then, I address the assumptions, scope and delimitations, and limitations of my research study. This chapter concludes with definitions of pertinent terms and a discussion of the significance of the research study.

Background to the Study

Intimate partner or relationship violence is the abusive physical or psychological behavior exhibited by one or both partners in an intimate relationship such as marriage, dating, family, friends, or cohabitation (Chapin et al., 2011). Relationship violence may escalate to women enduring rape, physical assault, stalking, or death (Maddoux et al., 2015). Researchers have identified intimate partner violence or relationship violence as a global health concern by the World Health Organization (Garcia-Moreno et al., 2015; Reisenhofer & Seibold, 2012). Survivors' use of health care services provides opportunities for research in the emergency department. In my study, I reviewed medical records to ascertain whether survivors of intimate partner violence accepted legal, mental health or social work, and community outreach resources and interventions that were offered to them in the emergency department. The outcomes allowed me to consider to what extent the totality of the survivors' needs were met; and, what proportion of survivors' accepted resources and intervention. I approached this gap in research from a perspective that differed from that used in past research. Rather than focusing on a health care facility's screening compliance or on confirming identified barriers to addressing

intimate partner violence in the emergency department, I focused on offered services and intervention. I also focused on the level of intervention or extent of services provided to survivors in the emergency department.

Identifying additional opportunities to address intimate partner violence may help improve policies, programs, and services to survivors of this form of violence (Todahl & Walters, 2011). Researchers found a systems approach is successful in producing changes in practice in health care settings (Ritchie, Nelson, Wills, & Jones, 2013) and overcoming barriers to screening and intervention (Hamber, Rhodes, & Brown, 2015). Coordinating efforts in emergency departments may lead to ensuring the entirety of intimate partner violence survivor needs are explored and met.

Background to the Problem of Intimate Partner Violence

Researchers have used the terms relationship violence, domestic violence, and intimate partner violence interchangeably with intimate partner violence being the current, common, and accepted term (Barner & Carney, 2011). Also used interchangeably for the individual experiencing intimate partner violence is the identifier of victim, battered woman, and survivor, with survivor as the current and preferred characterization. The characterization of survivor was a conscious effort by feminists, advocates, and scholar-activists to attribute strength and empowerment to the individual experiencing relationship violence (Dunn, 2005).

The negative effects of relationship violence are broad with direct and indirect impacts to society. The direct economic costs of intimate partner violence are estimated to exceed $8.3 billion annually with $4.1 billion attributed to direct medical and mental

health care services (Futures Without Violence, 2014; Heyman Slep, & Foran, 2015). Indirect societal impacts include chronic medical problems and the impact to witnessing children through compromised emotional and relationship development (Heyman et al., 2015).

Adverse effects for intimate partner violence survivors are also direct and indirect (Antle et al., 2010; Campbell & Lewandowski, 1997). Direct adverse effects include physiological and psychological injury such as neurological damage, sexually transmitted diseases, low-birth-weight babies, miscarriage, depression, and anxiety (Campbell & Lewandowski, 1997). Indirect adverse effects include emotional and behavior problems for the witnessing children, battered women lacking the fortitude to emotionally nurture their children, and childhood victimization leading to possible abusive relationships as adults with probable subsequent abuse of offspring (Renner & Slack, 2006). These direct and indirect adverse effects of intimate partner violence remain a public health concern and carry an economic cost to society; resulting in a loss in productivity because of medically treated injuries and work absenteeism (Bledsoe & Sar, 2011; Jaffee, Epling, Grant, Ghandour, & Callendar, 2005). The negative impact of relationship violence to individuals and society supports the need for continued work, research and intervention to address intimate partner violence.

Background to the Study of Intimate Partner Violence

The study and research of violence against women has occurred from multiple perspectives, and with some coordinated efforts. The multiple perspectives include legal, human, and women's rights, feminist, and medical standpoints (Russell, 2010). The

earliest legal studies reference the marital contract and the husband's ability to physically punish a spouse (Russell, 2010). A gradual shift occurred with a movement toward protection from the physically abusing spouse in the form of personal protection orders (PPOs) and mandatory reporting (Barner & Carney, 2011; Tatum & Pence, 2015). Law-enforcement research led to mandatory arrest laws implemented in many states. These law-enforcement policy and practices stipulated the immediate and automatic arrest of alleged perpetrators when responding to intimate partner violence complaints, and mandatory reporting laws when intimate partner violence is suspected (Coulter & Chez, 1997). These legal policy and practices evolved from concerns that survivors are unlikely to initiate requests for assistance (Antle et al., 2010). However, even with personal protection orders (PPO), women's safety risk does not diminish and perpetrators violate PPOs at a rate of 20% (Maddoux et al., 2015; Tatum & Pence, 2015).

In human and women's rights, the women's movement has been instrumental in drawing attention to intimate partner violence through increased public awareness, empowerment, and shelter with comprehensive family services (Barner & Carney, 2011). Intimate partner violence victims encountering both police services and health care is high, providing opportunities for coordinated efforts (Thomas, Sorenson, & Joshi, 2010). Research findings vary on the effectiveness of community coalitions and coordinated community responses with some researchers finding no effect on reducing intimate partner violence (Post, Klevens, Maxwell, Shelley, & Ingram, 2010). Yet, multi-disciplinary stakeholders continue to depend on one another for referrals (Cox et al., 2010; Pennington-Zoellner, 2009). Increased public awareness of relationship violence

may increase understanding of the varied needs of survivors and that addressing those needs would benefit from coordinated efforts.

Coordinated efforts of community coalitions and alliances were formed in response to the 2003 Centers for Disease Control and Prevention (CDC) support in developing community programs and inter-agency collaboration to prevent intimate partner violence (Cox et al., 2010). Alliances stressed the importance of communication and collaboration between the CDC and local communities to address intimate partner violence. Informal groups and volunteers comprise many vested local community organizations. Volunteers in community organizations provide services by the dispatch of outreach workers for education, advocacy, and community resources. To provide these services, community organizations continue to rely on law-enforcement and health care systems for referrals and requests for intervention (Cox et al., 2010). The move to collaboration and comprehensive intervention is also supported in the clinical and therapeutic domain, with an emphasis on a holistic approach and the value to addressing the entirety of the individual's mental health and interpersonal relationship needs (Schmidt, 2014).

The medical community is also divided on mandatory reporting, maintaining that mandatory reporting may impede doctor-patient relationships and decrease the likelihood of abused women seeking treatment (Hyman & Chez, 1998). In addition to medical and mental health professionals, intimate partner violence survivors were also divided in support or opposing mandatory reporting (Rodriguez, McLoughlin, Nah, & Campbell, 2001). However, recent research did not support these findings, reporting survivors

support screening (Beynon et al., 2012). Mandatory reporting varies from state to state and meeting mandatory-reporting criteria ranges from data collection, direct reporting to police, and referring individuals to social services agencies for survivor and family intervention (Lavicoli, 2005). Referring survivors to mental health services is significant, including use of services in the child-welfare system, which is instrumental because intimate partner violence often negatively affects children (Villagrana, 2010). Recent research supports collaboration by including emergency services personnel in working to identify and address intimate partner violence (Oehme, Stern, Donnelly, & Melvin, 2016). Goba (2016) reinforced these prior studies and included incorporating hospital security personnel as members of the collaborative team. To provide comprehensive services through screening, identification, referral, and intervention to address survivors' legal, medical, community resources, and mental health it takes a multidisciplinary or collaborative approach (Cox et al., 2010).

Intimate Partner Violence in the Emergency Room

Examining past research on intimate partner violence in medical settings demonstrates the need for continued study in health care. Although men and women experience intimate partner violence, women are more likely to seek medical services (Beynon et al., 2012) providing research and intervention opportunities. Statistics support the opportunity for identification and intervention for intimate partner violence survivors in emergency rooms. During the past decade, nearly 20% of adults utilized the emergency room for health care (Gindi, Black, & Cohen, 2016). In addition, when compared to individuals who did not experience relationship violence, intimate partner

violence survivors have an increased likelihood of using the emergency room to meet health care needs (Beynon, et al., 2012).

Hospital settings provide the opportunity for intimate partner violence survivor identification and intervention, as well as refer to other disciplines to address the varied needs of a survivor (Chanmugam, 2014; McAllister & Roberts-Lewis, 2010). Intervention in the emergency department with intimate partner violence survivors yields opportunities to provide patient access to optimal and quality care, reduce unnecessary readmission, and reduce patient stays (Bennett, 2012). Survivors of intimate partner violence seeking services in medical and mental health settings may present with medical, legal, immediate, and ongoing social and mental health needs (Antle et al., 2010; Beynon et al., 2012; Dichter & Rhodes, 2011). Professionals in the emergency room can play a role in addressing intimate partner violence protocols, supporting staff, making referrals, and continuing program development (Power et al., 2011).

In addition to offering linkage to community resources and law enforcement, the opportunity exists in the emergency room to ensure safe discharge and introduce the concept of intimate partner violence intervention and resources for resistant populations (Soskis, 1985). Regardless of where the intimate partner violence survivor is in their personal experience, professionals can provide support, problem identification, and resolution to improving survivors' quality of life (Bogeanu, 2012). Past research conducted in medical settings on intimate partner violence pertained to identifying medical staff and patient barriers to screening for intimate partner violence, the failure to screen, and the lack of developing protocols to address the low rate of screening for

intimate partner violence (Beynon et al., 2012; Jaffee et al., 2005). Additional identified barriers to addressing intimate partner violence in prior research include time constraints, lack of training, partner presence, and medical or legal staff's lack of insight regarding why survivors would remain with abusers (Sprague et al., 2013).

Medical and mental health professionals have a history of agreeing and disagreeing on addressing intimate partner violence in the emergency department. Medical and mental health professionals agreed on the prevalence of intimate partner violence, the need for intervention, and that an opportune venue for intervention is in health care settings, because of the increased likelihood of intimate partner violence survivors using health care services (Bledsoe & Sar, 2011; Colarossi et al., 2010). Disagreement exists among medical and mental health professionals on who, or which health care professional, should screen for relationship violence and initiate intervention. Researchers have extensively examined how intimate partner violence should be identified, when intimate partner violence should be identified, and who should initiate screening and intervention (Daugherty & Houry, 2008; Nelson, Bougatsos, & Blazina, 2012; Todahl & Walters, 2011). Research also continues to support the effectiveness of internal efforts to facilitate change in self-efficacy, education, and change in policy and practice (Ambuel, et al., 2013). Further, despite reported challenges to addressing intimate partner violence, the Affordable Care Act and Prevention Services Task Force holds health care facilities accountable for screening and intervention. This will continue to occur by linking accreditation and funding to compliance, but leaving implementation and process up to health care organizations (Ghandour et al., 2015).

Problem Statement

Intimate partner violence is a global and public health concern, which results in significant economic costs for society in the United States (Cotalano, 2012; Garcia-Moreno, et al., 2015). Children who witness violence often face compromised growth, development, and learning outcomes (Maddoux, et al., 2015). Researchers have studied the myriad needs of intimate partner violence survivors and illuminated important findings, particularly the continued prevalence of relationship violence and extensive direct and indirect negative impact to individuals, families, and society (Chapin et al., 2011; Todah & Walters, 2011). In my review of the literature, however, I did not find studies concerning the viability of collectively addressing intimate partner violence survivor needs in the emergency department, a venue that offers opportunities for screening, and intervention through offered services. Given the continued prevalence of intimate partner violence (see Catalano, 2012; Futures Without Violence, 2014), and burden to society, I believe that further research is warranted to examine how to best meet survivor needs in emergency departments in the United States.

Purpose of the Study

The purpose of this descriptive, exploratory, nonexperimental, quantitative study was to determine to what extent intimate partner violence survivors avail themselves of offered resources and interventions in health care settings. Specifically, ascertaining the proportion of intimate partner violence survivors who accepted mental health, law enforcement, and community outreach resources; the level of comprehensive intervention

received, and the associations, if any, between types of services. I defined levels as the acceptance of one, two, or all three offered resources.

My immediate goal, by ascertaining whether intimate partner violence survivors accept offered intervention and resources, was to unearth an opportunity to address relationship violence in health care. Addressing intimate partner violence in health care may result in survivors in receiving multi-disciplinary intervention sooner. Additional goals include informing mental health, legal, and community outreach that providing intervention in the emergency department is an opportune venue. Also, to use the information to provide future studies and to use the findings to develop hospital protocols for intervention and coordination of services.

Rationale for the Study

The continued prevalence of intimate partner violence is an economic burden to society (Catalano, 2012), calls for optimal and quality care with consistency across health care and multidisciplinary settings to address this ongoing social issue and public health concern. Understanding the multiple needs of survivors may offer opportunities to coordinate services and educate stakeholders with the potential to address those needs in the emergency room. Survivors seeking services in mental and medical health care settings provide a multitude of research and intervention opportunities for professionals working with intimate partner violence survivors (Beynon et al., 2012).

Therefore, the hospital setting, specifically the emergency department, offers an opportune venue to use a multidisciplinary approach to screening, identification, and referral. Through this study, I aimed to contribute to the growing body of literature

regarding addressing relationship violence in health care settings. The continued occurrence of intimate partner violence supported the rationale for the study.

Research Questions and Hypothesis

I sought to answer three research questions in my study.

RQ1. What proportion of intimate partner violence survivors' avail themselves of legal, social work or mental health, community outreach resources, and intervention when offered in health care settings such as the emergency department?

RQ2. What is the level of a comprehensive intervention for intimate partner violence in health care settings such as the emergency department?

RQ3. What is the relationship between the level of a comprehensive intervention for intimate partner violence and the level at which intimate partner violence survivors' accepted legal, mental health, and community outreach resources, and intervention in health care settings?

Comprehensive intervention occurs when all units participate (Barner & Carney, 2011; Bogeanu, 2012). Therefore, in my study I defined comprehensive intervention occurred when all three conditions were met: (a) the survivor accepted brief social work or mental health intervention, (b) the survivor was linked to law enforcement, and (c) the survivor was linked to community advocates for outreach services while in the emergency department. Law enforcement was defined as linkage to hospital security or community police agencies.

My research study initially included the null hypothesis and an alternate hypothesis to answer RQ3:

*H*01. There is no relationship between the level of a comprehensive intervention for intimate partner violence and the level at which intimate partner violence survivors' accepted legal, mental health or social work, and community outreach resources in health care settings.

*H*11. There is a significant relationship between the level of a comprehensive intervention for intimate partner violence and the level at which intimate partner violence survivors' accepted legal, mental health or social work, and community outreach resources in health care settings.

However, as levels of intervention was operationalized as to how many offered services were accepted, I was certain there would be a significant relationship with the acceptance of legal, mental health or social work, and community outreach resources. Therefore, instead of testing the null hypothesis and answering RQ3 I made an adjustment to the study. Instead, the analyses to answer RQ3 were instead performed in an exploratory rather than relationship manner, to determine any associations between types of services accepted and how many other services were accepted.

Through study findings, I considered which resources and interventions intimate partner violence survivors identified as beneficial. Further, study findings allowed me to affirm or dispute that legal, mental health and community-resource support can successfully be introduced to intimate partner violence survivors in the emergency room. The theoretical foundation proposed for the study was general systems theory.

Theoretical Foundation

The theoretical foundation for my study was general systems theory, introduced by biologist von Bertalanffy in the 1940s. Bertalanffy's (1969) general systems theory entailed a complex system structure relies on the interrelationship between system components and the whole. Understanding the dynamics of the general system provides an opportunity to create positive change in the overall system through the subsystems (Bertalanffy, 1969; Hanson, 1995; Luhmann, 2013). General systems theory was founded on biology, computer science, engineering, sociology, economics, medicine, and the psychology of family therapy. Offshoots include sociological-system theories, Marx's conflict theory, and Spencer's consensus theory (Hanson, 1995). Other systems theories emerged from general systems theory. The principles of general systems theory were found in dynamic-systems theory, family violence theories, and developmental systems theory (Greenfield, 2011; Keenan, 2010; Lawson, 2012).

Dynamic-systems theory, developed by Thelen in the 20th century in the field of developmental psychology, differed from general systems theory, focusing on human adaptation to change (Keenan, 2010). In 2006 Dutton applied family-violence theory, grounded in the sociological tenets of general systems theory, as an ecological theory to increase insight to the dynamics of intimate partner violence (Lawson, 2012). Developmental systems theory, developed by Ford and Lerner in the late 1990s, focused on the interconnectedness of the individual and the environment. Similarities of founding theories and subsequently emerging theories included deviation from a linear theoretical approach, uses in multiple conceptual contexts, development of general systems and

subsystems through increased understanding, and the connection between general systems and subsystems (Hanson, 1995). Brailsford, Harper, LeRouge and Peyton (2012) supported a systems approach, including everyone who contributed to maintaining the system. The health care system is one example of a general system and its interconnected subsystems. Within the health care system, the emergency department is also comprised of interconnected subsystems. The system as a whole and the subsystems has the opportunity to address intimate partner violence in the emergency department.

Subsystems, in addressing intimate partner violence in the emergency department, include law enforcement, medical and mental health professionals, and community coalitions. Individually, subsystems provide discipline-specific mental health, legal services, or community services. Each subsystem offers specific uses of general systems theory to address intimate partner violence identification, screening, and intervention. As a collective, the system aspires to influence policymaking and advocacy. Positive changes in the system result in improved service delivery to the targeted population. General systems theory offers the opportunity to develop the entirety of the system and its subsystems, with an improved system resulting in better service delivery.

Nature of the Study

Intimate partner violence remains a significant public health and economic concern (Bledsoe & Sar, 2011). Researchers have conducted qualitative, quantitative, and mixed-method studies regarding intimate partner violence in health care settings to identify and explore barriers to screening and assess compliance (Chibber & Krishnan, 2011; Heyman, Smith, & Foran, 2015). Exploratory descriptive quantitative research is

consistent with providing basic descriptive statistics for an identified key population to guide future analysis (Leppakoski & Paavilainen, 2013). Secondary-data analysis allows the researcher to specifically and consistently collect and analyze data from archival records (Frankfort-Nachmias & Nachmias, 2008). Social scientists have shown an increased use of secondary data analysis and attribute this increase to a few reasons. For example, compared to primary data, secondary data has the advantage of less cost and less time prohibitive, thereby offering the opportunity for comparison and longitudinal research. Secondary data allows researchers to sift through a large database, and is often preferred when studying sensitive content (Frankfort-Nachmias & Nachmias, 2008).

Through examination of findings, I affirmed or disputed the practicality of introducing legal, mental health or social work, community resources, and comprehensive intervention to intimate partner violence survivors in the emergency room. Bogeanu (2012) and Cox et al. (2010) emphasized the need to shift to a holistic or comprehensive approach to address intimate partner violence, and Ritchie et al. (2013) found a systems approach is effective in addressing intimate partner violence in health care settings. In clinical practice and therapeutic intervention, Schmidt's (2014) findings support the movement to a comprehensive approach to address intimate partner violence by incorporating the mental health, legal, resource, and community needs of the survivor. Increasingly accepted and promoted as an opportune location for comprehensive intimate partner violence intervention are health care settings (Garcia-Moreno, et al., 2015). In my study I explored addressing intimate partner violence in a health care setting to ascertain the possibility of making this shift in offering resources and intervention.

The nature of my study differed from prior research studies by exploring the possibility of dissimilar stakeholders addressing intimate partner violence survivor needs in the emergency department. This nature of my study was a nonexperimental, convenience sample, quantitative study design conducted through structured record reviews. The study consisted of a 6-month retrospective audit of hospital records in which patients in the emergency department screened positive for relationship violence. The audit and examination of the selected hospital patient participant records allowed me to collect data regarding acceptance or refusal of offered legal, mental health or social work, and community resource services. Analysis provided me the opportunity to determine frequency of acceptance for each offered intervention and level of comprehensive intervention. This study involved an analysis of data collected from the record reviews of patient participants who reported a positive response to the universal screening questions in the emergency department during a 6-month period. Through data analysis, I supported or refuted the ability to introduce legal, mental health or social work, and community resources to intimate partner violence survivors in the emergency room.

Although my study was unique, the literature supports examination of secondary data in researching intimate partner violence. Thomas et al. (2010) used a retrospective secondary review of case records of administrative police reports to explore the occurrence of adolescent intimate partner violence and to support routine screening for intimate partner violence in adolescence. Beynon et al. (2012) used frequency calculations for commonly described categories when examining nurse and physician

differences with reasons they do not screen for intimate partner violence. Further analysis by Beynon et al. (2012) included the use of Fisher's exact test to determine statistical significance. Chi-square tests allowed for examination of the variable relationships. Leppakoski & Paavilainen (2013) designed a descriptive, cross-sectional, convenience sample study design for information gathering on intimate partner violence intervention in the emergency room for practice, further research, and education.

To examine relationships between variables past researchers analyzed data by determining statistical significance (Beynon et al., 2012; Villagrana, 2010). Leppakoski & Peavilainen (2013) used two tests to examine the relationship between variables: the chi square test and the Fisher's exact test. After completing univariate, bivariate, and multivariate analyses for sample descriptions, Villagrana (2010) used chi square tests to examine the relationships between variables. Beynon et al. (2012) used Fisher's exact test to determine statistical significance and chi-square tests to examine variable relationships.

For my study, I conducted quantitative analyses from collected data. I used purposeful, convenience sampling to collect the data. The multiple steps for collection and analysis of the data are located and discussed in detail in Chapter 3. Data analysis involved use of SPSS and the chi-square test. The chi-square test was initially attempted to analyze the relationship between variables. However, as levels of intervention were operationalized, as how many offered services were accepted, it was certain that there would be a significant relationship with acceptance of services. As such, the analyses were formed instead in an exploratory manner, in order to determine any associations

between types of services accepted and how many other services were accepted. Chi-square is an appropriate statistical test when the researcher is interested in the relationship between two nominal/discrete variables (Howell, 2016). However, as previously discussed, as levels of intervention were operationalized it was certain there would be a significant relationship with acceptance of resources and interventions. As such, the analyses were instead performed in an exploratory, rather than relationship, manner.

Definitions

Barrier: A factor or variable that interferes with an intended goal (Colagrossi et al., 2010).

Collaboration: The use of planned and coordinated response to addressing an issue such as intimate partner violence (Allen, Larsen, Javdani, & Lehrner, 2012).

Comorbidity: Cooccurring or simultaneous occurring of conditions that may also occur independently (Ghandour, Campbell, & Lloyd, 2015).

Comprehensive: Including all units in order to be complete (Barner & Carney, 2011; Bogeanu, 2012).

Intervention: Brief counseling, education, and referrals to external service providers (Ghandour, Campbell, & Lloyd, 2015).

Intimate partner violence, domestic violence, and relationship violence: Physical and or psychological abusive behaviors by one or both partners in an intimate relationship such as marriage, dating, family, friends, or cohabitation (Chapin et al, 2011).

Micro-, meso-, and macro-levels: The breadth of coverage that occurs at three levels: micro or individual level; meso or organizational level; and, macro or societal and cultural level (Creswell, 2014).

Nonsummativity: The concept that the whole as greater than, but not comprised of, the sum of its parts (Bertalanffy, 1969; Hanson, 1995).

Screening (or, universal screening): The direct, question-specific inquiry of an individual to assess if the individual had experienced current or past relationship violence (Breitbart & Colarossi, 2010).

Secondary data analysis: The use of existing data for analysis that were collected by a previous researcher for another research question or were collected for another reason (Heaton, 2003).

Self-efficacy: The self-confidence and conviction that one can successfully execute a specific behavior or desired outcome (Chapin et al., 2011).

Subsystem: An independent element or component of the larger system (Bertalanffy, 1969).

Survivor: An individual who experiences intimate partner violence with the label of survivor preferred to "victim," as the term *survivor* is considered empowering for the individual (Barner & Carney, 2011).

System: Independent but interconnected elements or components organized in a meaningful way to accomplish an overall goal (Hanson, 1995).

Assumptions

My study involved a number of assumptions. The first assumption was that my sample was representative of the population in the geographic region of the study. Specifically, the traits and characteristics of survivors who accessed health care services at the health care facility under study were similar to survivors accessing services in other health care facilities. The second assumption was that the data in the medical records were accurate. A third assumption was that the quality of the data was consistent across participants. Fourth, I assumed survivors accessing health care services provided truthful responses to questions asked. A final assumption was that the tests used measured what they proposed to measure.

Scope and Delimitations

The research encompassed a range or scope of study and the boundaries or delimitations of the study. The scope of the research study was limited to the electronic hospital records of adult patient participants seen in one adult emergency department during a 6-month period. The archival records or secondary data from this one emergency department was also the scope of the study. Patient participants accessing health care services in the studied emergency department were primarily from the Midwestern region of the United States. Patient participants accessing health care services in this emergency department may differ in characteristics from those accessing services in other emergency departments. Therefore, generalizing the findings to the entire population is not possible.

A delimitation of the study was that the study only included data about patients accessing services at one facility in the Midwest U.S. A second delimitation was the study only included the records of adult patients. Also, for this study I did not look at the quality and effectiveness of the clinical intervention itself. Rather, this study focused on the process of collecting descriptive data from identified patient participants to determine acceptance or refusal of offered services, frequency of acceptance and refusal, the least and most requested resources, determining the level of intervention, and to provide data for future analysis.

Limitations

A number of limitations existed with the study. One limitation was that I examined only the records for one hospital in the Midwest U.S. The characteristics of the population accessing this emergency department may differ from populations in other emergency departments. Therefore, I cannot generalize the findings to the entire population. Replication of this study will be necessary in other emergency department settings to support the validity of this study's findings.

Another limitation was the use of secondary data, which meant using data for a purpose other than originally intended. The originally purpose of the data was for obtaining health histories and providing medical evaluation and treatment in the emergency department. A third limitation was the electronic charting system in Midwest U.S. health care systems was in the process of being updated; therefore, some data was not accessible. A final limitation was I used a nonprobability, or convenience sample, rather than a probability sample. Although researchers prefer a probability sample

because it is more reliable and valid, obtaining such a sample is not always feasible because of the vulnerable population under study, cost, and time constraints (Frankfort-Nachmias & Nachmias, 2008). Cost, time constraints, and participant vulnerability were all factors relevant to my study population of intimate partner violence survivors.

Significance of the Study

Intimate partner violence remains a significant public health and economic concern (Bledsoe & Sar, 2011). Prior researchers studying intimate partner violence screening and intervention focused on barriers, such as insufficient training of staff, staff discomfort with intimate partner violence, lack of resource awareness, partner presence, time constraints, and screening noncompliance (Beynon et al., 2012). Despite research supporting universal screening, it continues to fall short of being systematically adopted (Todahl & Walters, 2011). Medical providers reported needing evidence that domestic violence is prevalent in their specific clinic population before routinely incorporating intimate partner violence screening, identification, and intervention into their professional practices (Sugg, 2006). My study was unique because I focused on the little researched area of introducing legal, mental health or social work, community resources, and providing comprehensive intervention to intimate partner violence survivors while the survivor is in the emergency room.

Significance to Practice

Identifying survivor acceptance or refusal of offered services and intervention may provide direction regarding where to focus resources to improve intimate partner violence screening and intervention. Additionally, such examination may also provide

hospital leaders with evidence-based guidance to work in the hospital system and its management teams to develop policies and practices for service delivery in the emergency department (Bennett, 2012).

Outcomes from this study should help in defining roles to coordinate services for survivors of intimate partner violence, as well as educating providers in health care teams and systems. Efforts at facilitating referrals to law-enforcement personnel and community agencies ensure that the entirety of intimate partner violence survivors' needs are met and supports the urgency to identify intimate partner violence and facilitate multidisciplinary referrals. Despite the increased study of intimate partner violence, previous researchers continued focusing on describing deficits in screening, program planning, process, and policy (Chibber & Krishnan, 2011).

Because intimate partner violence continues to be a public health problem and screening does not occur consistently, interventions may not be timely. The development of policies, practices, and the monitoring of screening and intervention are an ongoing concern. Auditing records where patients reported a positive response to universal screening reveals if notification to mental health, law-enforcement personnel and community agencies occurred and if patient participants accepted the offered services and interventions. Examining findings provided insight into continued enhancement in deficient areas to increase identification of intimate partner violence and referrals for care coordination. My study represents one attempt to fill the knowledge and research gap and to effect social change in the face of health care reform.

Significance to Theory

My study provides information that contributes to existing general systems regarding the functioning and operations of health care systems management of intimate partner violence in the emergency department. General systems theory provides insight to the interrelationships between components or subsystems of the system and the entire system when working in a complex system. By creating change in the subsystems, opportunities may lead to creating positive change to the whole. The lack of research in addressing the comprehensive needs of survivors in the emergency department has resulted in a void in testing the theory. Because of this study's exploration, I generated empirical information that helps inform general systems theory.

Significance to Social Change

Examining emergency department efforts to provide a multidisciplinary approach supports the practice of identifying and addressing intimate partner violence. Ongoing efforts to close the gap in intimate partner violence screening, identification, and intervention may provide direction for subsequent research on the efficacy of interventions (Decker et al., 2012). These research efforts may then contribute to solutions at the individual or micro level, organizational or meso level, and at the societal, cultural or macro levels to address relationship violence (Power et al., 2011). Solutions at the micro-level may then contribute to addressing the comprehensive needs of intimate partner violence survivors on an individual basis in the emergency department. At the meso level, solutions may provide evidence-based, best practice guidelines to addressing the many needs of intimate partner violence survivors in health

care settings by shaping hospital policy and practice. Finally, solutions at the macro level may contribute to decreases in adverse direct and indirect effects of intimate partner violence to society.

Summary and Transition

Despite increased attention to identifying and addressing intimate partner violence, relationship violence remains a public health concern and results in economic costs to society (Heyman et al., 2015). Survivors of relationship violence may present with complex and unmet medical, legal, and mental health needs. Professionals in the justice system, health care, and community agencies attend to the needs of intimate partner violence survivors from their discipline-specific perspective but often work in isolation without understanding the complex and varied needs of intimate partner violence survivors. The purpose of this exploratory study was to examine the presenting factors of intimate partner violence survivors and the possibility of considering a multidisciplinary approach to address intimate partner violence in the emergency department. In Chapter 2, I will discuss the theoretical foundation and the literature review. For Chapter 3, I will provide an outline of the methodology used for the study. In Chapter 4, I will describe the data collection process, analysis of the data, and the study findings. Finally, a discussion of the results in relation to the pertinent literature, the study limitations, and directions for further research in intimate partner violence will comprise Chapter 5.

Chapter 2: Literature Review

Introduction

Intimate partner violence remains a significant public health and economic concern (Bledsoe & Sar, 2011). Prior researchers studying intimate partner violence in health care have used qualitative and quantitative methods (Beynon et al., 2012; Chibber & Krishnan, 2011; Heyman, Smith, & Foran, 2015; McGrath et al., 1997; Ramsden & Bonner, 2002). Qualitative methods were used by prior researchers to identify and explore the barriers to screening and intervention for relationship violence (Beynon et al., 2012; Chappin et al., 2011; McGrath et al., 1997; Ramsden & Bonner, 2002). By comparison, quantitative methods were used by researchers to analyze progress and compliance in those identified barrier areas (Chibber & Krishnan, 2011; Heyman, Smith, & Foran, 2015).

Although a significant amount of research has been conducted in health care settings (Beynon et al., 2012; Chibber & Krishnan, 2011; Heyman, Smith, & Foran, 2015; McGrath et al., 1997; Ramsden & Bonner, 2002), I found no research on examining the viability of offering relationship violence survivors resources and intervention by a variety of disciplines, as well as, research examining survivor acceptance of offered resources by these dissimilar stakeholders. Given this, the purpose of my study was to use a descriptive quantitative approach to explore the possibility of identifying and addressing the differing needs of survivors in the emergency room.

My study utilized a general system theory perspective to guide the process. General systems theory stipulates that a complex system structure relies on the

interrelationship between system components and the whole (Bertalanffy, 1969). By using a general system theory foundation opportunities present to create positive change in the overall system through the subsystems (Bertalanffy, 1969; Hanson, 1995; Luhmann, 2013). For my study, the subsystems or multidisciplinary professionals to address the entirety of survivor needs included law enforcement, social work or mental health, and community outreach.

Multidisciplinary professionals working with survivors of intimate partner violence frequently tend to only focus on addressing the needs of survivors from their particular area of specialization or discipline (Beynon, Gutmanis, Tutty, Wathen, & MacMillan, 2012; Ghandour, Campbell, & Lloyd, 2015). Discipline-specific areas of specialization include the legal, community-based, medical, and immediate crisis needs of survivors (Antle et al., 2012; Tatum & Pence, 2015). When social work or mental health, medical, law enforcement, and community advocacy professionals tend to only focus on their discipline-specific needs in isolation, they may lack an understanding of the importance of addressing the totality of the survivors' needs (Bogeanu, 2012). This oversight in recognizing the contributions of professionals from other disciplines may result in failing to address the multiple and complex needs of intimate partner violence survivors (Bogeanu, 2012; Cox et al., 2010).

In this literature review, I demonstrate the need for ongoing research concerning meeting the totality of survivors' needs in health care settings. There is a vast amount of literature on intimate partner violence (Catalano, 2012). For that reason I found I needed to narrow my focus. I focused my review of the literature review on victims of intimate

partner violence who seek medical services in the emergency department. My rationale was because health care settings such as the emergency room may provide opportunities to begin to identify and address intimate partner violence survivors' needs.

In the first section of this chapter, I describe the search strategy I used when reviewing the literature. In the second section, I present general system theory as the theoretical foundation to offer insight of divergent stakeholders working together to manage the entirety of intimate partner survivors' needs. The third section pertains to prior quantitative studies in the area of relationship violence, and the fourth section concerns prior qualitative studies in the area of relationship violence. In the fifth section of this chapter, I examine intimate partner violence in health care with an emphasis on intimate partner violence in emergency room settings. The sixth section includes identifying and exploring the variables relevant to offering opportunities to address survivor needs in the emergency room, and the feasibility of successfully addressing relationship violence survivor needs in the emergency room. Specific variables include social work or mental health, law enforcement, community outreach resources, and comprehensive intervention. For my study, comprehensive intervention occurs with survivor acceptance of all three offered resources and intervention: social work or mental health, law enforcement, and community outreach.

Literature Search Strategy

The primary databases searched were those in the EBSCOhost research portal at Walden University and the University of Michigan-Dearborn databases of ProQuest, Web of Sciences Arts and Humanities Citation Index, Arts for Digital Library, and Social

Science & Humanities Book Citation Index. Because addressing the entirety of intimate partner violence survivor needs spans a number of professional disciplines, I extended my search into the databases of varied disciplines. The other databases I searched included SocINDEX, PsycARTICLES, Academic Search Premier, Medline, PubMed, ERIC, Google Scholar, LegalTrac, and ProQuest. The search terms or key words I used included *domestic violence*, *relationship violence*, *intimate partner violence*, *survivor*, *hospital, emergency room*, *emergency department*, *health care*, *law enforcement*, *community agencies*, *criminal-justice system*, *advocacy*, *social work*, *hospital social work*, *community partnerships*, *community coalitions*, *coordinated efforts*, and *collaboration.* Because of the abundance of information on intimate partner violence and the multiple venues and contexts for addressing intimate partner violence, the search terms were used independently and in various combinations. Furthermore, because of changes in terminology over time and in response to social and political influences, I included additional search terms. Researchers have used the terms relationship violence, domestic violence, survivor, victim, intimate partner violence interchangeably (Barner & Carney, 2011). Therefore, these terms were all incorporated into my literature searches.

After identifying the general dissertation topic, I began my exploratory search at local libraries and online libraries in 2011. To gain an understanding of the available literature, I did not initially include date parameters and, instead, explored earlier research for comparison purposes and points of reference. In my more recent searches, from 2012 to 2016, I focused on literature from the past 5 years to incorporate the most current and relevant research. I initiated library alerts and continue to be notified of

recent publications and to incorporate current information in my revisions. I used the same subject terms in Walden's EBSCOhost research portal dissertation database, again using the past 5 years for date parameters to incorporate the most current and relevant research . I also implemented specific search strategies (e.g., setting alerts) after consulting with Walden's library staff. For primary sources on general system theory, which I used as a foundation for addressing relationship violence, I accessed the University of Michigan-Dearborn library, which is in my local area.

Theoretical Foundation

General systems theory is one theory that provides a foundation to manage the entirety of survivor needs (Bertalanffy, 1969; Hanson, 1995; Luhmann, 2013). Intimate partner violence survivors may present with myriad needs (Beynon et al., 2012). Specifically, intimate partner violence survivors may present with emergent crises and medical issues in addition to ongoing legal, counseling, community support, and advocacy needs (Antle et al., 2010; Beynon et al., 2012; Futures Without Violence, 2014; Rhodes et al., 2011). The general systems concept allows for varying definitions and the development of subsystem theories tailored to the objectives of the research and the goal of the topic (Bertalanffy, 1969, p. xvii). Therefore, all subsystem theories and applications share principles common to general system theory. The broad scope of the system concept ranges from the process to the mechanics, with process referring to abstract management and mechanics referring to the technological components of computer hardware and automation (Bertalanffy, 1969, p. xx). Bertalanffy (1969) first developed general system theory as a way to explain systems in all areas of sciences,

provide a foundation for research, and demonstrate the interconnectedness between the whole, or entirety, and its component parts.

When applying general system theory to relationship violence, varied disciplines of health care, mental health, law enforcement, and community agencies can address the entirety of intimate partner survivors' needs. Hanson (1995) reinforced a conceptual component of Bertalanffy's (1969) general system theory, particularly the concept of nonsummativity defined as "the whole is greater than the sum of its parts" (p. 4). Application of general system theory addresses the process of managing the entirety of the varied and complex needs of intimate partner violence survivors by acting as relational components. Survivors' needs for relational components of intimate partner violence include crisis, medical, legal, counseling and mental health, community support, and advocacy assistance. I focused on considering a systems approach to addressing these varied but relational needs of intimate partner violence survivors; specifically, to intimate partner violence survivors presenting to the emergency department. Although women and men experience relationship violence, a number of earlier researchers reported women are more often the victims of intimate partner violence (Bogeanu, 2012); therefore, mention of victims or survivors may be referenced in the feminine. Prior researchers support considering the use of a general system approach to address intimate partner violence in health care settings and other issue-related settings.

Beynon et al. (2012) supported previous research work by Antle et al. (2010), Luke et al. (2010), and Saunders and Brown (1997) in using a systems approach to addressing overall health care issues and related concerns. When comparing researchers

findings to studies conducted years earlier, Beynon et al. (2012) reported little change in removing the barriers to screening for intimate partner violence in health-care settings. As a result, Beynon et al. suggested using a collaborative, or multidisciplinary, approach to facilitate change. When studying the efficacy of the mandatory-reporting law requiring social-services notification in incidents of intimate partner violence, Antle et al. (2010) also advocated for a collaborative approach between law enforcement and social services. In contrast, Post et al. (2010) found no effect on reducing intimate partner violence pursuant to nonprofit organizations spearheading the Centers for Disease Control funding of coordinated community efforts. However, in related health care research, Luke et al. (2010) found a systems approach of collaboration effective in promoting tobacco-control efforts in creating smoke-free laws. While occurring earlier, supportive research by Saunders and Brown (1997) demonstrated the use of collaboration to prevent repeated adolescent pregnancies. Although the goal in each of the aforementioned studies differed, the process of achieving research-study goals supported a systems concept.

Luhmann (2013) deconstructed the general system concept into two component parts, providing the opportunity to differentiate the components from the overall process. Specifically, the general systems concept was deconstructed to differentiate the properties, purpose, and boundaries of each component from the interconnectedness of the components. The general systems concept was then further deconstructed from the overall structure of the general system to the events and processes, from its structure. My research study occurred at a University-affiliated emergency department in the Midwest U.S., with the emergency department a subsystem of the overall health care system.

When compared to Luhmann's premise, the survivors' experiences represented the event, the response to survivors' experiences represented the process, and the coordination of the responses to address the intimate partner survivor survivors' needs represented the overall structure. Further analogy can be extrapolated to the emergency room within the overall health system and to the varying medical disciplines within the emergency department with merging objectives towards a common goal. Therefore, Luhmann (2013) supported multidisciplinary collaboration. Collaborative efforts in health care also led to the launch of the *Health Systems Journal* in 2012.

In the editorial for the premier issue of *Health Systems Journal,* Brailsford et al. (2012) cited Bertalanffy (1969) as the founder of general systems theory. In summary, the tenets of general systems included taking a holistic view of the identified health care issue, recognizing the relationships of components taking precedence over the components themselves, the complexity of the subsystems, and how each subsystem's individual purpose differed (Mingers & White, 2010); and when merged nonsummativity occurs (Bertalanffy, 1969). Through my study, I addressed the entirety of intimate partner survivors' needs when those from multiple dissimilar disciplines attend to the survivors' varied needs while the survivor was in the emergency department. By collaborating in the emergency department, members of various disciplines can address their discipline-specific issues with the entirety of issues addressed as part of a larger, overall system.

In contrast, when applying general system theory to managing intimate partner violence, one does not speak to the content or effectiveness of each discipline's intervention. Rather, the theory's application offers insight to using a collaborative

approach to manage the process of attending to the intimate partner violence survivor by addressing the presenting divergent issues of medical care, law enforcement, mental health, and ongoing community support (Antle et al., 2010; Beynon et al., 2012; Futures Without Violence, 2014; Rhodes et al., 2011). One of the many arenas to study intimate partner violence in health care settings is the emergency department.

Relationship Violence in Health Care and the Emergency Department

Intimate partner violence survivors often seek services in health care settings, providing a wealth of opportunities for researchers to conduct studies on relationship violence. Researchers in health care have conducted qualitative and quantitative methodology studies on intimate partner violence. In past qualitative studies on intimate partner violence, researchers largely focused on exploring health care service provider and intimate partner violence survivor beliefs regarding relationship violence and identifying barriers to screening and intervention (Beynon et al., 2012; Chappin et al., 2011; McGrath et al., 1997; Ramsden & Bonner, 2002). Quantitative studies on intimate partner violence frequently pertained to identifying and analyzing factors surrounding the lack of progress in addressing relationship violence (Chibber & Krishnan, 2011; Heyman, Smith, & Foran, 2015). In spite of the diverging focus of qualitative and quantitative methodology studies, both aim to increase knowledge pertinent to relationship violence to respond to the complex needs of the intimate partner violence survivor. Further examination of previous qualitative and quantitative research provides a point of reference to direct future research needs.

Qualitative Research on Intimate Partner Violence

Beynon et al. (2012) analyzed data from 43-item mailed surveys of 931 respondents to identify themes from medical providers' experiences in screening for intimate partner violence. Inductive content analysis of the survey's two open-ended survey questions and frequency calculations identified the top barriers and facilitators for physicians and nurses, when screening for intimate partner violence. Barriers were the reasons why screening for relationship violence did not occur. Facilitators were the reasons why screening for relationship violence did occur. Barriers included lack of time, behaviors attributed to women living with abuse, lack of training, language or cultural practices, lack of resources, and partner presence. Facilitators included self-efficacy, training, community resources and professional tools, protocols, and policies (Chapin et al., 2011). The researchers calculated measures for the identified barrier and facilitator variables. Although the barriers and facilitators identified by nurses and doctors were the same, frequency differences emerged in the Fisher's exact test statistical analysis (Beynon et al., 2012).

For example, physicians cited lack of time as a barrier at a rate of 46.2%; nurses at 27.3%. Key components to lack of time by physicians and nurses included listening to responses, addressing issues, and responding to the emotional needs of a patient. Beynon et al.'s (2012) provided new insight to the complexity of the barriers and the facilitators faced by medical professionals in screening, but the issues from previous studies remained unchanged (McGrath et al., 1997; Ramsden & Bonner, 2002). To address persistent issues and incite change, Beynon et al. (2012) suggested a multifaceted

approach and comprehensive context, again suggesting support for a collaborative approach.

In examining barriers and facilitators to screening for intimate partner violence, Chapin et al. (2011) examined self-efficacy or "the conviction that one can successfully execute the behavior needed to produce a desired outcome" as a predictor and facilitator (p. 20). Specifically, medical providers needed knowledge and confidence in recognizing and assisting intimate partner violence survivors. The researchers analyzed 320 nurse and medical students' pre- and post- surveys on intimate partner violence using a domestic-violence-centered training module. Various themes consistently emerged to define self-efficacy in relationship violence screening to addressing intimate partner violence: knowledge of available services, self-confidence in the ability to screen for intimate partner violence, and understanding of the obstacles affecting a survivor's ability to leave his or her situation. The widespread range of levels of self-efficacy among health care providers supported the need for continuing education to develop and maintain self-efficacy. Chapin et al. (2010) suggested an approach of forming partnerships between hospitals and advocacy groups as means of achieving the goal.

Researchers have conducted additional qualitative research to address the needs of the intimate partner violence survivor by law-enforcement offered resources and intervention. Antle et al. (2010) used a structured interview guide to conduct a qualitative interview of 24 female survivors to evaluate mandatory reporting laws for intimate partner violence survivors in Kentucky. Antle et al. (2010) found survivors generally support mandatory reporting due to a general belief that professionals are responsible for

reporting abuse, as survivors are unlikely to self-identify. These findings differed from earlier findings by Coulter and Chez (1997), who reported survivors only supported mandatory reporting when it pertained to others.

Antle et al. (2010) attributed the divergent findings of Coulter and Chez (1997) to geography, i.e., the state where the latter conducted their study was a state that did not have mandatory reporting. An emerging theme from Antle et al.'s study was the need to consider the survivors' children in decision-making, a component incorporated into the second stage of their study. Consistent themes included that mandatory reporting by medical, social services, and law-enforcement personnel was supported; mandatory reporting held violent partners accountable and supported survivors; and all women with children supported mandatory reporting, stating it was beneficial to their children.

Although research findings by Antle et al., Chapin et al. (2011), and Beynon et al. (2012) differed, variables and perspectives of intimate partner violence aligned in themes or suggestions to take a multidisciplinary approach to managing intimate partner violence survivors' needs. Schmidt (2014) supported earlier findings and identified a consistent move towards adopting a holistic approach for intimate partner violence survivor clinical intervention. An opportune setting for use of holistic or comprehension intervention was identified for the health care system (Garcia-Moreno et al., 2015). As qualitative research studies focused on gaining insight to survivor and provider beliefs, researchers in the quantitative domain focused on analyzing factors contributing to the progress or lack of progress in addressing intimate partner violence.

Quantitative Research on Intimate Partner Violence

Dichter and Rhodes (2011) conducted a quantitative cross-sectional study with 173 adult women who experienced a police response because of intimate partner violence. The focus was to ascertain the interest in, the need for, and the use and benefit of various social services to allocate resources and direct intervention efforts. The various social services included health and economic support services, law enforcement, domestic counseling, community resources, and shelter (Dichter & Rhodes, 2011, p. 483). Outcomes showed that 97.6% of respondents had used medical care with an 87.8% interest endorsement, 89.9% current need, and 76.9% benefit (feeling safe). More than two-thirds of participants (71.4%) showed interest in mental health care with 70.7% reporting a current need (Dichter & Rhodes, 2011). Respondents reported less support for use of stress- and anger-management programs (35.9% and 29.7%, respectively), even though more than half of participants reported the need. Dichter and Rhodes (2011) found consistency among all respondents who had previously used the services and programs. Considering the varied needs of intimate partner violence survivors, conducting continued needs assessments and offering a continuum of services appeared to be of benefit and warranted further examination (Dichter & Rhodes, 2011).

Javdani and Allen (2011) considered the varying needs of survivors by examining the effectiveness of a coordinated-response approach. The authors examined the improvement response, coordination of prevention and intervention services, and education efforts of 21 family violence coordinating councils. Study findings empirically supported previous researchers and suggested promoting relationships among

stakeholders related to community change, survivor safety, batterer accountability, and community education. Through their findings, Javdani & Allen refuted earlier findings that discounted the efficacy of coordinated efforts (Post et al., 2010). Endorsement of the coordinated response suggested support for similar uses of collaborative effort in other settings; specifically, using coordinated responses in settings, such as the emergency department to address intimate partner violence (Javdani & Allen, 2011). Oehme et al. (2016) supported including emergency medical services responders in coordinated efforts to address intimate partner violence because of their early contact with individuals as first responders.

From auditing emergency-room social-work records and conducting quantitative data analysis with staff, Power et al. (2011) examined the influence of a domestic- and family-violence screening program. The surveyed staffs' written comments were themed and are consistent with those made in a later study by Beynon et al. (2012). Specifically, the recurring themes by staff included time constraints, insufficient training, and lack of self-efficacy regarding the issue of intimate partner violence. Quantitative data analysis revealed an increase in referring women to social work or mental health, 36% of the women entering alternative living situations, and comorbidity issues present in 38% of the women. Of the women surveyed, 85% had no prior contact with social workers, implying that without screening, the women would not have come to the attention of social workers. This study supported the importance of screening and supported women's use of services when offered (Porter et al., 2011).Research conducted by Sims et al. (2011) did not affirm the efficacy of screening found by Porter et al. (2011) and Javdani

& Allen (2011). Sims et al. used a pre- and post- retrospective chart review of 645 female trauma patients before and after introduction of educational intimate partner violence programs to residents. Study findings revealed patients were more likely to be screened only for alcohol, drugs, and tobacco use, even after the educational program. Additionally, no statistical difference emerged in screening before or after the educational program. Additional quantitative research focused on comparing law enforcement and health care records (Rhodes et al., 2011).

Rhodes et al. (2011) also conducted research in health care, completing a retrospective longitudinal cohort study by comparing police, prosecutor, and emergency-department records of 993 known abused women. Study outcomes showed 78.4% of women had an emergency-room visit with a medical complaint following abuse complaints documented by the police (Rhodes et al, 2011). Of that group, 72% were never identified as intimate partner violence survivors or subsequently referred for services. Although the study by Rhodes et al. was retrospective, it demonstrated the wealth of information gleaned from crossing disciplines to assess the use of screening and referral as well as affirming the complexity of survivors' issues and needs. In addition, the frequency with which survivors use emergency departments for health care provides a rich opportunity for screening, identification, and intervention (Beynon et al., 2012; Bledsoe & Sar 2011; Colarossi et al., 2010; Power et al., 2011).

My study differed from other studies because I analyzed descriptive statistics of identified variables to consider the feasibility of addressing the comprehensive and complex needs of intimate partner violence survivors in a health care setting and whether

or not comprehensive intervention was facilitated. The variables I used in my study were mental health intervention by social work, legal intervention by law enforcement or hospital security, community outreach services, and comprehensive intervention in the emergency department. Comprehensive intervention occurred as a result of the survivor's acceptance of linkage to all variables; specifically, social work or mental health, community outreach advocacy, and law-enforcement. After considering the variables in the context of historical reference, each variable considered for study warranted further exploration.

Description of Research Variables

Health care settings have been opportune settings for research regarding intimate partner violence. In a precursor to current studies, McGrath et al. (1997) found health care settings as an opportune place to screen for intimate partner violence because of survivor's likelihood of accessing health care. Dichter and Rhodes (2011), 34 years later, supported the earlier findings, reporting that 97.6% of participants used medical care. Historically, much of the research regarding intimate partner violence in health care settings has pertained to the importance of screening, barriers to screening, noncompliance, and the established protocols in health care to rectify deficits (Beynon et al., 2012; Chapin et al., 2011; Thomas et al., 2010). Beynon et al. (2012) found despite these past efforts, intimate partner violence remains a costly public health concern, and recommended considering a multidisciplinary approach. I explored the possibility of addressing the mental health, community resource, and legal needs of intimate partner violence survivors in the emergency department.

Researchers have studied screening for intimate partner violence versus self-identification of intimate partner violence from different perspectives with similar findings to support screening for intimate partner violence. For instance, the majority of survivors in Kentucky self-reported as unlikely to self-identify intimate partner violence and they supported mandatory screening for intimate partner violence (Antle et al., 2010; Tatum & Pence, 2015). Also supporting screening and similar to Antle et al. (2010), adolescent girls in a large metropolitan city were unlikely to voluntarily disclose intimate partner violence to family and friends (Thomas et al., 2010). The studies by Antle et al. and Thomas et al. (2010) built on results of earlier study by Ramsden and Bonner (2002). Later, Beynon et al. (2012) found that survivors are unlikely to disclose unless directly asked, and during a recent review of the literature, (Todahl & Walters, 2011) found survivors supported screening, at rates of 85–98%. Finally, pursuant to practitioner and advocate support of screening in health care settings, a tenet of the Affordable Care Act ensures intimate partner violence screening as a key component of disease prevention and health promotion (Ghandour et al., 2015). To further explore research relationship violence, the study variables for my study consisted of social work or mental health, law enforcement or hospital security, community outreach services, and comprehensive intervention in the emergency department health care setting.

Social Work and Intimate Partner Violence

The majority of health care social workers practice in hospital settings (National Association of Social Workers, 2011); suggesting social work may be increasingly available in the emergency department as a source for data mining. Social work is an

integral component of the multidisciplinary team in addressing intimate partner violence because of the skills and expertise in alignment with social work as a discipline (Chanmugam, 2014). Increased social work presence in health care settings further supports the potential for social workers to address intimate partner violence and participate in collaborative efforts between disciplines. Past collaborative efforts among advocates, victims, law enforcement, court systems, and community agencies led to the establishment of the Violence Against Women Act in 1994 and to reauthorization in 2000, 2005, and 2013 (Violence Against Women Reauthorization Act, 2013, para. 1). Additional contributions of social work skills and expertise constitute training and experience in interdisciplinary collaboration; community liaisons; mental health training; and insight to micro-, meso-, and macro- factors (Chanmugam, 2014).

Prior researchers supported the benefit to social work or mental health involvement after finding survivors frequently present with multiple unmet long-term socio-emotional needs (Dichter & Rhodes, 2011). Intimate partner violence survivors often had medical and psychological issues occurring secondary to experiencing intimate partner violence (Campbell & Lewandowski, 2011). Psychological effects included depression and anxiety (Campbell & Lewandowski, 2011).

Because of the majority of social workers practicing in hospital settings (National Association of Social Workers, 2011), opportunities are emerging for social workers to participate in addressing intimate partner violence in health care settings. Court officials support social workers' recommendations 90% of the time (Villagrana, 2010), lending credibility to the value of the contribution of social workers and collaboration with law

enforcement. For my study, I examined social work or mental health involvement as one of the variables in analyzing collected data.

Law Enforcement and Intimate Partner Violence

Emergency departments are unique organizations in the health care system, consisting of multidisciplinary teams with competing goals (Williams & Haizlip, 2013). Law enforcement is one of many entities responding to the intimate partner survivor in the emergency department. Of intimate partner violence survivor participants, 75% were generally supportive of mandatory reporting and arrest laws (Antle et al., 2010; Tatum & Pence, 2015; Villagrana, 2010). Additionally, 50% of study participants stated mandatory reporting led to taking steps to change their lives, and 54% reported it resulted in taking steps of self-protection (Antle et al., 2010). Support to address intimate partner violence interventions across the life span were further supported by studies with adolescents. In 2010, Thomas et al. conducted frequency distribution and cross-tabulations of 8 months of computer statistical data to estimate the frequency of intimate partner violence brought to the attention of law enforcement. Findings supported addressing intimate partner violence as soon as adolescence, earlier than previously thought. For my study, I examined law enforcement involvement as one of the variables in analyzing the collected data.

Community Response and Intimate Partner Violence

Villagrana (2010) found an increased use of services by intimate partner violence survivors, measured by the use of services after referrals. The increased use of services by intimate partner violence survivors speaks to the need for community resources and

services. Intimate partner violence survivor acceptance and use of available resources and services was successful when court officials and mental health services used a collaborative approach. Specifically, in a large and ethnically diverse county in California, when social workers recommended referring survivors to community services in court cases, it led to increased use of services by 50% (Villagrana, 2010). Community response to intimate partner violence includes providing information on available resources, bridging to community-based agencies for ongoing supportive services, and working collaboratively to address intimate partner violence in the emergency department. For my study, I used community response and outreach as one of the variables.

Comprehensive Intervention

A historical review completed by Barner and Carney (2011) supported the changing trend toward a collaborative and comprehensive approach between disciplines in various settings. Barner and Carney found that since the 1970s, community-based agencies have shifted away from working in isolation in the community and toward increased collaboration between advocacy groups and coordinated community responses. Study outcomes also revealed a high overlap among female adolescent intimate partner violence survivors, health care use, and law enforcement (Thomas et al., 2010), all of which support multidisciplinary collaboration in addressing intimate partner violence. Additional support for comprehensive intervention is recommended in health care and therapeutic care. Garcia-Moreno et al. (2015) found support for comprehensive intervention in health systems, and Schmidt (2014) supported comprehensive and holistic

support in clinical intervention. Therefore, taking this practice into the emergency room setting is a logical progression. For my study, I defined successful facilitation of interdisciplinary efforts as involving social work or mental health, law enforcement, community agencies, and comprehensive intervention with intimate partner violence survivors in the emergency department. Lacking involvement of law enforcement, social work or mental health, community agencies, and comprehensive intervention represents unsuccessful facilitation of linking patients to social work or mental health, community agencies, law enforcement, and comprehensive intervention while intimate partner violence survivors are in the emergency department. The identified variables of the study and the research question provided direction for determining the selection of the type of design or method, data collection, and analysis.

Review of Methods

Study methods have advantages and disadvantages, with the researcher selecting the type of design, data collection, and analysis best suited to the study (Creswell, 2008). One study method is the use of secondary data. Secondary-data analysis allows for the researcher to specifically and consistently collect and analyze data from archival records (Frankfort-Nachmias & Nachmias, 2008). Social scientists have shown an increased use of secondary data analysis and attribute this increase to a few reasons. For example, when compared to primary data, secondary data has the advantage of lower cost and it is less time prohibitive, thereby offering the opportunity for comparison and longitudinal research. Secondary data allows researchers to sift through a large database, and is often

preferred when studying sensitive content (Frankfort-Nachmias & Nachmias, 2008). Each study method also has disadvantages.

There are a number of disadvantages to use of secondary or archival data. One disadvantage is that the data collected is specific to the primary data-collection purpose (Frankfort-Nachmias & Nachmias, 2008). In other words, the data in the study is used for a different reason than the reason it was originally collected. In my study the data was originally collected for health care purposes yet I was utilizing the data to study intimate partner violence. A second disadvantage was difficulty with data access. Third, I did not determine the method for data collection. Specifically, the data was collected in a format designed to collect medical health histories. Despite the identified disadvantages of using secondary data, the advantages supersede them. I determined the use of secondary data was best for this research because I was working with a vulnerable population, it was cost-effective, and because I could collect a considerable amount of data in a relatively short period of time. Researchers have used a number of tests to analyze descriptive data when using secondary data or archival data for research purposes. A quantitative design and secondary data analysis were best suited for this study. In addition, I followed a descriptive quantitative design and secondary data analyses with chi-square tests to test statistical significance of the data.

Summary and Conclusions

A collaborative or multidisciplinary approach to addressing intimate partner violence in the emergency room setting is supported in the research by the evolution of a collaborative approach in other settings and by the providers in those settings. The

women's movement of the 1970s led to increased attention devoted to intimate partner violence, increased study of intimate partner violence, and the establishment of a database cataloging the research (Murphy & Ouimet, 2008). Qualitative and quantitative researchers have studied intimate partner violence and because of survivors' likelihood of seeking health care services, the majority of qualitative and quantitative research has occurred in health care settings. Researchers in medical settings have predominately focused on provider and survivor beliefs and experiences and on the lack of progress in addressing the complex needs of intimate partner violence survivors. I have provided an overview of past studies related to intimate partner violence and variables pertinent to addressing intimate partner violence in health care settings. Specific variables explored for use in this study included social work or mental health, law enforcement, community outreach and advocacy services, and comprehensive intervention. My study differed from prior studies by considering the possibility of coordinating and collaborating with mental health or social work, community agencies and law enforcement in the emergency room to address the comprehensive and complex needs of the intimate partner violence survivor.

I also reviewed and discussed the theoretical foundation for the study, general systems theory. The theoretical foundation avers multiple disciplines should work collaboratively in the emergency department to comprehensively meet the complex needs of intimate partner violence survivors. The next chapter, Chapter 3, provides a detailed outline of the methodology for the study.

Chapter 3: Research Method

Introduction

The primary purpose of my study was to explore the feasibility of identifying and attending to the entire survivor's need through the initiation of mental health, legal, ongoing community services, and providing comprehensive intervention while the survivor was in the emergency room. I explored the feasibility of providing services by determining to what extent survivors accepted intervention and resources. I used general system theory (Bertalanffy, 1969; Hanson, 1995; Luhmann, 2013) as my theoretical foundation for studying the interrelationship between various stakeholders and meeting intimate partner violence survivor needs within the larger system of a hospital. A quantitative approach, which allowed for statistical analysis of descriptive data, was used for my study. The following research questions were planned for the study and analyses:

RQ1. What proportion of intimate partner violence survivors avail themselves of legal, mental health or social work, community outreach resources, and intervention when they were offered in health care settings such as the emergency department?

RQ2. What was the level of a comprehensive intervention for intimate partner violence in health care settings such as the emergency department?

RQ3. What is the relationship between the level of a comprehensive intervention for intimate partner violence and the level at which intimate partner violence survivors accept legal, mental health or social work, and community outreach resources in health care settings?

However, after conducting three chi-squares to analyze the relationship between levels of intervention and service acceptance I found I needed to change the focus of my third research question. As the levels of intervention were operationalized as to how many offered services were accepted, I was certain a significant relationship existed with the acceptance of services. Therefore, the analyses were instead performed in an exploratory rather than relationship manner. I used a descriptive exploratory quantitative method to examine patient participants' use of offered services and the occurrence of providing comprehensive support services from mental health or social work, law enforcement, and community outreach.

In this chapter, I describe the variables explored in the study as well as the study method and research design. The chapter includes a description of my study population and sample as well as my analyses of the data. The chapter concludes with a discussion of potential threats to validity and ethical procedures.

Research Design and Rationale

I used a quantitative methodological design in this study. Because my goal was to examine statistically significant effects of quantifiable (i.e., numerically measurable) concepts, I determined that this was the most appropriate method. The focus of this research was to explore the feasibility of identifying and attending to all of the survivor's needs through the initiation of mental health or social work, legal, ongoing community services, and comprehensive intervention while the individual was still in the emergency room. I measured these concepts by operationalizing the measures of interest, or variables.

Methodology

The purpose of this descriptive, exploratory, nonexperimental, quantitative study was to determine to what extent intimate partner violence survivors availed themselves of offered resources and interventions in health care settings. The research design for this study was a descriptive exploratory design. Tukey developed exploratory statistics (as cited in Howell, 2016). Use of exploratory data provides researchers opportunities to emphasizes the importance of exploring social phenomenon by "paying close attention to the data and examining the data in detail before invoking more technically involved procedures" (Howell, 2016, p. 5). This form of data analysis involves use of descriptive statistics and graphical forms to analyze data. This was the appropriate design for this study, because the purpose of my study was to analyze descriptive data and determine the proportion of service acceptance, both of which can readily be presented in graphical forms. Assessing service acceptance and levels of intervention provided in an emergency department may help determine the feasibility of offering services to relationship violence survivors in the emergency department.

Secondary-data analysis allows for the researcher to specifically and consistently collect and analyze data from archival records (Frankfort-Nachmias & Nachmias, 2008). The use of a quantitative method for this study using secondary data had advantages and disadvantages. Advantages to using secondary data include cost effectiveness, time-saving, data quality, data size, and data accessibility because of the ability to access substantial data in a relatively short period of time (Grinnell & Unrau, 2005; Heaton, 2003; Vartanian, 2011). In the Midwest U.S. health care facility where I collected the

data I collected it from electronically recorded emergency department medical records. Therefore, an abundance of data was readily accessible and collected in a relatively short period of time which supports cost effectiveness and time saving. Data quality is another advantage of using secondary data. The data quality from reputable organizations is considered high (Vartanian, 2011). For the study, I collected data from a fully accredited Level 1 trauma center in the Midwestern United States to meet the standard of collecting quality data. Alternately, data is deemed of high quality if it represents the constructs to which it refers (Woodall, Oberhofer, & Borek, 2014). For the study, I collected data verbatim from information collected for medical health histories. Finally, using secondary data is an easier and less obtrusive way of collecting data from a vulnerable population (Connelly, 2008). These advantages generally outweigh the disadvantages.

Some disadvantages of using secondary or archival data for research include the data-collection mechanism and development of the research questions (Grinnell & Unrau, 2005; Heaton, 2003; Vartanian, 2011). Information already collected for a different reason does not provide researchers the looked-for data, placing the researcher in the position of designing a method of extracting desired data (Grinnell & Unrau, 2005; Heaton, 2003; Vartanian, 2011). Medical record or chart information in the emergency department is not collected for the purpose of research. Health care professionals collect emergency-room chart information for health care purposes; however, I used these data to examine variables that I hypothesized were related to relationship violence.

Furthermore, because I extracted historical data from already collected health histories I was not able to ask patient participants desired questions. Despite this, the

advantages to using secondary or archival data significantly outweighed the disadvantages and the advantages supported the method of inquiry in this study. To further determine the preferred method of inquiry for this study, I also considered the validity and reliability of data.

Use of secondary data provides the opportunity for unobtrusive data collection and avoids data contamination and researcher bias. Unobtrusive data collection removes the researcher from the population being researched, leaving the researcher unable to influence the conditions of data collection (Frankfort-Nachmias & Nachmias, 2008). Controlling for data contamination and researcher bias strengthens validity and reliability. To further strengthen validity and reliability, I implemented some additional strategies.

Additional strategies to strengthen validity and reliability in my study included an audit trail and peer review. Patton (2014) reported that no study can be totally free of researcher influence and bias. However, researchers can take steps to minimize bias through audit trails, acknowledging their own bias, and taking steps to control for accuracy and bias (Patton, 2014). An audit trail ensures accuracy of the data and supports objectivity.

I obtained data directly and verbatim from patient charts. This process decreased bias and ensured accuracy. To further ensure a reliable audit trail, I kept notes throughout the process for consistency and accuracy. I also used peer review to establish reliability and validity. For my study, I consulted with peers throughout the process regarding the study design, data collection, and data interpretation to ensure validity and reliability and

to decrease researcher bias. By controlling for these factors, study findings should be able to be utilized to provide a comprehensive response for intimate partner violence survivors in health care settings such as the emergency room. The data analysis instrument used was SPSS (Green & Salkin, 2011).

Data Collection

Through quantitative analysis of secondary data collected from identified patient medical records over a 6-month period, I collected descriptive data for analysis, as supported in research (Frankfort-Nachmias & Nachmias et al., 2008). The identified patient medical records were selected using convenience sampling. In purposeful sampling, documents were selected that were pertinent to the study. Specifically, the sample included patient participants reporting a positive response to screening questions for relationship violence. For the study, the findings were grouped by variables of social work or mental health, law enforcement, community outreach, and comprehensive intervention. These variables were dichotomous, with either a yes or no response for each variable. For example, a participant either responded “yes” that they had received social work or mental health, while also responding “no” they did not receive community outreach.

The collection and analysis of the data consisted of multiple steps. First, I identified the patients who registered a positive response to screening for relationship violence. Second, I examined the medical records of the identified patient participants for data collection and analysis. Third, I de-identified all medical records. Fourth, data analysis allowed me to answer the research questions. This collected data were

categorized into dichotomous variables (i.e., either the acceptance or refusal of services) and comprehensive linkage to services.

Intimate partner violence involves working with a vulnerable population. Using secondary data is a less obtrusive way of collecting data from a vulnerable population (Connelly, 2008). The advantages to this type of study design and methodology are additional reasons for selecting the design and method. Six months of data provided a rich data source, a particular advantage of using archival data (Grinnell & Unrau, 2005). The consistency and quality of the data was also an advantage of using secondary data from a reputable institution. In collecting data from obtained health histories, I expected the data to be consistent. The quality of data was high because I collected data from a fully accredited Level 1 trauma center in the Midwest U.S., a reputable organization (Vartanian, 2011).

Several limitations could occur during the data collection process. Social workers may have patient contacts for abuse or violence through referral, case-finding, patient request, or during intervention for an unrelated issue. When social workers see a patient for abuse or violence the patient may or may not have agreed to a brief intervention or education. The patient may or may not have agreed to intervention available to the emergency room 24 hours a day by community outreach advocates. The patient may or may not have had contact with law enforcement while in the emergency department. Finally, the patient may or may not remain in the emergency department until their medical examination and treatment are complete. By examining the identified medical

records, I collected data to determine whether or not each of these contacts was made or the interventions occurred.

I selected a convenience sampling method because it is unobtrusive, easily collected, cost effective, and allows gathering a great amount of data (Connelly, 2008; Grinnell & Unrau, 2005; Heaton, 2003; Vartanian, 2011).To determine the minimum number of participants needed for this study, I conducted a power analysis using the power calculator G*Power (Faul, Erdfelder, Buchner, & Lang, 2014).The power analysis was conducted based on a chi-square analysis with a medium effect size of 0.60, an alpha level of 0.05, a standard power level of 0.80, and an allocation ratio of 1. Through use of the power analysis I determined a minimum of 94 participants was needed to ensure statistical validity for my study.

Archival Data

I elected to use archival data because the advantages outweighed the disadvantages. The advantages included cost effectiveness, time-saving, data quality and size, and data accessibility (Grinnell & Unrau, 2005; Heaton, 2003; Vartanian, 2011). Emergency-room data were readily available electronically, supported cost effectiveness and time saving (Heaton, 2003). Finally, the primary reason I selected secondary data is because of the vulnerability of the population studied, survivors of relationship violence. Use of archival data is a less obtrusive way of collecting data from a vulnerable population (Connelly, 2008).

Data Analysis

I entered data into SPSS for all analyses (Green & Salkin, 2011). First, descriptive statistics were performed. I calculated means and standard deviations for continuous data, and calculated frequencies and percentages for categorical data (Howell, 2016). Descriptive data were analyzed to answer the first two research questions.

RQ1. What proportion of intimate partner violence survivors avail themselves of legal, mental health or social work, community outreach resources, and intervention when they were offered in health care settings such as the emergency department?

RQ2. What was the level of a comprehensive intervention for intimate partner violence in health care settings such as the emergency department?

I answered research questions 1 and 2 using exploratory (descriptive) statistics. Exploratory data analysis involves use of descriptive statistics to analyze data. Descriptive statistics included frequencies, percentages, means, and standard deviations. Frequencies and percentages were calculated for categorical or nominal data. Frequency is the count or number of participants who fall into a particular category; it is also useful to know the percentage of the sample that falls into that category. Means and standard deviations were calculated for interval/ratio data. The arithmetic mean is defined as the sum of scores divided by the number of scores. Standard deviation measures statistical dispersion, or the spread of values in a data set. If the data points are all close to the mean, then the standard deviation is close to zero.

I planned to utilize chi-square analysis to answer RQ3 to determine relationships and to test the null hypothesis.

RQ3. What is the relationship between the level of a comprehensive intervention for intimate partner violence and the level at which intimate partner violence survivors accept legal, mental health or social work, and community outreach resources in health care settings?

I intended to answer research Question 3 using a chi-square test to determine the relationship between variables. Chi-square is the appropriate statistical test when the researcher is interested in the relationship between two nominal/discrete variables. My null and alternate hypotheses were:

*H*01. There is no relationship between the level of a comprehensive intervention for intimate partner violence and the level at which intimate partner violence survivors accepted legal, mental health or social work, and community outreach resources in health care settings.

*H*11. There is a significant relationship between the level of a comprehensive intervention for intimate partner violence and the level at which intimate partner violence survivors accept legal, mental health or social work, and community outreach resources in health care settings.

However, when levels of intervention were operationalized as to how many offered services were accepted, I was certain that there would be a significant relationship. As such, the analyses were instead performed in an exploratory manner to determine associations between types of services accepted and how many other services

were accepted. For the chi-square analysis, row and column percentages are interpreted for each variable. To determine significance of the results, I compared the chi-square coefficient (χ^2) and the critical value coefficient; when the calculated value is larger than the critical value, given the degrees of freedom and an alpha of 0.05, this suggests a significant relationship (Howell, 2013). In this event, the null hypothesis is rejected and the alternative hypothesis is supported. The degrees of freedom for a chi-square are determined by the follow equation: (r - 1) x (c - l), where r equals the number of rows and c equals the number of columns (Howell, 2016).

Prior to analysis, I assessed the assumptions of chi-square. For chi-square to operate properly, data must come from random samples of multinomial mutually exclusive distribution, and the expected frequencies should not be too small. Traditional caution in chi-square examination is that expected frequencies below five should not compose more than 20% of the cells, and no cell should have an expected frequency of less than 1 (Pagano, 2009). Observations should be independent of one another; participants can only contribute one observation to the data (the row and column totals should be equal to the number of participants; Howell, 2013).

Threats to Validity

No study can be totally free of researcher influence and bias (Patton, 2014). In the study, I obtained data directly from patient charts, verbatim. Doing so decreased bias and ensured accuracy. I implemented additional strategies and took steps to strengthen validity and reliability. Controlling for data contamination and researcher bias helps strengthen validity and reliability (Frankfort-Nachmias & Nachmias, 2008). Secondary

data provides the opportunity for unobtrusive data collection and decreases data contamination and researcher bias by removing the researcher from the researched population. When the researcher is removed from the data collection, the researcher is unable to influence the conditions of data collection (Frankfort-Nachmias & Nachmias, 2008).

Strategies to further strengthen validity and reliability and reduce bias included member checks, an audit trail, and peer review. Peer review and member checks established reliability and validity. The hospital where I collected data required a principal investigator, particularly a physician in the emergency department supervise the research study and data collection. I consulted the assigned principal investigator throughout the process of the study design, data collection, and data interpretation to ensure validity and reliability and to decrease researcher bias. My relationship with the study, assumptions, and theoretical orientation were evaluated throughout the research by consultation with the principal investigator. A documented audit trail included detailed notes throughout the data collection, analysis, and interpretation. By controlling for these factors, I was able to apply study findings toward providing a comprehensive response for intimate partner violence survivors in emergency room settings.

Issues of Trustworthiness: Ethical Measures

The ethical procedures for this study included seeking Institutional Review Board (IRB) approval before beginning data collection. I obtained IRB approval from the Midwestern U.S. hospital where data collection occurred and through Walden University's IRB. I secured IRB approval by obtaining a data agreement between the

Hospital and Walden. I ensured confidentiality by removing all identifying information for intimate partner violence survivors, protecting data in several ways. First, I stored raw data in a locked file cabinet. Second, I recorded the data on a password-protected computer with a password known only to me. Finally, I adhered to the ethical standards of research and evaluation of the Hospital where I collected the data and that of the professional organizations to which I belong. My identified professional organizations are the National Association of Social Workers and the Michigan Association of School Social Workers.

Summary of Design and Methodology

In this quantitative descriptive exploratory study, I used secondary data to examine data from a number of variables to consider acceptance or refusal of services and intervention and successful or unsuccessful comprehension of intervention for intimate partner violence survivors in the emergency department. Successful comprehensive intervention is achieved if the survivor accepted brief social work or mental health intervention, and was linked to law enforcement and to community advocates for outreach services while in the emergency department. The variables I examined were social work or mental health, legal involvement, community outreach services, individually and to comprehensive intervention. I used descriptive statistics and chi-square analyses to assess the research questions related to these variables. The following chapter includes the results of the analyses.

Chapter 4: Results

Introduction

The purpose of this descriptive, exploratory, quantitative study was to explore the possibility of offering services and intervention to intimate partner violence survivors in health care settings such as emergency rooms. To explore this possibility, I examined survivor acceptance of offered services and intervention in a Midwest U.S. emergency room. Unearthing opportunities to address the numerous and varied needs of individuals who experience intimate partner violence may lead to ensuring the entirety of survivors needs are identified and met. Additionally, survivors' needs may begin to identify and offer services and intervention sooner. Past researchers on intimate partner violence in medical-care settings focused on identifying and exploring ways of eliminating barriers to relationship violence and assessing compliance in screening, program planning, process, and policy (Beynon et al., 2012; Chibber & Krishnan, 2011). My study differed from prior studies by exploring the possibility of dissimilar stakeholders addressing intimate partner violence survivor needs in the emergency department. The stakeholders I identified in my study included law enforcement, social work or mental health, and community outreach workers. For my study, I asked three research questions:

> RQ1. What proportion of intimate partner violence survivors avail themselves of legal, mental health or social work, community outreach resources, and intervention when they were offered in health care settings such as the emergency department?

RQ2. What was the level of a comprehensive intervention for intimate partner violence in health care settings such as the emergency department?

RQ3. What is the relationship between the level of a comprehensive intervention for intimate partner violence and the level at which intimate partner violence survivors accept legal, mental health or social work, and community outreach resources in health care settings?

In this chapter, I present the study results. First, I will describe the data collection process. Next, I will describe the sample. Then I present my study's demographic characteristics and analysis results.

Data Collection

For this study I collected archival data from a Midwestern U.S. Level 1 trauma center's emergency department electronic medical records from June 1, 2013 through December 31, 2013. Throughout the data collection stage, I had ongoing and frequent communications with the hospital assigned principal investigator, an emergency department physician and faculty member. I took a couple of steps to obtain the sample population. First, after receiving all necessary permissions through hospital IRB approval, I obtained the medical record numbers of the patients who registered a positive response to standard universal screening questions.

The Affordable Care Act and Prevention Services Task Force hold health care facilities accountable for screening and intervention, but leaves implementation up to health care organizations (Ghandour et al., 2015). To meet accountability expectations, patients in this health care facility in the Midwest U.S. are asked universal screening

questions by medical staff during their emergency room visit. Obtaining responses to the universal screening questions generally occurs during a patient's medical triage when she first presents to the emergency department. However, occasions exist when the universal screening questions may not be asked or may be asked later in the visit. Reasons why patients may not be screened include lack of privacy, family or friend presence, the patient's age, and staff inability to screen due to the patient's medical or psychiatric condition. The universal screening questions asked at this Midwestern U.S. health care facility consist of,

Are you afraid of anyone close to you?

Have you ever been physically hurt by your partner or someone close to you?

Has anyone forced you to have sexual activities?

Do you have any current or recent thoughts of self-harm?

Have you made recent attempt(s) to harm yourself?

Do you have current or recent thoughts of harming yourself?

Between the targeted timeframe of June 1, 2013 through December 31, 2013, 341 emergency department patients screened positive to standard universal screening questions.

The second step to the data collection process was to eliminate the patient records where the positive response(s) to the universal screening questions did not pertain to intimate partner violence. Of the 341 emergency department patients who screened a positive response to this health care facilities universal screening questions, I eliminated 220 medical records for various reasons. Of the 220 records that I eliminated, 26 patients

had screened positive due to staff error, two patients left before examination, 85 patients were minors, 18 patients were involved in physical altercations, 28 patients were intoxicated, 46 patients were psychiatric patients, and two patients presented with mental status changes. An additional 13 medical records were eliminated because the hospital restricts access to medical records of deceased patients. After I eliminated the patient records where the positive response to the universal screening questions did not pertain to intimate partner violence, a sample population of 121 remained.

The sample population was drawn from one site in the Midwestern United States during a limited time frame (June 1, 2013 through December 31, 2013). Therefore, the sample is not proportioned well to the entire population. Because the characteristics of the population accessing this emergency department may differ from populations in other emergency departments, the sample may not be an accurate representation of the population of interest of intimate partner violence survivors. Therefore the findings may not be generalized. In Chapter 3, I provided detailed information on this sample's limitation, which I will review again in Chapter 5.

Demographic Characteristics

The final population sample consisted of 121 emergency department medical records for patients who screened positive for intimate partner violence at a fully accredited Level 1 trauma center in the Midwest U.S. The data was collected from archival medical records between June 1, 2013 and December 31, 2013. Figure 1 presents the number of patient participants that screened positive for intimate partner violence by age group. Out of the 121 patient participants, 40 (33.1%) patient participants were

between 21-30 years old, 35 (28.9%) patient participants were between 31-40 years old, 18 (14.9%) patient participants were between 41-50 years old, 17 (14%) patient participants were between 51-60 years old, and nine (7.4%) patient participants were 61-70 years old. One patient participant (0.8%) was 76 years old, and the remaining patient participant (0.8%) was 90 years old. The youngest patient participant was 21 years old, the oldest patient participant was 90 years old, and the average age of patient participants was 38.64 (*SD* = 14.64).

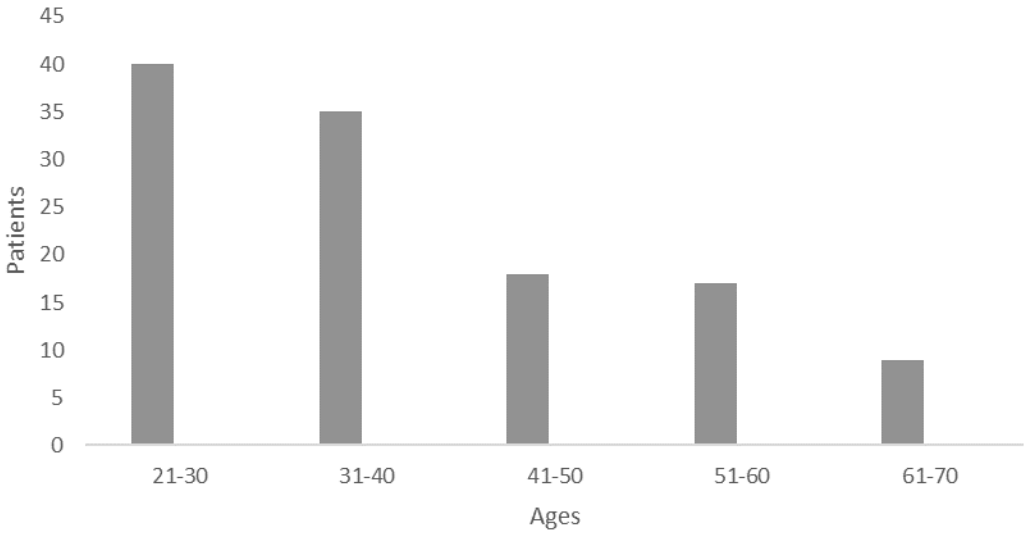

Figure 1. Participants by age.

Figure 2 presents a monthly breakdown of patient participants who screened positive for intimate partner violence by month. Of the 121 patient participants who screened positive for intimate partner violence the monthly breakdown consisted of 14 (11.6%) patient participants in June, 21 (17.4%) patient participants in July, 22 (18.2%) patient participants in August, six (5%) patient participants in September, nine (7.4%)

patient participants in October, 37 (30.6%) patient participants in November, and 12 (9.9%) patient participants in December.

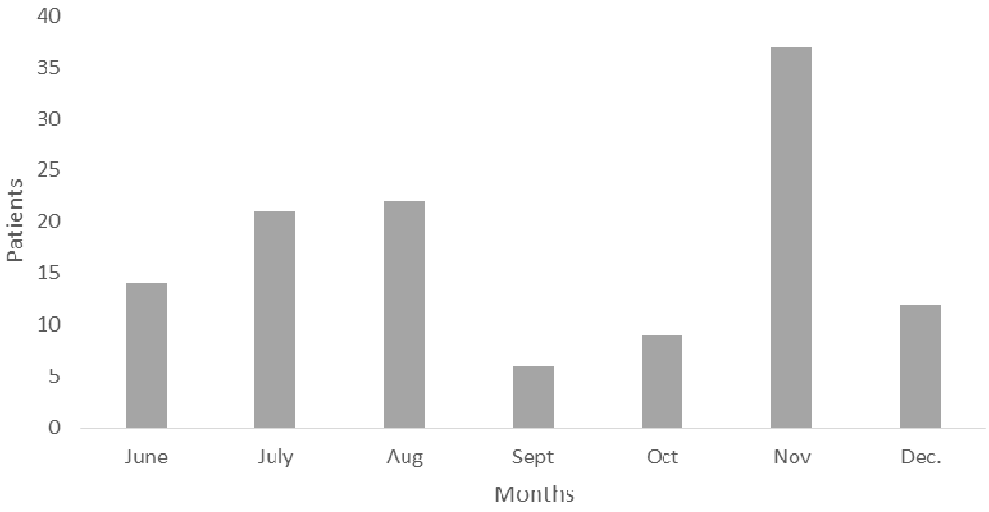

Figure 2. Participants by month.

Results

My first objective was to discover the proportion of intimate partner violence survivors who availed themselves of offered social work or mental health, community outreach, and law enforcement resources while in the emergency department. My second objective was to discover the level, or comprehensiveness, of services provided to intimate partner survivors while in the emergency department. For this study I defined comprehensive intervention as the acceptance of all of the three offered resources and interventions. The three offered resources were social work or mental health, law enforcement, and community outreach. To achieve this objective, I collected and analyzed data to answer the following three research questions.

Research Question 1

What proportion of intimate partner violence survivors avail themselves of legal, social work or mental health, and community outreach resources when they are offered in health care settings such as the emergency department?

Figure 3 presents the proportion of patient participants who accepted none, some, or all of the offered services. Of the 121 patient participants offered legal, mental health, and community outreach resources and intervention as a result of experiencing intimate partner violence, 64 (53%) patient participants accepted all three offered services, 42 (35%) accepted some offered services, and 15 (12%) of the patient participants declined all (accepted none) of the offered services. Each patient who accepted all offered services when they visited the emergency room indicated they were seeking treatment for intimate partner violence or sexual assault with relationship violence (i.e., it was the chief complaint or reason for their visit that day).

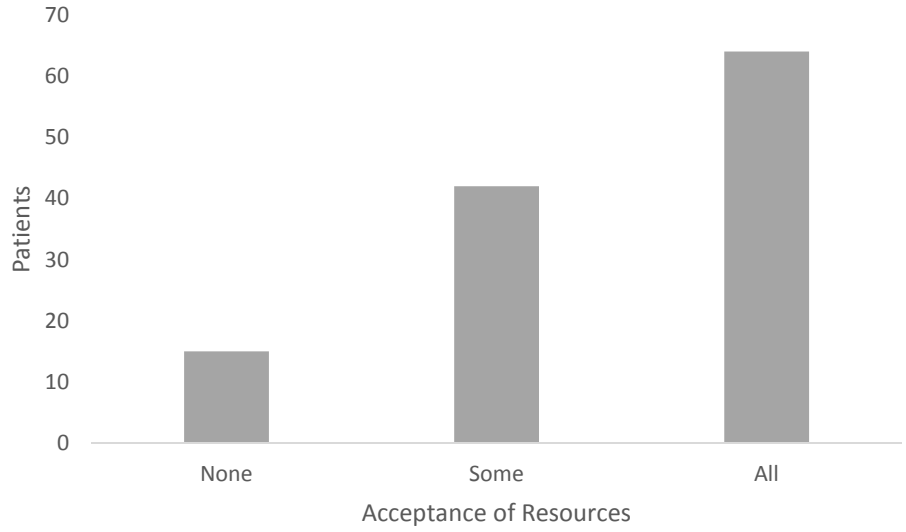

Figure 3. Participants' acceptance of resources.

Figure 4 presents the reasons patient participants provided when they declined resources and intervention. There were 51 (42.1%) patient participants who declined one or more offered services. When patient participants declined any of the offered resources, they were asked to share their reasons for declining. Of the patient participants declining services, 43 (35.5%) patient participants declined offered services because they had experienced intimate partner in the past and it was not a current complaint, one of which also cited that they were on probation. One (0.8%) patient participant stated their abuser was also a "friend" and they did not want to jeopardize the friendship, two (1.7%) patient participants reported the abuse they experienced was "verbal only", three (2.5%) patient participants left the emergency department before all services could be offered, one (0.8%) patient participant was not offered services, and one (0.8%) patient participant changed their story.

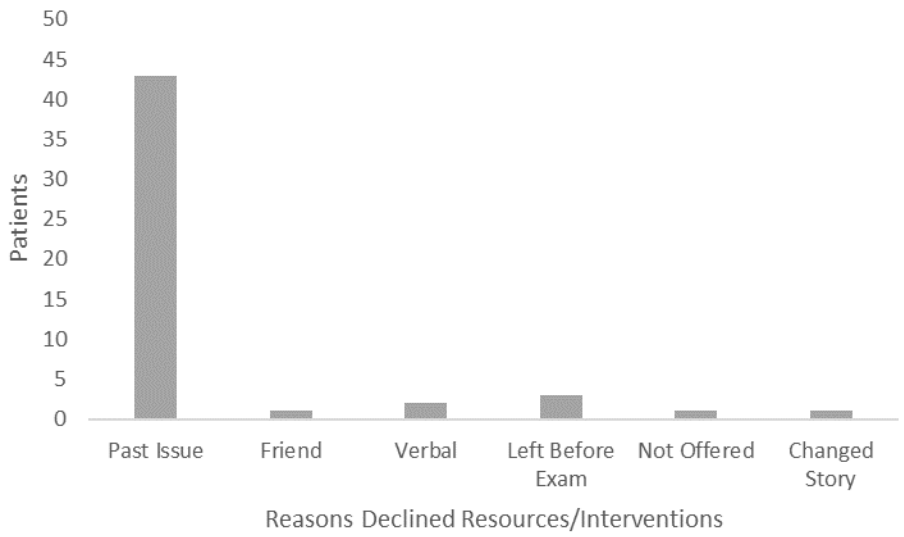

Figure 4. Reasons resources were declined.

Research Question 2

What was the level of a comprehensive intervention provided for intimate partner violence survivors in health care settings such as the emergency department?

Comprehensive intervention was defined as the acceptance of all three offered resources or intervention. Specifically, comprehensive intervention is met when the patient accepted legal, mental health, and community outreach resources. Of those patient participants who accepted at least one service, a majority of patient participants received comprehensive intervention (n = 64, 53%), while 57 (47.1%) patient participants did not receive comprehensive resources. There were 15 (12.4%) patient participants who did not receive any of the three offered services.

Figure 5 presents the proportion of patient participants who accepted and declined mental health, law enforcement, and community outreach resources respectively. Mental health or social work intervention was the most commonly accepted service: 104 (86.0%)

patient participants accepted this offer, and 17 (14.0%) patient participants did not accept this offer. Legal services and community outreach services were accepted at almost equal rates. There were 74 (61.2%) patient participants who accepted legal services, while 47 (38.8%) patient participants did not. Similarly, 76 (62.8%) patient participants accepted community outreach services, while 45 (37.2%) patient participants did not.

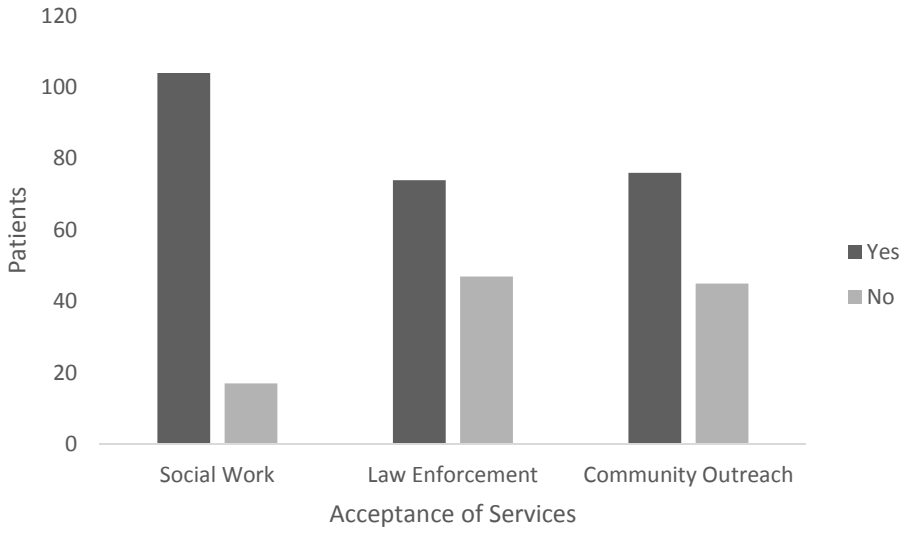

Figure 5. Acceptance of specific services.

Figure 6 presents the level of services provided. Of those patient participants who received services, 22 (20.8%) patient participants received at least one service, 20 (18.9%) patient participants received two services and 64 (60.4%) patient participants accepted comprehensive intervention.

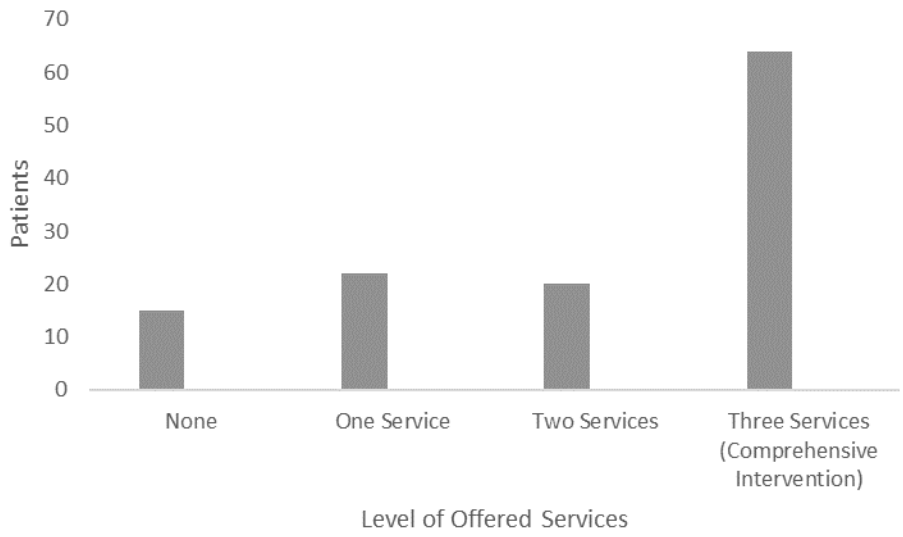

Figure 6. Levels of offered services.

Research Question 3

What is the relationship between the level of a comprehensive intervention for intervention and the level at which survivors accept legal, mental health, and community outreach resources in health care settings?

*H*01. There is no relationship between the level of a comprehensive intervention for intervention and the level at which survivors accept legal, mental health, and community outreach resources in health care settings.

*H*11. There is a significant relationship between the level of a comprehensive intervention for intervention and the level at which survivors accept legal, mental health, and community outreach resources in health care settings

I conducted three chi-square tests to assess the relationship between levels of intervention and service acceptance. As levels of intervention were operationalized as to how many offered services were accepted, I was certain a significant relationship existed

with acceptance of legal, mental health, and community outreach resources. As such, these analyses were performed instead in an exploratory manner, in order to determine any associations between types of services accepted and how many other services were accepted. Prior to each analysis, I assessed the assumption of adequate cell sizes. This assumption requires all cells of the chi-Square had expected values higher than zero, while 80% of the cells had expected values of 5 or more (McHugh, 2013). Both conditions of this assumption were met for each of the chi-squares.

Results of the first chi-square test of social work and level of intervention was significant, $\chi^2(3) = 105.94$, $p < .001$. Of those patient participants who accepted and received social work services, 19.2% accepted only that one service, 19.2% accepted at least two services, and 61.5% accepted all three services. Of those patient participants who did not accept and receive social work, 88.2% did not accept any service at all while the remaining 11.8% accepted at least one other service. Among the patient participants who did not accept social work services, none of those patient participants accepted more than one other service. Table 1 presents the full results of this chi-square analysis.

Table 1

Results of the chi-square test of social work and level of intervention

Social work accepted	Level of intervention			
	did not accept any service	accepted one service	accepted two services	accepted all three services
No	15 88.2%	2 11.8%	0 0.0%	0 0.0%
Yes	0 0.0%	20 19.2%	20 19.2%	64 61.5%

The second chi-square of legal services and levels of intervention was also significant, $\chi^2(3) = 96.14$, $p < .001$. Of those patient participants who accepted and received legal services, only 1.4% did not accept any other service. An additional 12.2% of patient participants accepted at least one other service, while most (84.5%) accepted all three services. This is more than the 61.5% of those patient participants who accepted social work and also accepted all other services. Of those patient participants who did not accept legal services, 31.9% did not accept any service, 44.7% accepted just the one service, and 23.4% accepted one other service in addition to legal services. Table 2 presents the full results of this chi-square analysis.

Table 2

Results of the chi-square of legal services and level of intervention

Legal services accepted	Level of intervention			
	did not accept any service	accepted one service	accepted two services	accepted all three services
No	15 31.9%	21 44.7%	11 23.4%	0 0.0%
Yes	0 0.0%	1 1.4%	9 12.2%	64 84.5%

The third and final Chi-Square between community outreach and level of intervention was significant, $\chi^2(3) = 91.81$, $p < .001$. Of those patient participants who accepted community outreach services, 2.6% only accepted that one service, while 13.2% accepted at least one other service. Again, the majority (84.2%) of patient participants who accepted community service also accepted all other services. This was in comparison to the 84.5% of patient participants who accepted legal services and all other services, and the 61.5% of patient participants who accepted social work also accepted all other services. Of those patient participants who did not accept community outreach services, 33.3% did not accept any services at all, 44.4% accepted one service, and 22.2% accepted at least two services. Table 3 presents the full results of this chi-square analysis.

Table 3

Results of the chi-square of community outreach and level of intervention

Community outreach accepted	Level of intervention			
	did not accept any service	accepted one service	accepted two services	accepted all three services
No	15 33.3%	20 44.4%	10 22.2%	0 0.0%
Yes	0 0.0%	2 2.6%	10 13.2%	64 84.2%

Summary

The results indicated a majority of patient participants accepted all offered services. Of the total sample, a majority of patient participants were offered comprehensive intervention, with mental health or social work resources being the most commonly accepted service. Of those patient participants who received at least one service, the majority received all three services in a comprehensive intervention. There was a small percentage (12.4%) of patient participants who were not offered any services at all. Chi-square analyses result findings presented that the majority of those patient participants who did not accept social work also did not accept any other service, while a majority of patient participants who accepted social work also accepted all other offered services. Slightly less than half of those patient participants who did not accept legal service did not accept any other service, while the large majority of patient participants who accepted legal services also accepted all three services, with almost identical results for those patient participants who did not and did accept community outreach. The

following chapter includes a discussion of the results as they relate to the pertinent literature and to the theoretical foundation. I will also discuss the strengths, limitations, and directions for future research.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this descriptive, exploratory, quantitative study was to explore the possibility of offering services and intervention to intimate partner violence survivors in health care settings such as emergency rooms. To explore this possibility, I examined survivor acceptance of offered services and intervention in a Midwest U.S. emergency room. Unearthing opportunities to address the numerous and varied needs of individuals who experience intimate partner violence may lead to ensuring the entirety of survivors needs are identified and met. It may also begin to provide resources and intervention sooner. Past researchers on intimate partner violence in medical-care settings focused on identifying and exploring ways of eliminating barriers to relationship violence and assessing compliance in screening, program planning, process, and policy (Beynon et al., 2012; Chibber & Krishnan, 2011). My study differed from prior studies by exploring the possibility of dissimilar stakeholders addressing intimate partner violence survivor needs in the emergency department. The stakeholders I identified in my study included law enforcement, social work or mental health, and community outreach workers. To explore the possibility of providing resources and intervention to survivors in the emergency, I ascertained survivor use of offered services and the levels of comprehensive intervention. When the initiation of mental health or social work, legal, and outreach community services occurred while the individual was still in the emergency room, comprehensive intervention was achieved. I plan to share the research outcomes with the Midwest U.S. medical facility's emergency department with the hope that the findings provide hospital

leadership with evidence-based data to improve service delivery to address the totality of the intimate partner violence survivors' needs and to increase collaborative efforts with community agencies. I sought to answer three research questions in my study.

RQ1. What proportion of intimate partner violence survivors' avail themselves of legal, social work or mental health, community outreach resources, and intervention when offered in health care settings such as the emergency department?

RQ2. What is the level of a comprehensive intervention for intimate partner violence in health care settings such as the emergency department?

RQ3. What is the relationship between the level of a comprehensive intervention for intimate partner violence and the level at which intimate partner violence survivors' accepted legal, mental health, and community outreach resources, and intervention in health care settings?

However, as levels of intervention was operationalized as to how many offered services were accepted, I was certain there would be a significant relationship with acceptance of legal, mental health or social work, and community outreach resources. Therefore, the analyses were instead performed in an exploratory rather than relationship manner, to determine any associations between types of services accepted and how many other services were accepted.

I categorized the collected data into dichotomous variables (i.e., either acceptance or refusal of services) for mental health or social work resources, legal resources, community outreach, and comprehensive linkage to services. I answered the first two

research questions using descriptive statistics (specifically, frequencies, percentages, means, and standard deviations). Because I expected a significant relationship in answering the third research question, once the levels of intervention were operationalized, I changed the focus of the analyses to answering RQ3 from determining significance to conducting exploratory analysis. Therefore, chi-square tests to answer RQ3 were conducted to determine any associations between types of services accepted and how many other services were accepted. My study results indicated that the majority of participants accepted all offered services with social work or mental health resources the most commonly accepted service. This chapter includes a discussion of the results in relation to the pertinent literature and theoretical foundation, the study limitations, and explores direction for future research.

Interpretation of the Findings

In this section of the chapter I will describe how the results of my study confirm or extend knowledge in meeting the needs of intimate partner violence survivors. I will do this by considering the findings of this study in terms of what has been found in the scholarly literature reviewed in Chapter 2. I will make this comparison by considering the descriptive data and each of the variables. The variables examined consisted of mental health or social work, legal involvement, community outreach resources, and association between types of services accepted and how many other services were accepted.

Descriptive Data

Researchers studying intimate partner violence have found that it occurs across age groups, social classes, cultures, and ethnicities (Leppakoski & Paavilainen, 2013).

The descriptive data from my study supported the earlier research, finding patient participants across the lifespan of the sample population. Age group data was categorized by women in their 20's, 30's, 40's, 50's, 60's, 70's, 80's, and 90's. Of 121 patient participants, the youngest patient participant was in her 20's and the oldest was in her 90's. In summary, I found that although there was a decline in occurrence of intimate partner violence as patient participants aged, it still occurred in every age group across the lifespan.

I gathered an additional sample description presented through a monthly breakdown over the six-month period of data collection. Of the 121 patient participants who screened positive for intimate partner violence, the monthly breakdown consisted of 14 (11.6%) patient participants in June, 21 (17.4%) patient participants in July, 22 (18.2%) patient participants in August, six (5%) patient participants in September, nine (7.4%) patient participants in October, 37 (30.6%) patient participants in November, and 12 (9.9%) patient participants in December. Despite a peak in the month of November, I found intimate partner violence occurred during each month throughout the study period without any particular pattern of occurrence. The outcomes from my study support past findings that intimate partner violence is indiscriminate with regard to population or time period (Leppakoski & Paavilainen, 2013).

Mental Health or Social Work Involvement

One of the variables examined in this study was mental health or social work involvement, separate from the other variables and in relation to the other variables of legal involvement and community outreach services. According to the National

Association of Social Workers (2011), social work is increasingly practiced in health care settings. Social workers provide a specialized skillset for addressing the multiple and varied needs of intimate partner violence survivors (Chanmugam, 2014). Dichter and Rhodes (2011) and Campbell and Lewandowski (2011) supported Chanmugam's finding reporting survivors' needs are varied and complex and often go unmet, especially in the psychological domain of depression and anxiety.

For this study, I explored mental health or social work as one of the offered resources for intimate partner violence survivors while in the emergency department. I found that mental health or social work intervention was the most commonly accepted service. Among the patient participants 104 (86.0%) participants accepted the offered service while 17 (14.0%) did not accept the offer. The findings of my study confirmed prior researchers findings that intimate partner violence survivors have needs that can be met by social work intervention or mental health support. Specifically, social work skills and expertise constitute training and experience in interdisciplinary collaboration; community liaisons; mental health training; and insight to micro-, meso-, and macro-factors (Chanmugam, 2014). Additionally, the majority of health care social workers practice in hospital settings (National Association of Social Workers, 2011); suggesting social work may be increasingly available in the emergency department for intervention, research, and participation in the policies and protocols.

However, a limitation to my study's finding was that, while staff at my study site tracked acceptance or refusal of offered services, they did not identify the specific services offered by mental health or social work providers. Therefore, additional research

is necessary to identify specific survivor needs in mental health, law enforcement, and community resources. I will discuss this in further detail in the limitations section of this chapter.

Law Enforcement

Another variable examined in this study was law enforcement involvement, separate from the other variables and in relation to the other variables of social work or mental health and community outreach services. Antle et al. (2010) and Villagrana (2010) found that 75% of intimate partner violence survivor study participants were generally supportive of mandatory reporting and arrest laws. Additionally, mandatory reporting often led intimate partner violence survivors to take steps to change their lives and to take steps of self-protection (Antle et al., 2010). Thomas et al. (2010) expanded on these findings by supporting the need to address intimate partner violence earlier in life, and the researchers recommended addressing it as soon as adolescence. Despite these findings, due to hospital IRB parameters, I chose to focus on adults in my study. It would have been interesting to explore the occurrence of relationship violence and use of offered services amongst adolescents, but this population was not included due to the restrictions in working with vulnerable populations at the Midwest U.S. medical facility. For my study, I examined law enforcement involvement as one of the variables in analyzing the collected data. In this study, 74 participants (61.2%) accepted legal services, while 47 (38.8%) did not. I confirmed what has been found in past studies: intimate partner violence survivors have legal needs ranging from mandatory reporting to arrest. However, a limitation to this finding is the Midwest U.S. facility tracks acceptance

or refusal of offered services but does not identify the specific services offered by law enforcement and accepted by the survivor. This will also be further discussed in the limitations section of this chapter.

Community Outreach

Another variable examined in this study was community outreach services, separate from the other variables and in relation to the other variables of legal involvement and social work or community outreach. Community response to intimate partner violence consisted of outreach workers presenting to the health care setting 24 hours a day, 7 days a week, and included providing information on available resources and connecting intimate partner violence survivors to community-based agencies for ongoing supportive services and advocacy. Previous researchers found a 50% increase in use of services by intimate partner violence survivors after referrals, supporting the need for ongoing community resources (Villagrana, 2010). I found 76 patient participants (62.8%) accepted community outreach intervention, while 45 (37.2%) did not. However, a limitation of this finding is the Midwest U.S. facility tracked acceptance or refusal of offered community outreach intervention while the intimate partner violence survivor was in the emergency department but did not identify the specific services offered by community outreach. Again, I will discuss this in further detail in the limitations section.

Comprehensive Intervention

Comprehensive intervention was the final variable I examined with comprehension intervention achieved when three conditions were met. Specifically, comprehensive intervention occurred when the intimate partner violence survivor

accepted mental health or brief social work intervention, the survivor was connected with law enforcement, and the survivor accepted contact with community advocates for outreach services while in the emergency department. Prior research supported a shift towards working collaboratively to address the diverse needs of the intimate partner violence survivor. In 2011, Barner found community-based agencies are increasingly shifting away from working in isolation and moving toward increased collaboration between advocacy groups and coordinated community responses. Thomas et al. (2010) supported these findings by studying an overlap in survivors encountering both health care and law enforcement in addressing intimate partner violence. More recently, Garcia-Moreno (2015) found support for comprehensive intervention in health systems, and Schmidt (2014) supported comprehensive and holistic support in clinical intervention. Therefore, taking this practice into the emergency room setting is a logical progression.

However, during the data analysis stage I needed to make an adjustment to the analyses. For this study, I initially proposed examining comprehensive intervention and conducting statistical analysis through chi-squares to test the null or alternative hypothesis of: There is no relationship between the level of a comprehensive intervention for intimate partner violence and the level at which intimate partner violence survivors accept legal, mental health or social work, and community outreach resources in health care settings. Rejecting the null hypothesis would support the alternate hypothesis. Specifically, there is a significant relationship between the level of a comprehensive intervention for intimate partner violence and the level at which intimate partner violence survivors accept legal, mental health or social work, and community outreach resources

in health care settings. However, as the levels of intervention were operationalized it was apparent there would be a significant relationship among the acceptance of legal, mental health or social work, and community outreach resources. Therefore, I made an adjustment to conduct the analyses in an exploratory rather than relationship manner to determine associations between types of services accepted and how many other services were accepted.

The first chi-square of social work and level of intervention was significant, $\chi^2(3) = 105.94$, $p < .001$. Of the intimate partner violence survivors who accepted and received social work services, 19.2% accepted only that one service, 19.2% accepted at least two services, and 61.5% accepted all three services. Of the intimate partner violence survivors who did not accept and receive social work, 88.2% did not accept any service at all, while the remaining 11.8% accepted at least one other service. No patient participant who did not accept social work services accepted more than one other service. I found the acceptance of social work intervention was likely to result in the acceptance of other resources.

The second chi-square between legal services and levels of intervention was also significant, $\chi^2(3) = 96.14$, $p < .001$. Of the intimate partner violence survivors who accepted and received legal services, only 1.4% did not accept any other service. A further 12.2% of intimate partner violence survivors accepted at least one other service, while most (84.5%) survivors accepted all three services. This was more than the 61.5% of those who accepted social work and all other services. Of those who did not accept

legal services, 31.9% did not accept any other service, 44.7% accepted just the one service, and 23.4% accepted one other service in addition to legal services.

The third and final chi-square of community outreach and level of intervention was significant, $\chi^2(3) = 91.81$, $p < .001$. Of those intimate partner violence survivors who accepted community outreach services, only 2.6% accepted that one service, while 13.2% accepted at least one other service. Again, the majority (84.2%) of those who accepted community outreach services also accepted all other services. This was in comparison to the 84.5% patient participants who accepted legal services and all other services, and the 61.5% of those who accepted social work and all other services. Of those patient participants who did not accept community outreach services, 33.3% did not accept any services at all, 44.4% accepted one service, and 22.2% accepted at least two services. Of the 121 patient participants offered legal, mental health, and community outreach resources and intervention as a result of experiencing intimate partner violence, 64 patient participants (53%) accepted all three offered services, 42 (35%) accepted some offered services, and 15 (12%) patient participants declined all (accepted none) offered services.

Of interest in my study was the finding that each intimate partner violence survivor who accepted all offered services reported that they were presenting to the emergency department seeking treatment for intimate partner violence or sexual assault with relationship violence (i.e., it was the chief complaint or reason for their visit that day). An implication may be that individuals' currently experiencing abuse may be the most receptive to intervention and in need of resources; however, further research will be

needed to explore this finding. It could also be beneficial for a future study to explore survivors' readiness to make a change in their situation based on their acceptance of services.

Theoretical Foundation Revisited

Research supports the fact that intimate partner violence survivors often have complex and varied needs (Beynon et al., 2012). General systems theory provided a foundation to manage the entirety of survivor needs (Bertalanffy, 1969; Hanson, 1995; Luhmann, 2013). Hanson (1995) reinforced the concept "the whole is greater than the sum of its parts" (p. 4). Using this theory, I explored the likelihood of survivors taking a comprehensive approach to their needs by accepting offered resources in their entirety. I found 64 patient participants (53%) accepted all three offered services, 42 (35%) accepted some offered services, and 15 (12%) patient participants accepted no offered services. By exploring survivors' acceptance of services and their varied responses I could broaden my understanding of the complex needs of survivors and individual differences. Bertalanffy (1969) first developed systems theory to demonstrate the interconnectedness between the whole, or entirety, and its component parts. Conducting chi-square analyses in an exploratory manner to determine associations between types of services accepted provided insight into the interconnectedness between the components and the whole within my study.

When applying general systems theory to intimate partner violence, one is not able to predict how, when, and to what extent survivors will accept and utilize resources. Also, one does not speak to the content or effectiveness of each discipline's intervention.

Rather, the theory's application offers insight into using a collaborative approach to manage the process of attending to the intimate partner violence survivor by addressing the presenting divergent issues (Antle et al., 2010; Beynon et al., 2012; Futures Without Violence, 2014; Rhodes et al., 2011). As applied to my study, the statement did appear to be true as a majority of survivors accepted all offered services and resources.

Limitations of the Study

There were limitations recognized in my study. One limitation was that I examined only the records for one hospital in the Midwest region of the United States. The characteristics of the population accessing this emergency department may differ from populations in other emergency departments and other regions. Therefore, the findings cannot be generalized to the entire population. Replication of this study will be necessary in other emergency department settings to support the validity of these findings. Another limitation was the use of secondary data, which meant using data for a purpose other than was originally intended. Specifically, the data was originally collected for health histories during medical treatment whereas I was using extracted data to research relationship violence. A third limitation was that the electronic charting system in the Midwest U.S. health care system was in the process of being updated; therefore, some data was not accessible. Additionally, some data was restricted from access. Specially, 13 medical records were eliminated because the hospital restricted access to medical records of deceased patient participants and IRB parameters limited access to records of minors. Another limitation is that I used a nonprobability, or convenience sample, rather than a probability sample. Although researchers prefer a probability

sample because it is more reliable and valid, obtaining such a sample was not feasible because of the vulnerability of the population studied. A final limitation to the findings was that while the Midwest U.S. facility tracked acceptance or refusal of offered services, it did not identify the specific services offered by mental health or social work providers, law enforcement, and community outreach workers. It would be informative for further research efforts to determine specifically what resources survivors' need from mental health or social work, legal, or community outreach providers. However, due to confidentiality requirements community outreach information is protected from disclosure and thus would probably remain restricted.

Despite the limitations, the design methodology selected for this study was valid and reliable for researching intimate partner violence survivors' use of offered resources in the emergency department. To strengthen reliability and validity I collected data from a reputable institution. The consistency and quality of the data was also an advantage of using secondary data from a reputable institution (Vartanian, 2011). In collecting data from obtained health histories, I also expected the data to be consistent. The quality of data was also assumed high because I collected data from a fully accredited Level 1 trauma center in the Midwest U.S., which is a reputable organization.

Additional strategies to further strengthen the validity and reliability of this study and reduce bias included member checks, an audit trail, and peer review. The Midwest U.S. medical center where I collected data required a principal investigator supervise the research study and data collection. I consulted the assigned principal investigator, an emergency department faculty and physician, throughout the process of the study design,

data collection, and data interpretation to ensure validity and reliability and to decrease researcher bias. My relationship with the study, assumptions, and theoretical orientation was evaluated throughout the research. A documented audit trail included detailed notes throughout the data collection, analysis, and interpretation. By controlling for these factors, it should be possible to utilize the study findings toward recommending a response for intimate partner violence survivors in this Midwest U.S. health care facility's emergency room settings. Each of the limitations is addressed by suggesting specific recommendations for future studies in with this population in this setting.

Recommendations for Action and Social Change

As previously mentioned, several limitations occurred within this study. To address the limitations, the following suggestions are recommended. First, because the study findings were obtained from only examining the records of one hospital in the Midwest U.S., the findings cannot be generalized. Therefore, one recommendation is to replicate this study in emergency departments located in other regions with a variety of demographics and population characteristics. Replication of the study in other regions with similar outcomes will support the validity of this study's findings. To address the limitations linked to the use of secondary data, another recommendation is to conduct a study in the emergency department and obtain data directly from intimate partner violence survivors. However, because of the vulnerability of this population, additional precautions will need to be taken to ensure the safety of the survivors and interviewing staff. This can occur by developing clear protocols and coordinating with hospital security to ensure everyone's safety. To address the limitation occurring because of the

loss of data because of the electronic charting system in the Midwest U.S. health care system being updated this study should be duplicated after the charting system has been updated. To address the limitation occurring from an inability to access the records of deceased patients, the researcher recommends further studies replicate this study after obtaining IRB approval to access hospital records of deceased patients prior to beginning the study. It would be interesting to include the records of deceased patients to consider if there was a relationship between the patients' death and intimate partner violence, particularly since Maddoux et al. (2015) found relationship violence may escalate to rape, physical assault, stalking, or death. To address the limitation of utilizing a nonprobability sample, replication of the study in other emergency departments is recommended because using a probability sample is not recommended due to the continued vulnerability of the sample studied. The final recommendation is to identify the specific services offered by mental health or social work providers, law enforcement, and community outreach workers. To determine specifically what resources intimate partner violence survivors need from legal, social work, and community outreach services, hospital charting could be modified to capture this valuable information.

Recommendations for Action

The development of policies, practices, and the monitoring of intimate partner violence screening and intervention remain an ongoing concern. Results from this study supported providing direction on where to focus resources to improve intimate partner violence screening and intervention and identifying survivor acceptance or refusal of offered services and intervention. The descriptive data findings of this study revealed

social work or mental health resources were overwhelmingly accepted. Future studies may consider exploring ways of allowing social work or mental health to coordinate intervention with other disciplines and participate in the development of policies and protocols. Additionally, such examination may also provide hospital leaders with evidence-based guidance for the hospital system and its management teams to also develop policies and practices for service delivery in the emergency department (Bennett, 2012). Outcomes from this study may help in defining roles to coordinate services for survivors of intimate partner violence, as well as educating providers in health care teams and systems. Efforts at facilitating referrals to law-enforcement personnel and community agencies ensure that the entirety of intimate partner violence survivors' needs are met and support the urgency to identify intimate partner violence and the need for multidisciplinary referrals and intervention.

Implications for Social Change

The significant number of individuals continuing to experience intimate partner violence supports the need to find ways to intervene and provide services in a variety of settings. Bledsoe and Sar (2011) found intimate partner violence remains a significant public health and economic concern. Through my study I aimed to consider the ability to provide resources and intervention to intimate partner violence survivors while they were in the emergency department. My study findings supported that a majority of intimate partner violence survivors utilized offered services. As a result, there are a number of implications to the current research findings. First, this research informs mental health, legal, and community outreach specialists that the emergency department is a valuable

venue to identify survivors and offer services. With each of the stakeholders having this information they can continue to develop ways to work collaboratively and reach out to survivors. Second, this research provides hospital decision makers with information regarding the need for resources and intervention and can be used to help lead to a number of protocols and policies. Decision makers may use these findings to develop protocols to provide direct services to survivors in the emergency department and to ensure accuracy and compliance in attending to survivors' needs. Further, the results of this study can be used to coordinate services with law enforcement and with community outreach agencies. Coordinating with law enforcement would also lead to holding alleged perpetrators accountable for behaviors. Coordinating with community outreach services will allow for the provision of community resources. By doing so, survivors may receive multi-disciplinary intervention sooner, which may ultimately lead to stopping relationship violence which will positively impact the individual, their offspring, and decrease the economic cost to society.

Conclusion

My research study used secondary data to conduct a quantitative, descriptive, exploratory study to unearth an opportunity to address survivors' needs in a healthcare setting. I examined descriptive data for a number of variables to determine the proportion of survivors availing resources, the level of comprehensive intervention, and the associations between service acceptance and the number of other services accepted. The results of my study reinforced past studies and the need for continued efforts in addressing the needs of intimate partner violence survivors through needs identification

and offered services. My results affirmed the need of finding additional ways of providing intimate partner violence survivors with opportunities to avail themselves of offered services, particularly because intimate partner violence is a current and significant social problem. My study's findings showed the majority of intimate partner violence survivors accepted services when offered in health care settings such as the emergency room. Furthermore, I found providing comprehensive services in the emergency department is a possibility and worthy of future research, because closing the gap in intimate partner violence screening, identification, and intervention may provide direction for subsequent research and support social change by impacting changes in relationship violence.

References

Allen, N. E., Larsen, S. E., Javdani, S., & Lehrner, A. L. (2012). Council-based approaches to reforming the health care response to domestic violence: Promising findings and cautionary tales. *American Journal of Community Psychology, 50,* 50-63. doi:10.1007/s10464-011-9471-9

Ambuel, B., Hamberger, L. K., Guse, C. E., Melzer-Lange, M., Phelan, M. B., & Kistner, A. (2013). Health care can change from within: Sustained improvement in the health care response to intimate partner violence. *Journal of Family Violence, 28*, 833-847. doi:10.1007/s10896-013-9550-9

Antle, B., Barbee, A., Yankeelow, P., & Bledsoe, L. (2010). A qualitative evaluation of the effects of mandatory reporting of domestic violence on victims and their children. *Journal of Family Social Work, 13,* 56–73. doi:10.1080/10522150903468065

Auerbach, C., & Mason, S. E. (2010). The value of the presence of social work in emergency departments. *Social Work in Health Care, 49,* 314–326. doi:10.1089/00981380903426772

Barner, J. R., & Carney, M. M. (2011). Interventions for intimate partner violence: A historical review. *Journal of Family Violence, 26,* 235–244. doi:10.1007/s10896-011-9359-3

Bennett, A. R. (2012). Accountable care organizations: Principles and implication for hospital administrators. *Journal of Healthcare Management, 57,* 244–254. Retrieved from https://www.ache.org/Faculty_Students/Accountable_Care_Organizations.pdf

Bertalanffy, L. (1969). *General system theory: Foundations, development, applications*. New York, NY: George Braziller.

Beynon, C. E., Gutmanis, I. A., Tutty, L. M., Wathen, C. N., & MacMillan, H. L. (2012). Why physicians and nurses ask (or don't) about partner violence: A qualitative analysis. *BMC Public Health 2012, 12,* 1-12. Retrieved from http://www.biomedcentral.com/1471-2458/12/473

Bledsoe, L. K., & Sar, B. K. (2011). Intimate partner violence control scale: Development and initial testing. *Journal of Family Violence, 26,* 171–184. doi:10.1007/s10896-010-9351-3

Bogeanu, E. L. (2012). The role of social services in the context of intimate violence. *Revista de Asistenta Sociala, 11*(4), 153–174. Retrieved from http://www.revistadeasistentasociala.ro

Brailsford, S., Harper, P., LeRouge, C., & Payton, F. C. (2012). Health editorial. *Health Systems, 1,* 1–6. doi:10.1057/hs.2012.9

Breitbart, V., & Colarossi, L. (2010). Implementing partner violence screening in family planning centers. *Family Violence Prevention & Health Practice, 1*(10), 3. Retrieved from http:/web.b.ebscohost.com.ezp.waldenulibrary.org/ehost/delivery? s…

Campbell, J. C., & Lewandowski, L. A. (1997). Mental and physical effects of intimate partner violence. *Psychiatric Clinics of North America, 20,* 353–374. doi:10.1016/S0193-953X(05)70317-8

Catalano, S. M. (2012). *Intimate partner violence, 1993–2010*. Retrieved from http://www.bjs.gov/index.cfm?ty=pbdetail&iid=4536

Chanmugam, A. (2014). Social work expertise and domestic violence fatality review teams. *Social Work, 59,* 73–80. doi:10.1093/sw/swt048

Chapin, J. R., Coleman, G., & Varner, E. (2011). Yes, we can! Improving medical screening for intimate partner violence through self-efficacy. *Journal of Injury & Violence Research, 3,* 19–23. doi:10.5249/jivr.v3i1.62

Chibber, K. S., & Krishnan, S. (2011). Confronting intimate partner violence: A global health priority. *Mount Sinai Journal of Medicine, 78,* 449–457. doi:10.1002/msj.20259

Colarossi, L., Breitbart, V., & Betancourt, G. (2010). Barriers to screening for intimate partner violence: A mixed-methods study of providers in family planning clinics. *Perspectives on Sexual and Reproductive Health, 42,* 236–243. doi:10.1363/4223610

Connelly, L. (2008). Retrospective chart reviews. *Medsurg Nursing, 17,* 322–323. Retrieved from CINAHL Search Database. (Acession No. 184932)

Coulter, M., & Chez, R. (1997). Domestic violence victims support mandatory reporting: For others. *Journal of Family Violence, 12,* 349–356. doi:10.1023/A:1022857022792

Cox, P. J., Finkelstein, D. M., Perez, V. E., & Rosenbach, M. L. (2010). Changes in capacity among local coordinated community response coalitions (CCRs) supported by the DELTA program. *Journal of Family Social Work, 13,* 375–392. doi:10.1080/10522158.2010.492495

Creswell, J. W. (2014). *Research design: Qualitative, quantitative, and mixed methods approaches* (4th ed.). Thousand Oaks, CA: Sage.

Daugherty, J. D., & Houry, D. E. (2008). Intimate partner violence screening in the emergency department. *Journal of Postgraduate Medicine, 54,* 301–305. doi:10.4103/0022-3859.43513

Decker, M. R., Frattaroli, S., McCaw, B., Coker, A. L., Miller, E., Sharps, P., … Gielen. A. (2012). Transforming the health care response to intimate partner violence and taking best practices to scale. *Journal of Women's Health, 21,* 1222–1229. doi:10.1089/jwh.2012.4058.

Dichter, M. E., & Rhodes, K. V. (2011). Intimate partner violence survivors' unmet social service needs. *Journal of Social Service Research, 37,* 481–489. doi:10.1080/01488376.2011.587747

Dunn, J. L. (2005). "Victims" and "survivors": Emerging vocabularies of motive for "battered women who stay." *Sociological Inquiry, 75,* 1–30. doi:10.1111/j.1475-682X.2005.00110.x

Faul, F., Erdfelder, E., Buchner, A., & Lang, A. G. (2014). G*Power version 3.1.2 (computer software. Uiversitat Kiel, German. Retrieved from http:www.psycho.uniduesseldorf.de/abteilungen/aap/gpower3/download-and-register

Frankfort-Nachmias, C., & Nachmias, D. (2008). *Research methods in the social sciences* (7th ed.). New York, NY: Worth.

Futures Without Violence. (2014). Violence Against Women Act of 2011 (Title V). Retrieved from http://www.futureswithoutviolence.org/userfiles/file/PublicPolicy/VAWA%20Summary.pdf

Garcia-Moreno, C., Hegarty, K., Lucas d'Oliveria, A. F., Koziol-McLain, J., Colombini, M., & Feder, G. (2015). The health-systems response to violence against women. Retrieved from http://dx.doi.org/10.1016/S0140-6736(14)61837-7

Ghandour, R. M., Campbell, J. C., & Lloyd, J. (2015). Screening and counseling for intimate partner violence: A vision for the future. *Journal of Women's Health, 24*(1), 57-62. doi: 10.1089/jwh.2014.4885

Gindi, R. M., Black, L. I., & Cohen, R. A. (2016). Reasons for emergency room use among U.S. adults aged 18-64: National health interview survey, 2013 and 2014. *National Health Statistics Report*, Number 90. Retrieved from http://www.cdc.gov/nchs/products/nhsr.htm

Goba, J. (2016). Critical partners in domestic violence advocacy – a unique collaboration. *Journal of health care protection management: Publication of the international association for hospital security, 32*(1), 34-40. Retrieved from https://www.safetylit.org/citations/index.php?fuseaction=citations.viewdetails&citationIds%255B%255D=citjournalarticle_515174_3

Green, S. B., & Salkin, N. J. (2011). *Using SPSS for Windows, and Macintosh: Analyzing and understanding data.* Boston, MA: Prentice Hall.

Greenfield, E. A. (2011). Developmental systems theory as a conceptual anchor for generalist curriculum on human behavior and the social environment. *Social Work Education, 30,* 529–540. doi:10.1080/02615479.2010.503237

Grinnell, R. M., & Unrau, Y. (2005). *Social work research and evaluation: Quantitative and qualitative approaches*. New York, NY: Cengage Learning.

Haggerty, L. A., Hawkins, J. W., Fontenot, H., & Lewis-O'Connor, A. (2011). Tools for screening for interpersonal violence: *State of the science. Violence and Victims, 26,* 725–738. doi:10.1891/0886-6708.26.6.725

Hamberger, L. K., Rhodes, K., & Brown, J. (2015). Screening and intervention for intimate partner violence in health care settings: Creating sustainable system-level programs, *Journal of Women's Health, 24*(1), 86-92. doi:10.1089/jwh.2014.4861

Hanson, B. G. (1995). *General systems theory: Beginning with wholes.* Washington, DC: Taylor & Francis.

Heaton, J. (2003). Secondary data analysis. In R. L. Miller & J. D. Brewer (Eds.), *The a–z of social research: A dictionary of key social science research concepts* (pp. 285–288). London, England: Sage.

Heyman, R. E., Smith, A. M., & Foran, H. M. (2015). Enhanced definitions of intimate partner violence for DSM-5 and ICD-11 may promote improved screening and treatment. *Family Process, 54*(1), 64-81. doi: 10.1111/famp.12121

Howell, D. C. (2016). *Fundamental statistics for the behavioral sciences* (9th ed.). Belmont CA: Brooks/Cole-Thompson Learning.

Hyman, A., & Chez, R. A. (1998). *Mandatory reporting of domestic violence.* San Francisco, CA: Family Violence Prevention Fund.

Iavicoli, L. G. (2005). Mandatory reporting of domestic violence: The law, friend or foe? *Mount Sinai Journal of Medicine, 72,* 228–231. Science Citation Index Search Database. (Accession No. 000230540300004

Jaffee, K. D., Epling, J. W., Grant, W., Ghandour, R. M., & Callendar, E. (2005). Physician-identified barriers to intimate partner violence screening. *Journal of Women's Health, 14,* 713–721. doi:10.1089/jwh.2005.14.713

Javdani, S., & Allen, N. E. (2011). Proximal outcomes matter: A multilevel examination of processes by which coordinating councils produce change. *American Journal of Community Psychology, 47,* 12–27. doi:10.1007/s10464-010-9375-0

Keenan, E. K. (2010). See the forest and the trees: Using dynamic systems theory to understand "stress and coping" and "trauma and resilience." *Journal of Human Behavior in the Social Environment, 20,* 1038–1060.

doi:10.1080/10911359.2010.494947

Lawson, J. (2012). Sociological theories of intimate partner violence. *Journal of Human Behavior in the Social Environment, 22,* 572–590. doi:10.1080/10911359.2011.598748

Leppakoski, T., & Paavilainen, E. (2013). Interventions for women exposed to acute intimate partner violence: Emergency professionals' perspective. *Journal of Clinical Nursing, 22*, 2273-2285. doi:10.1111/j.1365-2702.2012.04202.x

Lindhorst, T., Casey, E., & Meyers, M. (2010). Frontline worker responses to domestic violence disclosure in public welfare offices. *Social Work, 55,* 235–243. doi:10.1093/sw/55.3.235

Luhmann, N. (2013). *Introduction to systems theory*. Malden, MA: Polity Press.

Luke, D. A., Harris, J. K., Shelton, S., Allen, P., Carothers, B. J., & Mueller, N. B. (2010). Systems analysis of collaboration in 5 national tobacco control networks. *American Journal of Public Health, 100,* 1290–1297. doi:10.2105/AJPH.2009.184358

Maddoux, J., McFarlane, J., Faan, P. H., & Liu, F. (2015). Risks for women from abusers violating protection orders. *American Journal of Family Law*, Spring 2015. Retrieved from http://go.galegroup.com/ps/i.do?id=Gale%7CA456706478&v=2.1&u=minn4020&it=r&p=LT&sw=w&asid=Odba3055c37f572db2b28b8d4fc5ec9

McAllister, J. M., & Roberts-Lewis, A. (2010). Social worker's role in helping the church address intimate partner violence: An invisible problem. *Journal of the North American Association of Christians in Social Work, 37,* 161–187. Retrieved from http://search.proquest.com/docviews/5178424667

McGrath, M. E., Bettacchi, A., Duffy, S. J., Peipert, J. F., Becker, B. M., & St. Angelo, L. (1997). Violence against women: Provider barriers to intervention in emergency departments. *Academic Emergency Medicine, 4,* 297–300. doi:10.1111/j.1553-2712.1997.tb03552.x

McHugh, M. L. (2013). The chi-square test of independence. *Biochemia Medica, 23*(2), 143-149. Retrieved from http://dx.doi.org/10.11613/BM.2013.018

Mingers, J., & White, L. (2010). A review of the recent contributions of systems thinking to operational research and management science. *European Journal of Operational Research, 207,* 11–47. doi:10.1016/j.ejor.2009.12.019

Murphy, S. B., & Ouimet, L. V. (2008). Intimate partner violence: A call for social work action. *Health & Social Work, 33,* 309–315. doi:10.1093/hsw/33.4.309

National Association of Social Workers. (2011). *Social workers in hospital and medical centers: Occupational profile.* Retrieved from http://webcache.googleusercontent.com/search?q=cache:ciOGKBEUyyMJ:workforce.socsocialwork.org/studies/profiles/Hospital.pdf+&cd=1&hl=en&ct=clnk&gl=us

Nelson, H. D., Bougatsos, C., & Blazina, I. (2012). Screening women for intimate partner violence: A systematic review to update the U.S. preventive services task force recommendation. *Annals of Internal Medicine, 156,* 796–812. doi:10.7326/0003-4819-156-11-201206050-00447

Oehme, K., Stern, N., Donnelly, E. & Melvin, R. (2016). *Improving the emergency medical services system's response to domestic violence, 26*(1), 176-205. Retrieved from http://heionline.org/HOL/Page?handle=hein.journals/hmax26&div=10&start

Pagano, R. R. (2009). *Understanding statistics in behavioral sciences* (9th ed.). Belmont CA: Wadsworth Cengage Learning.

Patton, M. Q. (2002). *Qualitative research & evaluation methods* (3rd ed.). London, England: Sage.

Pennington-Zoellner, K. (2009). Expanding 'community' in the community response to intimate partner violence. *Journal of Family Violence, 24,* 539–545. doi:10.1007/s10896-009-9252-5

Post, L. A., Klevens, J., Maxwell, C. D., Shelley, G. A., & Ingram, E. (2010). An examination of whether coordination community responses affect intimate partner violence. *Journal of Interpersonal Violence, 25*(1), 75-93. doi:10.1177/0886260508329125

Power, C., Bahnisch, L., & McCarthy, D. (2011). Social work in the emergency department: Implementation of a domestic and family violence screening program. *Australian Social Work, 64,* 537–554.

doi:10.1080/0312407X.2011.606909

Ramsden, C., & Bonner, M. (2002). A realistic view of domestic violence screening in an emergency department. *Accident and Emergency Nursing, 10,* 31–39. doi:10.1054/aaen.2001.0312

Reisenhofer, S., & Seibold, C. (2012). Emergency health care experiences of women living with intimate partner violence. Journal of Clinical Nursing, 22, 2253-2263. doi:10.1111/j.1365-2702.2012.04311.x

Renner, L. M., & Slack, K. S. (2006). Intimate partner violence and child maltreatment: Understanding intra- and intergenerational connections. *Child Abuse and Neglect, 30,* 599–617. doi:10.1016/j.chiabu.2005.12.005

Rhodes, K. V., Kothari, C. L., Dichter, M., Cerulli, C., Wiley, J., & Marcus, S. (2011). Intimate partner violence identification and response: Time for a change in strategy. *Journal of General Internal Medicine, 26,* 894–899. doi:10.1007/s11606-011-1662-4

Ritchie, M., Nelson, K., Willis, R., & Jones, L. 92013). Does Training and Documentation Improve Emergency Department Assessments of Domestic Violence Victims? *Journal of Family Violence, 28*, 471-477. doi:10.1007/s10896-013-9514-0

Rodriguez, M. A., McLoughlin, E., Nah, G., & Campbell, J. (2001). Mandatory reporting of domestic violence injuries to the police: What do emergency department patients think? *Journal of the American Medical Association, 286,* 580–583. doi:10.1001/jama.286.5.580

Russell, B. (2010). *Battered woman syndrome as a legal defense: History, effectiveness and implications.* Jefferson: McFarland.

Saunders, R. B., & Brown, H. N. (1997). Innovative collaboration to prevent repeated adolescent pregnancies. *Nursing Connections, 10*(3), 5–11. Retrieved from http://web.a.ebscohost.com.ezp.waldenulibrary.org/ehost/delivery?s...

Schmidt, I. D. (2014). Addressing PTSD in low-income victims of intimate partner violence: Moving toward a comprehensive intervention.*Social Work, 59*(3), 253-261. doi:10.1093/sw/swu016

Sims, C., Sabra, D., Bergey, M. R., Grill, E., Sarani, B., Pascual, J., … Datner, E. (2011). Detecting intimate partner violence: More than trauma team education is needed. *American College of Surgeons, 212,* 867–872. doi:10.1016/j.jamcollsurg.22011.01.003

Snider, C., Webster, D., O'Sullivan, C. S., & Campbell, J. (2009). Intimate partner violence: Development of a brief risk assessment for the emergency department. *Academic Emergency Medicine, 16,* 1208–1216. doi:10.1111/j.1553-2712.2009.00457.x

Soskis, C. (1985). *Social work in the emergency room*. New York, NY: Springer.

Sprague, S., Kaloty, R., Madden, K., Dosanjh, S., Mathews, D. J., & Bhandari, M. (2013). Perceptions of intimate partner violence: A cross sectional survey of surgical residents and medical students. *Journal of Injury & Violence Research, 5,* 1–10. doi:10.5249/jivr.v5il.147

Sugg, N. (2006). What do medical providers need to successfully intervene with intimate partner violence? *Journal of Aggression, Maltreatment & Trauma, 13,* 101–120. doi:10.1300/J146v13n03_05

Tatum, K. M. & Pence, R. (2015). Factors that affect the arrest decision in domestic violence cases. *Policing: An International Journal of Police Strategies & Management, 38*(1), 56-70. doi: 110.1108/PIJPSM-07-2014-0075

Thomas, K. A., Sorenson, S. B., & Joshi, M. (2010). Police-documented incidents of intimate partner violence among young women. *Journal of Women's Health, 19,* 1079–1087. doi:10.1089/jwh.2009.1612

Todahl, J., & Walters, E. (2011). Universal screening for intimate partner violence: A systematic review. *Journal of Marital and Family Therapy, 37,* 355–369. doi:10.111/j.1752-0606.2009.00179.x

Vartanian, T. P. (2011). *Secondary data analysis: Pocket guides to social work research methods.* New York, NY: Oxford University Press.

Villagrana, M. (2010). Pathways to mental health services for children and youth in the child welfare system: A focus on social workers' referral. *Child Adolescent Social Work Journal, 27,* 435–449. doi:10.1007/s10560-010-0215-8

Violence Against Women Reauthorization Act, 42 U.S.C. § 13925 (2013). Retrieved from http://www.agpo.gov/fdsys/pkg/BILLS-113s47enr/pdf/BILLS-113s47enr.pdf

Williams, A. S., & Haizlip, J. (2013). Ten keys to the successful use of appreciative inquiry in academic health care. *OD Practitioner, 45*(2), 20–25. Retrieved from

http://www.mtpin.org/docs/FMBHP%20Leadership/Communication%20Strategies%20in%20the%20Changing%20Healthcare%20Infrastruture%20Series/Appreciative%20Inquiry%20Article.pdf

Woodall, P., Oberhofer, M., & Borek, A. (2014). A classification of data quality assessment and improvement methods. *International Journal of Information Quality, 3*(4), 298-321. doi: 10.1504/ijiq.2014.068656