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Correlation of Emergency Department Nurses' Beliefs about Wife Abuse and the Use of Carative Factors in Transpersonal Interactions with Abused Wives

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CORRELATION OF EMERGENCY DEPARTMENT NURSES' BELIEFS ABOUT WIFE ABUSE AND THE USE OF CARATIVE FACTORS IN TRANSPERSONAL INTERACTIONS WITH ABUSED WIVES

By

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ABSTRACT

CORRELATION OF EMERGENCY DEPARTMENT NURSES'

BELIEFS ABOUT WIFE ABUSE

AND THE USE OF CARATIVE FACTORS

IN TRANSPERSONAL INTERACTIONS WITH ABUSED WIVES

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Emergency department nurses from seven general hospitals were surveyed to elicit information on their beliefs about wife abuse (using the Inventory of Beliefs about Wife-Beating) and their self-reported behaviors with clients who may be physically abused. They were asked about beliefs about institutional and peer attitudes toward caring for abused wives. Information on the nurses' education about and experience with wife abuse was gathered. Data were summarized to provide descriptive statistics regarding beliefs and behaviors. High levels of caring behaviors were reported. Analysis of correlation between beliefs and behaviors was conducted. Significant findings were correlations between caring behaviors and the belief that help should be given to abused wives, and between caring behaviors and the belief that the institution and peers supported such caring behaviors. Multiple regression analysis showed the belief that the institution and peers support such caring behaviors had a greater influence on the self-report of caring behaviors.

Acknowledgments

The completion of this research endeavor has involved many people, not all of whom were aware of their involvement. To one such person I owe a great deal. She will remain nameless because to identify her would expose a private pain unknown to most of her friends. She is the emergency department (ED) nurse who set me on the path of finding out what it is that makes a difference in how ED nurses treat possibly abused women in the emergency room. She treats them as she would want to have been treated when she was abused. To her, and to the 21 nurses who identified themselves on the questionnaire as having been abused, thanks for your perspective, your honesty, and your care.

My thanks go also to all the nurses who took the time to respond to the questions about an unpopular, challenging subject that often provides more frustration than satisfaction. They inspired me to go further with the problem.

I am grateful to my committee for their attention to detail. Dr. Kay Kline has been patient and encouraging, and gave valuable assistance in accessing hospitals. Dr. Phyllis Gendler brought insight from her experience with abuse resources in nursing education and volunteer work. Dr. Mary De Young insisted that if I were going to use a social science theory, it needed to be the whole theory - which proved to be a most valuable component of the research in the end. Their collective discernment was tempered with empathy for the women needing help and an awareness of the difficulties encountered in finding it. Thank you to each of them.

To my husband, David, and my children, thank you also. The frequent questions, discussions, listening sessions, and computer assistance have been invaluable to me. Travel time, data collection difficulties, computer bugs, and missed meals have characterized my time in graduate school, and my family has paid the price. They have learned some of the pain of the subject through the eyes of the nurses. They provide me with joy.

Table of Contents

List of Tables

List of Figures

List of Appendices

CHAPTER 1

INTRODUCTION

Violence against women is as old as human history. The stereotypical caveman dragging his beloved by the hair is played out in contemporary society. Violence against all women is still tolerated today, and especially when it involves intimate partners. The concept of patriarchal dominance permitting a husband to control his wife and children by any means necessary finds support in some fundamentalistic Christian churches and in many middle eastern cultures. Domestic violence has been described as "an equal opportunity social issue" (Sabatino, 1992, p. 24). Wife abuse is old, accepted, and widespread.

The terminology found in contemporary society to describe the problem reflects some of the range of severity as well as the attitudes held toward the behaviors in question. We find the terms wife abuse, family violence, and domestic violence used commonly today, but in the recent past the term "battered woman" was descriptive as well as limiting. Abuse can take the form of physical, psychological, emotional, economic, or sexual control. Domestic homicide is a realistic outcome of the physically violent relationships seen in our nation's emergency rooms. The terms woman abuse or domestic violence could imply the inclusion of women abused by other than their partner, or children and elders, and in the formation of policy all of these categories of

vulnerable persons are included. However, because the attitudes of society toward women abused by their partners is less sympathetic than toward other vulnerable persons, this study will address only women abused by male partners, a spouse, former spouse, boyfriend, or significant other living in the same house.

In a summary statement about the prevalence of physical abuse of women by male partners in the United States, the document Healthy People 2000: National Health Promotion and Disease Prevention Objectives (1990) cites the following statistics:

> Studies suggest that between 2 million and 4 million women are physically battered each year by partners including husbands, former husbands, boyfriends, and lovers. . . . Between 21 and 30 percent of all women in this country have been beaten by a partner at least once. . . .More than 1 million women seek medical assistance for injuries caused by battering each year, and the vast majority of domestic homicides are preceded by episodes of violence. (p. 233)

The objective in Healthy People 2000 is to "reduce physical abuse directed at women by male partners to no more than 27 per 1,000 couples. (Baseline: 30 per 1,000 in 1985)" (p. 233).

A 1977 United Way Task Force on Battered Women in Minnesota determined that a battered woman will reach out to two places for help, the police and medical facilities. The criminal justice system becomes involved when the police are called in to intervene, protect, or clean up after incidents of physical violence. Medical professionals become involved at the emergency room and primary care physician/clinic level when the injuries sustained in physical abuse are severe enough to require medical attention.

In addition, the literature supports the statement that women injured in physically abusive relationships have more chronic physical problems which may be a result of ongoing abuse, secondary to injury, or as a manifestation of the stress of living in a chronic abusive situation (Appleton & Renton, 1980; Goldberg & Tomlanovich, 1984; McLeer, Anwar, Herman & Maquiling, 1989; Stark & Frazier, 1979). Allen (1994) reports a call by the National Conference on Family Violence for mandatory, comprehensive education in understanding family violence for health care professionals and persons in law enforcement and the justice systems, indicating that this has not changed in twenty years.

Nurses in their contacts with abused women have been cited, along with other health care professionals, as being among the least helpful in identifying and implementing appropriate interventions toward resolution of the problem. For a number of reasons, many nurses do not include historical evidence of violence in their assessments, do not investigate or encourage investigation of suspicious circumstances surrounding injuries, do not follow diagnosis of abuse with appropriate protective steps, and do not assist in pursuing safety following the woman's discharge (Campbell, Pliska, Taylor, & Sheridan, 1994). Since nursing has been defined almost universally as a caring profession, and these behaviors seem to lack caring, how can their existence be explained?

In the past sixty years there has been a great deal of effort made to understand the link between beliefs people hold and the influence these beliefs have on their attitudes about some external object, such as a person in a specific category or a behavior to be carried out. These attitudes in turn have been investigated to determine their relationship

to behaviors. Two of the more contemporary writers and researchers in this field, Ajzen and Fishbein, in a 1980 publication on attitudes and social behaviors state that their approach suggests that "appropriate measures of attitude are strongly related to action. . . .Any behavioral criterion can be predicted from attitude - be it a single action or a pattern of behavior - provided that the measure of attitude corresponds to the measure of behavior" (p. 27). In their work they pointed out that a great deal of work has gone into the development of valid and reliable measures of attitude, but very little attention has been made to accurately measuring behavior.

There is information from some studies about what is happening, or rather not happening to abused women in their contacts with health care professionals. Health care professionals historically have not identified and assisted women who present to hospital emergency rooms with injuries consistent with physical abuse (Brendtro & Bowker, 1989). The impact of attitudes upon behavior in theory is known. Social psychology research has demonstrated that attitudes toward a planned, deliberate behavior are the best predictor of the behavior occurring (Ajzen & Fishbein, 1980). There are some ideas about what the social and professional attitudes are toward abuse and women who are abused. King and Ryan (1989) describe myths common in the general population and among nurses, which included the beliefs that violence among family members is a private matter, and that abuse cannot be that terrible or the woman would leave. Rose and Saunders (1986) demonstrated how the attitudes of nurses differ from or are the same as those of physicians. Both physicians and nurses in this study believed that help should be given an abused woman. Both nurses and physicians who were female held

stronger beliefs that abuse was not justified and that the abused woman was not responsible for the abuse. A study by Tilden and Shepherd (1987) showed that education about abuse and possible professional interventions was effective in changing behaviors, and that this change in behavior was not necessarily associated with a change in attitudes.

What is not known is whether there is a correlation between the beliefs held by nurses and the quality and quantity of nursing actions demonstrating caring interventions on behalf of the client who is abused. From Jean Watson's theory of caring (1988), one could expect that human care interventions would be present when nurses interact with abused wives. If caring actions are not shown, and there is reason to suspect that at times they may not be, why are they absent? Is their absence related to beliefs and attitudes? Might there be other causes such as insufficient education or perceptions of diminished responsibility for making referrals?

The purpose of this study is to investigate whether there is a correlation between the beliefs of emergency department nurses about wife abuse and the caring behaviors shown toward women who visit the emergency department with physical injuries which might be caused by an abusive partner or former spouse.

CHAPTER 2

THEORETICAL FRAMEWORK AND LITERATURE REVIEW

Theoretical Framework

Victim blaming and failure to identify and implement appropriate interventions have been described as present in interactions between nurses and abused women (Brendtro & Bowker, 1989). The theory of reasoned action (Ajzen & Fishbein, 1980) and Watson's (1988) theory of nursing as human science and human care form the framework for studying nurses' beliefs about wife abuse and their behaviors with abused wives in the emergency department.

Theory of Nursing as Human Science and Human Care

Watson's theory of nursing as human science and human care defines the behaviors expected of nurses in any context in interactions with clients. Watson defines nursing as consisting of "knowledge, thought, values, philosophy, commitment, and action. . .generally related to human care transactions and intersubjective personal human contact with the lived world of the experiencing person" (1988, p. 53). Human caring is the moral ideal of nursing. It takes place within a specific frame of reference or phenomenal field. Therefore the context for caring actions occurs when the nurse and client interact, and the caring behaviors are perceived by the client as part of the frame of reference she experiences.

The nurse and client come together in an event or actual caring occasion. In this moment both persons can decide what to do with the moment, that is, how to be with each other. They are subjective to each other, and the values and views of the nurse are as relevant as those of the client. Choosing not to be subjective to the client results in reducing the client to an object.

The values inherent in this theory include a high regard for the "spiritual-subjective center of the person with the power to grow and change and a nonpaternalistic approach to helping a person gain more self-knowledge, self-control, and self-healing" (Watson, 1988, p. 73). The goal is mental-spiritual growth, finding meaning in one's existence and experience, discovering inner power and control, and potentiating instances of transcendence and self-healing. The agent of change is the client who makes use of internal mechanisms or the external means or agents through an interdependent process to preserve human dignity and integrity.

Specific interventions or carative factors associated with this theory require the participation of the nurse with the client. Watson (1988) defines ten carative factors (CF):

1. Humanistic-altruistic system of values.
2. Faith-hope.
3. Sensitivity to self and others.
4. Helping-trusting, human care relationship.
5. Expressing positive and negative feelings.
6. Creative problem-solving caring process.

7. Transpersonal teaching-learning.

8. Supportive, protective, and/or corrective mental, physical, societal, and spiritual environment.

9. Human needs assistance.

10. Existential-phenomenolgical-spiritual forces.

Four of them will be addressed by the questions in the study:

Sensitivity to self and others (CF#3). This is necessary in order for the nurse to perceive the cues of the possibility of an abusive source for the injury or condition bringing the woman to the emergency room. Self-awareness enables the nurse to use past experiences, both personal and professional, to recognize the potential in a current situation. Sensitivity to others permits use of assessment skills beyond the routine questions and techniques to probe with skill those areas which seem to indicate abuse.

A helping-trusting human care relationship (CF#4). A woman who has been abused is unlikely to give any information or ask for any help in dealing with her abuse or abuser unless a helping-trusting relationship develops. In the fast-paced emergency room setting with its low intensity personal interactions, it is difficult to develop the kind of relationship necessary to create trust. Nurses' time spent with the client is limited by variables including their own discomfort with discussion of such a sensitive and emotional subject as abuse. Physical assistance may aid in the creation of trust, but the risk taken by the woman in asking for help is great enough to require an emotional investment on the part of the nurse beyond that required by expert physical assessment skills or the implementation of physical comfort measures.

Supportive, protective, and/or corrective mental, physical, societal, and spiritual environment (CF #8). Because she needs this environment, the client will allow a trusting relationship to develop when it is present. The greatest focus in the emergency room should be on the supportive and protective mental and physical environment. There is a need for the staff to be aware of the possibility of changing societal norms to impact the secrecy with which this problem is treated, but that will not impact the individual client on a short term basis. The goal of the interaction with the emergency room staff should be to provide assistance with correcting the unsafe environment in which the woman lives.

Assistance with human needs (CF #9). In this setting assistance goes beyond treatment for the presenting physical problem, to include identification of the source of the illness or injury. Asking sensitive questions about implausible stories of causation, making probing questions a part of any assessment, implementing safety and reporting protocols, and aiding the woman to seek and use community resources after she leaves the emergency room are ways a nurse can demonstrate this carative factor.

In this study Watson's (1988) theory of nursing as human science and human care is used to define caring behaviors expected from emergency department nurses in interactions with women who may have been abused by a partner.

Theory of Reasoned Action

In a 1980 publication, Ajzen and Fishbein describe the major tenets of the theory of reasoned action.

According to the theory of reasoned action, a person's intention is a function of

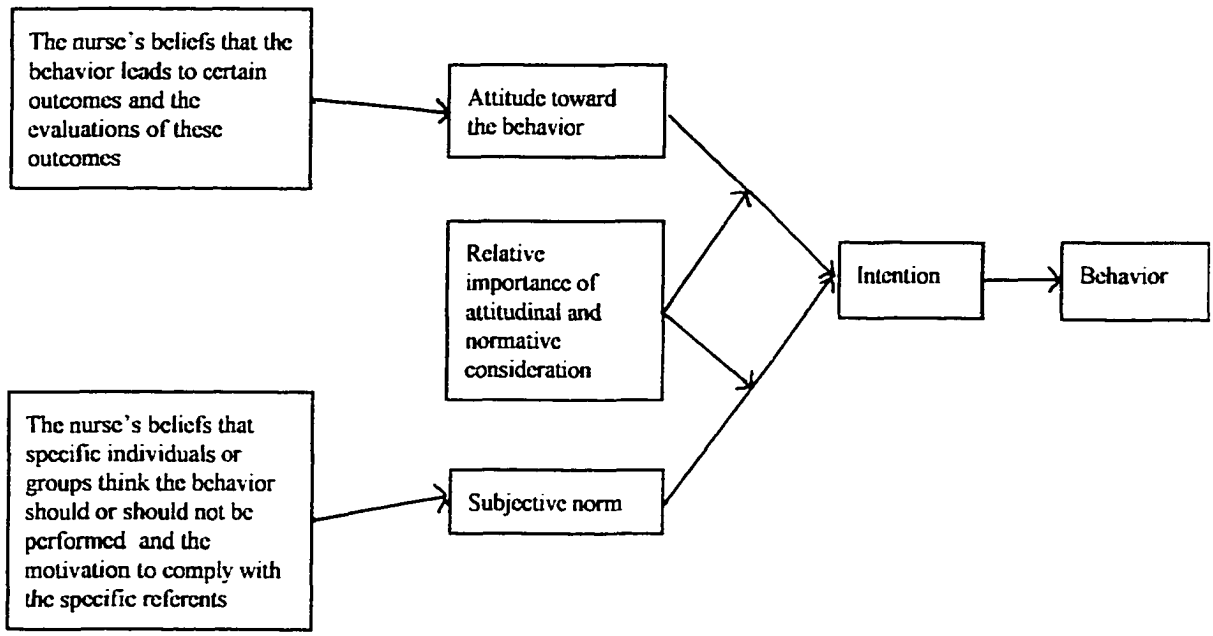
two basic determinants, one personal in nature and the other reflecting social influence. The personal factor is the individual's positive or negative evaluation of performing the behavior; this factor is termed attitude toward the behavior. It simply refers to the person's judgment that performing the behavior is good or bad, that he is in favor of or against performing the behavior. . . .The second determinant of intention is the person's perception of the social pressures put on him to perform or not perform the behavior in question. Since it deals with perceived prescriptions, this factor is termed subjective norm. . . .Generally speaking, individuals will intend to perform a behavior when they evaluate it positively and when they believe that important others think they should perform it. (p. 6)

In the theory of reasoned action (Ajzen & Fishbein, 1980), a person's intention is directly related to behavior, i.e. if the person intends the behavior, it is highly probable that the behavior will occur. The two influences on intention, attitude toward the behavior and the subjective norm carry different weights in different situations depending upon the relative importance of attitudinal and normative considerations as perceived by the person. Both the person's beliefs about the outcomes of the behavior and about the social pressure to perform the behavior may be influenced by external variables. The concepts of this theory are those of beliefs about the outcome of the behavior, attitude toward the behavior, beliefs that specific individuals or groups think the behavior should or should not be performed, motivation to comply with the behavior, intention to perform the behavior, and behavior. These are linked in the model adapted

from Ajzen and Fishbein (1980) (see Figure 1).

Two beliefs of nurses about the outcome of emergency room nurses applying carative factors in interactions with abused women may impact the nurses' behavior. One is the belief that abuse is not a problem and therefore it is unnecessary to demonstrate the caring behaviors described above. If the nurse believes that abuse is a problem, and that the outcome of caring behavior would result in helping the client resolve the problem, there should be a positive relationship between the belief, the attitude, the intention, and the behavior. The second pertinent belief is that abuse is not within nursing's realm of responsibility, and therefore nurses should not be treating it. This realm of responsibility might be defined by the institution and the expectations of superiors and peers. If the nurses believe abuse is not within their realm of responsibility, this may impact their intentions and thus their behaviors, even if they believe abuse is a problem. If the nurses believe it is in their realm of responsibility and they believe abuse is a problem, there should be a positive relationship between the beliefs, the attitude, the intention, and the behavior. If they do not believe abuse is a problem, and do not believe they are responsibile to do anything about it, the behavior is unlikely to occur.

The beliefs of emergency department nurses about abuse should lead to their attitudes toward carrying out caring behaviors toward abused wives. The attitudes of emergency room nurses can be directly linked to intentions and therefore to behavior, modified by the relative weight of subjective norms, using the theory of reasoned action (Ajzen & Fishbein, 1980) (see Figure 2).



Note: Arrows indicate the direction of influence

Figure 1. Factors determining a person's behavior.

Note. Adapted from Understanding attitudes and predicting social behavior (p. 8), by I. Ajzen and M. Fishbein, 1980, New Jersey: Prentice-Hall. Copyright 1980 by Prentice-Hall. Adapted with permission (see Appendix A).

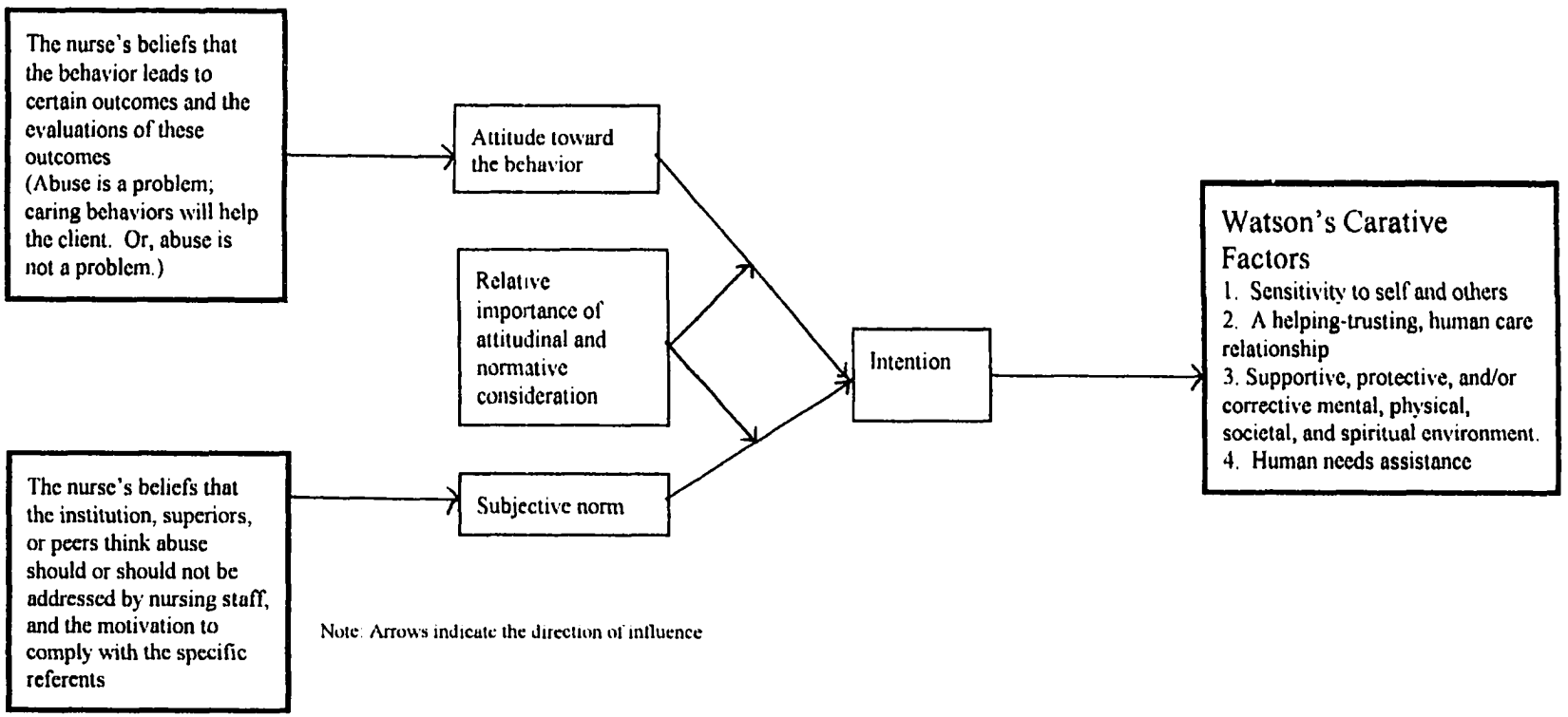


Figure 2. Factors determining a nurse's behavior, with behaviors identified as Watson's carative factors

Note. Adapted from Understanding attitudes and predicting social behavior (p. 8), by I. Ajzen and M. Fishbein, 1980, New Jersey: Prentice-Hall. Copyright 1980 by Prentice-Hall. Adapted with permission (see Appendix A).

In summary, the theory of nursing as human science and human care describes the expected nursing behaviors in terms of carative factors which include sensitivity to self and others; a helping-trusting, human care relationship; supportive, protective, and/or corrective mental, physical, societal, and spiritual environment; and human needs assistance (Watson, 1988). These are behaviors which are reasonably anticipated in any nurse-client interaction, and can be expected to be present in emergency room interactions between nurses and abused women. The theory of reasoned action describes the connection between beliefs held by the actor, the nurse, and observed or described behaviors, through the links of attitudes, intentions, and subjective norms.

Review of Literature

Research in family violence has spanned the professional domains of sociology, social work, psychology, medicine, nursing, feminist theory, and criminal justice. The impact on society is broad. Some of the early research came from general sociology and psychology with the focus on the dimensions and dynamics of the problem from the perspective of the individual and society (Straus, 1973, 1974; Straus, Gelles, & Steinmetz, 1980; Walker, 1979). Researchers then began to look at what happened to women when they reached the emergency room (Goldberg & Tomlanovich, 1984; Stark & Flitcraft, 1985). There have been a number of research efforts involving models and protocols for education of staff about domestic violence (McLeer & Anwar, 1989; McLeer, Anwar, Herman, & Maquiling, 1989), and assessment techniques, and interventions on behalf of abused women (Campbell, 1986). This review of literature will focus on the history of wife abuse from the nursing perspective beginning with some

of the psychology and sociology studies of abuse in general.

Attitude studies come largely out of psychology literature, and have been adapted to many different fields including nursing and patient compliance. The perspective of the medical and nursing staff, which impacts what happens to abused women in emergency rooms, was the subject of several studies in the late 1980's (Rose & Saunders, 1986; Kurz, 1987; McLeer & Anwar, 1989). Attitudes of nursing staff became the focus of a 1992 dissertation (Kilburn) that looked at the possible relationship between emergency department nurses' beliefs about battered women and their beliefs about women in general.

Discussion in the literature about abuse dates back to the 1960's when the focus on battered children brought violence in the home to the attention of the media and medicine, and led to mandatory reporting of such abuse. The initial connection between child abuse and wife abuse came through abuse involving pregnant women (Gelles, 1975), an area which continues to be researched. The connection between violence against children and violence against women has only recently been established in research (Campbell, 1994a), but early research describing the problem of wife abuse began to appear in the late 1970's and early 1980's. The first major descriptive work was published by Walker in 1979, and her book is still considered to be a seminal piece of work. At about the same time Dobash and Dobash (1979) published a descriptive work on wife battering. This was followed soon by several publications and much research by two psychology researchers, Straus and Gelles (1980, 1990) who, with others wrote about the problem both in professional literature and for the general public. Criticism of their

research and that of others in psychology appeared in the late 1980's with the introduction of a feminist perspective on wife abuse (Yllo, 1988). The critics addressed both methodology (self-reporting, biased instruments, and failure to distinguish levels of injury sustained in the abuse) and philosophy which included the fact that most of the researchers were male, and therefore targets of the charge of paternalism in their research bias.

The connection between the problem of abuse in the general population and its relationship to health care was described by Drake in a 1982 publication which identified battered women as a health care problem in disguise. Soon after that, Goldberg and Tomlanovich (1984) surveyed a general hospital emergency department and found that 22% of the patients identified themselves on a survey as domestic violence victims. Stark and Flitcraft reported in 1985 that abuse produces more injury episodes than auto accidents, muggings, and rape combined, and may be the most common cause of injury in women. In a study published in 1987, Kurz described the efforts of an emergency department to "medicalize" the battered woman, that is, to identify her problem as one requiring a response from medical professionals, not just a social problem. In Kurz's study, after education by a staff physician assistant about wife abuse, staff more frequently identified assessment and intervention with battered women as their responsibility, and responded more favorably to the battered women they encountered.

Bullock, McFarlane, Bateman, and Miller (1989) described the prevalence and characteristics of battered women in a study conducted in four clinics. In a review of intake forms from four Planned Parenthood clinics, the prevalence of physical battering

was found to be 8.2 %. Women seen in this setting who reported being battered were more likely to have experienced emotional problems, job loss, life changes, legal problems, parenting problems, and death of a family member than were non-abused women. Recent research (Muellman, 1996) looking at patterns of injury in battered women has demonstrated that women identified as physically abused are more likely to be injured in the head, neck, and torso, while non-abused injured women are more likely to come in with injuries in the spine and lower extremities.

Campbell, Pliska, Taylor, and Sheridan (1994) described the perceptions of battered women's shelter advocates and battered women regarding the treatment of battered women in emergency departments. Half of the battered women (50.0%) reported negative experiences in the emergency department, such as feeling humiliated, being blamed for their abuse, having abuse minimized, being given insufficient referrals, and not being identified as battered women. The advocates in this survey were employees of battered women's shelters. Their responses included recommendations for more education and training about battered women (34.2%), a need for the emergency department staff to facilitate referrals to advocates or shelters (28.9%), and some suggestions about how to treat battered women. These suggestions included "do not blame the woman, be empathetic, do not minimize her situation, and respect her decisions even if she returns to her batterer" (Campbell, Pliska, Taylor, & Sheridan, 1994, p. 284).

Efforts to change the experiences of these women have been tried in many places in the past ten years. Some of the efforts include education of staff (McLeer, Anwar,

Herman, & Maquiling, 1989), which was demonstrated to be insufficient by itself to change the failure of the emergency room staff to meet the needs of the abused women. A 1989 report of a study (McLeer & Anwar) done before and after the introduction of a protocol for assessment and intervention indicated that such instruments could be successful. Prior to introduction of a protocol designed to detect injuries caused by battering, 5.6% of female trauma patients were identified as battered. After the introduction of the protocol this increased to 30%. However, an eight year follow-up study showed that when on-going support and education are not present the percentage returned to 7.7% which is not statistically significantly different from the eight year earlier pre-protocol figure.

Research conducted in 1991 (Isaac & Sanchez, 1994) showed that only 20% of the responding emergency departments had protocols in place. Three model programs described in the literature have shown some success in increasing the numbers of women identified and referred in recent years. A post-shelter advocacy program for women with abusive partners showed improvement in their social support, quality of life, less depression, less emotional attachment to their assailants, and an increased sense of personal power (Sullivan, Campbell, Angelique, Eby, & Davidson, 1994). A hospital based program which sought to increase the identification rate for abused women entering the emergency department by providing 25 hours of in-service training to personnel is reported by Hadley (1992). Another purpose of this study was to provide support, information, education, and hospital or community resource referrals to battered women. On-going education of the staff was conducted, and the referrals to the advocacy

personnel by the staff increased from 15-20 women per month to 55-60 women referred per month at the time the article was written. Grunfeld, Ritmiller, Mackay, Cowan, & Hotch (1994) reported a study in which all women entering an emergency department were asked at triage whether they have any problem with violence or abuse in their lives. This produced an over-all rate of 6% of the women questioned, lower than most other reported studies. Campbell (1986) published a nursing assessment tool to determine the risk of battered women being killed by their partner. This tool has been used in several subsequent research efforts (Campbell, 1994b) and has been described as having adequate validity and reliability, while needing more research to confirm its predictive value.

In summary, research shows the problem of wife abuse exists in the general population, and the emergency department is one of the places where abused women are treated. There have been efforts to improve the care given these women when they reach the emergency department. Successful efforts have included staff education and on-going inservice to maintain a level of detection and assistance comparable to that achieved initially after education.

The theory of reasoned action says that educational and institutional pressures to enact a behavior are only part of what ultimately influences behavior (Ajzen & Fishbein, 1980). The other influence lies in the beliefs and attitudes of the person demonstrating the behavior. There have been a multitude of attitude scales and measures developed in recent years, measuring attitudes toward a large variety of things. Some of the attitude research pertinent to nursing includes a scale to measure nurses' comfort working with

clients who have been sexually abused, published by Gallop, McCay, Cote, Garley, Harris, and Vermilyea in 1994. A 1995 study by Carveth described avoidance by nurses when a patient was perceived as deviant. Another 1995 publication (Krueger) described the perception of sexual assault victim responsibility by emergency nurses when there was chemical use by the victim. A 1987 study by Briere of 191 university males concluded that 79% self-reported that they were likely to use violence in the future with a wife under at least one of five circumstances ranging from refusing to cook to publicly denying his masculinity. Briere states that "violence against wives is, to some extent, a socially acceptable phenomenon in North American culture" (p. 65).

This acceptance could presumably be extended to include nurses, and in fact, research has demonstrated that nurses' attitudes are quite consistent with those of the general public. Research specifically looking at attitudes of nurses toward abuse of women has been published in the past ten years. King and Ryan in a 1989 publication described several myths common in the general population, and among nursing professionals. These included:

1. Violence among family members is a private matter.
2. The abuse cannot be that terrible or the woman would leave.
3. Women who live in abusive relationships tend to become helpless.
4. Alcohol causes battering.
5. Battering occurs more frequently in certain racial and cultural backgrounds.

Rose and Saunders (1986) differentiated between the attitudes of nurses and physicians, and looked at the effects of gender and professional role. They found that women,

regardless of profession, were more sympathetic to the victim than were men ($p<.04$). Their research also demonstrated that liberal attitudes toward women in general were positively correlated with beliefs that wife-beating was not justified (nurses, $r=.21$, $p<.01$; physicians, $r=.35$, $p<.001$).

Two recent studies (Limandri & Tilden, 1996; Tilden, Schmidt, Limandri, Chiodo, Garland, & Loveless, 1994) looked at factors influencing the assessment and management of family violence, and specifically at nurses' reasoning in this assessment. The researchers were looking in both instances at the whole picture of family violence, including child, spouse, and elder abuse. One of their conclusions was that the extent of the subjects' (medical professionals) formal education on the topic of domestic violence had a significant impact on their suspicion of abuse in clients (95% Confidence Interval, 1.00 - 1.77 for physical spouse abuse and 0.98 - 1.98 for sexual spouse abuse). They concluded that there was a need for more attention to be paid to the subject of family violence in the curricula of nursing education programs. There was discussion in the 1996 Limandri and Tilden article about the different reasoning processes used by nurses when they are discussing cases clinically and when they are discussing legal reporting aspects of the cases. The reasoning process used when discussing abuse cases clinically followed a relational pattern. Subjective feelings, insight and intuition played a part in their judgment. When discussing the reporting of abuse cases to protective services, however, the nurses used a more linear style of reasoning, including hard physical evidence. Since there are not mandatory reporting laws for wife abuse, this may not be clinically significant, but is of interest in attempting to sort out all of the influences on

caring behaviors. These behaviors might include assisting a woman to seek community services, including perhaps protective services for her children or a restraining order.

Gender influences on reporting behaviors were also discussed by Tilden et al (1994). For spouse abuse, women were one-and-a-half times more likely than men to consult with another professional about suspected abuse. Men were one-and-a-half times more likely than women to discuss their observations about possible abuse with a family member. This was across professional lines, including dental hygienists, dentists, physicians, nurses, psychologists, and social workers.

These two research reports (Limandri & Tilden, 1996; Tilden, Schmidt, Limandri, Chiodo, Garland, & Loveless, 1994) were based on a triangulated study using survey and ethnological methods. They used interviewing and the analysis of narrative data using content analysis and constant comparative technique. The sample for the 1994 paper included clinicians in six disciplines, and had a sample size of 1521. The 1996 paper used just the nursing portion of the total sample, and had a sample size of 241. One of the findings included in the discussion of spousal abuse was that

> respondents became entangled in notions about culpability and responsibility for being victimized or assaultive. . . .With spousal abuse. . .both parties were culpable. . . .There was little awareness of the complexities that might influence spousal abuse and little tolerance for adults perceived as participating in their own abusive situation. (p. 251)

Two recent research studies have focused on different populations but with the goal of investigating the influence of education on the attitudes of health care

professionals and their screening behaviors for intimate partner abuse (Moore, Zaccaro, & Parsons, 1998; Smith, Danis, & Helmick, 1998). The Moore, Zaccaro, and Parsons study investigated the education, attitudes, and practices related to domestic violence of perinatal nurses in three practice sites. They found that only 54% reported having education about domestic violence in either formal or continuing education programs. Their findings suggested that education related to domestic violence does make a difference in practice. The Smith, Danis, and Helmick study surveyed a sample of physicians and a few nurses in a variety of outpatient care settings and looked at factors associated with screening behaviors. They found that the perception of professional preparation was the primary factor distinguishing clinicians who generally engage in any of the screening behaviors from those who do not.

Research on attitudes of emergency department nurses has shown that there is consistency between attitudes in the general public, which are based on myths, and those of emergency department nurses. Kilburn's research reported in her 1992 dissertation primarily addressed the hypothesis that "emergency department nurses who hold positive beliefs about women will hold more negative beliefs about wife beating than nurses who hold negative beliefs about women" (p. 9). As part of additional analysis of the data, she stated that she was interested in determining "if a difference existed between emergency department nurses' beliefs about wife beating and self-reported behavior of emergency department nurses toward women" (p. 65). This study was conducted in a southern state with a sample of 247 nurses employed full-time in the emergency departments of 63 of the 90 hospitals in the state with emergency departments. The nurses were surveyed

using the Beliefs About Women Scale (Belk & Snell, 1986) and the Inventory of Beliefs About Wife Beating (Saunders, Lynch, Grayson, & Linz, 1987). A demographic questionnaire was used which included the following question:

> Which of the following represent typical behavior of ER nurses in your opinion? (check one)
>
> (1) They establish a therapeutic interpersonal relationship with battered women.
>
> (2) They treat the physical injuries of battered women and ignore the emotional abuse.
>
> (3) They treat both physical and emotional abuse equally.
>
> (4) They resent or have ambivalent feelings about having to encounter battered women in the emergency room. (p. 107)

Kilburn's hypothesis was that emergency department nurses who hold positive beliefs about women will hold more negative beliefs about wife beating than nurses who hold negative beliefs about women (1992). The results of the initial analysis of data with respect to the hypothesis using Pearson product-moment correlation coefficients gave low to moderate correlation coefficients, the highest being 0.27. Kilburn concluded that the nurses believed in traditional roles of women and that these beliefs were not related to their beliefs about wife beating. When she factored in other variables such as basic education, years of emergency department nursing experience, and personal knowledge of abuse, the correlation coefficients were reduced to .10 to .01, which she states indicates "a spurious relationship between the beliefs about women and beliefs about wife beating" (p. 56).

The secondary question of a relationship between beliefs about wife abuse and behavior toward battered women was analyzed using Analysis of Variance (ANOVA) to test the significance of the differences between the means of the subscales of beliefs about wife beating and "self-reported typical behavior of these emergency department nurses" (Kilburn, 1992, p. 66). The ANOVA showed no statistically significant differences.

Some of the factors identified in the failure of this study to support the hypotheses include the location of the study (in Appalachia where culture and religion place women in a subservient role), the lack of support systems and resources for women who might be assisted to leave an abusive situation, a lack of education on the part of the nurses about abuse, and the significant proportion of nurses who reported personal acquaintance with a battered women or personal experience as a victim of abuse (Kilburn, 1992, p. 73). It was of interest that 96% of the respondents said that help should be given, although only about half said that nurses would address both physical and emotional problems.

A factor in the failure of the ANOVA to demonstrate statistically significant differences in the means of subscales of beliefs about wife beating and the typical behaviors of the nurses toward battered women may be that the question being asked was not a self-reported measure of the nurse's behavior, but a measure of the nurse's beliefs about how nurses behave. The findings may be invalid because the wrong question, or insufficient questions may have been asked and analyzed.

Summary and Implications for Study

The literature at this time gives clear indication that wife abuse exists as a problem in society, and that women who are abused sometimes seek medical assistance in emergency departments. The people who work with them in the emergency departments include nurses. Studies have demonstrated that the attitudes of the general public, and of nurses, are based on the belief of myths about abuse, abusers, and victims of abuse. Abused women have identified emergency rooms as places which have not been consistently helpful in resolving or addressing the problem of abuse, and the people in the emergency rooms, such as nurses, as failing to assess or refer when the abused woman is treated. Research has shown the effectiveness of protocols and the ineffectiveness of education alone on the outcomes.

An area which is not described in the literature is whether there is a correlation between an individual nurse's beliefs about abuse and an individual nurse's likelihood of including assessment, assistance, and referral in the nurse/client interaction with wives who may have been abused. It is this area which was addressed in this study.

It is important to nurses that they carry out screening and assistance behaviors because it is possible that with appropriate nursing care given at the time of visiting the emergency department, the abused woman may deal with the cause of the visit, and thus prevent future injuries or illnesses produced by the same cause. Since one of the goals of individual nursing care is health promotion/disease prevention, screening behaviors are consistent with the nursing role. It is inconsistent with nursing care to treat an injury without thinking about what is necessary to prevent it from happening again, whether

that is education, referral, or ultimately social action. Thus there is importance to the broader field of nursing which looks at the educational and social dynamics of treating abuse, and on institutional and educational ways of changing this health risk by changing beliefs of the nursing staff.

Hypothesis/Research Questions

This study will address the following questions:

1. What are the beliefs of emergency department nurses about wife abuse, abusers, and abuse victims?

2. What are the self-reported behaviors of emergency department nurses when working with abused wives?

3. What is the likelihood of emergency department nurses to demonstrate the carative factors as defined by Watson (1988) when working with abused wives?

4. What are the perceptions of emergency department nurses about the subjective norms with respect to intervening with abused women?

5. Is there a statistically significant relationship between emergency department nurses' beliefs about wife abuse, abusers, and abuse victims and their self-reported behaviors when working with abused wives?

6. Is there a relationship between emergency department nurses' beliefs about wife abuse, perceptions of subjective norms, and use of caring behaviors when working with abused wives?

This study proposes the following hypotheses:

1. Emergency department nurses who believe wife abuse is not justified will

report greater use of caring behaviors in their work with abused women than will nurses who believe wife abuse is justified.

2. Emergency department nurses who believe wife abusers should be punished will report greater use of caring behaviors in their work with abused women than will nurses who do not believe wife abusers should be punished.

3. Emergency department nurses who believe abuse victims should be helped will report greater use of caring behaviors in their work with abused women than will nurses who believe abuse victims should not be helped.

4. Emergency department nurses with higher scores on the subscales of beliefs about wife abuse and who perceive a subjective norm supportive of intervention with abused wives will demonstrate greater use of caring behaviors with abused wives.

Definition of Terms

1. Emergency Department - an area of the acute care hospital which receives and treats non-scheduled patients with acute illnesses or injuries.

2. Emergency Department Nurse - a registered nurse who provides nursing care in the emergency department of a hospital.

3. Wife Abuse - intentional hitting by a male spouse or partner which inflicts pain on a female over the age of 18. Resulting injury may range from long-term low level injury evidenced in symptomatic illness to acute serious injury short of homicide.

4. Belief - a statement of what one considers to be true.

5. Behavior - one's treatment of others.

6. Carative factors - caring behaviors expected of nurses in carrying out their role, as defined by Watson's theory of nursing as human science and human care. Caring includes use of assessment skills and relationships to provide the environment needed to treat and assist with referral of women who have been abused.

CHAPTER 3

METHODOLOGY

Research Design

A descriptive correlational survey design was used to examine the beliefs of emergency department nurses about wife abuse and their self-reported behaviors toward abused wives treated in the emergency department. Survey technique is appropriate to the research questions since beliefs can only be studied through self-report. Indirect methods of observation of behaviors would imply assumptions about the underlying beliefs (Woods & Catanzaro, 1988, p. 278). Observation of behavior would be possible, although problematic with the confidentiality and human subjects protection limitations of the staff-client relationship. The population of interest in this study is emergency department nurses, and the sample was self-selected from all of the emergency department registered nurses in the hospitals involved..

The survey design has the advantage over an interview design in that it can be completed at the convenience of the subject. Therefore a larger sample was probably included. This design provides greater anonymity than interviews in responding to sensitive questions of personal beliefs and behaviors. It focuses specifically on the target issues, beliefs and behaviors.

Disadvantages of the survey design include the fact that it is dependent upon the

willingness of the respondents to report on the topic. Nurses who did not complete the survey may have specific characteristics which will remain unknown to the investigator and may be relevant to the beliefs and behaviors being studied. If individuals were chosen for interviews, they would need to openly choose not to participate, rather than simply failing to complete a survey. Thus interviews may have changed the possibility of including subjects with relevant differences in the studied characteristics.

External factors which needed to be controlled in this design include environment, time, and communication with the subjects. The survey was distributed in the emergency department, although the subjects could take the survey elsewhere to complete it. Because of the sensitivity of the topic, the personal emotional content for some subjects, and the busyness of the setting, the work environment may not have been the best place for completion of the survey. Responses to the questions may differ based on the role the person assumes in the setting in which the survey was completed. This could have been controlled by requesting that the surveys be completed on site. Since that may have limited the response rate, it was not requested.

The dimension of time includes two factors. One is the shift the nurses customarily work. This may have influenced their exposure to dealing with abused wives or the types of injury or illness they see. The timing of recent education programs in each of the hospitals could also have impacted the results of the study since education has been shown to modify behavior. This education varied from one hospital to the next. That influence was monitored through a question on the characteristic data questionnaire about current or recent education on the topic of abuse.

Communication with the subjects was an external factor which needed to be controlled, since more than one hospital and different shifts made it impossible for the researcher to communicate verbally with all subjects at the same time. Consistency was addressed with a cover letter detailing the purpose of the study, the use to be made of the data, under whose auspices the study was being conducted, and the process of completing and returning the surveys.

Internal factors may have limited the design as well. Age, gender, and education have been demonstrated to be influential in a person's beliefs and behaviors. In addition, a nurse's years of professional experience as well as the personal experience of abuse or experience in a person of close relationship could have influenced the variables in question. Each of these factors was included as part of the characteristic data questionnaire, to allow for evaluation in the analysis phase of whether and how they influenced the results.

Threats to internal validity potential in this design include history and differential selection. History, including the prominent media coverage of the O.J. Simpson trial throughout 1995 and 1996 and the increasing discussion of gender issues since the Thomas-Hill hearings (Danforth, 1994, p. viii) has resulted in discussion in the general public about abuse of wives and women. Presumably this discussion extends to nursing. It is difficult to include in a survey all the potential sources of influence on beliefs, or to control for what is currently in the media in on-going situations such as these.

Differential selection produced by self-selection in returning or not completing survey forms could have influenced internal validity. A way of reducing this threat was

through the use of a reminder a week after the surveys were distributed.

One threat to the external validity of this study was the characteristics of the population from which the sample is drawn. The West Michigan area has a small-town intimacy which is different from rural or large urban settings (Olson, 1996, p. 57). This will limit generalization and indicate a need for replication of the study in a different setting with subjects of different geographic perspectives.

Sample and Setting

The setting for this study was the emergency departments of major acute care hospitals in the Greater Grand Rapids, Holland, and Kalamazoo, Michigan area. This was a sample of convenience, and was dependent upon the approval of the hospitals and nurse managers in these departments. Adding outlying hospitals in rural areas and nearby small communities may have allowed for a more diverse sample but would have limited the possibility of communicating directly with the nurses to enhance the return of surveys.

The sample was composed of emergency department nurses in the emergency departments of these seven hospitals. These were registered nurses, licensed to practice nursing in this state, who were employed in the emergency department. The population included all of the nurses employed by the seven hospital emergency departments. All of the hospitals and department managers contacted were willing to participate. The sample size was limited by willingness of the individual nurses to complete the survey and return it. Contact was made in person or by telephone with each of the department managers or designated contact persons to enhance hospital participation. Contact was

requested with as many of the staff nurses as possible, through a presentation at a staff meeting or change of shift report, to enhance survey returns. A target of 100 completed surveys was anticipated.

Instruments

Three instruments were used in this survey: Inventory of Beliefs About Wife Beating (IBWB) (Saunders, Lynch, Grayson, & Linz, 1987), a Carative Factors Tool (CFT) developed by the investigator, and a characteristic data questionnaire developed by the investigator (see Appendix B).

Inventory of Beliefs About Wife Beating

The Inventory of Beliefs About Wife Beating is a 31-item scale developed by Saunders, Lynch, Grayson, and Linz. Permission was sought from Daniel Saunders to use the scale in this study, and the investigator was told the inventory is in the public domain and may be used without permission. The inventory includes five subscales for analysis (Saunders, Lynch, Grayson, & Linz, 1987). The five subscales were derived through a factor analysis on student samples. Wife-beating is defined on the IBWB as it is in the present study, as hitting intended to inflict pain. The inventory includes both attitudes and beliefs, but the authors called it an inventory of beliefs to make its contents sound less controversial or threatening to respondents.

The five subscales are as follows:

1. Wife beating is justified (WJ).
2. Wives gain from beatings (WG).
3. Help should be given (HG).

4. Offender should be punished (OP).

5. Offender is responsible (OR).

Each item on the IBWB is scored on a seven-point Likert scale, from strongly agree (7) to strongly disagree (1). A high score on each of the scales would indicate agreement with the statement heading the subscale. In two studies using this measure (Kilburn, 1992: Rose & Saunders, 1986), mean scores on scales WJ and WG were low indicating belief that wife beating is not justified and the wives do not gain from beatings. High scores on HG indicated that help should be given.

Three of the subscales were used in the current study to measure the independent variable of beliefs about wife abuse, the eight-item WJ scale, the five-item OP scale, and the six-item HG scale. The alpha coefficient of internal reliability in the current study for the WJ scale was .73, for the OP scale it was .73, and for the HG scale is was .72. The authors of the inventory consider that the major strength of the measure is its validity. Support for its validity was detetermined through an evaluation of the relationship of the five subscales with theoretically relevant constructs. In particular this involved a study of several diverse samples using tools with known validity, such as the Attitudes Toward Women Scale and the Rape Myth Acceptance Scale (Burt, 1980). Known groups validity was established for groups ranging from advocates for battered women to men who batter. A major limitation of the measure is the internal reliability of three of the subscales (HG, OP, OR) which fell at the low end of the acceptable reliability.

Seven questions were added to this scale by the researcher for this study to

provide data on nurses' perceptions of the support of the institution, superiors, and peers for nurses intervening with abused wives. These responses were grouped to form a composite score measuring the subjective norms regarding assisting abused wives.

Carative Factors Tool

A Carative Factors Tool was developed by the researcher and used as part of this study. The tool included ten questions about self-reported behaviors used with abused wives, reflecting the four carative factors described in the Watson (1988) theoretical framework, 1) sensitivity to self and others, 2) a helping-trusting, human care relationship, 3) supportive, protective, and/or corrective mental, physical, societal, and spiritual environment, and 4) human needs assistance (see Table 1). It is assumed nurses could use some or all of these behaviors with women in the emergency department who may have been abused. The Carative Factors Tool generated a Caring Beliefs Score (CBS), which was a sum of the individual respondent's scores on the tool. A Likert scale was used for the responses to this part of the questionnaire. This type of question was not used in the Kilburn (1992) study, and has not been previously tested for reliability.

The Characteristic Data Questionnaire

A characteristic data questionnaire was used to gather data which allowed for analysis of internal factors affecting behaviors such as age, gender, education. The Kilburn (1992) questionnaire included 24 questions, some requiring a number, such as age, and some requiring the choice of an answer ranging from one to eight. The characteristic data questionnaire in this study included 18 questions, some with multiple yes-no responses. Several of the questions were similar to the questions in the Kilburn

Table 1

Watson's Carative Factors Addressed by Specific Questions on the Carative Factors Tool.

Carative Factors	Items
1. (CF#3) Sensitivity to self and others	a. Ask about visible injuries which are not the presenting complaint b. Ask further questions if the mechanism of injury reported is unlikely c. Ask if the woman has ever been hit, kicked, punched, or slapped by her partner
2. (CF#4) A helping-trusting, human care relationship	d. Try to spend enough time with the woman to gain her trust e. Attempt to talk with the woman without the partner
3. (CF#8) Supportive, protective, and/or corrective mental, physical, societal, and spiritual environment	f. Discourage the partner from staying in the room if abuse is suspected g. State suspicions of abuse verbally to physician h. Chart suspicion of abuse
4. (CF#9) Human needs assistance	i. Make a referral if battering is suspected or verified j. Assist the woman in obtaining help

study. The tool was designed to have the most sensitive questions, with the greatest possibility of evoking an emotional response from the subject, at the end of the last page. A subject could complete all but the last page without encountering personal references to experience with abuse. An open-ended question allowing for written response ended the questionnaire.

Procedure

In carrying out this study, the first step was to obtain institutional review board approval from Grand Valley State University. Next the investigator contacted the

research person in the seven acute care hospitals included in the study in person or by telephone. A copy of the research proposal was sent that included a cover letter in which the study purpose and process were briefly described (see Appendix C). The letter also included the offer to share the results with the hospital when the study was completed. Both permission to ask the emergency department nurses to participate, and the name of the contact person in the department was requested. The institutional review board in each of the hospitals, or a review process specified by the hospital, was involved in the hospital's processing of the request. Upon receipt of permission and the names of the appropriate departmental contact persons, the researcher contacted each in person or by telephone to determine the best route to make information about the study known to the greatest number of nurses in the department. Usually this was a staff meeting.

After permission was obtained and the target population informed about the study, the surveys were distributed in each participating hospital, by placing the surveys, or asking the appropriate person to place the surveys in each nurse's mailbox. A cover letter included information about the study (see Appendix D) which was the same as the verbal information given in the meeting with the nurses. Returning the completed survey implied informed consent. A return envelope was included with the survey packet in which to return the survey whether or not it was completed. The survey was returned in the envelope, placed in an enclosed, sealed box on site, in a location determined in conjunction with the staff. One week after the survey was distributed, a reminder note was distributed, using the same mechanism of distribution as for the surveys. Since return of the surveys was anonymous, this reminder was given to everyone with a note of

thanks if the person had already returned the survey. A follow-up note of thanks to the department was written a month after the survey was completed at that site. Since the completion of the surveys was voluntary, anonymous, individual, and confidential, there was no risk to the participants. The possible benefit to the nurses was to raise their awareness of abuse. Individuals who have had emotionally disturbing personal experience with abuse may have been uncomfortable answering some of the questions about personal experiences.

The returned data were kept in a locked file in the office of the researcher and were used only for this study. The tools were destroyed after completion of the data analysis.

CHAPTER 4

DATA ANALYSIS

In this chapter the data compiled from the three instruments will be presented and analyzed. Analysis of the data gathered in this study was conducted using the Statistical Package for the Social Studies (SPSS for Windows).

Description of Sample

Surveys were distributed in each of the seven hospitals to all of the RN staff working in the emergency department on a full-time, part-time, or per diem basis. They were distributed by either the unit secretary, department manager, or clinical educator. The total number distributed was approximately 340. Surveys were returned by 97 emergency department nurses from the seven participating hospitals. Four of those could not be used for various reasons, (respondent was not a Registered Nurse, survey returned after data analysis initiated, an entire page not completed) leaving a sample size of 93. The nurses ranged in age from 24 to 60 with a mean age of 42. Years of experience in nursing ranged from 0 (less than six months) to 40 years with a mean of 17 years. Years of experience in emergency department nursing ranged from 0 (less than six months) to 32 years with a mean of 9 years. Day shift nurses were 45% of the sample, 25% were evening staff and 25% were night shift staff, and 5% worked a combination of shifts. Other characteristic data can be seen in Table 2.

Table 2

Characteristics of ED Nurses in Sample

Variable	n	Percent
Gender		
Female	87	93
Male	6	7
Ethnic background		
Caucasian	91	98
Asian	1	1
Hispanic	1	1
Marital Status		
Married	68	73
Divorced	13	14
Separated	1	1
Widowed	1	1
Never Married	10	11
Religion		
Catholic	21	26
Protestant	53	66
Other	6	8
Declined to answer	13	
Nursing Education		
Associate Degree	30	32
Diploma	20	22
Bachelor of Science in Nursing	27	29
Non-nursing Baccalaureate	9	10
Masters in Nursing	4	4
Non-nursing Masters	3	3

Education and information about abuse were addressed by questions about hours of lecture on abuse in the respondent's formal nursing education (see Table 3). For 93% of the respondents the most recent source of information was within the last year, 70% within the last six months.

Table 3

Education about Abuse for ED Nurses in Sample

Variable		n	Percent
Formal Education about Abuse			
	Less than two hours	64	84
	More than two hours	12	16
	Declined to answer	17	
Recent Education about Abuse			
	Lecture or Grand Rounds	38	41
	Work in family violence center	1	1
	Workshop or symposium	33	36
	Nursing journal article	74	80
	Hospital inservice	53	57
	Television	78	84
	Newspaper	76	82
Most Recent Source of information			
	Hospital inservice	25	30
	Nursing journal article	15	18
	Television	16	19
	Newspaper	16	19

Individual experience of the emergency department nurses with abuse was explored with questions about contact with abused wives in the emergency department. Nurses were also asked about personal experience with friends and relatives who were abused, and about very personal experience with being abused themselves. Most of the nurses (90%) said they encountered between zero and five women per month in the emergency room whom they suspect as being physically abused wives but who are not diagnosed as such. About the same number (90%) said they encountered between zero and four diagnosed physically abused wives in the emergency room per month.

Responses to the question whether the nurse personally knew any physically abused wives are listed in Table 4. Two of the 21 nurses who identified themselves as

Table 4

Personal Experience with Wife Abuse by Surveyed Emergency Department Nurses

Relationship	n	Percent	Relationship	n	Percent
coworker	52	56	mother	12	13
friend	44	47	aunt	6	7
self	21	23	daughter	3	3
neighbor	17	18	other	8	9
sister	13	14			

being abused also checked that they are currently in an abusive relationship.

The final question on the characteristic data questionnaire was an open-ended question asking for any comments the respondent wished to make. These responses may be found in Appendix E.

Techniques

Responses to individual items on each of the survey instruments were summed and listed by frequency and valid and cumulative percent. The scoring of the Carative Factors Tool (CFT) was reversed to allow a high score to mean high self-reported caring behaviors. The item scores were summed for each subject to give a Caring Behaviors Score (CBS). Prior to distributing the surveys, seven items were added to the Inventory of Beliefs about Wife-Beating (IBWB) to measure the subjective component of institutional support for caring behaviors. The scores for these seven items were summed for each individual survey to give an Institutional Support Score (ISS). The

remaining 31 items on the IBWB were either summed directly, or reversed as directed by the authors of the inventory (Saunders, Lynch, Grayson, & Linz, 1987, p. 56). The items were grouped into subscales as directed and the scores for the subscales summed for each individual survey. The Likert scale used in this survey was reversed from the direction of the scale in the original instrument, so low scores on each subscale supported the statement heading the subscale. For example, a low score on Subscale A. Wife-Beating is Justified (WJ) would indicate the respondent agreed that it is justified.

Measures of central tendency were computed for each of the cumulative scores. Alpha coefficient of reliability was computed for the CFT and for each of the subscales of the IBWB used in this study (see Table 5). Item 38 on the IBWB ("If a man is

Table 5

Reliability of Scales

Scale Name	Items on Scale	Alpha Coefficient of Reliability
Caring Behavior Scale (CBS)	10	.89
Institutional Support Subscale (ISS)	7	.74
Wife-beating is Justified (WJ)	12	.72
Help Should be Given (HG)	5	.67
Offender Should be Punished (OP)	5	.52

convicted of beating his wife how long should he spend in prison or jail?") negatively affected the reliability of the Offender Should Be Punished (OP) scale. Since 68.8 % responded "Don't know" and one respondent did not answer the question, the question

was removed from the scale for further computation. According to Woods and Catanzaro (1988), "when the investigator is using the measure for group-level comparisons, the reliability coefficient typically must exceed .7 for new scales" (p. 248). The reliability score in Table 5 reflects the scale without item 38.

In order to answer the research questions and test the hypotheses, several additional statistical measures were run. The items on the CFT and the beliefs, other than institutional support, were ranked by means. Pearson's correlation coefficients were run for CBS, ISS, and the three subscales WJ, HG, OP. The CBS and HG scales, and the CBS and ISS showed positive correlation. Multiple regression analysis was computed for these three scales, and a linear regression was computed for the effect of ISS on CBS. Finally, t-tests were computed for the three subscales of beliefs with respect to their relationship to caring behaviors.

The three variables that were studied were the beliefs and attitudes of emergency department nurses about wife beating, the self-reported behaviors of the same nurses when interacting in the emergency department with women who may have been abused by their partners, and the institutional support (subjective norm) perceived by the nurses. Each of these variables were measured on Likert scales with responses ranging from one to five on the CFT and one to seven on the IBWB. The summation of data was measurable on an interval scale, allowing for use of Pearson product-moment correlation coefficient analysis.

Research Questions

The six research questions addressed by the study are as follows:

Question One

1. What are the beliefs of emergency department nurses about wife abuse, abusers, and abuse victims?

The Inventory of Beliefs about Wife Beating (IBWB) groups the 31 questions on the original instrument into five subscales. The scores on the subscales can be used to describe the beliefs about wife abuse, abusers, and abuse victims. Three of the subscales were used this study in describing the beliefs of emergency department nurses: Wife Beating is Justified (WJ), Help Should be Given (HG), and the Offender Should be Punished (OP).

On the WJ subscale, responses to questions 2, 4, 6, 7, 8, 12, 13, 26, 31, 33, 34, and 37 were included in the summary. A low score on this scale indicated support for the statement that wife beating is justified. The range of possible scores was 12 to 84. The actual range of responses was 59 to 84 with a mean score of 79.3. This high score indicates low support for the statement that wife beating is justified. These nurses did not believe wife beating was justified.

The second subscale, the HG scale, included responses to questions 1, 9, 10, 19, and 36. A low score on this scale indicated support for the statement that help should be given to an abused wife. The range of possible scores was 5 to 35. The range of responses was 5 to 18 with a mean of 8.8 and a median of 8. This low score indicates support for the statement help should be given to an abused wife. The nurses believed

help should be given.

The OP subscale regarding punishment for the offender included five questions, 22, 23, 24, 29, and 38. A low score on this scale indicated support for the statement that the offender (the abuser) should be punished. The range of possible scores was 5 to 36. One of the questions (38) had as a possible response "don't know." This response was chosen by 68.8% of the respondents, making the value of the responses in the total score questionable. The range of possible scores without this question was 4 to 28. The range of actual responses without this question was from 4 to 22, with a mean of 13.3 and a median of 14. Interpretation of these scores would be that there was neither strong support for nor against the statement that the offender should be punished.

Question Two

2. What are the self-reported behaviors of emergency department nurses when working with abused wives?

The self-reported behaviors in this study were listed in the Carative Factors Tool. The ten questions asked how likely it is that the nurse will do the listed things when assigned to a woman in the emergency department for treatment (see Table 6). Questions with a response of "likely" or "very likely" from more than 85% of the respondents could be considered behaviors in which the nurses are likely to engage. The questions meeting this criteria were a, b, e, g, i, and j. Of these behaviors, the most likely (99%) was to state suspicions of abuse verbally to the physician. Less than 85% of the nurses reported "likely" or "very likely" in response to questions c, d, f, and h. The least likely behavior was to chart suspicion of abuse. Possible scores on each question of this

Table 6

Self-Reported Behaviors by ED Nurses

With Women in the ED for Treatment

Behavior	very likely	likely	unsure	unlikely	very unlikely
a. Ask about visible injuries which are not the presenting complaint	50	37	5	7	1
b. Ask further questions if the mechanism of injury reported is unlikely.	52	38	7	2	1
c. Discourage partner from staying in room if abuse is suspected.	45	39	11	4	1
d. Try to spend time with woman to gain trust.	26	52	14	6	2
e. Attempt to talk with woman without partner.	55	37	5	2	1
f. Ask if woman has ever been hit, kicked, punched, or slapped by her partner.	34	37	14	12	3
g. State suspicion of abuse verbally to physician.	71	28	1		
h. Chart suspicion of abuse	34	26	34	5	1
i. Make referral if abuse is suspected	49	39	11		1
j. Assist woman in obtaining help.	57	38	4		1

tool ranged from 1 to 5. The mean for the individual questions ranged from 4.68 to 3.86 (see Table 7).

Table 7

Caring Behaviors Ranked by Mean

Behavior	N	Mean	Std Dev
g. states suspicion to MD	93	4.68	.59
j. assists in getting help	93	4.49	.69
e. try to talk without partner	93	4.42	.78
b. ask about unlikely mechanism	93	4.37	.80
i. make referral	93	4.35	.76
a. ask about visible injuries	93	4.26	.94
c. discourage partner from staying	93	4.23	.89
d. spend time to gain trust	92	3.95	.91
f. ask about history	93	3.87	1.12
h. chart suspicion	92	3.86	.99

Question Three

3. What is the likelihood of emergency department nurses to demonstrate carative factors as defined by Watson (1988) when working with abused wives?

Demonstration of carative factors, or Caring Behavior Score (CBS) was defined as the cumulative score on the CFT for each respondent. A high score indicates high reported use of caring behaviors by the nurse. The potential score for this tool ranged

from 10 to 50. The responses from this sample of nurses ranged from 12 to 50 with a mean of 42.5 and a median of 44. This says that nurses report high use of caring behaviors when working with women who may be abused.

Question Four

4. What are the perceptions of emergency department nurses about the subjective norms with respect to intervening with abused women?

Beliefs about the support of the institution, superiors, and peers for nurses intervening with abused wives were measured. These subjective norms were defined as the cumulative responses to seven questions about institutional support that were added to the IBWB, questions 5, 11, 16, 21, 25, 28, and 32. The possible range of responses to these questions was 7 to 49. The range for this sample of nurses was from 27 to 47 with a mean of 37.5 and a median of 38. This indicates belief that the subjective norm supports intervening with abused women.

Question Five

5. Is there a statistically significant relationship between emergency department nurses' beliefs about wife abuse, abusers, and abused wives and their self-reported behaviors when working with abused wives?

Question Six

6. Is there a statistically significant relationship between emergency department nurses' beliefs about wife abuse, perceptions of subjective norms, and use of caring behaviors when working with abused wives?

The Pearson product-moment correlation coefficient was used to determine the

probability of a relationship between beliefs and behaviors existing at a level of $p < .05$. Correlation coefficients were calculated for the relationship between self-reported behaviors and each of the three subscales in the IBWB (see Table 8). Of these three subscales, only the subscale HG, the belief that help should be given to the abused wife, showed a correlation with the report of caring behaviors at a significant level.

Table 8

Correlation of WJ, HG, OP and ISS Subscales

With Caring Behavior Scores

Subscale	Correlation Coefficient	Cases	P
WJ	.1579	88	.142
HG	-.2273	87	.034
OP	.1206	89	.260
ISS	.4407	85	.000

Perception of subjective norms was defined as the score on the beliefs about institutional support questions of the beliefs inventory. Possible scores on this section range from 7 to 49. Actual range on the surveys returned was from 27 to 47. A high score on this summary of beliefs indicated a high level of belief that various components of the institution supported the nurse in helping abused women. The mean for the component was 37.5, and the median was 38. Individual scores on each question had a range from 1 to 7. The means for all of the questions about individual or professional

support for caring behaviors ranged from 5.5 to 5.9. The questions about the referral process had lower means - 3.9 to 4.9 There were missing data from six surveys; four of these were on the question about finding the institutional protocol effective. Some nurses wrote in that they were not aware of a protocol.

Pearson product-moment correlation coefficient was calculated for the relationship between caring behaviors and subjective norms, and this showed statistical significance. The r value was .4407 with $p = .000$. Multiple regression analysis was done using caring behaviors, subjective norms, and the subscale HG from the Inventory of Beliefs About Wife Abuse, since that was the only subscale showing significant relationship to caring behaviors. The regression results showed an F value of 9.43 with significance of .0002 (see Table 9). When separated for influence of the variables, the t value for subjective norms was 3.75 with significance of .0003. The t value for the HG scale was -.626 with significance of .5530. There was a significant influence of subjective norms on caring behaviors. The presence of subjective norms supporting nurses providing care for abused wives may predict some of the reporting of caring behaviors by these emergency department nurses.

Table 9

Multiple Regression for the Influence of the Belief that Help Should be Given and of Institutional Support on Caring Behaviors

R Square	F	Significance of F	Variable	t	Significance of t
.19276	9.43	.0002	HG	-.626	.5330
			ISS	3.750	.0003

Hypotheses

The four hypotheses for the study were:

1. Emergency department nurses who believe wife abuse is not justified will report greater use of caring behaviors than will nurses who believe wife abuse is justified. A one-tailed t-test was used with the median score of 83 as the dividing point. The result was t =-1.19 with df = 86 and p = .119. The hypothesis was rejected, meaning that the data does not support that there is a difference between the caring behaviors of nurses who believe wife abuse is justified and those who believe it is not justified.

2. Emergency department nurses who believe wife abusers should be punished will report greater use of caring behaviors than will nurses who do not believe wife abusers should be punished. A one-tailed t-test was used with the median of 14 as the dividing score. The result was t = - .36 with df = 87 and p = .360. The hypothesis was rejected, meaning that there is no difference between caring behaviors reported by nurses who believe that the offender should be punished and those who believe the offender should not be punished.

3. Emergency department nurses who believe abuse victims should be helped will report greater use of caring behaviors than will nurses who believe abuse victims should not be helped. A one-tailed t-test was used with the median score of 8 as the dividing score. The result was t = 1.25 with df = 85 and p = .108 The hypothesis was rejected.

4. Emergency department nurses with lower scores on the subscales of beliefs about wife abuse and who perceive a subjective norm supportive of intervention with abused wives will demonstrate greater use of caring behaviors with abused wives.

Multiple regression analysis was done using the caring behaviors scores, the HG subscale, since that was the only subscale showing a statistically significant relationship to caring behaviors, and the subjective norms score. This showed a significant relationship, most of which can be attributed to the subjective norms rather than the belief that help should be given. With df = 2, F = 9.43 at a significance level of .0002. When the variables are separated for influence, subjective norms have a t value of 3.75 with a significance of .0003, while the HG subscale has a t value of -.626 and a significance of .5330. The hypothesis was supported with respect to the subjective norms only, so it was be rejected for the composite influence, meaning that the only significant influence on the nurses' report of caring behaviors was their perception of institutional support.

Other Findings of Interest

The subscale for subjective norms, or ISS, demonstrated a strong correlation with caring behavior scores, as seen in Table 8. This scale was not part of the research

questions or hypotheses alone, but showed a significant relationship to caring behaviors.

On the two instruments with Likert scales, the Carative Factors Tool and the Inventory of Beliefs About Wife Abuse, there were numerous responses with written-in qualifying remarks. A frequent qualifying statement on the CFT was that the behavior depended sometimes on the busyness of the unit. On the ISS, some of the nurses were not aware of a protocol for their institution, and stated this by the question about the effectiveness of the unit's protocol. The IBWB questions had frequent comments by the questions about the responsibility of the wife for the beatings. Some of these could be interpreted to mean that the nurse disapproved of the wife's behavior, but did not agree that it justified beating.

In speaking with the department contact person, and in reviewing the responses from the different hospitals, it was apparent that there was significant interest in the topic in each hospital. Responses from all but one hospital indicated that the most recent source of information for at least one of the respondents was a hospital inservice within the past year.

A final observation that is of importance is that every hospital had at least one, and some had several, nurses working on staff who had experienced abuse, either from a current or a former spouse. There were very few respondents who knew no one who had been abused.

CHAPTER 5

DISCUSSION AND IMPLICATIONS

Discussion of Findings and Conclusions

This was a retrospective, descriptive, correlational study of the beliefs and behaviors of emergency department nurses in caring for women in the emergency department who may have been abused. The ED nurses' perception of the support of the institution for demonstrating caring behaviors was also studied. The influence of beliefs about abuse, abusers, and abused women and beliefs about the institutional support for caring were statistically measured to determine relative influence of significant beliefs on behavior. Correlations which were significant at a level of $p < .05$ were: (a) caring behaviors and the belief that help should be given an abused woman, and (b) caring behaviors and the belief that the institution supports the behaviors. When these were analyzed by multiple regression, the institutional support was the stronger influence on caring behaviors.

Research Questions

Question one. What are the beliefs of emergency department nurses about wife abuse, abusers, and abuse victims?

Beliefs about wife abuse were defined as the cumulative scores on each of three subscales of the Inventory of Beliefs About Wife Abuse: Wife-beating is Justified, Help

Should be Given, and the Offender Should be Punished. Scores on the subscale Wife-beating is Justified (WJ) could be interpreted to support the negative of that statement, i.e. wife-beating is not justified. Many of the questions on this subscale addressed hypothetical situations to which the respondent was asked to agree or disagree. Several of the respondents disagreed that beating was justified in these situations, then wrote in alternate responses that they might agree with. For example, to the question "A woman who constantly refuses to have sex with her husband is asking to be beaten" one respondent answered "disagree," and wrote in "divorced, perhaps."

Some of the difficulty in responding to the questions on this subscale may come from two sources. First, in long-term abusive relationships the woman's self-esteem is often low, and following up on referrals is hard and perhaps dangerous. This can lead the nurse to believe that the woman is condoning the abuse, and perhaps therefore responsible for its perpetuation. A second concern is the association of alcohol or drug use with the abuse. Sometimes the woman comes into the emergency department having used alcohol or drugs, and it is difficult to sympathize or to work with her. Blame for the behavior becomes the focus of the interactions, rather than looking at the source of the alcohol or drug use. This is a particular problem for emergency department nurses, since they often see women under different circumstances than the general public. Nevertheless, the nurses in this study did not support the statement that wife-beating is justified, although this belief was not significantly correlated with reported caring behaviors.

The second subscale, Help Should be Given (HG), was strongly supported by the

nurses. The questions on this scale indicated willingness to help without identifying the emergency department as the place this would happen. It could be argued that the fact that the hospitals have conducted inservices on abuse, and supported the conduction of this survey (in other words, institutional support or the subjective norm) raised the belief of the nurses that they ought to give help. This could conceivably be the result of the education efforts of the institutions. This would be similar to the results of an education effort reported by McLeer and Anwar (1989) in which a protocol was introduced followed by an increased identification of female trauma patients as battered. Another similar study by Hadley (1992) demonstrated a link between education of staff and increased referrals to advocacy personnel.

Scores on the Offender Should be Punished (OP) subscale were similar to the results reported in the Kilburn (1992) study. Scores tended toward the middle of the scale, indicating weak agreement with the title of the scale. Reasons for this could be:

1. The items on the scale may not be a good measure of what the scale says it measures. Some of the options for punishment may not be perceived by the respondent as punishment for the abuser, such as "A wife should move out of the house if her husband beats her."

2. Nurses may not consider it their responsibility to decide what should happen to the abuser because it is outside their domain of expertise. They will support statements regarding what they should do, but not what someone else should do.

3. Nurses may not know what appropriate judicial treatment of the offense would be. This is supported by the high number who responded "don't know" to the question of how

long an abuser should spend in jail.

Question two. What are the self-reported behaviors of emergency department nurses when working with abused wives?

The nurses identified the ten items of the Carative Factors Tool as the behaviors they might demonstrate in caring for women in the emergency department who may have been abused. The range of means for these items (see Table 7) indicates that some of the behaviors would be carried out by more nurses than other behaviors. None of the behaviors was consistently identified as inappropriate or a behavior none of the nurses would be likely to carry out.

The CFT was a self-report of behaviors. As discussed earlier, this may not reflect the actual behavior of the nurses when confronted with a possibly abused woman in the emergency department. Actual behavior could only be surveyed by observation, and this would create confidentiality problems. In addition it could impact the behavior in either direction.

Question three. What is the likelihood of emergency department nurses to demonstrate carative factors as defined by Watson (1988) when working with abused wives?

Watson's (1988) theory of nursing as human science and human care was used as the framework for the questions on the Carative Factors Tool (CFT). Overall responses to these ten questions indicated a high level of self-reported caring behavior on the part of the nurses. Table 7 shows the means of the individual scores on these questions. The high means for these questions are consistent with a reported high likelihood that the

nurses would carry out these behaviors. These scores are not consistent with the report by Kilburn (1992) of her survey of 247 emergency department nurses. Her question about behavior was worded and measured in a different way, but her results showed less reported demonstration of caring behaviors by the nurses in that study. Some of the difference may be accounted for in the way the question was asked. Some of it may be the different location - the south versus the northern mid-west. Some may be changes in societal norms related to high media coverage of the trial in which O. J. Simpson was acquitted for the murder of his wife. Some may be the increasing education available for nurses about abuse in professional publications.

Looking at the questions with the highest and lowest means, the results of this survey are consistent with the Limandri and Tilden report (1996). They discussed the different reasoning processes used by nurses when they are discussing cases clinically (such as when they discuss a particular case with the physician) and when they are discussing legal reporting aspects of the cases (such as charting suspicion of abuse). Limandri and Tilden report that the reasoning process used when discussing abuse cases clinically followed a relational pattern, and feelings, insight, and intuition played a part in their judgment. However, when reporting abuse cases to protective services, or considering the legal system entering the case, the nurses used a more linear style of reasoning, including hard physical evidence. While reporting of domestic violence in cases of spouse abuse is not mandatory, if homicide occurred in a future instance of abuse, there could be concern that if it were suspected at an earlier time and not enough help was given this could become material used in a court trial. Or if the information

were used unwisely or inappropriately, it could increase the risk of the woman for further abuse. Concern about written documentation seems to carry through in the thinking of these emergency department nurses.

Other questions on this tool with lower means asked about behaviors which often take more time than is perceived as possible in a busy emergency department. Some nurses added that qualification to their response to one or more of these questions.

Question four. What are the perceptions of emergency department nurses about the subjective norms with respect to intervening with abused women?

Support of the institutions for the caring behaviors described in the CFT was high according to the Institutional Support Scores. The nurses felt high support from their peers, supervisors, physicians, the hospital, and the nursing profession.

There were other indications of strong institutional support as well. The fact that this study was approved by all seven hospitals approached, and implemented in all seven emergency departments with no resistance from nursing management indicated support for research in the area. All of the hospitals have had nursing inservices on abuse, six of them within the twelve months prior to the survey.

Concerns of the nurses in the area of institutional support were particularly in the area of what the protocol was and how the process worked. It is possible that this is a problem of dissemination of information about a protocol. Since there are structured guidelines for the care and reporting of child and elder abuse situations, and there are not the same legal structures of mandatory reporting for wife abuse, it is perhaps not seen in the same light. However, the hospitals are required to have a protocol on domestic

violence, so it is likely an awareness problem, not an availability problem.

Question five. Is there a statistically significant relationship between emergency department nurses' beliefs about wife abuse, abusers, and abused wives and their self-reported behaviors when working with abused wives?

Question six. Is there a statistically significant relationship between emergency department nurses' beliefs about wife abuse, perceptions of subjective norms, and use of caring behaviors when working with abused wives?

The theory of reasoned action states that "a person's intention is a function of two basic determinants, one personal in nature and the other reflecting social influence" (Ajzen & Fishbein, 1980, p. 6). In this study, the personal component or link to behavior was the beliefs of the nurses about abuse, abusers, and abused wives. It was measured on the three subscales of the IBWB, the WJ, HG, and OP subscales. Of these subscales, the only belief that showed correlation with caring behaviors at a significant level ($p = .034$) was HG, the belief that help should be given the abused woman.

The second determinant of intention, and therefore directly of behavior, is social influence. In this study social influence was defined as the belief that the institution, profession, and peers supported the nurse in providing care to the abused woman. While both of these determinants, belief that help should be given and belief that the institution supported giving help, showed correlation with the self-reported behavior of the nurses, the statistical analysis showed a greater influence from the social influence. The nurses responding to the survey supported the statement that help should be given the abused woman. This response could be a result of or a response to the belief that this

is what the social influencer, the institution, wants them to believe. Therefore separating the belief about giving help from institutional support may be impossible at a time when the institutions have clearly demonstrated what they want.

Hypotheses

The four hypotheses for this study were rejected. The hypotheses stated a directional relationship between the beliefs on the subscales of the IBWB and the behaviors listed on the CFT. The relationship appears to exist between the HG subscale and the Caring Behavior Score (although it is an indirect relationship), and between the ISS and the CBS. This gives support to the theory of reasoned action (Ajzen & Fishbein, 1980), since there is influence on the intention to perform the behavior, and therefore on the performance of the behavior, coming from both areas of influence, personal and societal. The stronger in this instance seems to be the societal influence.

Application to Practice and Education

Nursing Practice

Self-reports of behaviors by the 93 nurses in this study give hope for the care of abused wives. While self-report does not measure actual behavior, it does reflect what the nurses either would like to be doing, or what they believe the institution would like them to be doing. Either way, their support for behaviors which Watson (1980) calls caring was greater than was found in a previous study (Kilburn, 1992), and is different from what abused women have been reporting as their experience from nurses as recently as 1994 (Campbell, Pliska, Taylor, & Sheridan).

It would be easy to become optimistic about a change in behaviors based on this

self-report. It would be wiser to look at some of the possible influences on this apparent change and evaluate whether the changes are real or perceived, temporary or long-lasting. When the kinds of behaviors described in the CFT are practiced with consistency, more abused women should find the emergency department a place where they are helped and directed to long-term help. Healthy People 2000 (1990) has focused on domestic violence, and regional documents have followed suit. Media and education are pointing in the right direction. With all of these influences, perhaps what is needed next is to look at whether the results of earlier studies would reflect change if the studies were repeated in this atmosphere. There is a need to determine if the results have any long-term effects. The relationship between education, subjective norms, and behaviors needs to be reinforced. How frequently this must be done to be efficient and effective is not yet known.

The fact that 23% of the nurses were willing to identify themselves as having been abused, and that 57% of their coworkers were aware that they worked with someone who is or has been abused is a promising figure. Not that so many were abused, but that they were open to talking about it with coworkers, and to state it on a survey. This is not consistent with the description by King and Ryan (1989) of the myth in the general population, and among nursing professionals that violence among family members is a private matter. Of the nurses who stated they had been abused, nearly all had left the relationship. This is different from the myth that the "abuse cannot be that terrible or the woman would leave," and that "women who live in abusive relationships tend to become helpless." These women had left, and they were not helpless.

Laws are changing the judicial system's response to domestic violence. Media coverage is changing society's awareness and perhaps its tolerance. But violence against wives continues, and will continue to impact the emergency department. If change in beliefs is occurring, this may lead to a longer-term change in the behaviors of the nurses than if the behaviors seen in this study are only a reflection of institutional support.

Nursing Education

Of the respondents to the survey, 84% had two hours or less of lecture on abuse in their nursing education; 59% reported no lecture on abuse. Nearly everyone who completed the survey gave some source of information/education on abuse within the previous two years; for 57% this included hospital inservice, and 87% had read about abuse in a nursing journal. These are encouraging figures, if indeed education about a topic has the ability to change behavior. Studies such as the one reported by Hadley (1992) in which 25 hours of in-service was done in the emergency department, with on-going education provided support to this idea. The study by McLeer, Anwar, Herman, and Maquiling (1989) in which education of staff was initiated and an early follow-up study showed improvement in report rates, but an eight year follow-up study showed report levels had reverted to the pre-education levels, lead us to look at what is needed after the education is done. How often, how much, and for how long would be questions that need to be answered about education programs. There is no question that the beginnings of this education should be in nursing programs. The pain of abuse is not only seen in emergency departments, and nurses in other settings would be in perhaps a better position to prevent it from happening if they were sensitive to its presence and

influence. It should certainly be part of the advanced practice education for primary care, and women's and children's health care. There is also a need for interdisciplinary education, including the area of climinal justice, to enable both disciplines to begin to understand the limitations and enhance the strengths of each in increasing their effectiveness in working with abuse situations.

Limitations.

There are several limitations to the application of the results of this study. Two of the instruments used, the Caring Factors Tool and the Institutional Support Beliefs component of the IBWB were not used previously, and psychometric analysis was not done. For use in the future this needs to be done. The sample for the survey was self-selected, a convenience sample, and likely is not totally representative of the population of all emergency department nurses in this area, and certainly not nationally. Alpha coefficient of internal reliability was low on two of the subscales of the IBWB; reliability for the HG scale was .67, and for the OP scale it was .52. Another limitation is the recent inservices of nearly all the hospitals on the topic of abuse. It is difficult to know whether the level of caring behaviors is related to a change in what the nurses believe about abuse because of the recent education, or whether other variables not included in this study might have affected this significantly. Examples of such variables might be the level of media influence on beliefs or the changes in cultural norms because of the increasing numbers of women in the workplace.

Suggestions for Further Research

Follow-up studies to some of the research conducted several years ago (Campbell, Pliska, Taylor, and Sheridan, 1994; Isaac & Sanchez, 1994; Kilburn, 1992; Tilden, Schmidt, Limandri, Chiodo, Garland, & Loveless, 1994) could be done to see if changes have occurred in the care women are receiving in emergency departments, or whether nurses are receiving the education and support they need to assess, assist, and refer women who need help. There have been several education efforts initiated and there is little being done to evaluate their effectiveness. A replication of this study of emergency department nurses could be done in an area where no education has been conducted. Assessment tools, such as Campbell's (1986) to predict the risk of serious injury or homicide should be tested and refined and then used and researched. A longitudinal study could be done to see if caring behaviors change over time.

One area mentioned more than once in the comments is the need to look at husbands who come into the emergency department with injuries received in violent interactions with wives. Research in this area could be valuable for two reasons. There are some situations in which the husband truly is the victim, and the wife is using violence as a power tool to control him - the reverse of wife abuse. There are also many instances in which the husband is injured in a violent interaction in which he received the worse injuries on this occasion, but he is responsible for the violence initially, and the wife is acting in self-defense. This can be just another wife-abuse case in which help needs to be given to the wife as well, since she may be at risk for serious injury, or desperate enough to kill her husband.

Recommendations

Protocols in emergency departments have been mandated in recent years. Nurses who work there should know the protocol and their responsibility with respect to assessment and reporting. Nurses are able to impact what happens to the abuser only minimally, and have said in this survey that this is not something with which they are comfortable. But they can impact what information the woman receives, and can be open to on-going dialogue with the criminal justice people they see in the emergency department. If the nurses are educated about abuse, they can educate in turn.

People who are studying the interface of nursing and abused women are looking at instruments to assess risk (Campbell, 1986), including the risk the woman has for being killed by her abuser. This needs to be further researched and implemented when its predictive value is confirmed. Other resources in communities are becoming available, such as shelters, assistance programs, and counseling. Nurses need to know the resources, since many of them know women outside of their jobs who need assistance. All nurses need to be able to do more than refer the abused woman to the hospital social worker, especially if the nurses are not in their usual work setting.

Summary

This study explored the behaviors of emergency department nurses when caring for women in the emergency department who may have been physically abused. The nurses were surveyed with respect to self-reported behaviors, beliefs about wife abuse and beliefs about how much they felt institutional support in demonstrating caring behaviors. Concepts of caring were used from Watson's (1988) theory of nursing as

human science and human care. The theory of reasoned action (Ajzen & Fishbein, 1980) formed the framework for the study, with the relationship between beliefs and behaviors potentially modified by the perceived institutional support or subjective norm. Beliefs about wife abuse in society have been identified as not supportive of caring behaviors, and these beliefs are often held by nurses. It has been demonstrated in previous studies that education can modify behavior, although it does not change beliefs, and is not as long lasting as a change in beliefs. The hypotheses in this study, that nurses with positive beliefs about wife abuse would report greater use of caring behaviors than nurses with negative beliefs about wife abuse, were not supported statistically. The hypothesis that nurses with lower scores on the subscales of beliefs about wife abuse who perceived a subjective norm supportive of intervention with abused wives will demonstrate greater use of caring behaviors with abused wives was not supported statistically. There was an indirect correlation between caring behaviors and the belief that help should be given. There was a positive correlation between the belief that the institution supported caring behaviors and the self-report of such behaviors. The greater influence on caring behaviors in this study was the institutional support.

Continued efforts in this area are needed, (a) in research to improve the protocols and the systems already in place, (b) in consciousness raising for medical professionals and the general public about the inacceptability of violence in the home, and (c) the need for caring family structures to prevent the perpetuation of a chain of violence from one generation to the next. Emergency department nurses can help break this chain.

APPENDICES

GRAND VALLEY STATE UNIVERSITY
KIRKHOF SCHOOL OF NURSING

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Appendix B

Instruments

CARATIVE FACTORS TOOL

When you are assigned to a woman who is in the emergency department for treatment, how likely are you to:

		Very Likely	Likely	Unsure	Unlikely	Very Unlikely
a.	ask about visible injuries which are not the presenting complaint	1	2	3	4	5
b.	ask further questions if the mechanism of injury reported is unlikely	1	2	3	4	5
c.	discourage the partner from staying in the room if abuse is suspected	1	2	3	4	5
d.	try to spend enough time with the woman to gain her trust	1	2	3	4	5
e.	attempt to talk with the woman without the partner	1	2	3	4	5
f.	ask if the woman has ever been hit, kicked, punched, or slapped by her partner	1	2	3	4	5
g.	state suspicions of abuse verbally to physician	1	2	3	4	5
h.	chart suspicion of abuse	1	2	3	4	5
i.	make a referral if abuse is suspected	1	2	3	4	5
j.	assist the woman in obtaining help	1	2	3	4	5

INVENTORY OF BELIEFS ABOUT WIFE ABUSE

Instructions:

Below are a number of statements about violence toward wives which some people agree with and others disagree with. Please indicate how much you agree or disagree with each statement. There are no right or wrong answers.

"Beating" is used to mean intentional hitting to inflict pain.

	Strongly Disagree	Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Agree	Strongly Agree
1. Social agencies should do more to help abused women.	1	2	3	4	5	6	7
2. There is no excuse for a man beating his wife.	1	2	3	4	5	6	7
3. Wives try to get beaten by their husbands in order to get sympathy from others.	1	2	3	4	5	6	7
4. A woman who constantly refuses to have sex with her husband is asking to be beaten.	1	2	3	4	5	6	7
5. I find the abuse protocol helpful in my setting.	1	2	3	4	5	6	7
6. Wives could avoid being beaten by their husbands if they knew when to stop talking.	1	2	3	4	5	6	7
7. Episodes of a man beating his wife are the wife's fault.	1	2	3	4	5	6	7
8. Even when women lie to their husbands they do not deserve to get a beating.	1	2	3	4	5	6	7
9. Women should be protected by law if their husbands beat them.	1	2	3	4	5	6	7
10. Wife-beating as a social problem should be given a high priority by government agencies.	1	2	3	4	5	6	7
11. The referral process is working effectively.	1	2	3	4	5	6	7
12. Sometimes it is OK for a man to beat his wife.	1	2	3	4	5	6	7
13. Women feel pain and no pleasure when beaten by their husbands.	1	2	3	4	5	6	7
14. A sexually unfaithful wife deserves to be beaten.	1	2	3	4	5	6	7
15. Cases of wife-beating are the fault of the husband.	1	2	3	4	5	6	7
16. As a nurse my supervisor supports me in my interventions with abused wives.	1	2	3	4	5	6	7
17. Abused wives try to get their partners to beat them as a way to get attention from them.	1	2	3	4	5	6	7

	Strongly Disagree	Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Agree	Strongly Agree
18. Husbands who beat wives should be responsible for the abuse because they should have foreseen that it would happen.	1	2	3	4	5	6	7
19. If I heard a woman being attacked by her husband, it would be best that I do nothing.	1	2	3	4	5	6	7
20. Abused wives are responsible for their abuse because they intended it to happen.	1	2	3	4	5	6	7
21. As a nurse, I am supported by the hospital in my interventions with abused wives.	1	2	3	4	5	6	7
22. If a wife is beaten by her husband, she should divorce him immediately.	1	2	3	4	5	6	7
23. Husbands who beat their wives are responsible for the abuse because they intended to do it.	1	2	3	4	5	6	7
24. The best way to deal with wife abuse is to arrest the husband.	1	2	3	4	5	6	7
25. As a nurse, physicians support me in my interventions with abused wives.	1	2	3	4	5	6	7
26. Even when a wife's behavior challenges her husband's manhood, he's not justified in beating her.	1	2	3	4	5	6	7
27. When a wife is beaten it is caused by her behavior in in the weeks before the beating.	1	2	3	4	5	6	7
28. I am supported by other nurses I work with when I intervene with abused wives.	1	2	3	4	5	6	7
29. A wife should move out of the house if her husband beats her.	1	2	3	4	5	6	7
30. Wives who are beaten are responsible for the abuse because they should have foreseen it would happen.	1	2	3	4	5	6	7
31. A husband has no right to beat his wife even if she breaks agreements she has made with him.	1	2	3	4	5	6	7
32. The nursing profession supports nurses intervening with abused wives.	1	2	3	4	5	6	7
33. Occasional violence by a husband toward his wife can help maintain the marriage.	1	2	3	4	5	6	7
34. A wife does not deserve a beating even if she keeps reminding her husband of his weak points.	1	2	3	4	5	6	7
35. Most wives secretly desire to be beaten by their husbands.	1	2	3	4	5	6	7
36. If I heard a woman being attacked by her husband, I would call the police.	1	2	3	4	5	6	7
37. It would do some wives some good to be beaten by their husbands.	1	2	3	4	5	6	7

38. If a man is convicted of beating his wife how long should he spend in prison or jail? (Circle one); 0 1 mo. 6 mo. 1 yr. 3 yr. 5 yr. 10 yr. Don't know

Saunders, Lynch, Grayson, & Linz. (1987). Violence and Victims.2(1), 39-58. Adapted.

CHARACTERISTIC DATA QUESTIONNAIRE

1. Gender:
   _____ (1) female _____ (2) male
2. Age: _____
3. Ethnic Group:
   _____ (1) African-American _____ (4) Hispanic
   _____ (2) Asian _____ (5) Multi-ethnic
   _____ (3) Caucasian _____ (6) other _____
4. Marital Status:
   _____ (1) never married _____ (4) widow/widower
   _____ (2) divorced _____ (5) married
   _____ (3) separated
5. Religion _____
6. Highest Degree Earned:
   _____ (1) Associate Nursing Degree
   _____ (2) Nursing Diploma
   _____ (3) Baccalaureate Nursing Degree
   _____ (4) Non-nursing Baccalaureate Area:_____
   _____ (5) Nursing Masters Degree
   _____ (6) Masters other than nursing Area: _____
   _____ (7) Doctorate
7. Years of experience in nursing: _____.
8. Years of experience in emergency department nursing: _____.
9. What shift do you usually work:
   _____ day _____ evening _____ night _____ other
10. In your nursing education how many hours of lecture were spent on the nursing care of abused wives? _____
11. Have you obtained information about abused wives in any of the following ways?
    yes ____ no ____ a. lecture or grand rounds
    yes ____ no ____ b. work in a family violence treatment center
    yes ____ no ____ c. workshop or symposium
    yes ____ no ____ d. read a nursing journal article
    yes ____ no ____ e. hospital inservice
    yes ____ no ____ f. television
    yes ____ no ____ g. newspaper or magazine article
12. What is the most recent source of information? _____
13. How long ago was this?
    ___ (1) less than one month ___ (3) six to twelve months
    ___ (2) one to six months ___ (4) more than twelve months
14. On the average how many wives do you encounter in the emergency department per month that you suspect as being physically abused but are not diagnosed as such: _____.
15. On the average how many diagnosed physically abused wives do you encounter in the emergency room per month: _____.

16. Have you personally known any physically abused wives?

yes ___ no ___	a. friend	yes ___ no ___	f. mother
yes ___ no ___	b. neighbor	yes ___ no ___	g. aunt
yes ___ no ___	c. co-worker	yes ___ no ___	h. self
yes ___ no ___	d. daughter	yes ___ no ___	j. other_____
yes ___ no ___	e. sister		

17. Are you currently in an abusive relationship:

_____ (1) yes

_____ (2) no

18. In the space provided, please make any comment(s) you wish. .

APPENDIX C

Hospital Review Board Letter

Dear Hospital Research Review Board:

I am a masters student in the Kirkhof School of Nursing at Grand Valley State University. In order to complete the degree requirements, I am conducting a study of the beliefs of emergency department nurses about abused wives, and about the behaviors these nurses demonstrate when working with abused wives in the emergency department. The results of this study may be beneficial in raising the consciousness of emergency department nurses about beliefs which may interfere with or complement their interactions and interventions with victims of abuse.

The input of your emergency room nurses is important to this study. Their responses will be held in strictest confidence. The questionnaires will not include names or addresses of the nurses and their participation is voluntary and will require approximately 15 minutes. The questionnaires will be distributed in your institution in individual mailboxes, and will be returned in envelopes to a sealed box located in the department at a location to be determined in consultation with the staff.

Feel free to call me at 616 457-3273 if you have questions or reactions you would like to discuss with me related to this study. Once the study is completed, I would be willing to share the results with you.

Thank you for your time and cooperation.

Sincerely,

Judith A. Baker, R.N., B.S.N.

APPENDIX D

Cover Letter

Dear Colleague:

As part of the completion of requirements of the masters program in the Kirkhof School of Nursing at Grand Valley State University, I am conducting a study exploring self-reported behaviors in the emergency department. The results of this study may be beneficial in understanding what happens to physically abused wives (women abused by male partners, a spouse, former spouse, boyfriend, or significant other living in the same house) when they are seen in the emergency department.

Your responses are very important, and will be kept in strictest confidence. Your responses will remain anonymous. Your participation is voluntary, with completion and return of the completed questionnaires constituting your informed consent. You are free to withdraw your consent and discontinue participation at any time. There are no discomforts or risks expected. I do hope you will participate by taking the time to express your opinions on the attached questionnaires. When you have completed the questionnaires, kindly return them in the enclosed envelope, placing them in the sealed box (at the designated location) within two weeks. It will probably take about 10-15 minutes to complete the survey. If you choose to not complete the questionnaires, please return the blank forms in the envelope to the same location.

If you have questions or would like to discuss your reactions which occurred in the process of completing the questionnaires, please call me at my office at 616 957-7076. Any questions about your rights as a research participant may be addressed to Paul Huizenga, Chair of the Human Research Review Committee at Grand Valley State University, 616 895-2472.

If you are interested, I would be willing to share the results of this study with you. The results will be available to your department at the completion of the research, and if you would like a copy, indicate so on a separate note placed in the collection box. Thank you for your time and cooperation.

Sincerely,

Judith A. Baker, R.N., B.S.N.

APPENDIX E

Responses to Open-Ended Question on Survey

1. While I realize this study focuses on wives, I also worry about the abused husbands we miss. Husband abuse is probably even more underreported than wife abuse - and also deserves our attention. I have personally known several abused husbands - and they too need our help.

2. I was married 10 years to a man who physically and emotionally abused me. He threatened me with guns. I was in nursing school at the time and learned this pattern of abuse was unacceptable, but I stayed in the relationship for 2 additional years after becoming a nurse. This gave me the exposure and financial way to get out. My family knew about the abuse, but in my experience potentiated it by supporting the relationship and continuing behaviors of both my self and my husband. It is a societal problem not just a problem between a husband and wife.

3. It certainly exists. But sometimes the "wife" also abuses, then screams when she is hit subsequently. Neither is appropriate, mind you, but I've seen it when riding with various police agencies and taking report - MANY times. The man is cut and bleeding, too - she admits to starting the hitting - but HE goes to jail. We have to be careful.

4. As a male nurse I usually have female nurses around who would provide direct care to any patient suspected of being abused. I still feel uncomfortable with an abuse situation (an abused female). Having an established protocol (which we do at the hospital) does help but in terms of empathy I feel an abused female patient would feel more comfortable being cared for by a female RN. The female RN staff is ready and very willing to help in this. I personally have not had any patients under my complete care, i.e. where I have had to obtain items for evidence.

5. This may be Grand Rapids, but doesn't it work the other way also - women --> men.

6. The problems with retaliation by the perpetrator are a big issue that has to be faced. Jail may not keep the victim safe. The victim is often worse off after seeking ED help or police help. A life sentence in some instances would be the only way to ensure a safe life for the victim - for the revengeful. So What is the answer?? This is one of the key reasons people are unwilling to report their abuse! and who can blame them?

7. I feel counseling should be mandatory and monitored by professionals. The assailant should not be allowed to stop unless he is progressing.

8. On question #38 I circled 1 year because if I lost it and beat my wife, I think a year would be plenty to reform me: however, judging from the backgrounds and histories that many of my male patients have, I'd have to say that 3 - 10 years or longer would be more appropriate for many of them.

9. Most of the abused women I've seen have very low self esteem and even though a YWCA Domestic Violence card is given, I doubt they call -- hence the saying "You can lead a horse to water, but you can't make them drink."

10. Re: #1 - there is a lot of help out there available for victims of domestic violence but you/we can't make them use it. Why spend more dollars for unused services?

11. This survey is interesting but too long.

12. #18 I believe anyone who causes abuse should be responsible for it. However, I don't think this abuse is always intentional - sometimes it's a lack of control. #22 I think a wife should receive counceling if she is abused - if this continues she should divorce him. #38 He should definitely spend time in jail if he is convicted - of course this usually doesn't happen until the abuse occurs several times.

13. My dealings with personnel from (local program) have all been positive. I find them very supportive and caring for the clients we refer to them.

LIST OF REFERENCES

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Ajzen, I., & Fishbein, M. (1980). Understanding attitudes and predicting social behavior. New Jersey: Prentice-Hall.

Allen, T. (1994). Cohesive social systems key to breaking cycle of family violence. JAOA, 94, 535-536.

Appleton, W., & Renton, W. (1980). The battered woman syndrome. Annals of Emergency Medicine, 2, 84-91.

Belk, S., & Snell, W. (1986). Beliefs about women: Components and correlates. Personality and Social Psychology Bulletin, 12, 403-413.

Brendtro, M., & Bowker, H. (1989). Battered women: How can nurses help. Issues in Mental Health Nursing, 10, 169-180.

Briere, J. (1987). Predicting self-reported likelihood of battering: Attitudes and childhood experiences. Journal of Research in Personality, 21, 61-69.

Bullock, L., McFarlane, J., Bateman, L., & Miller, V. (1980). The prevalence and characteristics of battered women in a primary care setting. Nurse Practitioner, 14, 47-56.

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

Campbell, J.C. (1994). Child abuse and wife abuse: The connections. Maryland Medical Journal, 43, 349-350.

Campbell, J.C. (1994). Domestic homicide: Risk assessment and professional duty to warn. Maryland Medical Journal, 43, 885-888.

Campbell, J. C., Pliska, M. J., Taylor, W., & Sheridan, D. (1994). Battered women's experiences in the emergency department. Journal of Emergency Nursing, 20, 280-288.

Carveth, J. A. (1995). Perceived patient deviance and avoidance by nurses. Nursing

Research, 44, 173-178.

Danforth, J. C. (1994). Resurrection: The confirmation of Clarence Thomas. New York: Viking Penguin.

Dobash, R. R., & Dobash, R. (1979). Violence against wives. New York: The Free Press.

Drake, V. K. (1982). Battered women: A health care problem in disguise. Image: Journal of Nursing Scholarship, 14, 40-47.

Gallop, R., McCay, E., Cote, F. H., Garley, D., Harris, J., & Vermilyea, D. (1994). A scale to measure nurses' comfort working with clients who have been sexually abused. The International Journal of Psychiatric Nursing Research, 1(1), 15-20.

Gelles, R. (1975). Violence and pregnancy: A note on the extent of the problem and needed services. Family Coordinator, 24(1), 81-86.

Goldberg, W. G., & Tomlanovich, M. C. (1984). Domestic violence victims in the emergency department: New findings. JAMA, 251, 3259-3264.

Grunfeld, A. F., Ritmiller, S., Mackay, K., Cowan, L., & Hotch, D. (1994). Detecting domestic violence against women in the emergency department: A nursing triage model. Journal of Emergency Nursing, 18, 271-274.

Hadley, S. M. (1992). Working with battered women in the emergency department: A model program. Journal of Emergency Nursing, 18, 18-23.

Isaac, N. E., & Sanchez, R. L. (1994). Emergency department response to battered women in Massachusetts. Annals of Emergency Medicine, 23, 855-858.

Kilburn, F. L. (1992). Beliefs of emergency department nurses about battered women. Unpublished doctoral dissertation, University of Alabama, Birmingham

King, C., & Ryan, J. (1989). Abused women: Dispelling myths and encouraging intervention. Nurse Practitioner, 14(5), 47-58.

Krueger, J. (1995). Perceptions of sexual assault victim responsibility by emergency

nurses when there was chemical use by the victim. Journal of Emergency Nursing, 21, 174-175.

Kurz, D. (1987). Emergency department response to battered women: A care of resistance to medicalization. Social Problems, 34, 69-80.

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

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

McLeer, S. V., Anwar, R., Herman, S., & Maquiling, K. (1989). Education is not enough: A systems failure in protecting battered women. Annals of Emergency Medicine, 18, 651-653.

Moore, M. L., Zaccaro, D., & Parsons, L. H. (1998). Attitudes and practices of registered nurses toward women who have experienced abuse/domestic violence. JOGNN, 27, 175-182.

Muelleman, R. L. (1996). Battered women: Injury locations and types. Annals of Emergency Medicine, 28, 486-492.

Olson, G. L. (1996). A city renewed. Grand Rapids, MI: Grand Rapids Historical Commission.

Rose, K., & Saunders, D. G. (1986). Nurses' and physicians' attitudes about women abuse: The effects of gender and professional role. Health Care for Women International, 7, 427-438.

Sabatino, F. (1992, November 5). Hospitals cope with America's new "family value." Hospitals, 66, 24-30.

Saunders, D. G., Lynch, A. B., Grayson, M., & Linz, D. (1987). The inventory of beliefs about wife beating: The construction and initial validation of a measure of beliefs and attitudes. Violence and Victims, 2(1), 39-56.

Smith, P. H., Danis, M., & Helmick, L. (1998). Changing the health care response to battered women: A health education approach. Family & Community Health, 20(4), 1-18.

Stark, E., Flitcraft, A., & Frazier, W. (1979). Medicine and patriarchal violence: The

social construction of a private event. International Journal of Health Services, 9, 461-493.

Stark, E., & Flitcraft, A. (1985). Spouse abuse. In Surgeon General's Workshop on violence and public healrh: Source book. Leesburg, Virginia: October 27-29, 1985. (pp. SA1-SA43). Atlanta, GA: Centers for Disease Control, US Public Health Service.

Straus, M. A. (1973). A general systems theory approach to a theory of violence between family members. Social Science Information, 12. 105-125.

Straus, M. A. (1974). Leveling, civility, and violence in the family. Journal of Marriage and the Family, 36, 13-29.

Straus, M. A., Gelles, R. J., & Steinmetz, S. K. (1980) Behind closed doors: Violence in the American family. Garden City, NY: Anchor/Doubleday.

Straus, M. A., & Gelles, R. J. (1990). Physical violence in American families. New Brunswick, NJ: Transaction.

Sullivan, C. M., Campbell, R., Angelique, H., Eby, K., & Davidson, W. (1994). An advocacy intervention program for women with abusive partners: Six-month follow-up. American Journal of Community Psychology, 22, 101-123.

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

United States Department of Health and Human Services, Public Health Service. (1990). Healthy people 2000: National health promotion and disease prevention objectives (DHHS Publication No. PHS 91-50212). Washington, DC: U.S. Government Printing Office.

United Way of Minneapolis Area, Task Force on Battered Women. (1977). Battered women: A study of physical abuse of women. Minneapolis: United Way Task Force on Battered Women.

Walker, L. (1979). The battered woman. New York: Harper & Row.

Watson, J. (1988). Nursing: Human science and human care. New York: National League for Nursing.

Woods, N .F., & Catanzaro, M. (1988). Nursing research: Theory and practice. St. Louis: Mosby.

Yllo, K., & Bograd, M. (1988). Feminist perspectives on wife abuse. Newbury Park, CA: Sage.