1997

Attitudes of Student Nurses Toward Domestic Violence

Phyllis Jean Messing

ATTITUDES OF STUDENT NURSES

TOWARD DOMESTIC VIOLENCE

PHYLLIS JEAN MESSING R.N., B.A.

An Abstract Presented to the Faculty of the
Graduate School of Lindenwood College
in Partial Fulfillment of the Requirements
of Master of Arts
1997

ABSTRACT

The purpose of this study was to determine if student nurses needed more education about domestic violence. Nurses, more than any other profession, are frequently in a position to identify and assist the victims of abuse. Presently, however, rather than addressing the hidden problem of family violence, nurses may inadvertently contribute to it, due to their lack of awareness and knowledge. Nurses, including student nurses, need to fine tune their knowledge in order to recognize the signs and symptoms surrounding family violence. Once identified, it will take an expanded level of awareness and enhanced skills to deal effectively with this critical social issue.

ATTITUDES OF STUDENT NURSES

TOWARD DOMESTIC VIOLENCE

PHYLLIS MESSING, RN. BA.

A Culminating Project Presented to the Faculty
of the Graduate School of Lindenwood College
in Partial Fulfillment of the Requirements
of Master of Arts
1997

ABSTRACT

The purpose of this study was to determine if student nurses needed more education about domestic violence. Nurses, more than any other profession, are frequently in a position to identify and assist the victims of abuse. Presently, however, rather than addressing the hidden problem of family violence, nurses may inadvertently contribute to it, due to their lack of awareness and knowledge. Nurses, including student nurses, need to fine tune their knowledge in order to recognize the signs and symptoms surrounding family violence. Once identified, it will take an expanded level of awareness and enhanced skills to deal effectively with this critical social issue.

Committee in Charge of Candidacy

Marilyn Patterson, Ed, D,
Associate Professor, Advisor

Michael Kramer, C.S.W.
Adjuct Faculty

Betty LeMasters, Ph.D.
Associate Professor

DEDICATION PAGE

I would like to dedicate this research paper to all the women who have survived domestic violence and have found peace and serenity in their lives, as well as all the women who are still living in an abusive situation and are fighting for their survival.

I would also like to thank all my teachers and Ernie Edelman (my practicum supervisor) who have shared their knowledge, counseling skills, and love of learning with me,along with my family and friends who encouraged me to continue my education and supported me through all my frustrations, trials and tribulations of college.

TABLE OF CONTENTS

LIST of TABLES

CHAPTER I

INTRODUCTION

Historically, battering has not only been informally condoned but even supported by law. One old U.S. statute, derived from British common law, decreed that once married, a woman no longer existed legally; the law placed the husband in charge of his wife. Before 1700, laws allowed a husband to " chastise his wife with any reasonable instrument. " In the 1700's, a law was passed that was considered to be a compassionate reform of earlier statutes. It stipulated that the reasonable instrument used to chastise the wife be " a rod not thicker than his (the husband's) thumb," the origin of the "rule of thumb" (Jezierski, 1994, p. 362).

According to the Surgeon General, C. Everett Koop, in 1989, " An estimated 3-4 million American women are battered each year by their husbands or partners" (Congressional Caucus for Women's Issues, 1997). Not included in this estimate are abused women who are separated, divorced, or single, which results in under-reporting of abused women by 50% (King , 1993). In the United States a woman is beaten every 15 seconds. Surveys of American

couples show that 20% to 50% have suffered violence regularly in their marriages. Statistics collected in shelters indicate that 31% are beaten weekly or daily and 26% are beaten at least once a month. Each year, 1,000 women are killed by their male partner, almost always after having undergone years of physical abuse (Lazzaro & McFarlane, 1991). No social class is exempt. Domestic violence occurs in wealthy as well as poor communities. Abuse to women also occurs during courtship and cohabiting relationships, with physical abuse affecting 16-23% of all dating relationships (Lazzaro & McFarlane , 1991). It should be recognized that wife abuse is not solely a "women's issue" but a serious societal problem of widespread consequence (Trute & Sarsfield, 1988).

Although domestic violence occurs in all socioeconomic groups, research reveals that certain characteristics may be influential in the etiology of domestic violence. Violent couples appear to have more stressful life events such as financial problems, unemployment, and frequent location moves. There is often a history of the woman having been raised in insecure living conditions, having been abused as a child, and getting married when a teenager. It has also been noted that most violence occurs on weekends and in the evening (Fishwick, 1995).

At times a woman may report violence but attempt to minimize the frequency or severity of its occurrance. This may take the form of blaming herself, blaming alcohol use by her partner, or by asserting that the violence was a temporary aberration caused by family difficulties or unemployment. Many abused women use " forgetting" or " minimizing" as effective coping strategies (McFarlane & Parker, 1996).

Violent families breed violent families. Fifty percent of abusers and 30% of abused women grew up in violent homes. To stop the intergenerational transmission of violence, it first must be identified and intervened in these family patterns (Henderson & Erickson, 1994).

Abuse happens when people accept violence as an appropriate response to stressful situations.Over the years it has been tolerated by those who govern community affairs, the courts, medicine, psychiatry, police, schools and the church. History shows that the helping professions often protected patterns of family authority, unwittingly sanctioning wife abuse rather than condemning it.

According to M. Jezierski in his article Abuse of women by male partners , domestic abuse/violence can be physical abuse, emotional abuse, verbal abuse, or

sexual abuse. The effects of partner battering are extremely complex. Although physical scars are the most obvious sign of battering, emotional scars have more profound, long- term effects (Jezierski, 1994). Violence is a learned behavior. It is passed from generation to generation as a way to resolve conflict. In domestic violence, one partner is usually intimidating, controlling and/ or beating the other. It's not just the physical violence, but a pattern of domination and intimidation (Jewish Women International, 1996). Domestic abuse is not a communication issue. It is a control issue. The abused woman is afraid of and controlled by the abuser and will not talk to her present partner. The abuser has most of the power and control. The abused women has most of the fear and both have low self-esteem (Hadley, 1992). The tragedy is that many women suffer this abuse for years without getting help. It is known that battered women are victims of repeated violence.

The fact that many abused women "stay" or return to the relationship has aroused public dismay. The leaving pattern of women getting away from abusive relationships or ending the abuse demonstrates a process. The women's leaving usually requires them to be able to find resources within an environment that often is hostile and unsupportive. Leaving usually means the women must end an intimate relationship. The complexities involved in leaving an abusive intimate

relationship are not unlike those of leaving nonabusive relationships (King, 1993).

Abused women are often reticent to disclose issues of violence. Many societal myths operate to make it difficult for women to voluntarily disclose the experience of abuse. Matters of the home traditionally have been considered "private". Women are socialized to take full responsibility for the harmony of the home and family and risk personal feelings of failure when family harmony deteriorates. For many women, past disclosures of abuse to friends, family and professionals have been met with avoidance, prescription advise, or criticism. Society blames women for their victimization and, as men blame women for their abusive behavior ("she asked for it"), so do women blame themselves (King, 1993). The abuse of women will go on for as long as society continues to value dominance in males and submissiveness in females (Gentemann, 1984).

Violence within a battering situation appears to occur in a cyclical pattern. The cycle of violence is described by L.E. Walker (1979) as occurring in three cyclical phases: (1) the tension-building phase, (2) the acute battering incident, and (3) a calm (honeymoon) period. During these three phases, the characteristic behaviors of women include tendencies to deny their partner is a batterer; to deny being injured; to deny that there are alternatives; and to defend themselves by appealing

to high loyalties such as values regarding religion, marriage, and family. Other characteristic behaviors of women within the cycle of violence include self- blame, avoidance of reality, shock, and disbelief (Curnow, 1995).

Research reveals the presence of an " Open Window Phase" of help seeking and reality behaviors by battered women occurring in a cyclical pattern from within the cycle of violence. This phase occurs between the acute battering phase and the honeymoon phase. During the "Open Window Phase", a battered women is able to see the reality of her victimization and reach out for help. She is most receptive to interventions and learns whether or not there are alternatives to violence (Curnow, 1995).

There is evidence that the presentation of viable alternatives to abuse is an important role of professionals working with battered women. The more alternatives to remaining in an abusive relationship that women have, the more likely they are to take action to be physically safe. It should be the role of the health care professional to help the abused wife find ways to change her "cost/benefit" ratios in a direction beneficial to her and her children, whether or not she chooses to continue or dissolve the relationship between herself and the abusive partner (Ross & Glisson, 1991).

The purpose of this research study is to determine if student nurses formally educated about domestic violence have a different attitude toward domestic violence than student nurses who have not had any prior education on this topic. The student nurses' attitude toward domestic violence is measured by participants answering an attitude questionaire after reading a scenerio about a married couple. The student nurses attitude toward domestic violence for the purpose of this study is measured by the subjects positive or negative beliefs.

The general hypothesis is that there is no difference in attitude about domestic violence between student nurses with prior formal education about domestic violence and student nurses with no formal education about domestic violence.

Operational Definitions:

ABUSE: May include assault but there are special dynamics which make it different from assault. The abuser violates trust. Abuse is committed by a person with whom the victim has a relationship. The abuser threatens to repeat the assault. The woman who is abused feels trapped. The abused woman is blamed.

ASSAULT: Causing or threatening to cause physical harm to another.

BATTERING: Refers to a whole range of behaviors such as slapping, hitting, kicking, choking, beating, or biting. Verbal, emotional and frequently sexual abuse often accompany physical abuse. Battering usually means on-going and escalating behavior. The use of weapons is not uncommon. There are other terms that are frequently used to describe this behavior: woman abuse, wife abuse and spouse abuse..

BATTERED WOMAN: A woman who has been subjected to deliberate and repeated acts of physical and/or psychological violence and abuse by a man/woman with whom she has or has had an intimate relationship.

CYCLE OF VIOLENCE: Three phases: 1. Increased tension, anger, blaming and arguing; 2. Battering, hitting, slapping. choking, use of weapon or objects. Sexual abuse. Verbal threats and abuse. 3. Calm stage (this stage may decrease over

time). Many men deny violence, say he was drunk, say he's sorry and promise it will never happen again. Then the cycle starts over again.

DOMESTIC VIOLENCE: There are several types of violence that occur within the context of the family: child neglect, child abuse, incest, child sexual abuse, battering, woman abuse, marital rape, abuse or neglect of an elderly member of the family and sibling violence.

VICTIM: Anyone who has been violated is a victim of crime. While we want to validate the extreme, intense emotion a victim might experience we caution against the use of the word victim. It often becomes a descriptive title that prevents us from seeing a woman who has been abused beyond the definition of victim and prevents us from focusing on her strengths in our interactions with her.

VIOLENCE: Any behavior that caused fear in another person.

VIOLENCE AGAINST WOMEN: Any crime that violates, humiliates, degrades or otherwise compromises the safety or health and wellness of women.

CHAPTER 2

LITERATURE REVIEW

Although the identification of spousal abuse began primarily in the 1970's, society has been slow to recognize violence toward women. This lack of recognition has been the result of women not being viewed as consenting adults and husbands being viewed as having the right to control their lives (Quillian, 1996).

Within the last decade, violence and abuse have become recognized as important public health problems for women and children in the United States according to the Surgeon General's Report in 1985 (Fishwick, 1993). Research has documented a shift in public attitudes on domestic violence, whereby the public no longer accepts domestic violence but still blames victims for failing to leave. Laws that mandate the arrest and punishment of domestic batterers are consistent with public opinion toward such offenders and underscore the wrongfulness of violence against women (Stalans & Lurigio, 1995).

A substantial proportion of the public seem to subscribe to various stereotypes or "myths" about battered women. They seem to feel that a battered women is at

least partially responsible for the battering she suffers and can "simply leave" her batterer. It appears that the vast majority of the general public has little faith in the law, the police, or the courts to provide battered woman adequate protection from their batterers (Ewing & Aubrey, 1987).

There are many societal beliefs that create disregard for domestic violence, such as: 1. females are subservient to males, 2. behavior was provoked by the female, 3. family events are private affairs, 4. a probable and/ or just cause may exist, 5. penitent abusers should be forgiven, 6. abuse is a problem of the poor, uneducated and minorities, 7. cultural relativism may justify behavior, 8. personal matters are confidential and privileged, 9. it is acceptable to control by force, 10. love implies possession, and 11. violence in some forms should be tolerated (Deaham, 1995).

Violence is part of our culture, with graphic daily reports on the television, radio, and newsprint media. Additionally, recreation media portray violence in music, magazines, videos, and films. Everyone has feelings and beliefs about domestic violence and specifically about abuse of women (McFarlane & Parker, 1996).

All components of the criminal justice system--including police, prosecutors,

and judges--have a critical role to play in deterring domestic violence. Unfortunately, the system's traditional response has been one of nonintervention unless severe injury or death was involved. Reflecting the general attitude held by society, the system has viewed domestic violence as a private family problem, not a criminal issue. Offenders were rarely arrested or convicted of their crimes, and victims received little, if any, protection or support.

In recent years, however, the system has begun to take a tougher stance against domestic violence. The current trend is toward the arrest and prosecution of offenders. These changes are largely the result of the efforts of the battered women's movement, which continues to pressure the system into ensuring justice for domestic violence victims (National Woman Abuse Prevention Project, "n.d.").

Police officers are among the first to be contacted when wife abuse occurs. Their reactions to such situations are therefore of the utmost importance, both for the victim's protection and for putting an end to the violence itself. The position taken by police officers depends largely on their personal prejudices. Police officers are influenced not only by their prejudices, but also by the immediate context of the violent behavior and by specific characteristics of the spouses. Among the factors which may be influential are: the presence of drinking,

antagonism on the part of the wife, the type of assault or impact on the victim, the history of wife assault, the batterer's social class and his demeanor toward the investigating police officer, and the presence of stress-causing factors (Lavoie, Jacab, Hardy & Martin, 1989).

Violence against women is widely unreported to the police by the women themselves. Victims of abuse are traditionally reluctant to share with others their victinization because of fear of reprisal by their abusive partners. The US Department of Justice estimates that spousal abuse is not reported to the police 43% of the time (Ozmar, 1994).

Battered women who had been responded to by at least one policewoman appear more likely to have perceived the police response as helpful. They were, also, significantly more likely to perceive policewomen as "capable", and to prefer that at least one policewoman respond should they need help in the future. A significant number of policewomen have been found to bring a "modern", as opposed to a "traditional" set of values to policing, including a heightened sensitivity to women's issues (Homant & Kennedy, 1985).

Women in rural areas of the United States are faced with particularly enormous challenges when they attempt to end the abuse in their lives. Domestic violence is

as prevalent in rural areas as it is urban areas. However, the characteristics of rural life, the cultural traditions, and the social and geographic isolation contribute to a lack of attention to rural battered women by the rural health care system and the local police. The lack of anonymity in rural areas discourages women from seeking help from law enforcement agencies unless their safety or that of their children is in serious jeopardy. The police response to a battered woman's call for help depends on many factors, such as the relationship between the officer and the abuser, the officer's belief of the woman's story, the officer's attitude toward domestic violence and toward women in general, and the laws and customs of the region and state (Fishwick, 1993).

E. Stark and A. Filtcraft in 1982 reported in Medical Therapy as Repression that each year more than one million women seek medical assistance for injuries caused by battering. In 1987, Stark and Filtcraft wrote in Violence Among Inmates, "Research suggests that wife-beating results in more injuries that require medical treatment than rape, auto accidents, and mugging combined" (Congressional Caucus for Women's Issues, 1997). The Journal of the American Medical Association stated in 1990 " Between 22% - 35% of women who visit emergency rooms are there because of symptoms related to ongoing abuse" (Congressional Caucus for Women's Issues, 1997). Health care providers have an

obligation to identify, treat and provide appropriate resources for victims of spouse abuse (Fishwick, 1996).

Review of the literature indicates that health care professionals have failed to recognize the problem of domestic violence sufficiently. Some of the reasons cited for not recognizing abuse on the part of health care providers are: complexity of the problem, not considering it to be a medical problem, sexual bias, lack of understanding of the dynamics of domestic violence, not believing a woman's story, fear of offending, and lack of time (Quillan, 1995). Awareness of one's own attitudes and beliefs about domestic violence is a prerequisite to the effective nursing care of battered women (Brendtro & Bowker, 1989). The situation also exists partly because of the myths and fears that many nurses have about abuse. Nurses are afraid that they will intervene incorrectly and "damage" the woman, or they assume that the woman must enjoy the abuse because she would otherwise leave (Henderson & Ericksen, 1994; Yam, 1995).

The attitudes of health care professionals towards survivors of violence in close relationships have long been recognized as potentially dangerous. Survivors of violence often report being twice victimized-- once by their abuser, and once by the staff in the health care facility they visit (Henderson & Ericksen, 1994). Abused

women often state that it is the professional caretakers from whom they seek help--clergy, counselors, nurses, and physicians– who often tell them to go back to their homes and spouses and try again (Wilson, 1994).

Health care professionals must find ways to inquire about domestic violence. This is especially important because battering is not usually volunteered as the chief complant by women. Providers also must realize that the level of abuse can change over time. Once women are diagnosed as battered, health care professionals should perform a lethality assessment, identifying risk factors for homicide and/ or suicide, and inform clients about how their health problem(s) relate to the abuse (Denham, 1995).

Abused women are more likely to turn to their physicians for help than to police officers or lawyers. It is clear that of the abused women who do seek medical help, few are identified as having been battered. It seems that many battered women, scarred physically and emotionally, are silent and remain undected during medical treatment. Interviews with physicians have revealed that half do not view the detection and management of marital violence by physicians as "real medicine."

Physicians hold an important position as human-service professionals to have primary contact, to diagnose, and to make referrals for battered women. Yet,

primary care physicians appear to identify fewer battered women than do social workers, clergy, psychiatrists, or psychologists. While only a small proportion of doctors will draw attention to signs of possible abuse or ask in depth how a woman was injured, others may assume she is exaggerating if she does disclose. It seems that the most common response by physicians is to advise the abused woman to leave her violent husband (Trute & Sarsfield, 1988).

Central waiting rooms in health care settings should contain brochures and pamphlets on domestic violence written in language spoken in the geographic area of the clinic or practice. Local and regional telephone numbers should be posted for women to call in order to obtain information. Receptionists and those individuals who do initial patient intakes should be knowledgeable about local community services and locations of such services, if asked. In fact, all people who work with patients in health care settings should be empowered to understand the dynamics of domesticviolence and recognize its symptoms.

Henderson and Erickson (1994) found that supportive attitudes and interventions increased with the amount of accurate information and education that nurses recieved about the nature of abuse and its effects on women. Providing nurses with a subjective awareness of the nature of the experience may increase willingness to intervene. To feel comfortable when working with abused women,

nurses require the support of the institution in which they work.

Nurses encounter abused women in hospitals, clinics, physician's offices, and homes. Approximately 25% to 35% of the female patients who are examined in emergency departments are involved in domestic violence. Yet, nurses may identify only 3% of these injuries as abuse related. About 15% of pregnant women are abused before pegnancy and 8% are abused during their current pregnancy, 25% to 45% of all women beaten are pregnant. Pregnancy, therefore, is a risk factor for abuse (Bullock, 1993).

About 25% of all female psychiatric admissions to the emergency department are battered, and 64% of all female inpatient psychiatric admissions have been abused (Wilson, 1994). Although partner battering has affected our culture for generations, health care providers have only recently begun to address this problem (Jezierski, 1994).

Principles that nurses put into practice when accepting the challenge and responsibility of reaching out to abused women include recognition of partner abuse as a major health care problem, understanding the power and control issues driving partner abuse, nonjudgemental acceptance of women's choices, and empowerment of battered women. The nursing assessment should always include consideration of the possibility of domestic violence, regardless of the chief

complaint. Nurses must be supportive, caring, nonjudgemental, accepting, and objective. Some nurses believe that women should leave their abusers, or that they could if they wanted to. Beliefs such as these have a negative impact on the success of a nursing intervention. The nurse's role is that of advocate, not counselor (Jezierski, 1994).

It is important that nurses assess abused women for escalation of violence. An essential intervention for all abused women is assessing for safety. Women should also be assessed by nurses for thoughts of suicide (King, 1993).

Nurses who work in emergency are often the first to come in contact with abused women, the most common victims of family violence. When these women willingly disclose that they have been physically, sexually and/or psychologically abused it is because they believe that others will listen without judgement and respect their decisions. A sensitivity to their needs as well as the need for assessment, crisis intervention, documentation and follow up will support them in their decisions and allow them to remain in control of their lives (Kennedy, 1994).

It was found in a study in 1989 that even when abuse is identified, emergency room nurses treat these women in a derogatory manner, blame them for their predicament and do not implement protocols. In an investigation by Yam in 1994, none of the women conveyed positive feelings about the health care received. They

described instances of impersonal care, lack of support, and disinterest in their problems on the part of the emergency room nurses (Yam, 1995).

RN's gave numerous reasons for not responding to a victim of domestic violence. The reason RNs most often, give for not responding is that the women are "evasive". RNs say they are sometimes too busy to respond. As one nurse said, " She had two bruised eyes. I had no time to spend with her. I was busy" (Kurtz, 1987. p. 70). Even if a woman volunteers the information about what happened to her, many nurses ignore it. When questioned about their views of battered women, RN's generally indicated that battered women are a source of frustration and some held these women personally responsible for the batterings they received. When staff see a woman leave the emergency room with an abuser, this reinforces their view that the women are irresponsible (Kurz, 1987).

Lack of knowledge, stereotypes, and prejudices may frequently play a role in the failure of nurses to identufy the victim of family violence. King and Ryan (1989) reported in an article Abused women: Dispelling myths and encouraging intervention that only 10% of nurses had been exposed to family violence content in their curricula and this content was minimal. Except for a brief psychiatric/ mental health clinical learning experience, many nurses have not been educated to inquire about their patient's personal family issues and they may

feel uncomfortable doing so (Urbancic, Campbell & Humphreys, 1993).

According to Kurz in her research study reported in her article Emergency Department Responses to Battered Women: Resistance to Medicalization, 11% of the registered nurses in the emergency room take a woman's battering seriously and view it as legitimately deserving of their time and attention. In addition to giving a battered woman medical treatment, the registered nurse notes battering on the case record, speaks to the women about what happened, her current circumstances, her safety, and attempts to provide some assistance or give her a card with hotline numbers. What distinguishes these responses from others is that the R.N. attempts to follow through with a battered woman and ensure that when she leaves, something has been done for her (Kurz, 1987).

However, Maylou Yam reports in her article, Wife Abuse: Strategies for a Therapeutic Response, that all too often, professionals fail to identify abuse and are nontherapeutic. In spite of the large number of women who seek help for abuse-related injuries, according to Yam the evidence reveals that health care professionals neglect to uncover the domestic violence. In 1991, it was reported by the Director of the New York State Office for the Prevention of Domestic Violence that according to statistics, "25% to 40% of all injuries of women in

emergency rooms are related to domestic violence. Yet, health care providers may identify only 3% of these injuries as abuse" (Yam, 1995, p. 150).

Acute and critical care nurses work with victims of domestic violence around the clock, yet they are not always aware of the abuse and violence in the lives of their patients. Nurses may not assess the possibility of abuse in a patient's life due to the fact that they: 1. have been naive about the prevalence and complex nature of the problem, so have assumed that it is not an issue for the patients we happen to serve, 2. have avoided the topic of abuse with patients because of dealing with abuse in their personal lives or 3. if confronted with abuse, have focused attention on the patient's physical needs rather than the underlying problem (Fishwick, 1995).

Critical care nurses have to come to terms with their own beliefs about battering by learning the facts and dispelling the myths about batered women and batterers. Should the nurse find herself asking, "Why does she stay?", the nurse should use this red flag as a motivator for becoming educated about this trauma patient. Only then is the critical care nurse able to show genuine concern, caring, and respect for the battered woman (Curnow, 1995).

Psychiatric nurses who routinely assess clients for abuse in their personal

relationships are going to uncover abuse that has, perhaps, remained hidden for a long time. The information gained will provide a context in which to understand the woman's health status, distress symptoms, and behavior. However, the information may evoke strong emotions for the listener and the cumulative stories of many women may become overwhelming. Issues of professional boundaries and personal experiences with abuse may come to the surface and affect the nurse's ability to respond effectively to the disclosure. Supportive networks of colleagues and supervisors in the mental health field are essential for the nurse to maintain therapeutic effectiveness with abused women. Additional support, as well as education and insight, may be gained through contacts with staff and volunteers of local domestic violence programs. Those who staff domestic violence programs will be the first to point out that the nurse's goal is not to "rescue" the woman from abuse. Rather, the goal is to make it easier for the woman to disclose abuse and to support her as she embarks on a difficult course of decisions. changes, and, ultimately, healing (Fishwick, 1995).

Pregnant women are not immune from violence or trauma. Perhaps the most significant contribution of accumulated nursing research on violence has been on the subject of abuse during pregnancy (Harris & Lee, 1995). Victims of domestic violence during pregnancy deserve special attention by nurses in acute care settings

(Ozmar, 1994). There is growing evidence that abuse of women may be the most common form of family violence during the perinatal period. Nurses are in an ideal position to provide intervention to women experiencing violence and abuse (King & Torres, 1993).

All assessment for abuse, by the nurse, must be done in a private setting where the nurse can assure confidentiality. Pregnancy is one of the few times that healthy women routinely interact with the health care system. Because most women will not volunteer information regarding abuse, women must be assessed for abuse as part of standard prenantal care.

It is essential for the woman's safety that she be assessed, by the nurse, apart from the male partner and any children. (Children as young as two years old may report back to the male partner or family members that mother discussed the abuse.) Confidentiality can be assured by telling that the information she provides will not be shared with other family members or her male partner (McFarlane & Parker, 1996).

Most recent reports of pregnancy and battering documented that 40% to 60% of abused women have suffered abuse during pregnancy. Many of the women reported that the abuse became more frequent and severe during the pregnancy and the childs's infancy. Abuse during pregnancy was found to be associated with

increased severity and frequency of abuse as well as increased risk of homocide. Overall, the abused women were twice as likely to deliver a low--birthweight infant (weight less than 5.5 pounds) then women who were not abused (McFarlane & Parker, 1996).

Nurses conducting childbirth education classes may notice signs of abuse. During the classes, abusive men may appear impatient with the woman, especially if she is having difficulty with certain instructions. They are often rough with the woman, for example, pushing her into position for certain exercises. Often they act embarrassed by her behavior and appear more concerned with what the others in the class think about them than the woman's comfort. Abusive men frequently "tease" the pregnant woman about being "so fat, " "a cow" or "a blimp" (McFarlane & Parker, 1996).

Recent studies have shown that as many as one in six infants will be going home with mothers who were battered during pregnancy. Many nurses believe that one should not interfere with what goes on behind the closed doors of a person's home. Thus the nurse's attitude transferes the idea that home is a "man's castle" and this conveys approval or acceptance of domestic violence.

An obvious need of the battered woman is physical safety. The woman can be made aware of options available to her if she wishes to leave the abusive situation.

Referral to a battered women's shelter can provide temporary refuge for the woman and her children. Battered women's shelters received high effectiveness ratings from abusive women. The nurse should also help the woman to identify informal sources of help that might provide her a safe place, such as friends, relatives or neighbors. Another important intervention might be to inform the woman of legal options available to her to assure her safety. If the woman decides to return home, she should be helped to develop a plan of action should the battering recur. The nurse can provide the battered woman with the number of the local crisis hotline and encourage her to accumulate whatever she would need, such as money, clothing, and important documents, in a place unknown to the batterer should she have to leave suddenly (Brendtro & Bowker, 1989).

Public health nursing practice takes place in " the neighborhoods and homes of the most vulnerable people in America ". Only within the last decade, however, has this issue of family and community violence been considered by public health nurses to be a leading public health problem. The conception of violence as a public health problem is not new to public health nurses, who are in the position to detect community problems and trends before other health care providers (Bekemeier, 1995).

The public health nurse's main purpose in home visiting is the basic process of

encouraging self-help. "Detecting" is a particularly strong public health nursing skill. The public health nurse approaches the detection process with all of her senses on alert. However, public health nurses have expressed a reluctance to even note a reference to suspected abuse or neglect on the data encounter forms for fear of "labeling" a family as abusive. In working with a family in the home, public health nurses have the unique advantage of being in an intimate position to recognize a potential for violence before it occurs or worsens (Bekemeier, 1995).

Public health nurses are also increasingly involved in special disciplinary programs outside the home. Many public health nurses, for example, work in women's shelters providing counseling, referral, and parenting education; are involved in school-based violence- prevention programs; and are educating teams in hospital emergency departments in assessment of family violence. They are taking an active role in political and population-wide advocacy for women and children. In doing so, public health nurses are influencing change in social systems that perpetuate violence rather than high-lighting commonly perceived dysfunctions of survivors or abusers (Bekemeier, 1995).

Although public health nurses pride themselves on their socioenvironmental assessment, prevention, and intervention skills, there are indications that they are still identifying and documenting only a fraction of the actual cases of family

violence in their caseloads. Public health nurses are making efforts to improve their practice to more accurately reflect and better serve the potentially violent families with whom they are involved (Bekemier, 1995).

Supportive attitudes and interventions increased with the amount of accurate information and education that nurses received about the nature of abuse and its effect on women. It can be comforting to nurses to recognize that they are not responsible for making change happen in the abused womenn's life. The individual nurse's responsibility is to insure that there is a supportive environment in which the woman is empowered to explore her options and to take control of her life (Henderson & Ericksen, 1994).

Support from all levels of administration is another factor that can make a nurse more comfortable when working with abused women. Such support enables nurses to intervene in an area that they might otherwise avoid. It is important that administration develop clear, practical protocols so that nurses have a structure within which to intervene with abused women.

It is the responsibility of schools of nursing to prepare their graduates to work effectively with abused women. Specific and accurate information about abuse must be included in the curriculum. Myths about abuse must be exposed and corrected.

Students must be helped to clarify their own values about abuse. The concept of abuse must be integrated as a critical component of the full curriculum. Unfortunately, only a few nursing programs currently include organized content on abuse of women. If nurses are to be comfortable acting, they must have a strong moral and eduational base from which to proceed (Henderson & Ericksen, 1994).

Students need to hear the stories of women who have been abused. The only way we can get students to be excited , energized and empathetic in their practice with survivors of domestic violence is for them to get to know these women as people just like themselves. Survivors of domestic violence, which may include nurses, could be invited to class to share what they have undergone. Dialogue with these women can heighten students' sensitivity to the abused woman's plight, so that they are able to make sense of her fear, courage, and ability to survive.

Students who have experienced violence in their lives also need the opportunity to share their stories. Reactions to readings and course materials in the form of journal entries, logs, reaction papers, or small group discussions may provide them an outlet for conveying their personal experiences and stimulate all students to examine their attitudes and beliefs about abuse (Yam, 1995).

A large number of nurse graduates of most educational programs and those

practicing in most clinical settings have not received enough knowledge or skills to feel competant in intervening with women they know or suspect may be experiencing violence or abuse. Although nurses are excellent interviewers and educators, it is this perceived inadequacy and lack of education that limits their ability to assess and intervene for violence. Thus, it is important to redress this lack of knowledge and skills by presenting educational programs that will empower nurses to provide clinical intervention and leadership in addressing this major health problem (Ryan & King, 1993).

It is recommended that there be at least one lecture on domestic violence in all three major courses---maternal child, community health, and psychiatric nursing--in all nursing programs. Moreover, educational programs should sequence the three lectures so specifics related to each setting are addressed without overlap (Denham, 1995).

While our nation's health care system has made amazing strides in basic and continuing education related to domestic violence, the topic was not included in physician or nurse education programs until the late 1980s. This omission has been widely corrected in schools of nursing. Courses centered around battering or family violence have been successfully used in BSN programs for registered nurses and most community health and psychiatric texts now include a chapter on

domestic violence.

It is recommended that there be, at least, one lecture on domestic violence in all three major courses---maternal child, community health, and psychiatric nursing--in all BSN programs. Also, there should be more mandatory in-service programs to increase the awareness of R.N.s in their working environment (Denham, 1995).

Documented in the nursing literature are recommendations for many clinically based assessments, protocols, and interventions in a variety of health settings. Consistent within the clinical knowledge base for domestic violence survivors are the following concepts that the battered woman needs to hear from the nurse: her history of abuse is believed; she is not crazy; no one deserves to be beaten; she is not alone; domestic violence is a crime; there is hope the cycle of violence can be broken; and there are specific places where she can go for help (Sheridan, 1993).

From a community health perspective, it is clear that a comprehensive, long-term effect is needed if wife beating is to be eliminated. Nurses can contribute to this effort through community education, recognition of battering, appropriate referrals, and advocacy on behalf of increased funding for women's groups and for battered women's shelters (Brendtro & Bowker, 1989).

CHAPTER 3

METHOD

Instrument

The survey questionaire (see Appendix A) utilized in this study was developed by Moss Aubrey for a presentation in 1988. This researcher received permission by phone from Moss Aubrey to use this survey. The questionaire includes a hypothetical scenario (see Appendix B) describing an incident of domestic violence. A score of 1 was marked for the appropriate answer and 0 for an inappropriate answer.Responses were talleyed and rechecked for accuracy.

The statistical procedures used for the analysis of this study were descripitive statistics and chi-square. Descriptive statistics are the numerical data that describe the phenomena. Descriptive analysis were run on the personal data. With chi-square, the probability distribution was used to test the independence of two nominal and ordinal variables which were taken from the personal data sheet.. Chi-square was also used to determine if these differences were significant.

Subjects

Aubrey's (1989) questionaire, was administered to 30 nursing students at a

hospital based 2 year nursing school located in a large city in the midwest. The ages of the students ranged from 18-48. Demographics (see Apprndix C) was collected on their level at school, previous educational level, marital status, previous personal experience with domestic violence, and previous education about domestic violence. The variables used in the SPSS/ PC cross tabs were gender / previous or no previous domestic violence experience and gender / previous or no previous domestic violence education. The results of these cross tabs appear in Table 1 and 2.

Table 1 Cross Tabulation from Attitude Survey

The cross tabulation below describes the variables: gender vs. previous domestic violence experience/ no previous domestic violence experience.

	Gender		
	female	male	
	1.003	2.003	
1.0			
had previous	12	2	14
domestic violence	12.1	1.9	
experience	85.7%	14.3%	
	46.2%	50.0%	46.7%
	40.0%	6.7%	
2.0	14	2	16
no previous	13.9	2.1	
domestic violence	87.5%	12.5%	
experience	53.8%	50.0%	53.3%
	46.7%	6.7%	
	26	4	30
Total	86.7%	13.3%	100%

Table 2 Cross Tabulation From the Attitude Survey

The cross tabulation below describes the variables: gender vs. previous domestic violence education / no previous domestic violence education.

	Gender		
	female	male	
	1.003	2.003	
1.0	18	2	20
Had domestic violence education	17.3% 90.0% 69.2% 60.0%	2.7% 10.0% 50.0% 6.7%	66.7%
2.0	8	2	10
No domestic violence education	8.7 80.0% 30.8% 26.7%	1.3 20.0% 50.0% 6.7%	33.3%
	26	4	30
Total	86.7%	13.3%	100.0%

Procedure

The survey was sent to the assistant director of the nursing school, along with a letter (see Appendix D), and given to 3 nursing instructors with the directions on how to administer the survey. The nursing instructors and nursing students were randomly selected by the assistant director of nursing. The completed surveys were returned to the assistant director of nursing. A stamped self addressed envelope was enclosed for the completed surveys to be returned to this researcher by the assistant director of nursing immediately after being completed.

The personal data sheet collected data on gender, marital status, level of education, age range, and previous education about domestic violence. Subjects included 4 males and 26 females, ranging in age from 18-48 (mean age = 34.1). All the subjects were EuroAmerican. In terms of marital status, 66% were married, 17% single and 17% divorced. Regarding formal education, 77% completed high school and 23% were college graduates. The subjects were asked if they had personal experience with domestic violence involving themselves, a family member or a friend. Experience was divided equally with 50% of the subjects having previous experience with domestic violence and 50% having no previous experience.

Among the 15 subjects who had previous experience with domestic violence: 54% were personally involved, while 26% reported experience with a family member and 20% with a friend. Sixty-six percent of the subjects had previous classroom education about domestic violence while 33% of the subjects had never had any education about domestic violence.

The nursing students first filled out the demographics questionaire and then read the scenario. After the presentation of the scenario, the subjects were asked to respond to eight true or false statements. (see Appendix E). The eight statements dealt with the couple's relationship, the battering incident, Francine's responsibility for the battering, her inability to leave Robert, her "masochism," and the likelihood that further abuse could be prevented by counseling or by reliance upon the police and the courts.

CHAPTER 4

RESULTS

The overall results are presented in Table 3, which indicates the percentage of subjects who believed each statement was true. As shown in the table, a substantial percentage of subjects agreed with several of the statements presented. Many subjects (roughly 30% or more) appeared to "endorse" the "myths" that a battered woman can simply leave her batterer even if she is afraid and could prevent battering by counseling.

Subjects were more likely to find statements 2- 8 false if they had previous experience with domestic violence. Previous education about domestic violence is related significantly to the subjects' responses to the statements. Otherwise, neither age nor any other variable (i.e., education, age, or marital status) showed a significant relationship to the subjects' responses to any of the statements. The responses presented in Table 4, indicates the attitudes of the subjects.with and without previous education about domestic violence.

A chi-square analysis was conducted of " Previous Domestic- Violence Education" by Knowledge-Attitude Survey, and "Previous Domestic-Violence

Experience" by Knowledge- Attitude Survey. Due to the low expected-frequency cells, the results of the analysis are not able to be accurately interpreted. See table 5..

A 2-tailed Pearson correlation coeffiecient was calculated for the variables "Previous Domestic-Violence Education" and "Previous Domestic-Violence Experience" with the Knowledge-Attitude Survey. The results appear in table 5. No significant linear relationship was found.

Table 3. Percentage of Subjects Who Agreed with each Statement

Statement	Percentage of subjects who agreed
1. Robert and Francine have serious marital problems.	66%
2. Robert's battering of Francine is an isolated event unlikely to be repeated.	33%
3. Francine probably bears at least some responsibility for Robert's assaultive behavior.	20%
4. If Francine is really afraid for her future safety, she could simply leave Robert	33%
5. If Francine remains with Robert, she is masochistic.	0%
6. If Francine remains with Robert, she is probably emotionally disturbed.	10%
7. Francine could stay with Robert and prevent further battering by seeking counseling.	30%
8. Francine could stay with Robert and avoid further battering by relying on the police.	7%

Table 4: Number of Subjects and their Attitude with / without Education about Domestic Violence

	20 subjects with education		10 subjects without education	
	true	false	true	false
1. Couple has serious marital problems	16	4	4	6
2. The battering is an isolated event.	5	15	5	5
3. The victim bears some responsibility.	3	17	3	7
4. Victim could simply leave even if she is afraid.	5	15	0	10
5. If victim remains, she is masochistic.	0	20	0	10
6. If she remains, she is emotionally disturbed.	0	20	3	7
7. She could prevent battering by counseling.	5	15	4	6
8. Victim could stay and prevent battering by relying on the police.	0	20	2	8

The results of chi-square from the "attitude survey" appear in table below.

Table 5; Chi- Square of Domestic Violence Education with and without Previous Domestic Violence Experience

Chi-Square	SPSS Value	DF	Significance
Pearson	6.97727	4	.13709
Likelihood Ratio	7.75631	4	.10092
Mantel-Haenszel test for linear association	4.18735	1	.04073

Minimum Expected Frequency- .333

Cells with Expected Frequency <5- 7 of 10 (70.0%)

Number of Missing Observations: 0

CHAPTER 5

DISCUSSION

There are several flaws and weaknesses in this study of student nurses and their attitude towards domestic violence.. There were limitations with the personal data sheet (ie. no racial demographics, no Likert scale on the amount of education recieved on domestic violence.) A sample size of 30 was a very limited random sample. There were only 4 male student nurses compared to 26 female student nurses who participated in this study. Also, the amount of previous education on domestic violence for each subject was not assessed.

The study was also limited due to the fact that several students sampled stated that enough information may not have been presented in the scenerio. Therefore, a percentage of the subjects may not have had enough background information to answer true or false to the questions about the scenerio.

Many of the variables were limiting, such as the small sampling of students and low number of male participants. Additionally, amounts of previous education about domestic violence were unknown. As a result, the null hypothesis could not be substantiated. No significant linear relationship was found. Future analysis should address random sampling issues and should include a larger random sample

size from several nursing schools.

The results of this study were inconclusive due to it's limitations. However, the study did appear to relate to the findings in the literature reviewed (Denham, 1995; Urbancic & Humphreys, 1993; Fishwick, 1993; Kurz, 1987; Bekemier, 1995). Dispite previous education about domestic violence, nurses and student nurses still do not appear to understand the cycle of domestic violence.

The problem of domestic violence is an insidious one that extends into all parts of society. Recognition of violence as a public health issue has caused health care providers to reevaluate their mindset and acknowledge a responsiblity for, and commitment to, participation in eradication of battering and domestic violence. Nurses can be major players in combating domestic violence.

All educational programs for health care professionals should offer education on the issue of violence against women that is culturally sensitive. These programs should address assessment, intervention, referral and advocacy. Ideally, this education will be integrated throughout the curriculum and include experience in community settings.

A large percentage of student nurses and graduate nurses have not gained the knowledge or skills to feel competent in intervening with women they know or suspect may be experiencing violence or abuse. It has been reported by student

nurses that they are unsure how to ask about domestic violence directly and are reluctant to assess women for the presence of abuse in their relationships.

The goals of instruction about domestic violence should include: 1. having students examine their beliefs about abuse and the women who are victimized, 2. making students aware of the statistics indicating the prevalence of abuse, and 3. teaching assessment skills to identify abuse, as well as interventions and resources to empower the victim.

Thus, the growing problem of wife battering and family violence indicates a need to address this crucial social issue on many levels. Nurses are in a paramount position to provide unique and important interventions for women. For nurses to be effective in dealing with this social problem, learning experiences with victims of family violence must be incorporated into nursing curriculum. Nursing educators must teach students in those places where people live: in homes, in communities, in long term facilities, on the streets and in the shelters.

Shelter staff members can be very helpful in empowering nursing students and nurses. The staff's knowledge and understanding of clients and domestic violence make them valuable resources. Student nurses are encouraged to regard the women in the shelter as the real "experts" about surviving violence.

Inviting survivors of domestic violence to class can provide a safe place for

nursing students to become familiar with these women prior to clinical exposure. Domestic violence survivors, nurses, and other health professionals who have experience dealing with this type of population can serve as a panel presenters or lead group discussions. These individuals can enable student nurses to learn about resources for abused women, serve as models for change and provide specific information on how to assist abused women.

Many students openly share their abusive histories with classmates during clinical conferences. Students who were able to discuss their own abuse acknowledged that initially they felt anxious about coming to the shelter, but they all reported growth in their personal lives. The most important benefit from the shelter experience was the dramatic increase in the awareness of family violence and the nurse's ability to influence the situation.

For women who are experiencing violence and abuse in their intimate relationships, the issue of safety is paramount. It is crucial that nursing play an important role in helping women deal with violence and abuse. Nursing intervention designed to assist women make safe and informed choices is an ethical imperative. Abused women are not seeking rescue, rather, they are in need of informed and culturally sensitive advocacy and nursing practice in the area of violence against women (King et al., 1993).

Nurses and all health care professionals need to support a policy of zero tolerance for violence against women in a health care setting. Therefore, women may feel able to disclose the violence in their lives and receive validation and empowerment they need to begin the road to recovery.

It is the recommendation of this researcher that further studies must be done to determine the whole scope of understanding the dynamics of domestic violence by nursing students. Nursing educators need to be a part of the research studies with the goal to integrate more consistent classroom time integrating domestic violence into the curriculum.

APPENDIX A

SURVEY

ABOUT DOMESTIC VIOLENCE

DIRECTIONS: After reading the scenerio, please circle whether you believe the statement is true or false.

1. Couple has serious marital problems.	TRUE	FALSE
2. The battering is an isolated event.	TRUE	FALSE
3. The victim bears some responsibility.	TRUE	FALSE
4. Victim could simply leave even if she is afraid.	TRUE	FALSE
5. If victim remains, she is masochistic.	TRUE	FALSE
6. If she remains, she is emotionally disturbed.	TRUE	FALSE
7. She could prevent battering by counseling.	TRUE	FALSE
8. Victim could stay and prevent battering by relying on the police.	TRUE	FALSE

APPENDIX B

SCENARIO

Robert and Francine were married in 1970. For the first eight years of their marriage, Robert worked as a steelworker while Francine stayed home to raise their three children. In February of 1978, Robert was laid off from his job. For the first time since their marriage, Francine was forced to go to work while her husband remained at home. As the months passed by, Francine noticed a gradual change in Robert. He became moody and argumentative. Hoping things would improve, Francine continued working and hoped that Robert would get a lucky break.

In March of 1979. Francine was promoted to a managerial position. That evening after work, she celebrated with a few friends. When she arrived home, she found Robert waiting for her. Before she had a chance to announce the good news, Robert accused her of cheating and threw her to the floor. She lay there, stunned and ashamed. Robert became tearful and apologetic and swore that he would never hurt Francine again. Francine forgave Robert (Aubrey & Ewing, 1989).

APPENDIX C

PERSONAL DATA SHEET

DIRECTIONS: Please circle the appropriate answer.

GENDER: MALE FEMALE

LEVEL at SCHOOL: 1 2 3

EDUCATIONAL LEVEL: HIGH SCHOOL BACHELORS MASTERS

AGE: 18-27 28-37 38-47 48 OR ABOVE

STATUS: MARRIED SINGLE WIDOW DIVORCED

PREVIOUS- PERSONAL EXPERIENCE WITH DOMESTIC VIOLENCE:

YES NO

IF YOU ANSWERED YES....PLEASE ANSWER NEXT LINE:

SELF FAMILY MEMBER FRIEND

PREVIOUS EDUCATION ABOUT DOMESTIC VIOLENCE:

YES NO

Thank you for participating in my project for my master's degree in professional counseling.

APPENDIX D

January 16 1997

To: Karen Wilson
Associate Director of Student Development
Lutheran Hospital School of Nursing

From: Phyllis Messing, R.N. and graduate student at Lindenwood College

Re: Graduate Research Project:: The Attitude of Student Nurses Toward Domestic Violence

I worked for 6 months at A.L.I.V.E. for my practicum experience. This was an "eye opening" experience for me about domestic violence. Even though I am a psychiatric R.N (working at Hawthorn Psychiatric Hospital for Children and Adolescents), I was not aware of all the aspects of domestic violence. I wondered about the attitude and knowledge of student nurses and R.N.'s working in hospital situations. It is my hope that a research project on this topic could lead to increased awareness of the needs for student nurses and registered nurses and how they deal with victims of domestic violence.

If possible, I would appreciate if 30 student nurses would fill out the personal data sheet and the survey for my project. It will take about 10 minutes for the students to complete the survey.
Thank you for your help in completing this research project.

Phyllis Messing

REFERENCES

Aubrey, M., & Ewing, C. P. (1987), Battered woman and public opinion: Some realities about the myths, Journal of Family Violence, 2, 257 - 265.

Aubrey, M. & Ewing, C. P. (1989), Student and voter subjects: Differences in attitudes toward battered women. Journal of Interpersonal Violence, 4, 289 - 297. (survey used in study)

Bekemeier, B. (1995), Public health nurses and the prevention of and intervention in family violence, Public Health Nursing, 12, 222 - 227.

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

Bullock, L. (1993), Nursing interventions for abused women on obstetrical units, AWHONN'S Clinical Issues in Perinatal and Women's Health Nursing, 4, 371 - 377.

Campbell, J. (1993), Women abuse and public policy: Potential for nursing action, AWHONN'S Clinical Issues In Perinatal and Women's Health Nursing, 4, 503 - 512.

Campbell, J. & Harris, M. (1995), Violence research: an overview, Scholarly Inquiry for Nursing Practice: An International Journal, 9, 105 - 123.

Christian, A. (1995), Home care of the battered pregnant woman, Journal of Obstetric, Gynecologic, and Neonatal Nursing, 24, 836 - 841.

Cody, A. (1996), Helping the vulnerable or condoning control within the family: Where is nursing?, Journal of Advanced Nursing, 23, 882 - 886.

Curnow, S. (1995), Battered women in the critical care setting: Tragedies for critical care nurses, Dimensions of Critical Care Nursing, 14, 160 -167.

Denham, S. (1995), Confronting the monster of family violence, Nursing Forum, 30, 12-19.

Duchscher, Joy (1994), Acting on violence against women, Canadian Nurse, 90, 21 - 25.

Easteal, P. & Easteal, S. (1992), Attitudes and practices of doctors toward spouse abuse victims, Violence and Victims, 7, 217 - 228.

Fishwick, N. (1993), Nursing care of rural battered women, AWHONN'S Clinical Issues in Perinatal and Women's Health Nursing, 4, 441 - 447.

Fishwick, N. (1995), Nursing care of domestic violence victims in acute and critical care settings, AACH Clinical Issues, 6, 63 - 69.

Gentemann, K. (1984), Wife beating: Attitudes of a non - clinical population, Victimology: An International Journal, 9, 109 - 119.

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

Henderson, A. & Ericksen, J. (1994), Enhancing nurse's effectiveness with abused women, Journal of Psychosocial Nursing, 32, 11 - 51.

Hilton, N. Z. (1989), When is an assault not an assault?, Journal of Family Violence, 4, 323 - 327.

Homant, R. & Kennedy, D. (1985), Police perceptions of spouse abuse: A comparison of male and female officers, Journal of Criminal Justice, 13, 29 - 47.

Jenkins, P. & Davidson, B. (1990), Battered women in the criminal justice system, Behavioral Science and the Law, 8, 161 - 170.

Jezierski, M. (1994), Abuse of women by male partners: Basic knowledge for emergency nurses, Journal of Emergency Nursing, 20, 361 - 367.

Kennedy, L. (1994), Women in crisis, Canadian Nurses, 90, 26 - 32.

King, M. C. (1993), Changing women's lives: The primary prevention of violence against women, AWHONN'S Clinical Issues in Perinatal and Women's Health, 4, 449 - 457.

Kurz, D. (1987), Emergency department responses to battered women: Resistance to medicalization, Social Problems, 34, 69 - 81.

Lavoie, F. J., M., Hardy, J., & Martin, G. (1989), Police attitudes in assigning responsibility for wife abuse, Journal of Family Violence, 4, 369 - 386.

Lazzaro, M. & McFarlane, J. (1991), Establishing a screening program for abused women, JONA, 21, 24 - 29.

Loring, M. & Smith, R. (1994), Health care barriers and interventions for battered women, Public Health Reports, 109, 328 - 338.

McFarlane, J. & Parker, B. (1996), Abuse during pregnancy, March of Dimes Nursing Modules, 14 - 35.

McMurray, A. & Moore, K. (1994), Domestic violence: Are we listening? do we see?, Australian Journal of Advanced Nursing, 12, 23 - 28.

National Women Abuse Prevention Project, ("n.d"), Domestic violence fact sheets.

Orloff, L. (1996), Effective advocacy for domestic violence victims, Journal of Nurse - Midwifery, 41, 473 - 494.

Ozmar, B. (1994), Encountering victims of interpersonal violence, Critical Care Nursing Clinics of North America, 6, 515 - 523.

Parker, V. (1995), Battering, RN, 30, 26 - 33.

Quillan, J. (1996), Screening for spousal or partner abuse in a community health setting, Journal of the American Academy of Nurse Practitioners, 8, 155 - 160.

Ragaisis, K. (1994), Critical incident stress debriefing: A family nursing intervention, Archives of Psychiatric Nursing, 8, 38 - 43.

Jewish Women International. (1996). Resource Guide for Rabbis. Washington, DC.

Ross, M. & Glisson, C. (1991), Bias in social work intervention with battered women.

Journal of Social Service Research, 14, 79 - 105.

Sheridan, D. (1993), The role of the battered woman specialist, Journal of Psychosocial Nursing, 31, 31 - 47.

Stalans, L. & Lurigio, A. (1991), Public preferences for the court's handing of domestic violence situations, Crime and Delinquency, 41, 399 - 413.

Trute, B. & Sarsfield, P. (1988), Medical response to wife abuse: A survey of physicians' attitudes and practices, Canadian Journal of Community Mental Health, 7, 61 - 71.

Urbancic, J., Campbell, J., & Humphreys, J. (1993), Student clinical experiences in shelters for battered women, Journal of Nursing Education, 32, 341 - 346.

Wison, J. (1994), Guidelines for the care of abused women, Home Healthcare Nurse, 12, 47 - 53.

Yam, M., (1995), Wife abuse: Strategies for a therapeutic response, Scholarly Inquiry for Nursing Practice, 9, 147 -159.