THE BATTERED WOMAN AND THE EMERGENCY ROOM NURSE

BY

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- Linguistics 0290
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- Classical 0294
- Comparative 0295
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Theology 0469

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Anthropology
- Archaeology 0324
- Cultural 0326
- Physical 0327

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- General 0310
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Canadian Studies 0385
Economics
- General 0501
- Agricultural 0503
- Commerce-Business 0505
- Finance 0508
- History 0509
- Labor 0510
- Theory 0511

Folklore 0358
Geography 0366
Gerontology 0351
History
- General 0578
- Ancient 0579
- Medieval 0581
- Modern 0582
- Black 0328
- African 0331
- Asia, Australia and Oceania 0332
- Canadian 0334
- European 0335
- Latin American 0336
- Middle Eastern 0333
- United States 0337

History of Science 0585
Law 0398
Political Science
- General 0615
- International Law and Relations 0616
- Public Administration 0617

Recreation 0814
Social Work 0452
Sociology
- General 0626
- Criminology and Penology 0627
- Demography 0938
- Ethnic and Racial Studies 0631
- Individual and Family Studies 0628
- Industrial and Labor Relations 0629
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- Social Structure and Development 0700
- Theory and Methods 0344

Transportation 0709
Urban and Regional Planning 0999
Women's Studies 0453

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Agriculture
- General 0473
- Agronomy 0285
- Animal Culture and Nutrition 0475
- Animal Pathology 0476
- Food Science and Technology 0359
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- Plant Culture 0479
- Plant Pathology 0480
- Plant Physiology 0817
- Range Management 0777
- Wood Technology 0746

Biology
- General 0306
- Anatomy 0287
- Biostatistics 0308
- Botany 0309
- Cell 0379
- Ecology 0329
- Entomology 0353
- Genetics 0369
- Limnology 0793
- Microbiology 0410
- Molecular 0307
- Neuroscience 0317
- Oceanography 0416
- Physiology 0433
- Radiation 0821
- Veterinary Science 0778
- Zoology 0472

Biophysics
- General 0786
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Geophysics 0373
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Mineralogy 0411
Paleobotany 0345
Paleoecology 0426
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Paleozoology 0985
Palynology 0427
Physical Geography 0368
Physical Oceanography 0415

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Environmental Sciences 0768
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- General 0566
- Audiology 0300
- Chemotherapy 0992
- Dentistry 0567
- Education 0350
- Hospital Management 0769
- Human Development 0758
- Immunology 0982
- Medicine and Surgery 0564
- Mental Health 0347
- Nursing 0569
- Nutrition 0570
- Obstetrics and Gynecology 0380
- Occupational Health and Therapy 0354
- Ophthalmology 0381
- Pathology 0571
- Pharmacology 0419
- Pharmacy 0572
- Physical Therapy 0382
- Public Health 0573
- Radiology 0574
- Recreation 0575
- Speech Pathology 0460
- Toxicology 0383

Home Economics 0386

PHYSICAL SCIENCES
Pure Sciences
Chemistry
- General 0485
- Agricultural 0749
- Analytical 0486
- Biochemistry 0487
- Inorganic 0488
- Nuclear 0738
- Organic 0490
- Pharmaceutical 0491
- Physical 0494
- Polymer 0495
- Radiation 0754

Mathematics 0405
Physics
- General 0605
- Acoustics 0986
- Astronomy and Astrophysics 0606
- Atmospheric Science 0608
- Atomic 0748
- Electronics and Electricity 0607
- Elementary Particles and High Energy 0798
- Fluid and Plasma 0759
- Molecular 0609
- Nuclear 0610
- Optics 0752
- Radiation 0756
- Solid State 0611

Statistics 0463

Applied Sciences
Applied Mechanics 0346
Computer Science 0984
Engineering
- General 0537
- Aerospace 0538
- Agricultural 0539
- Automotive 0540
- Biomedical 0541
- Chemical 0542
- Civil 0543
- Electronics and Electrical 0544
- Heat and Thermodynamics 0348
- Hydraulic 0545
- Industrial 0546
- Marine 0547
- Materials Science 0794
- Mechanical 0548
- Metallurgy 0743
- Mining 0551
- Nuclear 0552
- Packaging 0549
- Petroleum 0765
- Sanitary and Municipal 0554
- System Science 0790

Geotechnology 0428
Operations Research 0796
Plastics Technology 0795
Textile Technology 0994

PSYCHOLOGY
General 0621
Behavioral 0384
Clinical 0622
Developmental 0620
Experimental 0623
Industrial 0624
Personality 0625
Physiological 0989
Psychobiology 0349
Psychometrics 0632
Social 0451

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I would like to dedicate this paper to my husband Wally, for his never ending confidence and encouragement. I also would like to acknowledge my children, Andy, Launi, and Jessi for keeping me on track and allowing me to use their computer. Thank you!

Abstract

The battered wife syndrome is a reality. Emergency Room nurses must be empowered with information on physical and psychological abuse in order to help break this cycle of violence. The aim of this quantitative study was to evaluate a specific presentation on battered women that was designed to provide interesting and understandable information that would increase the participant's knowledge about victims of abuse. At the end of the presentation a questionnaire was completed voluntarily be 85% of participants. The positive response from the questionnaire indicated that there is a need for all nurses, not just Emergency Room nurses, to understand their own limitations pertaining to beliefs and attitudes toward battered women, be knowledgeable about domestic abuse, and be able to assess properly suspected victims of abuse.

TABLE OF CONTENTS

Introduction

Behind closed doors women are being physically, emotionally and sexually abused every day. At least one in ten Canadian women is abused by men she lives with or dates. This ratio does not include the number of unreported cases (Walker, 1979; Morrison, 1987; MacLeod, 1987; Hoffman, Sinclair, Currie & Jaffe, 1990; Greene, 1991).

As recently as 13 years ago, wife abuse was considered a private problem. MacLeod (1987) reported that when the subject of battered women was brought to the attention of the House of Commons on May 12, 1982, many politicians laughed. The Canadian public responded with outrage. The concern of the public was finally heard and Government officials rallied in acknowledgement to the public outcry. Canada became the first country to adopt a nationwide charging policy, encouraging police to lay charges in wife battering cases. Provincial and territorial governments established public education programs. National task forces were created. Money was allocated to services helping battered women and their children. Transition houses that provide shelter for battered women and counselling programs for victims increased.

Today, there are many support systems in place for victims of violence. These services range from crisis intervention, domestic abuse counselling, sexual and chemical abuse counselling, and safe homes, to long-term support services.

Unfortunately, the violence continues. Battering is responsible for 85% of all murders of women in Canada. Only 50% of the women who are abused seek medical help and those that do seek medical treatment often deny the cause of their injuries (Straus, 1983; MacLeod, 1987).

The victim's silence is compounded by the failure of nurses and physicians to recognize the battered wife syndrome. Medical personnel must know what to look for and what to listen for to enable them to perceive the victim's silent pleas. By understanding what is meant by the term "battered women" and by knowing the various forms of abuse, medical personnel can begin to identify victims (Blair, 1986).

A report done by Varvaro and Lasko (1993) stressed that failure to recognize intentional injury arising from abuse is dangerous for women for three reasons: (a) it maintains the violence-prone situation; (b) it results in inappropriate treatment; and (c) it can be psychologically damaging by reinforcing the assumption that the woman's abusive situation is insignificant. Understanding abuse as the cause of injury will enable the health care provider to recognize, care for, treat and refer the battered woman.

Tilden and Shepherd (1989) examined the response of the health care delivery system to battered women and found social myths and attitudes - such as, women get what they ask for - to be among the obstacles that impeded both the identification of these women and the interventions to assist them. Research by Brendito and Bowker

(1989) revealed that battered women rated health care professionals as less effective than any other formal sources of help in supporting and advising about necessary aid. The implications discussed by these clinicians focused on the need to help nurses gain awareness of their attitudes about battered women, educate themselves about the dynamics of battering and obtain the knowledge and skills needed for effective assessment and nursing interventions. Work by American researchers, McCleer, Anwar, Maquiling, and Herman (1989), strongly supported the premise that health professionals lacked the educational preparation necessary to intervene effectively with battered women. According to Ewing and Aubrey's report in 1987, there is a definite lack of information about battered women, which results in health care providers accepting stereotype views (cited in Bokunewicz & Copel, 1992).

Emergency Departments may provide the first opportunity for battered women to find support assistance or protection. Since domestic violence recurs, Emergency Department identification may interrupt the cycle of violence and help to prevent further abuse. The development and implementation of policies and procedures reinforced by staff education may increase the rate of identification of battered adults (Nuttall, Greaves, Lent, 1985; McLoughlin, Lee, Letellier, & Salber, 1993).

Purpose and Rationale of Study

The Emergency Room nurse is in a unique position to identify and treat abused women and their families. By understanding the complexities of the problem of

abuse, nurses in the Emergency Department can help to break the cycle of battering. Thus, there is a need for Emergency Room nurses to understand their own limitations pertaining to beliefs and attitudes toward battered women, be knowledgeable about domestic abuse, be able to assess properly suspected victims of abuse and initiate education, advocacy referral, and counselling. The purpose of this study is to evaluate the effectiveness of an educational presentation to increase the Emergency Room nurses' knowledge and awareness pertaining to the identification and assessment of battered women.

Definitions

Battered Wife Syndrome

For purposes of this study, wife abuse, battered woman, wife battering, domestic abuse/violence and victim are terms that will be used interchangeably to denote the "battered wife syndrome." Simply stated, the battered wife syndrome refers to the physical, sexual, psychological, and/or financial abuse of a woman by her husband or any male with whom the woman has an intimate relationship (Blair, 1986; NiCarthy, 1986; Zachariades, Koumoura, Konsolaki- Agouridaki, 1990).

Physical Abuse

Physical abuse is any form of physical aggression done by the victim's partner such as punching, pinching, spitting, kicking, hitting, choking, burning, and/or using a weapon for purposes of inflicting harm (Blair, 1986; Bell, Kaban, Learner, McGrath,

Maxwell, Moyes, 1989).

Psychological Abuse

Psychological abuse is non-physical maltreatment such as threats, controlling victim's activities, emotional neglect and intentionally frightening the victim (Blair, 1986; Bell et al. 1989).

Sexual Abuse

Sexual abuse includes marital rape, forced sex, and other defiant sexual acts as well as physical attacks on the breasts and genitals of the victim (Blair, 1986; Bell et al. 1989).

Financial Abuse

Financial abuse may include any or all of the following: withholding the means of daily living, fraud , theft, misappropriation of funds, and misuse of power of attorney (Blair, 1986; Bell et al. 1989).

Cycle of Battering/Violence

Wife abuse is rarely an isolated event but instead follows a predictable cycle which includes three stages. Lenore Walker (1979) identified the cycle of violence in an effort to explain this recurring pattern of behaviour in abusive relationships. The first stage, the prodome phase, involves the build up of tension. The abuser becomes angry over some misbehaviour, real or imagined, and reacts by berating or slapping the victim. The victim may try to placate her partner or withdraw to avoid any further

confrontation. As the victim grows more passive, the abuser becomes more aggressive. The abuser and the victim do not have good coping mechanisms. Eventually their faulty coping mechanisms give way and the abuser's tension is released in a burst of physical violence that can result in serious injury or death. This acute phase is the second stage of the cycle . In the third stage, the remission phase, the abuser is contrite and tries to make amends. He asks for forgiveness and often promises never to hurt the victim again. He may actually believe that he can control himself. If the victim remains, inevitably the tension will start to build once the reconciliation is over, and the cycle begins anew. This cycle is cited in numerous articles including those by Blair (1986), Collier (1987), Ahluwalia & MacLean (1988), Moehling (1988), Bokunewicz & Copel (1992), and Erikson & Henderson (1992).

Crisis Intervention

The victim of abuse is in a crisis situation. Crisis is defined as a disruption of a life situation where the victim lacks adequate coping mechanisms to deal with the disruption (Lazzaro & McFarlane, 1991).

Steps of Crisis Intervention

The intervention steps include: (a) assessment, (b) therapeutic intervention planning, (c) intervention implementation, (d) resolution of crisis, and (e) planning for anticipated future (Lazzaro & McFarlane, 1991).

Literature Review

Barriers to Identification

Victims of domestic violence are most likely to enter the health care system through an Emergency Department (Goldberg & Tomlanovich, 1984; Bergman & Bismar, 1991). The Emergency services offer not only 24 hour availability, but also relative anonymity in comparison to scheduled services. Thus Emergency Departments constitute an access point for health care providers into violent families; however, less than full advantage is taken by staff to identify victims (White, 1991).

According to Lent (1986), Tilden & Shepherd (1987) and King & Ryan (1989), multiple factors impede identification and treatment of the battered women. The first factor includes the professional lack of knowledge about the problem of wife abuse. Many health care workers are not cognizant of domestic abuse and therefore cannot treat what they do not know.

The second factor pertains to stereotypes and prejudices that influence health care professionals. Such beliefs as the "sanctity of family," "the family's right to privacy" and "the right of husbands to control their wives," give some medical professionals an excuse not to interview for domestic abuse.

The third factor involves the need for some health care professionals to create a psychological distance from the problem. This distancing often evolves from feelings of impotence when faced with the overwhelming and often chronic problem of

spouse abuse. The medical personnel may reject the victim in an effort to protect themselves from painful awareness of vulnerability (Morkovin, 1982). To avoid personal involvement, the health professional may excuse the assailant who is apologetic and solicitous of the victim.

The fourth factor that hinders identification includes the behaviour of the victim. Passivity, dependency, rigidity, low self-esteem, and resistance to change are all behaviours that, when combined with fears of the unknown, of retribution from the abuser, of non-support from family and friends, and fear of ridicule from medical personnel, deter self-identification.

The fifth factor that impedes identification pertains to time allotment. Often medical staff delay assessing possible victims of abuse because the staff know that a great deal of time may be needed to interview properly and assess the situation. Other staff do not want to become involved for fear of the possible legalities involving time consuming court cases that could arise from the situation.

Walker (1979) and Tilden & Shepherd (1987) contend that the battered woman syndrome continues as the victim is unable to trust others, is wary of others' motivations, has a fear of not being believed by others, and has a persistent hope that each attack will be the last. Ambivalence is evident in the woman's reluctance to self-identify, while hoping that a non-judgmental medical staff member will ask directly about domestic violence.

Identification and Assessment

Swanson (1985) and Hunt (1990) agreed that the most significant contribution any member of the health care industry can provide is the initial accurate primary diagnosis that domestic violence has occurred. To comply with the victim's attempt to hide the phenomenon is to compound the problem.

The easiest method of identifying an abuse victim is for the medical personnel to simply ask the suspected victim in a straight-forward, non-judgmental manner (White, 1991). In some instances, this approach works very well; however, many abused women will deny any suggestion of battering. Victims may try to minimize feelings of shame or embarrassment by denying the significance of abuse. Some feel trapped economically, or fear retaliation by their partners. Many abused women feel responsible for keeping the family together (White). Therefore, looking for clues that will validate the suspicion of abuse is very important.

Morrison (1987), Campbell & Sheridan (1989), Hunt (1990) and Berrios & Grady (1991) have described several characteristics and physical findings that are common to the "battered woman syndrome". According to them, characteristics of the battered woman include having an increased number of visits to the Emergency Department for minor or vague complaints, possibly being labelled accident-prone; appearing anxious, withdrawn, apathetic, and/or depressed; having the male accompanying her refuse to leave; having a history of suicidal ideation or actual

suicidal attempts; and possibly exhibiting fear of family members. Some physical findings, characteristic to battered women, include multiple injuries in various stages of healing; wounds or injuries inconsistent with the reason stated for the injury; a delay between the time of the injury and the time the victim comes to the hospital; wounds resulting from a weapon such as a knife, firearm or belt; injuries to the face, head and neck; and injuries or wounds on breasts and abdomens of pregnant women. The most common instrument of violence is the hand (Hunt). Injuries done by the open hand or closed fist should be noted. Feet are also a weapon of violence (Hunt). Presenting or entrance complaints may include, sleep disturbances, chronic pain, asthma, allergies, stress related symptoms, and problems with intimate relationships (White, 1991).

As summarized by Ross & Hoff (1994) violence also has long-lasting physical and psychological effects. Serious health implications include feelings of helplessness and vulnerability, problems with self-esteem, a high incidence of addictions and eating disorders among survivors and depression as a coping mechanism and chronic reaction. A woman arriving at the Emergency Department with any of these characteristics or physical findings should be suspected of being a victim of abuse. Further investigations should be initiated.

Management

The triage nurse is the first person any patient comes in contact with in the

Emergency Department. The role the triage nurse plays is established practice in Canadian hospitals. She/he has the responsibility of assessing the patient's level of illness or injury. The skilled triage nurse combines physical assessment with medical history and statements made by the patient and family to evaluate the level of care needed by the patient. Most often, he/she is the first medical personnel to suspect abuse and thus has the responsibility to initiate treatment.

Morrison (1987), Moehling (1988), and Burge (1989) contend that the abuse victim is in a crisis situation. Treatment within the Emergency Room should therefore follow a therapeutic crisis intervention model. Once abuse is suspected, the victim should be approached in a non-threatening manner and escorted to a quiet, private room. In such an environment, she can be interviewed and assessed by a supportive, non-judgmental nurse. Lent (1986) and Salber & Blair (1992) claimed that the primary objective would be to relax the patient and encourage her to develop trust toward the nurse. By asking clear, direct, factual questions in a gently emphatic manner, the victim is given a chance to reveal necessary information.

Lent (1986), Morrison (1987) and Tilden & Shepherd (1987) concurred that initially the opening questions should touch the topic of abuse and thereby allow the nurse to open the interview regarding this emotionally laden problem. A statement followed by a question such as "It is not uncommon for a husband to hit his wife. Has this ever happened to you?" lets the victim know she is not alone and that someone

cares. Further questions should be designed to elicit a description of the abuse problem. Such questions about the present abuse event, the victim's relationship with the abuser, the household situation, the pattern of abuse and the coping strategies utilized to deal with the abuse should be designed in such a way so the nurse can assess the extent of the danger to the victim and her family while still being supportive.

Campbell (1986), Morrison (1987), McLeer & Anwar (1987) and Salber & Blair (1992) maintained that assessment of the level of danger or lethality is a major part of the treatment component. This assessment affords medical personnel an opportunity to feed material back to the victim with an objective evaluation of behaviour. This assessment also helps the medical personnel identify risk factors that could lead to homicidal behaviour.

Research done by Morrison (1987) and Hadley (1992) found that the abuser frequently isolates the victim from her family and friends and thereby deliberately removes her from any social contacts. Thus, friends and relatives are unaware of the frequency and severity of the victim's abuse. Further questioning by the Emergency Room nurse should pertain to the availability and quality of support systems, resources and plans for the future. Questions such as "If you needed to get away, do you have family or friends who could help you?" " Do you have access to any financial assistance?" will help the Emergency Room nurse ascertain the type of

resources the victim may need. Assessment of the victim's immediate resources is an inquiry common to any crisis intervention process. In terms of the battered woman this type of assessment means inquiring about family and friends, jobs or supervisory support, finances, and child care (Klingbeil & Boyd, 1984). These questions also will allow the victim an opportunity to work through her immediate plans and to identify resources (Blair, 1986). The process of working through part of her problem is very therapeutic for the victim as well as for supplying the nurse with information that will assist the health care team to plan for immediate and follow-up care. This process is an important part of crisis intervention. NiCarthy (1986), Carter (1986) and Ryan & King (1989) suggested that as the victim learns to evaluate her circumstances, she learns that she can control and change the situation.

Morrison (1987) and Salber & Blair (1992) recommended that battered women should be made aware of other support systems. Information regarding shelters for battered women and their children, support groups, and relevant community resources should be given to the victim. Discussion of the future often is very difficult for the abused woman as she frequently has difficulty visualizing choices. In their research, Billy (1983), Bullock, McFarlane, Bateman & Miller (1989) and Hunt (1990) asserted that the Emergency Room nurse can encourage the victim to imagine herself in a house without violence, help her to visualize circumstances where she would like to be living and aid in creating constructive ways in reaching that goal. By listening,

giving support and discussing options, the nurse encourages the victim to imagine other ways of living and to be aware of other possibilities.

Emergency Room Staff can help formulate and propose immediate resolutions if resources are available; however, if no resources are available, staff may suggest community resources. Nuttall, Greaves & Lent (1985), Blair (1986) and Hadley (1992) advised Emergency Room Staff to be well acquainted with community support systems. Some treatment plans and resources will work for some victims but will not be appropriate for other victims. Thus, the greater the knowledge of resources, the better the Emergency Room Staff can benefit the victim. Networking, the process of linking a number of support pieces to form an entire support system, is a valuable asset to competent Emergency Room Staff.

The victim should be asked if she wishes to make a statement to the police to ensure that a report has been filed (Blair, 1986). She does not have to press charges personally, but she does have the right to press charges at any time and any previously filed report may strengthen her present case (Morrison, 1987). In Manitoba, all suspected abuse cases must be reported to the police. The police will then interview the victim and inform her of her rights of protection. In some instances, when the police become involved, the victim will refuse any further help and in essence turns her back on those who could help her. She then returns to the abusive situation. Nevertheless, she has received some form of intervention and knows that she can get

further assistance if and when she needs this help. However, if there are reasonable grounds to believe a criminal offence has occurred, the police in Manitoba have been instructed by the courts to lay charges against the abuser even if the victim refuses to do so. Before discharge of the patient from the hospital setting occurs, two goals should be realized: (a) the assurance of safety and (b) the establishment of one or more follow-up appointments with the victim (Klingbeil & Boyd, 1984; Burge, 1989).

Emergency Room Personnel need to have a plan of care that allows variation for individualization of need based on the interview with the battered women. However, management of physical injuries should be the same for any patient sustaining similar trauma by any other mechanism (Jezierski, 1992).

Burge (1989) stressed the safety of the victim should be ensured. Whether or not the victim chooses to return home, she should be provided with options for safe shelter as well as given permission to take refuge there. Even when the patient denies the existence of abuse, referral resources should be provided.

The Emergency Room Staff is responsible for providing the abused patient with a sense of security while her ability to deal with her stress and her potential for suicide or homicide are being assessed. If the battered woman refuses to leave the home situation for whatever reason, the Emergency Room Staff should try to avoid becoming frustrated by remembering that the need for immediate resolution of the situation may be theirs rather than the victim's and that patience is a necessity when

dealing with victims of abuse. The victim should be thoroughly appraised of referral resources, given phone numbers and contacts and strongly encouraged to return to the Emergency Department if the need arises (Klingbeil & Boyd, 1984; Greany, 1984; Burge, 1989; Parker & McFarlane, 1991). As Hadley (1992) pointed out, an abused woman is in a process. She will move through that process when she has sufficient strength and a sense of safety. Hadley stressed the fact that the nurse must accept where the victim is within the process.

While making management care plans, the Emergency Room Staff should pay attention to geographic adaptations and cultural differences (Klingbeil & Boyd, 1984). In a culture where men are dominant and the male role is clearly defined and supported, other treatment approaches may be necessary. Enlisting assistance from a particular ethnic group, such as the Aboriginal Centre, may be essential before intervention is possible. The treatment process is the same but the parameters and providers may vary according to need (Klingbeil & Boyd). By having the knowledge of the cultural background of the victim, the nurse will know which resources will be most beneficial to aid the victim. The Emergency Room nurse does not work alone but as a member of the Health Care Team that includes doctors, social services and the community.

Documentation

Greany (1984), Campbell & Sheridan (1989), Randall (1990), Hunt (1990) and

Salber & Blair (1992) discussed the importance of appropriate and thorough documentation. They stipulated that the Emergency Room Staff must document their objective assessment of the victim as well as the injuries, the treatment, the referrals, and any follow-up referrals. The time and date of the victim's visit to the Emergency Department should be documented. When recording the history of the patient, the nurse and physician should include actual quotes from the victim. The use of prefaces such as "she states" makes the documentation more accurate then personal opinions and conclusions. For legal purposes, when assessing the mechanism of the injury, the use of qualifying terms such as "alleged", and "suspected", is beneficial. While documenting the extent and apparent acuity of the victim's injuries, the medical personnel should include diagrams, possibly drawn on a body map, accurate measurements, and if the patient permits, Polaroid photographs. If photographs are allowed, they must have the date and the time the photo was taken placed somewhere on the actual photo. The photo should also include a readily identifiable feature of the victim. If the victim states who the perpetrator is, this piece of information should be included in the report with the preface "she states." The emotional state of the victim should be included with qualifying statements, such as "She appeared frightened and upset. She was crying, she kept clenching and unclenching her hands and she kept looking at the door."

Any involvement of the police or the security should be documented. Any

resources or referrals made for the victim should be listed as well. Accurate and concise records of the Emergency Room visit are necessary, as these records may be subpoenaed during litigation (Burge, 1989).

Staff Education

Studies done by Drake (1982), Goldberg & Tomlanovich (1984), Stark , Flitcraft, Zuckerman, Grey, Robinson, & Frazier (1981) and Campbell & Parker (1992) found that a notable number of women that visited an Emergency Department were victims of abuse. These women had received significant injuries from their abuse and wanted to receive help specific to this abuse from health care professionals. The studies further indicated that only 2-8% of these women were identified as abused on their records and they did not receive as much or as useful assistance as they wanted. A study by Brendito and Bowker (1989) supported the lack of identification and useful interventions by health care professionals.

Studies by Shipley and Sylvester (1982) and Rose and Saunders (1986) found that health care professionals, including physicians and nurses, believed some myths about battered women; for example, "once a battered woman always a battered woman." They also found that experiences, including intensive training and increased clinical contact with victims, increased sensitivity in all groups. In 1987, Tilden and Shepherd used a carefully designed time-series quasi-experiment to demonstrate a significant increase in nurses' documentation of abuse after staff training and implementation of

an abuse victim protocol (Campbell& Parker, 1992).

A great deal of commitment and organization is required to establish the need for such a protocol. According to Lazzaro and McFarlane (1991), to authenticate the scope and cost of the problem, national, provincial and urban statistics pertaining to the number of abused women should be presented to the Director of Nursing Services. Included with these statistics should be the number of times the abuse victims visit the Emergency Department as well as the nature of their ailments. The need for abuse screening should be placed within the overall goals, objectives and care directives of the hospital.

Lazzaro and McFarlane (1991) further explained that with a properly documented presentation, the Director of Nursing Services will see the need for a program pertaining to abuse and it is hoped, allocate money for the implementation of the presentation. Formal administrative approval is essential for the allocation of needed resources and legitimization of the presentation. Essential resources include establishment of necessary committees, staff inservice sessions, and a budget for assessment forms and patient education materials. Administrative approval verifies the importance of the presentation to all clinicians including nurses, doctors, and social services, and implies expected compliance.

Once approval for the presentation has been granted, the scope of the problem of abuse should be discussed with staff members in the Emergency Department. Since

the Emergency Room nurse is the most likely health care professional to make the initial contact with abused women, the presentation could be focused initially on the Emergency Room Staff. More than likely, most staff members have encountered abused women and wondered about the abused status of a client but felt inadequately prepared to assess, counsel, advocate and refer the individual for assistance (Lazzaro & McFarlane, 1991).

Again, with proper documentation of the extent of the problem, according to Emergency Room nurses, acknowledgement of their beliefs, backgrounds, and attitudes regarding abuse, and their need for information and skills pertaining to screening for abuse, a presentation can be developed. The staff must acknowledge their own attitudes and beliefs pertaining to abuse in order to assist with proper intervention for the abused victim.

Lazzaro and McFarlane (1991) further explained that by including both the Emergency Room Staff and Administration in the development of a presentation, group ownership is initiated where every participating member becomes sensitized to the problem of violence and committed to assessing women for abuse. Screening for abuse must not be perceived as an individual's special project. All nurses within the Emergency Department, with the support of Administration, must be aware and sensitive to the extent and scope of abuse. Through experience as an Emergency Room nurse, the writer has found that delegating one nurse or one team of nurses to

look after victims of abuse would not be practical. Similarly, having only one nurse looking after cardiac patients while another nurse cares only for patients with abdominal problems would not be practical. All Emergency Room nurses should be knowledgeable about all facets of Emergency nursing and that includes victims of abuse.

The need to work together with social services also is imperative. This conclusion is derived from discussions with Emergency Room nurses and hospital social workers. Although the Emergency Room nurse may have the initial contact with the abuse victim, persons from social services will have the follow-up work. Thus, the people from social services must know what to expect from the Emergency Room nurses just as Emergency Room nurses must know what to expect from the people in social services. Working together, the Emergency Room nurses and social services personnel could identify available community resources. The liaison between health care and social care is considered imperative and treated as part of the total care of the patient. Often when the Emergency Department is busy and an abuse victim is present, social services will take over the care of the vicitim after medical intervention has been completed. Emergency Room nurses and social services work together with the medical staff to form a team to promote optimal care of the abused. Hadley (1992) suggested that the two services could compile a list of agency names, addresses, phone numbers, key personnel, hours of operation, services provided and

costs. Any use of special requirements within the agencies, i.e., financial status, age of children, and medical needs, should be noted. This information could be compiled into a brochure which could be given to staff and eventually to victims. This information should be updated every six months and should be available to any needful victims.

Carter (1986), Collier (1987), Burge (1989) and Bukunewicz & Copel (1992) affirmed that any new presentation requires change on the part of the people participating in the presentation. In the Emergency Department, the nurses will be asked to perform the new skill of assessing for abuse. Without an adequate knowledge base and support system, the nurses will be angry, frustrated and resistant to take on this new task. The goal of the staff education presentation is to increase awareness and knowledge pertaining to the care and treatment of victims of abuse. By the establishment of this knowledge base and the practice of the new skills, the nurse's self-esteem will be enhanced.

Violence often emits powerful personal responses. Within the staff education presentation, time should be allotted for a discussion of personal feelings regarding abuse. Fears that health care providers may harbour should be dealt with creatively through discussions with peers and with representatives from local battered women's shelters or women's centres and through personal examination of the myths operating within some of these fears (Carter, 1986).

The established practice in most urban hospitals usually has an instructor who keeps the staff members apprised of any new technology or new technique specific to their area. Ideally, the instructor for Emergency Services would be the person to lead an abuse education presentation for the Emergency Room nurses.

During the staff education presentation, information regarding family violence and crisis intervention should be presented. Material specifically designed for abuse assessment could be introduced. Abuse assessment questionnaires and documentation forms could be reviewed. Discussion of goals and realistic outcomes should be included along with the actual management of the abused victim. These topics of information for the presentation have been suggested by Carter (1986), Collier (1987), Burge (1989), and Bukunewicz and Copel (1992). Carter reiterated that, following the steps for crisis intervention, the staff should be reminded to start with the assessment and diagnosis of the presenting problem without ignoring the underlying violence. Campbell (1986) found that not all women will be comfortable discussing life situations at the initial contact and, therefore, the need for close communication with social services is imperative. If the woman is willing to talk, intervention proceeds to specific strategies. Such strategies may include encouraging the woman to discuss her abusive situation in specific concrete terms, helping the woman to recognize the seriousness and dangerous nature of her relationship, directing her to discuss exactly what has been occurring, the frequency of the

occurrences, and her emotional feelings and reactions. These strategies allow the woman to see the enormity, and possibly escalating nature, of the problem. These strategies also allow the woman to feel validated and supported by health professionals. The risk of suicide or the possibility of mutilation or murder by her partner must be discussed with the woman, regardless of the severity of the presenting signs of abuse (Campbell).

In addition, Carter (1986) and Burge (1989) related that the woman should be assisted in formulating a strategy for the immediate future. An examination of the personal support structure that the woman can identify will help in making plans for the present and the future. If the woman is determined to return home and she is not at risk of homicide or suicide, then a discussion on how she will manage and who she will get to help her should be initiated. If she is too scared to return home, the Emergency Room nurse should explore options of where she could go, i.e., neighbours, relatives, or a shelter. If she has children, she must be told to take the children with her or her partner could claim that she abandoned them (Carter, 1986).

King & Ryan (1989) related that more specific intervention involves helping the woman gain knowledge of the referral options and alternatives available to her. Therapeutic intervention allows the woman to make her own choices about the immediate and future situations. The process of setting her own goals and making decisions about her personal life may be lengthy, but they are essential steps in

assisting her to develop independent strength.

If possible, presentation sessions should be long enough to allow for role playing experiences and discussions. As a nurse educator as well as an Emergency Room nurse, the writer believes the Emergency Room nurse must feel as comfortable as possible in dealing with this sensitive problem. By role playing and discussions, the nurse can become more proficient in handling people under stress, and at the same time can improve her interviewing skills through suggestions from her co-workers. Care of the abused is a new skill which requires practice. Just as Emergency Room nurses theoretically learned how to deal with an amputated limb, so too must Emergency Room nurses learn to deal with victims of abuse. The reality of being handed a severed arm separate from the body is a shock. The Emergency Room nurses must disregard their own shock and draw from knowledge and experience to deal with the crisis before them. Once the crisis has been met, they then should have time to deal with their own reaction. The same is true with the abused victim. The Emergency Room nurses must deal with the situation before them. The better prepared they are through practice and discussion with other staff members, the better prepared they are to deal effectively with the situation.

To familiarize staff with community resources specifically for the abused woman, representatives from social service, law, and legal agencies should be present to answer specific questions and establish personal rapport with all staff (Lazzaro &

McFarlane, 1991). If this interaction is not possible, then the presentation facilitator should lead a discussion pertaining to community resources, support groups and legal issues, incorporating both the victim's and the nurse's own potential liabilities. The importance of chart documentation as well as legal protection of the staff should be clarified by knowledgeable legal representatives. Any questions pertaining to staff safety, rights, and legal procedures should be discussed at this time.

Tilden & Shepherd (1987) reported that exposure of all staff to the presentation is important to ensure integrity of the study design. The presentation could be videotaped so that those who could not attend would still be able to view the tape and become conversant with the protocol. Tilden & Shepherd explained that the videotape could help the shift staff initially to become aware of the presentation and then to be somewhat prepared to make the best use of the presentation when it is presented to them. The video also could be used for refresher purposes. Inservicing via workshops is becoming a common occurrence. The workshop format offers additional information to anyone who may be interested. However, the primary presentation should be developed by the emergency instructor of the particular hospital so that procedures and practices would be congruent with hospital policy.

Hadley (1992) contended that once an educational presentation and protocol for detecting battering is initiated, there should be a follow-up with institutionalized policies and procedures for diagnosing and treating victims of domestic violence.

These policies and procedures would help to ensure continued vigilance in detecting and treating this abuse.

Carter (1986) and Bullock, McFarlane, Bateman & Miller (1989) claimed that successful interventions occur when the woman has a clearer picture of her abuse and begins to develop awareness of what she wants to do and what she can do. She can name her problem . She can plan for the present and the future. She can believe in herself.

Program Goals

Through her experience working as an Emergency Room nurse, the researcher has encountered many patients who come to the department complaining of relatively minor problems but who in essence are suffering from possible life threatening dilemmas. For example, many cardiac patients will come to the Emergency Room complaining of epigastric discomfort and deny any heart involvement. The Emergency Room nurse must be competent in her assessment and interviewing skills to establish a nursing diagnosis of impaired oxygenation to the heart and then initiate the necessary treatment. The researcher believes that the same interviewing and assessment skills are needed to assess stubbed toes, severed arteries, and victims of abuse.

The researcher also believes that Emergency Room nurses must make every effort to overcome their personal bias to do their job effectively. There are many nurses

who do not enjoy caring for such patients as convicts, AIDS patients, or possibly the elderly. However, since Emergency Room nurses encounter all levels of humanity, they must be knowledgeable about their own beliefs and have the ability to deal with their individual biases in order to deliver the best care they can to their patients.

Thus, the researcher contends that the nurses in the Emergency Department can help break the cycle of violence first by acknowledging their own beliefs and biases; second by learning to understand the battered woman and her situation; and third by recognizing and assessing signals of abuse. This knowledge base can be supplied through an educational presentation. By utilizing assessment and intervention skills, Emergency Room nurses can be instrumental in decreasing the serious dilemma of wife abuse. A specific presentation on battered women and the Emergency Room nurse has been designed by the researcher to help Emergency Room nurses understand their own attitudes and beliefs toward battered women, understand the cycle of violence, and identify and appropriately assess victims of abuse. Due to time constraints, management of the victim and appropriate documentation will not be included in this presentation.

The primary goal of this presentation was to provide interesting and understandable information that would increase the participant's knowledge about victims of abuse. The following statements reflect the program goals of the presentation.

1. An educational presentation on battered women will provide information to increase Emergency Room nurse's knowledge about victims of abuse.

2. An educational presentation on battered women will increase awareness of an Emergency Room nurse's perceived attitudes towards victims of violence.

3. An educational presentation on battered women will increase the Emergency Room nurse's awareness of the complexities pertaining to the problems of abuse.

4. An educational presentation on battered women will increase awareness of the Emergency Room nurse in identifying victims of abuse presenting to their department.

Evaluation Goals

The program goals reflect what the presentation was designed to accomplish. Although measurement of the amount of change in awareness was not within the scope of this study, the following evaluation goals depict what the researcher attempted to achieve with her presentation on battered women.

1. Did the participant find the presentation interesting?

2. Did the participant find the overall presentation useful?

3. Did the participant find the following sections of the presentation useful in developing awareness of battered women?

    a) definitions

    b) barriers to identification

    c) myths

d) identification of victims

e) assessment of victims

4. Did the participant find the distributed materials useful?

5. What changes would the participant make to improve the presentation?

6. Would the participant recommend this educational presentation on battered women to other areas within the hospital?

7. Would the participant recommend this educational presentation on battered women to other hospitals?

8. Did the presentation meet the proposed goals?

Method

Population

This quantitative study was an evaluative survey that focused on Emergency Room nurses within a 300-bed community hospital in one of the major cities in Western Canada. All nurses of this particular Emergency Department were asked to participate in the study. The nursing staff consisted of 21 full time working nurses, 11 part-time working nurses and 9 casual working nurses. The program also was advertised throughout the hospital inviting any other interested staff member to attend.

Design and Procedure

The nurses were informed of the study and invited to participate in the

presentation at a regular scheduled Emergency Department staff meeting. A follow up letter was given to each Emergency Room staff member which outlined the presentation on battered women and invited the staff to complete a questionnaire at the end of the presentation. The letter stipulated that completion of the questionnaire would aid the presenter in substantiating the merit of the presentation and would provide ideas for improving the presentation. The staff were assured of confidentiality and reminded that their participation in completing the questionnaire was totally voluntary. Posters reminding staff of the presentation, the time, the date, and the location were posted in the Emergency Department and throughout the hospital. The presentation also was advertised in the local hospital newsletter.

A questionnaire was developed and tested for validity by members of the faculty of nurse educators at a school of nursing. Once the questionnaire had been judged valid, it was delivered to the participants after they attended the presentation on battered women (see Appendix C).

This questionnaire was designed to evaluate the presentation on battered women presented to the Emergency Room nurses. The questionnaire involved two parts. The first part of the questionnaire included brief demographic information pertaining to area of employment and employment status. The second part of the questionnaire included open-ended questions where the participants were encouraged to share their opinions, insights and criticisms pertaining to the presentation presented. The

participants were reminded that there were no right or wrong answers and that their opinions were considered important. Once the questionnaires were completed and returned, scores were tabulated and common themes were identified from the open-ended questions. From the tabulated scores, the researcher was able to ascertain if the presentation met the proposed goals. The open-ended questions answered the evaluative questions and supplied ideas and suggestions to improve the presentation.

The presentation given to the participants included:

1. Introduction
2. Definitions
    i) battered wife syndrome
    ii) physical, psychological, sexual, and financial abuse
    iii) cycle of violence
    iv) crisis intervention
3. Barriers to identification
    i) myths
    ii) common barriers
4. Identification of victims
    i) characteristics commonly found in victims of abuse
    ii) physical finding of abused victims
    iii) psychological findings of abused victims

5. Identify available resources

The agencies:

i) names

ii) phone numbers

iii) services provided

To accomodate time constraints and the shift work of the participants, the presentation was offered at two separate times on different days in a classroom within the hospital. A written literature review of the material presented was made available for the staff to read at their leisure.

Ethical Considerations

Ethical problems were not foreseen as there was not any patient contact involved in the study. The study had been approved by the hospital's administration and the University of Manitoba, Faculty of Education Ethic's Committee approved the process of data collection. All participants were informed that their contribution was voluntary and that they were free to leave at any time. The participants also were informed that they could attend the presentation but were under no obligation to complete the questionnaire. Letters of invitation included explanations of the study and provided phone numbers of the investigator and her advisor (see Appendix A).

Confidentiality of the data was maintained by storing the questionnaires in a locked file cabint in the home of the researcher. The researcher was the only

individual who had contact with the questionnaire. The participants did not sign an attendence sheet nor were they requested to sign their names to the questionnaire.

Results

Method of Analysis

The questionnaires were reviewed one question at a time. The number of yes and no responses were recorded. Some participants did not respond to some questions. Open ended questions were examined for common themes. These themes then were catagorized and priorized in the final documentation. The analysis carried out was descriptive in nature and was focused on evaluating the goals of the presentation delivered on battered women.

Characteristics of the Participants

Forty people attended the two presentations. Of these 40 people, 34 completed the questionnaire, providing a response rate of 85.0%. This high response rate adds confidence to the validity of the data.

The Emergency Department employs 41 nurses. Eight participants responded that they were employed in the Emergency Department; therefore, 19.5% of the Emergency staff attended the presentation. These 8 respondents make up 23.5% of the participants attending the presentation. Three participants (8.8%) were from a ward area within the hospital and 23 individuals (67.6%) marked "other" as their area of employment. Two people (5.9%) stipulated that they were from psychiatry and 1

individual (2.9%) responded that she was a student nurse. Twenty-three people (67.6%) acknowledged they were employed full time. Seven participants (20.6%) responded that they worked on a part time basis and four participants (11.8%) did not reply to the question. All participants (100%) that attended the presentation were female.

Evaluation Questions

1. Did the participant find the presentation interesting (see question 4, Appendix C)?

All 34 respondents (100%) marked "yes", they found the presentation interesting. Twenty-five people (73.5%) wrote comments. The majority of the respondents (14 or 41.2%) indicated that they found the presentation to be a good review and that the information presented would be helpful professionally in identifying and treating battered women. Six participants (17.6%) mentioned that they found the presentation helped increase their awareness of the battered woman syndrome. Three people (8.8%) expressed interest in the presentation due to personal reasons and two people (5.9%) stipulated that the topic was one of great interest to them. All respondents (100%) who marked Emergency Department as their area of employment, indicated they found the presentation interesting. Three (37.5%) of these respondents added the following comments: "Pertinent to my work, good review and new information presented to assist in identifying and treating battered

women; excellent presentation, very informative; gave good insight as to signs to watch for, very emotional, well presented."

2. Did the participant find the overall presentation useful (see question 5, Appendix C)?

Thirty-one participants (91.2%) indicated that they found the presentation useful to their needs. Two people (5.9%) did not answer the question and 1 person (2.9%) commented that she did not find the information currently useful to her at this time. Twenty-five people (73.5%) offered written comments. Eleven people (32.4%) reported that they found the presentation useful as it increased their knowledge and awareness of the problem of abuse. Ten respondents (29.4%) mentioned that they felt the information presented provided a good review that was pertinent to their work. Two individuals (5.9%) commented that they felt the presentation was well done. One participant (2.9%) remarked that she found the presentation useful in that it offered her an "opportunity to meet people who were interested in the topic which would be good for networking and effecting change." Of the 8 Emergency Department participants, 7 (87.5%) responded that they did find the presentation useful to their needs. One participant (12.5%) did not respond.

3. Did the participant find the following sections of the presentation useful in developing awareness of battered women? a) definitions, b) barriers to identification, c) myths, d) identification of victims, e) assessment of victims (see question 6,

Appendix C)?

All respondents (100%) indicated that they found the sections on barriers to identification, myths, and assessment of victims useful in developing awareness of battered women. Thirty-three participants (97.1%) indicated they found the definitions and identification of victims useful as well. One individual (2.9%) did not comment on the usefulness of the definitions and identification of victims. Six individuals (17.6%) wrote comments pertaining to how the presentation might be enhanced. These suggestions included; using slides of injuries which occur with these women, taped descriptions by abused women, focus more on prevention, the importance of including Emergency Physicians, as well as nurses and adding a bibliography. Two respondents (5.9%) wrote that they found the presentation to be excellent and two people (5.9%) commented that they found the information to be a good review. One participant (2.9%) wrote, "I have read that on average, a battered woman will not leave until she has sought help of some kind 37 times. Every act of empowerment is important in her gathering strength." Seven Emergency Room participants (87.5%) responded that they found all areas mentioned useful in developing awareness of battered women. One Emergency Room respondent (12.5%) did not comment of the usefulness of the definitions and identification of victims.

4. Did the participant find the distributed materials useful (see question 7,

Appendix C)?

Thirty-three participants (97.1%) indicated that they found the distributed material on myths associated with battered women, pertinent questions medical personal could ask suspected victims of abuse, and community resources useful. One person (2.9%) stated that she did not find the information useful to her as she already had the material. Four people (11.8%) elaborated by indicating the myths and resources were extremely valuable. Two participants (5.9%) suggested the material should be available throughout the organization. One individual (2.9%) mentioned that she found the questions very helpful. Another respondent (2.9%) wrote that she found the information to be clear, concise and factual. All Emergency Room participants (100%) reported that they found the distributed material useful.

5. What changes would the participant make to improve the presentation (see question 10, Appendix C)?

Twenty people (58.8%) did not write any comments to this question. Five participants (14.7%) wrote that there was no need for any improvement. Three people (8.8%) indicated that the delivery was just fine, easy to read overheads, easy to hear, good seating arrangements, in a comfortable environment. Two people (5.9%) indicated that they would have liked to have had more case studies included with the possibility of interviewing an abused victim. One individual (2.9%) suggested that the presentation could have moved along a bit quicker. Another

person (2.9%) would have liked to have seen more information on prevention of abuse. Still another respondent (2.9%) would have liked to have seen more emphasis on the psychological aspect of abuse. One participant (2.9%) indicated that she would like to have had the issue of male abuse included. Six Emergency Department participants (75.0%) did not suggest any improvements for the presentation. The 2 participants (25.0%) who did respond suggested, "perhaps more actual charts (with no I.D. information) available to illustrate how often these women come with suspicious presentations and are not I.D.'d; also address the question of male violence i.e., males being abused within presentation - I find it always comes up and needs to be dealt with - Use ER nurses as part of the presentation, also abused women who are now safe could describe turning points - what care made a difference to them."

6. Would the participant recommend this educational presentation on battered women to other areas within the hospital (see question 13, Appendix C)?

All participants (100%) responded that they would like to see the presentation delivered to other areas of the hospital. Suggestions were made that the Emergency Physicians, student nurses, and psychiatric nurses could benefit from the presentation. One person (2.9%) indicated that the presentation should be delivered to the Nursing Grand Rounds Forum. All Emergency Department participants (100%) responded that they would like to see the presentation delivered to other areas of the hospital.

7. Would the participant recommend this educational presentation on battered

women to other hospitals (see question 14, Appendix C)?

Thirty participants (88.2%) indicated that they would recommend the presentation be offered to other hospitals. Three people (8.8%) commented that they thought this type of presentation may already exist in some hospitals. Two people (5.9%) did not answer the question. Two respondents (5.9%) wrote "maybe" the presentation should be recommended to other hospitals. Six of the Emergency Department participants (75.0%) indicated that they would recommend the presentation be offered to other hospitals. Two Emergency Department participants (25.0%) did not answer the question.

8. Did the presentation meet the proposed goals (see questions 4, 5 & 6, Appendix C)?

The participants did not specifically mention developing an increased awareness of perceived attitudes toward victims of violence; however, all participants including the 8 Emergency Department participants (100%), responded that they found the information on myths pertaining to battered women useful to them. The questionnaire did not carry a precise question to measure the change in the Emergency Room nurse's awareness of the complexities pertaining to the problem of abuse nor did it carry a specific question to measure the change in awareness of the Emergency Room nurse's ability to identify victims of abuse. However, although most common responses made throughout the questionnaire pertained to the

information presented being a good review that helped reinforce the nurse's role when dealing with abused women (14 or 41.2%), numerous comments also stressed how the information increased the participant's awareness of battered women (11 or 32.4%).

9. Other (see questions 1, 2, 3, 8, 9, 10, 12, 15, Appendix C)

Overall, 28 people (82.4%) found the information a good review. These participants were knowledgeable about the topic but found the presentation a good reinforcement of the a nurse's role toward battered women. Six individuals (17.6%) responded that the information was new to them. Twenty respondents (58.8%) did not know there was a hospital policy on victims of abuse whereas 11 individuals (32.4%) were aware of the hospital's policy. Sixteen people (47.1%) had previously attended a presentation on battered women. Eighteen people (52.9%) had not attended any type of presentation on battered women. Five Emergency Department participants (62.5%) were familiar with the hospital's policy on abused women. Three Emergency Department participants (37.5%) were not familiar with this information. All Emergency Department participants (100%) reported that the information presented was mostly information they already knew. Five Emergency Department personnel (62.5%) responded that they had attended an educational presentation on battered women prior to this presentation. Three Emergency staff (37.5%) had not attended any educational presentation on battered women.

When asked what they liked most about the presentation all participants (100%) wrote comments. The majority of the comments pertained to how the topic was discussed in a clear, concise, knowledgeable manner that included personal anecdotes. Eighteen people (52.9%) commented on how the presentation become more personal by the use of these anecdotes. Such comments as "personal opening story - very touching - I could feel your hurt - eye contact maintained throughout" were common. Nine respondents (26.5%) mentioned that they appreciated how the presentation flowed easily from start to finish. They found the information clear, concise and very helpful. Three individuals (8.8%) stated they were pleased that nursing interventions were more practical rather than theoretical. One individual (2.9%) found the characteristics of the survivors an important issue. The last comment that was made pertained to the fact that the topic was indeed a "timely one". Seven Emergency Department participants (87.5%) commented on how the information was presented. Such comments as "relaxed, emotional manner in which presenter performed the presentation" were indicative of what the majority of respondents (7 or 87.5%) liked best about the presentation. One Emergency Department respondent wrote she liked the "factors associated with lethality - interesting."

When asked what they liked least about the presentation, 18 people (52.9%) did not make any comments and 7 people (20.6%) stated they liked it all. Three people (8.8%) commented on how the presentation made them feel sad yet angry with their

own ignorance. Two people (5.9%) expressed dislike that this situation of battered women exists in our society. One person (2.9%) would have liked to have had time for more discussion and another individual (2.9%) would have liked to have heard more case studies. One respondent (2.9%) felt too much time was spent on definitions. One person (2.9%) commented that she would have liked to know more about how this topic was part of the researcher's own academic accomplishments. Four Emergency Department participants (50.0%) did not comment on this question. Two Emergency Department respondent (25.0%) expressed their dislike that the situation of battered women exists today. The respondents who felt too much time was spent on definitions and the respondent who would have liked to have heard more case studies were Emergency staff.

When asked if the participants would like another presentation dealing with management of the victim, 32 people (94.1%) responded "yes" and 2 people (5.9%) did not respond. When asked if the participants would like a presentation dealing with documentation (hospitals/legalities), 25 people (73.5%) stated "yes", 7 people (20.6%) did not answer, 1 individual (2.9%) stated "no", and 1 person (2.9%) wrote "maybe". Four people (11.8%) added comments that pertained to the desire for more information regarding communication and prevention. "How can they follow-up with the victim? How can they best work with schools, police, family services, and victims to hopefully prevent further abuse?" All Emergency Department participants (100%)

indicated that they would be interested in a presentation dealing with both management of the victim and proper documentation.

The participants were asked what length of time they would consider appropriate for these presentations. Nineteen respondents (55.9%) marked one hour as the best length for a presentation. Ten people (29.4%) marked two hours as the desired length . Four individuals (11.8%) marked a half day as the best length of time for a presentation. One respondent (2.9%) wrote that she thought a half day or full day workshop would be beneficial. Another participant (2.9%) suggested the information should be delivered to Nursing Grand Rounds. One person (2.9%) did not respond to the question. Five Emergency Department participants (62.5%) indicated that they prefer the 1 hour length for a presentation. Two Emergency Department respondents (25.0%) recorded 2 hours as the appropriate length for the presentation and 1 Emergency Department personnel (12.5%) marked "half day" as the appropriate length for the presentation.

At the end of the questionnaire the participants were asked if they had any additional comments to add. Twelve people (35.3%) responded to this request. Four people (11.8%) mentioned that the topic was a very important issue for nurses and other health care providers as well as the lay individual. Groups such as Y Neighbours, Mother's Morning Off, Church groups, and community centers should be offered the presentation. Two respondents (5.9%) wrote the presentation was well

done/excellent. These respondents were Emergency Department personnel (25.5%). Two participants (5.9%) suggested a change in terminology i.e., use survivors rather than victims. One of these respondents was an Emergency Department staff member (12.5%). One individual (2.9%) would like to know more about court proceedings and what is expected of the nurse. Another person (2.9%) would like to speak with actual victims of abuse. One participant (2.9%) wrote "psychological abuse is incredibly common place. It doesn't lead to a woman coming to Emergency in most situations. This is an area all health care professionals need to know about." The last comment (2.9%) made stated " More education helps to improve my personal ability to assess these patients and better assist them. Thank you."

Limitations

This quantitative study was not designed to evaluate all program goals. The research focused on evaluating the presentation and achieving the evaluative goals. The actual scope of this study did not include the measurement of change in awareness of the participants.

The researcher was the individual who presented the educational presentation and administered the questionnaire. The researcher also was a member of the staff of the Emergency Department; this might have been a confounding variable in that it may have interfered with the outcome of the study. The researcher does not know if her presence had a positive, negative, or null effect on the participants. However, the

possiblity of some effect should be considered. The participants' responses could possible have been based on their feelings or attitudes toward the researcher rather than the educational presentation and therefore could have affected the external validity of the study.

Another limitation involved the lack of random selection. All staff members of the Emergency Department were invited to participate. They did have the option to withdraw or decline but, initially, they were not randomly selected volunteers. The motivation for attending the presentation i.e., support of researcher, personal experiences with abuse, interest in topic, illustrates the limitation of an open invitation as opposed to random selection. The participants had a reason for attending the presentation, they were not randomly selected.

Another possible limitation was related to history. The media have been very diligent in acknowledging the presence of violence in our society. The researcher did not have control over any news broadcast or television movie pertaining to abuse that was released near the time of the educational presentation. Such media coverage could be considered a confounding variable.

Another possible limitation was related to gender. The researcher offered the presentation to all personnel within the hospital but the only participants to attend were female. None of the 4 male Emergency Department staff members attended nor did any other male within the hospital. The absence of male participants could be

considered a confounding variable.

Due to shift work and irregular working patterns, time was another variable that created problems. Although every effort was made to ensure that all participants would have access to the educational presentation, there were still some who did not participate in the presentation. Thus, time constraints involving prior committments did affect the number of people participating in the presentation.

Every effort was made to control extraneous variables in order to deal with methodological problems. Therefore, generalization of findings in this study should be done only to hospitals of similar size, location, and with similar staff as the one used in this study.

Discussion

The purpose of this study was to evaluate the effectiveness of an educational presentation to increase the Emergency Room nurse's awareness and knowledge pertaining to the identification and assessment of battered women. Although measurement of the amount of change in awareness was not within the scope of this study, the results of the questionnaire indicate that the participants felt the presentation was very useful to them by either reviewing or reminding them about abuse or by increasing their present knowledge about battered women. The written comments supplied throughout the questionnaire support this fact.

The presentation was delivered in an informal fashion, with the inclusion of several

personal anecdotes. Based on the responses given, this type of delivery was well received and possibly was one of the reasons for such a high response rate. Another reason for the high response rate could have been the participants' own agenda for attending the presentation i.e., personal experience, support of researcher, interest in topic.

The main target for participation was directed toward the Emergency Room nurses. Yet only 8 participants (19.5%) were from the Emergency Department. The researcher wonders if there would have been higher participation from the Emergency staff if the presentation had been offered on separate weeks or in the evening. Would a verbal reminder of the presentation to each staff member have increased the participation rate? If there had been higher Emergency Department participation, would the results of the questionnaire have been alteretd? Twenty-three respondents (67.6%) marked "other" as area of employment, indicating an obvious interest in the topic throughout the hospital. This interest is supported by the recommendation from all participants (100%) to offer the presentation to other areas within the hospital.

Although the researcher attempted to focus the questionnaire on the evaluation goals, several other questions might have also been added to expand the survey. The questionnaire did not ask the age range of the participants. The age and possible life experiences could have affected the responses. The level of education of the participants also was not included in the questionnaire. Would the education of the

respondents have affected the results? The majority of the participants did not know about the hospital's policy on abuse. If the participants had known about the policy, the researcher wonders if they would be more comfortable dealing with vicims of abuse within their own work setting.

The researcher did not include a question pertaining to why the participant attended the presentation. If this type of question had been included, the researcher may have discovered if she had a positive, negative, or null effect on the participant. She also may have discovered other needs of the participants that may have lead to other areas of interest and possible further presentation topics.

Another question that would be of interest involves where the participants received their information about abuse. Most of the participants stated that the presentation was a good review. Did they gain their knowledge about abuse from books, lectures, magazines, television, or the newspaper?

The presentation took approximately 1 1/2 hours to deliver. The majority of participants felt that a 1 - 2 hour presentation was appropriate for the topic. If the suggestions of inviting actual survivors of abuse, people from the legal profession, and police to speak, would the participants be comfortable with a longer time frame for the presentation?

Conclusions

From the positive response of the participants both verbal and documented on the

questionnaire, the researcher contends that the evaluative goals were met and the purpose of the presentation, to evaluate the effectiveness of an educational presentation to increase the Emergency Room nurses' knowledge and awareness pertaining to the identification and assessment of battered women, was achieved.

Pertaining to the evaluation goals, I conclude the following:

1. Yes, the participants found the presentation interesting.

2. Yes, the majority of participants found the presentation useful.

3. Yes, all participants found the sections on barriers to identification, myths, and assessment of victims useful to develop their awareness of battered women. The majority of participants found the sections on definitions and identification of victims useful as well.

4. Yes, the majority of participants found the distributed material useful.

5. The majority of respondents indicated that changes were not necessary in the presentation. The suggestions that were made included such ideas as having more case studies to discuss, possibly interviewing a victim of abuse, moving the presentation along a little quicker, including more on prevention and possibly having more discussion pertaining to the psychological effect on the victim.

6. Yes, all participants would recommend the presentation on battered women be delivered to other areas of the hospital.

7. Yes, the majority of participants would recommend the presentation on

battered women be delivered to other hospitals.

8. Yes, the presentation met the primary program goal of increasing the Emergency Room nurse's knowledge of victims of abuse. By increasing this knowledge base of the Emergency Room nurse, the presentation may have indirectly met the second program goal of increasing awareness of an Emergency Room nurse's perceived attitudes toward victims of abuse.

By reviewing the presentation and the results of the questionnaire several ideas developed pertaining to improving the presentation. The time frame of 1-2 hours should be kept the same. The presentation itself could be offered again but rather than spending time discussing definitions, supply a handout with the definitions and utilize the time discussing more important issues and also allow for more discussion time with the participants. The presentation should have been videotaped to allow people to view it at their leisure. Another presentation could be developed to include the topics of management of the victim and appropriate documentation both for the hospital and for legal purposes. When developing these presentations, the researcher should keep in mind the suggestions of the previous participants and invite survivors of abuse to help participants better understand the battered wife syndrome. The police and someone from the law profession should be invited to another presentation to help educate participants with management of the victims and appropriate documentation of this management. Although the researcher considers the

presentation was well advertised, she may in future send letters of invitation to the Emergency Physicians as well as to the School of Nursing.

The fact that the majority of participant (23 or 67.6%) were not from the Emergency Department indicates an obvious interest and possibly a need to learn more about battered women throughout the hospital. Therefore, the presentation on battered women should be offered to the entire hospital rather than attempting to focus on only one department.

Recommendations

Based on the data analysis, limitations, and conclusions the following recommendations are made for further research, education and nursing practice.

Nursing Research

1. The study should be replicated with a larger sample size.

2. The educational presentation on battered women should be repeated to other areas within the hospital.

3. Utilization of different formats for presentation should be evaluated to find the best form of delivery that meets the nurses' needs.

4. The development and evaluation of presentations pertaining to management and documentation of victims of abuse should follow the presentation delivered on awareness and identification of victims of abuse.

5. An educational presentation on battered women should be recommended to

other hospitals.

6. Further studies should be done to evaluate the change in nurse's behaviour following presentations on battered women.

Nursing Education

1. The presentation should be offered to student nurses at the hospital's School of Nursing.

2. The presentation should be offered to Emergency Physicians.

3. The presentation should be delivered at Nursing Grand Rounds.

Nursing Practice

1. The presentation should be offered to interested members of the community with an effort to promote prevention or early detection of abuse.

2. Nurses should be supported in their efforts to identify, diagnose, and intervene with victims of abuse.

Summary

The battered wife syndrome is a reality. Since Emergency Room nurses are frequently the primary resource to women who have been battered, they must be vigilant in recognizing the victim of abuse. They must have the awareness and knowledge to identify and assess battered women. By awareness of the problem and appropriate utilization of assessment skills, the Emergency Room nurse can be instrumental in decreasing the serious adverse dilemma of wife abuse. A specific

1 - 1 1/2 hour presentation on battered women was designed to help nurses increase their awareness of their own attitudes and beliefs toward battered women, increase their awareness of the cycle of violence, and improve their ability to identify and assess victims of abuse. At the end of the presentation, the participants were asked voluntarily to complete a questionnaire which would evaluate the presentation. The response from the questionnaire was extremely positive, indicating that there is a need for all nurses throughout all areas of the hospital, not just the Emergency Department, to understand their own limitations pertaining to beliefs and attitudes toward battered women, be knowledgeable about domestic abuse, and be able to assess properly suspected victims of abuse.

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APPENDICES

APPENDIX A

LETTER OF INVITATION

Dear Colleague:

As you may be aware, battering is the major cause of female murders in Canada. Until a few years ago, only about 50% of abused women would seek medical help and those that did seek medical treatment would often deny the cause of their injuries.

Since Emergency Room nurses are frequently the primary resource to women who have been battered, they must be vigilant in recognizing the victim of abuse. They must have the awareness and knowledge to identify and assess battered women. By awareness of the problem and appropriate utilization of assessment skills, the Emergency Room nurse can be instrumental in decreasing the adverse serious dilemma of wife abuse. as a graduate student in Post-secondary Studies in the Department of Educational Administration and Foundations at the Faculty of Education, I have developed the following project as part of my Master's thesis. A specific 1-1 1/2 hour presentation on battered women and the Emergency Room nurse has been designed to help nurses increase their awareness of their own attitudes and beliefs toward battered women, increase their awareness of the cycle of violence, and improve their ability to identify and assess victims of abuse. This study had been approved by hospital administration. The University of Manitoba, Faculty of Education Ethics Committee has approved the process of data collection.

This letter is your invitation to attend the presentation on battered women on Tuesday, May 2, 1995 at 0900 hours OR Thursday, May 4, 1995 at 0900 hours in the Faculty Room, 3rd floor, School of Nursing. at the end of the presentation you will asked to complete a questionnaire that will require approximately 10 minutes of your time and is totally voluntary. The questionnaire will be distributed in an effort to substantiate the merit of the presentation and provide ideas for improving the presentation. Anonymity will be maintained. You are welcome to attend the presentation and are under no obligations to complete the questionnaire.

The questionnaire will be divided into two parts. The first part of the questionnaire will include brief demographic information pertaining to area of employment and status of employment. The second part of the questionnaire will look at ways to improve the presentation. There are no right or wrong answers. All comments and

opinions are important. A summary of the results of the study will be provided. If you have any questions, please feel free to call me at extension 2383 or contact my advisor, Dr. P. Madak at 474-8712, Department of Educational Psychology, Faculty of Education. Your participation will be appreciated.

Sincerely,

Penny Davis

APPENDIX B

HANDOUT GIVEN TO PARTICIPANTS ATTENDING PRESENTATION

Myths Associated With Victims of Violence

1. A battered woman frequently provokes the attack.
2. Battering occurs only in lower socioeconomic families.
3. A battered woman can leave the relationship at any time.
4. Abusers are less educated men who are unable to cope with the world.
5. Once a battered wife always a battered wife.
6. Violence among family members is a private matter.
7. Battering is an isolated incident.
8. The battered woman may be emotionally disturbed.
9. A battered woman can rely on the police and courts to protect her.
10. Alcohol alters the personality of the drinker and causes him to perform actions which would ordinarily be out of character.
11. The battered woman syndrome affects only a small percentage of the population.
12. Battered women are uneducated and have few job skills.
13. Batterers are violent in all their relationships.
14. Once a batterer always a batterer.
15. Women who live in abusive relationships tend to become helpless.
16. Long-standing battering relationships can change for the better.
17. Battered women are masochistic.
18. The batterer is not a loving partner.

19. Batterers will cease their violence once they are in a stable relationship.

20. Children need their father even if he is violent sometimes.

Pertinent Questions Medical Personal Could Ask Suspected Victims of Abuse
by McLeer and Anwar, 1987

How were you hurt?

Has this happened before?

When did it first happen?

How badly have you been hurt in the past?

Was a weapon involved?

Is there a weapon in the home?

Who lives in the home?

Are the children in danger?

Have they been hurt by him? How badly have they been hurt?

What have you done in the past to protect yourself?

Have you ever called the police?

What did they say?

Have you ever obtained a protective order?

Have you ever tried to press charges against him?

Does your boyfriend/husband have a criminal record?

Has he beaten up of hurt other people?

Has he threatened to kill you?

Has he tried to kill you?

What did he do?

Are you afraid to go home?

Where can you go?

Have you ever sought help before?

Questions to Assess Coping Mechanisms

Is the woman able to function at home and at work?

What efforts has she made in the past to cope with battering?

Has his behaviour or mental status changed?

Does she feel hopeless, as if nothing she does will extricate herself from the situation?

Factors Associated With Lethality

Children in the home

Abuser threatens to kill spouse

Presence of a weapon

Threat of retaliation

Isolation

Pathological jealousy in spouse

Use of drugs and/or alcohol

Escalation of violence

Winnipeg Resources

Osborne House (shelter)	942-3052
Manitoba Committee on Wife Abuse Winnipeg Crisis Line	942-3052
Women's Advocacy Program (legal and resource information)	945-1781
Evolve (domestic abuse counselling program)	784-4070
Klinic Crisis Line Sexual Assault Centre Community Outreach	 786-8686 774-4525 786-6943
Y.W.C.A.	943-0381
Women's Health Clinic	947-1517
Family Services of Winnipeg	947-1401
Police (general number)	 986-6222
MAMAWI WICHI ITTATA (mamawee) (Aboriginal women in transition - 2nd stage)	925-0300
Elder Abuse Resource Centre (investigate and assess in home)	942-6235
Missionary of Charity Crisis Shelter	582-2773

APPENDIX C

QUESTIONNAIRE

Thank you for attending the presentation on battered women and the Emergency Room nurse. The following is a questionnaire that will help evaluate the presentation. The questionnaire is divided into two parts. The first part of the questionnaire pertains to background information. The second part of the questionnaire looks at ways the presentation could be improved. Please note that there are no right or wrong answers.

Please take ten minutes to fill out this questionnaire. Your input is important. ALL QUESTIONNAIRES WILL BE KEPT CONFIDENTIAL. No one other than the presenter will have access to this material. Thank you for taking the time to complete this questionnaire. If you need more room for comments please use the back of the page.

SECTION ONE
Please complete the following questions by placing a check mark ( ) in the appropriate spaces.

1. Area of present employment

Emergency room	8	(23.5%)
Ward	3	(8.8%)
Other	23	(67.6%)

Comments

psychiatry
student nurse
psychiatric nurse

2. Present employment status

full time	23	(67.6%)
part time (including casual work)	7	(20.6%)
no answer	4	(11.8%)

No extra comments

SECTION TWO
Please answer the following questions based on your own opinions, insights, and criticisms.

1. Before the presentation, were you familiar with the hospital's policy on battered women?

Yes	11	(32.4%)
No	20	(58.8%)
No answer	3	(8.8%)

Comments
- didn't know of location of policy therefore haven't read it
- did know of legal aspects and have read it
- vaguely
- aware of some legalities but not of specific hospital policy

2. Overall, the information presented today was

mostly new information	6	(17.6%)
mostly information I already knew	28	(82.4%)

Comments
- good review
- knew but had forgotten, good review
- knew about topic, didn't know about detail
- some definitions new, easily understood
- still good to hear

3. Have you ever attended an educational presentation on battered women prior to this presentation?

Yes	16	(47.1%)
No	18	(52.9%)

Comments
- covered in nursing school

4. Did you find the presentation of interest to you?

Yes	34	(100%)
No	0	(0%)

Comments

- good reinforcement of nurse's role
- good review
- always interested in this topic. I like to know what people are doing with it now. It's ongoing work.
- personal situation
- we need to be aware of potential for abuse in all the women that we meet - professionally, personally, socially and how to help them.
- helped to refresh and remind me to be more vigilant and aware both in hospital and at home/community
- to be able to assist if and when required in an educated way
- this is an area of interest to me, and it is always helpful to learn more information
- up to date data
- we can never hear it enough because we forget and don't act
- increased awareness of battered wife syndrome in Emergency
- because it is becoming more talked about, I also have a friend that I think may be abused
- excellent presentation, very informative
- it is present in our society and therefore we as nurses and females need to know about it and what to do
- have facillitated support groups for women who had been or were in an abusive situation
- need to know what is happening and how to deal with it
- It's a real woman's issue - I am a feminist
- Reminded me of a social issue which could affect me or someone I know. Increased my awareness of what I should watch for
- It informed me as a future nurse, the behaviours both `physical/mental of what to look for in battered women. Also interventions such as how to get them to actually talk about the abuse and acknowledge it. Also facilities available.
- increased awareness again! Reminders are always necessary. Psychological is even more common than physical.
- if ever working on a ward, will be better able to deal with this situation.
- pertinent to my work, good review and new information presented to assist in identifying and treating battered women.
- gave good insight as to signs to watch for, very emotional, well presented
- good interventions suggested
- increased knowledge to help others

5. Did you find the overall presentation useful to your needs?
Why or why not?

Yes	31	(91.2%)
No	1	(2.9%)
No Answer	2	(5.9%)

Comments

- very helpful reminder when dealing with an actual situation on the wards
- very basic for me, but good to review
- Yes, I learned more than I already knew
- general information review
- a review of information
- I found it well presented. The personal sharing was important
- increased knowledge
- better baseline as to how to handle these people
- pertinent to work, good review
- help me work on wards, know how to deal with situation
- increased knowledge - reinforce
- useful to me as a future nurse
- no matter what aspect of work you're in, one might encounter this situation
- how to interact with the victims
- not currently
- working in Emergency, we often encounter women and/or children we suspect of being abused, helpful to remember to look for more
- excellent
- good behaviours to look for in battered women and methods of extracting information from women
- increased awareness of problem
- able to assist if and when needed
- help refresh and remind me
- more aware
- I wanted to meet people who are interested in the topic, good for networking and effecting change
- good review
- topic that we need to be more aware of

6. Did you find the following sections of the presentation useful?

i) definitions

Yes	33	(97.1%)
No	0	(0%)
No Answer	1	(2.9%)

ii) barriers to identification	Yes	34	(100%)
	No	0	(0%)
iii) myths	Yes	34	(100%)
	No	0	(0%)
iv) identification of victims	Yes	33	(97.1%)
	No	0	(0%)
	No Answer	1	(2.9%)
v) assessment of victims	Yes	34	(100%)
	No	0	(0%)

Suggestions for improvements?

Comments

- If you were to develop this further: slides of injuries which occur in these women, taped descriptions by women of abuse
- presentation very well done
- both have poor coping mechanisms - elaborate - does injury match the story? most fear serious injury or death - have no money etc. Every second week we hear of women dying!
- good review, helpful to refocus on topic. I often hope that our society is not that violent yet it is. Sometimes I just want to shut it out.
- important to cover material with Emergency nurses and Emergency physicians. Communication skills most important.
- An excellent presentation - very comprehensive and factual - also interesting
- I have read that on average, battered woman will not leave until she has sought help of some kind 37 times. Every act of empowerment is important in her gathering strength.
- how can situations really be followed up?
- Yes to all as a refresher
- touched on prevention - possibly more of this would be helpful

7. **Did you find the distributed materials useful?** Yes 33 (97.1%)
No 1 (2.9%)

Comments

- I have
- this type of information should be available throughout the organization as resource
- yes although haven't read it over completely
- it's nice to know the myths and the places listed for help are beneficial
- list of resources very useful
- clear, factual concise
- myths very important
- the myths were good to dispel
- resources and pertinent questions are good to distribute

8. What did you like most about the presentation?

Comments

- topic - some nice personal story illustration
- the information received - also the personal anecdotes
- communication strategies - from experience in pediatrics - the "bull in the china shop" syndrome doesn't work
- the knowledge of the presenter and the obvious interest in subject - personal anecdotes
- actual victim scenarios, action to be taken
- good flow from introduction to conclusion
- clear, concise, very helpful
- introduction - you were very successful in getting my attention to the subject
- the anecdotes from actual women experiencing battering
- genuine concern is contagious
- the interventions presented
- the introduction, stories, examples, ways of interacting with victims
- information provided - practical rather than just theoretical
- orderly concise information - well presented
- the personalizing way it was presented along with the reason for getting interested in it
- method of dealing with battered women in Emergency room setting, personal experiences was a nice touch - made it more relevant.
- concise, covered a lot of information in a short time - inclusion of personal

experiences

- easy to follow, easy to understand, liked your stories, good length
- very informative and interesting
- relaxed emotional manner in which the presenter performed the presentation
- good review presented in thoughtful coherent manner, good coverage of topic
- it was presented in an informal, relaxed and comfortable way
- the stories - situations shared
- great opening - very powerful and moving
- the story telling is an effective way to communicate the passion in an issue such as this
- refreshed my knowledge of abused women and interventions
- characteristics of survivors of abuse
- suggestions for communication techniques
- the stroies you told were effective in spurring interest and emotions
- timely topic - needs to be discussed openly
- factors associated with lethality - interesting
- personal story very touching - I could feel your hurt - eye contact throughout
- interweaving of personal experiences show prevalence of the issue and increased interest

9. What did you like least about the presentation?

Comments

- feelings of sadness within myself
- time constraint - perhaps more sharing of people present re: their experience, concerns, etc.
- why this occurs - control, aggression - broadly we need to value women in this society. In the information we give to women, phone #'s etc. we should tell them of financial assistance etc.
- definitions - too much time spent here - most people already aware of or have some inclination of what abuse is or they wouldn't be here
- being ignorant about the subject in some ways
- I would have liked some explanation of how this part fits with what you are studying ie) part of thesis, part of course, what will happen with information?
- the fact that this situation exists in our society
- I would like to have heard more case presentations in Emergency room setting, discussion of how generally this topic is viewed in Emergency with the host of other presentations (my own personal agenda).

10. What improvements, if any, would you suggest be made to the presentation?

Comments

- more case examples
- perhaps could move along more quickly
- perhaps more actual charts (with no I.D. information) available to illustrate how often these women come with suspicious presentations and are not I.D.'d
- method of delivery just fine - easy to read overheads, easy to hear, good seating arrangement, comfortable environment
- you made me comfortable even when discussing an uncomfortable topic
- more emphasis on psychological aspect
- include more on prevention
- also address the question of male violence ie) males being abused with in peresentation - I find it always comes up and needs to be dealt with - Use ER nurses as part of the presentation, also abused women who are now safe could describe turning points - what care made a difference to them

11. Today we covered identification and assessment. Would you be interested in a presentation dealing with

management of the victim?	Yes	32	(94.1%)
	No	0	(0%)
	No Answer	2	(5.9%)
documentation hospital / legalities?	Yes	25	(73.6%)
	No	1	(2.9%)
	Maybe	1	(2.9%)
	No Answer	7	(20.6%)

Comments

- follow up with victim
- how to best work with schools, police and family services to work with victims and perhaps prevent abuse
- communication
- prevention

12. What length of presentation would you consider appropriate?

one hour	19	(55.9%)
two hour	10	(29.4%)
half day	4	(11.8%)
full day	0	(0%)
other	0	(0%)
no comment	1	(2.9%)

Comments

- workshop format - half to full day
- nursing forum

13. Would you recommend this educational presentation on battered women to other areas within the hospital?

Yes	34	(100%)
No	0	(0%)

Comments

- Emergency Physicians
- presented to students in School of Nursing
- Psychiatry could certainly benefit
- Nursing Grand Rounds format

14. Would you recommend this educational presentation on battered women to other hospitals?

Yes	30	(88.2%)
No	0	(0%)
Maybe	2	(5.9%)
No Answer	2	(5.9%)

Comments

- perhaps this is happening now
- I think it already exists in some hospitals
- some hospitals have volunteer program in Emergency Rooms who were on call when needed - many have programs but they don't seem to last

15. Do you have anything else to add?

Comments

- felt using the terms ladies and victim implied negativity - term of women and survivors much more powerful
- this should be offered to all regular lay people - as you said to help friends
- students would benefit from this
- helpful to refer to women involved in abusive relationships as survivors, not victims. This seems to be very empowering to these women
- this presentation should also target the victims - you could consider groups such as Y Neighbour, Mother's Morning Off, Church groups, Community Centres etc.
- excellent presentation
- include what to do if you were called to court
- more education helps to improve my personal ability to assess these patients and better assist them, Thank you.
- it would be interesting to hear an actual victim of abuse talk about her experiences
- psychological abuse is incredibly common place. It doesn't lead to a woman coming to Emergency in most situations. This is an area all Health Care Professionals need to know about.
- a very important issue for nurses and other health care workers to address
- well done

THANK YOU FOR ATTENDING THE PRESENTATION AND FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE