# INTIMATE PARTNER VIOLENCE AND THE ROLE OF THE EMERGENCY DEPARTMENT NURSE

A DISSERTATION

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

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BY

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June 28, 2006
Date

To the Dean of the Graduate School:

I am submitting herewith a dissertation written by Ruthie Robinson entitled "Intimate Partner Violence and the Role of the Emergency Department Nurse." I have examined this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy with a major in Nursing.

Dr. Judith McFarlane, Major Professor

We have read this dissertation and recommend its acceptance:

Department Chair

Accepted:

Dean of the Graduate School

## DEDICATION

To my supportive husband, my beautiful children, my parents, and to the victims of abuse I have met along the way.

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ABSTRACT

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INTIMATE PARTNER VIOLENCE AND THE ROLE OF THE EMERGENCY DEPARTMENT NURSE

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The purpose of this study was to examine the role of the registered nurse in the emergency setting as it relates to intimate partner violence. Specifically, the goals of this research were to identify how registered nurses screen for intimate partner violence in the emergency department, to identify barriers to screening, to determine how the registered nurse perceives effectiveness of such screening, to identify resources available to nurses and what resources are still needed, to determine how the nurse perceives victims of intimate partner violence, and to determine how the nurse perceives his or her role in assisting victims of intimate partner violence.

This study was based on a Heideggerian phenomenological perspective. Thirteen registered nurses working in emergency departments in a mid-size county in the South Central United States were interviewed using a structured open-ended interview technique. Data were analyzed using Colaizzi's (1978) seven-step method of data analysis.

Four main themes emerged: (1) myths, stereotypes, and fears; (2) demeanor; (3) frustrations; and (4) benefits. Myths, stereotypes, and fears refers to beliefs and preconceptions held by nurses related to victims of intimate partner violence and the

dynamics of a violent relationship. Demeanor refers to behaviors or mannerisms of the person that alert the nurses to the need for intimate partner violence screening. Frustration, the feeling experienced by the nurse when victims of abuse do not respond as the nurse would like to their questions and interventions, was a universal theme throughout the interviews. Finally, the nurses interviewed did feel that their efforts could result in benefits, such as increased safety, to the patient. This study suggests that emergency department nurses are not screening for intimate partner violence based on a protocol but rather are screening certain patients for violence based on the nurse's perception of whether or not a particular patient is likely to be a victim of violence.

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# CHAPTER ONE

## INTRODUCTION

> The Family Violence Prevention Fund (2004) defines intimate partner violence (IPV), sometimes referred to as domestic violence, as a pattern of assaultive and coercive behaviors including inflicted physical injury, psychological abuse, sexual assault, progressive social isolation, stalking, deprivation, intimidation and threats. These behaviors are perpetrated by someone who is, was, or wishes to be involved in an intimate dating relationship with an adult or adolescent, and are aimed at establishing control by one partner over the other (p. 2).

According to the National Crime Victimization Survey (U.S. Department of Justice, Bureau of Justice Statistics, 2004) approximately 494,570 violent crimes were committed in 2002 against persons by their current or former intimates, and about 85% of these victims were women. The same study also revealed that in 1998, females were the victims in 72% of intimate murders. Over a lifetime, about one-half of women report intimate partner violence (Bachman & Saltzman, 1995). In fact, an estimated 1,500 deaths and 73,000 hospitalizations are attributed to intimate partner violence each year, with an estimated annual cost of $4.1 billion with an additional $1.8 billion attributed to lost productivity (Centers for Disease Control and Prevention, 2003). The World Health Organization (2004) estimates that intimate partner violence costs the United States

economy $12.6 billion dollars per year, or 0.1% of the gross domestic product. Intimate partner violence is not just a problem in the United States. The World Health Organization (2000) reported that in 1998, interpersonal violence was the tenth leading cause of death for women 15-44 years of age.

Women experiencing violence not only suffer physical injury and emotional distress, but also are more prone to experience chronic health problems and negative mental health effects. Violence in a household also impacts the children living there. Witnessing violence has numerous negative effects on children, including anxiety, guilt, fear, aggressive behavior, withdrawal, impaired communication and motor skills, decreased scholastic performance, sleep disturbances, low levels of self-worth, increased incidence of substance abuse, increased crime, increased risk of suicide, and an increased risk of being the victim of abuse (Bonomi et al., 2006; English, Marshall, & Stewart, 2003; Sox, 2004; Veenema, 2001).

Women who have been abused are often reluctant to disclose the abuse for a variety of reasons, including fear, shame, and/or denial (McCauley, Yurk, Jenckes, & Ford, 1998). The stigma surrounding intimate partner violence may prevent women from disclosing or from asking for help. Women may be more apt to disclose if asked directly in a caring, nonjudgmental manner. A study by McCloskey et al. (2005) of 2,465 women showed that screening for IPV prompts disclosure to healthcare providers. In fact, when women were screened for IPV they disclosed 36% more often than women who were not screened. Several studies have indicated that women approve of routine screening and

welcome inquiry by healthcare providers (Chang et al., 2005; Hurley et al., 2005; Lutenbacher, Cohen, & Mitzel, 2003; Newman, Sheehan, & Powell, 2005; Zink, Elder, Jacobson, & Klostermann, 2004). The high incidence and the negative health effects listed above make it important for healthcare professionals to routinely screen for intimate partner violence. The nurse in the emergency setting may be the first healthcare professional to ask women about this important health issue. These factors place the emergency nurse in a unique position to initiate early intervention and prevention for women who are experiencing violence.

Screening for intimate partner violence provides an opportunity for disclosure of abuse and provides a woman and her healthcare provider the chance to develop a safety plan and to improve her health (Family Violence Prevention Fund, 1999). Factors leading to failure to screen and identify intimate partner violence represent a lost opportunity to intervene in the cycle of violence (Willson et al., 2001). It is important to determine the role emergency nurses perceive they play in identifying and intervening with victims of intimate partner violence.

## Problem of Study

The purpose of this study was to examine the role of the registered nurse in the emergency setting as it relates to intimate partner violence. Specifically, the goals of this research were to identify how registered nurses screen for intimate partner violence in the emergency department, what the barriers are to screening, how the registered nurse perceives effectiveness of such screening, what resources are available to nurses, what

resources are still needed, how the nurse perceives victims of intimate partner violence, and how the nurse perceives his or her role in assisting victims of intimate partner violence.

## Rationale

Research has shown that 18% to 25% of women seen in emergency departments are victims of intimate partner violence (Fanslow, Norton, & Spinola, 1998). Despite these statistics, it is estimated that healthcare providers detect only 5% of battered women (Valente & Jensen, 2000). A study funded by the New Jersey State Nurses Association (as cited in Yam, 2000) revealed that, in fact, abused women felt that health care professionals often blamed them for abuse, were unconcerned, or did not address the abuse at all.

The Emergency Nurses Association (2003), in its position statement on domestic violence, asserts that the emergency nurse is an advocate for victims of domestic violence and has a duty to identify and report domestic violence. The statement further asserts that the universal screening of victims is the first step toward patient advocacy. Additionally, in its recent Delphi study, the association identified domestic violence and abuse as a national research priority for emergency nurses (Bayley, MacLean, Desy, & McMahon, 2004).

Other healthcare associations that have published guidelines and position statements related to routine screening for intimate partner violence include the American Academy of Family Physicians (2000), American College of Emergency Physicians

(2002), American College of Obstetricians and Gynecologists (2006), American College of Surgeons (1999), American Medical Association (1992), American Medical Women's Association (2000), American Nurses Association (2000), Association of Women's Health, Obstetric, and Neonatal Nurses (2002), Institute for Clinical Systems Improvement (2004), and the Institute of Medicine of the National Academies (2001). Despite these endorsements to routinely screen for intimate partner violence, many healthcare professionals rarely or never perform screening.

The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) since 1992, has mandated policies related to screening for domestic violence in emergency departments (JCAHO, 1992). In 2004, JCAHO instituted new standards to help hospitals identify and assess domestic violence (JCAHO, 2004). In addition, several states have passed legislation regarding the responsibilities of nurses and other healthcare professionals to screen for and intervene with victims of intimate partner violence. However, as Schroeder and Weber (1998) suggest, nurses may be aware of these policies but are uncomfortable, uneducated, or insecure in their knowledge of intimate partner violence.

The advantages of routine screening for intimate partner violence are numerous. Routine screening can uncover cases of intimate partner violence, make it easier for women to access support services, change healthcare professionals' attitude and knowledge base about intimate partner violence, and change the perceived acceptability of violence in relationships (Taket et al., 2003). Additionally, asking about intimate

partner violence sends a message to women that the behavior is unacceptable and has serious health consequences for both women and their children. Asking about intimate partner violence also can result in providing women with referral and resource information (Family Violence Prevention Fund, 2004).

Intimate partner violence remains a serious public health problem for women and their children. Emergency nurses can play a pivotal role in identifying and intervening with this group of women. While other studies have looked at aspects of this information, most have focused on physicians, and very few have focused on the registered nurse in the emergency department and his or her role in assisting victims of intimate partner violence. Knowledge gained from research in these areas will assist in developing education for nurses and more effective methods of screening and intervening with victims of intimate partner violence. It also will enhance knowledge and a better understanding of process issues and system barriers to screening and intervening.

## Philosophical Perspective

This study was based on a Heideggerian phenomenological perspective. This perspective is holistic – and emphasizes understanding individuals and their interactions with others within the context of the situation. Hermeneutics is more than simply a description of experiences but looks for meanings embedded in normal life practices (Lopez & Willis, 2004).

Heidegger's hermeneutic phenomenology views humans as social, dialogical, and self-interpreting beings that are embedded in the context of their world. Heidegger's

concept of "thrown-ness" reflects the belief that individuals are shaped by their past experiences and cannot be disassociated from them (Heidegger, 1926/1996). Each person is born into a particular culture or environment where behaviors are learned. As such, meanings and self interpretations are embedded in language and practices. The philosophical perspective focuses on the meanings of participants' being-in-the-world and how these meanings affect the choices they make (Lopez & Willis, 2004).

These tenets govern the nature of the investigation. Hermeneutic phenomenology seeks a holistic approach in that participants are studied in their context rather than the simple measurements of parts of the whole (Benner, 1999). Investigation does not focus on the structure of phenomena but on how phenomena are interpreted (Cohen, Kahn, & Steeves, 2000). Just as individuals are embedded in the context of their lives, Heidegger (1926/1996) believed that it is impossible to "bracket" one's feelings and that indeed, the researcher's prior experiences are inseparable with the interpretation process. In addition, participants' experiences and practices cannot be separated from their history (Johnson, 2000).

This study examined the practices and meanings of nurses' experiences screening for intimate partner violence in the emergency department. In hermeneutic phenomenology, the investigator and the participant engage in a dialogical process to uncover meanings and the context in which the phenomenon is found. This examination should be sensitive to the context of intimate partner violence screening and interventions and the meanings that nurses attach to their screening role. The researcher participated in

the process by engaging in self-reflection and incorporating previous experiences in interpreting the interview data. In other words, the researcher participated in the research as an instrument. The researcher obtained data through semi-structured interviews and analyzed the texts (interview transcripts) for shared meanings. As an instrument, the researcher's background and assumptions contributed to the way the texts were analyzed.

## Assumptions

The assumptions of this study were as follows:

1. Each individual – both those studied and the investigator, is situated in his/her own reality. Previous experiences shape current values.
2. The researcher must understand participants in their own context in order to understand what participants value.
3. Individuals are self-interpreting according to their own background.
4. The background and previous experiences of the researcher cannot be separated from the interpretation and analysis of the data.

## Research Questions

The research questions for this study are:

1. What are the intimate partner violence screening practices of registered nurses in emergency departments?
2. How do registered nurses respond to intimate partner violence when women disclose?

## Limitations

Limitations identified for this study included the following:

1. There is a lack of literature addressing the ways in which researchers interpret and analyze experiences of registered nurses responding to intimate partner violence.
2. Since this study explored registered nurses' professional responses to victims of intimate partner violence while working in the emergency department, they may have felt the need to respond in a professional and appropriate way so as not to present themselves negatively.
3. This qualitative study was conducted with a small number of registered nurses from emergency departments in one area of the country, and their responses may not be representative of all emergency department nurses.

## Summary

This chapter provides an overview of the significance and background of intimate partner violence and the research questions explored in this study. Intimate partner violence is a major health problem in the United States and around the world, resulting in immeasurable pain and suffering for its victims and their children. The economic cost to this country is staggering. Registered nurses working in emergency departments are in a unique position to be able to screen for intimate partner violence and to be able to intervene with these victims in a meaningful way. Presently, the screening practices of registered nurses in emergency departments and how nurses respond to women who disclose abuse are unknown. This research describes nurses' practices surrounding issues

of abuse and contributes to the design of meaningful training programs. By developing meaningful training programs, emergency department nurses can more effectively meet the needs of victims of intimate partner violence and their children. The study used a hermeneutical phenomenological approach.

# CHAPTER TWO

## REVIEW OF THE LITERATURE

Factors leading to failure to screen and identify intimate partner violence represent a lost opportunity to intervene in the cycle of violence (Willson et al., 2001). The National Crime Victimization Survey estimates that nearly 500,000 acts of intimate partner violence were committed in 2002 (U.S. Department of Justice, Bureau of Justice Statistics, 2004). Approximately 85% of these acts were against women. Further research has shown that 18% to 25% of women seen in emergency departments are victims of intimate partner violence (Fanslow et al.,1998). Despite these statistics, it is estimated that healthcare providers detect only 5% of battered women (Valente & Jensen, 2000).

Women who have been abused are often reluctant to disclose this information for a variety of reasons, including fear, shame, and/or denial (McCauley et al., 1998). They may be more apt to disclose if asked directly in a caring, nonjudgmental manner. Nurses in the emergency setting may be the first healthcare professionals to ask them about intimate partner violence. These factors place the emergency nurse in a unique position to initiate early intervention and prevention for women who are experiencing violence. It is important to determine the role emergency nurses perceive they play in identifying and intervening with victims of intimate partner violence.

The following is a review of the research literature on intimate partner violence and screening practices of healthcare providers. This review reflects results of both a manual search for printed articles and a search of online databases, including CINAHL, MEDLINE, PsycInfo, EBSCOhost, FirstSearch, and Women's Studies International. Key words used in the search included *intimate partner violence*, *domestic violence*, *screening*, and *emergency nurse*.

To place the large volume of literature focused on this important topic into a grouped format, this literature review has been organized into four sections: attitudes regarding intimate partner violence, educational issues impacting intimate partner violence, barriers to screening and intervening with survivors of intimate partner violence, and screening practices of health care providers.

## Recommendations from Healthcare Organizations

Multiple heath care organizations have made recommendations or developed interventional polices with regard to violence against women. The Emergency Nurses Association (2003), in their position statement on domestic violence, assert that the emergency nurse is an advocate for the victim of domestic violence and that they have the duty to identify and report domestic violence. Additionally, the Emergency Nurses Association's recent Delphi study identified domestic violence/abuse as a national research priority for emergency nurses (Bayley et al., 2004).

The American Nurses Association (2000) also supports intimate partner violence education and universal screening for violence in all healthcare settings as outlined in its

position statement. Other organizations that have published position statements regarding screening for intimate partner violence include the American Academy of Family Physicians (2004), the American College of Emergency Physicians (2002), the American College of Nurse-Midwives (1997), and the Association of Women's Health, Obstetric and Neonatal Nurses (2002). Each of these organizations supports universal screening for intimate partner violence as well as education for healthcare professionals and the general pubic on issues related to intimate partner violence. Other organizations have submitted guidelines for routine intimate partner violence screening. These include the American College of Obstetrics and Gynecologists (2006), the American Medical Association (1992), and the Family Violence Prevention Fund (2004).

Since 1992, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) has mandated policies related to screening for domestic violence in emergency departments. These policies should address identifying and assessing victims of abuse, providing referrals as appropriate, and measures instituted to educate staff (JCAHO, 1992).

Healthy People 2010 has identified intimate partner violence as a leading health indicator. The goal of this indicator (15-34, physical assault by intimate partners) is to reduce the rate of physical assault by current or former intimate partners (U.S. Department of Health and Human Services, 2000).

Each of the identified health care organizations recognizes the impact of violence against women. These policies provide a mandate for intervention.

## Attitudes Regarding Intimate Partner Violence

Attitudes of registered nurses regarding intimate partner violence affect not only the nurse-patient relationship, but also nurses' screening practices and responses to women who choose to disclose their situation. A prevailing feeling among nurses involved in screening for intimate partner violence is one of frustration. Nurses have described feeling frustrated and even angry about the choices made by abused women. A study of healthcare provider behavior in screening for domestic violence by McGrath et al. (1997) reported that 78% ($n$ = 161) of healthcare providers surveyed cited frustration that victims would return to the abusive situation. A study of attitudes of 275 perinatal registered nurses working with women who had been abused revealed that 40% ($n$ = 110) experienced frustration (Moore, Zaccaro, & Parsons, 1998). A qualitative study by Nelms (1999) evaluating an educational intervention for emergency nurses reported the predominate theme of the nurses' interactions with abused women was one of frustration. In fact, nurses in this study expressed feelings of anger when women refused to press charges or when they decided to leave the hospital with the abuser. Varcoe (2001) reported similar findings in interviews with 21 emergency nurses participating in an ethnographic study. These feelings among healthcare professionals may lead to nonsupportive or victim-blaming attitudes.

In fact, one study showed that some nurses believed that many of the abused women they saw were of "undeserving status" (Varcoe, 2001). Women who nurses felt to be undeserving were those that they perceived to be abusing alcohol or misusing the

emergency department and who were not doing anything to improve their situation. A study consisting of questionnaires of 76 physicians designed to measure the beliefs of physicians about victims of abuse conducted by Garimella, Plichta, Houseman, and Garzon (2000) found that 30% ($n = 23$) of physicians in a large general hospital held victim-blaming attitudes. In addition, 34% ($n = 26$) of physicians felt that abused women must be "getting something out of the relationship," and 55% ($n = 42$) believed that some women had personalities that caused them to be abused.

Woodtli (2001), in a qualitative study, interviewed 11 registered nurses, one social worker and one counselor in an attempt to identify knowledge and skills needed by nurses to provide sensitive care to victims of abuse. Participants revealed feelings of anger and frustration when dealing with victims of intimate partner violence. One participant stated that she did not want to deal with these patients because "They will go back and just let them do it again" (p. 177). Others felt that the victims were "Stupid to go back again and again" (p. 177). One nurse interviewed stated that these patients had been "Stripped of their personhood by society, the perpetrator, and sometimes by the nurse," acknowledging that in some instances, perhaps, nurses added to the patient's pain (Woodtli, p. 177).

In addition, studies examining the attitudes of healthcare professionals towards victims of abuse reveal that many professionals stereotype victims. Stereotyping can obscure abuse in the "atypical" patient. An ethnographic study by Varcoe (2001) of 21 nurses revealed that nurses anticipated violence predominantly among women from lower socioeconomic classes and those from minorities As one nurse stated, "...there's also a

[American] Native population that drink a lot, and there's a lot of physical violence in the family units. I'll just say, 'maybe this could be,' rather than, really, 'look, let's deal with this, I think there is some violence here,' which I would do with the Indian women, which I probably wouldn't do with the (wealthy) ladies" (Varcoe, p. 104). This view was shared in other studies. In fact, in a survey by Moore et al. (1998) of 275 nurses, 92% ($n = 253$) felt that middle- and upper-class women were unlikely to be victims. McCloskey et al. (2005) surveyed 2,465 women regarding their experiences with health care screening for intimate partner violence. Results demonstrated that low-income women were more likely to be asked about IPV by a health care provider (OR, 1.66; 95% CI = 1.10 to 2.51). A study conducted by Witting, Furuno, and Hirshon (2006) of 108 emergency department nurses and physicians revealed that providers were 1.5 times more likely to inquire about intimate partner violence in "high risk" patients than with "low risk" patients.

One would expect that these attitudes would affect how nurses screen and respond to abused women. In an evaluation of a training model designed to improve emergency department response to battered women in Pennsylvania and California, findings suggested that a change in practitioner attitudes did not always translate into a change in clinical practice. Twelve hospitals participated in this study. Although the hospitals that received education showed higher levels of staff knowledge ($F = 5.57, p = 0.019$), there was no significant difference in the identification of abused women ($F = 15.43, p < 0.001$) (Campbell et al., 2001). The question remains, what type of knowledge and what type of protocols will best assist with screening and identification of abused women?

## Educational Issues Impacting Intimate Partner Violence

Studies revealed that most nurses felt they had insufficient education regarding intimate partner violence to effectively screen or intervene with abused women. Morgan (2003) studied 147 nurses working in maternity, gynecology, and neonatal units and found that most nurses had minimal to no education regarding intimate partner violence in their undergraduate programs. In addition, only 24% ($n$ = 35) of these nurses reported having any continuing education on IPV. In Tilden's et al. (1994) survey of 241 nurses in a northwestern state, only 44% of nurses could recall any intimate partner violence content in their undergraduate education. These findings are similar (45%, $n$ = 76) to those found in nurses working in emergency settings in New England (McGrath et al., 1997) and among perinatal nurses (54%, $n$ = 148) in a study by Moore et al., (1998). A study of 557 nurse practitioners revealed that only 4.8% ($n$ = 27) had received IPV education in their undergraduate preparation (Hinderliter, Doughty, Delaney, Pitula, & Campbell, 2003). Additionally, 82% ($n$ = 562) of 685 healthcare workers questioned by Cann, Withnell, Shakespeare, Doll, and Thomas (2001) said that they would like education and training on intimate partner violence.

Studies indicate that educating healthcare providers on intimate partner violence increases the level of detection and treatment of abused women. A survey of 193 healthcare professionals, including physicians, nurse practitioners, and dentists, revealed a positive association between education and patients screened for abuse (Goff, Byrd, Shelton, & Parcel, 2001). Similar results were found by McGrath et al. (1997), who

discovered that healthcare providers who receive domestic violence education were more likely to screen patients for IPV (RR 1.5, 95% CI 1.27-1.92, $p \leq 0.001$). In 1999, Shepard, Elliott, Falk, and Regal evaluated an educational intervention and implementation of an intimate partner violence screening protocol with public health nurses. They found that by using the new protocol, 9% of abused women were identified compared to 6% the year before. A randomized trial involving intimate partner violence training conducted with five primary care clinics showed long-term effects (21 months) in screening for intimate partner violence (Thompson et al., 2000). However, at least one study showed that additional training and education with physicians did not seem to have any long-term efficacy (Davis, Parks, Kaups, Bennink, & Bilello, 2003). When questioned, these physicians admitted that screening made them feel uncomfortable and unsure of what to do if they received an affirmative response. These results seem to indicate that these are areas that should be emphasized in any educational intervention.

An analysis of 12 studies evaluating educational interventions regarding intimate partner violence concluded that the interventions were generally brief (lasting 1 to ½ day), didactic in nature, and the original studies did not include the content of their (Waalen, Goodwin, Spitz, Petersen, & Saltzman, 2000). Results from this review of the literature were mixed regarding efficacy of educational interventions. However, it is difficult to make any determinations regarding usefulness of education, since the content of the programs was not discussed. The review did seem to indicate that programs that incorporated protocols and/or screening aids in addition to education showed an increase

in the identification of intimate partner violence victims, although no specific content of the protocols or screening aids was presented.

### Barriers to Screening and Intervening With Survivors of Intimate Partner Violence

Registered nurses and other healthcare providers have reported numerous barriers to screening and intervening with survivors of intimate partner violence. Previous sections have discussed nurse attitudes and educational issues as barriers to practice. Many other factors may exist that may constitute barriers to effective screening.

A study of 206 clinicians (including 58 registered nurses, six nurse practitioners, and 25 licensed practical nurses) in primary care settings revealed that 31% perceived domestic violence as rare (defined as 1% of the population) (Sugg, Thompson, Thompson, Maiuro, & Rivara, 1999). Thirty percent ($n$ = 17) of the nurses in this study stated that they had never identified an abused person. Fifteen percent ($n$ = 31) of these clinicians believed that a person's personality caused them to be abused. Almost 27% ($n$ = 56) felt that their workplace was not secure enough to inquire about abuse.

Concern over misdiagnosis was listed as a major barrier by 74% ($n$ = 153) of 207 healthcare workers in emergency departments in New England (McGrath, et al., 1997). Lack of time to screen and intervene was listed as a common barrier among nurses and other healthcare providers (Centers for Disease Control and Prevention, 2004; Elliott, Nerney, Jones, & Friedman, 2002; Ellis, 1999; McGrath et al., 1997; Rodriguez, Bauer, McLoughlin, & Grumbach, 1999). Another barrier mentioned in two studies was personal discomfort in screening (Ellis; McGrath et al.).

Many emergency department protocols include screening women at triage. Triage occurs as patients enter emergency departments and is often conducted in open areas, affording minimal privacy. Lack of privacy has been mentioned numerous times as a barrier to screening women. A study of 40 registered nurses working in a large Level I emergency department indicated that 60% ($n = 24$) of them felt that the major barrier to screening was a lack of privacy in their departments (Ellis, 1999). Forty-eight percent ($n = 192$) of 400 primary care physicians surveyed also cited a lack of privacy as a major barrier to screening for intimate partner violence (Rodriguez et al., 1999).

McGrath and associates (1997) reported that 57% (n = 118) of healthcare providers ($N = 207$) were concerned that women would consider screening an invasion of their privacy. Other barriers reported in the literature include fear of offending the patient and the lack of knowledge regarding intervening in cases of disclosure (Elliott et al., 2002; Ellis, 1999; Garimella et al., 2000).

Few qualitative studies exist that explore the issue of barriers to screening for intimate partner violence and emergency department nurses. A qualitative study by Loughlin, Spinola, Stewart, Fanslow, and Norton (2000) of 18 healthcare professionals, including nurses, used in-depth interviews to evaluate education on an intimate partner violence screening protocol. Barriers identified by this study included concern for offending patients, a lack of preparation to counsel women who disclose, a lack of available follow-up services, lack of time, concern over an invasion of privacy, language barriers, and healthcare professionals' lack of comfort with the issue as barriers to

screening for intimate partner violence. One participant stated "I don't think I've got the right to ask [about abuse] when she comes in for a sprained ankle...I haven't got the time and I haven't got the facilities—the private room, the good surrounds, the safe environment." In a qualitative study, 45 emergency department physicians identified lack of time and resources necessary to address the problem as major barriers to screening (Gerbert, Caspers, Bronstone, Moe, & Abercrombie, 1999).

## Screening Practices of Healthcare Providers

It is interesting to note that although universal screening is recommended by many healthcare organizations and the accrediting agency for healthcare institutions, there is no "best practice" model by which to formulate intimate partner violence screening programs in emergency departments. A critical pathway for intimate partner violence, developed by Dienemann, Campbell, Wiederhorn, Laughon, and Jordan (2003) has not yet been tested in regard to patient outcomes. Even though many hospitals have protocols designed to address this issue, studies have indicated that most of the nursing staff were not aware that their facility even had a protocol for screening (McGrath, et al., 1997). This study revealed that only 34% ($N = 76$) of nurses in a large New England emergency department knew that a protocol was in place.

In addition, although nurses and other healthcare providers feel that it is their obligation to screen for intimate partner violence, very few do so on a routine basis. As discussed previously, several national organizations recommend routine screening for intimate partner violence. Even so, in a study of 76 nurses conducted by McGrath et al.

(1997) 64% of nurses ($n = 49$) reported that they never or rarely screen for IPV and none reported that they always screen for intimate partner violence. Moore et al. (1998) reported similar findings in a study of 275 gynecological nurses. Only 17.6% ($n = 48$) of these nurses stated that they routinely screened their patients. A review of 1,509 charts from visits to emergency departments by women revealed that intimate partner violence screening was not documented as being done in 66.1% of cases (Larkin, Hyman, Mathias, D'Amico, & MacLeod, 1999). A study of 400 California physicians indicated that 79% ($n = 316$) of primary care physicians often or always asked patients direct questions about intimate partner violence only in patients with physical injuries. Otherwise, only 9% ($n = 36$) routinely screen their patients (Rodriguez et al., 1999). A study of 112 English nurses revealed that 89% ($n = 100$) felt intimate partner violence was a healthcare issue, yet only 7% ($n = 8$) felt that they should routinely screen for violence (Richardson et al., 2001). A qualitative study of emergency department healthcare providers indicated that the decision to screen women was based solely on the providers' suspicion of abuse (Loughlin et al., 2000). These findings are similar to those of a study of Alaskan physicians ($N = 296$) reported by Chamberlain and Perham-Hester in 2002. Only 6.2% ($n = 18$) screened for intimate partner violence on an initial visit and 7.5% on annual checkups, unless the patient presented with an obvious injury (Chamberlain & Perham-Hester). Similarly, in a review of 527 charts in an academic emergency department, only 150 (29%) of the patients were screened (Richter, Surprenant, Schmelzle, & Mayo, 2003). Of the 15 victims identified in this study, only three had a safety assessment

performed, less than one-half were referred to a shelter, and only one victim was given the domestic violence hotline number.

A study of 11 emergency departments in Pennsylvania and California reviewed every medical record of women aged 18 and older over a three-year period (Glass, Dearwater, & Campbell, 2001). According to the medical records, 74% of the 4,641 female patients who presented to the emergency departments were screened for intimate partner violence. However, when these women were surveyed, fewer than 25% stated that they were asked about intimate partner violence by the emergency department staff. These results are similar to those found by Willson et al. (2001), who reported that of 128 women who had sought health services in the past year, only 24% (n = 31) had been asked about intimate partner violence. Kothari and Rhodes (2006) conducted a retrospective observational study of emergency department use by a known population of women identified as victims in a Michigan county's intimate partner violence database ($N$ = 964). These women had 4,456 emergency department visits over a three year period, a rate three times the annual rate of emergency department use by a population-based sample of women in the same age range. Only 5.8% ($n$ = 259) of these visits included any documentation of intimate partner violence identification. Additionally, 69.7% ($n$ = 3,107) of records had no documentation of any type of screening for intimate partner violence. However, an injury-related visit was 50% more likely to contain documentation of screening than a non-injury-related visit.

A qualitative study of 11 nurses described "helping" the victim as one of their major roles. Help was defined as providing knowledge, support, resources, and safety to women who disclose (Woodtli, 2000). Healthcare professionals in a New Zealand emergency department described similar helpful interventions. However, many of the healthcare providers studied only intervened if they felt they had time or if the woman specifically asked for help (Loughlin et al., 2000).

A review of 20 articles reviewing intimate partner violence screening in emergency departments concluded that there is no "gold standard" for the identification of intimate partner violence victims and recommended further research on screening (Anglin & Sachs, 2003). The review further suggested that perhaps screening, in and of itself, might be considered an intervention. These findings are similar to the conclusions of another review of 22 articles. That review found that no studies have adequately evaluated the benefits of screening tools in regard to a decrease in violence or an increase in the woman's health (Wathen & MacMillan, 2003). However, in a qualitative study of 11 nurses, Woodtli (2001) found that the nurses' preferred screening outcomes were that women leave the violent situation, or that they at least become more aware of the danger of the situation and of safety plans, and that they follow up on referrals, or at least know that they exist.

## Summary

Intimate partner violence remains a major health problem for both women and their children, despite the efforts of many organizations and individuals to address this

issue. Healthcare providers detect only a small number of these women. Emergency nurses are in a key position to screen and intervene with these women. Many organizations support screening for intimate partner violence and several offer guidelines for use by healthcare professionals. However, despite numerous discussions of intimate partner violence in the literature, there still does not exist a best practices model that emergency departments can follow when screening and intervening with women who have been abused. In order to develop this model, a thorough understanding of the perceptions and needs of emergency department nurses regarding intimate partner violence must be achieved. Qualitative studies may offer opportunities for researchers to gain understanding and greater depth of knowledge on this important topic.

Of the studies reviewed in this chapter, only three were qualitative. None focused solely on emergency department nurses. One study explored the approach of physicians in the identification of intimate partner violence victims (Gerbert et al., 1999). Loughlin et al. (2000) used qualitative methodology to determine emergency department staff responses to implementation of an intimate partner violence protocol; however, this study, conducted in New Zealand, included healthcare providers other than nurses. The last qualitative study was conducted by Woodtli (2001) and included healthcare providers from a variety of settings.

More numerous are quantitative studies of intimate partner violence. While several of them reported that intimate partner violence education affected the behaviors of healthcare providers (Campbell et al., 2001; Goff et al., 2001; McGrath et al., 1997;

Moore et al., 1998; Tilden et al., 1994), none described the specific educational needs of nurses involved in screening.

Other quantitative studies attempted to identify healthcare provider barriers to screening for intimate partner violence (Elliott et al., 2002; Ellis, 1999; Rodriguez et al., 1999). Only one of these focused on emergency department nurses (Ellis). Although numerous barriers were identified—particularly practitioner discomfort, lack of time, and lack of privacy—these studies did not offer suggestions on how to overcome these barriers.

The most glaring gap in the literature involves a lack of specific protocols for screening and intervening or, if they exist, they are not described, a lack of evidence regarding the efficacy of screening for intimate partner violence, and a lack of specific educational content for nurses involved in the care of these women. Further research should address these areas.

The research studies reviewed suggest that, although there has been an increase in awareness of intimate partner violence in the past few years, there remain many victim-blaming attitudes among nurses and other healthcare professionals and that these same professionals are holding on to myths regarding intimate partner violence. Although most nurses report that they believe it is their duty to screen for intimate partner violence, very few nurses routinely screen, and few feel comfortable in responding effectively to women who do disclose. Little literature exists that addresses what interventions nurses perform when women disclose a history of intimate partner violence.

The vast majority of nurses report little or no education regarding intimate partner violence in their undergraduate programs. In fact, most report little education of any type regarding intimate partner violence. However, studies indicate that education alone does not necessarily increase levels of detection. It has been suggested that education combined with protocols and/or screening aids have been effective.

It is essential that those developing educational programs and screening and intervention protocols to be implemented by nurses in the emergency department have an in-depth understanding of these nurses' particular perceptions and needs. Gaps in the published research reveal a need for qualitative analysis of these issues, focusing specifically on emergency department nurses. In addition, research should provide data regarding how common myths affect nurses' attitudes toward intimate partner violence. Not only should protocols and screening tools be developed and implemented based on research findings, they must also be tested in future research.

# CHAPTER THREE

## PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

The purpose of this hermeneutical phenomenological study was to examine the role of the registered nurse in the emergency setting as it relates to intimate partner violence. This chapter describes the setting in which the study took place, the population and sampling technique, the procedure to ensure protection of human subjects, the instruments used, and the method of data collection and treatment of data.

### Setting

The setting for this study was a mid-size urban county in the South Central United States. In 2004 this county had an estimated population of 248,223, 49.7% of which were female. Racial distribution was 57.2% White, 33.7% Black, 10.5% Hispanic, and 2.9% Asian. High school graduates comprised 78.5% of residents, with 16.3% possessing a bachelor's degree or higher. In 1999, the median household income was $34,706, with 17.4% persons below the poverty level (U.S. Census Bureau, 2006).

### Population and Sample

A networked sample was used in this study. This type of sampling required the researcher to select participants who were registered nurses working in one of three emergency departments in the designated county. An attempt was made to include nurses with varied levels of experience and included both male and female nurses. The

anticipated sample size, based on other qualitative studies, was 14 emergency department nurses.

The following inclusion criteria were followed: (a) registered nurses working in emergency departments in the designated county; (b) English speaking; (c) over the age of 18; and (d) consent to participate in the study.

## Protection of Human Subjects

Prior to data collection, approval from the Texas Woman's University Institutional Review Board was obtained. Consents to participate and be audiotaped were obtained from each participant. To protect participant confidentiality, no names were used on any transcript. Each participant was given a code number that was logged in a codebook. One transcriptionist was used, and all transcribed materials and field notes were maintained in a locked cabinet in the researcher's private office. Any names that were spoken during the interview were deleted during the transcription.

## Instruments

Before beginning the interview, each participant completed a Demographic Questionnaire (see Appendix A). The questionnaire was designed to collect information regarding gender, age, nursing education, nursing experience, nursing certifications, and prior training regarding intimate partner violence. A structured open-ended interview technique was used consisting of 10 primary questions with several probes (see Appendix B). These questions focused on discovering the who, what, and where of experiences of

emergency department nurses and their screening practices regarding intimate partner violence.

Methodological rigor was maintained through credibility, transferability, dependability, and confirmability. Member checking and confirmation by researcher peers established credibility. Transferability was enhanced through a thorough description of the participants and through saturation of data. Dependability was established through an audit trail. Confirmability was achieved when credibility, transferability, and dependability were established.

## Data Collection

Participants were solicited by talking to emergency department nurses and nurse managers of emergency departments. After soliciting participation, a time and place convenient to the participant was selected. At the time of the interview, the purpose of the study was explained and the participant read and signed consent forms to participate and to be audiotaped. The participants were reminded that participation was voluntary and that they were free to stop the interview at any time.

The interviews were conducted using a digital recorder that was then downloaded to the researcher's personal computer for confidentiality. After the interviews were downloaded, they were erased from the digital recorder. No names were used in any of the transcripts and each transcript was given a unique code number.

This research began with a pilot study conducted in fall 2004. Three participants were interviewed. Based on the brevity of these interviews, they were not included in the

final study. The pilot study participants were two females and one male ranging in age from 29 to 46. All worked in a large emergency department in the South Central United States. Two had seven years of emergency nursing experience and the third had 16 years experience. One was certified as a sexual assault nurse examiner. In addition, none of the participants had received formal education on intimate partner violence and only one had any education on this topic since graduation. Although all three nurses worked in the same emergency department, only one was aware that policies existed in the department regarding screening for intimate partner violence.

These interviews revealed five common themes including policies, specific questions to ask, triggers, preconceived ideas, and barriers. Each theme centered on education, beginning with education regarding existing departmental policies. They also agreed that they would benefit from education and role-playing regarding exactly what to ask and how to ask it. A belief in common myths regarding the victim of IPV was evident by feelings that the nurse could "tell by looking" at someone if he or she were a victim of IPV or not. In addition, it is important to take into consideration the feelings of male nurses in this setting. Based on the pilot study, modifications were made to the interview protocol to eliminate questions that could be answered with "yes" or "no."

## Treatment of Data

Descriptive statistics were used to identify characteristics of the participants. Data analysis was conducted simultaneously with data collection. Data was coded and themes

were derived from groups of data in order to gain an in-depth understanding of the interview data.

Colaizzi's (1978) seven-step method of data analysis was used. The seven steps of this process are:

1. Read all the participants' descriptions of the phenomenon under study.
2. Extract significant statements that pertain directly to the phenomenon.
3. Formulate meanings for these significant statements.
4. Categorize the formulated meanings into clusters of themes.
5. Integrate the findings into an exhaustive description of the phenomenon being studied.
6. Validate the exhaustive description by returning to some of the participants to ask them how it compares with their experiences.
7. Incorporate any changes offered by the participants into the final description of the essence of the phenomenon.

## Summary

This chapter discusses the procedure for collection and treatment of data, including setting, population and sampling technique, the protection of human subjects, instruments, and treatment of data. Registered nurses working in emergency departments are in a unique position to be able to screen for intimate partner violence and to be able to intervene with these victims in a meaningful way. Currently, the screening practices of registered nurses in emergency departments and how nurses respond to women who

disclose abuse are unknown. This research describes nurses' practices surrounding issues of abuse and contributes to the design of meaningful training programs. By following meaningful training programs, emergency department nurses can more effectively meet the needs of victims of intimate partner violence and their children.

# CHAPTER FOUR

## ANALYSIS OF DATA

The purpose of this study was to examine the role of the registered nurse in the emergency setting as it relates to screening for intimate partner violence. Specifically, the goals were to identify how registered nurses screen for intimate partner violence in the emergency department, to identify barriers to screening, to determine how the registered nurse perceives effectiveness of such screening, to identify resources available to nurses and what resources are still needed, to determine how the nurse perceives victims of intimate partner violence, and to determine how the nurse perceives his or her role in assisting victims of intimate partner violence. Two research questions were addressed in this study:

1. What are the intimate partner violence screening practices of registered nurses in emergency departments?
2. How do registered nurses respond to intimate partner violence when women disclose?

This chapter also describes the sample used, documents the participants' responses, and groups the findings into thematic categories.

## Description of the Sample

Thirteen registered nurses from three urban emergency departments in the South Central United States were interviewed for this study. Eight were female and five were male. Participants ranged in age from 25 to 54 with a median age of 31. One nurse was a diploma school graduate, six were graduates of an Associate Degree program, and the other six were graduates of a Baccalaureate program. None of the participants possessed a graduate degree. The participants' years of nursing experience ranged from one to 20 with a median of six years. The participants reported one to 10 years of emergency department experience with a median of four years. Three participants stated that they had completed training in a sexual assault nursing program. None of the participants reported certification in emergency nursing at the time of the interviews. Five participants recalled receiving education on intimate partner violence in their formal nursing education. Eight said they did not receive, or could not recall receiving, education on partner violence. In addition, only three participants could recall receiving continuing education on intimate partner violence since graduation. Five participants stated that the emergency department where they worked had written policies and/or procedures related to screening for intimate partner violence. The other eight participants were unaware of policies relating to intimate partner violence in the emergency department where they worked.

## Findings

Four major themes emerged during analysis of the interviews. The four themes were (a) myths, stereotypes, and fears, (b), demeanor (c) frustrations, and (d) safety benefits. These themes are conceptually described in Table 1.

Table 1

*Conceptual Descriptions of Themes*

| Themes | Conceptual Description |
|---|---|
| Myths, stereotypes, and fears | Beliefs and preconceptions held by nurses related to victims of intimate partner violence and the dynamics of a violent relationship |
| Demeanor | The behaviors or mannerisms of the person that alert the nurse to the need for intimate partner violence screening |
| Frustrations | Feelings experienced by the nurse when victims of abuse do not respond as the nurse would like to their questions and interventions |
| Safety Benefits | Nurses feel that there are some benefits to screening for intimate partner violence |

Each of these four themes is important in responding to the goals of the study and to answer the research questions. Each research question and supporting data will be presented. The first research question, What are the intimate partner violence screening practices of registered nurses in emergency departments?, can best be answered by

supporting data discovered in the theme myths, stereotypes, and fears and the theme demeanor. These responses indicate that emergency department nurses are screening based on their perceptions of women who present to the emergency department rather than on an established protocol. The two themes "myths, stereotypes, and fears" and "demeanor" that answer the first research question are described with supporting quotes.

*Myths, Stereotypes, and Fears*

A theme prominent in each of the interviews was myths, stereotypes, and fears. Myths, stereotypes, and fears can be conceptually defined as beliefs and preconceptions held by emergency department nurses as it relates to victims of intimate partner violence and the dynamics of a violent relationship. These beliefs can prevent nurses from screening for abuse. Nurses voiced that they can judge whether or not a woman needs to be asked about intimate partner violence based on their appearance and demeanor. Other nurses feel that screening is a waste of time because victims of violence will not disclose. Another myth expressed is that women will find screening as offensive and an invasion of their privacy. Many nurses have adopted victim-blaming attitudes and feel that women in abusive relationships need only to leave the relationship to solve the problem. Other nurses have fears of getting involved with women who are victims.

As one nurse said, "People just kind of judge based on what they see, stereotyping is the word I'm looking for." One nurse stated that he/she sometimes does not bother to follow through when women disclose intimate partner violence in the emergency department; "There were probably five other phone calls I had to make because of that

lady saying she was abused, and so, you know, it can be labor-intensive and if you don't want to follow up then you just don't." Another said, "So even if they do say, 'Yeah, I get abused everyday', you just say oh, OK, and keep on going." One nurse related feeling that intimate partner violence was not an issue that the emergency department should be dealing with, "It gets put on the back burner. It's a social problem and that's not an emergency problem."

Some nurses felt that patients were not always willing to reveal intimate partner violence. One stated that "It's kind of hard sometimes because they won't tell you the truth." Another nurse stated that there have been times when he/she "had suspicions and they (the patient) just played dumb and said 'everything's fine'." Other comments included "I don't ask. You're not going to get a correct answer anyway" and "Usually they will deny, you know, they won't admit it."

Many nurses related a fear of getting involved in intimate partner violence. Not wanting to possibly testify in court, one nurse related, "A lot of the nurses don't want to get involved in a court issue." Some nurses adopted a "don't ask, don't tell" policy, stating that "We are scared of the answers that we may get and then where do you go from there?"

Several nurses perceived that patients would view screening as offensive and as an invasion of their privacy. One nurse said, "I would think people would think that we were trying to invade their personal lives and not really dealing with why they said they

were here." One nurse said that he/she did not screen for intimate partner violence because patients "...would get offended that it would even be suggested."

Some nurses mentioned perceived patient characteristics that could impede effective screening and intervening with women who are victims of intimate partner violence. "People don't want to talk about it, patients and nurses, it's hard," remarked one nurse. Another stated that patients do not want to disclose intimate partner violence and that "They want to protect the ones they love even though they see that it is hurting them." Another reason given for patient reluctance to disclose violence was fear, "Fear of it happening again, probably retaliation is the main thing, they would rather just deal with it by keeping quiet in fear of retaliation." Some nurses blamed the women for their situation. One nurse stated, "About one-half of the emergency department staff openly verbalize how they don't understand how anybody can stay in that situation and essentially it's their own fault and then the other half are sympathetic towards the patient but are also fearful of getting involved." Other remarks included, "We tend to think, 'well, that's stupid-why would you not want to get out of that situation'. Not to the patient, just outside the room."

*Demeanor*

Demeanor can be conceptually described as behaviors or mannerisms of a patient or their significant other that would alert the nurse to the need for intimate partner violence screening. These are behaviors or mannerisms that the nurse perceives to be indicative of a victim of violence or of an abuser. Abusers may be felt to be dominating

and victims may be perceived to be as submissive and quiet. Nurses' decisions to screen may be based, in part, on their perceptions of the demeanor of one or both partners upon presentation to the emergency department.

Although each of the emergency departments that these nurses worked in had written policies stating that all patients admitted to the emergency department should be screened for violence, only two of the 13 nurses stated that that was his or her practice. The majority of nurses relied on the demeanor of the patient. As one nurse stated, "It is more of a gut feeling, really." Another stated, "It is just an intuition thing."

When asked what types of things would cause the nurse to screen for intimate partner violence, these nurses stated that their decision to screen was based upon physical injuries or certain behaviors exhibited by the patient or her significant other. "I would ask if there were any bruising, any kind of facial injury," reported one nurse. Several nurses mentioned the demeanor of the patient. One nurse stated, "You have to look at the patient's demeanor and the demeanor of the person that is with them. Do they (the person accompanying the patient) have a dominating personality and is the patient shy and quiet?" Another said, "Basically the demeanor of the patient. Generally someone that is in an abusive relationship tends to have more of a subdued, so to speak, demeanor." Yet another nurse mentioned that sometimes patients do not disclose violence and "We just take them at their word unless something about their demeanor told us otherwise; it would just be something that we picked up on." Another nurse felt that he or she would "know" if a patient was being abused because "They'll be glancing up at the partner while

they're talking to you and they may be a little nervous and shaky with their answers." Basically, many of these nurses felt that they should be able to tell if a patient is a victim of intimate partner violence by what they observe based on their perceptions of victims of abuse. One nurse felt that "Unless there's just some weird relationship between them (the patient) and the other person and you pick up on it, that really would be the only way you would know." Most of the nurses stated that their perception is that nurses do not screen for intimate partner violence on a routine basis. As stated by one nurse, "We won't ask questions. We don't screen unless something arises that causes suspicion."

Several nurses indicated that they did not agree with universal screening for intimate partner violence and that one should ask about violence only "If you suspect abuse." One nurse responded, "I don't think everybody needs to be asked. I think you have to look at the whole picture of what's going on." Others stated that the nurse should ask about this issue only if that is the person's main complaint. One nurse felt that there should be a specific reason to screen for intimate partner violence and stated, "If it is not pertinent to the reason they came to the emergency department, then it's not a justifiable question to ask them."

The second research question addressed in this study is: How do registered nurses respond to intimate partner violence when women disclose? The responses of nurses are represented in the themes frustrations and safety benefits. Although nurses do believe that they can be of benefit to some women, they describe their primary response to disclosure to be one of treating any injuries and reporting the violence to law enforcement officials.

*Frustrations*

Frustration can be described as feelings experienced by the emergency department nurse when victims of abuse do not respond as the nurse would like to questions and interventions. Emergency department nurses who work in a fast-paced environment may be used to seeing immediate results when they intervene with patients. Intimate partner violence is a complex issue and not one that can be solved in an emergency department visit. Nurses also experience frustration when women go back into an abusive situation and many do not understand why the woman would stay in such a relationship. These feelings of frustration can eventually result in nurses deciding not to screen for intimate partner violence.

Many emergency department nurses expressed their satisfaction with "seeing things through to the end" and their frustration that they could not do this with victims of intimate partner violence. One nurse indicated that he/she would like an immediate response to attempts to help the patient, "It is kind of frustrating if the patient doesn't make the call (to the women's shelter) while they are here where you kind of feel like something actually is going to happen for the patient. That can be frustrating." Another nurse indicated frustration that this issue could not be fixed in the emergency department and stated, "If they do say yes, what's the point? What are we going to do-nothing. Where are we going to send them-nowhere." One nurse stated feeling helpless when dealing with victims of intimate partner violence, "If they're not going to file a report then there is nothing we can do other than to treat their injuries and advise them." Another nurse said,

"I won't really have a long-term relationship with these people. It is really up to them to seek counseling after that. We are here to report it and treat their injuries." One nurse justified his/her feelings related to reporting the violence to the police by stating, "She (the patient) said she was afraid of him killing her. I said, 'How do you think I would feel if I let you leave here without talking to the police at least, and he kills you? I would feel like I didn't do right by you."

One nurse commented, "It's frustrating. They come up here because their boyfriend hit them and 20 minutes later they've called him. It makes you not want to do anything. You think, 'if they're not going to leave them, what's the point?'" However, another nurse stated, "Some people who don't understand abuse say, 'why don't they just get out', they really don't understand the reasons why women stay in abusive relationships." Frustration, coupled with the lack of time, caused one nurse to remark "I don't have time to hear a 30-minute story about it. You're a grown person-get out of it. That's horrible, I shouldn't be saying that."

*Safety Benefits*

Safety benefits can be described as those intangible things that women receive as a result of the screening and intervening efforts of emergency department nurses. It is this knowledge of benefit to the patient that may encourage nurses to screen for intimate partner violence. Although many nurses reported myths, stereotypes, knowledge deficits, and frustration related to screening for intimate partner violence, they also reported benefits and successes related to effective screening and interventions. One nurse felt that

although screening may not produce immediate results that it could be have benefit in the future, "At least address it. Maybe this time nothing's done. Maybe the next time it might help." Expressing a common sentiment that they wish resolution could occur in the emergency department, one nurse stated "I always feel good about it one way or the other. You know, it might not always turn out the way I want it to. I would hope that the woman that I had talked to—that she had contacted the numbers that we have given her. I feel good about it because it's helping some." Another nurse felt that there was some possible benefit to screening, although he/she felt that only "certain" patients needed to be screened, "You could help prevent future abuse and violence and we could help possibly save a life." One nurse with sexual assault training felt that screening was an intervention and said, "Just your attempt to intervene should be a good experience." In fact, other nurses indicated that the emergency department was viewed as a safe place by patients and that not all victims of abuse are ready to leave the relationship. One stated we can "...get them out of an abusive situation if they're ready to be. We can give them some sort of safety and security and help them relocate. It's a start. We can help them find the right resources."

Another nurse related an incident where the staff, in this case, a clerical person, used their creativity to defuse a situation, "Once she (the patient) got away from him (the husband), she confided in the staff person (clerical staff) what was going on. The husband had the baby and we were afraid he would run out with the baby. The clerical staff

member went up to the husband and said 'Oh, how cute! Let me go show my coworker'. So she got the baby away from him. The wife was afraid for her child's safety."

*Additional findings*

Although each of the three emergency departments had specific policies related to screening for intimate partner violence, most of the nurses were unaware of these policies. The following remark was typical of those made by the majority of the nurses, "I am not aware of any policies. I'm sure there may be some but it's never been brought to my attention at all. I can't honestly tell you if there are (policies) or not." Nurses most likely to be familiar with policies related to intimate partner violence were the nurses with sexual assault training and those who served as charge nurses.

These policies could have been helpful to the nurses responsible for screening patients for intimate partner violence for the nurses indicated a lack of knowledge regarding how to screen. One nurse remarked, "I don't think we've been educated as far as what questions to ask, who we contact, or what to look for." Another stated that "We really need to know the way to handle it (screening)". Most of the policies directed the nurse to ask "Do you feel safe at home?" One nurse felt that it was a simple question to ask, but that "It almost seems ridiculous to ask it. I don't think that question gets asked." Another nurse felt that one question was not enough and that "We could probably develop a more specific screening tool that's not just limited to one question." Not all nurses felt that the question, which was prompted on their triage screen, was even meant

to be asked and stated, "I think that at the most those screening questions were given for things to look for. I don't necessarily think that they get used."

When asked what screening for intimate partner violence in the perfect world would look like, several nurses mentioned that it would be helpful to have someone specially trained on this topic to be there to intervene when women disclosed. "I think to have a specialized person to come and deal with them and help them work through their issues would be helpful," stated one nurse. Another felt that it would be helpful to have individuals on-call to assist, "You would have people from different agencies on call." Others believed that current processes should be improved upon, "I think it should start in triage and be more focused in the treatment area. Maybe a questionnaire? We need more privacy." Many nurses felt that women were not honest and forthcoming when asked about violence, so that in a perfect situation "You would have to take into consideration that everyone is honest and straight forward."

Five males were interviewed in this study. All had similar views related to gender issues and intimate partner violence except one. Most of the males admitted feeling more comfortable dealing with injuries than the more emotional aspects of care. One said, "I think it's touchy as far as asking questions. I would be more apt to deal with the physical injuries. I would think a lot of females tend to talk more open with other females than they would open up to a male if it was a male that hurt her." One of the males interviewed had a different perspective and felt that gender would provide an advantage in dealing with victims of intimate partner violence. He stated, "Males are looked at as kind of to

protect, you know. I feel like being a man that a woman will actually tell me more, thinking that I will somehow protect her if someone were to come in."

## Summary of the Findings

Thirteen registered nurses working in three different emergency departments in the South Central United States were interviewed for this research in an attempt to describe the intimate partner violence screening practices and the responses to intimate partner violence when women disclose. Four main themes emerged: (1) myths, stereotypes, and fears, (2) demeanor, (3) frustrations, and (4) safety benefits.

Myths, stereotypes, and fears refer to beliefs and preconceptions held by nurses related to victims of intimate partner violence and the dynamics of a violent relationship. Numerous examples were identified in the interviews such as assumptions that victims of intimate partner violence will not follow up with recommended referrals, that intimate partner violence is not a health problem but a social problem, that victims of intimate partner violence will not be truthful with healthcare providers, and that women will perceive screening for intimate partner violence as offensive. Additionally, several nurses expressed a fear of getting involved with these victims and some adopted a victim-blaming attitude.

Demeanor refers to behaviors or mannerisms of the person that alert the nurses to the need for intimate partner violence screening. Only two of the 13 nurses interviewed stated that it was his/her practice to screen all patients for intimate partner violence. The remaining nurses relied on the demeanor of the patient to suggest the possibility of

intimate partner violence. This then aroused suspicion in the nurse causing him/her to ask specific questions related to possible violence. These nurses felt they should be able to tell by looking at someone if they were being abused.

Frustration, the feeling experienced by the nurse when victims of abuse do not respond as the nurse would like to their questions and interventions, was a universal theme throughout the interviews. These nurses wanted to see immediate results of their efforts to assist the women and became frustrated when no immediate benefit was seen.

The nurses interviewed did feel that their efforts could result in benefits, such as increased safety, to the patient. The nurses realized that their efforts, although achieving no immediate results, could be of benefit to the patient in the future.

The research questions presented at the beginning of this study can be answered through an analysis of the responses obtained during the interviews. (1) What are the intimate partner violence screening practices of registered nurses in emergency departments? Although many health care organizations recommend routine screening for intimate partner violence, these nurses indicate that they screen based on stereotypes they have regarding victims of violence, especially the demeanor of the patient. (2) How do registered nurses respond to intimate partner violence when women disclose? Nurses provide referrals to local women's shelters but feel that their primary role is to treat any injuries sustained and to report the violence to local law enforcement.

# CHAPTER FIVE

## SUMMARY OF THE STUDY

This study examined the role of the registered nurse in the emergency setting as it relates to screening for intimate partner violence. The specific goals were to identify how registered nurses screen for intimate partner violence in the emergency department, to identify barriers to screening, to determine how the registered nurse perceives effectiveness of screening, to identify available resources to these nurses and what resources are still needed, to determine how the nurse perceives victims of intimate partner violence, and to determine how the nurse perceives his or her role in assisting these victims.

The specific research questions for this study were as follows:

1. What are the intimate partner violence screening practices of registered nurses in emergency departments?
2. How do registered nurses respond to intimate partner violence when women disclose?

Findings of the study are discussed in relation to previous research done related to healthcare providers and their screening practices and interactions with victims of intimate partner violence. Conclusions based on analysis of the data are presented with

implications for nurses, hospital administrators, and nursing educators. The chapter concludes with recommendations for future research.

## Summary

The role of 13 registered nurses working in emergency settings as it relates to intimate partner violence was examined using a hermeneutical phenomenological approach. A networked sampling method was used recruiting nurses from three different emergency departments in a mid-size urban county in the South Central United States. Inclusion criteria included: (a) registered nurses working in emergency departments in the designated county, (b) English speaking, (c) over the age of 18, and (d) consent to participate in the study.

Approval from the Texas Woman's University Institutional Review Board was obtained prior to data collection. Participation in the study was voluntary and informed consent was obtained from each individual. Demographic data was collected on each participant prior to the interview. To protect confidentiality, code numbers were assigned to each participant and demographic forms and transcribed interviews were kept in a locked cabinet in the researcher's locked office.

A structured open-ended interview technique was used consisting of 10 primary questions with several probes. The interview began with the question "Tell me about screening for intimate partner violence in the emergency department." Probe questions such as "What was that like for you" and "Give me an example" were used throughout the interview process.

The study was piloted in late 2004 with three participants. Several modifications were made to the interview questions. Therefore, those three interviews were not included with the 13 reported in this final study. The interviews, audio recordings, and transcriptions were analyzed using the Colaizzi (1978) method.

Four main themes emerged during this study: (1) myths, stereotypes, and fears, (2) demeanor, (3) frustrations, and (4) benefits. Myths, stereotypes, and fears refer to beliefs and preconceptions held by nurses related to victims of intimate partner violence and the dynamics of a violent relationship. Demeanor refers to behaviors or mannerisms of the person that alert the nurses to the need for intimate partner violence screening. Frustration is the feeling experienced by the nurse when victims of abuse do not respond as the nurse would like to their questions and interventions. Lastly, nurses did feel that their efforts could result in benefits to the patient such as increased safety.

## Discussion of the Findings

The hermeneutic phenomenological framework of Heidegger (1926/1996) was used for this study. The researcher used this perspective to gain an understanding of individuals and their interactions with others to look for meanings embedded in their practices. Heidegger's concept of "thrown-ness" reflects the belief that individuals are shaped by their past experiences and cannot be disassociated from them. This was reflected in the statements made by the participants and assisted in analysis of the transcripts. Transcripts of the interviews were analyzed in a holistic manner as opposed to looking at fragments or pieces of the interviews.

The specific goals of this study were addressed through findings derived from the interviews. The first goal was to identify how registered nurses screen for intimate partner violence in the emergency department. Although policies exist that require routine screening, nurses reported looking for signs that might indicate a need to screen. Nurses reported that patient characteristics such as a shy and quiet demeanor or signs of obvious physical injury prompted them to ask further questions. Only two of the nurses reported that their practice was to screen all patients. This study suggests that emergency department nurses are not screening for intimate partner violence based on a protocol but rather are screening certain patients for violence based on the nurse's perception of whether or not a particular patient is likely to be a victim of violence.

Most of the nurses' decisions regarding which patients to screen for violence are based on stereotypes of what a victim of intimate partner violence looks like and acts like. Stereotyping by nurses and other healthcare providers is common. An ethnographic study by Varcoe (2001) of 21 nurses revealed that nurses anticipated violence predominantly among women from lower socioeconomic classes and those from minorities. In a survey by Moore et al. (1998), of 275 nurses, 92% ($n = 253$) felt that middle- and upper-class women were unlikely to be victims of abuse.

Nurses may stereotype based on a lack of knowledge. Only five nurses (38%) in this study could recall any formal education on this topic and only three (23%) could recall any continuing education on intimate partner violence since becoming a nurse. These results are similar to a study by Morgan (2003) of 147 nurses. These nurses

reported minimal to no education regarding intimate partner violence in their undergraduate programs and only 24% ($n$ = 35) reported any continuing education on this topic. Tilden et al. (1994) surveyed 241 nurses and only 44% (n = 106) could recall any IPV content in their undergraduate programs. These findings are similar (45%, $N$ = 76) to those found in nurses working in emergency settings in New England (McGrath et al., 1997) and among perinatal nurses (54%, $n$ = 148) in a study by Moore et al., (1998). A study of 557 nurse practitioners revealed that only 4.8% ($n$ = 27) had received IPV education in their undergraduate preparation (Hinderliter et al., 2003). Additionally, 82% ($n$ = 562) of 685 healthcare workers questioned by Cann et al. (2001) said that they would like education and training on intimate partner violence. The nurses interviewed in this study indicated that additional education on this topic would be helpful, particularly related to what to ask and what to do if the patient disclosed violence. Other studies have also shown that nurses are unsure of appropriate interventions when women disclose (Elliott et al., 2002; Ellis, 1999; Garimella et al., 2000; Loughlin et al., 2000). Nurses reported feeling uncomfortable with the screening process and stated that they were unsure of what questions were appropriate to ask and what to do when a woman disclosed intimate partner violence. They felt that the question, "Do you feel safe at home?" was inadequate and would not elicit the desired information.

The second goal of the study was to identify barriers to screening for intimate partner violence. Numerous barriers were identified. Perhaps the most common barrier identified, discussed previously, was stereotyping of women by emergency department

nurses. Nurses commented that they screened based on injuries the patient had and behaviors exhibited by patients. Nurses in this study stated that screening questions would be perceived to be offensive to women who come to the emergency department. These findings are similar to those by McGrath and associates (1997), who reported that 57% ($n$ = 118) of 207 healthcare providers were concerned that women would consider screening an invasion of their privacy. Other studies revealed that nurses did not screen for intimate partner violence for fear of offending the patient (Elliot et al., 2002; Ellis, 1999; Garimella et al., 2000; Loughlin et al., 2000). However, several studies confirm that women want to be asked about partner violence, indicting an additional knowledge gap (Chang et al., 2005; Hurley et al., 2005; Lutenbacher, Cohen, & Mitzel, 2003; Newman et al., 2005; Zink et al., 2004).

The prevalence of myths, stereotypes, and fears in this study and other literature suggest that despite a heightened awareness of intimate partner violence and the role those healthcare providers can play, that nurses are still uncomfortable with this topic. Nurses selectively screen patients based on preconceptions as to who constitutes a victim and cite reasons not to screen for violence. Also noted in this study are the judgmental attitudes held by many of the nurses regarding the futility of screening and their reliance on stereotypical images of a victim's demeanor.

Each of the emergency departments where the study participants worked had policies requiring screening of all patients for intimate partner violence. However, the nurses were unfamiliar with or unaware of these policies representing another barrier to

effective screening. These results are similar to those in a study conducted of nurses in a large New England emergency department. Only 34% ($N = 76$), were aware that their facility even had a protocol for screening (McGrath et al., 1997).

The majority of nurses interviewed in this study do not conduct universal screening for intimate partner violence, nor do they think it is necessary unless that is the patient's complaint or the nurse suspects violence due to the patient's injuries or behaviors. As a matter of fact, only two nurses stated that they routinely screen for intimate partner violence. One of those nurses functioned as a charge nurse and did not typically work in a role where initial patient contact was frequent. These results are similar to those discussed in other studies. In a study of 76 nurses conducted by McGrath et al. (1997), 64% of nurses ($n = 49$) reported that they never or rarely screen for intimate partner violence and no one reported routine screening. Moore et al. (1998) reported similar findings in a study of 275 gynecological nurses. Only 17.6% ($n = 48$) of these nurses stated that they routinely screened their patients. Additionally, a review of 1,509 charts of emergency department visits revealed that intimate partner violence screening was not documented as being done in 66.1% of cases (Larkin et al., 1999). A study of 400 California physicians indicated that 79% ($n = 316$) of primary care physicians often or always asked patients direct questions about intimate partner violence only in patients with physical injuries. If they did not have obvious physical injuries, only 9% ($n = 36$) stated that they routinely screened patients (Rodriguez et al., 1999). Another study of 296 Alaskan physicians reported that only 7.5% routinely screened for intimate partner

violence on annual checkups unless the patient presented with an injury (Chamberlain & Perham-Hester, 2002). A study of 112 English nurses revealed that only 7% ($n$ = 8) felt that they should routinely screen for violence (Richardson et al., 2001). A study by Kothari and Rhodes (2006) showed that healthcare providers were 50% more likely to screen for intimate partner violence in patients with injury-related complaints.

The third goal of this study was to determine how the registered nurse perceives effectiveness of screening. Many nurses felt the process to be ineffective because they were unable to see resolution of the problem during the patient's stay in the emergency department. These nurses wanted the woman to make the decision to leave and to make a call to the local women's shelter while in the emergency department. The prevalent feelings of frustration voiced among the participants in this study are reported in other studies that have surveyed nurses' behavior regarding screening for intimate partner violence. In a study by McGrath et al. (1997), 78% ($n$ = 161) of healthcare providers cited frustration that victims would return to an abusive situation. Another study of 275 perinatal registered nurses revealed that 40% ($n$ = 110) experienced frustration when working with women who had been abused (Moore et al., 1998). Nelms (1999) conducted a qualitative study of emergency nurses and reported frustration as a predominate theme of nurses' interactions with victims of abuse. Varcoe (2001) reported similar findings in an ethnographic study of emergency nurses. A qualitative study of 11 registered nurses revealed feelings of frustration and anger when dealing with victims of intimate partner violence (Woodtli, 2001). Nurses' frustrations with themselves for feeling that they have

been of no help and frustration with patients may lead to nonsupportive or victim-blaming attitudes. Frustration and failure to screen for partner violence is a common finding in this and many other studies.

Many nurses expressed frustration that the patient's situation could not be fully addressed and solved in the emergency department indicating their lack of knowledge of dynamics surrounding intimate partner violence. These nurses indicated they would like to see immediate benefits as a result of their efforts. The fact that this is rarely possible in a violent relationship was a source of great frustration to them. Some nurses felt that if the woman did not commit to leave the relationship at that moment that she was not following the plan of care and therefore not worthy of any more of the nurse's time. In a qualitative study of 11 nurses in 2001, Woodtli found that the nurses' preferred screening outcomes were that the woman would leave the violent situation, or at least become more aware of the danger of the situation and of safety plans, and that they follow up on referrals, or at least know that the exist.

The fourth goal of this study was to identify available resources and to identify what resources were still needed. The only resources identified by the nurses interviewed were social workers or sexual assault nurse examiners in their facilities. The nurses were aware of contact numbers for shelters in their areas but were unaware of any specific services provided at the shelters. Nurses indicated that they would prefer an individual specifically trained in the area of intimate partner violence to be available as a resource to them. No studies reviewed in the literature addressed specifically what resources nurses

would find helpful when intervening with victims of intimate partner violence. However, nurses interviewed for this study did indicate that further education on the topic would be helpful. Similarly, Cann, et al. (2001) found that 82% ($n$ = 562) of 685 healthcare workers questioned reported that they would like additional education and training on intimate partner violence.

The final goal of this study was to determine how the nurse perceives his or her role in assisting victims of intimate partner violence. Few studies addressed how nurses actually responded to women when they disclosed abuse. Nurses felt that their role was to treat injuries that these women may have sustained, to offer a list of resources and phone numbers, and to report the abuse to local law enforcement. Nurses felt uncomfortable in dealing with the emotional issues surrounding intimate partner violence. Other nurses stated that they did not bother to follow through when women disclosed because they felt that the victims would return to their abusers despite efforts of the nurses. The nurses interviewed did state, however, that the emergency department was seen as a safe place by most patients. A qualitative study of 11 nurses by Woodtli (2000) reported that nurses described "helping" (defined as providing knowledge, support, resources, and safety) as one of their major roles when intervening with victims of intimate partner violence.

The male perspective on intimate partner violence was different from that of females. Most felt that a female victim would feel more comfortable speaking to a female nurse about their situation. One male felt that women would be more apt to discuss their problems with him. None of the studies reviewed for this research identified any

differences between male and female nurses. All participants stated that it would be helpful to have a specially trained person in the emergency department to deal with these women. Interestingly, none of the participants perceived themselves or nurses in general, as that specially trained individual.

## Conclusions and Implications

The following conclusions were derived from this study:

1. Stereotypical beliefs and myths about intimate partner violence and its relational dynamics influenced nurses' decisions about screening for intimate partner violence.
2. Myths, stereotypical beliefs, and victim-blaming attitudes are still held by practicing nurses.
3. Most nurses are not completing universal screening for intimate partner violence and do not believe universal screening is necessary. Instead, nurses are screening patients for partner violence based on the nurse's perception of whether or not a particular patient is likely to be a victim of violence.
4. Nurses felt frustrated that an immediate resolution for the victim of intimate partner violence can not be achieved in the emergency department.
5. Nurses recognized that intimate partner violence screening efforts may be beneficial to these women in the future.
6. Many nurses were unaware of written policies mandating universal screening for intimate partner violence and were not familiar with regulations regarding

mandatory reporting. In fact, healthcare providers in the state are required only to report gunshot wounds. There is no specific requirement regarding the mandatory reporting of intimate partner violence (Family Violence Prevention Fund, 2006).

7. Many nurses were unable to recall formal undergraduate education or ongoing education on the topic of intimate partner violence. However, almost all nurses stated that education on this topic would be of interest and of assistance to them in their practice.
8. Nurses felt gender played a role in a woman's willingness to disclose intimate partner violence. All but one male interviewed in this study believed that female victims of violence would be more likely to disclose to a female nurse.

The following are implications for practice as generated by the findings of this study:

1. Findings from this study and other studies in the literature indicate that nurses hold numerous myths and stereotypes related to victims of intimate partner violence. Traditional educational programs do not focus on dispelling these myths and stereotypes. Future education must focus on assisting nurses to become aware of their own stereotypes and myths regarding partner violence. Education that enables the nurse to view his or her values, beliefs, and assumptions may enable nurses to practice from a more holistic, unbiased perspective.
2. The findings from this study point out the importance of facilities to educate their staff on relevant hospital policies and state laws designed to assist victims of

violence. This should include components of the facility's policies, applicable state laws, what to ask patients, what to do when individuals reveal a history of violence, referral sources, dynamics of intimate partner violence, and myths surrounding this issue. In fact, some states (Alaska, California, Kentucky, New Hampshire, New York, Ohio, Oklahoma, Pennsylvania, and Washington) have specific laws surrounding the training of healthcare providers on the topic of domestic violence (Family Violence Prevention Fund, 2002). The State of Florida also requires mandatory continuing education for nurses on domestic violence (Maker, 2002). In addition, recommendations for national mandatory continuing education on this topic have been found in the literature (Stinson & Robinson, 2006).

3. Emergency nurses want immediate benefits as a result of their interventions. Educational programs for this group need to emphasize the dynamics of a violent relationship and the chronicity of the problem. The nurses' expectations need to be realistic and focused on the long-term benefits of their efforts.

## Recommendations for Further Study

The following recommendations for future research are based on the findings of the current study.

1. Future research needs to evaluate educational programs designed to eliminate victim-blaming and integrate myth/stereotype/blame-free screening into routine practice.

2. Emergency department nurses can play a pivotal role in identifying and intervening with victims of intimate partner violence. These nurses may be the first healthcare professionals to ask women about violence in their relationships. The fact that they are not doing so on a consistent basis represents a lost opportunity to intervene in the cycle of violence. Further research is needed in this area in order to increase nurses' effectiveness in screening and intervening with this vulnerable population.
3. This study examined 13 registered nurses working in three emergency departments in a mid-sized county in the South Central United States. The study should be replicated in other areas of the country to determine if the results obtained are regional.
4. Despite efforts by professional organizations, regulatory agencies, governmental agencies, and others to increase awareness and knowledge of intimate partner violence, nurses continue to hold on to stereotypes and myths related to intimate partner violence and its victims. Many of these beliefs may be attributed to a lack of knowledge. Research should occur that will examine the knowledge base of nurses, determine appropriate educational programs related to intimate partner violence, and evaluate those programs.
5. Although universal screening for intimate partner violence is recommended by many healthcare organizations, no "best practice" model exists on which to formulate intimate partner violence screening programs in emergency

departments. Further research should be conducted on what types of screening tools best would identify intimate partner violence victims in the emergency department and other settings. Additional research should evaluate the effectiveness of these screening tools.

6. Many emergency department screening protocols place the triage nurse as the primary person to screen for intimate partner violence. Many triage areas are open and not conducive to privacy. Future research should compare rates of screening and identification of victims of violence in emergency departments that conduct screening in the triage area and those that conduct screening in other, more private areas.
7. This study suggests that one barrier and source of frustration for emergency department nurses when dealing with victims of intimate partner violence is the fact that these nurses would like to see immediate benefits for their efforts in working with this patient population. Since immediate resolution of this complex issue is rarely, if ever, solved in one emergency department visit, nurses became frustrated and, in some cases, quit screening and intervening with these women altogether. This finding was one that was not identified in the literature review. Future research should further examine these attitudes held by emergency department nurses.
8. No research was identified in the literature review focusing on differences between male and female nurses when screening for intimate partner violence.

This study did reveal differences and further studies need to be conducted to examine these differences and to determine the needs of male and female nurses related to screening and intervening with victims of intimate partner violence.

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# APPENDIX A

## Demographic Questionnaire

Demographic Questionnaire

1. Gender _____ Female _____ Male

2. Age _____

3. Level of Nursing Education

_____ADN

_____Diploma

_____BSN

_____MSN

4. Nursing Experience

Years of Nursing Experience in any setting _____

Years of Emergency Nursing Experience _____

5. Please list any nursing certifications held:

_____

6. Did you receive any education regarding intimate partner violence in your formal nursing education?

Yes _____ No_____ If Yes, Year_____

7. Have you received any education or training on intimate partner violence since becoming a nurse?

Yes _____ No_____ If Yes, Year_____

8. Does your emergency department have a formalized policy/procedure for screening for intimate partner violence?

Yes_____ No_____ Don't Know _____

# APPENDIX B

## Interview Protocol

Intimate Partner Violence and the Role of the Emergency Department Nurse

Interview Questions

1. Tell me about screening for intimate partner violence in the emergency department. Who is responsible for that? How does it happen? Where does it happen? What does screening for intimate partner violence mean to you, or, how would you define screening?

   Probes: Tell me about a time you have screened for intimate partner violence? What was that like for you? Give me an example. How do you manage to screen? What did you ask? What triggered you to include that in your assessment?

   If they have not screened, explore the barriers to screening.

2. What makes it difficult to screen for intimate partner violence in the emergency department?

   Probes: Can you think of a time that you had a bad experience screening? In what way has the administration at your facility helped or hindered your ability to screen for intimate partner violence? In what ways does the physical set up of your facility help or hinder your ability to screen for intimate partner violence? What kind of difficulties did you encounter during the screening? How could some of these be overcome?

3. Tell me about any education or training you have received regarding intimate partner violence.

Probes: What kind of additional training do you think you need, if any?

Did you receive this type of education in your undergraduate program?

4. When you have screened for intimate partner violence in the emergency department, how did the men/women you screened respond to the question(s)?

   Probes: Can you give me an example?

5. What do you do for men/women who report intimate partner violence in the emergency department?

   Probes: What kind of information do you need regarding resources?

6. Can you tell me about your most successful experience working with a victim of intimate partner violence in the emergency department?

   Can you tell me about your least successful experience working with a victim of intimate partner violence in the emergency department?

   Probes: What was that like for you?

7. What are benefits of screening for intimate partner violence in the emergency department?

   Probes: Tell me more about that.

8. Tell me about the policies in your department regarding screening.

   Probes: Do you feel like these are realistic? How could they be better?

   Can you describe the general attitude toward battered women in your emergency department?

9. How do you think your personal experience with intimate partner violence impacts your screening and referral practices? (as applicable)

   Probes: Do you need any referrals or help for yourself?

10. In the ideal emergency department, what would be the best way to screen for intimate partner violence?

# APPENDIX C

## Agency Approval

# Memorial Hermann
BAPTIST HOSPITALS

November 9, 2005

Texas Woman's University
Houston Campus

Ruthie Robinson has our permission to ask registered nurses working in the emergency department of Memorial Hermann Baptist Beaumont Hospital if they would like to participate in her study "Intimate Partner Violence and the Role of the Emergency Department Nurse". I understand that these interviews are voluntary and will be held at a time and place convenient to the nurse.

Please contact me at 409-212-5016 if you have any questions.

Sincerely,

Nancy Sims

Nancy Sims
Chief Nursing Officer

BEAUMONT HOSPITAL
P.O. DRAWER 1591 • BEAUMONT, TEXAS 77704 • 409-212-5000

ORANGE HOSPITAL
608 STRICKLAND DRIVE • ORANGE, TEXAS 77630 • 409-883-9361

CHRISTUS®
Hospital

November 10, 2005

Texas Woman's University
Houston Campus

Ruthie Robinson has our permission to ask registered nurses working in the emergency department of CHRISTUS Hospital – *St. Elizabeth* if they would like to participate in her study "Intimate Partner Violence and the Role of the Emergency Department Nurse". I understand that these interviews are voluntary and will be held at a time and place convenient to the nurse.

Please contact me at 409-924-6918 if you have any questions.

Sincerely,

Freda Lyon, RN, BSN, MHA
Director of Emergency/Trauma Services

St. Elizabeth
2830 Calder Street P. O. Box 5405 | Beaumont TX 77726-5405
Tel 409.892.7171

St. Mary
3600 Gates Boulevard | P. O. Box 3696 Port Arthur TX 77643-3696
Tel 409.985.7431

CHRISTUS Hospital

November 10, 2005

Texas Woman's University
Houston Campus

Ruthie Robinson has our permission to ask registered nurses working in the emergency department of CHRISTUS Hospital – *St. Mary* if they would like to participate in her study "Intimate Partner Violence and the Role of the Emergency Department Nurse". I understand that these interviews are voluntary and will be held at a time and place convenient to the nurse.

Please contact me at 409-989-5540 if you have any questions.

Sincerely,

Jane Rawls, RN
Executive Nursing Director

St. Elizabeth
2830 Calder Street | P. O. Box 5405 | Beaumont TX 77726-5405
Tel 409.892.7171

St. Mary
3600 Gates Boulevard P. O. Box 3696 | Port Arthur TX 77643-3696
Tel 409.985.7431

# APPENDIX D

## Human Subjects Review Committee Approval

**TEXAS WOMAN'S UNIVERSITY**
DENTON DALLAS HOUSTON
**Institutional Review Board**
1130 John Freeman Blvd., Houston, Texas 77030 713/794-2074

**MEMORANDUM**

TO: Judith McFarlane
Ruthie Robinson

FROM: IRB

DATE: December 14, 2005

SUBJECT: IRB Application

Proposal Title Intimate partner violence and the role of the emergency department nurse

Your application to the IRB has been reviewed and **approved.**

**This approval lasts for 1 year. The study may not continue after the approval period without additional IRB review and approval for continuation. It is your responsibility to assure that this study is not conducted beyond the expiration date.**

**Any changes in the study or informed consent procedure must receive review and approval prior to implementation unless the change is necessary for the safety of subjects. In addition, you must inform the IRB of adverse events encountered during the study or of any new and significant information that may impact a research participant's safety or willingness to continue in your study.**

**REMEMBER TO PROVIDE COPIES OF THE SIGNED INFORMED CONSENT TO THE OFFICE OF RESEARCH, MGJ 913 WHEN THE STUDY HAS BEEN COMPLETED. INCLUDE A LETTER PROVIDING THE NAME(S) OF THE RESEARCHER(S), THE FACULTY ADVISOR, AND THE TITLE OF THE STUDY. GRADUATION MAY BE BLOCKED UNLESS CONSENTS ARE RETURNED.**

Gretchen Gemeinhardt, Ph.D.
Chairperson