

**IDENTIFICATION OF AND INTERVENTION WITH BATTERED WOMEN:
AN INSERVICE FOR EMERGENCY ROOM PERSONNEL**

by

Clarice Tracy Flanagan

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Clarice Tracy Flanagan

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November 27, 1995
Date

Heaven Guskovich
Chairperson, Graduate Committee

Approved for the Major Department

November 29, 1995
Date

Marty Lee, PhD, RNCS
Head, Major Department

Approved for the College of Graduate Studies

12/26/95
Date

RL Brown
Graduate Dean

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ABSTRACT

Estimates indicate 20-30% of all women in the United States have experienced physical abuse at the hands of their husbands or partners at least once. Approximately 30,000 emergency room visits per year result from battering. However, fewer than one in 25 battered women seeking medical treatment for their injuries are identified as battered women by nurses and physicians. Reasons given for the lack of identification include little or no training in assessing abuse issues, the presence of misinformation, the rigidity of the medical module structure, sex bias which affected objectivity by professionals, and/or professionals not believing the women's accounts. A need exists for education of emergency room personnel to better recognize and intervene with battered women. An educational inservice for emergency room personnel at Montana Deaconess Medical Center was developed and presented. Presentation objectives were to define battering, enhance assessment of battered women, identify interventions, and develop awareness of community resources. These objectives were accomplished. A hypothetical case study and relevant handouts were utilized during the inservice presentation.

CHAPTER 1

STATEMENT OF THE PROBLEM

Estimates indicate 1.8 million women (Lazzaro & McFarlane, 1991) to 2 million women (Hamberger, Saunders, & Hovey, 1992) have been victims of physical abuse by their husbands. King (1993) states 20-30% of all women in the United States have experienced physical abuse at the hands of their husbands or partners at least once. One in two marriages have had at least one incident of physical violence (Moss, 1991). Stated differently, every 7.4 seconds a woman is battered by her husband (McLeer & Anwar, 1987). Three of four women who are killed within the family are murdered by domestic partners (Jordan & Walker, 1994). One third of the women murdered in America are killed by boyfriends or husbands (Feldman, 1992). Moss and Taylor (1991) indicate that estimates of the total annual cost for health care to victims of domestic violence runs about \$44,393,700. Hospitalization estimates include 100,000 inpatient days and 30,000 emergency room visits per year (Feldman, 1992). These statistics reflect the battering of women to be a significant societal and health problem.

According to recent studies, 20-25% of women seen in the emergency room have been victims of physical, sexual, or psychological abuse by their significant others (Jeziarski, 1992). More importantly, only one in ten (Moss & Taylor, 1991) or even one in 25 (McLeer & Anwar, 1987) battered women who seek medical treatment for

injuries are identified as battered women by nurses and physicians. Abused women may feel stigmatized by their abuse and are hesitant to report the cause of their injuries (Limandri & Tilden, 1993).

The United Way Task Force in Minnesota found that care given to battered women in emergency rooms was usually confined to just providing physical care to the victim (Hadley, 1992). Reasons identified included little or no training in identifying or serving battered women (Hadley, 1992); lack of knowledge in assessing abuse issues; the presence of misinformation; the rigidity of the medical model structure; sex bias which affected objectivity by professionals (Moss, 1991); and/or the professionals not believing the woman's account (Moss & Taylor, 1991). Because of the large number of visits by battered women to emergency rooms and the high proportion of this group not being identified as battered, a need exists for the education of professionals so they can better recognize these women and intervene appropriately.

In consideration of this national trend, inquiries to emergency rooms of the two hospitals in Great Falls, Montana were made. A discussion with registered nurses on duty confirmed a need for more information on identification of, interventions with, and referrals for battered women.

The significance of this problem has been recognized by the Joint Commission on Accreditation of Health Care Organizations which has established criteria for hospitals seeking accreditation (JCAHCO, 1991). Part of the criteria of JCAHCO includes identifying possible victims of domestic abuse. Further criteria contained in the standards are examination and treatment of possible victims, safeguarding material

that could be used as evidence, notification of proper authorities, providing a list of resources available in the community, making referrals as appropriate, and carefully documenting all actions taken. These standards also require education of emergency room staff in relation to battering and its effects. Both of the hospitals in Great Falls seek accreditation by JCAHCO.

Population Considered Battered

Battering is not a phenomenon exclusive to women only. Men also experience this phenomenon. However, for purposes of this project the focus is on women. The term "wife battering" is used even though frequently the victim is not legally married to her batterer but is living with him in an intimate relationship.

Goals

Domestic violence is a growing concern for health care professionals because of its frequency and its often overlooked status. If violence is identified, health care professionals need to know resources or processes available to help battered women. Therefore, to complete this project, an educational inservice for emergency room personnel at Montana Deaconess Medical Center was developed and presented. A list of potential content areas was first developed to ascertain/survey the learning needs and interests of the emergency room personnel (the adult learner). The objectives as identified by the involved adult learners were to (a) define what constitutes battering, (b) enhance assessment of battered women, (c) identify interventions to be used by the

staff in the emergency room, and (d) develop their knowledge of resources available to battered women in the community. After the educational presentation, an evaluation tool was also utilized to identify if objectives were met and to guide future changes in educational inservices.

CHAPTER 2

LITERATURE REVIEW

Definition

Wife abuse is the use of physical force by a male partner (Noel & Yam, 1992). The U.S. Department of Justice defines a battered woman as one whose abuse or history of abuse came from an intimate other or close relative (Helton & Snodgrass, 1987). Walker (1979) defines a battered woman as one who has been repeatedly subjected to forceful physical or psychological behavior by a man to make her do something he wants without concern for her rights. For the purpose of this project, the following definition will be utilized: a battered woman is one who is physically and/or emotionally abused by an intimate male partner.

Defining The Abusive Process

The Stockholm Syndrome has been proposed as a model in explaining the behavior of battered women. In a study of hostages, the victim developed a fondness for the captor and a feeling of apathy toward those wanting to help. The captor would mix terror with kindness. Similar traits can be attributed to a battering situation including the power imbalance between hostages and captors and battered women and abusers (Moss, 1991).

The battering relationship has been categorized into phases or stages (Landenburger, 1993; & Walker, 1979). Landenburger (1993) identifies four phases: binding, enduring, disengaging, and recovering. The binding phase is a time when abuse is becoming part of the woman's life. The relationship is just developing and abuse is just beginning. The woman views the relationship from a positive framework with a "dream" or perception of what she wants from the relationship. Warning signals are overlooked and the woman seeks to give her partner what the partner wants. During the enduring phase the abuse becomes more overwhelming and the woman begins to lose her identity. The woman tolerates the abuse because she places high value on the good aspects of her relationship. She stays committed to the relationship and takes on responsibility for the abuse. Eventually, she feels drained by the constant demands of her partner and feels badly about herself. She feels she cannot leave the relationship but recognizes she may not survive if she does not leave. These feelings of being trapped causes her to reassess the relationship.

In the disengaging phase (Landenburger, 1993) the abuse continues to overpower her but the woman starts identifying inner strengths and ways to leave the relationship. The woman struggles with feelings of loyalty to the partner and a feeling of faithfulness to herself. The woman begins to take risks and seek out people who will support her. She realizes her life is meaningless if she stays and may believe she would be better off dead. The last phase is the recovery phase. This is the time after leaving the abusive relationship and before the woman gains "balance" in her life. She focuses on survival. The abuse has distorted her image of self, others, and the world

around her. She seeks new meaning in her experiences as she gives up the relationship and the abuse.

Walker (1979), in a different model, identified three phases in an abusing relationship: tension building phase, explosion or acute battering, and final phase consisting of calm, loving respite. These phases correlate well with Landenburger's (1993) phases. During the tension building phase, minor battering occurs (Walker, 1979). The woman attempts to calm the batterer through nurturing, compliant behavior. She believes she can prevent his anger from escalating by what she does. If she is successful, the incident will be over but if she is unsuccessful and he explodes, she takes on the guilt. She assumes responsibility for his behavior and rationalizes that perhaps she deserved the abuse. She attempts to put blame on outside factors. As the tension of each minor battering incident builds, it becomes difficult for either partner to utilize previous coping techniques. Tension becomes unbearable. This phase is similar to the binding and enduring phases as noted by Landenburger (1993).

A point is reached at the end of the tension building phase where the process no longer responds to any controls and acute battering takes place (Walker, 1979). Both partners realize the batterer's rage is out of control. The batterer will begin by wanting to teach the woman a lesson and will stop when he feels the woman has learned it. Usually, at this point, the woman has been severely beaten. The second phase is the briefest phase and usually lasts from two to 24 hours. Only the batterer can end this phase and the reason he stops is unclear. He may be exhausted or emotionally worn out. This phase is usually followed by shock, denial, and disbelief at what has

occurred. A woman frequently does not seek help immediately following this phase unless her injuries require immediate medical attention. This phase resembles Landenburger's (1993) disengaging phase in that the abuse overwhelms the woman but she begins to identify personal strengths and ways she might leave the relationship.

The third phase consists of kindness and contrite loving behavior (Walker, 1979). The batterer realizes he has gone too far and attempts to make amends. The batterer is sorry for his behavior, asks for forgiveness, and promises it will never happen again. He truly believes he will never harm the woman again, that he can maintain control of himself and that he has taught the woman a lesson so she will not behave in a way that will cause the batterer to beat her up again. The batterer's kind, caring behavior reinforces the woman staying in the relationship. Again, there is no distinct end to this phase. It is shorter than the first phase but longer than the second. But soon, the loving behavior changes to a tension building process and the cycle starts over. As the woman recognizes the hopelessness of remaining in the abusive relationship, she may be motivated to seek change. This last phase has similar characteristics to Landenburger's (1993) recovery phase where the woman seeks out supports for herself, puts meaning into her life, and attempts to build a life separate from the abusive partner. The battering cycle is complete after all phases have been experienced. Building a more satisfying life can occur if the woman breaks free of the cyclic pattern of abuse.

Common Indicators/Patterns of Physical Abuse

Much has been written recently regarding the impact of physical abuse to women. Common physical indicators that abuse has occurred include unexplained bruises, welts, burns, lacerations or abrasions, and fractures in various states of healing (Miller, 1993). Other signs of abuse include delays between injury and seeking help (Feldman, 1992); injuries to the trunk or pelvic areas (Feldman, 1992; Moss & Taylor, 1991); hematomas; broken teeth, ribs, nose, and limbs; concussions; and stab wounds (Noel & Yam, 1992).

Yale University conducted a study analyzing trauma cases of an urban hospital in the United States (McLeer & Anwar, 1987). Results showed victims of domestic violence tended to present to the hospital after 5 p.m. with multiple and bilateral injuries involving the head, neck, chest, breasts, back, and abdomen. While fractures, dislocations, and lacerations occurred equally in nonbattered and battered women, abrasions and contusions were more common in battered women (McLeer & Anwar, 1987). The physical violence experienced by battered women include hitting, slapping, kicking, punching, shoving, choking, and using weapons (King, 1993).

Acts of violence lead to consequences other than the immediate physical injury. Results may include chronic pain, disfigurement, physical limitations, miscarriages, stress and anxiety disorders, hypertension, hyperventilation, insomnia, gastrointestinal and eating disorders (King, 1993). Awareness of these conditions should clue the professional to assess the accompanying symptoms as possible indicators of abuse.

Other common indicators include drug abuse, alcohol abuse and depression (Moss & Taylor, 1991; Noel & Yam, 1992). Forty percent of alcoholic women are involved in an ongoing abusive relationship and 25% of female suicide attempts are estimated to occur during this type of a relationship (Noel & Yam, 1992). A suicide attempt may be a subtle way to ask for help or may be viewed as the only way out of an intolerable situation (Moss & Taylor, 1991).

"At Risk" Factors

General system theorists maintain spouse abuse is a problem of interaction between the couple (Moss & Taylor, 1991). Others view it as a way of maintaining the family system. A sociological perspective bases abuse on the legal, cultural, and religious traditions upholding the marital hierarchy. Feminists believe abuse results from the unequal power relationship between men and women (Moss & Taylor, 1991) and the powerlessness of women in a patriarchal society (Goodwin, 1985). Whatever the theoretical basis for spouse abuse, there are certain indications that are considered "at risk" factors.

Miller's (1993) research utilizing military families identified that multigenerational pattern of abuse and exposure to violence are "at risk" factors. The multigenerational pattern has also been shown through other research. In a battered women's shelter, more aggressive behavior was noted among boys than girls (Webersinn, Hollinger, & DeLamatre, 1991). Men who observed their fathers to be

abusive to their mothers were more likely to act in a similar manner, a learned behavior that was continued (Webersinn et al., 1991).

A discrepancy in status between the couple, especially occupational under achievement by the male or higher occupational achievement by the female increased the risk of violence (Webersinn et al., 1991). Another factor may be the changing role of women with their increased status and the diminished role of males. The findings of the study would indicate that as power disparity between the sexes decreases, the potential for violence increases.

Abuse support groups identified through social service agencies noted that women who had a history of witnessing or experiencing abuse in their family system were more likely to have abusive partners (Nurius et al., 1992). Battered women frequently come from emotionally deprived childhoods in which they were battered or witnessed battering of the mother by a father or step-father. They may have a sense of vulnerability and feel unable to succeed on their own. These women see the world as a dangerous place and their survival depends on a protector always being there. Battering husbands are viewed as powerful persons who can protect, punish, and give meaning to life. Loneliness, isolation, and fear of abandonment are often themes present with these women. It is not the relationship that holds the couple together but the women's terror of being alone (Weingourt, 1985). A study by Moehling (1988) indicates that women more susceptible to abuse were early and repeated victims of sexual molestation, exposed to violence among family members, perceived childhood events to be out of their control, and were members of a large family.

The presence of any battering could be considered a risk factor. Battering increases in frequency and severity over time (McLeer & Anwar, 1987; Moehling, 1988). Without intervention, one or the other member of the couple could lose their life (Moehling, 1988). Professional caregivers, with knowledge of these factors and risk indicators, have the ability to ask questions and collect data that can identify victims of abuse.

Abuse During Pregnancy

Abuse during pregnancy is a major health concern. At least 8% of pregnant women are abused during pregnancy (AAN Working Paper, 1993; Campbell et al., 1993; Helton & Snodgrass, 1987). In fact, battering may first begin in pregnancy (Noel & Yam, 1992). Reasons for abuse during this time include the batterers' resentment of the intrusion of the fetus and the females' increased outside contacts with friends, family, and health care providers (Helton & Snodgrass, 1987). The batterers may feel threatened by the women's emotional changes during pregnancy and become jealous of the women's bond with the fetus (Staff, 1992). They may be grieving the fact that they no longer are the women's center of attention (Noel & Yam, 1992).

Gelles (cited in Campbell et al., 1993) was one of the first to address the issue of battering during pregnancy. In this study, women were asked about abuse during pregnancy. He speculated on several reasons for the abuse. Since pregnant women often refuse sex, male sexual frustration could be a factor. Other reasons identified are the mood swings of the women, the strain of family transition, and the defenselessness

of pregnant women. Campbell et al. (1993) conducted a study with 79 battered women recruited through newspaper advertisements and bulletin board postings. They sought the women's perspectives of why abuse occurred during pregnancy. Reasons given were jealousy of or anger towards the unborn child, pregnancy induced violence not aimed towards the unborn child, and "business as usual".

Health care providers need to be aware of the possibility of physical abuse during pregnancy. Abuse has been found associated with low birth weight and miscarriages (Campbell et al., 1993; Noel & Yam, 1992). It is also a leading cause of infant mortality or birth defects and pre-term deliveries (Noel & Yam, 1992).

Reasons for Staying or Returning

Health care professionals frequently question why a battered woman stays in a battering situation or returns to her batterer after she has left. Studies indicate various reasons for staying. These reasons can be grouped into three categories: resource issues, beliefs/values of the person, and the feelings related to repercussions. Resource issues include the financial dependence on the husband and/or little awareness of or no resources available (Helton & Snodgrass, 1987; Sullivan, Tan, Basta, Rumptz, & Davidson, 1992; Webersinn et al., 1991). Beliefs/values may include socialization to keep the marriage together (Sullivan et al., 1992), promises by the batterer to change, promises by the batterer of gifts and privileges which the woman believes he will provide (Schutte et al., 1987), religious beliefs that do not allow leaving the relationship, a sense of responsibility for the abuse, and/or overvaluing positive aspects

of the relationship (Helton & Snodgrass, 1987). Examples of potential repercussions created in leaving the abuser include threats of harm (Helton & Snodgrass, 1987) and persistent reminders of her family responsibilities (Schutte et al., 1987). Examples of feelings related to these repercussions include insecurity in living independently (Schutte et al., 1987; Varvaro & Palmer, 1993), loneliness or lack of emotional support (Helton & Snodgrass, 1987; Sullivan et al., 1992), fear of losing the children and concern about raising the children alone (Schutte et al., 1987), low self-esteem and little self worth, and oftentimes learned helplessness (Helton & Snodgrass, 1987).

Reasons for Leaving

Many women are able to leave the abuser. One reason centers on personal growth. Some of the women identified their increased self-awareness of the abusive relationship and the resulting personal growth as a reason for leaving (Ulrich, 1993). Women gradually recognize their role as victims. This awareness oftentimes leads to anger which can act as a catalyst to leave the relationship. At other times, the lack of improvement on the abusers' part or recognition of the futility of the relationship motivated some to leave. From a different perspective the positive social supports were important to many women. Some reported what helped most was the support of family, a friend, a safe house, or professionals (Sullivan et al., 1992; Ulrich, 1993). As women's needs for nurturance outweigh the stress and stigma of the violence, they will begin seeking help from others. At this time, they recognize their increased stress, fearfulness and low self-esteem. These are motivators in seeking help. As their self-

esteem is restored, validation develops and they feel accepted by their helpers. Thus, they are able to remove themselves from the violent relationships (Limandri, 1986).

Schutte et al. (1987) completed a study of 117 women who had entered a Colorado crisis shelter for battered women. They found that women who had been battered as children and were more educated were less likely to return to the abuser. Women who had been victims of sexual abuse were less likely to return to the abuser. Also, the more often women had left the batterer, the less likely they were to return and the more likely they were to seek help at shelters. This would suggest that battered women may be slow in leaving the relationship but many will eventually leave permanently. They are not hopelessly tied into the role of victim.

Battering in the Rural Area

Fishwick (1993) presented an overview of rural life and her opinion of the particular needs of battered women in rural areas. These needs can be categorized as rural environment, culture, reduced opportunities, and social isolation.

The rural environment presents numerous obstacles to seeking help (Fishwick, 1993). Shelters may serve women in vast geographic areas, but frequently, battered women are many miles from the nearest shelter. Few accessible programs exist in rural areas for the treatment of alcohol and drug abuse. This is problematic because women report more frequent physical abuse when the batterer is intoxicated. Transportation and communication are also impediments to help-seeking behaviors of battered women. Difficulties may be encountered because of greater distances, poor roads, and reliance

on private vehicles. The remoteness of some rural/frontier areas may result in limited access to telephone service and lack of information about the experiences of abuse and help resources. Cultural norms are also a factor for rural battered women (Fishwick, 1993). A cultural norm for self-reliance may inhibit women from seeking help from others.

Reduced opportunities may inhibit battered women from leaving abusive relationships (Fishwick, 1993). Jobs are limited in the rural areas and few child care facilities are available. Opportunities for higher education are limited which restricts the ability for gainful employment. Safe, affordable housing may not exist. Rural battered women may not have a driver's license or access to a vehicle.

Sources of help are often not readily accessible to the rural battered woman. Also, the lack of anonymity in rural areas may create an atmosphere of reluctance for helper involvement. Fear of "interfering" or embarrassing the families involved may inhibit helper response. Additionally, abuser awareness of the partner's help-seeking behavior may result in retaliation and further abuse by the batterer.

No research was found regarding battering in rural Montana. Lack of available research on battering of women in rural areas indicates a strong need for research in this area.

Professional and Societal Attitudes

Oftentimes, professionals caring for battered women presenting in the emergency room are reluctant to intervene in a battering situation. Reasons include

believing battering is a private problem (Hoff, 1993), inadequate training of health care providers to identify abuse, or placing blame on the victim's personality or mental state. Patients who choose not to leave their husbands or do not have a pleasant personality received less support from the health care providers. Also receiving less support were women who had been drinking and were evasive about their injuries. Physicians were also found to be reluctant to intervene for the same reasons (Easteal & Easteal, 1992).

Sugg & Inui (1992) conducted an ethnographic study to learn more about barriers to domestic violence intervention. Participants were 38 primary care physicians practicing in an urban health maintenance organization. They indicated a fear of opening Pandora's box if they explored the issue of violence with their patients. Participants who came from white, middle-class backgrounds with no history of violence assumed patients of similar status would also not be victims of violence. Participants admitted they were more likely to ask questions regarding abuse of women from lower socioeconomic status. Women physician participants closely identified with their female patients and feared their own vulnerability and lack of control so did not discuss the possibility of abuse. Participants feared offending the patient or felt it would endanger the physician- patient relationship if they inquired about abuse. Some felt they needed to get unbiased information about whether abuse occurred so they needed to talk to someone other than the patient. Other physicians shared feelings of frustration and inadequacy when exploring interventions and in their inability to "fix it." Many physicians felt their attempts at intervention were useless until patients were

motivated to change. The need to gain control and solve the problem by the physicians were obstacles in addressing domestic violence. A majority of physicians were concerned about the required amount of time for dealing with this issue.

Hamberger et al. (1992) determined that beliefs and attitudes of health care providers affected their response to battered women. Many were found to be judgmental, often asked why the women did not just leave, or found it difficult to believe the battered women's partners beat them.

Health care providers often believe violence is a problem of a deviant group (AAN Working Paper, 1993). They may identify battered women as masochistic (Moss, 1991; Weingourt, 1985). A further impediment to providing care was the stereotyping of the sanctity of family by the health care providers. Examples include belief in the right to privacy, belief in the right of husbands to control their wives, or the belief that violence might be justified (Moss & Taylor, 1991). Another reason for health care neglect was the fact that emergency rooms over the past several years have become places of high technology dealing with life-threatening situations. These personnel view emergency from a different perspective than the patients, with a resulting clash in expectations (McLeer & Anwar, 1987). Health care providers need to assess their values and understand victims cannot control or are not responsible for the violent behavior of their partner (Jordan & Walker, 1994).

Until recently, society accepted violence as a common and accepted part of marriage (Morrison, 1988). Abuse towards women has historically permeated almost every culture (Moehling, 1988). The topic of violence has been taboo and people did

not get involved in their neighbor's family problems (Durst, 1991). Violence in the media has sent a message that violence in relationships is normal or is expected (Limandri, 1986).

Current Programs & Interventions

One of the first hospital based programs offering services to battered women was developed in 1975 by emergency room Registered Nurse Betty Cavanaugh. Her program has served as a model for other hospital based programs (Jackson, 1992). It is affiliated with a Minneapolis shelter for battered women which ensures that when women leave the hospital, they have a safe place to go. This program provides an advocacy program for battered women and also education to emergency room nurses and physicians.

An important first step in any intervention program is to develop a protocol to follow when domestic violence is suspected (Sheridan & Taylor, 1993). A 7-step protocol developed by McLeer and Anwar (1987) for use in emergency departments include these steps: (a) obtain an adequate trauma history, (b) diagnose and treat medical and/or surgical problems, (c) evaluate the emotional status of the battered woman, (d) determine the risk to the woman and the children, (e) determine need for legal information, (f) develop a follow-up plan, and (g) document findings and recommendations in the medical record.

A program was developed at Misericordia General Hospital in Winnepeg to provide awareness to staff on all areas of domestic abuse (MacKay & Rosolowich,

1988). A series of eight sessions was scheduled and included hospital staff, outside speakers, and audiovisual aids to assist in presenting the information. Sponsors of the program felt staff had an increased awareness and recognition of abused patients at the completion of the program (MacKay & Rosolowich, 1988).

WomanKind, a hospital based program, was developed to provide assistance to a battered woman (Hadley, 1992). The major purpose of this program is to provide advocacy-support, information, education, and hospital or community referrals. An advocate stays with the woman while medical procedures are being done and assists the woman in finding medical, law-enforcement, legal, and social service resources available to her. The advocate helps the woman to review her options, set priorities, make decisions, and access other resources available. The advocate also helps develop a plan for protection if the woman should choose to return to her abuser. This program also provides follow up support services. Additionally, WomanKind provides in-service training to hospital and health care providers to assist them in identifying a battered woman seeking help. Stated goals are to increase the knowledge and awareness of health care providers and aid them in effectively using the services of WomanKind. Long term follow up of clients in this program has indicated that a battered woman can make changes, take the steps necessary to protect herself, and eliminate violence in her life if given support and information.

Sullivan et al. (1992) conducted a study on 141 battered women. Data were collected as the women left a domestic violence shelter and again 10 weeks later. Half the sample were randomly assigned to receive assistance from trained advocates in

accessing needed community resources. The other half became a control group. Those in the experimental group saw their advocate an average of 2 times a week. Interviews conducted at 10 weeks revealed that women seeing an advocate were more likely to have worked on obtaining resources needed or had a greater success in having obtained those resources. Findings from this study indicated that 70% of the women who were involved with their batterers continued to be physically abused; 29% of the women not involved with their batterers continued to be battered by them. Ending the relationship does not necessarily end the abuse.

One of the most useful strategies health care providers can offer is a referral support group where women are able to identify resources, develop interpersonal skills, and get feedback on their perceptions (Hoff, 1993; Limandri, 1986). Emergency room personnel should be aware of these support groups because appropriate referrals can be made as set forth by the JCAHCO standards.

Principles for Emergency Room Interventions

The following points with their supporting rationale are appropriate interventions which need to be utilized by emergency room professionals:

1. Ask the woman about the possibility of abuse. Many women are relieved when asked and are given an opportunity to talk about their feelings (Furniss, 1993; King, 1993; Landenburger, 1993; Moss & Taylor, 1991; Noel & Yam, 1992). Asking about the possibility of abuse shows care and concern and establishes a trusting relationship.

2. Never ask the woman if she is abused unless she is alone, without a significant other present. The victim cannot freely talk if her abuser is present (Feldman, 1992; Furniss, 1993; Moss & Taylor, 1991). The possibility exists for further abuse after leaving the safety of the emergency room if the abuser knows the woman has reported the abuse.

3. Maintain a nonjudgmental attitude (Hoff, 1993; Moss & Taylor, 1991). The nurse will not be perceived as a caring or knowledgeable resource if blame is placed on the battered woman for the abusive relationship.

4. Do not blame the woman for her abuse. Support the victim's ability to take control of her life and give credit for action already taken (Feldman, 1992; Landenburger, 1993; Ulrich, 1993). A battered woman often feels deserving of the abuse and hopelessly locked into an abusive relationship. Helping her identify previous survival techniques helps her to recognize she does have skills.

5. Help the woman recognize she is not the cause of the violence (Hoff, 1993; Moehling, 1988; Noel & Yam, 1992). This allows the battered woman to accept that she has control over her behavior but not her abuser's behavior. Often times the woman blames herself for her partner's abuse and needs to recognize that the batterer is responsible for his own actions.

6. Assist the woman to recognize that violence is not a norm in a loving relationship (Noel & Yam, 1992) and no one has the right to hurt her (Feldman, 1992; Landenburger, 1993). A battered woman may believe abuse is the norm especially if

she came from an abusive household as a child. Helping her to identify that an abusive relationship is not the norm allows her to reassess her situation.

7. Explore with the woman aspects of a healthy relationship (Landenburger, 1993). If she has had limited experience in this type of a relationship she may need education as to role expectations of a constructive relationship.

8. Accept the abused woman where she is in the various phases of the abusive relationship and understand her perspectives of the situation (Landenburger, 1993; Moss & Taylor, 1991). This is perhaps one of the most difficult interventions for a nurse. Nurses must be cautious about imposing their own values on the battered woman. Leaving an abusive situation is rarely an easy or simplistic action and a battered woman needs to be supported in making her decisions at her own pace.

9. Problem solve with the battered woman to identify her options (Furniss, 1993; Moss & Taylor, 1991). A battered woman may believe she has no options other than to return to the battering environment. Giving and helping her identify options can also give her a sense of hope.

10. Allow the battered woman to grieve the loss of her relationship (Landenburger, 1993). A battered woman may be giving up her hope of having a loving relationship. She may grieve the loss of her unrealistic ideals for that relationship.

Referrals could include two processes. The first is to inform the battered woman about legal services available to her (Moss & Taylor, 1991). The law does protect her by giving her the right to keep her children and property. The law also

allows a restraining order to be placed on the abuser. The second referral is to inform the battered woman about other community resources (Noel & Yam, 1992). These resources would include the crisis line number, safe shelters, and police emergency numbers.

Beside interventions, abuse prevention processes have been enumerated by several authorities. The following is a list of these preventive activities and their rationale:

1. Develop a safety plan with input from the victim. If the woman is not ready to leave her abuser, she needs a plan of action to follow the next time abuse is imminent (King, 1993; Landenburger, 1993). This plan would include items needed for hasty retreats and plans of how and where the woman would go.

2. Empower the battered woman by helping her clarify some of her distorted self-appraisals that create actions of passivity (Limandri, 1986) and by helping her increase her self-esteem (Landenburger, 1993). Distorted self-appraisals could include feelings of blame, guilt, unworthiness, or lack of ability to change the situation. Empower the woman further by providing referrals to supportive services (King, 1993; Landenburger, 1993; Moss & Taylor, 1991). Because a battered woman is frequently very vulnerable to her abuser's desires, she may be persuaded to return to the relationship before more constructive coping techniques have been learned by either partner.

3. Provide assertiveness training (Hoff, 1993). Hoff believes assertiveness training will help a woman to lessen her dependency on the man in her life for fulfillment of her economic and emotional needs.

4. Encourage self-defense training (Hoff, 1993). Hoff believes this training would possibly save the battered woman's life and also increase her sense of self-confidence and self-esteem. This would give a sense of control and ability to take action against the abusive process.

5. Advocate for enforcement of abuse prevention laws (Hoff, 1993). Most states have now passed laws banning domestic violence but nurses need to be aware of how adequately these laws are being enforced so they can advocate for stronger enforcement if necessary.

Conceptual Framework

The conceptual framework for this project is based on principles of adult education. These principles provided the framework for development of the inservice presentation.

Functions of the adult educator are to help learners identify what they need to learn, to plan with the learners how they learn what they need, to develop a desire to learn in the learner, to decide the best techniques to teach, to provide the resources for learning, and to help learners decide whether they learned what they set out to learn (Knowles, 1970). An educator can be defined as a change agent who helps learners achieve their full potential through the acquisition of new knowledge and behavior.

The educator's role is described as that of helper, guide, encourager, consultant, and resource person (Knowles, 1970). The educator provides the support needed as learners process new information, experiment with the use of new knowledge, and are motivated to expand and acquire more knowledge.

Other key factors influencing the learning process have been identified by Knowles (1970). These factors are establishing the right environment for effective learning and helping adult learners feel at ease, accepted, respected, and supported.

Adult learners have a rich resource of knowledge and learn best if they can relate new learning experiences to previous experiences (Knowles, 1970). Adult learners are usually problem-oriented rather than subject-oriented, so more effective learning will be accomplished if new knowledge can be applied to their every day experiences.

Seaman and Fellenz (1989) indicate that evaluation is an important step in the teaching process for several reasons. Evaluation gives feedback that helps a teacher improve instruction. Evaluation promotes growth and self-evaluation of the educator by assisting in the assessment of the adult learners' reactions to the teaching strategies. The evaluation process allows the educator to learn from the learners. Evaluation data provides the educator with an opportunity to diagnose future learning needs of the learner and areas in which the educator needs to enhance teaching skills. Finally, the adult learners' evaluation can improve the teacher's self-concept and sense of worth by accepting positive experiences and comments.

Evaluation also helps adult learners by having them reflect on newly learned information which increases the retention of this information (Seaman & Fellenz, 1989). Providing an opportunity to think about the content of newly acquired information and to process usefulness of that information helps reinforce the learning. Finally, learners may become motivated to gain more knowledge about specific areas.

Summary

A presentation to the adult learners of the emergency room staff at Montana Deaconess Medical Center utilized adult learning concepts. Factors considered in the development of the presentation included identifying the needs of the learner, providing the learners with needed information, applying that information in a meaningful and applicable manner, and evaluating the presentation. The environment was supportive and allowed for questioning and sharing of personal experiences.

CHAPTER 3

METHODOLOGY

Project Design

The project was to develop and present an educational inservice to the emergency room staff at Montana Deaconess Medical Center. A literature review provided increased knowledge and understanding about battered women. The literature review revealed that battering was frequently overlooked as a reason for help-seeking. Other resources obtained were JCAHCO standards (1991), which address caring for the adult victim of suspected abuse, and the Montana Deaconess Medical Center's current policy on Care/Intervention of the Patient of Domestic Violence Who Presents to the ER (1994). After reviewing this information, tools and information utilized by other agencies involved with the care of battered women were accessed. Agencies contacted included the Johns Hopkins School of Nursing, the New York State Office for the Prevention of Domestic Violence, and the Center for Women Policy Studies.

The director of emergency services of the Montana Deaconess Medical Center and the head nurse of the emergency room were contacted about the project. They confirmed a need for a presentation on providing care to battered women. The head nurse revealed an educational inservice had not recently been presented to the staff regarding battered women or domestic violence. This reinforced the need for such a presentation.

Assessment of Learning Needs

Using Knowles' (1970) principle of identifying the interests of learners and helping learners recognize what they need to learn, a questionnaire was developed and given to emergency room staff (Appendix A). A list of potential content areas was distributed to ascertain the learning needs and interests of emergency room personnel. Twenty-six questionnaires were placed in the mail boxes of registered nurses, licensed practical nurses, and emergency medical technicians. Instructions were given as to where to return the completed form. A 15-day period was given for questionnaire response. This allowed all staff time to cycle through their schedule, so all were given an opportunity for input into identifying their learning needs and interests. Eight questionnaires were returned. Three weeks later, a phone call to the head nurse confirmed no further questionnaires had been returned. The responses were tabulated. The limited number of returned questionnaires may not have been representative of the learning needs and interests of the emergency room personnel. Responses to the questionnaire have been tabulated in Table 1.

Table 1. Questionnaire Responses (N=8)

	No Interest	Some Interest	Very Interested
Definition of battered women	1	4	3
Common signs of physical battering	1	4	3
"At risk" factors for battered women	1	4	3
Attitudes of professionals that affect ability to intervene in a battering situation	1	3	4
Facts and myths about battering relationships	1	5	2
The phases of abuse	1	4	3
Factors influencing the battered woman's choice to stay in a battering situation	1	5	2
Factors influencing the battered woman's choice to leave a battering situation	1	5	2
Abuse during pregnancy and potential consequences	1	4	3
Differences between urban and rural areas related to battered women	1	5	2
Nursing interventions most effective with battered women	1	4	3
Resources available in the Great Falls area for battered women	1	3	4

Respondents were asked to indicate preferences for day and time. Optimal learning modes were elicited. Responses to "how do you learn best?" were visual (n=2), listening and visual (n=2), and one respondent indicated "more than one sense stimulated at a time."

Presentation Development

Brevity and relevance were important factors in the development of the presentation. Because of relatively consistent responses to certain content areas, the presentation was limited to include the process of battering, the physical presentation and warning signals of women being abused, the appropriate interventions to be utilized by the staff, and the resources available in Great Falls for battered women. A list of objectives was developed to provide organization for the content and to inform the staff of the learning goals (Appendix B). An outline was developed to meet the objectives of the presentation (Appendix C). A hypothetical case study of a battered woman presenting in the emergency room was reviewed and discussed (Appendix D).

Handouts presented (Appendix E) to the participants included the following:

1. The current Montana Deaconess Medical Center's policy (1994) for emergency room procedures for patients who are possible victims of domestic violence. This policy was provided as a review for staff.
2. The guidelines established by JCAHCO (1991) in handling patients suspected or known to be victims of domestic violence. These guidelines must be followed to assure continued accreditation by this agency.

3. A brochure (1990) defining the various types of abuse. Staff awareness of the different types of abuse was deemed necessary (Domestic Abuse, 1990).

4. An abuse assessment screen. This would be a quick, easy to follow tool to assist in identifying and documenting information during the assessment process.

5. A brochure entitled "Empowering Interventions with Battered Women" (1987). This brochure reinforced interventions presented during the educational inservice. It also offered techniques to utilize in assisting battered women to regain control of their lives.

6. A table identified as "Guidelines for Battered Partners of Domestic Violence" (1986). This pamphlet could be given to the women leaving the emergency room and returning to the battering environment. This pamphlet guides the women in actions to take before, during, and after an attack.

Knowles (1970) recognizes that establishing the right environment is essential for effective learning. Adult learners were made to feel at ease, accepted, respected, and supported. This environment was established using an accepting and non-threatening posture, and an acknowledgment that the learners have their experiential knowledge base to relate to during the learning process.

At the conclusion of the inservice, an evaluation form was given to the participants (Appendix F). An evaluation reinforces what learners have learned and makes retention of material easier by helping them look at ways they can use the new knowledge (Seaman & Fellenz, 1989). Feedback from the evaluation was gathered to improve the presentation for future educational offerings.

The presentation was one-half hour beginning at 7:00 a.m. to access both shifts, the shift going off duty and the shift coming on duty. At the head nurses's suggestion and from input received from the questionnaires, the presentation was given on a Tuesday in a conference room in the emergency room department. Four registered nurses employed by the Montana Deaconess Medical Center's emergency room attended.

Conclusion

The presentation was developed and based on adult learning principles. Needs of the staff were addressed and handouts were given as useful tools and reinforcers of learning. A hypothetical case study was reviewed as a problem- oriented approach with practical applications. The current hospital policy (1994) regarding domestic violence along with JCHACO (1991) standards were reviewed to increase awareness of national and hospital expectations. Finally, the presentation was evaluated by the participants to increase retention and provide feedback to the presenter.

CHAPTER 4

PROJECT OUTCOME

Results

The presentation was attended by four registered nurses, three female and one male. Information was provided to assist the participants in identifying symptoms of potentially battered women, intervening appropriately, and making available resources known to battered women as they leave the emergency room. A discussion of a hypothetical case study in an emergency room was developed. The educator also helped the learners to rethink previous beliefs (Knowles, 1970). Comments made at the beginning and at the end of the presentation indicated some of the learners beliefs were challenged. Early in the presentation, a male participant asked "Why doesn't she just leave?" At the conclusion of the presentation he was able to recognize the complexity of the situation. He stated he had not realized all the factors involved in the battering situation.

All four marked "yes" for all the questions evaluating the presentation. This indicated the adult learners believed the presentation met both stated and personal objectives. According to participants, the presentation was stimulating, attention holding, clear, and easily understood. Feedback indicated the presenter was able to provide information that could be applied to their current work situation, questions were encouraged, and the presenter listened to ideas and experiences of the participants.

Written comments were sought regarding what parts of the presentation were most useful. Feedback was global and very favorable in nature. Comments reflecting the participants' perceptions about the content and style of presentation included the following: "allowed flow of questions from audience and applied to lecture," [learned how to] "support during ER visit," [awareness of] "task force," "the fact that finally abuse is being recognized and steps are being taken to address the problem," "good information," and "good job." No comments were submitted regarding what part of the inservice was least helpful or how the presentation could be improved.

The presenter's evaluation of the inservice included several areas for improvement. The amount of information presented was excessive for the time allotted. More opportunity was needed for participants to share their experiences and concerns. Enhancing the interest in the problem of identification and intervention of battered women is an ongoing process. Major changes in the care of battered women will not occur until staff actively participate in learning experiences that enhance their knowledge base, self awareness, and assessment skills.

Summary

The small number of questionnaires returned and the minimal staff attendance could indicate a lack of concern, lack of awareness of the need to know, or a feeling of already knowing the information as suggested by the head nurse. The information presented was reduced to a basic level. Written comments evaluating the presentation indicated some personal beliefs were challenged regarding battered women.

The staff verbalized appreciation in getting more information about the abuse process and resources available in Great Falls. The presenter volunteered her time to the head nurse for further presentations if other staff expressed interest in learning more about the battering situation.

Implications for Further Study

Little is known about battering in rural areas and more specifically in the state of Montana. Research needs to be done to address the needs of battered women in Montana. Communities need to develop an awareness and an action plan given the significance of this problem.

Assessing and responding to the learning needs of staff members of other emergency rooms throughout the state is a priority. Information regarding battered women needs to be made available to emergency room personnel. Research focusing on the identification of approaches, interventions, or resources most useful to battered women is needed. This information can assist emergency staff in developing protocols and referral materials.

The problem of battering should be a concern for all health care providers, especially emergency room staff who may provide care to battered women more frequently than those in other areas of the hospital. Educational presentations, focusing on awareness of the problem, myth dissipation, and enhancement of clinical intervention skills, will help staff in meeting the needs of these women. In

turn, as the needs of abused women are met, they may feel empowered to make necessary changes to break the cycle of the battering process.

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APPENDICES

APPENDIX A
QUESTIONNAIRE

Dear ER Staff Member:

My name is Clarice Flanagan and I am currently working on completing my Master's degree in nursing at Montana State University. One of my areas of concern has been with battered women. I am interested in presenting an inservice to the ER staff re: assessment, recognition, understanding the dynamics, etc. of this particular population. Please take a few minutes and fill out this questionnaire so I have a better awareness of your particular learning needs. Leave the completed questionnaire on Susan O'Leary's desk. I am looking forward to working with you as we all strive to enhance our clinical skills.

On which of the following areas of content are you interested in having more information?

Please mark as follows: 1 = No interest
2 = Some interest
3 = Very interested
4 = Know and want review

- | | | | | |
|--|---|---|---|---|
| 1) Definition of battered women: | 1 | 2 | 3 | 4 |
| 2) Common signs of physical battering: | 1 | 2 | 3 | 4 |
| 3) "At risk" factors for battered women: | 1 | 2 | 3 | 4 |
| 4) Attitudes of professionals that affect ability to intervene in a battering situation: | 1 | 2 | 3 | 4 |
| 5) Facts and myths about battering relationships: | 1 | 2 | 3 | 4 |
| 6) The phases of abuse: | 1 | 2 | 3 | 4 |
| 7) Factors influencing the battered woman's choice to stay in a battering situation: | 1 | 2 | 3 | 4 |
| 8) Factors influencing the battered woman's choice to leave a battering situation: | 1 | 2 | 3 | 4 |
| 9) Abuse during pregnancy and potential consequences: | 1 | 2 | 3 | 4 |
| 10) Difference between urban and rural areas related to battered women: | 1 | 2 | 3 | 4 |
| 11) Nursing interventions most effective with battered women: | 1 | 2 | 3 | 4 |
| 12) Resources available in the Great Falls area for battered women: | 1 | 2 | 3 | 4 |

Are there areas not listed related to battered women that you would like information on?

How do you learn best - listening, visual, etc.?

If given as an inservice, what would be the best time?

Days _____ Times _____

Thank you.

APPENDIX B
PRESENTATION OBJECTIVES

Presentation Objectives

At the end of the presentation, participants will know and understand the following:

1. Definition of abuse
2. Basic understanding of the process of battering
3. Physical presentation and/or warning signals to observe for during an assessment
4. Appropriate and useful interventions to utilize before, during, and after an assessment
5. Resources available in Great Falls for battered women

APPENDIX C
PRESENTATION OUTLINE

Presentation Outline

I. Review of handouts

II. Statistics

- A. 1.8 million to 2 million women have been victims of physical abuse by their husbands
- B. 20 - 30% of all women in the U.S. have experienced physical abuse at the hands of their husbands or partners at least once
- C. 20 - 25% of women seen in ER's have been victims of physical, sexual or psychological abuse by their significant others
- D. 1 in 10 or even 1 in 25 battered women seeking medical attention for injuries are identified as battered women by nurses or physicians

III. Definition of battered women

- A. Has had use of physical force by a male partner
- B. Abuse or history of abuse comes from an intimate other or close relative
- C. One who has repeatedly been subjected to forceful physical or psychological behavior by a man to make her do something he wants without concern for her rights

IV. Phases of abuse

- A. Walker identifies 3 phases
 - 1. tension building
 - a. minor battering occurs
 - b. woman attempts to calm batterer through nurturing, compliant behavior
 - c. believes can prevent his anger from escalating by what she does
 - 1. if successful incident will be over
 - 2. if unsuccessful and he explodes, she takes on the guilt
 - d. rationalizes perhaps she deserved the abuse
 - e. blames outside factors
 - 2. acute battering
 - a. occurs when process no longer responds to any controls

- b. characteristic is uncontrolled discharge of tensions that have accumulated in phase one
 - c. begins by batterer wanting to teach the woman a lesson and ends when he feels she has learned the lesson
 - d. the woman usually is severely beaten
- 3. calm, loving respite
 - a. batterer realizes has gone too far and tries to make amends
 - b. batterer sorry for his behavior, promises it will never happen again
 - c. his kind, caring behavior reinforces her staying in the relationship
 - d. soon loving behavior changes to tension building process and cycle begins over again

V. Common signs of physical battering

- A. Unexplained bruises and welts
- B. Unexplained burns
- C. Unexplained fractures in various stages of healing
- D. Delay between injury and seeking treatment
- E. Injuries to trunk or pelvic areas, hematomas, broken teeth, ribs, nose, limbs, concussions, and stab wounds
- F. Abrasions and contusions are more common in battered women than non-battered women

VI. Interventions

A. Protocol

- 1. know the protocol to follow when domestic violence is suspected
- 2. carefully document findings

B. Approaches

- 1. ask about possibility of abuse
- 2. never ask the women if she is abused unless she is alone
- 3. do not blame the woman for her abuse
- 4. maintain a nonjudgmental attitude
- 5. help the woman recognize she is not to blame for the violence

6. help her recognize violence is not a norm in a loving relationship and no one has the right to hurt her
7. help her identify aspects of a healthy relationship
8. help her identify her partner is responsible for his abusive behavior
9. help her identify her options
10. accept the woman where she is at in the various phases of abuse and understand her perspective of the situation
11. allow her to grieve the loss of the relationship

VII. Case Study

VIII. Referrals

1. Mercy Home 453-1018
2. Police Department 9-1-1
3. Legal Support Services 453-3102
4. Battered Women's Support Group 452-1315

APPENDIX D

CASE STUDY

A Case Study

A 24 year old woman presents to the emergency room accompanied by her husband. She complains of rib pain. Upon x-raying the woman, the nurse finds she has two fractured ribs and two others that are partially healed. An exam of her body shows numerous contusions and abrasions in various stages of healing. She explains she fell down the stairs several days ago but only now is the pain severe enough to seek treatment.

The woman's husband is very reluctant to leave her side. He appears anxious and concerned and is resistive to leaving the woman alone with the nurse.

The nurse is able to spend some time alone with the woman and asks about the possibility of abuse. The woman denies any physical abuse from her husband. She chooses to leave the emergency room accompanied by her husband.

What are signs this could be a battered woman?

What interventions are appropriate by the nurse?

Referrals:

1. Mercy Home 453-1018
2. Police department 9-1-1
3. Legal Support Services 453-3102
4. Battered Women's Support Group 452-1315
5. A task force on domestic violence is currently being organized and developed in Great Falls.

APPENDIX E

HANDOUTS

MONTANA DEACONESS MEDICAL CENTER
Great Falls, Montana
Division of Patient Care Services Operating Policies and Procedures
Emergency Department Services

SUBJECT: Care/Intervention of the Patient of Domestic Violence Who Presents to the ER

DEPTS.

AFFECTED: Emergency Department

PURPOSE: It is important for emergency care personnel to assess and manage properly men and women who enter the Emergency Department as victims of domestic violence. While recognizing that not all patients will openly identify themselves as being abused, intervention can aid in the resolution of the crisis if it occurs during the acute phase of emergency care.

PROCEDURE:

1. For emergency patients who admit to domestic abuse, the emergency care provider will:

- a. Maintain privacy.
- b. Perform and document an accurate history and assessment of physical abuse.
- c. Call Social Services/Police as per patient's request.

2. For emergency patients who do not openly identify themselves as victims of abuse, but are suspect:

- a. Maintain privacy.
- b. Perform and document an accurate history and assessment.
- c. Observe.
- d. Obtain consent to photograph and photograph as necessary for documentation.
- e. Psychosocial Assessment:

1) Assess:

- a) Condition upon arrival: (whether patient is hesitant or open with personnel.
- b) Factors concerning admission (alone or accompanied by another).
- c) Time span between incident and ER Department admission.

- d) Interaction between patient and accompanying family for friends.
- e) Level of comfort displayed by patient toward personnel.

2) Physical abuse assessment:

- a) Repeated abuse on certain portions of body, including head and face.
- b) Noted reoccurrence of injuries and bruises on body parts frequently covered by clothing.

(1) Body indicators of domestic trauma: head, face, chest, breasts, abdomen, buttocks, back, bodily injury during pregnancy.

3) Emotional Assessment:

- a) Level and evidence such as fear, quiet anger, depression, lack of self esteem, shame or despair.
- b) Manner of misdirecting their feelings in physical destruction rather than verbally.

3. Dismissal:

Assure patient's referral to:

- a. Mercy Home (453-1018).
- b. Social Services

Date of Origin: 12/94
Revision Date:
Review Date:

Effective Date: 12/94

Manager: _____ Director: _____

Accreditation Manual for Hospitals, 1992 Hospital-Sponsored Ambulatory Care Services

HO.3.2.15 The handling of adult and child victims of alleged or suspected abuse or neglect.

HO.3.2.15.1 Criteria are developed for identifying possible victims of abuse:

HO.3.2.15.1.1 The criteria address at least the following types of abuse:

HO.3.2.15.1.1.1 physical assault;

HO.3.2.15.1.1.2 rape or other sexual molestation;
and

HO.3.2.15.1.1.3 domestic abuse of elders, spouses, partners, and children.

HO.3.2.15.2 Procedures for the evaluation of patients who meet the criteria address:

HO.3.2.15.2.1 patient consent;

HO.3.2.15.2.2 examination and treatment;

HO.3.2.15.2.3 the hospital's responsibility for the collection, retention, and safeguarding of specimens, photographs, and other evidentiary material released by the patient; and

HO.3.2.15.2.4 as legally required, notification of, and release of, information to the proper authorities.

HO.3.2.15.3 A list is maintained in the ambulatory care services department of private and public community agencies that provide, or arrange for, evaluation and care for victims of abuse, and referrals are made as appropriate.

HO.3.2.15.4 The medical record includes: documentation of examination, treatment given, any referral(s) made to other care providers and to community agencies, and any required reporting to the proper authorities.

HO.3.2.15.5 There is a plan for education of appropriate staff about the criteria for identifying and the procedures for handling possible victims of abuse.

Accreditation Manual for Hospitals, 1992 Emergency Services

ES.5.1.2.10 the handling of adult and child victims of alleged or suspected abuse or neglect.

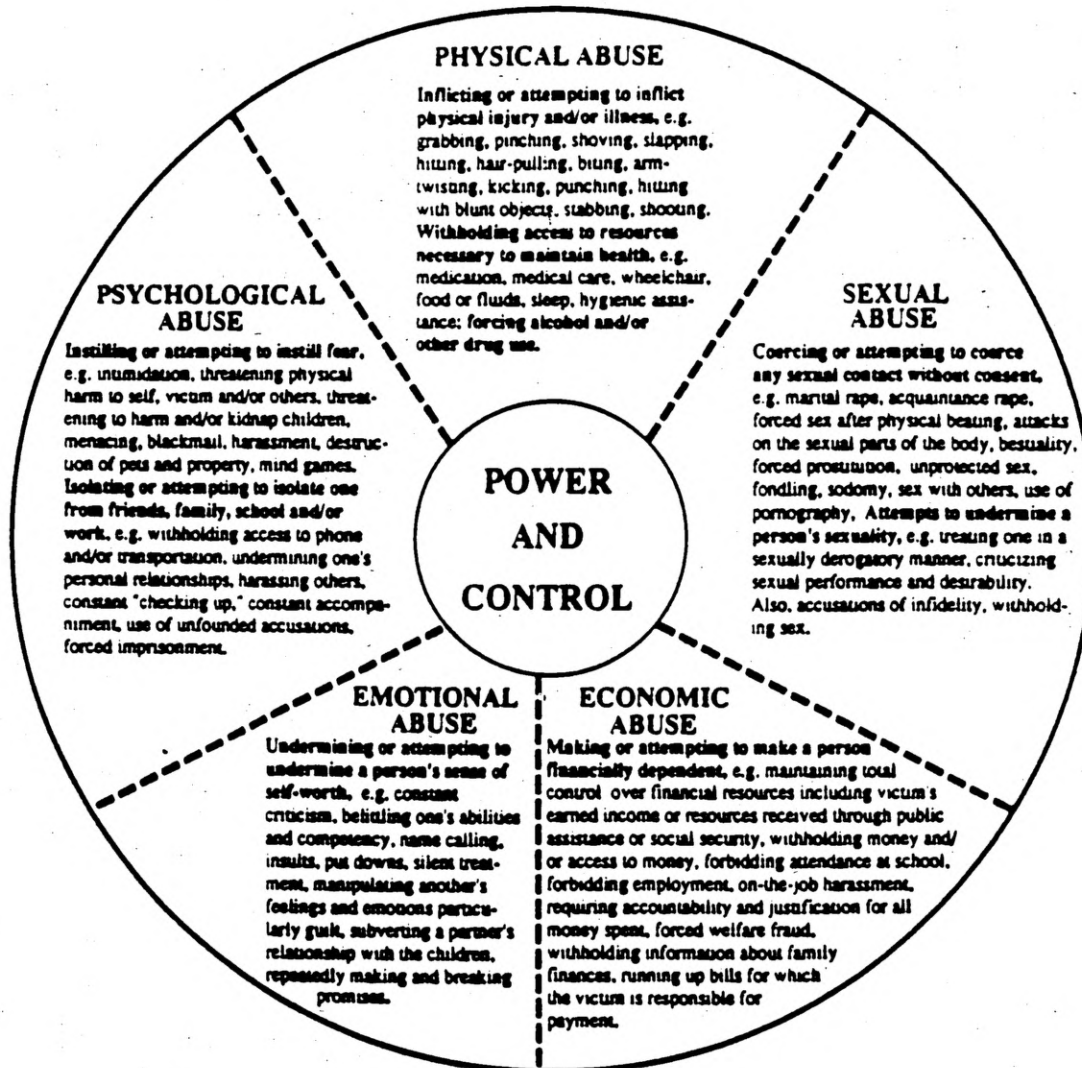
ES.5.1.2.10.1 Criteria are developed for identifying possible victims of abuse.

ES.5.1.2.10.1.1 The criteria address at least the following types of abuse:

- ES.5.1.2.10.1.1.1 physical assault;
- ES.5.1.2.10.1.1.2 rape or other sexual molestation;
- and
- ES.5.1.2.10.1.1.3 domestic abuse of elders, spouses, partners and children.
- ES.5.1.2.10.2 Procedures for the evaluation of patients who meet the criteria address:
 - ES.5.1.2.10.2.1 patient consent;
 - ES.5.1.2.10.2.2 examination and treatment;
 - ES.5.1.2.10.2.3 the hospital's responsibility for the collection, retention, and safeguarding of specimens, photographs, and other evidentiary material released by the patients; and
 - ES.5.1.2.10.2.4 as legally required, notification of, and release of information to, the proper authorities.
- ES.5.1.2.10.3 A list is maintained in the emergency department/service of private and public community agencies that provide, or arrange for, evaluation and care for victims of, abuse, and referrals are made as appropriate.
- ES.5.1.2.10.4 The medical record includes documentation of examinations, treatment given, any referrals made to other care providers and to community agencies, and any required reporting to the proper authorities.
- ES.5.1.2.10.5 There is a plan for education of appropriate staff about the criteria for identifying, and the procedures for handling, possible victims of abuse.

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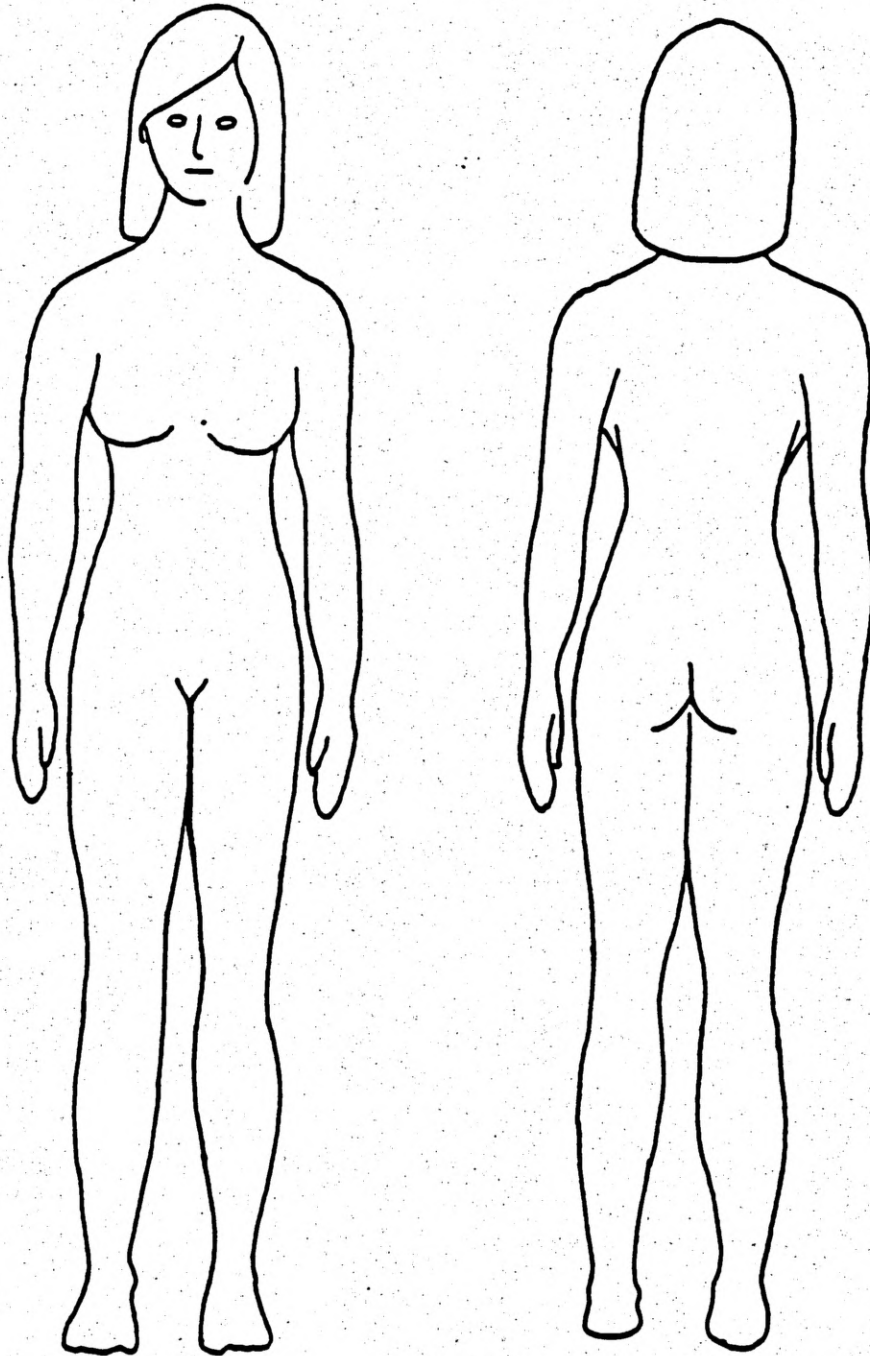
A POWER AND CONTROL PERSPECTIVE



Adapted from: Domestic Abuse Intervention Project, Duluth MN
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Abuse Assessment Screen

Examine the entire body and record the patterns and description of all injuries.



Interviewing Battered Women

Many women will eagerly talk about the violence if they feel safe and supported. Because few women initially define themselves as battered, the mental health practitioner should routinely ask questions like those that follow:

- * Is anyone in your family hitting you?
- * Does your partner ever threaten you?
- * Does your partner prevent you from leaving the house, from getting a job or returning to school?
- * What happens when your partner doesn't get his way?
- * Does your partner threaten to hurt you when you disagree with him?
- * Does your partner destroy things that you care about, i.e., your family photographs, your clothes, pets?
- * Are you forced to engage in sex that makes you feel uncomfortable?
- * Do you have to have intercourse after a fight to "make up?"
- * Does your partner watch your every move? Call home 10 times a day? Accuse you of having affairs with everyone?

As the practitioner declares the violence unacceptable and helps the woman name the forms of abuse she has endured, the therapeutic work of empowerment continues. The therapist has four tasks in the empowerment process:

- I. Validating the woman's experiences
- II. Exploring her options and advocating for her safety
- III. Building on her strengths and avoiding victim-blaming
- IV. Respecting her right to self-determination

Reproduced from Guidelines for Mental Health Professionals by Susan Schechter, 1987, with permission from the National Coalition Against Domestic Violence. Complete Guidelines available from NCADV at \$7.00 for members, \$9.50 for non-members.

The following examples illustrate useful interventions in each category:

I. VALIDATING THE WOMAN'S EXPERIENCES

A. Interview the battered woman separately from her abuser and do not ask the abuser to verify her story.

B. Do a history of the violence. Ask women to tell you about the first, worst and most recent violent assaults.

C. Using the questions provided above, ask the woman directly about the violence. If the practitioner avoids talking about it, so will the woman. Interview her in the language she is most comfortable speaking. Support her for telling her story.

D. Empathize with her and validate her feelings. Because the abuser blames her for the violence and because the society frequently does nothing to stop the assaults, many battered women feel crazy and self-doubting. The practitioner needs to take a stand against the violence and make an alliance with battered women so that they can talk about their confusion, fear, guilt, anger and pain. The practitioner also must articulate a clear set of beliefs about violence to the woman, i.e., you are not responsible for the violence, no matter what you do; even if you strike back, drink, or take drugs, the assailant is responsible for the abuse. Practitioners need to make statements like the following, "abuse is criminal and wrong; leaving an abuser is frequently the only way to stop the violence; keeping the family together is not always best."

E. Universalize, i.e., "Many women who are beaten come here and they feel the way you do. Most feel discouraged but, with help, they have changed their lives. Two million women are beaten every year. Many never know that this happens to others until they go to a shelter or join a support group for battered women."

F. Give women information, resource guides like, Violence Against Women: A Curriculum for Empowerment and books such as Getting Free: A Guide for Women in Abusive Relationships (see Bibliography). Offer data, i.e., violence tends to escalate and increase in severity and frequency over time. Urge women to join support groups.

II. EXPLORING HER OPTIONS AND ADVOCATING FOR HER SAFETY

A. Insure that she is fully informed of her shelter, legal and welfare options. Refer her immediately to battered women's programs that are knowledgeable about her rights or, if these agencies do not exist in your community, take the time to learn about her rights so that you can help her explore alternatives carefully.

Battered Women's Shelters and Safe Homes

- * Does she know about shelters?
- * What has she heard about them and what have her experiences been?
- * Will she call the hotline?
- * Can the practitioner and the shelter staff help her get to services safely?
- * Does she need to use a shelter in another county or state because the abuser is so dangerous?
- * Can the practitioner provide transportation to a shelter?
- * What other housing options does she have?
- * If she left her home in the past, where did she go? Was this helpful? Was she safe? Will she be safe if she goes there again?

The Criminal Justice System

- * Are there protective orders available for battered women in your state that may help her?
- * Can the assaultive person be evicted from the home under these orders and is it safe and empowering for her to use this kind of legal remedy?
- * Is the abuser currently violating an order for protection or other criminal or civil court orders?
- * Does she want him arrested?
- * Can you, the practitioner, advocate for her in court, write a letter to the court or find her an advocate so that she does not have to go to court alone?

The Welfare System

- * Is she receiving any form of welfare benefits?
- * Does she know that she may be entitled to benefits?
- * Can the practitioner or an advocate help her secure them?
- * Is there a pending child abuse petition in court?
- * Can the practitioner be an advocate for her with child protective services and the court?

B. Design safety plans with battered women

The practitioner should conduct a lethality assessment with every battered woman. Although we cannot predict lethality by past conduct, the following assailant behaviors, especially in a cluster, should lead the practitioner to warn the woman and see that she has a safety plan.

- * The abuser's threats and fantasies about homicide and suicide. A history of homicide and suicide attempts.
- * Depression and situational stresses, such as job loss, that exacerbate a depression.
- * Weapons possession or past use of weapons.
- * Obsession about the partner, i.e., "I can't live without her;" and centrality of the victim to the batterer's life. Is the batterer so isolated that her loss represents a sense of hopelessness about the future?
- * Rage over her leaving.
- * Drug and alcohol consumption in a state of fury and depression.
- * Access to the battered woman.
- * Hunting the woman down and continually harassing her.
- * Escalation of the abuser's threats and violence.

The practitioner cannot keep confidentiality if the abuser threatens harm or violence. Every effort must be made to inform the potential victim, the police and the local program for battered women when harm is threatened.

It is important to tell every battered woman that you are concerned about her safety and plan together for her protection. Remember that she is an expert about her batterer and that she, not you, must live with her choices. Do not choose for her. Rather, help her assess her options and the consequences of her decisions. Ask some of the following questions as you discuss safety:

- * How can we help insure safety? What does she feel she needs in order to be safe?
- * Can you, the practitioner, safely call her? How does she want you to identify yourself? What should you do if the batterer answers the phone?
- * What does she think the batterer will do if she leaves, or gets a protective order?
- * If she moves, can she prevent his finding her by making long distance phone calls from your phone, asking the new school system, the court or welfare center not to reveal her address?

When battered women choose to live with their partners, safety is still a priority.

- * Would she find a protective order helpful? Does she know how to have it enforced?
- * If she senses that the violence might escalate, can she leave for a few days? Does she have a place to go and the phone numbers for shelters?
- * If she has a car, has she hidden a set of keys? If she has any money, can she hide it in case of emergency?
- * Can she run to a neighbor's house or work out a signal so that the neighbor calls the police?

III. BUILDING ON HER STRENGTHS AND AVOIDING VICTIM-BLAMING

Battered women are complex human beings with many hopes and dreams. The practitioner should help a woman plan for her life. What does she envision for the future? Does she want to go back to school or get a job? What are the steps she needs to take to realize her dreams? Will she be safe if she acts?

Battered women are also not passive recipients of abuse. Rather, they constantly try to stop the violence and protect themselves and their children. Their thoughtfulness is often invisible to the outsider because frequently, in the face of erratic and irrational assault, it is best to proceed very cautiously. Even talking to you, the practitioner, may set off another round of attacks.

The practitioner's job is to build on battered women's experiences, ideas, resources and support systems. Acknowledge a woman's strengths, the specific ways she has protected herself or her children, methods she used to leave the abuse or maintain her sanity, the courage she demonstrated by telling you about the violence or calling for help.

Do not ask questions that are victim-blaming, e.g. "What keeps you with a person like that? Do you get something out of the violence? What did you do at that moment that caused him to hit you? What could you have done to de-escalate the situation? Is there any way you participate in the escalation of the violence?"

IV. RESPECTING HER RIGHT TO SELF-DETERMINATION

Battered women are adults who are making difficult choices during crises. Abused women face multiple material and emotional losses - the loss of a relationship and the comforts of home, disruptions for the children, the shame of admitting abuse, the exhaustion that comes from living in constant fear. Because the abuser strips away the woman's sense of control and dignity, the practitioner must work to restore this control:

1. Allow abused women to make decisions for themselves. Do not bully them or mandate conditions for your help, i.e., "you must prosecute your partner; you should leave him."

2. Recognize that some battered women leave and return to their partners several times. This is not a failure. Women return because it is difficult to find housing and jobs; they return out of fear, love, loneliness, poverty or concern for the children. Sometimes they are pressured relentlessly by family and friends. Once they leave, they can do it again, if they choose to.

3. Allow women to take about their ambivalence toward their abuser. No one gives up a relationship without a struggle.

4. Accept that each woman must find solutions that she can live with. For example, some women find divorce unacceptable. Black, Latina and Native women may feel conflicted about using a racist criminal justice system. For some Asian and Latina women, it is not an option to leave their abuser and move to a new community or a shelter where no one speaks their language or understands their culture.

5. Always ask questions like, "In what way can I be helpful to you?" "What do you want to do?" Listen carefully to her request and try to respond to it.

6. Examine your expectations for her. Frequently we urge battered women to change their lives overnight and this is often impossible. The practitioner's success should not be measured by the woman's leaving her partner. It is a victory that she can talk to you about the violence and start to make plans for her life. Respect her pace in this process.

TABLE

Guidelines for Battered Partners of Domestic Violence

BEFORE AN ATTACK

Make contacts. Read this sheet and contact a domestic violence agency to find out what to do the next time your partner becomes violent.

Have quick access to: A phone, cash, clothing, and important items such as: car title and keys, birth certificates, apartment lease, marriage license, Public Aid I.D. and medical cards, records of partner's income, a list of phone numbers to call for shelter or transportation, credit cards, blank checks, and bank books. Keep an emergency kit, the keys, cash, and essential papers in an old purse or small container so that you can grab it easily and quickly before leaving.

DURING AN ATTACK

Defend and protect yourself.

Call for help. Scream loudly and continuously. You do not need to be ashamed.

Get away. Escape if you can. Go to a relative's or friend's house or shelter.

Call the police. The police must now attempt to protect you from further abuse. They are required to provide or arrange transportation to a hospital or safe place, and are encouraged to arrest your abuser if they have enough evidence of a crime. (This last provision applies only in certain states.)

AFTER AN ATTACK

Seek medical attention immediately. Tell the doctor or nurse what happened and ask them to take pictures of your injuries. Find out how to get copies of records.

Make a police report. This should be done even if you do not want your abuser arrested. The abuser will not be notified you made the report. Complete report within 24 hours if possible.

Save evidence. Include copies of medical records and police reports, dated photographs of your injuries or the house in disarray, torn clothing, any weapons used, and statements from anyone who heard or saw the attack.

Talk to someone. Find out about the legal remedies now available through a Domestic Violence Order of Protection and choices open to victims.

ORDER OF PROTECTION

Get a written court order. This requires abusive household or family members to do or not do certain things such as: forbidding further abuse, ordering the abuser out of the shared home for a period of time, keeping the abuser away from the victim's place of employment, schools, or other specified places. It may also prohibit child snatching, and require counseling for abusers, and other relief as needed. (Consult the Domestic Violence Act in your state and get specific information in your locality.)

From the Handbook for Domestic Violence Victims by the Illinois Coalition Against Domestic Violence, 1986, Chicago, IL: Illinois Criminal Justice Information Authority. Adapted by permission.

APPENDIX F
EVALUATION OF PRESENTATION

Evaluation of Presentation

Please check the correct response to the following questions regarding the presentation on battered women:

	No	Some	Yes
1. Did the presentation meet the objectives?.....	---	-----	---
2. Did the presentation meet your personal objectives?.....	---	-----	---
3. Was the presentation given in a stimulating and attention holding manner?.....	---	-----	---
4. Was the presentation clear and easily understood?.....	---	-----	---
5. Did the presentation provide information that can be applied to your current work situation?.....	---	-----	---
6. Did the presenter encourage questions from participants?.....	---	-----	---
7. Did the presenter listen to participants ideas and experiences?.....	---	-----	---

What part did you find most useful?

What part did you find least useful?

Suggestions for improvement of presentation?