

WRITING A MANUSCRIPT FOR PUBLICATION: INFORMING ADVANCED
PRACTICE NURSES ABOUT ROUTINE SCREENING FOR INTIMATE
PARTNER VIOLENCE IN RURAL HEALTH CARE SETTINGS

by

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A professional paper submitted in partial fulfillment
of the requirements for the degree

of

Master

of

Nursing

MONTANA STATE UNIVERSITY
Bozeman, Montana

April 2013

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Jacqueline Helene Moen-Leibrand

April 2013

DEDICATION

My Mom
Linda Lee Hall
The Most Beautiful Girl
In The World

ACKNOWLEDGEMENTS

I have taken many efforts in this project. However, it would not have been possible without the support and help of many individuals. I would like to express my gratitude to all of them.

I would like to thank my committee members, Patricia Holkup, Laura Marx, and Susan Raph for providing support, expertise, and guidance throughout my writing journey. I am highly indebted to my committee chair Patricia Holkup for giving me the most precious gift of all which is ‘time’. Thank you for your patience and devotion in overseeing this project to completion. Enjoy your next journey, you deserve it.

A special thanks to my editor and writing coach, Mary Averill, who inspired me with hope, even in the face of hopelessness. I do not think I could have done it without you.

To my family, I would like to express my gratitude to my kind parents, supportive sister, joyful nieces, and supportive family and friends who always wished me success.

Finally, yet importantly, I would like to thank my husband, Todd, for wiping away my tears, making me laugh, providing words of encouragement, and pushing me to believe in myself. Without you I would still be just ‘thinking’ about going back to school. We did it honey, nothing but blue skies coming our way.....

I Have Neglected So Many

Please Forgive Me

And Celebrate This Glorious Day

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ABSTRACT

Millions of women in the United States experience intimate partner violence (IPV) which can lead to devastating physical and psychological problems. Intimate partner violence is the leading cause of injury to women of childbearing years. Approximately 1200 women are murdered every year by their husband or boyfriend. Children who witness IPV are 3 times more likely to be abused than children who do not witness IPV. The economic burden to the individual and society as a whole are enormous. Despite endorsements by several health care and professional organizations, only 10% of healthcare providers screen for IPV routinely. The Centers for Disease Control and Prevention (CDC) estimates the costs of IPV to society are over 8 billion dollars each year. Advanced Practice Nurses (APNs) working in rural primary care settings face unique challenges to routine screening for IPV including geographical and social isolation, limited IPV resources, and a culture that values self-reliance and may normalize IPV. The purpose of this project is to write a manuscript that is suitable for publication which will identify strategies for the successful implementation of routine IPV screening in rural primary care settings.

CHAPTER I

INTRODUCTION

Intimate partner violence (IPV) is a universal, preventable, and pervasive public health problem in our society which knows no boundaries of class, culture, gender, religion, geography, or education (Black et al., 2011; Boyle, Georgiades, Cullen, & Racine, 2009; Coyer, Plonczynski, & Baldwin 2006; Zolotor, Denham & Weil, 2009). Intimate partner violence is estimated to affect up to six million women in the United States each year with enormous financial consequences to the victims and to society (Black et al., 2011; Elliott, Nerny, Jones, & Freidmann, 2002; Rennison, 2003; Rivara et al., 2007; Rodriguez, Bauer, Mcoughlin, & Grumbach, 1999; Snow et al., 2006). Abused women may experience health consequences that result in life long mental and physical health problems (Black et al., 2011; Boyle et al., 2009; Campbell, 2002; Coker et al., 2007; Coyer et al., 2000; Ellsberg et al., 2008; Plitcha, 2004; Snow et al., 2006). Intimate partner violence has been defined as:

A pattern of assaultive and coercive behaviors that may include inflicted physical injury, psychological abuse, sexual abuse, progressive isolation, stalking, deprivation, and threats. These behaviors may be perpetrated by someone who is, was, or wishes to be in an intimate or dating relationship with an adult or adolescent, and are aimed at establishing control by one partner over the other. (Family Violence Prevention Fund, 2004, p. 2)

In primary care settings in general, only 10% of women are screened for IPV (Elliot et al., 2002), and rural areas face even more challenges for the provision of IPV screening. This manuscript will improve knowledge about intimate partner violence screening as well as provide useful information that will improve screening practices in

the rural primary care settings. The next section includes a brief review of literature, background and significance, summary of the problem, purpose statement and an outline of the guiding framework.

Literature Review

A comprehensive review of the literature (ROL) was completed using Montana State University's Online Library, MEDLINE, CINAHL, Web of Science, Google Scholar, PsycINFO, ProQuest, Wiley Online Library, Science Direct and reference lists of selected articles. The search terms included intimate partner violence, routine screening, advanced practice nursing, rural, primary care setting, universal screening, barriers; health consequences, disclosure, health care providers, and domestic violence. The literature collected was mainly from 2000 until present with a few exceptions for relevant literature in the 1990s. A limited amount of literature exists in the area of rural advanced practice' screening practices. For this reason, the literature was expanded to include all health care providers and various health care settings.

Background and Significance

Intimate partner violence is recognized by leading health care organizations as a serious public health problem affecting millions of people in the United States. According to the National Intimate Partner and Sexual Violence survey, women account for the majority of IPV cases (Black et al., 2011). In fact, 85% of all IPV cases are women (CDC, 2012; Family Violence Prevention Fund, 2004). The CDC (2012) stated

that non-fatal IPV rates are up to four times higher in women than men. Almost 8 million women have been sexually assaulted by their intimate partner in their lifetimes (CDC, 2012; National Coalition Against Domestic Violence, 2011). Prevalence studies have found lifetime IPV incidence rates for women are between 25% and 50% (Bonomi et al., 2006; Breiding, Black, & Ryan, 2008; Humphreys, Tsoh, Kohn, & Gerbert, 2011; Thompson et al., 2007; Kramer, Lorenzon, & Mueller, 2003). In 2012, the CDC reported that 4.8 million women are physically assaulted and raped each year by an intimate partner. The National Coalition Against Domestic Violence (2011) reported that the most serious injuries to women are a result of IPV and 50% of all female homicides are committed by an intimate partner. Intimate partner violence by a husband or boyfriend claims three lives every day (American Psychological Association (APA, 2013). On average, 1200 women are killed each year by their boyfriend or husband (APA, 2013; CDC, 2012).

The economic burdens of IPV for society and victims are enormous with health care costs exceeding 8 billion dollars annually (Black et al., 2011; CDC, 2012; Max, Rice, Bardwell, & Leadbetter, 2004; Rivara et al., 2007). Victims of IPV utilize the health care system more often, incurring higher annual health care costs than non-victims (CDC, 2003; Littleton, Berenson, & Breitkopf, 2007; Snow et al., 2006; Ulrich et al., 2003). Even when the IPV victim survives and the abuse stops, health care costs often persist due to ongoing physical and mental health problems (CDC, 2003; Littleton et al., 2007; Rivara et al., 2007; Ulrich et al., 2003).

Numerous studies have consistently shown that abused women have higher rates of physical and mental health problems as well as substance abuse disorders than non-abused women (Dillon, Hussain, Loxton, & Rahman, 2013; Fischbach & Herbert, 1997; Garimella, Plichta, Houseman, & Garzon, 2000; Plitcha, 2004). Victims of IPV also engage in more unsafe behaviors, such as unprotected sex, multiple sex partners, and self-harm behaviors than non-abused women (Bonomi, et al., 2006; CDC, 2012; Kramer et al., 2003; Plitcha, 2004). Rural areas also face limited services regarding substance abuse and mental illness which places them at higher risk for victimization.

The exposure of millions of children to violence in their homes every day can cause long-term negative health outcomes for them as adults (CDC, 2012; Falsetti, 2007; Felitti, 2002; Hamby, Finkelhor, Turner, & Ormond, 2011; McFarlane, Groff, O'Brien, & Watson, 2003). It is estimated that over 15 million children in the United States witness IPV annually (McDonald, Jouriles, Ramisetty-Mikler, Caetano, & Green, 2006). Children exposed to IPV are at much greater risk for physical, behavioral, and mental health problems than children who don't witness IPV (Falsetti, 2007; Hamby et al., 2011). The risk of child abuse is 3 times higher in families with IPV (APA, 2013; Appel & Holden, 1998; Family Violence Prevention Fund, 2012).

Intimate Partner Violence Screening

Although intimate partner violence affects approximately 50% of women at some time in their lives and has been deemed a public health crisis, researchers suggest that the healthcare industry is not identifying or addressing IPV (APA, 2013; Elliot et al., 2002;

Stinson & Robinson, 2006). Elliott et al. (2002) reported that only 10% of health care providers screen for IPV. Various reasons have been cited for healthcare providers' lack of addressing and identifying IPV, including a lack of IPV education, limited awareness of community resources, time constraints, fear of offending the patient, forgetfulness, and lack of clear guidelines and screening tools (Elliot et al., 2002; Hughes, 2010; Kramer et al., 2003; Stinson & Robinson, 2006). Unless solicited, victims of IPV will rarely volunteer that they have been abused (Ulbrich & Stockdale, 2002).

Several organizations including the American Medical Association (AMA), American Psychological Association (APA), American Academy of Nurse Practitioners (AANP), American Academy of Family Physicians (AAFP), the American College of Obstetrics and Gynecology (ACOG), American Nurses Association (ANA), American Academy of Pediatrics (AAP), American College of Nurse Midwives, Institute of Medicine (IOM), United States Preventive Task Force (USPSTF), Institute of Medicine (IOM) and the Joint Commission on the Accreditation of Healthcare Organization (JCAHO) have all implemented IPV screening guidelines, yet screening rates remain low (Family Violence Prevention Fund, 2012). The World Health Organization 2002 report recommended that all healthcare providers receive training about IPV so they are able to identify IPV and provide appropriate interventions (Krug et. al., 2002). Victims of IPV reported that being asked about IPV in a caring non-judgmental way was one of the most important factors when it came to disclosure (Liebschutz, Battaglia, Finley, & Averbuch, 2008). Between 70 to 80% of IPV victims want their health care provider to screen for abuse during their appointments (Elliot et al., 2002). Intimate partner violence often

goes undetected because health care providers are not routinely screening for IPV (Elliot et al., 2002).

Rural Environment

Rural settings face several unique challenges with respect to IPV when compared to non-rural settings. Some of the challenges include isolation, fewer employment opportunities, less education, lower income levels, and higher unemployment rates (Annan, 2008; Evanson, 2006; Gallup-Black, 2005; Gamm, Graciela, & Pittman, 2003; Grama, 2000; Lanier & Maume, 2008; Logan et al., 2003; Websdale, 1998; Ulbrich & Stockdale, 2002). The obstacles of confidentiality and anonymity are concerns in small communities where gossip can spread quickly (Annan, 2008; Coker et al., 2007; Evanson, 2006; Websdale, 1998; Wendt, 2008). In rural areas there are often overlapping relationships that may prohibit victims from reporting abuse to law enforcement or healthcare providers out of shame or fears of breaches in confidentiality (Annan, 2008; Coyer et al., 2006; Evanson, 2006; Gallup-Black, 2005; Websdale, 1998). Other obstacles include long distances to services, lack of public transportation, limited IPV services, and healthcare shortages (Annan, 2008, Evanson, 2006; Gallup-Black, 2005; Lanier & Maume 2008; Ulbrich & Stockdale, 2002; Websdale, 1998).

More and more physicians are leaving the primary care setting for more profitable specialties, which leaves the nurse practitioner with an emerging role in the rural primary care setting (National Conference of State Legislatures, 2011). Nearly half of all rural health care providers are non-physician practitioners (National Conference of State

Legislatures, 2011). The growing number of rural APNs must be provided with the insight, knowledge, and benefits of routine IPV screening.

Routine screening has the potential to play a pivotal role in decreasing rates of mortality and morbidity which result from IPV (Family Violence Prevention Fund, 2004; Plitcha, 2004). Routine screening is essential to aid the APN with identifying and providing resources to the IPV victim (Bryant & Spencer, 2002; Johnson, 2006). Since most women in rural areas receive their health care in primary care settings, APNs play a critical role in identifying IPV through diligent screening practices (Asher, Crespo, & Sugg, 2001; Gamm, Castillo & Pittman, 2003; Rhodes et al., 2007).

Problem Statement

A lack of research exists that focuses on APNs' IPV screening practices in rural primary care settings. Most of the available literature focuses on urban settings and targets physicians' views and practices. For this reason, this manuscript will target the APN working in the rural primary care setting, since this is an under-researched area of study.

Millions of women are affected by intimate partner violence in the United States each year and it has been associated with a multitude of negative physical and psychological health conditions (CDC, 2012). The literature estimates that only 10% of providers routinely screen for IPV despite the numerous endorsements by professional healthcare organizations (Elliot et al., 2002; Waalen et al., 2000). A growing number of APNs working in the rural primary care setting are faced with the challenge of improving

IPV screening rates in order to recognize IPV. At some point every APN will face a victim of IPV and with the proper education they can help or even save lives by simply asking about IPV.

Project Purpose

The purpose of the manuscript will be to improve knowledge and awareness of intimate partner violence screening for rural APNs. The goal of this manuscript will be to provide useful information to the rural APN about the importance of screening and ultimately recognizing IPV. In addition, the rural APN will feel more prepared and qualified to identify IPV and ultimately provide resources to IPV victims.

Guiding Framework

The process of writing a journal article is complex with several imperative steps along the way. The use of a writing guide provides valuable information that can improve one's chances for successful publication. The work of Belcher (2009), *Writing Your Journal Article in 12 Weeks: A Guide to Academic Publishing Success*, is highly recommended for its pragmatic and goal-oriented focus (M. B., personal communication, October 1, 2012). Belcher (2009) designed this workbook with input from hundreds of scholarly writers over a ten-year period. Belcher stated, "My aim is to help graduate students and junior faculty understand the rules of the academic publishing game so they can flourish, not perish" (p. xii). Belcher's (2009) step-by-step weekly outline is located in (Appendix A).

CHAPTER 2

METHODS

This methods section is based on the works of Belcher (2009) and Heinrich (2009) and will include the topics of target audience, journal selection, manuscript writing, individual writing challenges and a writing schedule. Please see the Guiding Framework section for Belcher's 12-week outline in (Appendix A) and the proposed content outline in (Appendix B). First, Heinrich (2009) discussed the "four S's" when writing for publication as

Shift your perspective: Think of publication writing in a new context. Not one of selfishness, but an act of generosity. Self-reflect: View your experiences as potential topics for writing. Specify essentials: Consider four elements before beginning to write. The four essentials are to focus on a single idea, to address a particular group of people, to appear in a publication that this group reads, and to open with an irresistible slant. The equation below incorporates the four essentials: Idea + Readers + Vehicle + Slant = Great article. Seek support: Having a positive support system is essential when writing for publication. A support system provides knowledge, ideas, encouragement, editing and a peer-review before final submission. (p.12)

Target Audience

This manuscript will focus on the growing number of APNs who work in the rural primary-care settings.

Journal Selection

Selecting a journal is as critical as selecting a topic. According to Belcher (2009) the author should become familiar with the journal. One should consider at least six questions:

- Is the journal reputable?
- Can I meet the journal requirements?
- Does this journal target my desired audience?
- Will the journal consider my topic?
- Is it peer-reviewed?
- How long will it take to find out if the article is going to be published?

Many professors discourage beginning writing until after a journal is selected. This helps ensure the author guidelines are met. Usually, one can only submit to one journal at a time. Therefore, in order to save time, doing one's homework for the appropriate journal is critical. Once a person has narrowed the potential journals down to two or three, s/he should start corresponding with the journal's editor. This will assist the author's journal selection, based on the editor's feedback (Belcher, 2009). Journals have a section for writers called "author requirements" which provides information about the journal, style requirements, formatting guidelines and details on the submission process. This section is a good tool to utilize when selecting a journal appropriate for one's manuscript. The *Online Journal of Rural Nursing and Health Care* was selected for this proposed manuscript based on the journal's content, target audience, type (peer-

reviewed), and author requirements. Author requirements can be found in (Appendix B) and query e-mails to the editor can be located in (Appendix C).

Strengths and Barriers to Manuscript Writing

The literature reports that nurses lag behind other professions when it comes to writing articles for publication (Heinrich, 2009). Other professionals view writing as a responsibility and generosity to move their profession forward (Heinrich, 2009). Nurses feel like they get mixed messages about academic writing. For instance, Heinrich (2009) stated:

Tell your stories, but don't stand out or call attention to yourself, these messages seem to say. Don't write too much about what you do, or you'll be seen as selfish in a caring profession. With writing for publication eliciting more criticism than kudos from colleagues, no wonder so many nurses silence themselves. (p. 11)

Other barriers include time, mentorship, institutional preparation, rejection, motivation and lack of confidence in one's writing abilities (Belcher, 2009).

Nurses have a wealth of knowledge in large part due to first-hand experience. Nurses should share their insights and knowledge to ensure continued growth within the nursing profession (Mee, 2003). Writing for publication provides an opportunity for nurses to share their knowledge, insights, and experiences with a large audience (Heinrich, 2009) The dissemination of knowledge through writing adds to the body of nursing literature and professionalism (Heinrich, 2009). With over 100 nursing journals, a constant need exists for quality manuscripts (Heinrich, 2009). Finally, publication writing provides a sense of personal fulfillment, as well as professional recognition (Mee, 2003).

Writing Challenges

A critical aspect of writing is maintaining a writing schedule. Organizing and managing writing, working, clinical hours, homework, family, everyday tasks and unexpected events can be difficult. Another problem is a tendency for writers to get lost in the literature. Many hours, days, months can be spent going from article to article. This tendency can be a result of feeling the need to have complete mastery of a topic as well as to delay the actual writing process (Heinrich, 2009). According to Heinrich (2009), many people can't get started, thus they fail before they even begin.

Writing Schedule & Supports

Belcher's (2009) workbook provides the structure and plan for overcoming many writing limitations. The workbook provides a systematic, 12-week writing plan. A significant goal of the workbook is to set up a writing schedule in order to set deadlines and meet goals. A calendar with daily specific tasks and estimated task times should be created to reach goals (Belcher, 2009). Belcher warns not to become overly distressed if all goals are not met. Inevitable setbacks must not halt the entire writing process (Belcher, 2009). The writer must forge ahead with new goals in order to complete the journal article (Belcher, 2009).

In addition, working closely with a professional editor and writing coach provides editorial skills and support. Graduate writing centers can also be helpful and provide editorial support at no cost. Finally, maintaining a close working relationship with one's

committee chair and members is imperative to help produce a manuscript suitable for publication.

Making a plan for writing may be the most critical component for writing a journal article in 12 weeks. A writing plan will help ensure meeting goals and deadlines that will facilitate completion of the manuscript. Finally, targeting and meeting the author requirements for a journal is essential for consideration, which can ultimately lead to successful publication.

CHAPTER 3

BREAKING BARRIERS: INTIMATE PARTNER VIOLENCE
SCREENING IN THE RURAL PRIMARY CARE SETTING

Contribution of Authors and Co-Authors

Manuscript in Chapter 3

Author: Jacqueline L. Helene Moen-Leibrand, BSN, RN

Contributions: Conceived and implemented the project design. Reviewed and summarized relevant scientific literature. Explored nursing health care journals and selected the most appropriate journal for targeted audience. Served as corresponding author. Wrote all drafts of the manuscript.

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Manuscript Information Page

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Publisher: The Online Journal of Rural Nursing and Health Care

Status of Manuscript:

Prepared for submission to a peer-reviewed journal

Officially submitted to a peer-review journal

Accepted by a peer-reviewed journal

Published in a peer-reviewed journal

Moen-Leibrand, J. L., Holkup, P. A., Marx, L., & Raph, S. (2013). *Breaking Barriers: Routine Screening for Intimate Partner Violence in the Rural Primary Care Settings*. Manuscript submitted for publication April 15, 2013.

Abstract

Intimate partner violence (IPV) impacts millions of people in the United States and has been recognized as an important public health problem that can lead to chronic and devastating physical and psychological health conditions. The economic burden to the individual and society as a whole are enormous. Despite endorsements by several health care and professional organizations, only 10% of healthcare providers screen for IPV routinely. The United States Preventive Services Task Force (USPSTF) recently changed their 2004 recommendations, which did not support routine screening, to a recommendation of screening all women of child-bearing years. The decision was based on an updated literature review in 2012, which concluded that asymptomatic women should be screened routinely in the health care setting for IPV. These new recommendations could have significant influence on the identification of IPV, because many clinicians look to the USPSTF for evidence-based recommendations about clinical preventive services such as screenings. A growing number of advanced practice nurses (APNs) are working in the rural primary care setting and face the challenge of implementing routine IPV screening despite the challenges of the rural environment, such as lack of IPV services and geographical isolation. At some point every APN will face a victim of IPV and with proper education, training, and implementation of routine screening APNs have the chance to provide thousands of women with an opportunity to receive interventions.

Introduction

Intimate partner violence (IPV) is a universal, preventable, and pervasive public health problem in our society which knows no boundaries of class, culture, gender, religion, geography or education (Black et al., 2011; Boyle, 2009; Coyer, Plonczynski, & Baldwin 2006; Zolotor, Denham & Weil, 2009). Intimate partner violence is estimated to affect up to six million women in the United States each year with enormous financial consequences to the victims and to society (Black et al., 2011; Elliott, Nerny, Jones, & Freidmann, 2002; Rennison, 2003; Rivara et al., 2007; Rodriquez, Bauer, Mcoughlin, & Grumbach, 1999; Snow et al., 2006). Abused women may experience health consequences that result in acute and/or chronic psychiatric and physical problems (Black et al., 2011; Boyle et al., 2009; Campbell et al., 2002; Coker et al., 2007; Coyer et al., 2006; Ellsberg et al., 2008; Plitcha, 2004; Snow et al., 2006). The term intimate partner violence has been defined as:

A pattern of assaultive and coercive behaviors that may include inflicted physical injury, psychological abuse, sexual abuse, progressive isolation, stalking, deprivation and threats. These behaviors may be perpetrated by someone who is, was, or wishes to be in an intimate or dating relationship with an adult or adolescent, and are aimed at establishing control by one partner over the other. (Family Violence Prevention Fund, 2004, p. 2)

Intimate partner violence prevalence rates for urban and rural areas are similar, however inconsistencies in data exist (Coker et al., 2007; Logan et al., 2003; Ulbrich & Stockdale, 2002). The rural environment and the limited IPV research in rural settings are

barriers to the accurate reporting of IPV (Coker et al., 2007; Coyer et al., 2006; Gama 2000; Gallup-Black, 2005; Ulbrich & Stockdale, 2002; Websdale, 1998). Despite similar prevalence rates in rural and urban settings, studies have found that both severity and lethality rates are actually higher in rural communities (Coker et al., 2007; Evanson, 2006; Wendt, 2008). Increased rates of gun ownership (Zolotor, Denham, & Weil, 2009; Wendt, 2008), limited services, lack of public transportation, and distance to emergency care, are all thought to contribute to the increased morbidity and mortality rates in rural settings (Adler, 1996; Coyer et al., 2006; Peek-Asa et al., 2011; Tjaden & Thoennes, 2000; Websdale, 1998; Wendt, 2008).

Abused women utilize the health care system more frequently than non-abused women, giving health care providers many opportunities to recognize and assist victims of IPV (Family Violence Prevention Fund, 2012; Feder, Hutson, Ramsay & Tacket, 2006; Plitcha, 2004; Rivara et al., 2007; Snow et al., 2006; Ulrich et al., 2003; Wilson et al., 2007). Estimates are that between 30% and 40% of women seek treatment as a result of IPV in the primary care setting (Chang et al., 2010; Coker et al., 2007; Peralta, Michael, & Fleming, 2003; Rodriguez et al., 1999). Despite increased exposure to IPV, victims are not being identified in the rural health care setting (Black et al., 2011; Coker et al., 2007; Stenson & Clayton) due to inconsistent IPV screening practices across all medical areas, including the primary care setting (Coker et al., 2007; Rodriguez et al., 1999; Stenson & Clayton,). The provision of IPV screening in rural areas is even more challenging for the rural advance practice nurse (APN) due to the limited IPV resources, geographical isolation, social isolation, and cultural influences (Breiding, Ziembroski, &

Black, 2009; Coyer et al., 2006; Johnson, 2000; Tjaden & Thoennes, 2000; Wendt, 2008).

This article will review the most updated IPV screening recommendations by the USPSTF and other leading professional healthcare organizations. The information will improve knowledge and provide useful information about IPV and the importance of screening and ultimately recognizing IPV, with the goal of helping the rural APN feel better prepared to identify IPV and ultimately provide interventions to rural IPV victims.

Relevant Literature

Intimate partner violence impacts millions of people and is recognized as an important health problem all over the world (Centers for Disease Control and Prevention (CDC, 2012). Studies indicated that between 25% and 50% of all women in the United States have experienced IPV at some point in their life (Breiding et al., 2008; Humphreys et al., Thompson et al., 2007; Kramer, Lorenzon, & Mueller, 2003). According to the National Intimate Partner and Sexual Violence survey, women account for the majority of IPV cases (Black et al., 2011). In fact, 85% of all IPV cases are women (CDC, 2012); Family Violence Prevention Fund, 2004). The CDC (2012) stated that non-fatal IPV rates are up to 4 to 6 times higher in women than men. Almost 8 million women have been sexually assaulted by their intimate partner in their lifetimes (CDC, 2012; National Coalition Against Domestic Violence, 2011). In 2012, the CDC reported that 4.8 million women are physically assaulted and raped every year by an intimate partner. The National Coalition Against Domestic Violence (2011) reported that the most serious

injuries to women are a result of IPV and 50% of all female homicides are committed by an intimate partner. Intimate partner violence by a husband or boyfriend claims three lives every day (American Psychiatric Association (APA, 2013). On average, 1200 women are killed each year by their boyfriend or husband (APA, 2013; CDC, 2012).

The literature supports the devastating effects of IPV to the individual, family, and society as a whole. Many professional health care organizations such as the (American Medical Association (AMA), American Psychiatric Association (APA), American Academy of Nurse Practitioners (AANP), American Academy of Family Physicians (AAFP), the American College of Obstetrics and Gynecology (ACOG), American Nurses Association (ANA), American Academy of Pediatrics (AAP), American College of Nurse Midwives, Institute of Medicine (IOM), and Joint Commission on the Accreditation of Healthcare Organization (JCAHO) all recommend and have implemented IPV screening guidelines, yet screening rates remain low (Family Violence Prevention Fund, 2012). One barrier has been the 2004 USPSTF recommendation that did not support routine IPV screening. However, after a recent clinical review, the USPSTF (2012) recommended “clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services”(p.1). The updated USPSTF recommendation for routine IPV screening will hopefully improve screening rates and the subsequent identification of IPV victims.

Consequences of IPV

The economic burdens of IPV for society and victims are enormous (Black et al., 2011; CDC, 2012; Snow et al., 2006). The financial costs to the healthcare system are devastating, with estimated health care costs at 8.3 billion dollars annually (Black et al., 2011; CDC, 2012; Max, Rice, Finklestein, Bardwell, & Leadbetter, 2004; Rivara et al., 2007). The largest portion of IPV costs come from physical assaults, because they are the most prevalent (Black et al., 2011). Intimate partner violence victims miss 8 million days of work or what equals 32,000 full-time jobs, as well as 5 million days of household productivity (CDC, 2012). Women also lose daily earnings due to time away from work to recover from violence (CDC, 2012). Victims of IPV utilize the health care system more often, incurring higher annual health care costs than non-victims. (CDC, 2003; Littleton, Berenson, & Breitkopf, 2007; Snow et al., 2006; Ulrich et al., 2003). Even when the IPV victim survives and the abuse stops, health care costs often persist due to ongoing physical and mental health problems (CDC, 2003; Littleton et al., 2007; Rivara et al., 2007; Ulrich et al., 2003).

Numerous studies have consistently shown that IPV is detrimental to a women's physical and psychological health (Bonomi, Thompson & Anderson, CDC, 2012; Boyle, 2009; Campbell, 2002; Chang et al., 2010; Coker et al., 2002; Ellsberg et al., 2008; Fischbach & Herbert, 1997; Johnston, 2006; Kramer, Lorenzon, & Mueller, 2008; Plitcha, 2004; Wilson et al., 2007). The literature supports increased rates of mortality, injuries, headaches, sexually transmitted infections, trauma, reproductive disorders, back pain, abdominal pain, cardiovascular diseases, digestive problems, urinary tract

infections, and chronic pain for victims of IPV (Bonomi et al., 2007; Boyle et al., 2009; Campbell, 2002; CDC, 2012; Chang et al., 2010; Coker et al., 2007; Kramer et al., 2003; Plitcha, 2004; Wilson et al., 2007). Victims of IPV also have higher rates of anxiety, depression, somatization, PTSD, insomnia, and suicidal behaviors (Bonomi et al., 2007; CDC, 2012; Chang et al., 2010; Coker et al., 2002; Kramer et al., 2003). Advance Practice Nurses need to be aware that pregnancy is an especially vulnerable time for IPV, with a 6% increase in prevalence rates, as well as the leading cause of maternal death (Family Violence Prevention Fund, 2004; Johnston, 2006). Women with histories of IPV display more unhealthy behaviors such as tobacco use, substance abuse, alcoholism, eating disorders, and suicide attempts than women without histories of IPV (Coker et al., 2002; Fiscbach & Herbert, 1997; Garimella, Plichta, Houseman, & Garzon, 2000; Kramer, et al., 2003; Plitcha, 2004). Victims of IPV engage in more unsafe behaviors, such as unprotected sex, multiple sex partners, and self-harm behaviors than non-abused women (Bonomi, Thompson & Anderson, 2006; CDC, 2012; Kramer et al., 2003; Plitcha, 2004).

The exposure of millions of children to violence in their homes every day can cause long-term negative health outcomes for them as adults (CDC, 2012; Feletti, 2002; Falsetti, 2007; Hamby, Finkelhor, Turner, & Ormond, 2011; McFarlane, Groff, O'Brien, & Watson, 2003). McDonald, Jouriles, Ramisetty-Mikler, Caetano, and Green (2006) have estimated that over 15 million children in the United States witness IPV annually. Children who witness IPV are at much greater risk for physical, emotional, and mental health problems than children who don't witness IPV (Feletti, 2002; Falsetti, 2007;

Hamby et al., 2011). The risk of child abuse is 3 times higher in families with IPV (Appel, 1998; Family Violence Prevention Fund, 2012). Additionally, 50% of children who witness IPV will go on to be physically and or sexually abused (Bohn & Holz, 1996; Hamby et al., 2011). Children who are victims or who witness IPV are 4 to 6 times more likely to experience IPV in adulthood (Falsetti, 2007). Children who witness IPV are 1000 times more likely to become abusers themselves (Falsetti, 2007; Paluzzi, 1998; Wilson, 1998). Boys that have witnessed IPV are 6 times more likely to commit suicide and 24 times more likely to sexually assault women in adulthood (Paluzzi, 1996; Wilson, 1998). A high percentage of children murder convictions are a result of efforts to protect their mothers from IPV (Paluzzi, 1996; Wilson, 1998).

Advanced Practice Nurses in the Rural Environment

Rural communities in general share some common features including low population density, remoteness, isolation, lower education levels, limited healthcare services, increased poverty and unemployment rates compared to urban communities (Annan, 2008; Logan et al., 2003; Tjaden & Thoennes, 2000). Although rural areas account for approximately 80% of the geography in the United States, only 20% of the population resides in these areas (United States Census Bureau, 2012). For the sake of this article four rural definitions by Crandall & Weber (2005) are provided:

- *Urban Rural* – a geographical area that is at least 10 miles by road from an urban community (at least 50,000); characterized by many individuals

commuting; an economy with fewer natural resources; easy and immediate access to health care services and numerous paved streets and roads.

- *Rural*-a geographical area that is at least 30 miles by road from an urban community; characterized by some commercial businesses, activities, and reasonable but not immediate access to health care services and numerous paved streets and roads
- *Isolated Rural* – a rural area that is at least 100 miles from a community of 3,000 or more individuals; characterized by low population density (fewer than 5 persons per square mile), an economy of natural resources...large areas of land owned by the state or federal government and predominately unpaved streets.
- *Frontier-Rural* – a rural area that is at least 75 miles from a community of less than 2000 individuals; characterized by an absence of densely populated areas, small communities, individuals working in their communities, an economy dominated by natural resources and agriculture activities, and few paved streets and roads. (p.12-13)

More and more physicians are leaving primary care settings for more profitable specialties. This leaves APNs with an emerging role in the rural primary care setting (National Conference of State Legislatures, 2011). Nearly half of all rural health care providers are non-physician practitioners (National Conference of State Legislatures, 2011). Nurses are trained holistically, which emphasizes not only the individual, but the family and community (Lenz et al., 2004). The values of APNs are based on advocacy,

holism, and integration of best evidenced- based practices (Donnelly, 2006). In addition, nurses often possess attributes which include compassion, empathy, trust, and responsiveness to patient needs. These values and attributes make APNs well suited to help victims of IPV (Donnelly, 2006; Family Prevention Fund, 2004). These attributes have all been cited by victims of IPV as being essential for them to disclose their abuse (Family Prevention Fund, 2004). Advanced practice nurses working in the rural primary care setting may be the first and only access for possible support for rural IPV victims (Annan, 2008). Therefore, rural APNs are in a key position to identify and provide appropriate interventions for victims of IPV.

Routine Screening

Screening is defined as, “brief procedures used to determine the presence of a problem, substantiate that there is reason for concern, or identify the need for further evaluation” (United States Department of Health and Human Services, 1994, p.6).

Routine IPV screening has been defined by several health care organizations and IPV advocates as the routine inquiry of all female patients over the age of 14, whether signs of abuse are present or absent on a routine basis (Family Violence Prevention Fund, 2004; Lawoko, Sanz, Helstrom, & Castren, 2011). The World Health Organization (WHO), (2008) reported that primary care practitioners should place a focus on screening and treating women who are victims of IPV (Ellsburg et al., 2008). A growing body of literature supports the view that routine screening helps identify and reduce future IPV, and improves quality of life and health outcomes (Coker et al., 2007; Gadamski, Wolff, Tripp, Lewis & Short, 2001; IOM, 2011; MacMillan et al., 2009; Nelson, Bougatos, &

Blazina, 2012; USPSTF, 2012). The literature found that most women do not mind being asked about IPV (Gielen et al., 2000; Thackery et al., 2007). Studies have found that both abused and non-abused women believe it is part of the health care provider's job to assess for IPV (Coker et al., 2007; Hurley et al., 2005). The majority of studies reported that routine IPV screening does not cause any significant harm (Feder et al., 2006; Koziol-McLain et al., 2010; Liebschutz et al., 2008; MacMillan et al., 2009; Nelson, Bougatos, & Blazina, 2012; Renker & Tonkin, 2006). In fact, Stenson, Sidenvall, and Heimer (2005) reported women are comfortable being asked about IPV and it actually improves their overall satisfaction with healthcare. Phelan (2007) found most women will not spontaneously disclose IPV unless solicited. This only stresses the need for routine IPV screening across all health care settings.

Screening Methods and Tools

There are numerous screening methods and tools available to the rural APN. The literature is inconsistent with regard to a preferred screening method (Feder et al., 2009; Nelson, Bougatos, & Blazine, 2012). Rodriguez, Quiroga, & Bauer (1996) found that simply asking about IPV was beneficial because it validated patients' experiences, provided information, and reduced the isolation surrounding IPV. Studies have found that both abused and non-abused women did not mind being asked a question about IPV (Gielen et al., 2000; Thackery et al., 2007). Spangaro, Zwi, and Poulos (2011) reported that three key elements supported IPV disclosure which included directly asking about IPV, the choice to disclose, and a trustworthy interviewer. The literature supported that

the provider-patient relationship in a private setting is essential for the disclosure of IPV (Thackery et al., 2007). In contrast, some studies revealed higher rates of IPV disclosure using computerized screening (Ahmad, 2007; Humphreys, Tsoh, Kohn, & Gerbert, 2011; Rhodes et al., 2006) and self-administered questionnaires (Kapur & Windish, 2011; Kozoil-McLain, Rameka, & Fyfe, 2008; MacMillan et al., 2006) instead of face-to-face interviews. Rhodes et al. (2006) found that self-administered screening methods were more comfortable to patients because it is private. The majority of studies concluded that one of the most important elements for the disclosure of IPV was not a particular screening tool or method but that the relationship with their provider ultimately played into their decision whether to disclose or not (Family Violence Prevention Fund, 2004).

The literature does not support a gold standard screening tool. Many screening tools are beneficial but one must consider the healthcare setting when choosing a screening tool. Lengthy tools would not be beneficial in a busy primary care setting. The literature reports that effective screening tools geared towards the busy primary care setting are the OVAT (Ongoing Violence Assessment Tool), HITS (Hurt, Insult, Threaten, Scream), the WAST (Woman Abuse Screening Tool), HARK (Humiliation, Afraid, Rape, Kick), and Slapped, Threatened and Throw (USPSTF, 2012). If the patient screens positive for IPV the next step would be to assess their immediate danger and homicide risk using the Danger Assessment and HARASS (Harassment in abusive relationships: A self-report scale) (USPSTF, 2012). Information on screening tools can be found at <http://www.cdc.gov/NCIPC/pub-res/images/IPVandSVscreening.pdf>

Healthcare Provider Barriers

Although intimate partner violence affects up to 50% of women at some time in their lives and has been deemed a public health crisis, researchers suggest that the healthcare industry is not identifying or addressing IPV (Breiding et al., 2008; Humphreys et al., 2011; Kramer et al., 2002; Plitcha, 2004; Rodriguez et al., 1999; Slayton & Duncan, 2005; Stinson & Robinson, 2006; Thompson et al., 2006). Elliott et al. (2002) reported that on average only 10% of health care providers screen for IPV. Various reasons have been cited for healthcare providers' lack of addressing and identifying IPV which include: lack of IPV education; limited awareness of community resources; fear of offending patient; time constraints; lack of privacy to conduct screening; forgetfulness; mandatory reporting requirements in some states; blaming attitudes; frustration; lack of clear IPV guidelines and screening tools (Elliot et al., 2002; Ellis, 1999; Family Violence Prevention Fund, 2004; Hughes, 2010; Kramer, Lorenzon, & Mueller, 2003; Stinson & Robinson, 2006; Waalen et al., 2000).

Rural IPV Disclosure Barriers

The APN must be aware of the challenges IPV victims face. Some barriers are common to both rural and urban settings such as feeling shame about their situation, financial insecurity and/or no health insurance coverage, fear of being negatively judged by their healthcare provider, distrust in the healthcare system based on previous unhelpful experiences, and/or fears their children will be removed from the home if they disclose IPV (Hathaway, Willis, & Zimmer, 2002; Lanier & Maume, 2008; Coyer et al., 2006)

However, rural areas face other obstacles that are not found in urban areas including rural cultural norms, challenges to confidentiality and anonymity, and geographical and social isolation (Lanier & Maume, 2008; Tjaden & Thoennes, 2000; Wendt, 2008).

Rural cultural norms may prohibit women from publicly talking about their IPV experiences (Eastman et al., 2007; Gallup-Black, 2005; Wendt, 2008). Individuals tend to be self-reliant and place a high value on their privacy which can prohibit them from seeking help (Eastman et al., 2007; Gagne, 1992; Webdale, 1998; Wendt, 2008). Komiti, Judd, and Jackson, (2006) reported that when rural women decide to disclose IPV they prefer to receive help from informal supports of family and friends rather than involving formal supports such as the healthcare industry and law enforcement. Rural residents who adhere to traditional gender roles that support patriarchal relationships may tend to accept the concept of IPV as a hidden norm (Annan, 2008; Eastman et al., 2007; Gallup-Black, 2005; Wendt, 2008). The obstacles of confidentiality and anonymity are also primary concerns in close knit rural communities where gossip can spread readily (Coker et al., 2007; Evanson, 2006; Wendt, 2008). The abuser and or victim may know or be related to the health care provider or law enforcement personal which may prohibit the victim to disclose out of shame or fear of retaliation (Annan, 2008; Gallup-Black, 2005; Wendt, 2008). Victims may choose to not disclose because they fear: abuser retaliation; judgment by providers, law enforcement, family, and other community members (Coker et al., 2007; Gagne, 1992; Gamm, Graciela, & Pittman, 2003; Websdale, 1998; Wendt, 2008). In situations where public health education is poor, people may not even be aware of the seriousness and consequences IPV (Gamm, Graciela, & Pittman, 2003;

Websdale, 1998; Wendt, 2008). Furthermore, people may be uninformed of existing supportive IPV resources or, in areas with high poverty, resources are simply lacking. (Annan, 2008; Evanson, 2006; Gamm, Graciela, & Pittman, 2003; Grama, 2000; Webdale, 1998).

Geographical and social isolation are significant challenges found in rural communities (Evanson, 2006; Gamm, Graciela, & Pittman, 2003; Grama, 2000; Hughes, 2010; Johnson, 2000; Lanier & Maume, 2008; Tjaden & Thompson, 2000; Wendt, 2008). Crisis intervention, police officers, or emergency services may not be immediately available (Wendt, 2008). Travel time and distances to healthcare, law enforcement, and/or social services can be lengthy (Annan, 2008; Gamm, Graciela, & Pittman, 2000; Lanier & Maume, 2008; Tjaden & Thompson, 2000). The IPV victim may not have access to a car and often public transportation is not available in rural communities (Lanier & Maume, 2008; Websdale, 1998) Rural roads are often not as well maintained as urban roads so bad weather can severely limit travel (Evanson, 2006; Hughes, 2010; Tjaden & Thompson, 2000; Websdale, 1998). Some rural areas lack landline telephone service or have poor or nonexistent cell phone reception which hinders communication (Evanson, 2006; Tjaden & Thompson, 2000; Websdale, 1998). In sparsely settled areas neighbors and family are further apart so social supports are limited (Evanson, 2006; Lanier & Maume, 2008; Tjaden & Thompson, 2000; Wendt, 2008). Although social isolation occurs in both urban and rural settings, it is exacerbated in remote rural settings with limited resources.

Recommendations

Overcoming barriers to the disclosure of IPV is critical in order to improve the identification of IPV, use effective interventions, and provide appropriate IPV referrals. From the literature reviewed, three components were identified as essential for the implementation of effective, routine screening in health care settings for IPV. These components included: a) workplace IPV education, b) the development of policy and procedures in the health care setting, and c) the identification of available IPV resources. Table 1 identifies barriers to the implementation of the essential components as well as strategies for overcoming these barriers, with particular emphasis on the rural setting.

Conclusion

This article presented the updated USPSTF (2012) recommendations for routine IPV screening. Barriers to IPV screening were discussed and possible solutions were provided. Identified in the literature were three essential components for the successful implementation of routine IPV screening in the health care setting. Advanced Practice Nurses working in rural primary care settings face unique challenges to routine screening for IPV including geographical and social isolation, limited IPV resources, and a culture that values self-reliance and may normalize IPV. Strategies to address the three essential components within a rural environment were presented in Table 1. At some point every rural APN will face victims of IPV. With the essential IPV screening components in place thousands of rural women will have opportunities to end the violence in their lives .

Table 1: *Barriers to Essential Components for Implementation of Effective IPV Screening Practices*

Barriers to Essential Components	Strategies for Overcoming Barriers	Helpful Resources
Lack of IPV Education	<ul style="list-style-type: none"> • <i>Mandatory annual workplace IPV education</i>: scope of the problem; dynamics of IPV; health consequences; screening strategies; screening tools; documentation; local mandatory reporting laws; cultural considerations • <i>Encourage staff self-reflection about IPV</i>: Staff meetings focused on examining providers' beliefs and values regarding IPV; correct faulty beliefs; presentation by advocate and/or IPV victim, or case study to facilitate understanding • <i>Provide an environment that facilitates disclosure</i>: treat women with respect; nonjudgmental attitude; form trusting and caring relationships; empathetic listening; ensure privacy; normalizing (i.e. "I ask all my patients about violence"); IPV pamphlets, posters, stickers, and safety plan wallet cards available in restrooms, exam rooms, and waiting areas • <i>Implement screening prompts</i>: IPV question on the health history and/or intake form; chart reminders; RADAR • <i>Respond to disclosure</i>: assess immediate safety (danger/lethality & suicide/homicide assessments); if victim has children assess their safety; review safety plan; provide IPV materials including IPV crisis lines, safety plan wallet cards, IPV programs, shelter resources, transportation assistance, legal assistance, law enforcement, social services, clergy support, mental health services, community organizations, substance abuse resources if warranted; offer frequent follow-up appointments for support; allow patient to use clinic phone. • 	<p>Comprehensive website on domestic abuse www.endabuse.org/health</p> <p>Center for Disease Control and Prevention http://www.cdc.gov/ncipc/pubres/images/ipvandsvscreening.pdf</p> <p>Responding to domestic violence in clinical settings www.dveducation.ca</p> <p>Violence against women http://vawnet.org/</p> <p>Reporting requirements www.futureswithoutviolence.org/userfiles/file/HealthCare/MandReport2007FINALMMS.pdf</p> <p>Health care and domestic materials for purchase http://store.yahoo.com/fvpfstore</p>

Policy/ Procedure Limitations	<ul style="list-style-type: none"> • <i>Develop IPV screening policies and procedures:</i> gather policy and procedure templates from other rural areas or the internet; gather specific screening tools for possible use; implement RADAR; consult with an external IPV expert as needed; elicit staff input on policy content and screening tools • <i>Routinely evaluate the implementation of policies and procedures:</i> conduct chart reviews; elicit staff input; identify continuing problems; identify successes; revise policy as needed 	<p>National health resource center on domestic violence http://www.endabuse.org/programs/healthcare/</p> <p>Sacred Circle: legal resources http://www.sacred-circle.com/</p> <p>National Coalition Against Domestic Violence: national referral center for providers and victims www.ncadv.org</p>
Resource Limitations	<ul style="list-style-type: none"> • <i>Identify resources:</i> assemble information about local IPV resources for inclusion in a pamphlet; disseminate to available community service providing agencies (i.e. law enforcement, public and mental health, social services, hospitals, libraries, booth at county fairs). • <i>Collaborate with available community resources to ensure effective use of services:</i> convene a meeting of available agencies involved with IPV to discuss best use of resources (i.e. law enforcement, county attorneys, social services, public health, county commissioners, local shelter) • <i>Increase community awareness of IPV:</i> Disseminate IPV posters to available public gathering places (i.e. grocery stores, post offices, gas stations/convenience stores, libraries, churches, restaurants, schools, a booth at county fairs, health fairs, movie theaters, bowling allies) 	<p>Futures Without Violence formerly Family Violence Prevention Fund www.futureswithoutviolence.org/</p> <p>National Network to End Domestic Violence: resources for providers and victims http://www.nnedv/.</p> <p>National Violence Domestic Hotline: advocates available to assist victims http://www.thehotline.org/ or 1-800-799-SAFE</p> <p>Rape abuse incest national network www.rainn.org</p> <p>Crisis hotlines: 1-800-656-HOPE; 1-800-799-SAFE</p>

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CHAPTER 4

LESSONS LEARNED: SELF-REFLECTION ON THE PROCESS
OF WRITING A MANUSCRIPT FOR PUBLICATION

The goal of this professional project was to write an article suitable for publication in a peer-reviewed journal. The requirements for successful completion of this project closely followed the scientific process with the completion of four chapters. In Chapter One, the topic of the manuscript was introduced including the background and significance, a problem statement, and the purpose of the manuscript. A conceptual framework was identified and described in Chapter Two. The conceptual framework provided direction and structure for the remaining components of the project. These included: a) identifying challenges nurses face when writing for publication along with strategies to overcome the challenges; b) developing a writing schedule; c) constructing a content outline; and d) reviewing and selecting an appropriate peer-reviewed journal for manuscript publication. The prepared manuscript, as it was written for the selected journal, comprises Chapter Three. Finally, reflections on the writing experience are found in Chapter Four. Ten “lessons learned” were identified and are discussed below.

Lesson 1: Organization from the
Beginning is Key to Writing

Writing for publication often involves an iterative process, beginning with a review of the scientific literature. For this project, the topic was screening for intimate partner violence (IPV) in rural areas. An exploratory review of the literature, with the

goal of gaining an understanding of what was written about the topic of interest, was conducted first. During this preliminary literature review, articles were appraised to determine the extent of the existing information focusing on the topic. The literature related to IPV screening practices in rural areas was very sparse. Thus, the need for more information was determined. An article would be helpful in addressing this need. A subsequent, more comprehensive literature review was conducted next to learn the details of what is and is not known about screening practices for IPV in general and to see if any articles specifically related to IPV screening practices in rural areas had been overlooked.

As literature was amassed from this search, it quickly became apparent that an organizational plan was needed to manage the collected literature. The articles were categorized and filed according to themes, which also provided direction for the content outline for the manuscript. Because some articles contained multiple themes, upon reflection, it would have worked better to use a color-coding system, with a different color for each theme. At a glance the themes contained in each article could have been easily identified.

Notes taken from the articles were also categorized by theme; however an important lesson learned was to keep track of the citation for each thematic note at the time it was recorded. Having to return to the articles to find the correct source was time-consuming.

Organization, as it pertained to a writing schedule, also was necessary. When time was designated for writing, priorities were set regarding which distractions were allowed to stop a scheduled writing time and for how long. Non-allowable distractions

included phone calls and e-mail messages. Multi-tasking with other household chores also was not allowed. Taking time to visit and debrief with a family member arriving home early from work was an allowable distraction. However, writing resumed once the conversation was over.

Lesson 2: Writing Helps Clarify Thinking

The task of beginning the writing process, trying to decide what to include, and finding the right words sometimes felt daunting. The best strategy for this challenge was to believe that the very act of writing would help to clarify thinking, and then acting upon this belief. Putting thoughts to paper (or to word processor), no matter how they first appeared, provided a concrete base from which to begin revising. Writing this manuscript involved an iterative, revision process.

It was important to recognize, and accept, that some phases of writing were more difficult than others. At these times, journaling about the difficulty and the writing process was helpful. Journaling also provided writing practice, loosened writing inhibitions, and instilled a certain amount of comfort with expressing ideas in a more permanent manner than the spoken word.

Lesson 3: Writing on a Regular Basis Improves Writing

When the sentences and paragraphs of this manuscript were flowing and coming together, it was important to maintain momentum. Returning to writing after a long

period of time away was difficult. Ideas were lost. Putting forth the effort to recover the flow and rhythm of the manuscript was discouraging.

Sometimes reading the articles selected from the literature review became a writing distraction. Combining reading with writing notes about the content helped to maintain the balance between taking in information and organizing it for later use. It also kept up the momentum and practice of writing.

Lesson 4: Deadlines Keep the Manuscript Moving Forward

Some deadlines were self-imposed via a writing calendar developed at the beginning of the project. Other deadlines were externally imposed, with the primary one being the university set deadline for the project defense and submission of the report to the graduate school. Interim deadlines were scheduled by the project committee and external editor. Weekly meetings with the project committee chair also kept the writing momentum moving forward.

Lesson 5: Critiquing the Article is not a Critique of the Author

One basic challenge that needed to be faced with courage was fear that if the writing was poor it reflected poorly on the writer. It was important to remember that feedback received on the writing was not a reflection on the writer as a person. Before gaining that insight, writing was laborious and sharing written work was dreaded. Yet,

receiving feedback was vital to continued progress on the manuscript. Once that barrier was faced, writing flowed with more confidence.

Lesson 6: Receiving Feedback is Essential

Using any and all writing resources was valuable. After several months of feeling overwhelmed with the manuscript project, finding a writing editor, who also became a writing coach, provided the support needed to overcome the perceived barriers to successfully completing the project. The editor/coach suggested an excellent writing workbook (Belcher,2009) that provided the structure needed for this project. She also provided assistance with clarity, organization, and grammar. But more than that, she provided hope and encouragement. Additional resources included the committee and committee chair. Although not used for this project, some schools offer assistance through university sponsored writing and editorial centers, which can be helpful. Finally, forming an understanding student peer group provided practical and emotional support.

Lesson 7: Revision, Revision, Revision Makes a Great Article

It was necessary to realize, and accept, that the manuscript was not going to be perfect the first time. Getting the article written, at least as a first draft, was the most important thing. It could always be revised and then revised again. With each revision, the article improved, growing in precision and clarity.

Lesson 8: Setting Aside Large Blocks of Time for Writing Does Not Work

This lesson was closely related to procrastination. For example, thinking that a holiday would provide the opportunity to work 12 hours a day on writing was not realistic. In reality, scheduling smaller blocks of time, five to six times a week, was much more productive and reduced the sense of burning out. Writing in smaller blocks of time, also allowed for flexibility to meet unplanned life events, while still being able to find 30 minutes in most days to work on writing.

Lesson 9: Technical Problems Can Waste Time

Although technology has made writing so much easier, learning what technology has to offer—and how to use it—is the only way it will ease the work of writing. It is wise to stay up-to-date on word processing programs and formatting features. Without this knowledge, valuable writing time will be spent learning the features and use of the program, rather than writing.

Lesson 10: No Matter how Difficult, Writing a Manuscript for Publication is an Attempt to Add to the Pool of Knowledge for Nurses

Once the manuscript has been submitted, take some time to reflect and celebrate the fact that your best effort was given to further the knowledge of nurses. Remember that reviewers for journals are asked to make one of the following recommendations: a) accept the manuscript as is or with a few minor recommendations, b) revise the

manuscript according to the reviewers' comments and re-submit it to the selected journal or, c) the manuscript should not be published in the selected journal. Regardless of the recommendation, pay attention to the reviewers' comments, make the appropriate revisions, and resubmit the article either to the originally selected journal or a new one. The suggested rule following a manuscript rejection is to submit it up to three times to three different journals. After three times, perhaps it is time to retire various components of the manuscript and/or move on to another manuscript.

Final Words

Although knowledge of the literature is critical for an excellent manuscript, it can also serve as a distraction and a form of procrastination. For the next manuscript, spending less time reading and more time writing will be important to remember.

Important Personal Qualities of a Writer

Self-Discipline

Hard Work

Perseverance

Self-Confidence

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APPENDICES

APPENDIX A

WRITING OUTLINE AND SCHEDULE

Writing Outline and Schedule

- I. Week 1: Designing Your Plan for Writing
Week December 24-31
- II. Week 2: Starting Your Article
Week January 1-7
- III. Week 3: Advancing Your Argument (Making a Publishable Article)
Week January 7-14
- IV. Week 4: Selecting a Journal
Week January 14-21
- V. Week 5: Reviewing the Related Literature
Week January 21-28
- VI. Week 6: Strengthening Your Structure (Organization & Coherent Article)
Week February 4-11
- VII. Week 7: Presenting Your Evidence
Week February 11-18
- VIII. Week 8: Opening and Concluding Your Article
Week February 18-25
- IX. Week 9: Giving, Getting, and Using Other's Feedback
Week February 25-March 4
- X. Week 10: Editing Your Sentences
Week March 4-10
- XI. Week 11: Wrapping Up Your Article
Week March 10-17
- XII. Week 12: March 17- April (final edits; send article, presentation).

APPENDIX B

ANTICIPATED CONTENT OUTLINE

Anticipated Content Outline

1. Abstract
2. Key Terms
3. Introduction
 - a. Background & Significance of IPV
 - b. Problem Statement
 - c. Purpose
4. Prevalence of IPV
5. Consequences of IPV
 - a. Financial Burdens
 - b. Health Consequences
 - c. Impact of IPV on Children
6. APNs and the Rural Environment
 - a. Defining Rural
7. Screening for Intimate Partner Violence in the Rural Setting
 - a. Routine Screening
 - b. Screening Methods and Tools
 - c. Healthcare Provider Barriers
 - d. Disclosure Barriers
8. Recommendations Table
 - a. Education
 - b. IPV Resources
 - c. Policies
9. Conclusion

APPENDIX C

AUTHOR GUIDELINES FOR PROPOSED JOURNALS

Author Guidelines for Proposed Journals

Online Journal of Rural Nursing and Health Care

The mission of the Online Journal of Rural Nursing and Health Care (OJRNHC) is to be a leading source of information on rural health care practice, education and research, supporting the health of rural populations. The OJRNHC is the official journal of the Rural Nurse Organization (RNO). The journal is peer-reviewed and addresses US and global rural nursing and health care. At least one author of each manuscript must be a member of the RNO at the time of review and publication. RNO members can be nurses or those that support rural nursing and health care. Details on RNO membership can be found at <http://www.rno.org/index.htm>

This journal does use an online submission process. All manuscripts need to be submitted electronically. In order to submit a manuscript for review you must first be registered as a user at the journal URL. This is a separate process from joining the RNO. To Register please go to the following website

<http://rnojournal.binghamton.edu/index.php/RNO> On the line of light green tabs that begins with HOME go to the 4th over to REGISTER. You will be asked to fill in your profile. At the bottom of this page make sure you click on the role of AUTHOR Style

The Online Journal of Rural Nursing and Health Care uses the American Psychological Association (APA) style. Manuscripts not in APA style will not be accepted for review. One alteration in style is that we encourage authors to submit manuscripts with single vs. double spacing. Each manuscript requires an abstract limited to 300 words. Research manuscripts should be 18 pages single spaced, not including title page, abstract and references. Manuscripts that are not research should be limited to 10 pages single spaced. We do accept literature reviews.

Please prepare your manuscript in a word document with Times New Roman 12 font for the majority of the manuscript. Tables should be single spaced, in Times New Roman 11 font and included within the document. References should be submitted with a hanging indent of 5 spaces. Please do not use a hard return (enter) at the end of a line of the first line of references; instead use the ruler feature in Word to set your margins. An example of a reference in APA style would be

References

Yonge, Myrick, and Ferguson (2011). The challenge of evaluation in rural preceptorship. *Online Journal of Rural Nursing and Health Care*, 11(2), 3-15.

To cite this reference in text, the first time use the following... in describing the evaluation process (Younge, Myrick & Ferguson, 2011) noted... or The authors Younge, Myrick and Ferguson (2011) noted ... Subsequent references would be cited as (Younge et al., 2011) or Younge et al. (2011).

The author is responsible for securing any permissions needed to reproduce work of others and citing such work appropriately. Quotes from other sources need to be referenced with page numbers as specified in APA style. All material in this journal is publically available since it is an open source journal.

Special Notes

Please make sure you identify how you defined “rural” in your study or work. To be of interest to this journal your work needs to address the rural aspect of the work throughout the paper, having the word rural in the title is not sufficient. You will also need to note in the manuscript how you protected the rights of subjects, at a minimum you should note whether you received permission to conduct research from an Institutional Review Board (IRB) and include your protocol number. This information usually goes into the section on sample. This information is not pertinent to non-research papers. Please make sure you have addressed how this work relates to rural nursing, health care or policy. Lack of information as specified in these special notes are often reasons for declining submissions of manuscripts.

Preparing for Submission

In preparing for electronic submission you will need to create 2 files.

File One

File one will include information for the title page and abstract. This should include all author names, email addresses, affiliation (university or employer), and bio information including credentials, position and department / school or site names. You should have the title of the paper (which you can type or cut and paste into the designated box) and the abstract followed by Key Words. You will be instructed to cut and paste the body of the abstract and Key Words into the designate box. Abstracts should include a Purpose, Sample, Method, Findings, and Conclusions as appropriate to the type of article and be no more than 300 words.

File Two

File two should be your word document that includes the body of your paper, tables, figures, and references. There should be no author identifying information in this file, to allow for blind review. You should have a short running head in the header along with the page number.

Online Submission

When you are ready to submit go to USER HOME and here you will see your name and on the right side will be a SUBMISSION tab, click on this tab. There is a drop down box where you have to stipulate that it is an Article. You will be asked to input author information, you can cut and paste from file one. Remember each author must have an email address in the system or the system will not recognize that author. One author should be noted as the primary contact. If this is not the first author, you may designate another author with a click of the circle below the correct contact author name. After you have put in the information for the first author, at the bottom you can “add author” as needed. Next you will be asked to upload your file; this should be the body of the manuscript without identifying information, noted as file two above. The file can have any file name, but will show on the system as a number. Finally you will be asked to put in the title of the paper (cut and paste from file one) and the abstract (cut and paste from file two). Key Words should also be inserted at the bottom of the abstract box.

There is a box to identify any funding agencies, you may also cut and paste acknowledgements into this box. Click on SAVE at the bottom of the page to actually submit your manuscript. You will be asked if you wish to upload other data files. Most authors do not need to use this part of the system unless you are sharing your raw data or have a table that is exceedingly long. If you do use this file upload for extra data, there should be no identifying information in the file.

If you have any questions please email me the editor, Dr. Pamela Stewart Fahs at psfahs@binghamton.edu

Submission Preparation Checklist

As part of the submission process, authors are required to check off their submission's compliance with all of the following items, and submissions may be returned to authors that do not adhere to these guidelines.

1. The submission has not been previously published, nor is it before another journal for consideration (or an explanation has been provided in Comments to the Editor).
2. The submission file is in Microsoft Word file format.
3. Where available, URLs for the references have been provided.
4. The text is single-spaced; uses a 12-point font; employs italics, rather than underlining (except with URL addresses); and all illustrations, figures, and tables are placed within the text at the appropriate points, rather than at the end.
5. The text adheres to the stylistic and bibliographic requirements outlined in the Author Guidelines, which is found in About the Journal.
6. If submitting to a peer-reviewed section of the journal, the instructions in Ensuring a Blind Review have been followed.
7. Title information and abstract with key words are to be submitted separately through type in or copy and paste into appropriate areas. Manuscript should not have identifying information for blind review. Manuscript may be uploaded in a word document.

APPENDIX D

QUERY MANUSCRIPT LETTER & RESPONSE

Query Manuscript Letter and Response

Query Letter for *Online Journal of Rural Nursing and Health Care*

January 18, 2013
Dr. Pamela Stewart Fahs, RN, DSN
Editor in Chief
Online Journal of Rural Nursing and Health Care
Decker School of Nursing
Binghamton University
Box 6000
Binghamton, NY 13902-6000

Dear Dr. Fahs:

I'm in the process of writing a manuscript that focuses on the importance of intimate partner violence screening by nurse practitioners in the rural primary care setting. I'm currently reviewing journals that would be appropriate for my manuscript. *The Online Journal of Rural Nursing and Health Care* targets the audience I hope to reach. I was hoping you could provide me with some information to help my journal selection process. After reviewing the author requirements, I have a few additional questions, which are listed below.

1. How many submissions does your journal receive a year?
2. How many of your manuscript submissions get published a year?
3. How long does it take to find out the status of one's manuscript?

Thank you in advance for responding to my questions. I look forward to hearing from you.

Sincerely,
Jacqueline Moen-Leibrand
Montana State University
jacquel.moenleibrand@msu.montana.edu

Response Letter from *Online Journal of Rural Nursing and Health Care*

From: Pamela S Stewart Fahs <psfahs@binghamton.edu>
Date: Fri, Jan 18, 2013 at 11:27 AM
Subject: Query Letter
To: jacquel.moenleibrand@msu.montana.edu

Dear Ms. Moen-Leibrand:

The Online Journal of Rural Nursing and Health Care is a small but open-source journal, and our content is available online without charge to the viewer. The Journal is part of the Rural Nurse Organization. We do require that at least one author on each manuscript be a member of the RNO at the time of review and publication. Membership cost is currently \$55 per year for full and associate (non nurse) members and \$25 per year for students or those who are retired.

We have been running the journal from here at Binghamton University for just little over a year and our statistics are not currently accurate since we have been importing the "archives" from when the journal was hosted by the University of Alabama. Our staff (myself and Erin Rushton, Managing Editor are not compensated by the journal, it is volunteer service).

I would estimate that we get about 50 manuscripts a year and publish about 16 to 20 a year. We have a philosophy of working with our authors to produce the best manuscript possible, thus, if a manuscript is not completely acceptable on a first round review, we may ask for revisions (with or without further peer review, depending on how much revision the reviewers deem to be necessary). Each manuscript is subjected to two blind peer reviews. If needed I will ask for a third review.

Most often the manuscripts that are rejected by the reviewers are not appropriate for the journal. For instance they may have the word Rural in the title but never mention the concept again. We do insist that how you operationally define rural in your manuscript be explicitly stated. Our reviewers also want a discussion of how the work relates to rural nursing, populations and or health care throughout the paper, especially in the findings / conclusions.

If the manuscript is research and you had human subjects in your study you must indicate where you received human subjects approval and if possible give the approval number or if it was decided that the study was "exempt" by a review body, please state that in the manuscript.

Please see our URL <http://rnojournl.binghamton.edu/index.php/RNO> under author guidelines for the details of submitting a manuscript.

If you have any other questions, please feel free to contact me at psfahs@binghamton.edu

Sincerely,
Pam

Pamela Stewart Fahs, RN, DSN
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