Measuring Changes in Attitude, Skill and Knowledge of Undergraduate Nursing Students after Receiving an Educational Intervention in Intimate Partner Violence

A dissertation submitted

by

Connie M. Wallace

to

College of Saint Mary

in partial fulfillment of the requirement

for the degree of

DOCTORATE IN EDUCATION

with an emphasis on

Health Professions Education

This dissertation has been accepted for the faculty of

College of Saint Mary.

We hereby certify that this dissertation, submitted by your name, conforms to acceptable standards and fully fulfills the dissertation requirements for the degree of Doctor in Education from College of Saint Mary

Name and Title, Credential
Chair

Peggy L. Hawkins, Ph.D., RN

Name, Title and Credential
Committee member

Patricia J. Morin, Ph.D., RN

Name, Title and Credential
Committee member

Charlotte M. Herman, Ed.D., RN

Acknowledgements

Nine tenths of education is encouragement. ~ Anatole France

It is with genuine appreciation and gratitude that I acknowledge my dissertation committee members for their time, support and guidance.

My heartfelt thanks go to Dr. Peggy Hawkins, the chairperson of my committee, who unfailingly offered positive words of encouragement and unwavering support as I began this educational journey. She was my first mentor in the role of nurse educator; what a great privilege to again receive her continued mentoring while in the doctoral program. She gave me confidence when my own was fading. I admire the role modeling she provided and strive to emulate her!

My gratitude also goes to Dr. Pat Morin, who shared a wealth of knowledge, and made the entire dissertation process appear effortless. I so appreciate her enthusiasm for learning and writing!

I am grateful to the guidance of Dr. Char Herman, who has been not only a colleague and mentor, but a dear friend, for many years. I will always be indebted to her!

I am grateful to the Nebraska Methodist College administration, for allowing time and financial support to obtain my doctoral education. I am also grateful to the Nebraska Methodist Hospital Foundation for awarding me a Carolyn Scott Memorial Scholarship to further fund this educational undertaking.

I would like to thank my friends and colleagues Nebraska Methodist College, who offered support in many forms, and shared their expertise, which I value greatly; a special thank you to Dr. Fran Henton, Dr. Marlin Schaich, and Ms. Sonja Maddox.

Finally, my unending gratitude goes to my family; my mother, who made sacrifices to make herself available to me and offers support in countless ways. And to my children, Joe and Betsy, now college students themselves, who have been my inspiration, making every single day brighter by their presence and enriching my life in more ways than one could imagine.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

TABLES PAGE

Abstract

The purpose of this quasi- experimental study was to determine whether an educational intervention had an effect on nursing students' perceived attitudes, skills, and knowledge regarding Intimate Partner Violence (IPV). The research question was as follows: Is there a difference in nursing students' perceived attitudes, skills, and knowledge after an educational intervention than before the educational intervention?

The nursing profession is uniquely positioned to make a difference in the lives of adults and children who experience the harsh reality of IPV. Literature findings indicated nurses often believe themselves to be ill-equipped to offer appropriate and beneficial interventions.

This study employed an educational intervention in the form of a two credit hour elective nursing course and assessed its effectiveness as measured through perceived change in student attitudes, skills, and knowledge. A variety of active learning strategies were used in the elective nursing course designed for this study.

The experimental sample had a total of 20 participants, and the control sample had a total of six participants. Repeated measures ANOVA were used to analyze the data. Qualitative responses were obtained through the use of short answer questions.

The experimental group mean scores indicated an improvement in attitude, skills, and knowledge. There was a statistically significant difference in

the mean scores for attitude ($P < .01$). The mean scores for skills and knowledge increased, but were not statistically significant.

Findings from this study suggested that students who received education and structured learning experiences related to IPV intervention have a positive change in attitude, skills and knowledge. Further research is recommended to assess whether these changes diminish over time, after completion of the course. It may also be of interest to examine the effects of personal experiences with IPV in students and nurses who provide care to clients who experience IPV.

CHAPTER 1

Background

Introduction

This quasi-experimental study explored the change in student attitudes, skills, and knowledge pertaining to Intimate Partner Violence (IPV) after participating in an educational intervention. The educational intervention was a two-credit hour elective course on IPV.

Background

Intimate partner violence (IPV) is viewed as a highly prevalent and pervasive issue (Belknap, 2003; Bryant & Spencer, 2002; Campbell, 1992; Caralis & Musialowski, 1997; Gielen et al., 2000; Grogan, 2003; Hinderliter, Doughty, Delaney, Pituala, & Campbell, 2003). Alpert (2002) voiced this concern very eloquently in the following statement: "Over the course of human history, virtually no other public health problem has been as prevalent or as challenging to the health and well-being of humanity" (p. 162).

The occurrence and effects of IPV have been identified by governmental entities, national health agencies, health care organizations, nursing practice organizations, and nursing education organizations. In addition, health care providers in numerous nursing specialties, including women's health, mental health, pediatrics, school nursing, geriatrics, and community health, have documented the need for increased, expanded, and consistent identification and intervention (Bryant & Spencer, 2002; Vandermark & Mueller, 2008; Knapp, Dowd, Kennedy, Stallbaumer-Rouyer, & Henderson, 2006; Amar & Gennaro,

2005; Davila, 2006; Kingston, Penhale & Bennet, 1995). Due to the high incidence of IPV and associated sequelae of "poorer physical mental health, and the increased use of health care resources, it is reasonable to anticipate that all health care providers will come into contact with survivors of abuse" (Campbell, Laughon, & Woods, 2006, p. 52).

Yet, literature has indicated nurses often perceive themselves as being ill-equipped to intervene effectively in situations pertaining to intimate partner violence due to a lack of education. In a study of public health nurses and hospital staff nurses, Moore, Zaccaro and Parsons (1998) reported that "only slightly more than 50% of practicing nurses reported having any education related to abuse" (p. 180). Additional research by Woodtli (2000) indicated there was a "lack of violence related content" in nursing education curricula (Woodtli, 2000, p. 175). The review of literature clearly indicated there is a need for IPV content in basic undergraduate nursing curricula.

Purpose/Research Question

The purpose of this quasi-experimental study was to determine whether an educational intervention had an effect on nursing students' perceived attitudes, skills, and knowledge regarding IPV.

The research question was as follows: Is there a difference in nursing students' perceived attitudes, skills, and knowledge after an educational intervention than before the educational intervention?

Research Hypothesis

The research hypothesis was as follows:

Participants who take a non-clinical elective course on IPV will score higher on attitudes, skills, and knowledge than those participants who did not take a non-clinical elective on IPV.

Data Collection Methods

Data were collected three times during the study period for the experimental group. Data were obtained through a survey which was conducted before the implementation of the two-credit elective nursing course, at week nine, and after the completion of the elective course. The survey was administered in the first class session and during the last class session for the control group. Findings were analyzed using repeated measures analysis of variance (repeated measures ANOVA).

The control group was surveyed two times during their non-clinical elective. Data were obtained using the same survey, and were administered during the first week of class and again in the last week. The class used for the control group did not address any content related to IPV.

Definitions of Terms

The following operational definitions were used in this research study:

1. **Intimate Partner Violence**: "a pattern of purposeful coercive behaviors that may include inflicted physical injury, psychological abuse, sexual abuse, progressive isolation, stalking, and threats. These behaviors may be perpetrated by someone who is, was, or wishes to be in an intimate or dating relationship with the adult or adolescent, are aimed at establishing control by one partner over the other (Family Violence Prevention Fund, 2004, p. 3).

2. **Self-efficacy**: "the belief in one's capabilities to execute the course of action required to manage prospective situations" (Bandura, 1995, p. 2). For the purpose of this study, efficacy referred to attitudes, skills, and knowledge used to achieve the tasks of understanding and intervening in IPV.

3. **Quasi-experimental design**: a design for an intervention study in which subjects are not randomly assigned to treatment conditions (Polit & Beck, 2008, p. 763).

4. **Undergraduate nursing students**: students enrolled in a Bachelor of Science in Nursing program.

5. **Educational intervention**: a two-credit, non-clinical elective including didactic content and community-based experiences.

6. **Attitude**: mental position, emotion, or feeling toward a fact or state *(Merriam-Webster Online Dictionary, 2009).*

7. **Skill**: the ability to use one's knowledge effectively and readily in execution or performance *(Merriam-Webster Online Dictionary, 2009).*

8. **Knowledge**: the fact or condition of knowing something with familiarity gained through experience or association *(Merriam-Webster Online Dictionary, 2009).*

9. **Non-Clinical elective course**: A course students elect to take, as it not required in the curriculum. The course does not include an actual clinical component.

Delimitations and Limitations

According to Bryant (2004) delimitations are "factors that limit generalization" to other people, times, and places; limitations are "restrictions created by your methodology" (Bryant, 2004, pp. 57-58). Delimitations for this study included:

1. The participants all attended a baccalaureate nursing program in a small, private, Midwestern college.
2. Some participants may have already received prior IPV education in previous coursework.
3. Participants may have very similar clinical experiences upon which to draw.
4. This study had a limited number of participants.

Limitations of this study may have included:

1. Participants elect to take the non-clinical elective and this may reflect a personal interest in the subject matter.
2. Participants may have prior, personal experience with the subject matter.
3. Participants may encounter personal experience with the subject matter during the time they are enrolled in their coursework.
4. Generalizability is limited due to the small sample size.

Significance

Because nurses often provide the first exposure to health care experience for recipients of IPV, it is crucial that they be knowledgeable in factors associated with intimate partner violence and appropriate resource referral, skillful in

screening and assessment protocol, and empathetic in creating a therapeutic interpersonal environment. However, many nurses have not had the experience or guidance to become adept in these areas, so they may not be prepared to intervene. For these reasons, nursing education must design appropriate, responsive curricula which foster the development of sensitive skilled nursing care delivery.

Summary

In summary, the literature indicated IPV is a multi-faceted issue which carries pervasive, far-reaching consequences for society. The occurrence of IPV has been identified in many health care settings; therefore, it is imperative that nurses be skilled at recognizing IPV and possess the ability to intervene. Nursing researchers reported that nurses perceive themselves as lacking preparation to intervene effectively (Moore, Zaccaro & Parsons, 1998; Woodtii, 2000). Thus, nurse educators must provide their students the educational preparation to develop the knowledge and skills to compassionately care for those who experience IPV. Therefore, the research question in this study is: Is there a difference in nursing students' perceived attitudes, skills, and knowledge after an educational intervention than before the educational intervention?

CHAPTER 2

Literature Review

Introduction

This chapter reviews relevant literature pertaining to the study. This review of the literature describes the following topics: (a) historical perspective and significance of the issue, (b) definitions of IPV, (c) the association between IPV and health care, (d) IPV issues in nursing care, (e) IPV in nursing education, (f) assessment tools applicable for nursing education interventions, (g) selected theoretical framework, and (h) recommendations for future research.

Historical Perspective and Significance

Intimate partner violence (IPV) has long been recognized as a health care epidemic (Belknap, 2003; Bryant & Spencer, 2002; Caralis & Musialowski, 1997; Campbell, 1992; Gielen, et al., 2000; Freedberg, 2008; Grogan, 2003; Hegarty, 2006; Hinderliter, Doughty, Delaney, Pituala, & Campbell, 2003). In 1999, the Commonwealth Fund reported an estimated three million women are recipients of intimate partner violence per year (Commonwealth Fund, 1999). The National Center for Injury Prevention and Control (2003) reported that IPV victimizes 5.3 million women and results in 1,300 deaths per year. The Bureau of Justice Statistics (2004) estimated that between 1.5 and 4.4 million women are physically or sexually assaulted by an intimate partner every year. This statement was supported by the Centers for Disease Control and Prevention (CDC) which reported IPV affects 5.3 million women annually on a national level (CDC, 2003).

Furthermore, Stinson and Robinson (2006) stated that nearly 50% of women in America will experience intimate partner violence at some point in their lives.

Interestingly enough, while history outlined the evolution of awareness of IPV, it was not until the mid-to-late 1970's that IPV, and ensuing community responses, gained recognition (Minnesota Center Against Violence and Abuse [mincava], 1995). The health care community started to identify IPV as a significant "medical and public health problem" at this time (Alpert, 2002, p. 162). However, in 1992 the U.S. Surgeon General identified abuse by husbands as the leading cause of injury to women 15 to 44 years of age, thus bringing IPV to the attention of medical practice (mincava, 1995).

Definition

Several definitions of IPV have emerged over time. The American Nurses Association (ANA) in its 1992 position statement, referred to physical violence against women, defining it as "behavior intended to inflict harm and includes slapping, kicking, choking, punching, pushing, use of objects as weapons, forced sexual activity and injury or death from a weapon" (American Nurses Association, 1992). There is much literature documenting the extent of intimate partner violence in the 1990's, and as awareness and sensitivity grew, the definition of IPV expanded, taking on additional dimensions. The American Association of Colleges of Nursing (AACN) issued its position statement identifying violence as a public health problem in 2000. In this document IPV was defined in the following manner:

> Domestic violence is defined as sexual, or emotional/psychological violence directed toward men, women, children, or elders occurring in current or past familial or intimate relationships whether the individuals are cohabiting or not and including violence directed toward dating partners. (AACN, 2000, p. 63).

For the purpose of this study, the definition put forth by the Family Violence Prevention Fund (2004) will be used:

> Intimate partner violence is a pattern of purposeful 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, are aimed at establishing control by one partner over the other (p. 3).

IPV in Health Care

The literature indicated that devastating effects of IPV are seen in virtually every health-care setting (Carbonell, Chez, & Hassler, 1995; Minsky-Kelly, Hamberger, Pape, & Wolff, 2005; Gutmanis, Beynon, Tutty, Wathen, & MacMillan, 2007), both large and small (Woodtli, 2000). Such settings include college health settings (Amar & Gennaro, 2005), women's health care (Bryant & Spencer, 2002), obstetrics and gynecology (D'Avolio et al., 2001; Furniss, McCaffrey, Parnell, & Rovi, 2007; Moore, Zaccaro, & Parsons, 1997), Veterans Affairs Medical Centers (Caralis & Musialowski, 1997), public health departments (Davila, 2006; Shattuck, 2002), the emergency department (Davis & Harsh,

2001; Davis, Parks, Kaups, Bennink, & Bilello, 2003; Furniss et al., 2007; Gielen et al., 2000; Hurley et al., 2005; Reisenhofer & Seibold, 2007; Yonaka, Yoder, Darrow, & Sherck, 2007), pediatrics (Knapp et al., 2006), primary care clinics (McFarlane, Groff, O'Brien, & Watson, 2006), Planned Parenthood clinics (McFarlane, Christoffel, Bateman, Miller, & Bullock, 1991), and behavioral health (Minsky-Kelly et al., 2000; Vandemark & Mueller, 2008). According to Freedberg (2008), one could expect that "nurses will have contact with victims or perpetrators of violence in all practice settings" (p. 202).

The U. S. Department of Justice, Bureau of Justice Statistics, (2004) reported that while men can also be victims of domestic violence, at least 85% of domestic violence victims are female. Intimate partner violence remains the leading cause of injury and death among American women in their child-bearing years (D'Avolio et al., 2001; Stinson & Robinson, 2006). Clearly, intimate partner violence has been recognized as a major health concern for women (Davis, Parks, Kaups, Bennick, & Bilello, 2001) and carries significant implications for the nursing profession. Intimate partner violence has moved beyond "closed doors" as a family matter, and has been identified as a social and public health concern wherein sectors such as health care providers, educators, and legislators have obligations to intervene (Freedberg, 2008; Hinderliter et al., 2003; Sekula, 2005).

National objectives were identified in *Healthy People 2010,* including an objective to reduce intimate partner violence through detection and intervention (U.S. Department of Health and Human Services, 2000). This concept was previously articulated by the ANA in its 1992 position statement. The ANA

endorsed "education for nurses, health care providers, and women in skills necessary for prevention of violence against women" (p. 8). The ANA went on to document support for "assessment of women in health care institutions and community settings, and research on violence against women" (p. 8). This statement was made in 1992, yet it remains a pressing issue in professional practice of nurses in 2009. The American Association of Colleges of Nursing (AACN) formulated its position statement in 2000, with the recommendation that "faculty in educational institutions preparing nurses in baccalaureate and higher-degree programs ensure that the curricula contains opportunities for all students to gain factual information and clinical experience" (AACN, p. 63) pertaining to intimate partner violence.

Hinderliter et al. (2003) articulately expressed the responsibility of nursing faculty, "Nurse educators must provide students with the words, body language, and screening measures" in order to become effective caregivers with clients who have experienced IPV (p. 449). Warshaw, Tart and McCosker-Howard (2006) identified that educators have far-reaching obligations, among them, the ability to "provide training experiences that foster the development of . . . understanding and skills, institutional structures that support their integration into routine practice, and faculty who model non-abusive behavior in all aspects of training and clinical care" (p. 63). Freedberg (2008) clearly affirms "It is time for faculty to closely examine current violence prevalence statistics, make curricular decisions that are data driven and based on empirical research" and develop

original and creative teaching strategies to equip nurses to respond to societal issues related to violence (p. 204).

IPV and Nursing Care

Nurses are in an exceptional role to intervene with recipients of intimate partner violence (AACN, 2000; Carney & McKibbin, 2003; Davila, 2005; Freedberg, 2008; Roberts, 2006; Shattuck, 2002). Such interventions may take the form of routine physical and emotional assessments, assisting with safety planning, and accurate, appropriate documentation. Additionally, nurses are in the position to offer referrals to suitable, and often life-saving, resources. While IPV has been identified as a public health and nursing curricula priority, literature indicated that nurses in professional practice report a lack of education related to IPV in their nursing education programs (Hinderliter, et al., 2003; Warshaw, Taft, & McCosker-Howard, 2006; Woodtli, 2000; Woodtli & Breslin, 2002).

IPV and Professional Education

A study of public health nurses and hospital staff nurses reported that "only slightly more than 50% of practicing nurses reported having any education related to abuse", (Moore, Zaccaro & Parsons, 1998, p. 180). In addition, Woodtli (2000, p. 175) identified there was a "lack of violence-related content" in nursing program curricula.

Woodtli (2000) conducted a qualitative study to identify attitudes, essential skills, and knowledge required by nurses in order to offer appropriate, sensitive care to survivors of IPV. That study interviewed 13 nurses regarding their experiences in caring for clients in violent relationships. Themes included

feelings, judgments, and actions taken by nurses. When asked, "What do nurses need to know about domestic violence?" answers revealed such themes as specific knowledge, to include referrals, safety, legal issues, and understanding that nurses must screen all women. Follow-up questions asked about core skills and specific skills needed by nurses. Core skills included physical assessment skills as well as social and psychological assessment skills. The respondents emphasized the need for "high level interpersonal skills" in compiling a detailed history and family assessment (Woodtli, 2000, p. 178). Specific skills cited included cultural sensitivity, empathy, and teaching skills when providing information regarding safety measure, referrals, and resources. Additionally, respondents identified the need for more formal education and encouraged health professions to examine their curricula for the presence of IPV content. "Their theme was clearly, 'EDUCATE, EDUCATE, EDUCATE"' (Woodtli.2000, p. 179).

In 2002, Woodtli and Breslin conducted a national follow-up study to survey nursing programs regarding the extent of change in curricular content regarding IPV. Of the 395 responses, 56% of schools reported two to four hours of classroom content on women abuse, and 30% reported this content was addressed in one hour of classroom content or in readings alone. Furthermore, related clinical experiences were for the most part coincidental.

Campbell (1992) confronted the lack of clinical experience with the following statement:

> The only way we will get students to envision a role as leaders in a new healthcare system that will be responsive to victims of violence and actually begin to prevent further violence is for them to be involved in that effort as students. (p. 464)

Literature reported varied attempts to include violence-related content in clinical experiences (Davila, 2005; Helton & Evans, 2001; Hinderliter, et al., 2003; Woodtli, 2000). The clinical component may take the form of immersion experiences, which allow nursing students to be exposed to women affected by violence. Davila (2005) discussed a one-day immersion experience which began with an initial preparation including required readings, learning activities such as case studies, and group assignments. The immersion activity incorporated an educational video, mock assessment, and a visit to a local shelter. This was followed by a debriefing phase, as students often have personal experiences or awareness of IPV.

Hayward and Weber (2003) documented the Domestic Violence Partnership Project, a joint venture between a college, local law enforcement, and family service organizations. It encompassed a 20-hour training session in the nursing leadership practicum. This project included 16 hours of classroom teaching and a four-hour interactive role-play activity. Once the students had completed the educational component they were required to respond to IPV victims on the crisis line. Course evaluations indicated not only student satisfaction but a desire for continued involvement, resulting in professional engagement and personal fulfillment.

Helton and Evans (2001) developed a 22-hour domestic violence learning module. They described a unique application in this module, in which the students spent an eight-hour day in court, meeting with judges, hearing protection orders, and viewing the role of the advocates. The student experience also consisted of three group therapy sessions at the shelter or with perpetrators. The students were required to keep a journal throughout their experience. Helton and Evans (2001) identified the following themes in their qualitative study: being scared, surprised, seeing similarities and differences, and change in perceptions. Evans, Helton, and Blackburn (2001), in their subsequent writing, described the results of student evaluations. Students identified an increased sense of confidence in their abilities, increased knowledge, and decreased anxiety.

Hinderliter et al. (2003) examined the occurrence of formal interpersonal violence education during basic and advanced nursing education programs and its correlation to screening practices. According to Hinderliter's study, 4.8% of the respondents received IPV education solely in their basic nursing degree program, and 39% received this education exclusively in their advanced practice program. This study indicated there was essentially no difference in the number of hours of IPV education in basic and advanced (nurse practitioner) programs. "Approximately 70% received one to four hours of education on IPV, approximately 20% received five to ten hours, and less than 10% reported receiving 11 or more hours of education" (Hinderliter et al., 2003, p. 450).

Kingston, Penhale, and Bennet (1995), using a prospective survey design, reviewed all medical schools, nursing colleges, and universities with social work

programs in the U.K. to determine the amount of curricular content related to elder abuse, child abuse, family violence, and IPV. Findings confirmed that 30% of the medical schools, 60% of the nursing programs, and 85% of the social work programs included IPV content. The median amount of time allotted to IPV content in nursing curricula was 4.25 hours, as compared to the median time allotment of 8 hours for child abuse. Elder abuse received a range from 1 hour to 1 day.

Kripke, Steele, O'Brien, and Novack (1998) reported the results of their IPV workshop for medical residents at the Medical College of Pennsylvania. They surveyed attitudes, knowledge, and skills pre- and post-intervention and found significant improvement. However, they found the changes were not maintained over time.

Jonassen et al. (1999) reported their findings regarding attitudes, knowledge, and skills of third-year medical students following an "interclerkship" consisting of 2-day or 3.5-day training sessions regarding domestic violence. The Jonassen study, using the Doepel survey, used a paired *t*-test to compare survey scores before and after the training sessions, and six months after the sessions were completed; quantitative and qualitative measures were used to assess knowledge, skills, and attitudes of the medical students. The students who participated in the interclerkship "significantly improved their knowledge, attitudes, and skills ($p < .001$)" and maintained those improvements six months later (p. 821).

Kiner (1995) surveyed nursing students' opinions on IPV using a 23-item questionnaire composed of opinion statements using a four-point Likert scale. Interestingly, while only two respondents identified the possibility that nursing education should include content related to violence, 52% recommended education as the chief intervention for violence prevention.

Assessment Tools

The inclusion of IPV content in nursing curricula requires ongoing evaluation to determine effectiveness. For this reason a valid assessment tool must be identified. The literature recognizes several assessment tools which have been used to survey change in nursing students' knowledge and attitudes when working with specialized populations. For example, Froman and Owen (2001) reported the validation of an alternative form of the Acquired Immune Deficiency Syndrome (AIDS) Attitude Scale for use in regard to individuals with AIDS in the general population as opposed to patients. This tool measured the attitudes of empathy and avoidance and has often been used to compare attitudes of health profession students as they progress through their coursework. While there are differences between AIDS populations and IPV populations, one might consider the possibility of stigma occurring in both; thus, this tool may be modifiable for use to assess change in attitude, awareness, and knowledge in students learning about IPV.

Rassool and Rawaf (2007) reported findings from their quasi-experimental study which utilized a pre- and post-test design in the study of nursing students' confidence skills with regard to alcohol and drug abuse. This study from the

United Kingdom assessed changes in confidence skills, ability to recognize symptoms, and intervene in the form of providing care, and education/prevention information and referrals. The population in this study presented unique needs, but yet has potential similarities with IPV survivors such as family dynamics, stigma, and misperceptions. It could be an appropriate tool to measure attitudinal, skill confidence, and knowledge change in nursing students after they have had course content on IPV.

Jonassen (1999) assessed the effectiveness of a Domestic Violence Interclerkship for medical studen using the Doepel survey, which included qualitative and quantitative measures. This survey was developed by a panel of five experts in the field and test-retest reliability and concurrent reliability had previously been validated. Doepel (1994) reported a Cronbach's alpha of 0.84 for this survey tool. Changes in knowledge, attitudes, and skills regarding IPV were measured using paired *t*-tests.

Davila (2006) surveyed the public health department to determine what learning needs were present in public health nurses regarding IPV. This study used a pre- and post-test design, and incorporated the Doepel survey to measure attitudes, skills, and knowledge. Davila reported a reliability coefficient of 0.7 in this study. Davila reported a 48% return rate; findings indicated significant difference in skill level after the nurses participated in the IPV training program. Systematic evaluation of IPV training was recommended, along with debriefing opportunities for students/staff that provide care to IPV recipients. Brackley (2008) reported using the same Doepel survey to measure knowledge,

skills, and attitudes as a pre- and post-survey after staff training. This study reported an increase in knowledge from 47% to 65%. The study also reported a staff improvement on skill items from 5.4% to 6.4%. However, the self-reported attitude toward victims decreased slightly, from 126 to 119.

Several studies have measured the effect of IPV education on the attitudes and comfort level of practicing nurses. Schoening, Greenwood, McNichols, Heerman, and Agrawal (2004) reported their findings of a quasi-experimental study using a pre- and post-test in their study of 52 inpatient nurses. In that study, the participants, all licensed nurses, participated in either a 1- hour or 3-hour educational session on IPV. The study participants then received a post-test two months later. Study results indicated a significant three-way interface between length of educational session, previous education, and time. Perrin, Boyett, and McDermott (2000) studied the effectiveness of mandatory continuing education regarding IPV. In 1993, Florida instituted a mandatory 1-hour continuing education in-service on IPV. The researchers surveyed conference attendees from Florida who attended the National Perinatal Association (NPA) in 1993 and again in 1997 to determine change in awareness and identification rates of IPV in pregnant women. Results indicated there was no statistically significant change in awareness and identification; yet, there was a statistically significant increase in the amount of patient education given between 1993 and 1997.

Recommendations for Future Research

The studies reviewed indicate benefits of IPV-focused education on individuals in nursing practice. Recommendations for further research included studying the effect of personal IPV experience on the attitudes and practices of nurses. It would also be useful to study changes in attitudes and skill confidence in nursing students prior to licensure. As indicated earlier, it would be advantageous to determine the effects of IPV education on health professionals over time.

Additionally, due to the prevalence of IPV, it is quite likely that nurses, themselves, have experienced abusive relationships (Stenson & Heimer, 2007); therefore, it would be valuable to survey nurses to determine the extent of personal exposure to IPV and how that personal experience impacts professional practice. Because IPV appears in widely diverse practice settings, it would be helpful to study changes in attitudes and behaviors of nurses in specialty settings, i.e., mental health, community health, dialysis, or substance abuse recovery. There is limited information regarding spiritual distress in clients experiencing IPV (Copel, 2008). Thus, it would be noteworthy to study the change in responses and perceived effectiveness by members of the clergy before and after IPV education.

Theoretical Framework

“Concepts frame our understanding and guide our responses" (Cruz, personal communication, May 19, 2009). The concept of self-efficacy has been used in a variety of contexts to discuss the process of creating change in

behavior, skills, and attitude (Dennis, Tomayasu, McCrone, Goldberg, Bunyard, & Oi.2002; Shellman, 2007; Temple, 2003; Tschetter, 2001). According to Shortridge-Bagget (2002), there are several aspects that impact change in behavior. Such aspects include knowledge, skills, beliefs, attitudes, and social support. Shortridge-Bagget stated that one key variable is "self-efficacy, the belief of people that they can perform specific behaviors necessary to achieve their goals" (2002, p. 3). Bandura (1986) identified self-efficacy as a person's appraisal of one's ability to perform effectively in a specific situation. It is not concerned with the skills one has, but "with judgments of what one can do with" those skills one possesses (Bandura, 1986, p. 891). A well-defined sense of self-efficacy is crucial to promote the perseverance required to achieve a successful outcome.

Bandura (1986, 1977) stated that behavior depends upon one's perceived self-efficacy, which in turn determines not only the behavior selected, but also the extent of perseverance and the quality of the performance. The basic concept behind the self-efficacy theory is that efficacy expectations and outcome expectations predict whether an individual will participate in a specific behavior. Personal characteristics such as perceptions, along with behavior and outcomes of the behavior, in addition to efficacy and outcome expectations, comprise Bandura's model of self-efficacy theory (van der Bijl & Shortridge-Baggett, 2002).

An outcome expectation refers to a person's conviction about the outcome resulting from a particular behavior, while an efficacy expectation (self-efficacy) pertains to the confidence in one's own ability to successfully perform the desired

behavior (Kara, van der Bijl, Shortridge-Baggett, Asti, & Erguney, 2005). Bandura indicated that the strength of one's convictions about their capability to achieve a particular outcome is a determining factor in whether they will make the effort to address a difficult situation (1997). As Van der Bijl and Shortridge (2002) explained individuals "tend to avoid situations they believe exceed their capabilities" (p.14). Bandura (1986) and van der Bijl and Shortridge-Bagget (2002) also stated that outcome expectations are largely dependent upon efficacy expectations. Consequently "self-efficacy predicts performance" much better than does expected outcomes (van der Bijl & Shortridge-Baggett, 2002, p. 10).

Dimensions impacting efficacy expectations include magnitude, strength, and generality. Magnitude pertains to the degree of difficulty associated with the task; strength pertains to the degree of confidence the individual has in achieving a particular task, and generality pertains to the extent that a behavior can be generalized to other situations (Kara, van der Bijl, Shortridge-Baggett, Asti, & Erguney, 2005).

Bandura's model, as illustrated by van der Bijl and Shortridge-Baggett (2002), identified four sources of information which impact self-efficacy. The first source of information is known as mastery experience, or prior successful performance. This is considered the strongest source of information; it is based on the individual's direct experience with previous success. Modeling, the second source, is learned through observing the performance of others. The third source is social or verbal persuasion. This type of persuasion is received through

encouragement and support and is best used to support other sources. The last source, physiological feedback, is least concrete, because people rely on physical and emotional states, such as stress perceptions, to evaluate their capabilities. See figure 1, Self Efficacy Model.

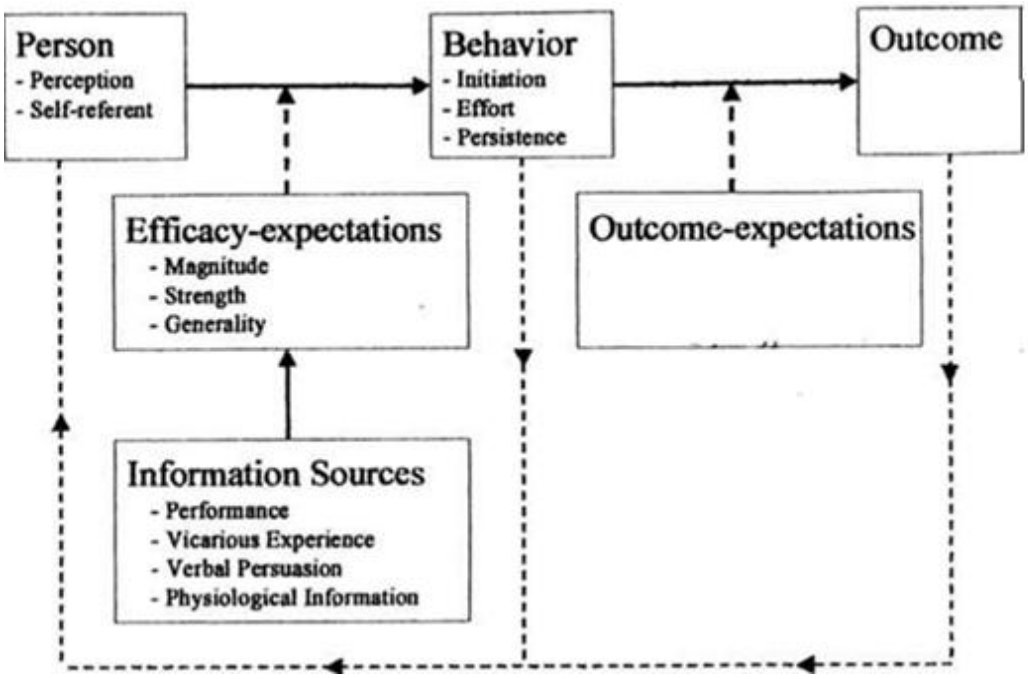


Figure 1: Self-efficacy model (Shortridge-Bagget & van der Bijl, 2002)

Teaching strategies were selected to facilitate efficacy expectations. Active learning principles pertain to "information sources" used in the self-efficacy model as illustrated by van der Bijl and Shortridge-Bagget (2002). According to Driscoll's perspective on active learning, learning occurs in context; therefore, faculty may have to create a context for students to process their learning. Learning is active and learning activities that engage the student will help the learner draw connections between existing knowledge and new material. Learning is social; thus, students benefit from working collaboratively with others which allows different perspectives to be shared. Lastly, according to Driscoll,

learning is reflective, and student learning improves when given the opportunity and support to evaluate their thinking (Driscoll, 2002). This course included discussion forums and reflection on experiences and observations related to course activities. Course activities included observational experiences at many community agencies, such as, a domestic violence shelter, correctional facilities, the YWCA, and other agencies serving children and adults who have experienced violence. "An effective curriculum provides multiple opportunities to apply and practice what is learned," (Diamond, 1998, p. 85). In order to provide opportunities to practice vital assessment skills, the use of standardized patients proved to be an effective option. Standardized patients are individuals who have been trained and briefed by medical experts "to portray real patients with specific problems" and symptoms (Freedberg, 2008). Standardized patients are used to promote instruction and evaluation of clinical skills (Jonassen et al., 1999; Brender, Burke, & Glass, 2005; Freedberg, 2008). Many authors indicated this sort of focused and highly developed role play used in clinical settings, such as, medical school, nursing and pharmacy programs has well established success and has been used for more than 40 years (Barrows, 1993; Becker, Rose, Berg, Park, & Shatzer, 2006; Freedberg, 2008; Gibbons et al., 2002).

Summary

The literature indicated IPV carries dramatic and far-reaching consequences for society. Those in the nursing profession have a unique opportunity to make a difference in the lives of women and children who experience the harsh reality of IPV. However, according to the literature, nurses

often indicated they believe themselves to be ill-equipped to offer appropriate and beneficial interventions.

ANA issued clear directives in 1992 for nursing education to address IPV; in 2000, AACN published the statement that nursing education must provide "factual information and clinical experience" (p. 63). Numerous studies reported the need for nursing curricula to incorporate education on assessment and intervention related to IPV. This study documents an educational intervention and assesses its effectiveness as measured through perceived change in student attitudes, skills, and knowledge. IPV will continue to be a national health care epidemic until health professional education can adequately prepare nurses of the future.

CHAPTER 3

Methodology

Introduction

This chapter presents the study design used for this research study. A description of the sample, ethical considerations, instrumentation used and data analyses are also discussed.

Design

This study used a quasi-experimental design. Polit and Beck (2008) described quasi-experimental design as "a design for an intervention study in which subjects are not randomly assigned to treatment conditions" (p. 763). This particular design was especially appropriate for this study because randomization was not possible, as students were placed in the experimental group by self-selection, meaning they personally selected to enroll in the IPV course. Burns and Grove (2003) indicated the purpose of quasi-experimental research is to "determine the effect of one variable on another" (p. 28).

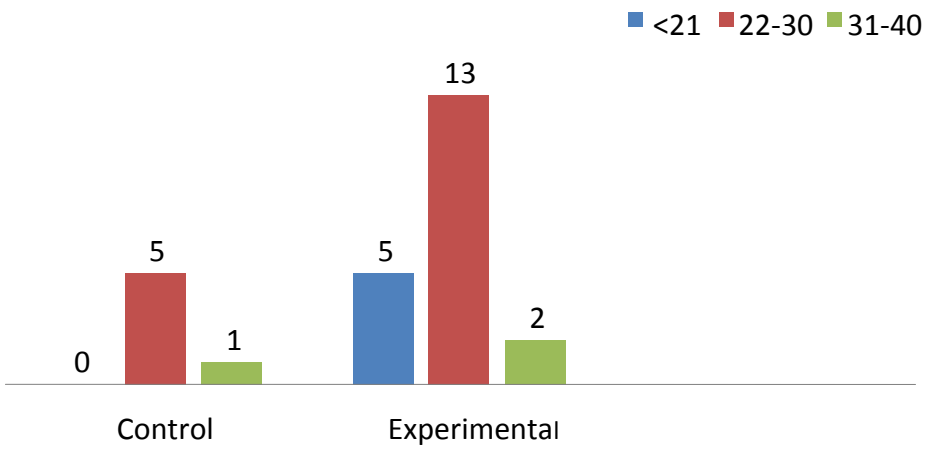
Sample

The sample participants were students enrolled in a non-clinical nursing elective at a local Midwest college. Students enrolled in a non-clinical nursing elective on IPV were invited to participate in the study (see Appendix A). Originally there were 21 students enrolled in the course on IPV; however one student withdrew from the course. Thus, the experimental group was comprised of 20 students (N=20). The control group originally started with seven students enrolling, however one student withdrew from the course leaving a sample size

of six (N=6). The control group was very similar to the experimental group, because they were students who chose to enroll in a different non-clinical elective course. The time period for enrolling in non-clinical elective courses is typically during the junior or senior years. Thus, the control and experimental groups were similar in educational progression.

The majority, 69% (N= 18), of the entire student samples of both the experimental and control groups, was between 22- to 30-years of age (Figure 2: Age of Participants).

Figure 2: Age of Participants



In the experimental group, 65% (N=13) and 83% (N=5) in the control group, were between the ages of 22- to 30-years of age. The sample was predominantly female (88.5%, N=23) (See Figure 3: Gender). Of the entire combined group of both experimental and control subjects, 65% (N=17) perceived themselves as having "some" background knowledge, with 13 in the experimental group and 4 in the control group (See Figure 4: Background Knowledge). In the experimental group, 70% (N=14) had previously attended a

three-hour presentation on family violence in their community/mental health nursing course, while 50% (N=3) of the control group had attended the three-hour family violence presentation in a previous course. (See Figure 5: Prior Nursing Education).

Figure 3: Gender of Participants

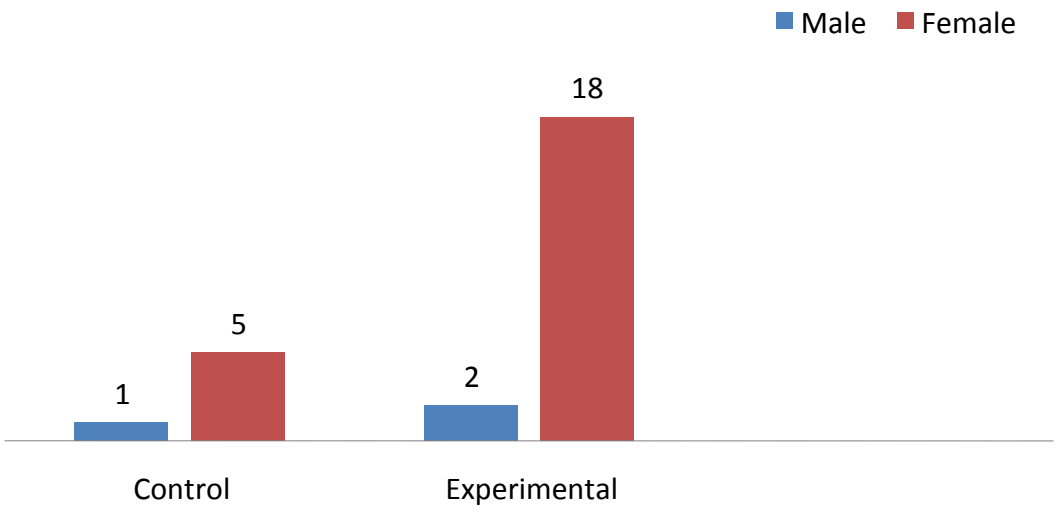


Figure 4: Background Knowledge

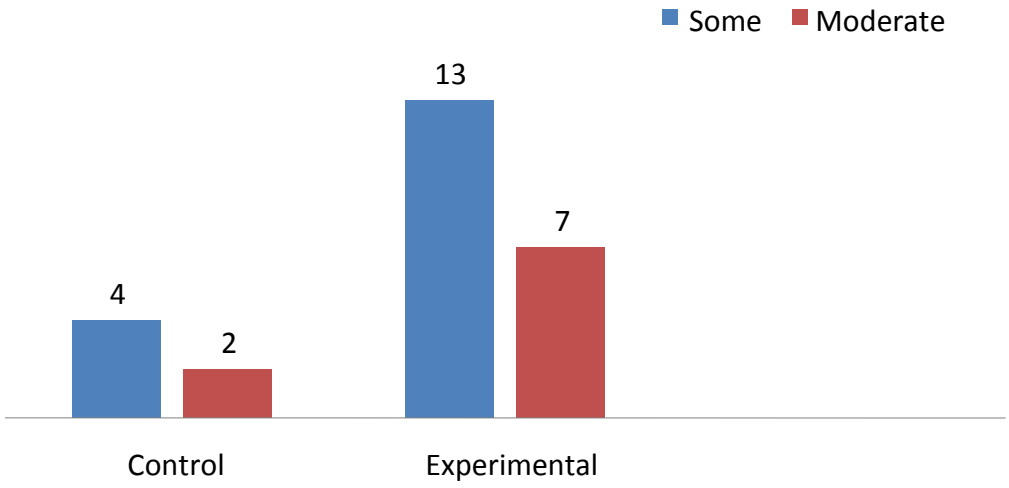
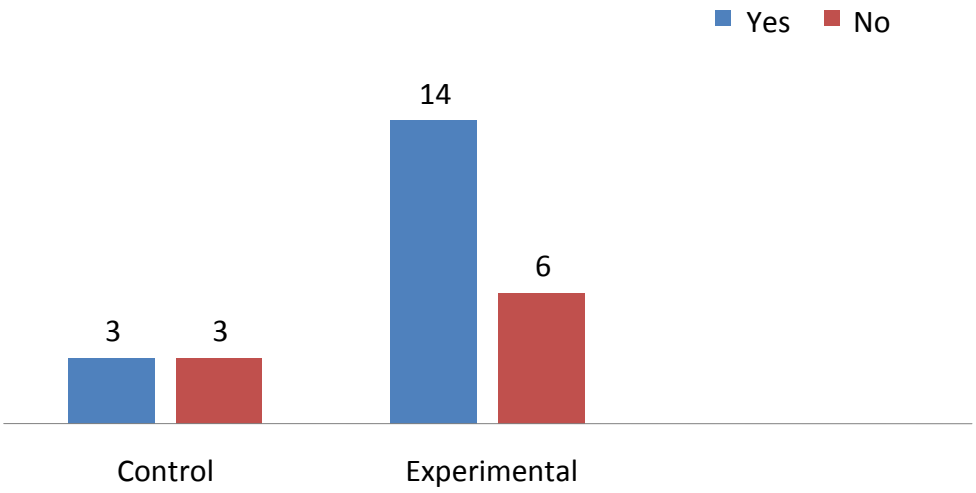


Figure 5: Prior Nursing Education



All participants were Caucasian. One student from each of the control and experimental groups dropped out of the study due to withdrawal from their non-clinical elective courses.

Variables

The dependent variables were attitudes, skills, and knowledge of IPV as held by nursing students. The independent variable was a 10-week, 2-credit, non-clinical nursing elective course on IPV (see Appendix G). A variety of instructional strategies were used to facilitate student learning in this course. In addition to assigned readings and class and online discussions, the course also included several active learning strategies involving a selection of community-based experiences. These experiences included, but were not limited to, the following options: visits to a domestic violence shelter, a community agency

serving psychosocial, physical, and legal issues related to children experiencing effects of IPV, ongoing interactions with a representative from the Domestic Violence Coordinating Council, a training overview with the Sexual Assault Nurse Examiners and Sexual Assault Response Team (SANE/SART), and community presentations to various local schools regarding bullying prevention. After completing these experiences, students developed a community campaign of their choice and presented it to an appropriate entity. On the last day of the course students were placed in simulation assessment situations using standardized patients.

Ethical Considerations

Ethical considerations included informed consent and confidentiality. Confidentiality was assured and maintained through the use of students self-selecting an identifying code known only to them. Thus, the surveys were completed anonymously. The students who chose to participate were informed that their participation was voluntary. They were informed of their rights as research participants and given the opportunity to ask questions and to opt out of the study at any time (see Appendix B). They signed the consent form (see Appendix A) at the first class session. They were made aware that their course grade was in no way influenced by their participation in the study. Institutional Review Board (IRB) application processes were followed, and IRB approval was obtained. (See Appendix A). Both the experimental and control groups completed the pre-survey in the first class session and post-surveys were completed at the end of the course. The course syllabus outlined the experiences included in the

course content. The students gave written consent for use of their reflective writing excerpts (See Appendix C), and the students enrolled in the course were reminded that confidential counselors were available through student services in the event emotional responses were elicited.

Instrumentation

A demographic questionnaire was used to describe the sample (see Appendix D). Demographic data included age range, gender, and prior experience/education pertaining to IPV. The Doepel survey (See Appendix E) was the instrument selected for this study. The Doepel survey "was created by five experts in the area of domestic violence; its test-retest reliability and concurrent validity have been previously validated" (Jonassen et al., 1999, p. 823). Electronic communication with the tool's originator, David Doepel, was obtained to verify accuracy in scoring and to acquire approval of minor modifications of the tool to reflect terminology/values consistent with social circumstances in 2009. Doepel acknowledged that these minor alterations would not alter the intent or integrity of the survey tool (personal communication, Oct. 24, 2008 – Nov. 20, 2008). Additional qualitative questions were added by the investigator to elicit further data from the respondents regarding personal perceptions (see Appendix F).

Internal consistency of the survey tool was determined with both the experimental and control groups by the calculation of a coefficient alpha, or Cronbach's alpha score. The Cronbach's alpha is a commonly used reliability indicator that estimates the "extent to which different subparts of an instrument

are reliably measuring the critical attribute" (Polit & Beck, 2008, p. 455). The typical values range from .00 to +1.00, and higher values reflect greater internal consistency. Doepel (1994) reported a Cronbach's alpha score of .84 when using this survey with medical students. Davila (2006) reported a Cronbach's alpha of .7 when using the survey tool with registered nurses. The Cronbach's alpha score for this study was .679. George an d Meary (2003) offered the following guidelines regarding interpretation of Cronbach's alpha scores: "_ > .9 – Excellent, _ > .8 –Good, _ > .7 – Acceptable, _ > .6 – Questionable, _ > .5 – Poor, and _ < .5 –Unacceptable" (p. 231). Using this guide, the Cronbach's alpha score for this study of .679, would fall within the upper range of questionable and acceptable. Rudner and Schafer (2001) reported that test reliability coefficients of .50 or .60 may be satisfactory for tests not administered for making decisions such as academic progression or standardized achievement.

Attitudes toward batterers, survivors, abusive relationships and personal and professional responses were measured using a 6-point Likert scale. The Likert scale was a 26-item tool. The minimum possible score for the attitude scale was 26, with a maximum possible score of 156. The higher score was reflective of a more positive attitude toward situations associated with IPV. Skills were measured through the use of ten multiple-choice and true-false items addressing referral strategies, safety planning, initial communication, and actions taken by nurses when responding to IPV. Knowledge was also measured with ten multiple-choice and true-false items focusing on disclosure, abuser and recipient profiles, safety, and follow-up actions.

Repeated measures analyses of variance (ANOVA) were used to compare students' scores on the Doepel surveys at three different times during the intervention period. According to Polit and Beck (2008), repeated measures ANOVA is used "when there are three or more measures of the same dependent variable for each subject" (p. 599).

Short-answer questions asked participants to recall and describe their initial understanding of IPV and discuss how their understanding of IPV changed after taking the course. Participants were also asked to describe selected experiences and describe their impact on the students' perceptions. Lastly, participants were asked to rate the degree of their perceived confidence in responding effectively to IPV when they are practicing as RNs.

A demographic questionnaire was used to obtain information regarding the sample. Demographic data included age range, gender, and prior experience/education pertaining to IPV. Descriptive statistics, "used to describe and summarize the data" were used to describe the study sample (Polit & Beck, 2008 p. 792).

Summary

In summary, this study used a quasi-experimental design to determine change in student attitude, skills, and knowledge after participating in an educational intervention. The elective nursing course designed for this study used a variety of active learning strategies.

The experimental sample had a total of 20 participants, and the control sample had a total of six participants. Repeated measures ANOVA were used to

analyze the findings and qualitative responses were obtained through the use of short answer questions. The study was approved by the Institutional Review Board.

CHAPTER 4

Results

Introduction

The purpose of this study was to determine whether an educational intervention had an effect on the attitude, skills, and knowledge of nursing students. This chapter will discuss the descriptive, inferential, and qualitative findings from this study.

Overview

The impact of the non-clinical nursing elective was assessed primarily through the use of quantitative measures. Qualitative measures were also used to verify students' perceptions of their experiences.

The participants completed the survey at the beginning of the course, at week nine, at which time all didactic content was completed, and again at week ten, after which they had completed all aspects of the course, including the standardized patient assessment. The survey tool measured students' attitudes, skills, and knowledge pertaining to IPV. This survey tool was developed by five professionals who had expertise in the area of IPV. Test-retest reliability and concurrent validity had prior validation (Jonassen et al, 1999).

Data Analysis

Repeated measures ANOVA were obtained from each of the three survey periods. The means of each testing period were obtained.

The research question under investigation in this study was: Is there a difference in nursing students' perceived attitudes, skills, and knowledge after an educational intervention than before the educational intervention?

The research hypothesis was as follows:

Participants who take a non-clinical elective course on IPV will score higher on attitude, skills, and knowledge than those participants who did not take a non-clinical elective on IPV.

Table 1

Descriptive Statistics, Attitude, Time 1, 2, 3 Experimental Group

	Minimum	Maximum	Mean*	Standard Deviation*	N
Time 1 attitude total	109	145	134.00	9.06	19
Time 2 attitude total	105	154	138.32	10.58	19
Time 3 attitude total	118	156	146.47	8.30	19

*Rounded to nearest hundredth

Data were analyzed using descriptive statistics and inferential statistics. Repeated Measures ANOVA was the inferential statistic used to determine differences in attitude, skills, and knowledge reflected in mean scores of three different testing periods. The dependent variable was total attitude score. As indicated by Table 1, the initial minimum score was 109 and the maximum score was 145 out of a possible 156, indicating a rather wide range of attitude at the beginning of the course. The pretest mean score was 134 (*SD* = 9.06). On the second testing session the minimum score actually decreased to 105, while the

maximum score increased to 154. The mean attitude score for time 2 was 138.32 (*SD* = 10.58). On the final testing session the minimum score was 118 and the maximum score was 156.The mean attitude score for time 3 was 146.5 (*SD* = 8.3). The standard deviation decreased, indicating there was, in fact, a smaller range of scores for attitude at the end of the course. For attitude, the ANOVA was significant, *F* (2, 36) = 26.20, *P* <.01. Comparisons revealed that all three means were significantly different from each other. Thus, the hypothesis that participants who take a non-clinical elective on IPV will score higher on attitudes, skills and knowledge than those participants who did not take a non-clinical elective on IPV was supported. (See figure 6)

Figure 6. Experimental Group Attitudes.

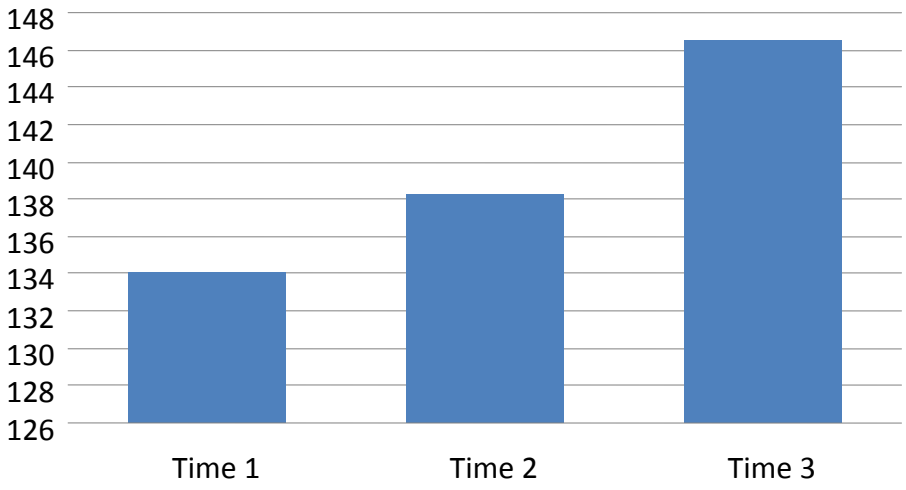


Table 2

Descriptive Statistics, Attitude, Time 1, 3 Control group

	Minimum	Maximum	Mean*	Standard Deviation*	N
Time 1 attitude total	127	154	138.67	9.61	6
Time 3 attitude total	115	149	135.43	14.33	5

*Rounded to nearest hundredth

The control sample was surveyed twice, at the beginning of their elective nursing course, and again at the end. The times are reported as Time 1 and Time 3. There is no report for Time 2, as only pre-and post-surveys were obtained. Due to the small sample size of the control group, data were not inferentially analyzed; however, changes in mean score of attitude can be examined visually. The dependent variable was total attitude score. As indicated by Table 2, the initial minimum score for attitude was 127, with a maximum score of 154. Factors that may account for this high initial score included the age of learners and the number of students who had previous education on the subject. The pretest mean score was 138.67 (*SD* = 9.60). On the final testing session, time 3, the minimum score was 115 and the maximum score was 149. The mean attitude score for time 3 was 135.4 (*SD* = 14.33). The mean attitude score in the control group actually decreased between the two testing periods. The standard deviation increased between the initial and final testing periods, indicating that the range of attitude scores increased over time. (See figure 7.)

Figure 7. Control Group Attitudes.

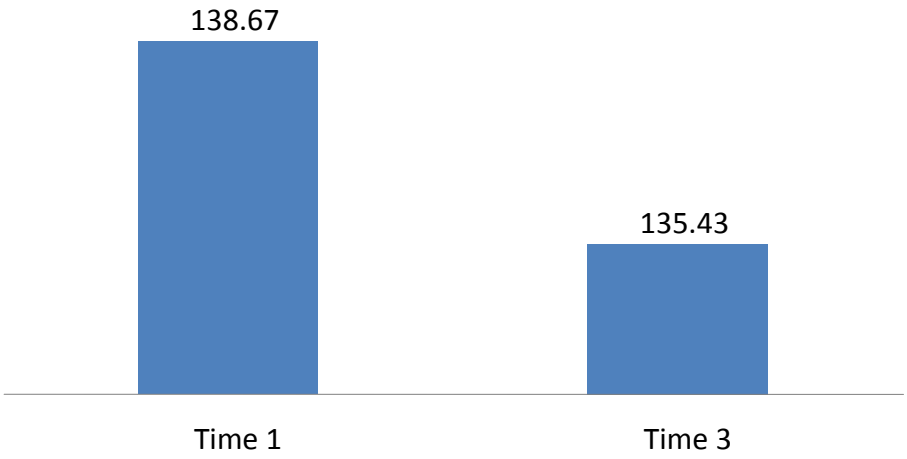


Table 3

Descriptive Statistics, Skills, Time 1, 2, 3 Experimental Group

	Minimum	Maximum	Mean*	Standard Deviation*	N
Time 1 skills total	4	9	6.74	1.48	19
Time 2 skills total	4	9	7.32	1.38	19
Time 3 skills total	5	9	7.63	1.26	19

*Rounded to nearest hundredth

Data were analyzed using descriptive statistics and inferential statistics. Repeated Measures ANOVA was the inferential statistic used to determine differences in attitude, skills, and knowledge reflected in mean scores of three different testing periods. The dependent variable was total skills score. As indicated by Table 3, the initial testing minimum score was 4 and the maximum

score was 9. The pretest mean score was 6.74 (*SD* = 1.48). The mean skills score for time 2 was 7.32 (*SD* = 1.38), with scores ranging from a minimum of 4 and a maximum of 9. The mean skills score for time 3 was 7.63 (*SD* = 1.26), with scores ranging from a minimum of 5 to a maximum of 9. For skills, the ANOVA was not significant, *F* (2, 36) = 2.67, *P* >.05. Comparisons revealed that while scores differed, with the trend appearing to show an improvement, there was no significant difference between the mean scores. With the resulting increase in scores for skills, the hypothesis stating that participants who take a non-clinical elective course on IPV will score higher on attitudes, skills, and knowledge than those participants who did not take a non-clinical elective on IPV is supported. (See figure 8.)

Figure 8. Experimental Group Skills.

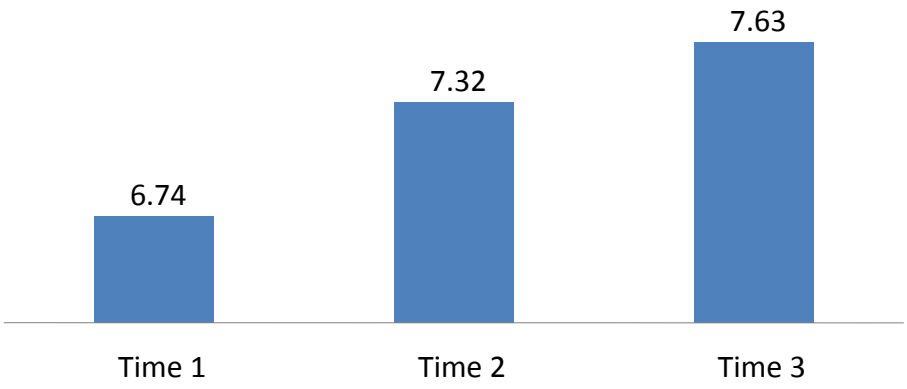


Table 4

Descriptive Statistics, Skills, Time 1, 3 Control Group

	Minimum	Maximum	Mean*	Standard Deviation*	N
Time 1 skills total	4	8	6.00	1.41	6
Time 3 skills total	6	8	7.00	1.00	5

*Rounded to nearest hundredth

Due to the small sample size of the control group, data were not inferentially analyzed; however, changes in mean score of attitude can be examined visually. The dependent variable was total skills score. As indicated by Table 4, the pretest mean score was 6.00 (*SD* = 1.41), with the initial minimum score of 4 and the initial maximum score of 8. The mean attitude score for time 3 was 7.00 (*SD* = 1.00) with the final scores ranging from a minimum of 6 and a maximum of 8. The mean skills score in the control group showed a slight increase between the two testing periods. The standard deviation increased between the initial and final testing periods, indicating that the range of attitude scores decreased slightly over time. (See figure 9.)

Figure 9. Control Group Skills.

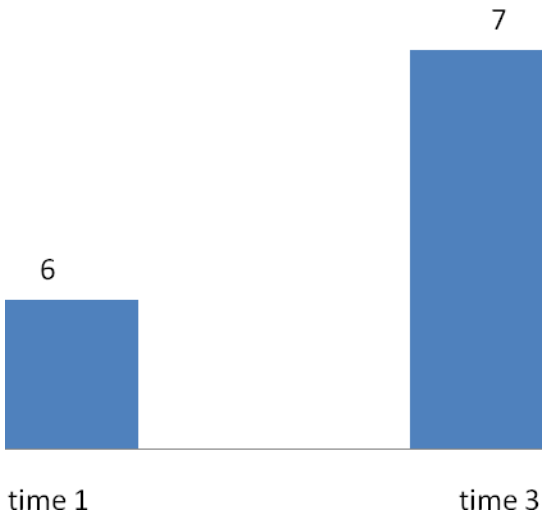


Table 5

Descriptive Statistics, Knowledge, Time 1, 2, 3 Experimental Group

	Minimum	Maximum	Mean*	Standard Deviation*	N
Time 1 knowledge total	3	9	5.89	1.60	19
Time 2 knowledge total	4	8	6.21	0.98	19
Time 3 knowledge total	4	10	6.63	1.38	19

*Rounded to nearest hundredth

Data were analyzed using descriptive statistics and inferential statistics. Repeated Measures ANOVA was the inferential statistic used to determine differences in attitude, skills, and knowledge reflected in mean scores of three different testing periods. The dependent variable was total knowledge score. As indicated by Table 5, the initial testing minimum score was 3, and the initial

testing maximum score was 9. The pretest mean score was 5.89 (*SD* = 1.59). The mean skills score for time 2 was 6.21 (*SD* = 0.98) with a minimum score of 4 and a maximum score of 8. The mean skills score for time 3 was 6.63 (*SD* = 1.38), with scores ranging from a minimum of 4 and a maximum of 10. For skills, the ANOVA was not significant, *F* (2, 36) = 2.18, *P* >.05 (*P*= .127). Comparisons revealed that while the means differed, with the trend appearing to show an improvement, there was no significant difference between the mean scores. Thus, the hypothesis that participants who take a non-clinical elective course on IPV will score higher on attitudes, skills, and knowledge than those participants who did not take a non-clinical course on IPV is supported. (See figure 10.)

Figure 10. Experimental Group Knowledge.

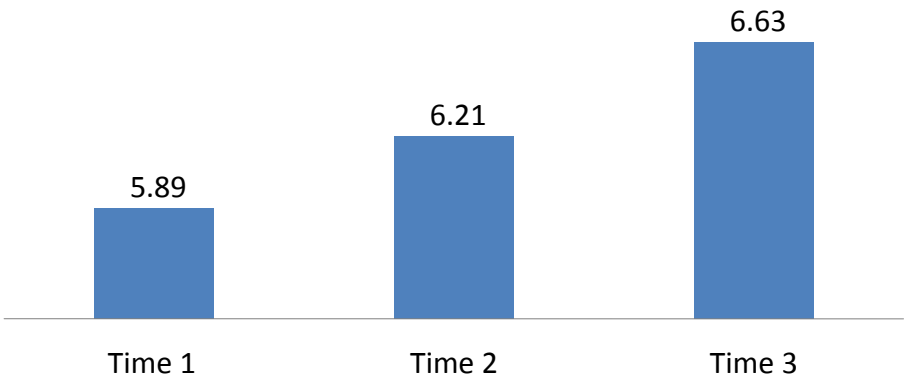


Table 6

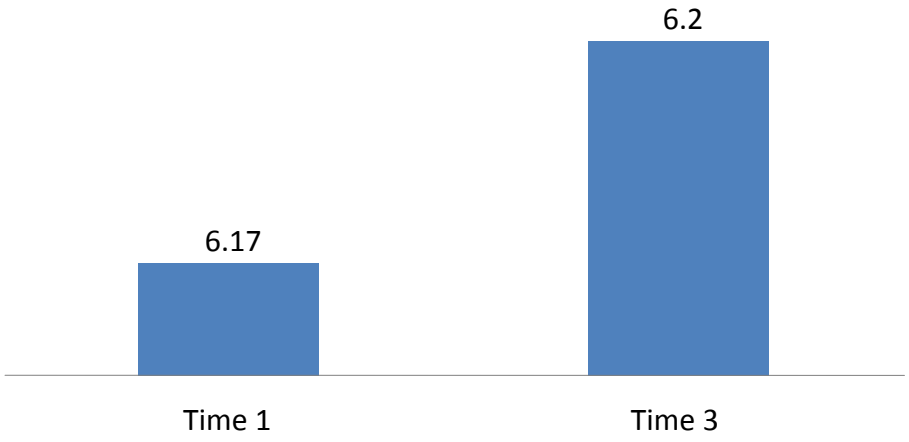
Descriptive Statistics, Knowledge Time 1, 3 Control Group

	Minimum	Maximum	Mean*	Standard Deviation*	N
Time 1 knowledge total	4	8	6.17	1.47	6
Time 3 knowledge total	4	8	6.20	1.48	5

*Rounded to nearest hundredth

Due to the small sample size of the control group, data were not inferentially analyzed; however, changes in mean score of knowledge can be examined visually. The dependent variable was total knowledge score. As indicated by Table 6, the pretest mean score was 6.17 (*SD* = 1.47), with scores ranging from a minimum of 4 and a maximum of 8. The mean attitude score for time 3 was 6.20 (*SD* = 1.48), with scores ranging from a minimum of 4 and a maximum of 8. There was little change in the range of scores for the control group regarding knowledge. (See figure 11.)

Figure 11 Control Group Knowledge.



Qualitative Findings

The last survey session also included the opportunity for respondents to reply with short answers to open ended questions.

Question 1: Recall and describe your initial understanding of IPV.

Twelve out of the 19 respondents stated their initial understanding was mental, physical, and emotional abuse between partners in a current or past relationship. Data suggested that students overall had a basic understanding of IPV prior to taking the course. This may, in part, be due to the three hours of content presented in an earlier nursing course. It could also be due to the possibility that students who already had an awareness of IPV were more likely to register for the elective course. Other responses included “a recurring cycle,” and “stuff you see on “*Lifetime,*” not to real people.”

Question 2: How has your understanding changed as a result of taking this course?

Themes identified in the responses were “greater understanding” (9 responses); another change identified was an increased awareness of the prevalence of IPV (5 responses). Students also identified an increased knowledge regarding how to assess for IPV. Students commented that they became more aware of community resources. One of the responses stated, “I understand how women think, act, and react, which will help me when I am confronted with this situation.”

Question 3: Select 1-2 experiences you had in the course and how it impacted your attitude toward IPV.

Thirteen respondents identified the guest speakers, who were survivors of IPV, as having the most significant impact on their attitudes. One student, when referring to the speakers wrote, “I felt captivated,” “the speakers were heartbreaking yet inspiring.” Another student wrote, “The speakers made me feel like I could make a difference.” Students agreed that the speakers “put a face to this issue.”

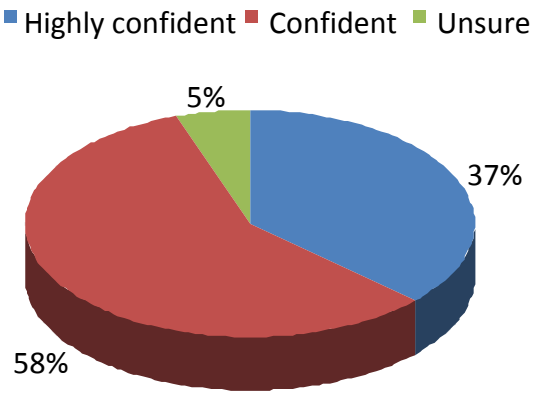
Students also selected their time with the Sexual Assault Nurse Examiners and Sexual Assault Response Team (SANE/SART) as having an impact on their learning; they also identified the simulation experience as being valuable because it “allowed us to do an entire assessment.” Another course experience students identified was the community campaign, in which students selected a particular aspect of IPV and created a community campaign to share

with an appropriate audience. Examples included IPV in pregnancy, IPV in other cultures, and date rape.

Question 4: When you are licensed as an RN, and you encounter IPV, how confident are you that you will respond effectively?

One student (5 %) responded as being “unsure;” 34% (N= 7) responded with “highly confident,” and 57 % (N= 11) responded with “confident.” (See figure 12: Perceived Confidence.)

Figure 12: Perceived Confidence



Summary

In summary, analyses of each of the scores revealed findings worthy of consideration. Students who enrolled in the elective nursing course on IPV did have a statistically significant change in attitude. Mean attitude scores improved in each of the testing sessions. Mean scores on skills and knowledge did improve over the duration of the course but were not statistically significant. Furthermore, a review of the qualitative responses indicated that students perceived themselves as being “confident” to “highly confident” in their ability to intervene

effectively with survivors of IPV when practicing as a licensed registered nurse.

Similar findings were not seen in the control group who did not take the IPV elective. Because of the small size of the control group, inferential statistics were not obtained and interpretation is based upon a visual review of means and standard deviations. The scores in the control group reflected little change. Overall, their scores were not dissimilar from the experimental group during pre-testing, but did not reflect consistent or major increases during the length of the course. A possible explanation for this phenomenon may be because the experimental and control groups were very comparable in terms of age, amount and type of education, and the majority of the entire sample had previously attended a three-hour presentation on IPV in their psychiatric-community health nursing course.

The experimental group scores did indicate an improvement in all three aspects, those of attitude, skills, and knowledge. The improved scores suggest an increased awareness of and sensitivity toward IPV survivors and related issues which was supported by the qualitative analysis.

CHAPTER 5

Discussion and Summary

Introduction

This chapter will discuss the purpose of this study, research design, interpretation of results and correlation to the literature and correlation to the theoretical context. It will also discuss the implications for nursing education and future research.

Research Question and Interpretation

The purpose of this quasi-experimental study was to determine whether or not an educational intervention would make a difference in nursing students' perceived attitudes, skills, and knowledge regarding IPV. The research question was as follows: Is there a difference in nursing students' perceived attitudes, skills, and knowledge after an educational intervention than before the educational intervention?

A summary of the findings indicated that the experimental group who received the educational intervention in the form of a ten-week elective nursing course on IPV had an increase in mean scores related to attitude, skills, and knowledge. The control group, who did not receive the educational intervention on IPV, demonstrated scores that did not reflect a meaningful change in attitude, skills, or knowledge.

Limitations of Study

The limitations of this study included the study design. The quasi-experimental design allowed for study subjects who were not randomly assigned.

In this study, participants self selected which nursing elective course in which they would enroll. The possibility that an individual participant would select a particular course based on specific reasons such as personal interest, personal history, or prior experience could not be discounted. Additionally, participants may have encountered personal experience or awareness of IPV during the time period in which they were enrolled in the course.

This course was offered in a small Midwestern private college of nursing and allied health professions. The student body at this college is rather homogenous in nature, having minimal ethnic, gender, and/or socioeconomic diversity. Elective nursing courses are offered to students in the last two years of their nursing program. Thus, participants will have very similar levels of education and bring into the course a very similar educational background.

Generalizability is limited due to the small sample size. Twenty-one participants registered for the elective course on IPV, and of those, twenty completed the course. The control group consisted of seven participants who were registered for a different elective course which did not address any IPV related content. Of these, six participants completed the course. Both courses had one participant withdraw from the course after the first week of class.

Discussion

This study carries many implications pertinent to issues identified in the literature. Numerous authors reported that distressing effects of IPV are seen in a multitude of health care settings. Some of the identified settings reported include college student health services (Amar & Gennaro, 2005), women's health (Bryant

& Spencer, 2002), obstetrics (Furniss, McCaffrey, Parnell, & Rovi, 2007), primary care clinics and public health departments (McFarlane, Groff, O'Brien, & Watson, 2006; Davila, 2006). Effects of IPV have also been reported in health care settings such as pediatrics (Knapp, Dowd, Kennedy, Stallbaumer-Rouyer, & Henderson, 2006), emergency care settings (Yonaka, Yoder, Darrow, & Sherck, 2007) behavioral health (Vandemark & Mueller, 2008), correctional settings and forensic nursing (Freedberg, 2008). "It is reasonable to believe that nurses will have contact with victims or perpetrators of violence in all practice settings" (Freedberg, 2008, p. 202).

Because of the vast array of health care settings in which nurses function, and the wide assortment of professional and interpersonal contacts inherent in the nursing role, nurses remain in a unique position to initiate opportunities for disclosure and assess for the occurrence of IPV (AACN, 2000; Roberts, 2006). Subsequent follow up in the form of physical and emotional assessments, safety planning, and suitable referrals can then occur. To ensure that professional nurses were equipped for tasks such as these, AACN and ANA issued position statements making the recommendation that nursing students enrolled in baccalaureate and graduate education programs receive both theoretical and clinical content on IPV (AACN, 1999; ANA 2000). As Freedbergy (2008) confirmed, creative teaching strategies are needed to prepare nurses to respond to violence related issues.

Upon completion of the assigned community campaign project, it appeared that students had recognized that IPV occurs in a variety of hospital

and community settings. They developed educational community campaigns to address IPV in a variety of contexts. For example, one community campaign addressed IPV as a cultural issue, created a brochure identifying resources specific to that particular culture, and placed them in the Visiting Nurses Association. Another community campaign project addressed the occurrence of IPV in pregnancy and created an educational leaflet to be placed in an obstetrics clinic, outlining warning signs and suggesting available resources. One campaign included the development of a poster to educate a college population on date rape. Students acknowledged the learning value of this assignment and appeared to demonstrate an awareness of the diverse health care settings in which IPV may be seen.

The literature revealed that nurses in professional practice reported a lack of education related to IPV in their nursing curricula (Hinderliter, et al., 2003; Woodtli & Breslin, 2002). Woodtli (2000) surveyed nurses who identified skills needed by nurses when providing care of women and family members affected by IPV. The core skills that were identified included physical assessment skills and social and psychological assessment skills. Campbell (1992) recommended that nursing education include IPV and offer clinical experiences as well as classroom content as a means of violence prevention by involving students in those efforts. Various authors cited educational strategies including one-day immersion project (Davila, 2005), or training modules of 20-22-hour duration, placed in selected nursing courses (Hayward & Weber, 2003; Hinderliter, et al., 2003).

Upon completion of the nursing elective, students identified significant learning experiences including hearing first-hand experiences from survivors who experienced IPV. Students also stated that the simulated assessment with the standardized patient had a key impact on their attitudes toward IPV. During the simulated assessment each student was randomly assigned a role of a health care team member and performed the skills associated with that role, working together as a team in a simulated emergency room scenario. Such roles included triage, assessment, documentation, referral, and planning care for a victim of IPV. As noted in qualitative findings, students perceived themselves as being capable and confident in their assessment and intervention skills.

When the respondents were asked to identify their perceived level of self-confidence in their abilities to respond effectively as Registered Nurses, 37% (N=7) respondents identified themselves as being “highly confident,” and 58% (N=11) identified themselves as being “confident.” One respondent, or 5% of the sample, rated him/herself as being “unsure.”

The findings of this study relate well to Bandura’s theory of Self-Efficacy and appear to correlate directly with the model depicted by Shortridge-Baggett and van der Bijl (1996). In this study, the “Information Sources,” would pertain to the “performance“ addressed through the use of role modeling of therapeutic communication processes involved in assessment and in the demonstration achieved through the simulated assessment with the standardized patient. “Vicarious experience” may have been addressed through time spent with the SANE/SART team and reviewing assessment strategies and documentation. The

simulated assessment, which included giving and receiving feedback from faculty and peers allowed for students to participate in “verbal persuasion.” The “Physiological information” was evidenced when students identified their own levels of anxiety and tension. They recognized that an experience they expected to be stressful, the simulated assessment scenario, which would result in decreased self-efficacy, proved to be a challenge they met with increased skill and confidence. These “information sources” then contributed to the efficacy expectations held by the individual student, which allowed them to competently perform desired behavior. The confidence to initiate action at this level may result in strengthened outcome expectations, as it is likely students will recognize that they can take effective action which can make a difference in the lives of their clients experiencing IPV. It is hoped that outcome expectations will influence the overall outcome regarding nursing’s response to IPV.

Recommendations for Future Research

There are several recommendations for future research based on a review of literature. Because of the prevalence of IPV, one area suggested in the literature would be the examination of the effects of personal experiences with IPV on nurses who are providing care to other victims of IPV. Do nurses who personally experienced IPV respond more supportively and demonstrate different capabilities in intervening effectively?

The findings from this study suggested that nursing students who receive education and structured learning activities have an improvement in attitude, skills, and knowledge regarding IPV intervention. Further study would be

beneficial to determine if these changes persist over time or diminish once the course is completed.

Some literature indicated that recipients of IPV identified spiritual distress as a result of their experiences. Because clergy are often approached for guidance and support for families experiencing IPV, it may be valuable to survey clergy members regarding their attitudes, knowledge, and skills before and after an educational program addressing IPV related content.

Summary

This quasi-experimental study examined the effects of an educational intervention on attitudes, skills, and knowledge held by nursing students. One of the strengths of this study is that it is field research, conducted “in real time.” Generalizability of the findings is limited due to the small sample size and localized geographic region. According to Shortridge-Baggett (1996), effective educational interventions are “essential for persons to learn the necessary knowledge and skills required” for self-efficacy (p. 5). This study was an attempt to facilitate a change in nursing students’ attitudes, skills, and knowledge related to intervening in the difficult circumstances associated with IPV.

References

American Association of Colleges of Nursing. (2000). Position statement: Violence as a public health problem. *Journal of Professional Nursing, 16*(10), 63-69.

American Nurses Association. (1992). Position statement on physical violence against women. *American Nurse, 24*(4), 8.

Alpert, E. (2002). Domestic violence and clinical medicine: Learning from our patients and from our fears. *Journal of General Internal Medicine, 17*(2), 162-163.

Amar, A., & Gennaro, S. (2005). Dating violence in college women. *Nursing Research, 54*(4), 235-242.

Attitude. (2009). In *Merriam-Webster Online Dictionary.* Retrieved June 2, 2009, from http://www.merriam-webster.com/dictionary/attitude

Bandura, A. (1977). Toward a unifying theory of behavioral change. *Psychological Review, 84*(2), 191-215.

Bandura, A. (1986). *Social foundation of thought and actions: A social cognitive theory.* Englewood Cliffs, NJ: Prentice Hall.

Barrows, H. (1993). An overview of the uses of standardized patients for teaching and evaluating clinical skills. *Academic Medicine, 68,* 443-453.

Becker, K.; Rose, L.; Berg, J.; Park, H.; & Shatzer, J. (2006). The teaching effective of standardized patients. *Journal of Nursing Education, 45*(4), 103-111.

Belknap, R. (2003). Understanding abuse and violence against women: A two-day immersion course. *Nurse Educator, 28(4),* 170-174.

Brender, E.; Burke, A.; & Glass, R. (2005). JAMA patient page: Standardized patients. *Journal of the American Medical Association, 294,*1172.

Bryant, M. (2004). *The portable dissertation advisor.* Thousand Oaks, CA: Corwin Press.

Bryant, S., & Spencer, G. (2002). Domestic violence: What do nurse practitioners think? *Journal of the American Academy of Nurse Practitioners, 14*(9), 421-427.

Burns, N., & Grove, S. (2003). *Understanding nursing research* (3rd edition). Philadelphia: W. B. Saunders Co.

Campbell, J. (1992). Ways of teaching, learning & knowing about violence against women. *Nursing & Health Care, 13*(9), 464-470.

Campbell, J., Laughon, K., & Woods, A. (2006). Impact of intimate partner abuse on physical and mental health: How does it present in clinical practice? In: G. Roberts, K. Hegarty, & G. Feder (Eds.), *Intimate partner abuse and health professionals: New approaches to domestic violence* (pp. 43-60). Edinburgh: Elsevier.

Caralis, P., & Musialowski, R. (1997, November). Women's experiences with domestic violence and their attitudes and expectations regarding medical care of abuse victims. *Southern Medical Journal, 90*(11), 1075-1080.

Carbonell, J., Chez, R., & Hassler, R. (1995). Florida physician and nurse education and practice related to domestic violence. *Women's Health Issues, 5*(4), 203-207.

Carney, D., & McKibbin, L (2003). Screening for domestic violence. *Nursing Management, 34*(9), 35-36.

Copel, R. (2008). The lived experience of women in abusive relationships who sought spiritual guidance. *Issues in Mental Health Nursing, 29*(20), 115-130.

D'Avolio, D., Hawkins, J., Haggerty, L., Kelly, U., Barrett, R., Toscano, S., et al. (2001, June). Screening for abuse: Barriers and opportunities. *Health Care for Women International, 22*(4), 349-362.

Davila, Y. (2005). Teaching nursing students to assess and intervene for domestic violence. *International Journal of Nursing Education Scholarship, 2*(1), 1-11.

Davila, Y. (2006). Increasing nurses' knowledge and skills for enhanced response to intimate partner violence. *Journal of Continuing Education in Nursing, 37*(4), 171-177.

Davis, R., & Harsh, K. (2001). Confronting barriers to universal screening for domestic violence. *Journal of Professional Nursing, 17*(6), 313-320.

Davis, J., Parks, S., Kaups, K., Bennink, L, & Bilello, J. (2003). Victims of domestic violence on the trauma service: Unrecognized and underreported. *Journal of Trauma, 54*(2), 352-355.

Dennis, K. , Tomayasu, N., McCrone, S., Goldberg, A., Bunyard, L., & Qi, B. (2002). Self-efficacy targeted treatments for weight loss in postmenopausal women. In E. R. Lenz, & L. M. Shortridge-Baggett (Eds). *Self-efficacy in nursing: Research and measurement perspectives* (pp. 79-94). New York: Springer Publishing Company.

Diamond, R. (1998). *Designing and assessing courses and curricula: A practical guide.* San Francisco: Jossey-Bass.

Doepel, D. (1994). *Understanding psychological trauma: Final report, Phase 1 SBIR Grant*. 2R44MH51512-02A1. Boston: National Institutes of Health.

Driscoll, M. (2002). How people learn. Retrieved May 29, 2008, from http://tlt.its.psu.edu/suggestions/research/How People Lear n.shtml

Evans, G., Helton, S., & Blackburn, L. (2001). Students go to court: Experiential learning about domestic violence. *Journal of the American Psychiatric Nurses Association. 7*(3), 67-71.

Family Violence Prevention Fund. (2004). The National Consensus Guidelines on identifying and responding to domestic violence victimization in healthcare settings (2nd ed.). Retrieved March 19, 2008, from underghttp://endabuse.org/proqrams/displav.php3?DocID=2 06

Freedberg, P. (2008). Integrating forensic nursing into the undergraduate nursing curriculum: A solution for a disconnect. *Journal of Nursing Education, 47*(5), 201-208.

Froman, R., & Owen, S. (2001). Measuring attitudes toward persons with AIDS: The AAS-G as an alternate form of the AAS. *Scholarly Inquiry for Nursing Practice, 15*(2), 161-177.

Furniss, K., McCaffrey, M., Parnell, V., & Rovi, S. (2007). Nurses and barriers to screening for intimate partner violence. *MCN: American Journal of Maternal Child Nursing, 32*(4), 238-243.

George, D., & Mallery, P. (2003). SPSS *for Windows step by step: A simple guide and reference. 11.0 update* (4th ed.). Boston: Allyn & Bacon.

Gibbons, S., Adamo, G., Padden, D., Ricciardi, R., Graziano, M., Levine, E., et al. (2002). Clinical evaluation in advanced practice nursing education: Using standardized patients in health assessment. *Journal of Nursing Education, 41,* 215-221.

Gielen, A., O'Campo, P., Campbell, J., Schollenberger, J., Woods, A., Jones, A., et al. (2000). Women's opinions about domestic violence screening and mandatory reporting. *American Journal of Preventive Medicine, 19*(4), 279-285.

Grogan, M. (2003). Interpersonal violence issues in the nursing classroom. *Journal of Psychosocial Nursing & Mental Health Services, 41*(3), 44-49.

Gutmanis, I., Beynon, C., Tutty, L., Wathen, N., & MacMillan, H. (2007). Factors influencing identification of and response to identification of intimate partner violence; a survey of physicians and nurses. *BMC Public Health, 7,* 1-11.

Hayward, K., & Weber, L. (2003). A community partnership to prepare nursing students to respond to domestic violence. *Nursing Forum, 38*(3), 5-10.

Health Concerns Across a Woman's Lifespan: The Commonwealth Fund 1998 Survey of Women's Health, Karen Scott Collins, Cathy Schoen, Susan Joseph et al., The Commonwealth Fund, May 1999. Retrieved March 19, 2008 from www.thecommonwealthfund.org/publications

Hegarty, K. (2006). What is intimate partner violence and how common is it? In G. Roberts, K. Hegarty, & G. Feder (Eds.). *Intimate partner abuse and health professionals: New approaches to domestic violence* (pp. 19-40). Edinburgh: Elsevier.

Hegarty, K., Feder, G., & Ramsay, J. (2006). Identification of intimate partner abuse in health care settings: Should health professionals be screening? In G. Roberts, K. Hegarty, & G. Feder (Eds.). *Intimate partner abuse and health professionals: New approaches to domestic violence* (pp. 79-92). Edinburgh: Elsevier.

Helton, S., & Evans, G. (2001). "She looked just like me." A domestic violence learning module. *Issues in Mental Health Nursing, 22*(5), 503-516.

Hinderliter, D., Doughty, A., Delaney, K., Pitula, C., & Campbell, J. (2003). The effect of intimate partner violence education on nurse practitioners' feelings of competence and ability to screen patients. *Journal of Nursing Education, 42*(10), 449-454.

Hurley, K., Brown-Maher, T., Campbell, S., Wallace, T., Venugopal, R., & Baggs, D. (2008). Emergency department patients' opinions of screening for intimate partner violence. *Emergency Medical Journal, 22*(2), 97-98.

Jonassen, J., Pugnaire, M., Major, K., Regan, M., Jacobson, E. Gamon, W., et al. (1999). The effect of a domestic violence interclerkship on the knowledge, attitudes, and skills of third-year medical students. *Academic Medicine, 74*(7), 821-828.

Kara, M., van der Bijl, J., Shortridge-Bagget, L, Asti, T., & Erguney, S. (2006). Cross-cultural adaptation of the diabetes management self-efficacy scale for patients with type 2 diabetes mellitus: Scale development. *International Journal of Nursing Studies, 43,* 611-621.

Kiner, H. (1995). Nursing students' opinions on interpersonal violence. *Journal of Nursing Education, 34*(7), 325-331.

Kingston, P., Penhale, B., & Bennett, G. (1995). Is elder abuse on the curriculum? The relative contribution of child abuse, domestic violence and elder abuse in social work, nursing and medicine qualifying curricula. *Health & Social Care in the Community, 3*(6), 353-362.

Knapp, J., Dowd, D., Kennedy, C., Stallbaumer-Rouyer, J., & Henderson, D. (2006). Evaluation of a curriculum for intimate partner violence screening in a pediatric emergency department. *Pediatrics, 117*(1), 110-116.

Knowledge. (2009). In *Merriam-Webster Online Dictionary.* Retrieved June 2, 2009, from http://www.merriam-webster.com/dictionary/knowledge

Kripke, E., Steele, G., O'Brien, M., & Novacek, D. (1998). Domestic violence training program for residents. *Journal of General Internal Medicine, 13,* 839-841.

McFarlane, J., Christoffel, K., Bateman, L., Miller, V., & Bullock, L. (1991). Assessing for abuse: Self-report versus nurse interview. *Public Health Nursing, 8*(4), 245-250.

McFarlane, J., Groff, J., O'Brien, J., & Watson, K. (2006). Secondary prevention of intimate partner violence. *Nursing Research, 55*(1), 52-61.

Minnesota Center Against Violence and Abuse (1999). *Herstory of Domestic Violence: A Timeline of the Battered Women's Movement.* Retrieved July 26, 2008, from http://www.mincava.umn.edu/documents/herstorv/herstorv.html

Minsky-Kelly, D., Hamberger, L., Rape, D., & Wolff, M. (2005). We've had training, now what? Qualitative analysis of barriers to domestic violence screening and referral in a health care setting. *Journal of Interpersonal Violence, 20*(10), 1288-1309.

Moore, M., Zaccaro, D., & Parsons, L. (1998, March). Attitudes and practices of registered nurses toward women who have experienced abuse/domestic violence. *JOGNN: Journal of Obstetric, Gynecologic, & Neonatal Nursing, 27*(2), 175-182.

Perrin, K., Boyett, T., & McDermott, R. (2000, November). Continuing education about physically abusive relationships: Does education change the

perceptions of health care practitioners? *Journal of Continuing Education in Nursing, 31*(6), 269-274.

Polit, D., & Beck, C. (2008). *Nursing research: Generating and assessing evidence for nursing practice* (8th ed.). Philadelphia: Lippincott, Williams and Wilkins.

Rassool, G., & Rawaf, S. (2007). Educational intervention of undergraduate nursing students' confidence skills with alcohol & drug misusers. *Nurse Education Today, 28*(3), 284-292.

Reisenhofer, S., & Seibold, C. (2007, February). Emergency department care of women experiencing intimate partner violence: Are we doing all we can? *Contemporary Nurse, 24*(1), 3-14.

Roberts, G. (2006). The history of intimate partner abuse and health professionals: What have we inherited? In G. Roberts, K. Hegarty, & G. Feder (Eds.). *Intimate partner abuse and health professionals: New approaches to domestic violence* (pp. 3-18). Edinburgh: Elsevier.

Rudner, L. M. & Schafer, W. D. (2001). Reliability. In *ERIC Digest.* College Park, MD: ERIC Clearinghouse on Assessment and Evaluation, ID # ED458213.

Shattuck, S. (2002). A domestic violence screening program in a public health department. *Journal of Community Health Nursing, 19*(3), 121-132.

Schoening, A., Greenwood, J., McNichols, J., Heermann, J., & Agrawa, S. (2004). Effect of an intimate partner violence education program on the

attitude of nurses. *JOGNN: Journal of Obstetric, Gynecologic, & Neonatal Nursing, 33*(5), 572-579.

Shortridge-Bagget, L. (2002). Self-efficacy: Measurement and intervention in nursing. In E. Lenz, & L. Shortridge-Baggett (Eds.). *Self-efficacy in nursing: Research and measurement perspectives* (pp. 3-8). New York: Springer Publishing Company.

Skill. (2009). In *Merriam-Webster Online Dictionary.* Retrieved June 2, 2009, from http://www.merriam-webster.com/dictionary/skill

Stenson, I., & Heimer, G. (2008). Prevalence of experiences of partner violence among female health staff: Relevance to awareness and action when meeting abused women patients. *Women's Health Issues, 18,* 141-149.

Stinson, C., & Robinson, R. (2006). Intimate partner violence: Continuing education for registered nurses. *Journal of Continuing Education in Nursing, 37*(2), 58-62.

U.S. Department of Health and Human Services. (2000). Healthy People 2010: Leading health indicators. Retrieved March 19, 2008, from http://www.healthypeople.gov/LHI/

U.S. Department of Justice, Bureau of Justice Statistics. (2004). Crime characteristics. Retrieved March 19, 2008, from http://www.oip.usdoi.gov/bis/cvict c.htm

van der BijI, J., & Shortridge-Bagget, L. (2002). The theory and measurement of self-efficacy construct. In E. Lenz, & L. Shortridge-Bagget (Eds.). Self-

efficacy in nursing: Research and measurement perspectives (pp. 9-25). New York: Springer Publishing Company.

Vandemark, L., & Mueller, M. (2008). Mental health after sexual violence: The role of behavioral and demographic risk factors. *Nursing Research, 57*(3), 175-81.

Warshaw, C., Taft, A., & McCosker-Howard, H. (2006). Educating health professionals; Changing attitudes and overcoming barriers. In G. Roberts, K. Hegarty, & G. Feder (Eds.). *Intimate partner abuse and health professionals: New approaches to domestic violence* (pp. 61-78). Edinburgh: Elsevier.

Wielichowski, L., Knuteson, C., Ambuel, B., & Lahti, J. (1999, January). A model for collaborative nursing and medical education within the context of family violence. *Journal of Nursing Education, 38*(1), 13-16.

Woodtli, M. (2000). Domestic violence and the nursing curriculum: Tuning in and tuning up. *Journal of Nursing Education, 39*(4), 173-182.

Woodtli, M., & Breslin, E. (2002). Violence-related content in the nursing curriculum: A follow-up national survey. *Journal of Nursing Education, 41*(8), 340- 348.

Yonaka, L., Yoder, M., Darrow, J., & Sherck, J. (2007, January/February). Barriers to screening for domestic violence in the emergency department. *Journal of Continuing Education in Nursing, 38*(1), 37-45.

IRB # CSM 08-68
Date Approved11/10/08
Valid Until: 11/10/09

APPENDIX A

COLLEGE OF SAINT MARY

Quantitative Consent Form

IRB#: CSM 08-68

THE EFFECTIVENSS OF EDUCATIONAL INTERVENTION ON UNDERGRADUATE NURSING STUDENTS' ATTITUDES, SKILLS AND KNOWLEDGE PERTAINING TO INTMATE PARTNER VIOLENCE

Invitation
You are invited to take part in this research study. The information in this form is meant to help you decide whether or not to take part. If you have any questions, please ask.

Why are you being asked to be in this research study?
You are being asked to be in this study because you are a student enrolled in a non-clinical elective on intimate partner violence at Nebraska Methodist College (NMC).

What is the reason for doing this research study?
The purpose of the study is to determine whether an educational intervention has an effect on nursing students' perceived attitudes, skills and knowledge regarding Intimate Partner Violence.

What will be done during this research study?
Participants in this study will fill out a survey prior to and at the end of their course.

What are the possible risks of being in this research study?
There are no known risks to you from being in this research study because there is no way to connect your responses to you individually.

What are the possible benefits to you?
You may benefit from participating in this research study by having an opportunity to reflect upon factors associated with intimate partner violence on a personal and community level and the satisfaction of contributing to educational research. However, you may not get any direct benefit from being in this research study

What are the possible benefits to other people?
The possible benefits of this study to other people, especially survivors of intimate partner violence, ultimately include the delivery of compassionate timely care, and better understanding of how to prepare nurses for more thorough, accurate and timely response to intimate partner violence. It may also benefit nursing faculty in planning and implementing nursing curricula which impact nursing students' attitudes, skills and knowledge.

W**hat are the alternatives to being in this research study?**
Instead of being in this research study you can choose not to participate. Instead of participating in the pre and post surveys conducted during class time, an alternative written project will be offered.

What will being in this research study cost you?
There is no cost to you to be in this research study.

Will you be paid for being in this research study?
You will not be paid or compensated for being in this research study.

Participant's initials_____

What should you do if you have a problem during this research study?
Your welfare is the major concern of every member of the research team. If you have a problem as a direct result of being in this study, you should immediately contact one of the people listed at the end of this consent form.

How will information about you be protected?
No identifying information will be present on your survey. Responses are completely confidential. You will not put your name on your survey. You will be identified as a member of a course, not as an individual. There will be no connection between you and your responses. Reasonable steps will be taken to protect your privacy and the confidentiality of your study data. Completed surveys will be stored in a locked cabinet in the office of Connie Wallace at NMC.

The only persons who will have access to your research records are the study personnel, the Institutional Review Board (IRB), and any other person or agency required by law. The information from this study may be published in journals and presented at professional meetings, but your identity will be kept strictly confidential.

What are your rights as a research participant?
You have rights as a research participant. These rights have been explained in this consent form and in *The Rights of Research Participants* that you have been given. If you have any questions concerning your rights, talk to the investigator at 402-354-7071 or call the Institutional Review Board (IRB), at 402-399-2400.

What will happen if you decide not to be in this research study or decide to stop participating once you start?
You can decide not to be in this research study, or you can stop being in this research study ("withdraw") at any time before, during, or after the research begins. Deciding not to be in this research study or deciding to withdraw will not affect your relationship with the investigator, or with the NMC.

You will not lose any benefits to which you are entitled.

Documentation of informed consent
You are freely making a decision whether to be in this research study. Signing this form means that (1) you have read and understood this consent form, (2) you have had the consent form explained to you, (3) you have had your questions answered and (4) you have decided to be in the research study.

If you have any questions during the study, you should talk to one of the investigators listed below. You will be given a copy of this consent form to keep.

If you are 19 years of age or older and agree with the above, please sign below.

_____ _____
Signature of Participant Date

My signature certifies that all the elements of informed consent described on this consent form have been explained fully to the participant. In my judgment, the participant possesses the legal capacity to give informed consent to participate in this research and is voluntarily and knowingly giving informed consent to participate.

_____ _____
Signature of Investigator Date

Authorized Study Personnel
Connie M. Wallace, Associate Professor, RN, MSN, 402-354-7071
Connie.wallace@methodistcollege.edu
Peggy Hawkins, Ph.D., RN, 402- 399-2658
phawkins@csm.edu

APPENDIX B

THE RIGHTS OF RESEARCH PARTICIPANTS*

AS A RESEARCH PARTICIPANT YOU HAVE THE RIGHT:

1. TO BE TOLD EVERYTHING YOU NEED TO KNOW ABOUT THE RESEARCH BEFORE YOU ARE ASKED TO DECIDE WHETHER OR NOT TO TAKE PART IN THE RESEARCH STUDY. The research will be explained to you in a way that assures you understand enough to decide whether or not to take part.

2. TO FREELY DECIDE WHETHER OR NOT TO TAKE PART IN THE RESEARCH.

3. TO DECIDE NOT TO BE IN THE RESEARCH, OR TO STOP PARTICIPATING IN THE RESEARCH AT ANY TIME. This will not affect your relationship with the investigator or Nebraska Methodist College.

4. TO ASK QUESTIONS ABOUT THE RESEARCH AT ANY TIME. The investigator will answer your questions honestly and completely.

5. TO KNOW THAT YOUR SAFETY AND WELFARE WILL ALWAYS COME FIRST. The investigator will display the highest possible degree of skill and care throughout this research. Any risks or discomforts will be minimized as much as possible.

6. TO PRIVACY AND CONFIDENTIALITY. The investigator will treat information about you carefully and will respect your privacy.

7. TO KEEP ALL THE LEGAL RIGHTS THAT YOU HAVE NOW. You are not giving up any of your legal rights by taking part in this research study.

8. TO BE TREATED WITH DIGNITY AND RESPECT AT ALL TIMES.

THE INSTITUTIONAL REVIEW BOARD IS RESPONSIBLE FOR ASSURING THAT YOUR RIGHTS AND WELFARE ARE PROTECTED. IF YOU HAVE ANY QUESTIONS ABOUT YOUR RIGHTS, CONTACT THE INSTITUTIONAL REVIEW BOARD CHAIR AT (402) 399-2400.

***ADAPTED FROM THE UNIVERSITY OF NEBRASKA MEDICAL CENTER , IRB WITH PERMISSION**

APPENDIX C

Written Consent for IPV Reflections

I give consent for Connie Wallace to use selected excerpts from my written assignments with the condition that they will be used anonymously and will in no way identify me personally.

Signature

Date

APPENDIX D

DEMOGRAPHICS

This is an anonymous questionnaire! Do NOT put your name on it. Thank you.

Age

- ❒ 21 or less
- ❒ 22-30
- ❒ 31-40
- ❒ 41-50
- ❒ 51-60
- ❒ Over 60

Sex

- ❒ Male
- ❒ Female

Race/Ethnicity

- ❒ Asian
- ❒ Hispanic
- ❒ Caucasian
- ❒ African American
- ❒ Native American
- ❒ Other

Nursing Education

Did you attend NS350 Presentation of Family Violence?

- ❒ Yes
- ❒ No

My background knowledge of the subject of domestic violence:

- ❒ None
- ❒ Some
- ❒ Moderate
- ❒ Extensive

How much training have you received on domestic violence?

- ❒ None
- ❒ Some
- ❒ Moderate
- ❒ Extensive

Professional experience with victims of domestic violence in clinical or work?

- ❒ None
- ❒ Some
- ❒ Moderate
- ❒ Extensive

APPENDIX E

TO WHAT EXTEND DO YOU AGREE:

Key:	**A =**	**Strongly Agree**
	B =	**Agree**
	C =	**Somewhat Agree**
	D =	**Disagree**
	E =	**Strongly Disagree**

1. It is not called domestic violence if there is only one violent act by the spouse.
2. In cases of domestic violence, couples should be encouraged to work out their problems together.
3. Husbands are usually provoked to violence because of the actions of their wives.
4. I would contribute financially to a battered women's shelter.
5. A woman who strikes her partner in self defense is just as responsible for the violence as her partner.
6. Intervention with victims of domestic violence who are unwilling to leave their abuse partners is ineffective.
7. Physical assault is a criminal act regardless of the relationship between the perpetrator and the victim.
8. A woman with young children should not leave her abusive partner.
9. A perpetrator of domestic violence is likely to minimize the severity and impact of the violence.
10. A female victim of domestic violence has a tendency to exaggerate the actions of her spouse.
11. If I knew a victim of domestic violence, I would offer my support.
12. Nothing can justify the use of violence between spouses.
13. An abused wife is not responsible for her husbands violent behavior.
14. If asked, I would testify in court on behalf of a victim of domestic violence.
15. A woman who is intentionally hit by her husband is a victim of domestic violence.
16. A wife should never be required to have sex with husband if she does not want to.
17. A woman should do everything possible to keep the relationship together regardless of the presence of domestic violence.
18. Some women don't fight back because they enjoy being beaten by their husbands.
19. If, in our professional practice, we encounter someone we suspect is a victim of domestic violence we should raise the issue with him or her.
20. A person should seek help or support because of an abusive partner even if it risks the break-up of the family.
21. A person should intervene by calling the police if he or she witnesses an act of domestic violence.
22. I would put a poster or brochure about domestic violence in my professional office or treatment room.
23. A woman should stay with her husband even though she is being hit.
24. It is not very difficult to change a violent spouse into a non-violent spouse.
25. A female victim of domestic violence who makes no attempt to leave the violent relationship takes on some responsibility for herself for the on-going violence.

26. Husbands who are violent towards their wives are entirely responsible for abuse.

Doepel Survey

Please select the one correct answer for each question:

1. A nurse notices bruising on the forearms of a woman patient. The patient indicates that the bruising occurred while lifting a heavy box. Which of the following is the most appropriate response?

    a. "That must have been a very heavy box. Did you injure your back as well?"
    b. "Many women come to our clinic who have been hurt by a partner and who are scared to say that this is what happened. Did someone do this to you?"
    c. "It actually looks more like someone grabbed you real hard. What did you do to make someone so angry?"
    d. Do not comment on the injury either way. But note any inconsistencies in injury pattern in the medical record.

2. A woman client/patient discloses to you that she has been beaten up by her husband some days earlier and that it wasn't the first time. Which one of the following should you NOT do?

    a. Encourage her to leave.
    b. Tell her that this is a criminal offense and that no one had a right to do this to her.
    c. Assess her immediate risk of danger.
    d. Develop a safety plan.

3. A person beaten by a partner is most at risk for serious injury or death when:

    a. She/he stands up to the abuser and fights back.
    b. She/he discloses being beaten at home to a third party.
    c. She/he attempts to leave the relationship.
    d. She /he attempts to pacify the partner.

4. Which of the following is most true about batterers? They are:

    a. People who have trouble controlling their anger.
    b. People who use violence as a means of controlling their partners.
    c. People who are violent because they drink.
    d. People who pick fights with anyone.

5. Ms. Jones has called the police for the 8th time to intervene in family disputes in which she has been severely beaten by her husband. She has four children ages 4 to 11, and has few marketable job skills. One week later, Mrs. Jones arrives at an emergency room with injuries from another beating. Which of the statements is the least accurate?

    a. She perhaps lacks job skills to support herself.
    b. If she really wanted help she would have left by now.
    c. Although her situation is almost unbearable she still fears the unknown.
    d. She stays because she believes he will change.

6. If a couple is referred for counseling about anger and conflict in their relationship, the counselor should:

    a. Assume if there were violence in the relationship they would bring this up.
    b. Ask each partner, confidentially and separately, specifically if physical safety is a concern.
    c. Defer questions of possible domestic violence to a later session when rapport is established.
    d. Assume that because they sought counseling together than there is not physical abuse in the relationship.

7. Which of the following is an incorrect statement about children who are raised in a home where battering occurs?

    a. They are at increased risk for being victims of physical violence themselves.
    b. They can suffer extreme psychological harm from witnessing physical violence, between their parents even if they are not being physically hurt themselves.
    c. They are at increase risk for becoming batterers or victims as they grow up.
    d. They will most usually tell someone also about it, particularly a friend their own age.

8. If a woman discloses to a professional that she has been battered, which of the following would be the best response?

    a. "Do you think he might hit you because one or both of you gets drunk?
    b. "What did you do that made him hit you? Are there ways you can keep him from becoming so angry?"
    c. "Do you feel you will be in danger if you go home from here?"
    d. "What do you think might be your contribution to the problem?"

9. Which of the following is not true of domestic violence?

    a. Victims believe that they are sometimes to blame for the violence.
    b. Alcohol consumption is the major predictor of the likelihood of domestic violence.
    c. Victims are often isolated by the perpetrator and are unable to see their friends or family.
    d. Battering is associated with an increased incidence of birth defects.

10. Most health care professionals do not talk about domestic violence with their patients or clients. Which of the following is the least likely reason why?

    a. These professionals are not concerned about domestic violence.
    b. They are pressured by time constraints, so bringing up the issue might be like opening Pandora's Box.
    c. They feel ill-equipped to respond to the needs of victims.
    d. They fear their clients/patients might think they are prying into their personal lives.

11. An Emergency Department (ED) of a hospital located in an upper middle class suburb reports a lower incidence of domestic incidence of domestic violence cases than the ED of an inner city hospital serving a lower socio-economic, primarily minority community. Which of the following explanations is the most accurate?

a. The population served by the urban hospital has a higher percentage of domestic violence cases.
b. Victims of domestic violence in upper middle class suburbs do not go to emergency rooms.
c. Drug and alcohol abuse is at elevated levels in inner city communities.
d. Suburban hospital staffs tend to under-report observed incidents of domestic violence.

12. Which of the following does not contribute to a woman's willingness to disclose to a professional the presence of domestic violence in her life?

a. A poster about domestic violence on a waiting room or bathroom wall.
b. Being asked directly about domestic violence as part of a routine intake.
c. Having a long-standing relationship with a health care professional.
d. Having the health care professional create a safe climate in which the patient has permission to "tell her story when she is ready."

13. What three things are most important as an initial response when you, as a professional, come in contact with a woman who is being abused by her partner?

a. Make a statement about how seriously you take this issue.; Assess her safety plan. Make a plan for what she can do if this happens again.
b. Help the patient work out how to confront the batterer with the criminality of his behavior. Help the patient work out how to protect her children from violence. Offer to help the situation by referring the couple to marriage counseling.
c. Show her where she can look in the phone book to get help. Encourage her to leave her abusive spouse. Assess her suicidality/homicidality.
d. Assess potential lethality of the situation including the presence of a firearm in the home. Assess the involvement of drugs and alcohol in the home setting. Encourage her not to tell friends/family about the violence because of confidentiality issues.

14. If as a health care professional, you have insufficient time with a patient/client to discuss options after the client discloses being battered, your best immediate course of action is to:

a. Cancel your next appointment so that you could take more time with your patient/client.
b. Offer to see your client and her partner together.
c. Schedule a follow-up appointment.
d. Indicate that you consider the issue very serious and refer her to a battered woman's hotline.

Please select one correct answer for each question:

15. You should give women who are victims of domestic violence a written phone number for emergency help.

a. True
b. False

16. An effective intervention with a client who is a victim of violence can be done in 5 to 10 minutes.

    a. True
    b. False

17. You should always try to make a follow-up appointment with a client you have identified as a victim of domestic violence.

    a. True
    b. False

18. A woman who is a victim of domestic violence feels so disempowered and helpless that she can not make decisions on her own behalf.

    a. True
    b. False

19. If a woman discloses that she is a victim of domestic violence, you should encourage her to leave the relationship.

    a. True
    b. False

20. When woman are pregnant they are at less risk for being victims of domestic violence.

    a. True
    b. False

APPENDIX F

Short Answer Questionnaire

1. Recall your initial understanding of Intimate Partner Violence and describe.

2. How has your understanding of Intimate Partner Violence changed after completing the course?

3. Select one or two of your experiences in the course and describe the impact it had on your attitude/perceptions toward Intimate Partner Violence.

4. When you are licensed as an RN and you encounter Intimate Partner Violence, how confident are you that you will respond effectively?
   4= highly confident
   3= confident
   2= unsure
   1= very unsure

APPENDIX G

FACULTY: CONNIE WALLACE, MSN, APRN, BC

CREDIT HOURS: 2

PRE-REQUISITES: All year 1 and 2 courses

COURSE DESCRIPTION:

This course examines the concept of intimate partner violence as it relates to biological and psychosocial issues. Students explore intimate partner violence and related issues, analyzing both historical and contemporary situations. By having the exposure to a variety of community responses, students develop a sense of professional responsibility and legal/ethical accountability to intimate partner violence. Students analyze the role of the professional nurse and the use of evidence based practices to develop an understanding of assessment, documentation, advocacy and referral for survivors of intimate partner violence.

COURSE OUTCOMES:

Upon completion of _____, the student will demonstrate ability to:

1. Examine the biologic and psychosocial (BPS) effects of intimate partner violence (IPV) on the client.
2. Use critical thinking strategies to identify appropriate solutions based on scientific and humanistic rationale for intimate partner violence (IPV) actions.
3. Analyze historical and contemporary situations to promote self-awareness regarding responses to intimate partner violence (IPV).
4. Integrate professional responsibility and legal/ethical accountability into nursing practice with clients experiencing intimate partner violence (IPV).
5. Apply selected research findings and evidence-based practice when caring for clients experiencing intimate partner violence (IPV).
6. Exhibit increased awareness of individual/community needs and responses to intimate partner violence (IPV).

INSTRUCTIONAL STRATEGIES:

Active learning experiences including seminar, guided discussion, reflective journaling, guest speakers, panel discussion, observational experiences in the community, student presentations, simulated case study.

EVALUATION METHODS:

2 Discussion Forums (50 points each)	100
Research/website review	100
Humanities Paper	100
Assessment Simulation (Practical exam)	300
Class Prep	50
Reflective Journal	100
Communication Awareness Campaign	250
TOTAL	1000