Occupational Health Nurses' Knowledge, Experience and Attitudes about Abuse

By

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Abstract

Title: Occupational Health Nurses' Experience, Knowledge, and Attitudes about Abuse

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Physical, verbal, psychological and sexual abuse against women, inflicted by a male partner, is a serious public health problem. Contributing to national efforts towards abuse screening and intervention, health care authorities have called on all health care professionals to implement abuse protocols within their respective health care settings. However, a number of studies indicate that many health care professionals avoid screening and intervening with abuse, due, in part, to the perceptual and practice constraints of (a) lack of time, (b) fear of making the situation worse, (c) belief in abuse myths, and (d) lack of abuse screening and intervention skills. While occupational health nurses (OHNs), as health care providers for populations of workers, are strategically positioned to screen and intervene for abuse in work settings, several indicators suggest that they experience the same abuse screening and intervention perceptual and practice constraints as other health care professionals.

To identify these constraints, a self-administered, 28-item questionnaire was mailed to a homogeneous convenience sample of OHNs (N=175). Questionnaire items elicited information about respondents' knowledge about abuse (based on belief in abuse myths), professional and personal experiences with abuse, and attitudes about implementing abuse screening and intervention strategies in occupational health settings.

Quantitative and qualitative data analysis of 75 usable questionnaires revealed that a majority of respondents believe that abuse screening and intervention is appropriate for occupational health settings, and that current abuse screening and intervention training is inadequate. In addition, previous training on abuse correlated with frequency of suspicion of abuse. These findings provide a basis for the development of occupational health focused abused screening and intervention training programs and protocols.

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Chapter I

Introduction

Physical, verbal, psychological, or sexual abuse against women is a serious public health problem. Authorities estimate that 3-4 million women suffer abuse each year at the hands of an intimate partner (Bullock, McFarlane, Bateman, and Miller, 1989; Council on Scientific Affairs, 1992). In addition, male partners kill approximately one half of women murdered in the United States each year. (Council on Ethical and Judicial Affairs, 1992). It is also estimated that 20-30 % of emergency room visits are due to women seeking treatment for physical injuries from abuse (Campbell, Harris, and Lee, 1995; Tilden, Schmidt, Limandri, Chiodo, Garland, and Loveless, 1994).

Numerous studies reveal that a majority of health care providers treat the physical symptoms of abuse, without recognizing the cause (Bell, Jenkins, Kpo, Rhodes, 1994; Council of Ethical and Judicial Affairs, 1992; Tilden, et al., 1994). These same studies describe the constraints that health care professionals' experience when dealing with suspected cases of abuse. They include, but are not limited to (a) lack of time, (b) lack of screening and intervention skills, (c) fear of making the situation worse, (d) concern about the lack of legal system support, and (e) belief in abuse myths. Despite these significant and understandable constraints a number of health care professionals have successfully integrated abuse screening and intervention protocols into their practice. These tested protocols are available for implementation in other clinical arenas.

Occupational health settings offer an additional health care arena for the implementation of abuse screening and intervention protocols. Occupational Health

Nurses (OHNs), as providers of primary, secondary and tertiary health care services for populations of workers, are well-positioned to implement abuse screening and intervention programs in business organizations. As caregivers within sometimes cold and uncaring business environments, OHNs fill an employee health care advocacy role. In this role, OHNs receive information about employees' private lives and problems, including lives affected by abuse. This provides an excellent opportunity to screen and intervene with abuse. In addition, a number of OHN roles (clinical care, pre-placement physicals, health promotion screening, etc.) require physical evaluation, providing an opportunity for screening for physical signs of abuse.

Abusive males often accompany abused females, seeking treatment for their injuries from abuse, to medical facilities to prevent them from revealing the real cause of their injuries. Abusive males are usually absent from their abused female partner's workplace. Therefore, an occupational health setting can offer a potentially safe environment for an abused female employee to seek intervention. This is especially true if the organization's security services are aware of the abusive situation, and have a plan in place to prevent the abusive male from accessing the site.

A potential constraint in implementing abuse intervention programs in business environments is the philosophy of some companies to avoid getting involved in employees' personal lives. Some traditional organizations continue to believe that employees should leave their personal lives "at home". OHNs can influence these organizations by providing data on the potential financial and legal cost of abuse to the organization's "bottom-line". Among other things, these costs include increased absenteeism, increased medical care benefit costs for treatment of injures, and potential

legal liability if the violence erupts in the workplace and employees are injured. Concern for employees' safety, and a desire to avoid the serious legal and financial consequences of inaction, have prompted some enlightened organizations to design and implement violence recognition and prevention programs, including domestic violence education and intervention programs. Bonnie Campbell (1997) Director of the Violence against Women Office of the U.S. Department of Justice, states:

> Each year nearly 1 million violent assaults occur on the job—accounting for 15 percent of the more than 6.5 million violent acts experienced annually by U.S. residents age 12 and older. In more than 60 percent of on-the-job cases of violence involving female victims, the assailant is a male whom the victim knows. In 5 percent of such cases the assailant is or has been the victim's intimate partner. (p.1)

Many programs include zero-tolerance violence policies, training for managers and supervisors, and in some cases, affirmative support for abused women trying to escape abuse at home. This support includes provision of legal assistance, paid time off to deal with legal and childcare issues, assistance with locating safe houses, and on-site abuse support groups. Polaroid Corporation, Blue Shield of California, Marshall's Inc., and Liz Claiborne, Inc are recognized corporate leaders in the fight against abuse. In addition to understanding the economic repercussions of abuse, they exhibit compassion for employees suffering abuse.

Although this study focuses on workplace screening and intervention efforts for abused women, occupational health abuse prevention efforts could also include the identification and referral of abusive males. Abusive males may demonstrate anger and controlling behaviors on the job. Although legal constraints dictate that performance

plans stay focused on work performance, personnel and supervisory staff, trained to recognize abusive male behavior patterns, can encourage the employee to seek counseling.

A number of indicators suggest that occupational health nursing, in general, has not realized the opportunities for abuse screening and intervention in occupational health settings. First, there is minimal information about abuse in occupational health journals and other occupational health reference sources. A literature search of the past 10 years in Medline, CINAHL, and PSYCHINFO databases, using the individual and combined search words of (a) occupational health nursing, (b) abuse, c) battered woman, and d) domestic violence, revealed only one occupational health journal article on abuse. Fitzgerald, Dienemann, and Cadorette (1998), in a comprehensive review of domestic violence issues in the workplace, presented information on abuse epidemiology, risk factors, corporate responses, OHN roles and responsibilities, abuse protocols, and other helpful resources. Second, national and regional occupational health conferences seldom include workshops on the subject of domestic violence. And third, abuse screening and intervention information is not included in occupational health nursing texts (Rogers, 1994), or required knowledge for national certification in occupational health nursing.

Continuing education is a method used within the health care industry to increase the knowledge and skill level of practicing health care professionals. To identify if previous training on abuse increases skill in recognizing abuse, this study included the additional research question: Does previous training on abuse have an effect on the frequency of suspicion of abuse? Tilden, et al., (1994) in a landmark study of 1521 professionals, in six health care disciplines, found that "Respondents who reported

receiving any educational content on family violence in their training programs were more likely to indicate that they commonly suspected child, adult, and elder abuse, both physical and sexual, among their patients." (p. 630).

The purpose of this study was to gain information regarding respondents' knowledge about abuse (based on belief in abuse myths), professional and personal experiences with abuse, and attitudes about implementing abuse screening and intervention strategies in occupational health settings. For purposes of this study, abuse is defined as physical, verbal, psychological or sexual abuse against a woman, inflicted by a male partner. This study is important to occupational health nursing, and nursing in general, because it adds to the existing body of knowledge regarding nurses' abuse screening and intervention activities. With this information, identification of occupational health abuse knowledge and practice gaps can occur, and occupational health abuse training programs, aimed at closing the gaps, can be developed.

Chapter II

Conceptual Framework and Review of Literature

Neuman Systems Model

The Neuman Systems Model provides a solid conceptual framework to view nursing interventions with abused women (Neuman & Young, 1972). Many of the underlying assumptions of the model are congruent with an understanding of the dynamics of abuse, and abuse intervention strategies. A primary assumption of the model is that the client's composite variables, including: (a) physiological, (b) psychological, (c) socio-cultural, d) developmental, and (e) spiritual, are important elements to be understood, and included in the design of a therapeutic response. Helping the abused women get away from immediate danger addresses physiological needs. Understanding an abused woman's psychological status is crucial in designing an effective therapeutic response. For instance, intervention attempts for women exhibiting behaviors associated with low self-esteem or learned helplessness may take longer, requiring time and patience on the part of the intervener. Socio-cultural, and religious/spiritual variables form an abused women's perceptions of right and wrong, and consequently, influence responses to specific intervention strategies. Intervention attempts for abused women with developmental issues, due to parental childhood abuse, may produce exaggerated reactions based on previous unresolved emotions. It is clear that effective abuse intervention strategies include an understanding and integration of all of these variables.

The Neuman model stresses the importance of joint healthcare decisions between the client and caregiver. This concept is consistent with a concept found in abuse intervention literature that strongly urges the caregiver to allow the abused women to

move at her own speed, despite fears of repeated abuse. An abused woman will not make a move out of an abusive relationship until she is emotionally and physically ready. Many well intentioned, but unknowing health professionals, add to the abused woman's sense of confusion and guilt by urging her to leave an abusive relationship, without considering her physical or emotional readiness.

The model defines nursing within the framework of four major concepts: (a) person, (b) environment, (c) health, and (d) nursing. The person, or client system, includes a central core, composed of basic vital functions common to all organisms, i.e. physiological and psychological. Three boundaries surround the central core, all engaged in the work of protecting the core. Closest to the central core are the innermost lines of resistance, surrounded by the normal line of defense, and finally, the outermost flexible line of defense. The outermost line of defense (flexible) protects the normal line of defense. The normal line of defense represents the usual wellness state. If the normal line of defense is penetrated, illness symptoms, including death, can occur. The innermost lines of resistance offer the final line of defense, protecting against penetration of the inner core. The penetrators are internal and external environmental influences or stressors, also defined as unmet variable needs. Internal, or interpersonal stressors, affect the internal client system and are unique to the individual. Physiological illness is an example of an internal stressor. However, physiological disease can, and does, affect other variables. For example, a chronic childhood disease can influence psychological and/or developmental variables. Inter-and extrapersonal stressors are external to the client system. Interpersonal stressors primarily involve interactions with other individuals

(significant others, caregivers, etc.). Extrapersonal stressors include other more removed influences (environment, cultural issues, and finances).

Within the context of the Neuman model, abuse is defined as an interpersonal stressor because it involves interactions with significant others. However, intra and extrapersonal factors play a part in the client's total response to the stressor of abuse. Interpersonal (ego, physical status) characteristics can influence the degree of adaptation or perception of options. For example, a physically disabled woman would most likely experience greater obstacles, thus perceiving fewer options in attempting to leave an abusive relationship. Likewise, extrapersonal stressors (finances, cultural beliefs) are significant factors that can influence an abused woman's perceived options and corresponding actions. A financially dependent abused woman will face more constraints in leaving an abusive relationship. The nursing goal in working with abused women, as interpreted through the Neuman Model is to strengthen the lines of resistance and defense, through the implementation of effective screening and intervention strategies.

Stressor Terms and Characteristics

The synonyms for abuse, as an interpersonal stressor, are (a) abuse, (b) domestic violence, (c) intra-family or family violence, (d) spouse abuse, and (e) interpersonal violence (Bell et al., 1994; Buel, Candib, Dauphine, Sassetti, and Sugg, 1993; Tilden, et al., 1994). The terms "family violence", and "domestic violence", are used frequently, especially in more dated literature, to describe abuse. These terms can be harmful, as they attribute the blame for what is essentially a criminal act, perpetrated by a male against a female, onto a dysfunctional family unit. Using the term "domestic violence" to describe abuse against a woman contributes to the myth that abused women, through their actions

or behaviors, somehow provoke abuse, or that men are equally abused by women (Campbell, 1993; Council on Ethical and Judicial Affairs, 1992; Sassetti, 1993). Relationships in which abuse is occurring may be dysfunctional, however abuse is an antecedent, not the result.

Physical Abuse

It is estimated that 20-30% of all women in the United States experience physical abuse from their male partner at least once (King, 1993). Physical abuse can include: (a) slapping, (b) punching, (c) kicking, (d) burning, (e) choking, (f) smothering, and (g) biting (Council on Scientific Affairs, 1992; King, 1993). Commonly seen injuries from physical assault include: (a) contusions, (b) multiple bruises; in different stages of healing, on the face, head, breasts, abdomen or genitals, (c) fractures, (d) bite marks, (e) gunshot wounds, (f) internal injuries, (g) chronic pain, and (h) miscarriages (Bullock et al., 1989; King, 1993; Parker, 1995). Additional studies document that "women in the United States are more likely to be assaulted and injured, raped, or killed by a current or ex-male partner than by all other types of assailants combined." (Langan & Innes, 1986). An alarming statistic is that over one-half of women murdered in the U.S. are killed by a current or former male partner (Council on Scientific Affairs, 1992). "At least two-thirds of the women murdered by intimate partners or ex-partners were physically abused by the man before they were killed. When women kill, they usually kill husbands, ex-husbands, and lovers; in at least two-thirds of such cases, there is a documented history of assault of the woman by the man." (Campbell, p. 503).

Psychological and Sexual Abuse

Psychological and sexual abuse often accompanies physical abuse, and can be as damaging (Campbell, et al., 1995; King, 1993). Psychological and sexual abuse includes: (a) yelling, (b) name calling, (c) public humiliation, (d) threats of abandonment, (e) threats of taking children away, (f) withdrawal of economic support, (g) accusations of unfaithfulness, (h) negative remarks, (i) forced sex, and (j) comparing a women's sexual abilities to other partners (Kennedy, 1993). As King (1993) points out "Sexual abuse is experienced by many abused women but may not be easily disclosed because of intense feelings of embarrassment and shame." (p. 450). Chronic pelvic pain and pelvic inflammatory disease are common physical findings in sexually abused women (Campbell, 1993).

Psychological abuse can lead to lifelong mental health problems, including: "feelings of low self-esteem, anxiety, PTSD [Post Traumatic Stress Disorder], depression, disturbed parent-child relationships, symptoms of paranoia and chaos, and sometimes suicide" (King, 1993). "It is psychological abuse that moves a woman closer to feeling entrapped in an abusive relationship, and to the belief that she is unworthy of respect." (Kennedy, 1993). Other concerning statistics are that "Twenty-five percent of all female psychiatric admissions to the emergency department are battered, and 64% of all female inpatient psychiatric admissions have been abused." (Wilson, 1994).

Socio-Cultural Characteristics of Abuse

Abuse against women crosses cultural, racial, and socio-economic lines (Council on Scientific Affairs, 1992; Sassetti, 1993). It is widely believed that abuse occurs mostly among minorities and lower socio-economic groups. Sassetti (1993) points out that abuse

against women from lower socio-economic groups is merely more public because of their financially driven tendency to use public health care facilities for treatment of injuries. Abused women from higher socio-economic groups may be able to hide the problem by seeking treatment from private providers (Parker, 1995). Regardless of economic status, many abused women are reluctant to admit abuse in any health care setting, due to feelings of shame, humiliation, or fear of retaliation from the abuser. The client's socio-cultural belief system can impede abused women from seeking or accepting help. Cultural beliefs that promote male dominance within the family structure set up a framework for the legitimization of abuse. Latin American and Asian cultures are more prone to the male dominance family structure. In some cultures, there is a stigma about revealing private family matters, especially behaviors with socially negative connotations. These cultural influences can make it extremely difficult for some abused women to seek help.

Abuse Myths

Myths about abuse stubbornly persist in society, and within the belief systems of many health care professionals. These myths are popularized through media messages (violence in movies and TV), and more insidiously sanctioned by religious and cultural institutions. Sassetti (1993) presents four common myths including: (a) "Battering Occurs Mostly Among Minorities and Low Socioeconomic Groups", b) " The Battered Woman Is Masochistic", (c) "Battered Women Must Provoke the Violence Inflicted on Them", (d) "Men Who Batter Are Drunk or Just out of Control" (p. 293). Adragna (1991) adds the myths of (a) "Stress and psychopathology cause abuse", (b) " Family violence is not serious, only a momentary lapse of control", (c) "If the wife wanted to leave, she

could at any time", (d)" Violence is an acceptable part of family life and the female experience" and (e), "No one should interfere in the sanctity of the family." (p. 33). These myths contribute to society's long-standing denial of the problem. Believing that if a woman does not want the abuse, she should just leave the relationship, or that somehow she is provoking the abuse, allows the health care professional to stay uninvolved and detached.

Additional perceptual or practice constraints for pursuing a diagnosis of abuse are documented by Sugg & Inui, (1992), in an ethnographic study of thirty-eight physicians. They include: a) most abuse occurs in lower socio-economic groups, (b) fear of offending the patient, (c) frustration over the physician's inability to control intervention outcomes, and (d) limited time to engage in the questioning. These findings contribute to additional research that confirms that health care providers, in general, do not understand the complex emotional and situational factors that contribute to an abused woman's decision to remain in, or leave an abusive relationship. It is understandable that many abused women perceive health care professionals as uncaring and indifferent.

Yam (1995) attributes a great deal of the "uncaring" attitude on the use of the medical model which trains medical professionals to stay focused on the physical elements of care, rather than understanding the life circumstances that underlay the physical problems. Health care professionals must recognize their own biases about abuse before they can effectively intervene with abused women. They must learn to understand and separate the myths about abuse, from the more complex socio-cultural etiologic factors. Elliott (1993) urges physicians to "identify his or her own biases regarding the causes of violence." (p. 278).

Nurses must also examine their beliefs by recognizing and separating myths from reality, working towards changing ingrained paradigms that do not serve the nursing profession, or abused women. Recognizing that the nurses' beliefs can significantly impact intervention attempts, Limandri (1987), describes numerous "Facilitative", and "Inhibitive Helper Responses (P. 11) that can guide nurses' intervention strategies. Limandri also cautions: "For the nurse, recognizing her own feelings and how the client affects her is useful not only in increasing the effectiveness of therapy, but also in preventing the therapist's personal exhaustion."

Etiology of Abuse

The conceptual framework of perpetrating, tolerating and defending against abuse is helpful in describing the etiology of abuse. Perpetration of abuse deals with theories explaining why men, and people in general, act abusively. Tolerating abuse deals with the complex dynamics involved in staying in, or coping with an abusive relationship. Defending against abuse describes the theories explaining how and why abused females are able to break away from abusive relationships.

The most prevalent theme in the literature on perpetration of abuse is the power theory. Power theory suggests that traditional societal gender roles give more power in a relationship to the male. This sanctions the use of force and domination over the female. Media, and other cultural communication systems, promote the image of male violence and force as an acceptable method to solve problems and control others. (Sassetti, 1993). The need for control and domination drives men who abuse. As Sassetti (1993) describes "Violence is thus the ultimate expression of a fierce desire for control and domination,

while the threat of violence against the battered woman and her loved ones serves as the means by which her submissiveness and secrecy are enforced." (p. 291).

Adding to cultural gender roles, are religious influences that place the male as the spiritual leader of the family. Leadership is often confused with feelings of power and control, especially in individuals suffering from low self-esteem. To question these cultural and religious norms is to question a lifetime of subtle, but extremely powerful messages. Socio-cultural and developmental characteristics of abusive men include: (a) growing up in an abusive family, especially witnessing abuse against their mother; inflicted by their father, (b) economic expectations resulting in high stress jobs, and (c) social isolation.

Elliott (1993) describes abuse etiologic factors as psychopathological and systems theories. Psychopathologic theory attributes abuse to mental disorders or personality dysfunction. Systems theory attributes abuse to a dysfunctional family system. There is very little support in the research for either psychopathologic or systems theories. Mental health therapists are cautioned not to use family therapy to treat abuse. The use of family therapy implies that abuse is due to unhealthy family dynamics, instead of the sole responsibility of the abuser. In fact, the use of family therapy can expose the abused women to greater danger if she reveals the abuse to the therapist in front of the abuser during family therapy.

Landenburger (1993) offers an etiologic model that incorporates the concepts of tolerating and defending against abuse. The model includes: (a) binding, (b) enduring, (c) disengaging, and (d) recovering from abuse. The binding phase includes the beginning of the relationship, and the abuse. The woman defers her identity, merges with the man, and

takes responsibility for the relationship, and consequently the abuse. In addition, because of a woman's intense desire for a storybook relationship, she easily rationalizes the beginning signs of abuse. "Concentrated efforts are made to give the partner what he wants. The abuse is not labeled as such and is considered minor." (p. 380). During the enduring phase the abuse continues and actually escalates. The woman "feels responsible for the abuse and tries covering all signs of discordance between her and her partner." (p.381). It is during this phase that the woman becomes more aware of the real danger of the abuse, which actually stimulates her to take a more realistic look at her situation and begin to move into the next phase of disengaging. During this disengaging phase, the "self begins to re-emerge at different points in the relationship and often is pushed down or negated by the abused woman." (p.381). As Landenburger explains further "Such women have renounced their feelings for so long that they are overwhelmed by these feeling of "self" re-emerging." (p.381). During the final, or recovering phase, the woman's "primary focus is survival". (p.381). Success in leaving the abusive relationship assists the woman in starting the long process to recovering her self-awareness and self-esteem. Landenburger provides useful intervention strategies for each stage.

The concept of defending against abuse includes the theories supporting a woman finding the strength and social support to leave an abusive relationship. Ulrich (1993) describes the process of leaving an abusive relationship as extremely complex. "Women who describe themselves as changing during the process of leaving identify learning about themselves as being as important to their leaving the relationship as was the presence of social support." (p.389). Interpersonal strength, a strong self-concept, and social, professional, and family support systems were critical elements in a woman's

ability to move out of an abusive relationship. Ulrich suggests that "Women with higher self-esteem attribute these releases to their own efforts, whereas women with lower self-esteem attribute the help as coming from the environment in the form of support from family, friends, or agencies." (p.3880).

Physiological and psychological factors of abused women include (a) learned helplessness, (b) low self-esteem, (c) shame, and (d) a belief system that supports traditional gender roles. Most theorists support the belief that characteristics of abused women are the result of abuse, not antecedents (Adragna, 1991; Affairs, 1992; Parker, 1995).

Abuse During Pregnancy

McFarlane (1993), describing a 1992 prospective study including 691 White, African-American, and Hispanic pregnant women, reports a prevalence rate of one in six women being abused during pregnancy, with white women reporting more frequency and severity of abuse during pregnancy (p. 357). The same study revealed that "21% of abused women begin prenatal care during the third trimester, compared with 11 % of the non-abused." (p.358). Third trimester entrance into prenatal care has potentially negative effects for the mother and infant. Treatment of maternal malnutrition, or other fetal abnormalities, is less successful, if discovered late in the pregnancy. McFarlane speculates that a controlling abusive male partner may, through threats and control, be a barrier to a pregnant woman's entrance into pre-natal care (p.358). McFarlane also explains that the greatest risk for abuse during pregnancy is prior abuse. Pre-natal care visits provide an excellent opportunity to screen for abuse, and provide appropriate intervention. McFarlane urges all nurses to realize the significant potential for

identification and referral for abused pregnant women, due to their routine and frequent contact with health care providers.

Campbell et al., (1993) in a retrospective study of 97 women, using the Conflict Tactis Scale (CTS) identified four primary causes of male abuse against pregnant women. They are (a) male jealousy, (women paying more attention to the unborn fetus than to the male partner), (b) the need for power and control, (c) anger at the unborn child, and (d) "business as usual" or the normal pattern of abuse. An interesting finding from this study was that pregnancy provided protection from abuse for 50% of the study population, that is, the abuse decreased or stopped during the pregnancy. An additional 25 % of the study population were at increased risk during pregnancy, and the final 25 % experienced the same pre-pregnancy risk. Despite these somewhat misleading statistics, an additional conclusion was that a man, who abuses a pregnant woman, has a high potential for being an extremely violent man.

Abuse Public Health Policy

Over the past decade, numerous public and private organizations, in recognizing the serious public health problem of abuse, have published position statements and intervention protocols to guide medical providers in screening, intervention and prevention efforts. In 1990, the Department of Health and Human Services published Healthy People 2000. These public health prevention objectives include eight goals that address reduction in the rates of (a) homicide, (b) suicide, (c) assault, (d) child maltreatment, (e) abuse of female partners, (f) rape and attempted rape, and (g) adolescent suicide attempts (Campbell, 1993, p.508). More specifically, the guidelines call for (a) a reduction of physical abuse directed at women by male partners to no more than 27 per

1000 couples, (b) to extend protocols for routinely identifying, treating and referring spouse abuse, and (c) to reduce, to less than 10%, the proportion of battered women and their children turned away from emergency housing because of lack of space (Wilson, 1994). In 1992, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), included a guideline to develop "unit specific" policies, procedures, and protocols to identify, intervene, evaluate interventions, and refer, for emergency departments, ambulatory care and prenatal clinics (Sheridan & Taylor, 1993).

Health Care Providers' Response: Constraints and Contributions

Despite the impressive efforts of a number of health care professionals, a consistent finding in the literature is that many health care providers lack the knowledge and skill to effectively intervene with abuse. (Campbell, et al., 1995; Limandri & Tilden, 1993; Tilden, et al., 1994; Yam, 1995). Professional organizations, including the American Nurses Association (ANA) and the American Medical Association (AMA), have urged health care educational institutions to include training in recognition and intervention skills for child, spouse and elder abuse in their undergraduate curriculums. The ANA has a published position statement on prevention of violence against women. These guidelines call for, among other things: (a) the routine education of all nurses and other health care providers, in screening and intervention skills, (b) routine assessment of all women, and documentation of cases of abuse for all women in any health care setting, (c) education on women abuse for all undergraduate nursing students, (d) education of all women about the cycle of violence, and (e) continued research and development of nursing models for the treatment of abused women and their children (American Nurses Association, 1992). The AMA, the American College of Obstetrician and Gynecologist,

the Centers for Disease Control, and the Office of the Surgeon General have all published position statements and protocols encouraging all health care providers to routinely screen for abuse. They have also encouraged the use of accepted and published screening, intervention, and referral protocols in the treatment of abused women (Council on Scientific Affairs, 1992; Wilson, 1994)).

Although health care professionals in general lack effective abuse knowledge and intervention skills, some nurses have made, and continue to make, significant contributions to the formation of national policy related to the prevention of abuse against women. Nursing, and health care in general, was invited to join a national panel, formed in 1975 by the Department of Justice to link the medical community with the Department of Justice in developing broad-based prevention strategies. (Campbell, 1993). The International Nursing Network on Violence Against Women (NNVAW), formed in 1985, is a recognized and influential body of nurses, providing expertise and networking opportunities for nurses involved in the prevention of abuse against women. One of its main functions is to provide a liaison between "grass-roots" coalitions and the health care system (Campbell, 1993). Nurses have also contributed a substantial part of the research linking abuse during pregnancy with low birthweight infants (Campbell, et al., 1995). Tilden, et al (1994) landmark study, documenting significant gaps in health care professionals' knowledge and training related to abuse, has led the way in acknowledging the need to develop abuse education models for educational institutions. "In 1975, a hospital emergency department nurse in Minnesota initiated the first hospital-based program to provide services to female survivors of domestic violence." (Sheridan & Taylor, 1993. p. 471). Nurses need to continue and increase their leadership efforts,

working with other health professionals, and the criminal justice system, to develop effective abuse screening and intervention strategies.

Chapter III

Methods

The purpose of this descriptive study was to gain information from a convenience sample of OHNs regarding their knowledge about abuse (based on their belief in abuse myths), professional and personal experience with abuse, and attitudes about implementing abuse intervention strategies in occupational health settings. The survey instrument was a mailed 28-item self-administered anonymous questionnaire (Appendix A). The mailed packet also included a self-addressed, stamped return envelope, an envelope marked "survey", to seal the completed questionnaire, and a cover letter (Appendix B). The cover letter included standard information including the purpose of the study; name and telephone numbers of the principle investigator, and faculty sponsor, participation, confidentiality, and consent information. It also included abuse hotline numbers for respondents experiencing emotional reactions generated by some survey items. As a self-administered survey, the participant had total autonomy in deciding when (within a designated 2-week period), and where, to complete the questionnaire.

Study Sample

Study participants were accessed through a regional chapter of the American Association of Occupational Health Nurses (AAOHN). The homogeneous convenience sample (N=175) consisted of the entire membership of the regional association, excluding the pilot test nurses, and those involved in instrument development. AAOHN represents approximately 13,000 OHNs nationwide. As a non-probability sample, study findings are limited in their generalizability to the larger AAOHN population.

Survey Instrument

The 28-item self-administered questionnaire in a 5.5in by 8.5in.eight-page pamphlet format, followed design recommendations found in Salant & Dillman (1994). Categories of items within the questionnaire included: (a) sample characteristics, (b) training about abuse, (c) professional experience with abuse, (d) personal experience with abuse, (d) attitudes about abuse, and (e) knowledge about abuse, based on belief in abuse myths.

Sample characteristics. The instrument included general demographic items of age, gender, ethnicity, years in occupational health nursing, highest level of nursing education, and date of completion of education.

Training about abuse. To gain information about respondents' previous training or education on abuse, one multi-choice item listed six types of training/education (basic nursing education, textbooks/journals, etc). Instructions were to mark all types of training that applied.

Professional experience with abuse. The first "professional experience" item requested information about the respondent's previous clinical experiences with abuse. Previous clinical experience with abuse (Public Health, ER, Women's Health, etc.) could have a positive or negative influence on current practices, attitudes, and knowledge about abuse.

The second "professional experience" item asked if abuse protocols are part of the respondent's current practice. Occupational health nursing protocols form the basis for quality occupational health practice (Rogers, 1994). Abuse screening and intervention protocols are readily available in the literature on abuse (Wilson, 1994; Continuing Education Forum, 1995). Knowledge about, and use of abuse protocols, would indicate

advanced practice in abuse screening and intervention. Correspondingly, absence of knowledge, or use of abuse protocols, would indicate a practice gap.

The third "professional experience" item requested information regarding the respondent's role in providing direct clinical care. While many OHNs provide direct clinical care, usually requiring more frequent and physical contact with employees, others function in managerial, academic, case management, and other non-direct care roles. Of interest is whether the direct care subset of respondents differ from the non-direct care subset, in their frequency of suspicion of abuse, or frequency of contact with suspected male abusers.

The fourth and fifth "professional experience" items dealt with the respondent's frequency of suspicion of abuse as a contributing factor in a female employee's physical or emotional symptoms, and frequency of contact with suspected male abusers. For both items, response choices included: (a) never, (b) rarely, 1-2x year, (c) occasionally, 3-6x year, (d) often, 7-12x year, and (e) frequently, > 12x year.

The sixth "professional experience" item explored the respondent's interactions with abused women. They were asked to write a narrative description of an interaction, in their occupational health practice, with an abused female employee. They were then asked what, if anything, would they do differently during this interaction? Narrative responses were evaluated using content analysis techniques.

Personal experience with abuse. Three questionnaire items elicited information about the respondent's personal experiences with abuse. These included: (a) the respondent's direct or indirect (witness) experience with abuse, (b) the effect of that experience, if any, on their current beliefs, and nursing practice, and (c) their concerns

about their safety in any of their current relationships.

Attitudes about abuse. Five attitudinal statements about the appropriateness of implementing abuse protocols in an occupational health setting, and the role of the OHN in screening and intervening with abuse, were presented. A five-item Likert scale (strongly agree, agree, no opinion, disagree, strongly disagree) measured respondents' attitudes regarding the statements. To deter the response bias of acquiescence, statements were positively and negatively worded.

Knowledge about abuse. The Respondent's ability to accurately discriminate myths about abuse, from factual statements about abuse, was used to test their knowledge about abuse. The concept underlying the design of this knowledge test is that a belief in abuse myths is mutually exclusive to an understanding of the real issues surrounding abuse. Information on abuse myths is abundant in both the professional and lay literature on abuse, and presented frequently at workshops and seminars on abuse. Seven statements (myths) about abuse required a "true" or "false" response choice. To combat the response bias of acquiescence, the statements were positively and negatively worded, with three out of the seven requiring a "true", or positive response choice.

Survey Procedure

Participants were instructed to place the completed questionnaire in an enclosed envelope marked "survey", seal it, then place the sealed envelope in a second enclosed self-addressed, stamped envelope, returning it within a two-week period. Numerical coding of the outer envelope only, to identify non-respondents, assured anonymity during the data recording process. Response data were entered into a database for final transfer into a quantitative statistical analysis program.

Instrument Pilot Test

Seven currently practicing OHNs pilot tested the survey to assure its clarity and ease of use. Overall, the pilot respondents found the questionnaire clear and concise. Three out of the seven respondents made minor recommendations to improve the clarity in the wording of two items. The two items were re-worded as recommended.

Protection of Human Subjects

Protection of human respondents followed the guidelines included in the Oregon Health Sciences University (OHSU) IRB (Institutional Review Board) document obtained from the OHSU Research Support Office.

Chapter IV

Results

Of 175 mailed questionnaire packets, 59 were returned within the requested two-week time limit. There were eight packets returned, marked "undeliverable". Packets returned "undeliverable" were not re-mailed. Non-respondents (108) received a follow-up reminder postcard, (Appendix C) resulting in receipt of sixteen additional questionnaires, for 75 usable questionnaires (43% response rate).

Quantitative data were analyzed using the data analysis software tool, Statistica. Descriptive statistics include frequency counts (raw numbers and percentages), and means and standard deviations for continuous data. Correlations were computed using Pearson's R and chi-square for continuous and categorical data, respectively. Content analysis techniques were used to formulate themes for reporting qualitative data.

A small number of respondents sporadically omitted responses to several items. Where missing data significantly affected results, the N for that item is reported separately. Results are presented under the following headings, (a) sample characteristics, (b) abuse training, (c) professional experience with abuse, (d) interactions with abused women, (e) personal experience with abuse, and (f) knowledge about abuse, based on belief in abuse myths.

Sample Characteristics

Respondents' (N=71) ages ranged between 28 years and 63 years, with a mean age of 49 years. Ninety-eight percent were Caucasian, with 1% Black, and 1% Spanish. Females comprised 96% of the sample. Years of experience in occupational health nursing ranged from 1-33, with a mean of 12 and SD of 7. Figure 1 presents data on

respondents' nursing education.

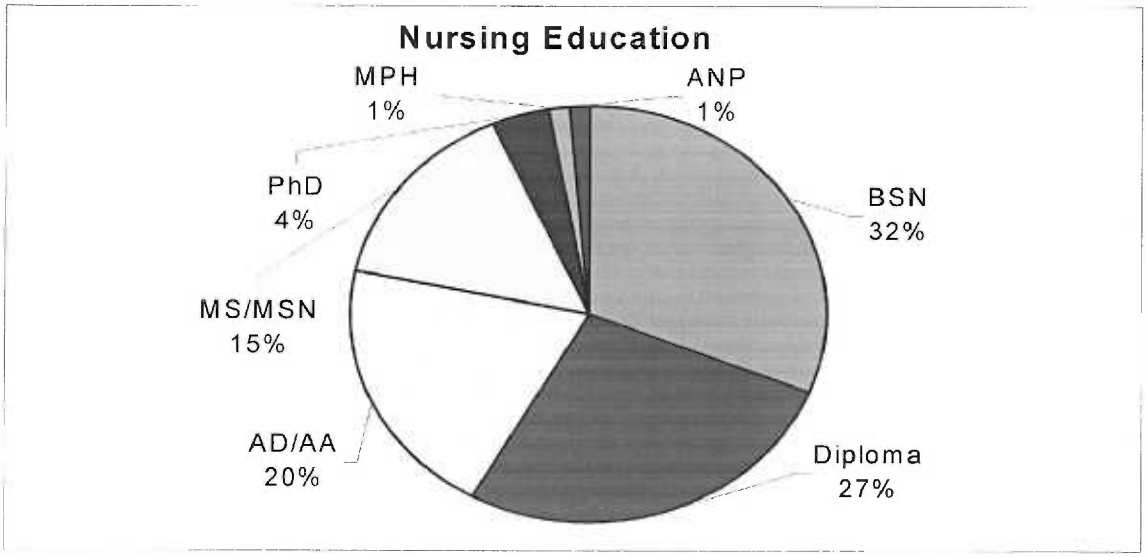

Figure 1. Respondents' Nursing Education (N=74)

Completion date for highest level of respondent education ranged from 1959-1998, with a mean of 1981 and SD of 11.2 years (N=59). The small N for completion date for "highest level of education" may be due to a confusing question structure. Based on survey data, the typical OHN who responded to this survey was 49 years of age, Caucasian, female, has practiced occupational health nursing for 12 years, and has a BSN, Diploma, or Associate Degree in Nursing. Respondent data was congruent with national OHN data for the attributes of age and gender. Overall, respondent educational level was higher than the national level.

Direct care vs. non-direct care. The field of occupational health nursing includes a variety of nursing roles. While many OHNs provide direct clinical care, others work in managerial, nursing education, case management, and other non-direct care roles. While all OHN roles offer unique opportunities for abuse screening and intervention, clinical care offers the most opportunity for direct contact with employees. Increased contact

results in increased abuse screening and intervention opportunities. From 74 total responses, 68% of respondents provide direct care.

Abuse training. Figure 2 presents data on types and total amounts of respondent education/training on abuse. Instructions were to indicate all types of training that applied. Textbooks/Journal" and "Conferences/Workshops" accounted for 62% of responses. Nine respondents did not answer this item. It is impossible to determine if these respondents were indicating that they had had no training on abuse, or if they just overlooked the item.

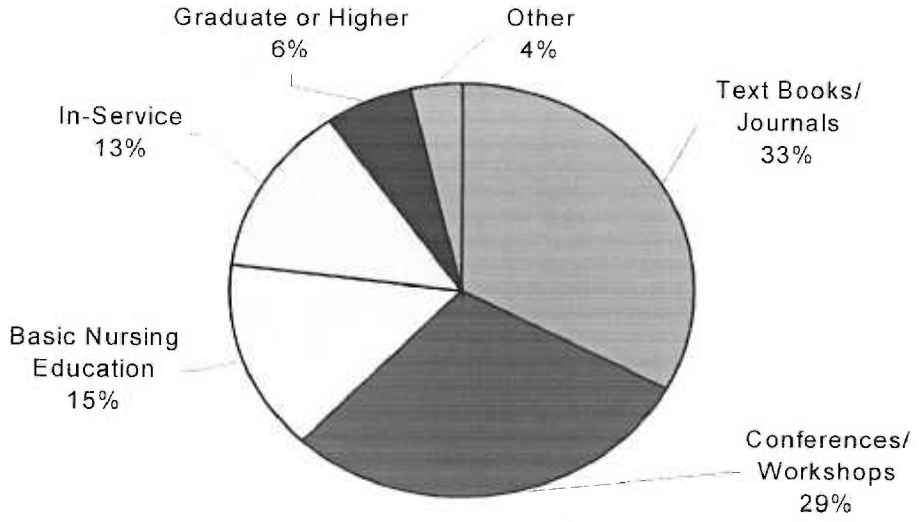

Figure 2. Types of Abuse Education *(N=167)*

In comparison with the current study, the Tilden et al. (1994) study, reported 44% of nurse respondents (N=241) with "little" or "some" course work, or training, in spouse abuse (response choices differed slightly). Consistent with the Tilden et al. (1994) study, there was no association in the current study between level of nursing education, and type, or number of types, of abuse training or education.

Figure 3 presents respondent attitudes about the importance of OHNs possessing abuse screening and intervention skills. It is encouraging that 95% of respondents agreed, or strongly agreed, that OHNs should possess these skills.

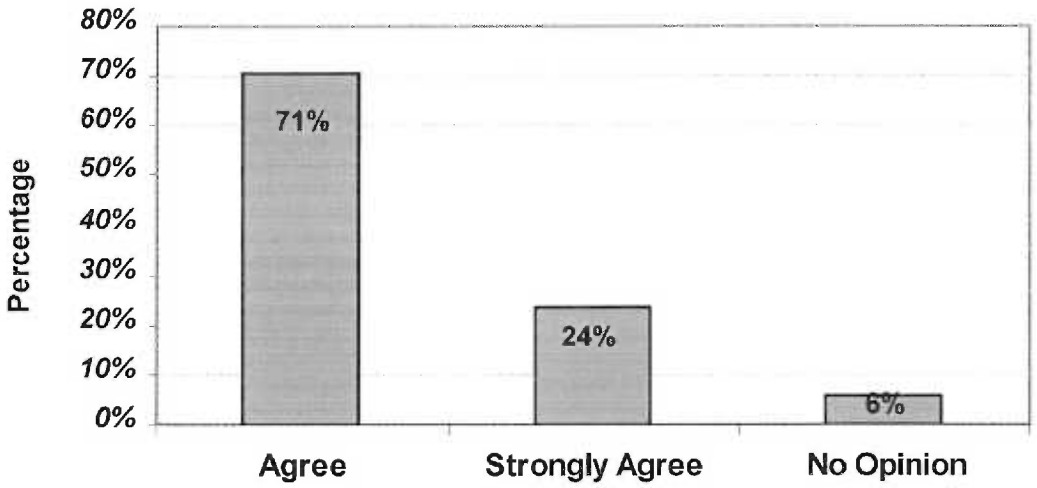

Figure 3. Attitudes about the Importance of OHNs Possessing Abuse Screening and Intervention Skills *(N =68)*

Of interest were respondent attitudes regarding the adequacy of current abuse screening and intervention training for nurses in practice. Figure 4 indicates 88% percent of respondents disagreed, or strongly disagreed, with the statement that there is adequate abuse screening and intervention training for nurses in practice. Respondent attitudes about the importance of OHNs possessing abuse screening and intervention skills, combined with their beliefs about the inadequacy of current abuse training, lends support to the development and delivery of abuse screening and intervention training programs for occupational health nurses.

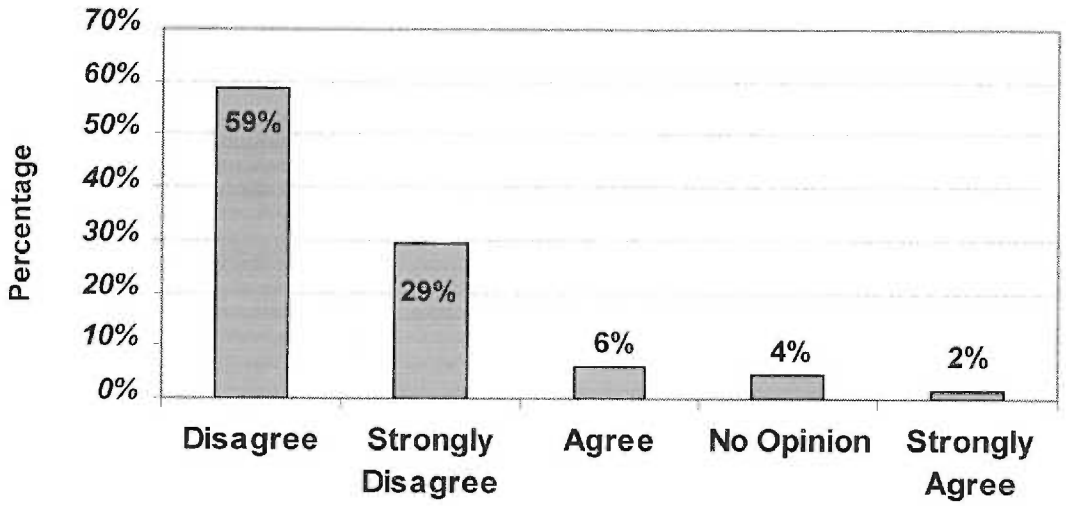

Figure 4. Attitudes about Adequacy of Abuse Screening and Intervention Training *(N =68)*

Professional Experience with Abuse

Results dealing with the category of professional experience with abuse are grouped under the following headings (a) previous nursing experience with abuse, (b) use of abuse protocols, (c) frequency of suspicion of abuse, and (d) frequency of contact with male abusers.

Previous experience with abuse. Thirty-seven percent of respondents (N=72) had previously worked with abuse, in ER, Mental Health, Pediatrics, and a variety of other health care settings. Previous nursing experience with abuse could influence current attitudes, skills, and knowledge about abuse. Surprisingly, previous nursing experience with abuse did not correlate with any other study variables.

Use of abuse protocols. Occupational health nursing protocols are an important quality assurance tool. Only 19% (N=73) of respondents use abuse screening and intervention protocols in their occupational health practice. Despite the small number of respondents using abuse protocols, 80% of respondents agreed, or strongly agreed, that abuse protocols are important to occupational health practice (Figure 5).

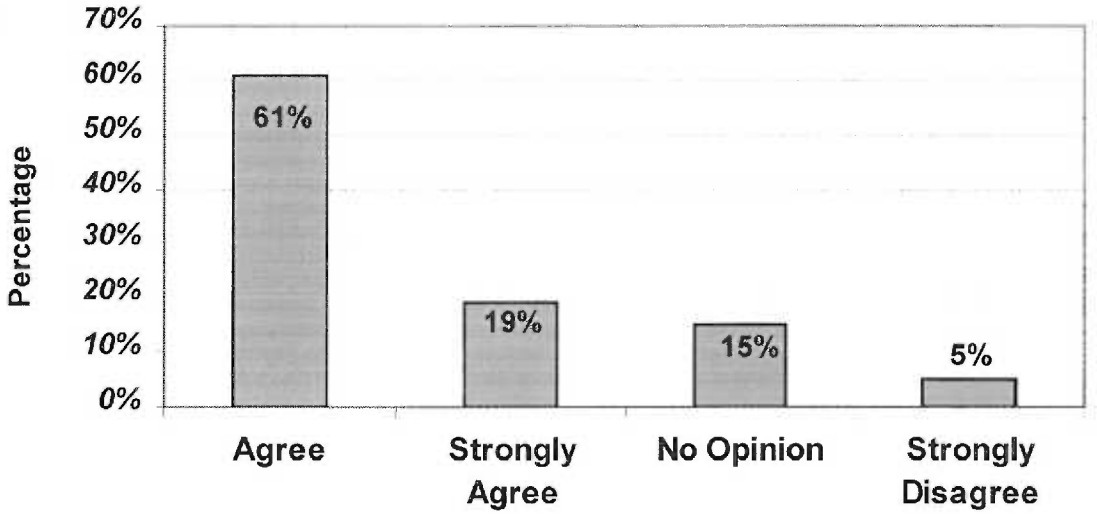

Figure 5. Attitudes about Importance of Including Abuse Screening and Intervention Protocols in Occupational Health Programs *(N =68)*

Not surprisingly, amount of training on abuse moderately correlated (r =.29, p =.001) with use of abuse protocols (Figure 6) That is, the more types of abuse training the respondent had, the more likely they were to use abuse protocols in current practice.

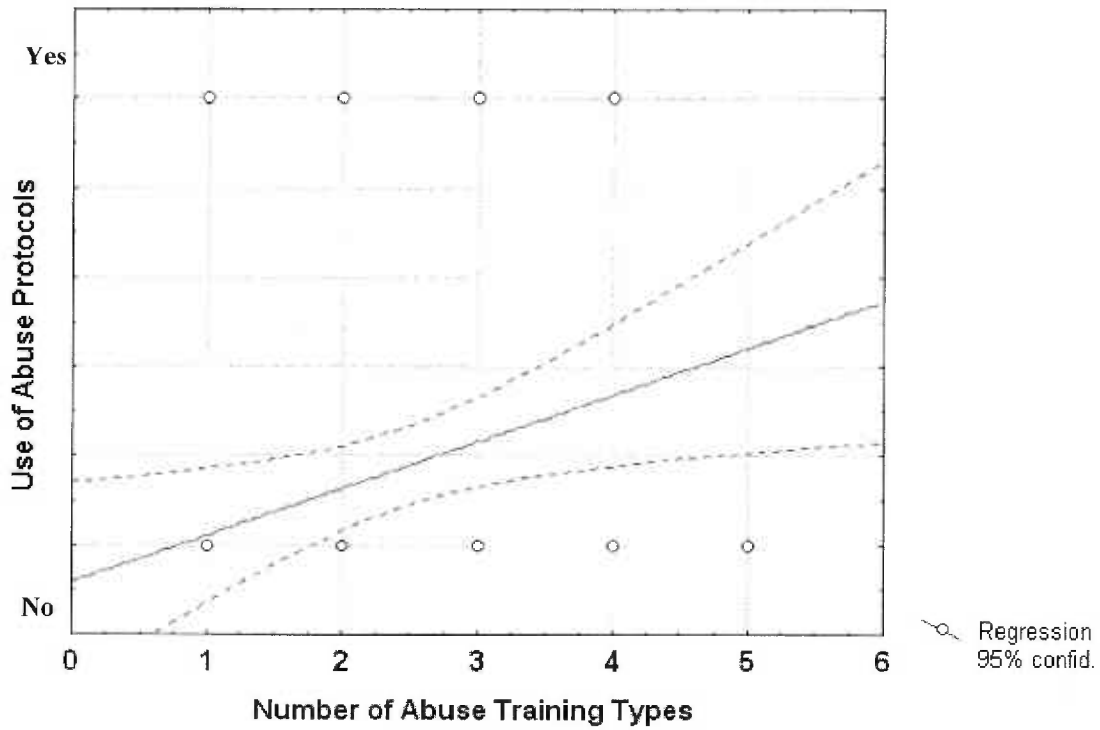

Figure 6. Use of Abuse Protocols with Number of Types of Abuse Training *(r=.29 p=.01).*

Frequency of suspicion of abuse. An additional professional experience item dealt with how often the respondent was suspicious that abuse may be the cause, or a contributing factor, to a female employee's physical or emotional symptoms. Responses (N=71) ranged from frequently (0%), often (7%), occasionally (35%), rarely (47%), and never (11%). Responses were furthered collapsed into "suspicious" (often, frequently and occasionally), and "not suspicious" (rarely and never). Using this criterion, 42% were "suspicious". The Tilden et al (1994) study reported that "A surprising number of nurses reported seeing few or no clients in their practice whom they suspected were in abusive

family situations." (p.4).

Cross-tabulating the variables of suspicion about abuse with direct care vs. non-direct care revealed the unexpected finding that the greatest number of respondents provide direct care, and, at the same time, are "never" or "rarely" (defined as "no"), suspcious about abuse as a contributing factor to a female employee's physical or emotional symptoms. (Figure 7).

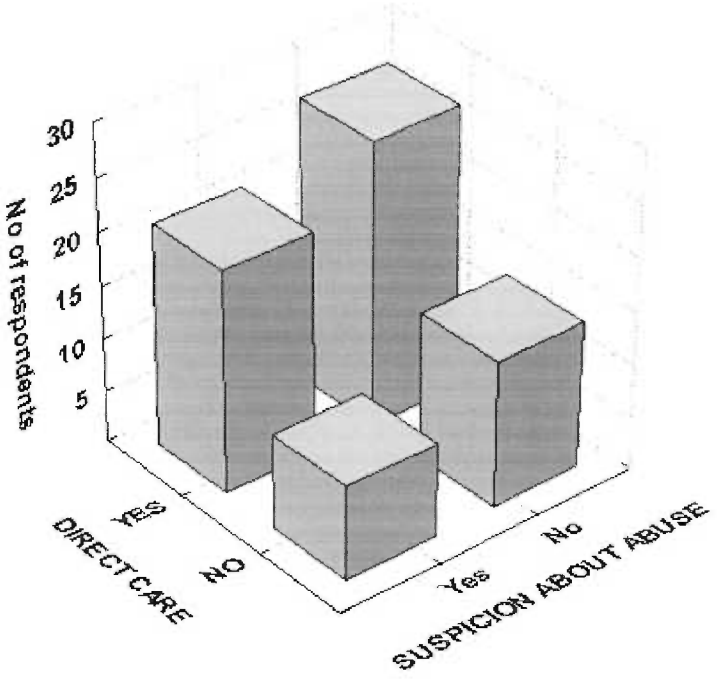

Figure 7. Frequency of Suspicion about Abuse with Direct Care vs. Non-Direct Care *(N=71)*

Frequency of suspicion of abuse significantly correlated with number of types of training on abuse (r =.399, p=.01), (Figure 8). Specifically, the more types (workshops, books, etc.) of abuse training the respondent had; the more frequently they suspected abuse as a contributing factor to a female employee's symptoms.

Figure 8. Frequency of Suspicion about Abuse with Number of Types of Abuse Training *(r =.40 p = .001)*

A significant correlation (r =.33, p =.01), (Figure 9) was found between suspicion about abuse and graduation date. That is, the more recent the graduation date, the more frequently the respondent was suspicious about abuse. This finding is consistent with the Tilden et al. (1994) study that also found the more recent the nursing education; "the more likely the nurse had had some course content related to family violence." (p.4).

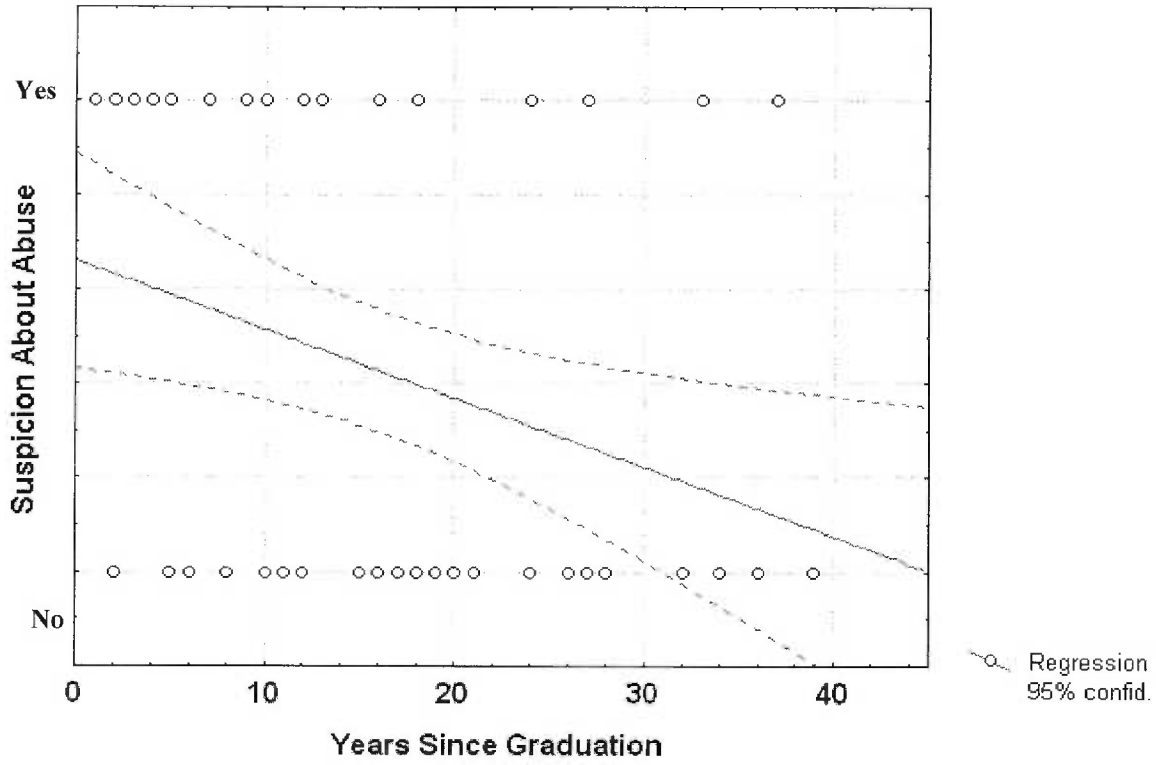

Figure 9. Frequency of Suspicion about Abuse with Years since Graduation *(r = -.33, p =.01)*

Contact with male abusers. An additional professional experience item requested information about respondents' frequency of contact with suspected male abusers. Responses (N=70) ranged from frequently (3%), often (1%), occasionally (26%), rarely (49%), and never (21%). Responses were further collapsed into "yes" (often, frequently and occasionally) and "no" (never and rarely). Respondent roles were dichotomized into

"direct care" vs. "non-direct care". Figure 10 presents cross-tabulated data, including the variables of direct care vs. non-direct care, and contact with male abusers. Consistent with data on "frequency of suspicion of abuse", an unexpected finding was that the largest number of respondents answered "yes" to direct care, but answered "no" (defined as "never" and "rarely") to contact with abusive male employees.

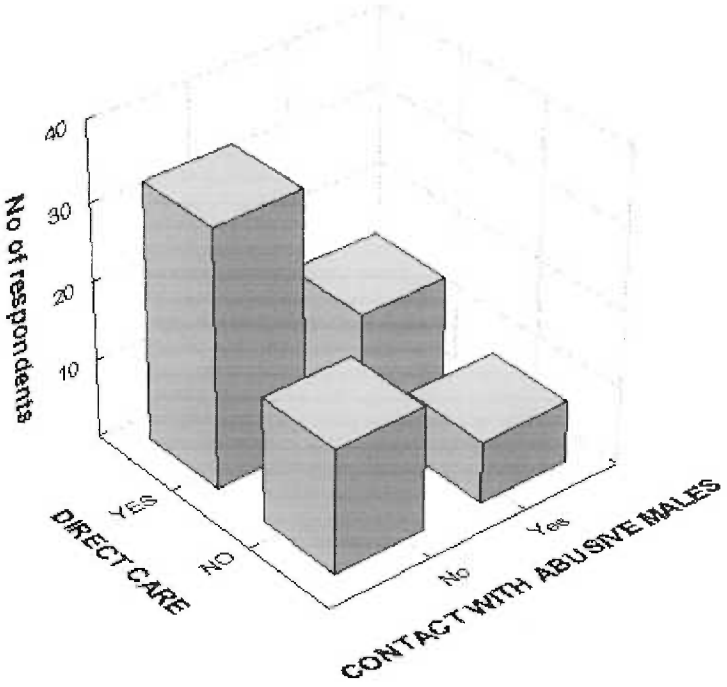

Figure 10. Frequency of Contact with Male Abusers with Direct Care vs. Non-Direct Care *(N=70)*

Interactions with Abused Female Employees

Thirty-seven respondents described an instance or interaction in their occupational health practice in which they intervened with a female employee experiencing abuse. An additional item asked what would they have done differently, if anything? Twenty-seven respondents described an interaction. Narrative responses were grouped into the following categories (a) methods of abuse identification, (b) types of abuse reported, (c)

intervention strategies and outcomes, and (d) things they would have done differently.

Methods of abuse identification. The most frequently reported method of abuse identification was self-referral. That is, 34% of respondents described the abused female employee initiating contact with the respondent. For example, "Female employee came to me stating married 25 yrs [years], and graphically described a controlling husband that mentally and emotionally abused her for all their married yrs [years]." Another respondent reported "Had a visit from an employee who said they were leaving the home and husband because of physical abuse." Abused female employees may be initiating contact with OHNs because, in general, employees view OHNs as confidential and empathetic advocates within a sometimes un-caring business environment. In addition, supervisors often refer employees, with physical or emotional problems, to OHNs for evaluation and referral. These organizational roles give OHNs the opportunity to learn about employees' private lives, including situations of abuse.

Respondent recognition of physical symptoms of abuse was the second most frequently reported method of abuse identification. Twenty-two percent of respondents reported finding bruises, and other physical indicators of abuse during occupational health evaluations. One respondent wrote "c/o shoulder pain that I was led to believe was RMI [Repetitive Motion Injury] until I saw discoloration on shoulder and upper arm." Another reported, "This year a woman came to work and I noticed bruises on her upper arms (in the shape of fingers) and on lower arms (defense marks)." All but one respondent reported success in getting the abused female employee to talk about the abuse. In this particular case, the respondent reported "Employee absent from work and made up an excuse about a car accident that she didn't want to report, and didn't want to

see MD."

In addition to self-referral and physical symptom identification, five respondents described supervisor and co-worker reports of suspected abuse. They sought advice from the respondent about how to help the identified employee. One respondent wrote, "Was notified by her supervisor that an employee was a victim of abuse (she had confided in supervisor)." In three cases, the supervisor reported employee performance problems as one of the first indicators of the abuse. For instance, "She came to employee health referred/recommended by her supervisor-who was concerned about her fatigue (exhibited by napping in the corner on her breaks)." Although not as generally effective as direct intervention, these referrals were helpful in educating supervisors and co-workers about effective intervention strategies, and in some cases, ultimately resulted in successful interventions.

Types of abuse reported. Fourteen narratives included information that the female employee was experiencing some form of physical abuse, including: (a) hitting, (b) slapping, (c) hair pulling, and most unfortunately (d) murder. One respondent offered a distressing narrative that supports the reality of abused women's fears in trying to leave an abusive relationship.

> Receptionist in occupational medicine clinic came to work with signs of abuse; black eye, bruises, MD and OHN provided counseling and referral for F/U with counselor. Receptionist ultimately left spouse, was threatened and murdered in front of her 2 children and mother by her spouse, even though a restraining order was in place.

Other respondents reported the physical signs of (a) bruises (in the shape of

fingers), (b) lacerations, (c) defense marks, (d) broken eardrum, (e) black eyes, and (f) facial fractures. Another respondent uncovered the cause of a physical injury while attempting to change a female employee's finger dressing. " The patient became hysterical as the dressing was removed....She would not discuss cause until the next day when she told how her husband had tried to rip her wedding ring off.

Three cases involved reports of emotional, verbal or psychological abuse, including: (a) verbal put-downs, (b) questioning of decisions, (c) isolation, (d) domineering and controlling behaviors, (e) jealousy, (f) threats of physical harm, and (g) threats of taking children away. One respondent wrote "She acknowledged stress @ [at] home, specifying she and her husband were not getting along. She detailed how he verbally put her down, questioned her every decision. She wondered if he would hurt her physically". A respondent's co-worker reported spousal abuse of their child. "Co-worker offered info that spouse was abusing her child." Another respondent reported "An employee from another shift was found sleeping in her car in our parking lot at 2am. Stated her husband kicked her out and she had nowhere to go." For employees without family, or other social support systems, the workplace can become a primary support system.

In six cases, alcohol, or other drugs contributed to the abusive situation. For example, she found a copy of his counselors eval. [sic] of him. DX: late stages of alcoholism. She was unable to directly discuss this with him for extreme fear of bodily harm....she came home sick from work, surprised him, found him in bath room demonstrating strange behavior, after, she noted white powder on B.R. counter took it to have it tested, proved to be methamphitamine [sic].

Respondent interventions and outcomes. The most frequently reported

intervention strategy was referral of the abused female employee to the organization's Employee Assistance Program. One respondent wrote, "Co-worker expressed fear of husband. I listened and referred her to EAP." The absence of the abusive male partner in the workplace can provide a safe environment for the abused female employee to seek help. One respondent wrote "We talked about our EAP and eventually made a conference call to them. They made an appointment for that afternoon while at work so her husband wouldn't know."

The next most frequently reported intervention strategy was referral to abuse shelters, rape, and other local, state, and national abuse hotlines. One respondent reported personally driving the abused female employee to the women's shelter. Before referral, 19% of respondents reported listening to the abused female employee tell their experiences of abuse, and in some cases the respondent provided limited counseling.

Four respondents reported the abused female employee expressing fear of leaving the abusive situation. For example, one respondent wrote "In clinic practice female relating abusive behavior mainly psychological but afraid of physical, afraid to leave." A recommended strategy to help abused women leave an abusive relationship is to assist them with developing a safety plan. Three respondents assisted the abused female employee in making a safety plan. For instance, "Had a visit from an employee who said they [sic] were leaving the home and husband because of physical abuse. I asked her if she was safe and I made sure I felt she had a plan to keep her safe." Several narratives described the abused female employee as unable to focus on her own needs. One respondent wrote, "She wanted me to suggest ways she could help her husband, both with his drinking and temper....The women reported that she was considering divorce but

wanted to try to help him first. Because she was so focused on him, she was not willing to get help for herself." At the same time, one abused female employee was beginning the process of focusing on her needs, and after suffering 25 years of mental and emotional abuse was "seriously considering divorce and is learning to take care of herself-not worry about him slow, painful process, no resolution yet." Two other respondents helped the abused female employee get a restraining order against the abusive male.

Some narratives included information on whether the abused female left or stayed in the relationship. In seven cases, the abused woman left the relationship. Several moved into shelters, three obtained restraining orders and two others moved to another community to escape the abuser. One of the abused women, who moved to another community, was eventually murdered by her abuser. Five narratives specifically reported the abused female employee staying in the abusive relationship. In many of these cases, the respondent reported the abused woman as wanting to stay to help the abuser change his behavior. In several other cases, the abused woman was afraid to leave, or left temporarily and then returned.

A number of respondents described interventions that were more active, that is, requiring more participation from the respondent. For instance, one respondent wrote "after finding an abused female employee sleeping in her car in the company's parking lot, brought her into the clinic and provided her a bed for the night." Another respondent personally drove the abused employee to a woman's shelter. Several other respondents helped get restraining orders, and several others assisted in writing a safety plan. The degree of involvement by the respondent appeared to correspond with the severity of the situation. The Tilden et al. (1994) study found that the largest number of respondents

intervened passively, such as charting the information, or continuing to observe the situation.

An additional question related to the respondent's abuse interaction narrative was: Looking back, what would you have done differently, if anything? The following responses, in order from highest to lowest frequency, were: nothing (13), intervened sooner (3), more direct questioning (3), not sure (2), encouraged victim to leave (1), accompanied to shelter (1), referred to attorney (1), offered more resources (1), encouraged to get medication (1), and finally, followed up (1).

Personal Experience with Abuse

Personal experience with abuse, either as the direct recipient, or as a child witness, can significantly affect reactions to abuse in later life. Fifty-percent of respondents (N=72) answered "yes" to the question have you ever personally experienced abuse, either directly, or as a witness? From this group, 59% were the direct recipients, 25% were the support person for another person being abused, 8% were child witnesses of abuse, and 8% choose "other".

Another personal experience question asked if the subject had concerns about their safety in any of their current relationships. Only three (N=67) respondents indicated that they were concerned about their safety in a current relationship. Eight respondents failed to answer this item.

Personal experience with abuse can positively or negatively influence nursing practice. From twenty-two responses, ninety-one percent reported that their personal experience had positively influenced their nursing practice. "Positive influence" included: (a) greater awareness (41%), (b) more effective counseling (27%), and (c) increased

empathy (22%). "Negative influence" included (a) no patience with abusers (5%), and (b) conflict avoidance (5%).

Knowledge Test

Table 1 presents percentages correct for individual abuse myth questions. It is difficult to determine if the large number of incorrect responses on several questions was the result of actual respondent error, or confusing or biased question design. The wording of the abuse myth questions was consistent with wording found in the lay and professional literature on abuse myths.

Only 9% of respondents answered question 4b correctly. That is, they answered "true" to the statement "Neither stress or psychopathology are leading causes of abuse". The negatively worded structure of the question may have confused some respondents. However, the belief that men abuse during times of stress, or due to psychopathology, is a commonly held myth. Perhaps the most prevalent myth about abuse is that if the abused woman does not want the abuse, she should just leave the relationship. This belief omits the fact that the risk of serious injury, or death, increases when an abused women attempts to leave an abusive relationship. Surprisingly, only 4% of respondents answered question 4f correctly. That is, only 4% of respondents understand that abused women, "in general, or most of the time", are unable to leave an abusive relationship, even when they want to. Only 15% of respondents answered question 4g correctly. The phrase "sanctity of family life" is emotion provoking, and as such, may have biased responses.

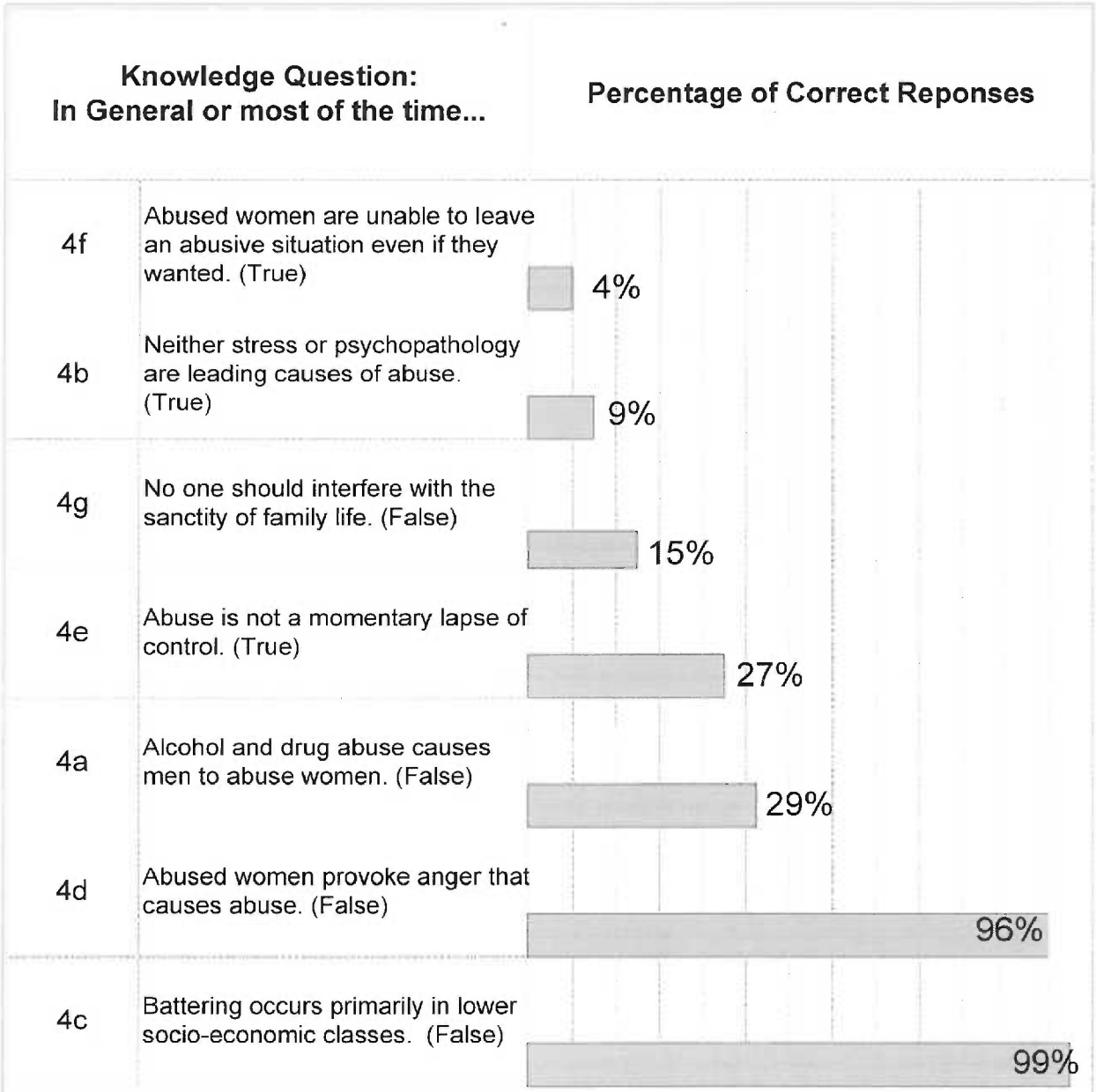

Figure 11. Percentage Correct for Individual Abuse Myths Questions (N =75)

Chapter V

Discussion

This study revealed several important concepts related to the goal of integrating abuse screening and intervention strategies into occupational health practice. To begin with, almost all respondents believe it is important to screen and intervene with abuse in occupational health settings. Not surprisingly, they also believe that OHNs should possess abuse screening and intervention skills, and that existing abuse screening and intervention training is inadequate. Next, although most respondents infrequently suspect abuse, infrequently use abuse protocols, and believe the myths about abuse, they are, for the most part, intervening appropriately. Finally, frequency of suspicion of abuse, and use of abuse protocols, positively correlated with the number of types of abuse training.

Respondents' positive attitudes about the importance of screening and intervening with abuse in occupational health settings are highly encouraging. OHNs, as health care agents for business organizations, have traditionally focused on the prevention and treatment of work-related injuries and illnesses. This is due to the business need for compliance with governmental health and safety regulations, and to a lesser degree, to business profit motives. Preventing work-related injuries keeps employers compliant with health and safety regulations, keeps employees at work, and contains costs through prevention of injuries. At the same time, OHNs, as health care providers for populations of workers, are required to deal with a full range of employee health problems. OHNs have long recognized that if ignored, these problems will not only negatively affect the life and work performance of the employee, but eventually the health of the business organization, and the community at large.

Although a majority of respondents infrequently suspect abuse, when it is reported to them, they are, for the most part, intervening appropriately. The described interventions of listening, helping develop safety plans, and referring to organizational (EAP), or community abuse intervention resources, are all appropriate and advisable abuse intervention strategies, given the limitations of occupational health practice. OHNs encounter a wide range of health problems in their employee populations. As health care generalists, they recognize their clinical limitations, and frequently refer to external health care resources. It is therefore not surprising that respondents are referring abused female employees to community abuse intervention resources.

OHNs generally develop long-standing health care relationships with employees. These relationships can foster mutual trust and confidence, allowing the OHN access to information about an employee's personal life, including information about abuse. This trust and confidence factor is evident in the finding that the most frequent method of abuse identification was self-referral. That is, the abused female employee reported the abuse to the OHN. This finding is especially significant because previous studies (Yam, 1995; Sugg & Inui, 1992), reveal that abused women, in general, are reluctant to reveal abuse to health care professionals, due to negative perceptions about health care professionals' uncaring attitudes. These long-term, usually trusting, OHN/employee relationships may be the most important and useful occupational health specific condition supporting abuse screening and intervention in occupational health settings.

Surprisingly, belief in abuse myths did not appear to negatively impact respondents' intervention strategies. For instance, believing the myth that an abused women can leave the abusive relationship at any time, without a safety plan, can lead to advice that places

the abused women in serious jeopardy. However, only two narratives described a respondent encouraging the abused female employee to leave the relationship, with no mention of a safety plan. More importantly, three respondents described helping the woman develop a safety plan, and several others helped the abused female employee obtain a restraining order.

A significant number of respondents described a deeper understanding of the complex issues involved in leaving or recovering from an abusive relationship. Intervention strategies, in general, focused appropriately on helping the abused women come to their own decisions about their relationship. Respondents' personal experiences with abuse may have influenced, in some cases, their understanding of the complex emotional issues around leaving an abusive relationship. With 50% of respondents having personally experienced abuse, either directly, or as a child witness, it is reasonable to suspect that this experience has influenced their reactions to abuse encountered in their nursing practice. This would be an interesting area for additional research.

Although respondents are intervening when abuse is reported to them, a concerning finding, consistent with other studies (Tilden et al., 1994), is that a majority of respondents "rarely" or "never" suspect abuse. This finding raises the question; why are respondents who have positive attitudes about the importance of screening and intervening with abuse, and in fact, are appropriately intervening, infrequently suspecting abuse? An obvious explanation is that respondents, who infrequently suspect abuse in female employees, are working in primarily male environments. Another, more complex explanation, is that it is clearly harder to initiate the subject of abuse, for fear of being wrong, and offending the female employee. Previous studies (Sugg & Inui, 1992) indicate

that other health care providers share similar fears. Implementing abuse protocols, which include universal abuse screening, can help reduce this fear. If female employees are informed that abuse screening is a normal part of an occupational health exam, similar to a growing number of other female health care exams (Women's Health), then it is less likely that individual female employees will be offended. The use of abuse protocols, to increase abuse screening, could be a major component of occupational health specific abuse screening and intervention training. Another explanation may be that existing abuse screening and intervention training does not include adequate information on the signs and symptoms of abuse, or, more importantly, does not offer practical advice on how to start the conversation about abuse. For example, one respondent wrote "I sometimes feel very inadequate because I don't 'pick-up' on the subtle signs of abuse- I probably could refer more women for assistance if I were more aware." Training programs could include role playing, to give OHNs specific examples of non-threatening approaches to the subject of abuse with their female employees.

This study found a positive correlation between frequency of suspicion of abuse and number of types of abuse training. This finding supports the continued development of occupational health focused abuse screening and intervention training programs, with the ultimate goal of increasing OHNs suspicion of abuse. As one respondent wrote "Thanks for picking this topic, it is one in which I feel inadequate. I'm sure with adequate training I would be more aware of abused employees and know what to do." Most respondents indicated they had two or more types of abuse training. Journal articles and conferences were the most frequently selected types of training. This was a confusing finding given the minimal amount of abuse information found in occupational health literature, or

offered at occupational health conferences. Respondents may be referencing abuse information in journals and at conferences outside their occupational health specialty. Abuse screening and intervention training, developed for other nursing specialties, would exclude occupational health nursing specific limitations and opportunities. This may be the basis for the finding that most respondents believe existing abuse screening and intervention training is inadequate.

OHNs are the best candidates to develop occupational health specific abuse screening and intervention training programs. They are aware of the unique abuse screening and intervention opportunities and constraints inherent in occupational health settings. Public, Mental and Women's Health nurses have pioneered the development and implementation of abuse screening and intervention protocols and training programs in their respective nursing practices (Jordan & Walker, 1994; Sheridan & Taylor, 1993). These training programs and protocols are available to form the basis for occupational health abuse screening and intervention protocols and training programs. The American Association of Occupational Health Nursing (AAOHN), can be encouraged to publish a position statement urging all OHNs to screen and intervene with abuse, and to acquire the necessary training. This strategy is highly endorsed and promoted by national health care authorities, and other health care professional associations, including the U.S. Surgeon General, the American Nurses Association (ANA), and the American Medical Association (AMA).

The finding that the more recent the date of graduation, the more likely the respondent is suspicious about abuse, may indicate that schools of nursing are now including abuse education in their nursing curriculums. This conclusion is consistent with

the Tilden et al. (1994) study that found "the more recent the education, the more likely the nurse had had some course content related to family violence." (p.4). Congruent with health care authorities directives, abuse education needs to be included in all levels of nursing education, including continuing education for occupational health nurses. Published literature contains useful abuse educational strategies (King & Ryan, 1993).

Implications for Occupational Health Nursing Practice

OHNs have a significant opportunity and responsibility to join other healthcare professionals in combating the national public health tragedy of abuse. Occupational health settings are untapped reservoirs for abuse screening and intervention programs. Because of the absence of the male abuser, the workplace can offer an abused female employee a safe environment to seek intervention. Business organizations are interested in retaining employees, and maintaining profits. OHNs are concerned about employee health and safety. These are mutually compatible goals. Providing abuse screening and intervention programs assists in keeping employees on the job, controls costs, and contributes to abuse intervention opportunities for working women. OHNs' unique roles within work settings allow them access to information about employees' personal lives, including lives that involve abuse. Respondents' positive attitudes are encouraging, and an essential component for the successful integration of abuse screening and intervention programs in occupational health settings. To increase abuse intervention opportunities for working women, occupational health abuse training programs need to focus on improving OHNs' screening skills. The implementation of occupational health abuse protocols can secure abuse screening for female employees, providing much needed help for abused working women.

Limitations

There are several important limitations of this study. First, the sample size was small. A contributing factor to the low response rate may have been omitting sending a second reminder postcard to non-respondents, although recommended by Salant & Dillman (1994). The number and complexity of several of the questionnaire items may have deterred some participants from taking the necessary time to respond. Finally, participants who have, or are currently experiencing abuse, may have been emotionally unprepared to deal with the subject. A larger study sample may have improved the reliability of the chi-square statistical tests for categorical data.

A clearer picture about respondents' abuse training could have been obtained if a response choice of "none" had been included in questionnaire item regarding types of abuse training. It is impossible to determine if failure to answer this question implied "none" (no training), or if some respondents simply overlooked the item.

Confusing question structure may have contributed to the large number of inaccurate responses on the "abuse myth knowledge test". The negative wording, to prevent the response bias of acquiescence, may have added an unnecessary level of complexity.

Finally, additional information about the demographics (age, gender, industry type) of the respondents' occupational health setting, may have helped clarify respondents' "frequency of suspicion" findings. For instance, in a primarily male work environment, frequency of suspicion of female abuse will be obviously low.

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Screening and Interventions with Abused Women in an Occupational Health Setting: A Self-Assessment Survey

Abuse, for the purpose of this survey, is defined as physical, psychological, verbal, or sexual abuse against a woman, inflicted by a male partner.

Occupational Health Nursing is broadly defined to include medical case management, employee health, wellness promotion, and nursing education.

YOUR RESPONSES ARE ANONYMOUS AND CONFIDENTIAL

****

1. How many years have you have worked in occupational health nursing?

_____ Years

2. (a) Indicate your highest level of education (completed)

AD/AA____BSN____ Diploma____ MS/MSN_____PhD____Other _____

(b) Date Completed_____

3. Mark true or false to the following questions:

In general, most of the time:	True	False
a. Alcohol and drug abuse causes men to abuse women.	☐	☐
b. Neither stress nor psychopathology are leading causes of abuse.	☐	☐
c. Battering occurs primarily in lower socio-economic classes.	☐	☐
d. Abused women provoke anger that causes abuse.	☐	☐
e. Abuse is not a momentary lapse of control.	☐	☐
f. Abused women are unable to leave an abusive situation even if they wanted to.	☐	☐
g. No one should interfere with the sanctity of family life.	☐	☐

4. Does your occupational health role include direct clinical care?

(1)Yes____(2) No_____

5. Does your occupational health practice include abuse screening and intervention protocols?

(1) Yes_____(2) No_____

6. In your OHN role, how often are you concerned that abuse may be the cause, or a contributing factor, to a female employee's physical or emotional symptoms?

Circle one

Never
Rarely (1-2x year)
Occasionally (3-6x year)
Often (7-12x year)
Frequently (> 12x year)

7. In your OHN role how often do you have contact with a male employee that you suspect may be abusive?

Circle one

Never
Rarely (1-2x year)
Occasionally (3-6x year)
Often (7-12x year)
Frequently (> 12x year

8. (a) Please describe an employee interaction in your occupational health practice that involved abuse or domestic violence. (If you have never had an interaction involving abuse please skip to question #9)

(b) Looking back, what would you have done differently, if anything?

9. Please indicate your level of agreement or disagreement with the following statements:

(a) It is important that occupational health clinical protocols include abuse screening and intervention protocols.

1_____ 2_____ 3_____ 4_____ 5_____
strongly disagree disagree no opinion agree strongly agree

(b) Occupational health nurses should develop skills in abuse screening and intervention.

1_____ 2_____ 3_____ 4_____ 5_____
strongly disagree disagree no opinion agree strongly agree

(c) The occupational health nurse is an appropriate workplace resource for a female employee seeking assistance for an abusive situation.

1_____ 2_____ 3_____ 4_____ 5_____
strongly disagree disagree no opinion agree strongly agree

(d) It is more important for occupational health nurses to screen for hearing and other occupationally related conditions, than to screen for abuse.

1_____ 2_____ 3_____ 4_____ 5_____
strongly disagree disagree no opinion agree strongly agree

(e) There is adequate abuse screening and intervention education and training for nurses in practice.

1_____ 2_____ 3_____ 4_____ 5_____
strongly disagree disagree no opinion agree strongly agree

10. Please indicate all forms of training/education you have received on abuse, or abuse screening and intervention strategies

Included in basic nursing education _____
Included in graduate or higher nursing education _____
Conferences Sessions/Workshops _____
Textbooks/ Journal Articles _____
In-Service Education _____
Other _____

11. Have you had any other direct clinical experience (other than occupational health) working with abuse?

(1) Yes_____ (2) No_____

If yes, please describe:

12. Indicate your age category

20-30 _____
31-40 _____
41-50 _____
51-60 _____
>60 _____

13. Gender: (1) Female_____ (2) Male_____

14. Ethnic Background:

(1) Caucasian _____
(2) Spanish-American _____
(3) Asian-American _____
(4) Native American _____
(5) Black/African American _____
(6) Pacific Islander _____
(7) Other _____

An individual's personal life experience with abuse and violence may have a significant effect on their responses to similar situations encountered in later life. For this reason, the following questions are concerned with your personal experience with abuse. You may notice an emotional response. If so, you may find it helpful to contact one of the following numbers.

Domestic Violence Hotline	**1- 800- 799- SAFE**
Portland Women's Crises Line	**(503) 235- 5333**
WA. State Domestic Violence Hotline	**1- 800- 562- 6025**

15. Have you ever personally experienced abuse either directly, or as a witness?

(1) Yes_____ (2) No_____

If Yes, were you

_____ The abused
_____ The abuser
_____ Child witness of abuse in your family of origin
_____ Adult support person to someone experiencing abuse
_____ Other

Describe:

16. Do your currently have concerns about your safety in any of your relationships?

(1) Yes_____ (2) No_____

comments:

17. If you answered yes to either question # 15 or # 16, please describe how this has influenced your nursing practice

18. Additional Comments

THANK YOU FOR COMPLETING THIS SURVEY

Louann Beck
2004 SE 158th Ave.
(360) 212-5028
Vancouver, WA

Oregon Health Sciences University Information Sheet

Study Title: Occupational Health Nurses' Experience, Knowledge and Attitudes about Abuse (Domestic Violence).

Principle Investigator: Louann Beck, RN, BSN (360) 212-5028

Co-Investigator: Leslie Ray RN, Ph.D. (503) 494-3806

Purpose:

I am an Occupational Health Nurse (OHN) completing my Masters Degree in Community Health Nursing at Oregon Health Sciences Center, and I am asking for your assistance in helping me complete my Master's Research Project (MRP). You have been invited to participate in this research study because your knowledge, experience and attitudes in working with female employees suffering abuse (domestic violence) are important to OHN practice.

The purpose of this study is to gain an understanding of OHN's knowledge, experience and attitudes about abuse, and, more importantly, use this information to identify OHN's abuse screening and intervention training needs. Once training needs have been identified, a training curriculum, including abuse screening and intervention protocols for occupational health settings, can be developed.

Aggregate study findings will be presented at conferences, and submitted for publication. Ultimately, occupational health specific abuse screening and intervention protocols will be submitted for publication to encourage routine abuse screening for all female employees.

Procedures:

The 18 item self-administered questionnaire includes knowledge, practice, attitude, personal experience, and general demographic questions. It should take you approximately 30 minutes to complete.

To return the survey, please place the completed survey in the enclosed envelope labeled "survey". Next, place this sealed envelope into the larger self-addressed stamped envelope and return by October 12, 1998. Only the outer self-addressed envelope is numerically coded in order to send a follow-up reminder and additional survey to non-respondents. Responses will be kept anonymous and confidential.

Risks And Discomforts:

You may experience an emotional response to several survey questions related to your personal experience with abuse. Domestic Violence hotline numbers are included for those respondents needing assistance.

Benefits:

You may or may not personally benefit from participating in this study. However, by participating, you may contribute new information, which may benefit patients in the future. A copy of the study findings will be mailed to respondents.

Alternatives:

You may choose not to participate in this study.

Confidentiality:

Neither your name nor your identity will be used for publication or publicity purposes. Survey procedures are designed to assure confidentiality and anonymity.

Costs:

There is no cost to you to participate

Liability:

The Oregon Health Sciences University, as a public corporation, is subject to the Oregon Tort Claims Act, and self-insured for liability claims. If you suffer any injury from this research project, compensation would be offered to you only if you establish that the injury occurred through the fault of the University, its officers or employees. However, you have not waived your legal rights by signing this form. If you have further questions, please call the Medical Services Director at (503) 494-6020.

Participation:

Leslie Ray RN, Ph.D., OHSU faculty advisor for this research, has offered to answer any other questions you may have about this study. If you have any questions regarding your rights as a research subject, you may contact the Oregon Health Sciences University Institutional Review Board at (503) 494-7887. You may refuse to participate, or you may withdraw from this study at any time without affecting your relationship with or treatment at the Oregon Health Sciences University.

Your participation is highly appreciated and will help advance Occupational Health Nursing's contribution to the significant public health problem of abuse. Do not hesitate to call either myself @ (360) 260-8500, or my research advisor, Dr. Leslie Ray @ (503) 494-3806 for any additional questions, or to discuss the study in greater detail. Thank you.

Domestic Violence Resources:

National Domestic Violence Hotline - 800-799-SAFE
Washington State Hotline - 800-562-6025
Portland Women's Crises Line - (503) 235-5333

JUST A REMINDER

Several weeks ago you were sent an occupational health survey about your experiences, attitudes and knowledge regarding the Women's Health issue of Domestic Violence, as observed in occupational health settings.

In order to ensure the statistical reliability of my data. I need as many completed surveys as possible.

If you have misplaced your original survey, I would be glad to send you a replacement. Call (360) 212-5028 (leave a message with name and address).

Thank you in advance for your time and effort in returning your survey, and contributing to the research needed for the development of occupational health domestic violence protocols.

Sincerely,
Louann Beck RN
OHSU Graduate Nursing Student