

TRAINING HEALTH CARE PROVIDERS AS FIRST RESPONDERS
TO VICTIMS OF INTIMATE PARTNER VIOLENCE

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DEDICATION

This dissertation is dedicated to my husband, David, and our five beautiful children: Kristie, Zachary, Ethan, Audrey, and Jared. You are my reason for breathing. Life may change us but it always begins and ends with family! The strength and faith of the Greuel and Plunkett families have been indelibly etched upon my heart and soul. I love you all forever and always!

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ABSTRACT

Sarah Elizabeth Plunkett

TRAINING HEALTH CARE PROVIDERS AS FIRST RESPONDERS TO VICTIMS OF INTIMATE PARTNER VIOLENCE

Intimate partner violence (IPV) has been declared a public health epidemic. Initial and annual training of healthcare providers regarding guidelines for identification and response to intimate partner violence has been mandated by the Joint Commission and endorsed by the Institute of Medicine. However, many providers/institutions lack the preparation necessary to implement such guidelines. The purpose of the feasibility study was to test the efficacy of an existing IPV training curriculum on participants' perception of knowledge, cultural competence, confidence (self-efficacy), and attitudes related to identifying and responding to victims of IPV. A sample of convenience including twenty-three registered nurse home-visitors and one social work intern participated in the mandatory one-day training program. However, consent to enroll in the study was voluntary and indicated by completing the study instruments. Participants were asked to complete three evaluative measures: The 11-item Plunkett Demographic Questionnaire (pre-training), a 15-item Training Program Evaluation (post-training), and the 21-item Instructional Measurement Subscales across three time points (pre-Training, post-Training, and six weeks follow-up). All items were numerically coded so the higher the score, the more favorable the response. Data were analyzed using descriptive and inferential statistics (percentages; minimum-maximum, mean, and composite scores; standard deviations; repeated measures analysis of variance; and, paired samples dependent *t* tests).

Four hypothesis statements were made regarding participation in the training program on IPV: “There will be an overall increase in healthcare providers’ perceived level of knowledge and cultural competence,” (hypothesis 1); “There will be an overall increase in healthcare providers’ perceived level of confidence in implementing routine enquiry,” (hypothesis 2); “There will be an overall positive change in healthcare providers’ attitudes towards routine enquiry,” (hypothesis 3); and, “There will be an overall positive change in healthcare providers’ attitudes towards victims of abuse following participation in *Improving the Health Care Response to Domestic Violence*,” (hypothesis 4). Findings supported previous research outcomes that presently recognized barriers to routine screening/ assessment for IPV can be overcome and positive changes can persist over time as a result of participation in a standard IPV training program. Future research involving larger, random sample populations, are needed to confirm these results.

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Chapter One

Introduction

In 1985, Surgeon General Everett Koop, declared intimate partner violence (IPV) a “public health dilemma”. In 2002, the World Health Organization declared IPV a “world-wide public health epidemic”. Initial and annual training of health care providers regarding guidelines for identification and response to intimate partner violence has been mandated by The Joint Commission (TJC) and endorsed by the Institute of Medicine (IOM). Despite the fact that multiple screening instruments and training programs have been developed over the past two decades, many providers/institutions lack the preparation necessary to implement such guidelines. Furthermore, the feasibility of a standard curriculum to train health care providers in screening and assessing for IPV has not been tested. The purpose of the feasibility study was to test the efficacy of a standard IPV training curriculum, to increase health care provider’s knowledge, cultural competence, confidence (self-efficacy) and attitudes related to identifying and responding to victims of intimate partner violence following participation in training from the Family Violence Prevention Fund (FVPPF), *Improving the Health Care Response to Domestic Violence* (Ganley, 1998).

The greatest indicator of a nation’s well being is the health of its maternal-child population broadly encompassing factors such as education, employment and income, health, population and family characteristics, poverty, and youth risk factors (Anne E. Casey Foundation, 2007-2008). Injury and violence prevention, were targeted as two of the top ten indicators for the implementation of Healthy People 2010 (USDHHS, 2000). These indicators coincide with the Center for Disease Control (CDC) national research

agenda related to family violence, intimate partner violence (IPV), sexual violence and child maltreatment (NCIPC, 2006). Family violence has been defined as:

“...encompassing a broad range of controlling behaviors, commonly of a physical, sexual, and/or psychological nature and which typically involve fear, intimidation and emotional deprivation...It occurs within a variety of close interpersonal relationships, such as between partners, parents and children, siblings, and in other relationships where significant others are not part of the household but are part of the family and/or are fulfilling the function of family” (Fanslow, 2005, p. 11).

Child abuse has been defined as “The harming (whether physically, emotionally or sexually), ill treatment, abuse, neglect, or deprivation of any child or young person” (The children, young persons and their families amendment no. 121, 1994). Child abuse has been further defined as “...at minimum any recent act or failure to act on the part of a parent or caretaker which results in death, serious harm, sexual abuse or exploitation...an act or failure to act which presents an imminent risk of serious harm” (NCCAN, 2006).

Intimate partner violence (IPV) was defined as a specific type of family violence that refers to physical, emotional, and sexual abuse or neglect occurring primarily in the home environment with a previous or current intimate partner of the same or opposite gender (Kimberg, Bilbao and Marjavi, 2005; NCIPC, 2006; Silverman, et al., 2006). In addition to the theoretical or conceptual definitions presented above, it is important to note that statutory laws may also be incorporated to create operational definitions of family violence that may vary from state to state. In the United States, nearly 5.3 million women are victims of intimate partner violence, resulting in almost 2 million injuries and 1,300 deaths each year (CDC, 2003). Furthermore, the CDC has estimated that the economic toll of intimate partner violence exceeds \$5.8 billion (2003). Seventy percent of severe injuries and deaths occur when the victim is trying to leave or escape from the

perpetrator (BJS, 2001). Ongoing research to explore health care providers knowledge of the need for and intent to implement an intimate partner violence screening assessment protocol is essential to promoting positive outcomes for all victims of intimate partner violence particularly women of childbearing age.

Problem (Gap in the Literature)

Health care providers, especially nurses, have many points of contact with pregnant women during prenatal care, which can be windows of opportunity for prevention and intervention of intimate partner violence (Coker, et al., 2002; Curnow, 1997). Initial screening for intimate partner violence may be an early form of prevention and/ or intervention because women who choose to disclose information have taken the first step toward treatment, simply by breaking the silence. Therefore, follow-up preventive intervention must also be available. In 1992, the Joint Commission on Accreditation of Health Care Organizations (JCAHO, 1995) mandated that hospitals develop policies and procedures, for early identification and referral for victims of abuse (JCAHO, 1995). The mandate was most recently revised in 2004 (JCAHO, 2004). Additionally, the Institute of Medicine, endorsed recommendations that health care institutions adopt screening protocols and train health care workers in the prevention and treatment of intimate partner violence (Cohn, Salmon, & Stobo, 2002).

Implementing the mandate set forth by JCAHO (Appendix A) and the IOM recommendations (Appendix B) to train health care professionals in the screening/assessment for IPV is complicated by the fact that numerous screening methods and multiple training programs have been developed for IPV but with no standard definitions or measurements. The CDC made no recommendations in the use of

routine IPV screening/assessment instruments due to insufficient supporting evidence (USPSTF, 2004). However, JCAHO endorsed the *National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings* to help health care providers comply with its mandate (FVPPF, 2004). A standard training curriculum to implement the *National Consensus Guidelines* has also been established by the FVPPF: *Improving the Health Care Response to Domestic Violence* (Ganley, 1998).

Despite strides to unify universal efforts toward primary prevention of IPV, health care providers struggle with barriers regarding effective implementation of current tools for screening/assessment, and for training of health care professionals. Barriers to individual health care providers' responses are frequently related to knowledge, skills, attitudes, beliefs, behaviors, and/or institutional policies and procedures including health care providers' lack of knowledge and skill in using contextual factors and instruments to screen/assess for IPV. Preliminary studies have shown that training on routine enquiry may raise awareness and increase identification of victims living with IPV (Bacchus, Mezey, & Bewley, 2004; Cohn, Salmon, & Stobo, 2002; Davidson, et al., 2001; Herzig, et al., 2006; Ramsay, et al., 2002). However, there are still broad gaps in the literature concerning the effect of such training and measured change in institutional response that is sustainable over time (Bacchus, et al., 2007; Hamberger, et al., 2004; Minsky-Kelly, et al., 2005; Nicolaidis, Curry, & Gerrity, 2005; Thurston & Eisener, 2006). Furthermore, researchers have not compared existing training programs.

Purpose

The purpose of the feasibility study was to explore the efficacy of the Family Violence Prevention Fund (FVVPF) training program, *Improving the Health Care Response to Domestic Violence* (Ganley, 1998), on health care providers' perceived knowledge, cultural competence, confidence (self-efficacy), and attitudes related to identifying and responding to victims of IPV. The FVVPF educational training intervention, *Improving the Health Care Response to Domestic Violence*, was selected because it is intended to implement the *National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization* (FVVPF, 2004) endorsed by JCAHO. However, evidence based research confirming the effectiveness of the FVVPF training program, *Improving the Health Care Response to Domestic Violence*, is lacking.

Hypotheses/Assumptions

The feasibility study addressed the following four hypotheses.

Hypothesis 1: There will be an overall increase in healthcare providers' perceived level of knowledge and cultural competence following participation in the FVVPF training program, *Improving the Health Care Response to Domestic Violence* (Ganley, 1998).

Hypothesis 2: There will be an overall increase in healthcare providers' perceived level of confidence (self-efficacy) in implementing routine enquiry following participation in the FVVPF training program, *Improving the Health Care Response to Domestic Violence*

(Ganley, 1998). Hypothesis 3: There will be an overall positive change in health care providers' attitudes towards routine enquiry following participation in the FVVPF training program, *Improving the Health Care Response to Domestic Violence* (Ganley, 1998).

Hypothesis 4: There will be an overall positive change in health care providers' attitudes

towards victims of abuse following participation in the FVPF training program, *Improving the Health Care Response to Domestic Violence* (Ganley, 1998).

Participants' perceived changes in knowledge and cultural competence were measured using the *Training Program Evaluation*, developed by the author. Participants' perceived changes in confidence (self-efficacy) and attitudes were measured using the *Instructional Measurement Subscales: A) Confidence in Implementing Routine Enquiry; B) Attitudes Toward Routine Enquiry; and C) Attitudes Toward Victims of Abuse* (Bacchus, et al., 2007). Additionally, the Plunkett Demographic Questionnaire was used to explore possible relationships among socio-demographic characteristics and participants' perceived knowledge, cultural competence, confidence (self-efficacy), and attitudes.

Three assumptions were made regarding health care providers (HCP's) participation in the feasibility study.

Assumption 1: HCP's must receive initial and/or annual training on IPV.

Assumption 2: HCP's are interested in training on IPV; and see themselves as having a collaborative role with clients in prevention of and/or emancipation from IPV.

Assumption 3: HCP's will want to participate as subjects in the feasibility study.

Chapter Two

Review of Literature

Intimate partner violence (IPV) is a world-wide problem, costing billions of dollars, and destroying families. This researcher was interested in studying the efficacy of a standard training curriculum on health care providers' perceived knowledge, cultural competence, confidence (self-efficacy), and attitudes as first responders to victims of IPV among women of childbearing age. In order to realize directives in reducing the impact of IPV on our society, it is essential to build a foundational knowledge of past work in family violence research. Therefore, review of the literature was presented in the following sections: 1) Origins of Family Violence Research; 2) Dynamics of Victimization, Perpetration, Prevention and Intervention of IPV; 3) Incidence and Prevalence of IPV Among Women of Childbearing Age; 4) Universal Screening/Assessment for IPV; 5) IPV Curriculum for Medical and Nursing Students; 6) Training Healthcare Providers To Screen/Assess For IPV; and 7) Theoretical Underpinning for the Feasibility Study. Note that sections one and three were further subdivided. Section 1 had four subheadings: Legal protection and programs to prevent child abuse; Victims' rights movements; Legal protection and programs to prevent IPV; and Co-occurrence of child abuse and IPV. Section 3 had two subheadings: IPV and adolescent pregnancy; and, IPV and military culture.

Origins of Family Violence Research

Research related to family violence has been an item on research agendas for over six decades. Individual communities officially began taking responsibility for the welfare of children when President Franklin D. Roosevelt signed the New Deal and Social

Security Act in 1935, Title V Grants to States for Maternal and Child Welfare (www.ssa.gov/history/35actinx.html). In 1938, President Roosevelt established the March of Dimes with the initial purpose of saving American children from the cruel fate of polio.

In 1941, the bombing of Pearl Harbor marked the beginning of the World War II era when fathers were no longer exempt from military service. Military families who suffered the strain of war separation and reunion were among the first subjects of the stress and coping research in the disciplines of sociology and psychology (Hill, 1949, 1958). Hill identified eight generic features of families under stress that researchers continue to study today.

1. Crisis-proneness, the tendency to define troubles as crises, is distributed disproportionately among families of low income adequacy.
2. The course of adjustment is a roller-coaster pattern of disorganization-recovery-readjustment (modal pattern for separation but not reunion).
3. Family reactions to crisis divide between short-time immediate reactions and secondary long-time adjustments.
4. Demoralization following a crisis usually stems from incipient demoralization before the crisis.
5. The length of time a family continues to be disorganized as a result of crisis is inversely related to its adequacy of organization.
6. Unadaptable and unintegrated families are most likely of all to be unpredictable deviants in adjusting to crisis.
7. Foreknowledge and preparation for a critical event mitigates the hardships and improves the chances for recovery.
8. The effects of crisis on families may be punitive or strengthening depending on the margin of health, wealth, and adequacy possessed by the family (Hill, 1958, pp. 139-150).

Research on child abuse and maltreatment began in the 1960's-1970's. Initially, the effects of nurturance versus psychological and/or physical neglect on parent-infant attachment relationships were studied (Ainsworth, Blehar, Waters, and Wall, 1978; & Bowlby, 1969). Bowlby (1969, 1973, 1980) and Ainsworth, Blehar, Waters, and Wall

(1978), identified that infants have an intense and protective need for nurturant physical contact with parents during periods of alarm or fear. In the absence of such contact, whereby the infant's needs are unmet and/ or the infant is separated from the parent, phases of protest, despair, and detachment were consistently observed (Bowlby, 1969). Bowlby and Ainsworth determined that attachment is essential to promoting healthy human emotional growth and that anger follows when attachment needs are unmet (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1969; Dutton, 1995).

The results of Ainsworth and Bowlby's research on the development of attachment behavior lends support to Bandura's research on aggression, concluding that abusiveness is a learned behavior. Bandura proposed that, for behavior to be learned, it must serve some valued function and be either rewarded or not punished. Therefore the enactment of a learned behavior such as IPV depends upon three conditions: 1) favorable inducement; 2) functional value; and, 3) reward for or lack of accountability for actions (Bandura, 1979; Maysless, 1991; McClellan & Killeen, 2000). Bandura also suggested three primary sources of observational learning regarding violence including: 1) family of origin; 2) immediate subculture or microsystem (i.e. military culture) in which the family of origin resides; and 3) violence portrayed by television media (Bandura, 1979). Each of these sources of learning shares four common mechanisms: 1) explicit demonstration of an aggressive style of conflict resolution, 2) a decrease in the normal restraints over aggressive behavior, 3) desensitization and habituation to violence, and 4) a shaping of expectations (Dutton, 1995).

Legal protection and programs to prevent child abuse. Legal protection for children started in 1972, when Title IX of the Educational Amendments Act made public

school discrimination against pregnant/parenting adolescents illegal. In 1974, the Child Abuse Prevention and Treatment Act (CAPTA) was signed by President Nixon, which has since undergone many revisions. As a result of CAPTA, the National Center on Child Abuse and Neglect (NCCAN) was established, providing financial support to develop a program of prevention, identification and treatment of child abuse and neglect. In 1988, the act was amended, creating the National Clearinghouse for information on Child Abuse and Neglect with provision for the National Child Abuse and Neglect Data System that annually analyzes data voluntarily submitted by all fifty states (USDHHS, 2004). The act was revised in June 2003 to standardize definitions, in conjunction with the first World Health Report on Family Violence Prevention (Krug, 2002). Standardization of definitions was key to comparing and synthesizing data across studies, to expedite change in screening and intervention for IPV among families.

In an effort to prevent child abuse and neglect in the early 1970's, researcher, David Olds and his colleagues conceptualized and began testing the Nurse-Family Partnership (NFP) Model, also known as the Nurse Home-Visitor Program, (Olds, Henderson, Chamberlin & Tatelbaum, 1986; Olds, Henderson, Tatelbaum & Chamberlin, 1986; Olds, Henderson, Tatelbaum & Chamberlin, 1988; Olds, Henderson, Kitzman, 1994). The NFP now spans over three decades of operation and is supported by studies of long-term outcomes (Kitzman, et al., 1997; Kitzman, et al., 2000; Olds, et al., 1997; Olds, et al., 1998). Initial randomized control trials were conducted among diverse populations and targeted first-time, low-income mothers (risk factors for IPV). The NFP program maintains a client-centered approach today, using solution-focused techniques, and strict adherence to visit-by-visit guidelines. However enrollment of mothers in the

program remains voluntary. The NFP has three overarching goals: 1) to improve pregnancy outcomes; 2) to promote child health and development; and, 3) to impact economic self-sufficiency via parental life course development (NFP, 2009). NFP interventions to achieve these goals are centered around five broad domains of family functioning: 1) personal physical and mental health; 2) home and neighborhood environmental health; 3) family and friend support systems; 4) parental roles; and, 5) major life events (i.e. pregnancy planning, education, employment) (NFP, 2009).

Outcomes for the NFP Model are consistently documented in the literature including:

1. Improved prenatal health and birth outcomes with fewer pre-term and low birth weight infants;
2. Improved parenting and home environment with a decrease in childhood injuries;
3. Fewer repeat unintended pregnancies, and increased intervals between births;
4. Increased maternal employment;
5. Improved school readiness for children with reduced incidence of conduct disorders, involvement in criminal activity and delinquency;
6. Savings of \$4 to \$5+ for every dollar invested in NFP, due to reduced welfare system, judicial system, and health care costs. (Karloly, L. A. et al., 2005; NFP, 2009; Olds, et al., 1998; Olds, et al., 2002, Old, et al., 2004; SAMHSA, 2009).

In a fifteen year follow-up of the first randomized control trial there were multiple long-term program effects. Benefits to mothers included 61% fewer arrests, 72% fewer convictions, and 98% fewer days in jail. Benefits to the children at age 15 included 48% reduction in child abuse and neglect, 59% reduction in arrests, and 90% reduction in adjudications for incorrigible behavior (Olds, et al., 1998; Olds, et al., 2002; and Olds, et al., 2004).

In 2000, the NFP expanded its efforts to replicate the model across the United States, becoming part of the National Center for Children, Families and Communities

(NCCFC). In 2007, the Denver-based NFP program embarked on a 50 million dollar expansion plan aimed at employing 6,000 nurse home-visitors serving an estimated 100,000 families in the United States by the year 2017 (RWJF, 2009). As of January 2009, the NFP serves over 16,000 families in 355 counties across 28 states in the United States (NFP, 2009). In 1977, Oklahoma was the first of four states (Colorado, Louisiana, Oklahoma, and Pennsylvania) to implement the NFP Model statewide via the Children First Program, serving all 77 counties, averaging 700 visits per month for Tulsa County (Sullivan, 2008), and 3000 visits per month statewide (Adams, 2009). The Oklahoma Children First Program has been nationally recognized for maintaining fidelity to the NFP (OSDH, 2008).

The mission of the Children First Program is to empower “families to care for themselves and their babies by providing information and education, assessing health, safety and development and providing linkages to community resources, thereby promoting the well-being of families through public health nurse home-visitation, ultimately benefitting multiple generations” (OSDH, 2008). The Children First Program targets first-time mothers of low socio-economic status (Carabin, et al., 2005; Sharps, et al., 2008). Overall, families who participate in NFP home visitation programs during pregnancy and infancy have experienced significantly fewer episodes of mothers maltreating their children (Olds, et al., 1998; Olds, et al., 2002; Olds, et al., 2004). However, it has been noted the effectiveness of the NFP model may be decreased in homes where IPV is also present (Eckenrode, et al., 2000). Furthermore, the “effectiveness of nurse home visitors in screening and addressing IPV has not been demonstrated” (Sharps, et al., 2008). A lack of specific curricula designed for the home-

visitor to provide direct intervention has been cited as the reason that effectiveness of the NFP model may be decreased in homes where IPV is also present (Eckenrode, et al., 2000; Sharps, et al., 2008). Consequently, a training program for nurse home-visitors to screen and intervene in IPV could improve the outcomes for families with a history of IPV.

Victims' rights movements. Parallel to the research on child abuse and neglect, rape victimization and spouse abuse was studied. As crime began to steadily rise in the United States in the early 1960's, the victims' rights movement began. The victims' rights' movement evolved in four stages:

(Stage one, 1972-1976) response to crime;
(Stage two, 1977-1981) polarization and unstable funding;
(Stage three, 1982-1986) public awareness; and
(Stage four: 1987-present) legislation and professionalism. (Young, 1986; NVC, 1994).

Stage one, the response to crime, began when the first victim assistance programs were established by volunteers: aid for victims of crime (St. Louis, Missouri); bay area women against rape (San Francisco, California); and, the first rape crisis center (Washington, DC). In 1974, the first battered women's shelter was established in Denver, Colorado and the first law enforcement-based victim/witness programs were established by the Law Enforcement Assistance Administration (LEAA) in Fort Lauderdale, Florida and Indianapolis, Indiana. The term "rape trauma syndrome" (RTS) was coined in 1974 (Burgess & Holmstrom, 1974) facilitating improved services for victims in the criminal justice and mental health systems. The public was becoming aware that rape trauma was often perpetrated by intimate partners and was not just a matter of stranger violence (Burgess & Holmstrom, 1974).

Stage two, polarization and unstable funding included establishment of the National Coalition Against Sexual Assault (NCASA); the National Coalition Against Domestic Violence (NCADV); and Parents of Murdered Children (POMC). The founding of Mothers Against Drunk Driving (MADD) followed in 1980, and the Victims Assistance Legal Organization (VALOR) in 1981. A landmark study for prevalence of IPV was conducted in 1975, reporting that 1.8 million women per year were being abused and when divorced or separated women were included the number increased to 3 to 4 million women per year (Straus, Gelles, & Steinmetz, 1980). Prior to this time, IPV was considered strictly a private matter of the home, hence the use of “domestic” violence. The majority of health care providers at this time were hesitant to screen/assess and/or report any findings of IPV relative to fear, indifference, resistance and apathy (Straus, Gelles, & Steinmetz, 1980). In 1977, Oregon was the first state to pass mandatory arrest laws in domestic violence cases. In 1978, Minnesota passed legislation making it possible to arrest perpetrators of IPV without a warrant or previously existing protective order. In 1981, President Reagan proclaimed the first national “Crime Victims Week” to increase public awareness of victims’ issues.

Stage three, public awareness included President Reagan’s appointment of a Task Force on Victims of Crime that resulted in Congress passing the Federal Victim and Witness Protection Act (1982). This act provided for witness protection, restitution and fair treatment for federal victims and witnesses of violent crimes and led to changes at the state level regarding the Victims’ Bills of Rights and Victims of Crime Act (VOCA) in 1984. In 1985, the United States Surgeon General declared intimate partner violence a public health dilemma (Draucker, 2002). The criminal justice and mental health systems

became aware of “second victimization” due to a lack of, or inappropriate response, at the institutional level. The diagnosis of post-traumatic stress disorder (PTSD) was officially recognized by mental health professionals with the publication of the DSM III-R in 1987. From the 1980’s to the present, research on both the negative and positive effects of family stress and adaptation has continued to be a focus across disciplines (McCubbin & Patterson, 1983a, 1983b; USDHHS, 1990; Patterson, 2002; Walsh, 2002, 2003).

Stage four, legislation and professionalism (1987-Present) focused on victim service funding, victims’ rights, legal concerns, and professionalism (Young, 1986; NVC, 1994). The 1990’s marked the beginning of a decade with a new focus, first on intervention; and second, on prevention research for both victims and perpetrators. In 1992 the Joint Commission on Accreditation of Health Care Organizations (JCAHO, 1995) first mandated that hospitals develop policies and procedures, for early identification and referral for victims of abuse (JCAHO, 1995). In order to better understand the dynamics of family violence, the United States government launched a study to explore characteristics of strong and healthy families. Results of the study identified the following characteristics of strong and healthy families, including: communication, encouragement of individuals, expressing appreciation, commitment to family, religious/spiritual orientation, social connectedness, ability to adapt, clear roles, and time together (USDHHS, 1990).

Legal protection and programs to prevent IPV. In 1994, the Violent Crime Control and Law Enforcement, Violence Against Women Act (VAWA) was instituted. This act was the first to create penalties for gender-associated violence (USDOJ, 2009).

The Violence Against Women Act stated that civil protection orders issued by one state should be enforced by any and all other states (USDOJ, 2009). The act was reauthorized in 2000 and again in 2005 with additions and revisions regarding stalking, sexual and dating violence, help for children exposed to violence, training for healthcare providers, coaching the next generation of men to promote nonviolent relationships, expansion of crisis services for IPV victims, improved legal services, and provision of emergency support services (i.e. transitional housing). Unfortunately, due to national government budget constraints in the United States, congress has yet to fund all of these new programs (USDOJ, 2009).

Enactment of VAWA also encouraged new grant programs to address IPV in all states via the creation of the Family Violence Prevention Fund (FVPPF) (USDOJ, 2009). The FVPPF operates the National Health Resource Center on Domestic Violence, funded by the United States Department of Health and Human Services. The FVPPF first supported development and publication of *Improving the Health Care System's Response to Domestic Violence: A Resource Manual for Health Care Providers* in collaboration with the Pennsylvania Coalition Against Domestic Violence (Warshaw & Ganley, 1998). This second edition was renamed, *Improving the Health Care Response to Domestic Violence: A Resource Manual for Health Care Providers* (Warshaw & Ganley, 1997). One year later a companion modular training program was published, *Improving the Health Care Response to Domestic Violence: A Trainer's Manual for Health Care Providers* (Ganley, 1998). In collaboration with an expert advisory committee, the FVPPF also published *Preventing Domestic Violence: Clinical Guidelines on Routine Screening* (FVPPF, 1999). The document endorsed the need for national screening guidelines for

IPV, offering initial recommendations on whom to screen, how often and in what settings (FVPPF, 1999). Building on the 1999 publication, the Family Violence Prevention Fund later released the first edition of the *National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization* (FVPPF, 2002) and a second edition in 2004 (FVPPF, 2004). The 2004 publication was expanded to include guidelines regarding more specific assessment and response issues once a victim of IPV has been identified, “including providing appropriate health and safety assessment, intervention, documentation and referral” (FVPPF, 2004, p. 1). Only one study was found that tested the 1999 FVPPF publication, *Preventing Domestic Violence: Clinical Guidelines on Routine Screening* (Campbell, et al., 2001). However the effectiveness of the standard training program, *Improving the Health Care Response to Domestic Violence: A Trainer’s Manual for Health Care Providers* (Ganley, 1998) in promoting implementation of the *National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization* (FVPPF, 2004) has not been tested.

Today IPV is considered a crime in every state and perpetrators may also be prosecuted according to federal laws. For example, Senate Bill 1020 became effective July 1, 2009, and makes any person who commits intimate partner violence, and who has a history of physical abuse, guilty of a felony. This bill defined a history or pattern of abuse as three or more separate incidents on separate days within a six-month period (USDOJ, 2009). Civil and criminal laws have also been enacted to promote victim safety and to hold perpetrators accountable. Additionally, many states have instituted “dominate aggressor” laws to protect victims, who fight back in self-defense, from being arrested as perpetrators (Salber & Taliaferro, 2006, p. 23). Health care providers must

also be aware of individual state reporting laws regarding IPV (USDHHS, 2004).

Despite such progress in the health and legal arenas,

“In many communities, victims of domestic violence seek help in a fragmented, disjointed system of separate agencies offering related but uncoordinated services...In the end, victims get frustrated, exacerbating the trauma, and may never actually receive the critical services they need” (Salber & Taliaferro, 2006, p. 107).

In October, 2003, President George Bush responded to the problem of fragmented services for victims of IPV, signing the President’s Family Justice Center Initiative. The initiative provided more than twenty million dollars to fifteen U. S. communities for planning, development, and establishment of comprehensive domestic violence victim services and support centers (“one stop shop”, Family Justice Center, or Family Safety Center). The initiative is administered by the United States Department of Justice, Office on Violence Against Women and the month of October was proclaimed National IPV Awareness Month (Salber & Taliaferro, 2006; USDOJ, 2007).

Co-occurrence of child abuse and IPV. Researchers, Appel and Holden (1998) expanded the focus on family violence by drawing attention to five models for co-occurrence of physical partner aggression and child abuse: single perpetrator (Bowker, Arvitell, & McFerron, 1988; Hilton, 1992; McCloskey, 1997; Suh & Abel, 1990), sequential perpetrator (Kruttschnitt & Dornfield, 1992), dual perpetrator (Jouriles & Lecompte, 1991; Walker, 1984), marital violence (Moore & Pepler, 1998; Simons, Wu, Johnson, & Conger, 1995), and family dysfunction (Gelles & Straus, 1988, Jouriles & Norwood, 1995; O’Keefe, 1994). Additional research suggests there is a sixth model where IPV takes place in the presence of children in the home who also become victimized as visual and/or auditory witnesses of the IPV (Margolin, 2005; Margolin &

Gordis, 2003; Ross, 1996; Straus, Gelles, & Steinmetz, 1980). All of these models suggest strong evidence of a link between IPV and child abuse. Margolin (2005) supported Straus, Gelles, and Steinmetz (1980) findings more than two decades earlier that a “double-whammy” effect occurs when children are victims of physical abuse by their parents and again when they witness (visual and/or auditory) IPV between their parents. It has been reported that children who suffer this “double-whammy” effect are five to nine times more likely to become violent themselves when compared with people who experienced neither type of violence (Straus, Gelles, & Steinmetz, 1980). Health care providers recognize the detrimental effects of IPV on childbearing women (Vargo & Trotter, 2002) and other children in the home who witness the violence (Margolin, 2005; Margolin & Gordis, 2003; Ross, 1996; Straus, Gelles, & Steinmetz, 1980) as a worldwide public health dilemma (Krug, et al., 2002). Approximately one half of all women who are victims of IPV are living with children under the age of 12 (NCIPC, 2006). Sixty-two percent of children living in a home with IPV are also abused (NCIPC, 2006). Male children who witness IPV against their mothers are ten times more likely to become perpetrators in adulthood (NCIPC, 2006). Sixty-three percent of males, age 11-20, arrested for murder were arrested for murdering the man assaulting their mother (NCIPC, 2006).

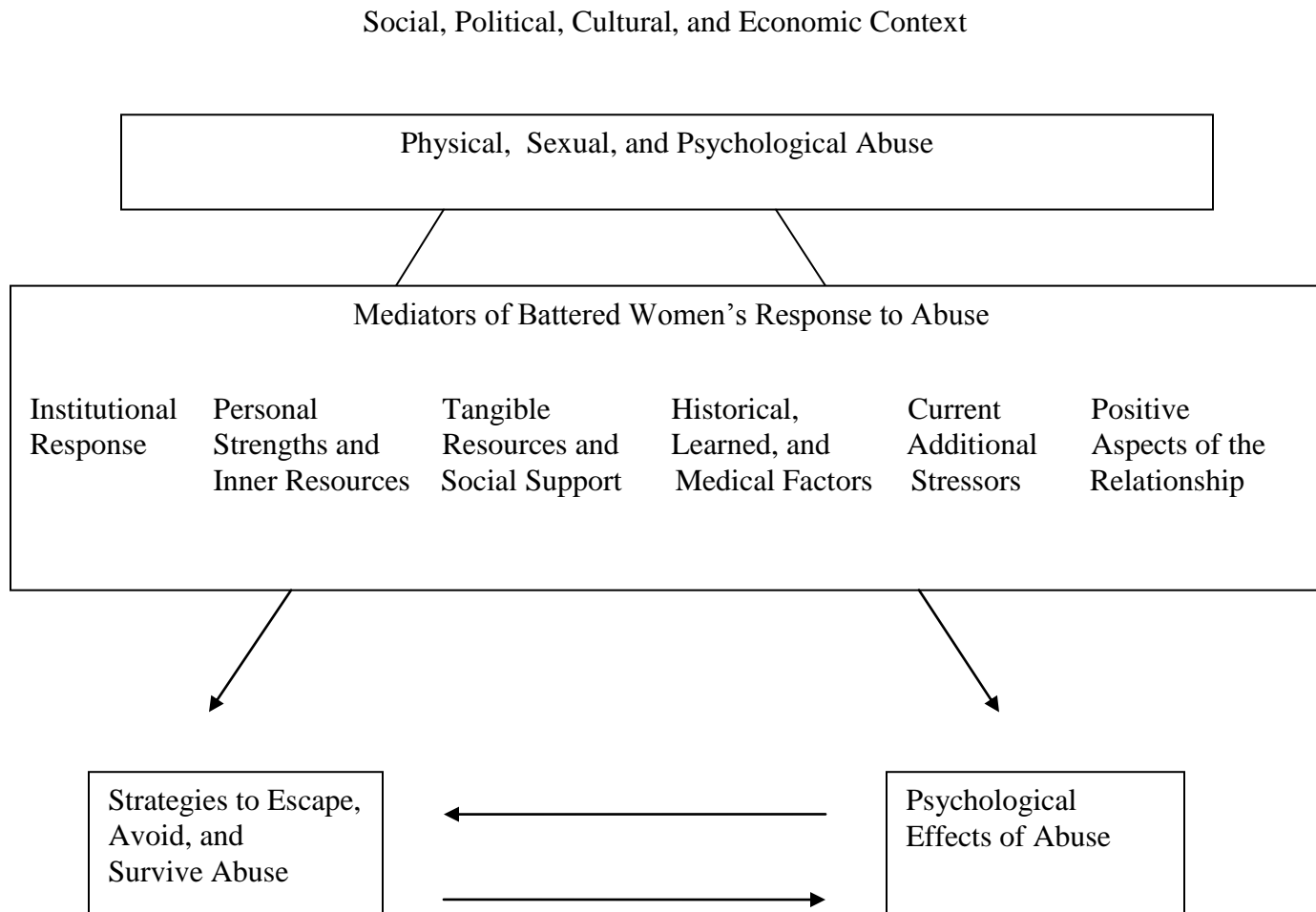
Dynamics of Victimization, Perpetration, Prevention and Intervention of IPV

Dutton's research created a model to explain the dynamics of victimization and the role of empowerment to overcome victimization (Figure 2.1). According to Dutton, the goals for effective intervention for victims of IPV can be divided into three components: 1) developing a safety plan, 2) "empowering the woman to regain her own control and power"; and 3) promoting healing from the effects of the abuse (Dutton, 1992, p. xii). Dutton's model proposed that researchers study "battered" women's responses within a social, political, and economic context (Dutton, 1992, p. 5). The model defines the construct of battering as "physical, sexual, and psychological abuse", henceforth referred to by the more current term, intimate partner violence (IPV). Women's responses to abuse are categorized as: 1) strategies to escape, avoid, and survive abuse; and 2) psychological effects of abuse (Figure 2.1). Dutton's model proposed there are six categories of mediating factors that may account for the variation in women's response to intimate partner violence: 1) institutional response; 2) personal strengths and inner resources; 3) tangible resources and social support; 4) historical, learned, and medical factors; 5) current additional stressors; and 6) positive aspects of the relationship (Dutton, 1992, pp. 5, 76-85; Dutton, 2008).

This model affirms the mandates for training of healthcare providers as first responders to IPV, set forth by JCAHO (1995, 2004) and the IOM (Cohn, Salmon, & Stobo, 2002). Family violence researchers must study the effectiveness of educational interventions targeting an improved response at the institutional level ultimately empowering potential and/or actual victims of IPV. Dutton's model implies that a positive institutional response to victims of IPV encompasses effective screening and

assessment for “personal strengths and inner resources; tangible resources and social support; historical, learned, and medical factors; current additional stressors; and, positive aspects of the relationship” (Dutton, 1992, p. 5). Effective screening and assessment empowers the woman in her ability to develop and implement strategies to escape, avoid and survive abuse and reduce psychological effects of abuse. However, barriers and facilitators to effective training related to assessment and screening for IPV may include the healthcare provider’s prior professional and/or personal knowledge and experience of IPV (Dutton, 1992).

Figure 2.1 Model of battered women's response to abuse (Dutton, 1992, p. 5). Reprinted with author's permission.



Tolan and Guerra (1994) noted a fundamental distinction between traditional public health definitions for levels of prevention and family violence researchers' types of interventions. The relationship between the two sets the stage for interdisciplinary partnerships and collaborative action (Table 2.1) (Tolan & Guerra, 1994, pp. 251-273). The IOM uses the same nomenclature to classify intervention research: universal, selected, or indicated.

Table 2.1 Levels of Prevention and Types of Intervention

Levels Of Prevention (public health model)	Types Of Intervention (family violence research)
Primary Prevention: Prevent violence before it occurs.	Universal Interventions: Aimed at groups or general population without regard to individual risk (i.e. school curricula, media campaigns, all childbearing families).
Secondary Prevention: Immediate response to violence (i.e. pre-hospital care, emergency services or treatment for sexually transmitted infections).	Selected Interventions: Aimed at high risk groups (i.e. low income, single parents).
Tertiary Prevention: Long term care (i.e. rehabilitation and reintegration, attempts to lessen trauma or reduce the long term disability associated with violence).	Indicated Interventions: Treatment for identified victims and perpetrators.

Payne's work in the education discipline, related to the way families overcome socio-economic disparities, has also been fundamental in assisting researchers to understand the potential role of poverty in perpetuating family violence (Payne, 1998). Payne identified eight resources as "bridges out of poverty": financial, emotional, mental,

spiritual, physical, support systems, relationships/role models, and knowledge of hidden rules (Payne, 1998). Researchers in the discipline of psychology began exploring the combination of family stress theory with family resilience theory (Patterson, 2002; Walsh, 2002, 2003), and identified two hallmarks of family resilience: “initiative” and “persistence” (Walsh, 2002, 2003).

With the onset of the millennium, the United States Center for Disease Control and the World Health Organization began a new focus on prevention in the campaign to stop family violence. In 2002, the World Health Organization released the first *World Report on Violence and Health* (Dahlberg, L. L. & Krug, E. G., 2002). The report contains standardized definitions for three overarching categories of violence: 1) self-directed violence (suicidal behavior; self-mutilation; and substance abuse); 2) interpersonal violence (family and intimate partner violence; and community violence); and, 3) collective violence (social; political; and economical). Global agreement on these definitions was a crucial step in the WHO’s proposal for a comprehensive public health approach to stop IPV, using a four-level ecological model (Figure 2.2). The model was adopted by the United States, Center for Disease Control and Prevention, in nationwide initiatives to promote primary prevention of IPV in the community.

Figure 2.2 Four-Level Ecological Model (Dahlberg and Krug, 2002)



The ecological model not only addressed individual risk factors for IPV but also the norms, beliefs, social and economic systems creating the environment in which IPV may be perpetrated and experienced. At the *individual level*, biological and personal history factors such as age, education, income, substance use or prior history of abuse are identified (Dahlberg & Krug, 2002). At the *relationship level*, influence on behavior of the individual's closest social circle, including their partners, family members and peers is examined (Dahlberg & Krug, 2002). The third *level of community* explores the location in which social relationships occur, including schools, workplaces, kinship networks and residential neighborhoods, and seeks to identify specific characteristics related to victims and perpetrators. Legal concerns and fears regarding citizenship status, substance abuse, legal/medical system exposure, and same sex relationships may contribute to isolation, marginalization, exclusion and discrimination (Anderson, et al., 2008; Dahlberg & Krug, 2002), all seen at the community level. At the final *level of society*, factors that may contribute to the environment, encouraging or inhibiting violence are found. Such factors may include social and cultural norms; and health,

economic, educational or social policies responsible for maintaining economic and social disparities (Dahlberg & Krug, 2002). Also “included are factors creating a climate in which violence is seen as acceptable or inevitable, those that reduce inhibitions against violence, and those that create and sustain gaps between different segments of society or tensions between different groups” (Anderson, et al., 2008, p. 42).

In 2004, the World Health Organization published a companion document to the original *World Report on Violence and Health* (Dahlberg, L. L. & Krug, E. G., 2002), *Preventing Violence: A Guide to Implementing the Recommendations of the World Report on Violence and Health*. The companion document presented strategies for a collaborative national-level approach across multiple disciplines, using the four-level ecological model (WHO, 2004). At this point researchers had documented progress toward understanding the dynamics of victimization and had developed a blue print for multi-level global interventions. However, relatively little was known about the perpetrators of IPV.

Consequently, the Domestic Violence Project was launched as a grass roots advocacy movement to further explore the dynamics of the cycle of abuse and the role of perpetrators of intimate partner violence. The Power And Control Wheel, created by the Domestic Violence Project, Incorporated, in Duluth, Minnesota, is now a classic model depicting the cycle of abuse (Figure 2.3). This model was developed with input from survivors of IPV attending women’s educational groups presented by advocates for IPV victims. Each spoke in the wheel represents one of eight major tactics perpetrators use to exert power and control of their victims (Property Destruction, Psychological and Emotional Abuse, Isolation: Restricting Freedom, Physical Abuse, Using the Children,

Sexual Abuse, Economic Abuse, and Threats and Intimidation). The outer rim of the wheel represents the cyclic nature of physical and sexual abuse perpetuating IPV.

Researchers, Jackson and Garvin (2003), subsequently developed the Coordinated Community Action Model (Figure 2.4), in their work at the Domestic Violence Institute of Michigan, based on the Power and Control Wheel from Duluth, Minnesota. This model suggests a condensed plan for community-based advocacy programs to support victims of IPV and their children while also holding the perpetrator accountable for their actions. Each spoke of the wheel represents one of eight domains of victim advocacy that an individual or group may select to take specific action (Health Care Systems, Justice System, Education System, Clergy, Media, Employers, Government, and Social Service Providers).

Figure 2.3 Power and Control Wheel

(Domestic Abuse Intervention Project, Duluth, MN)

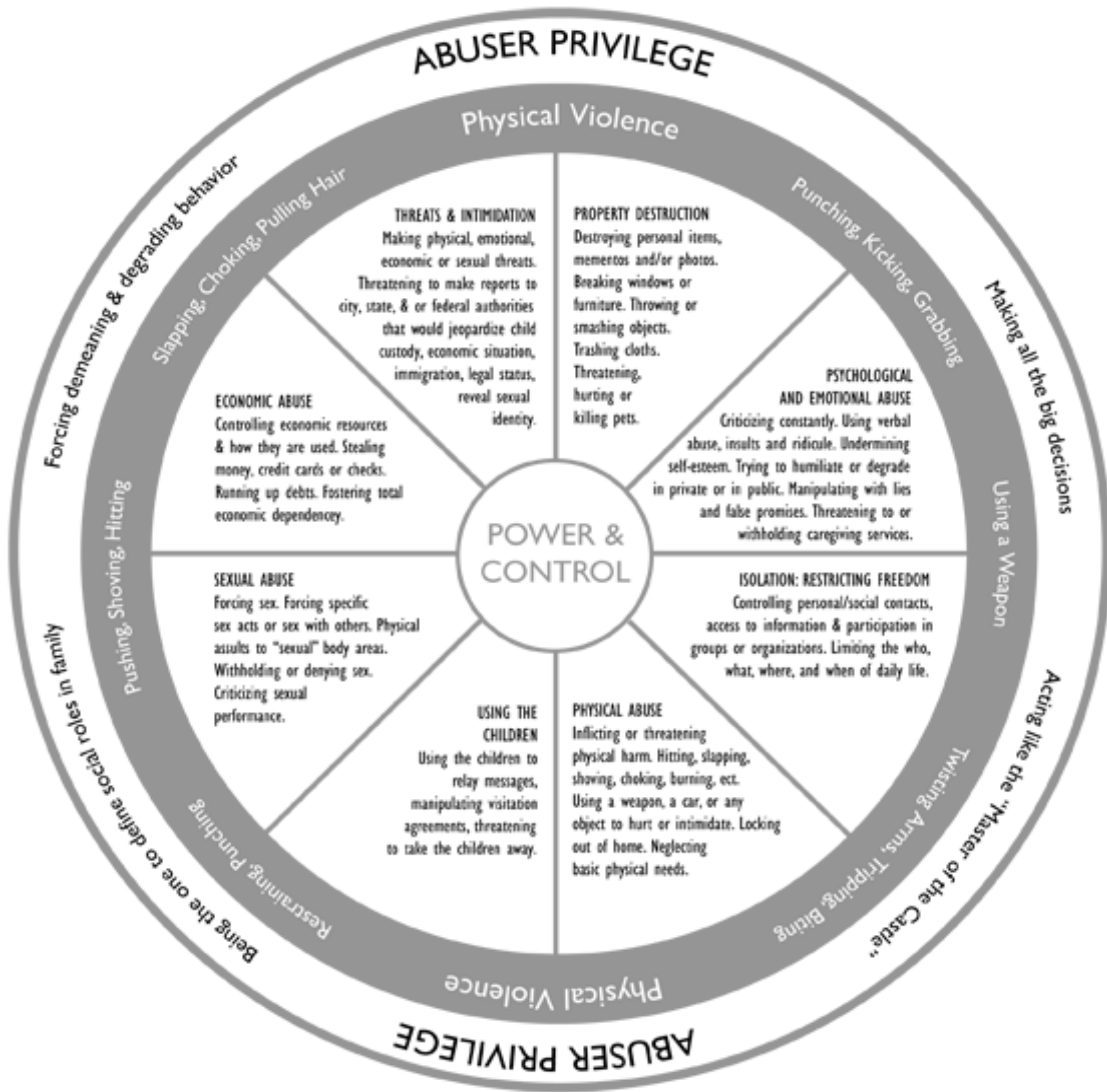
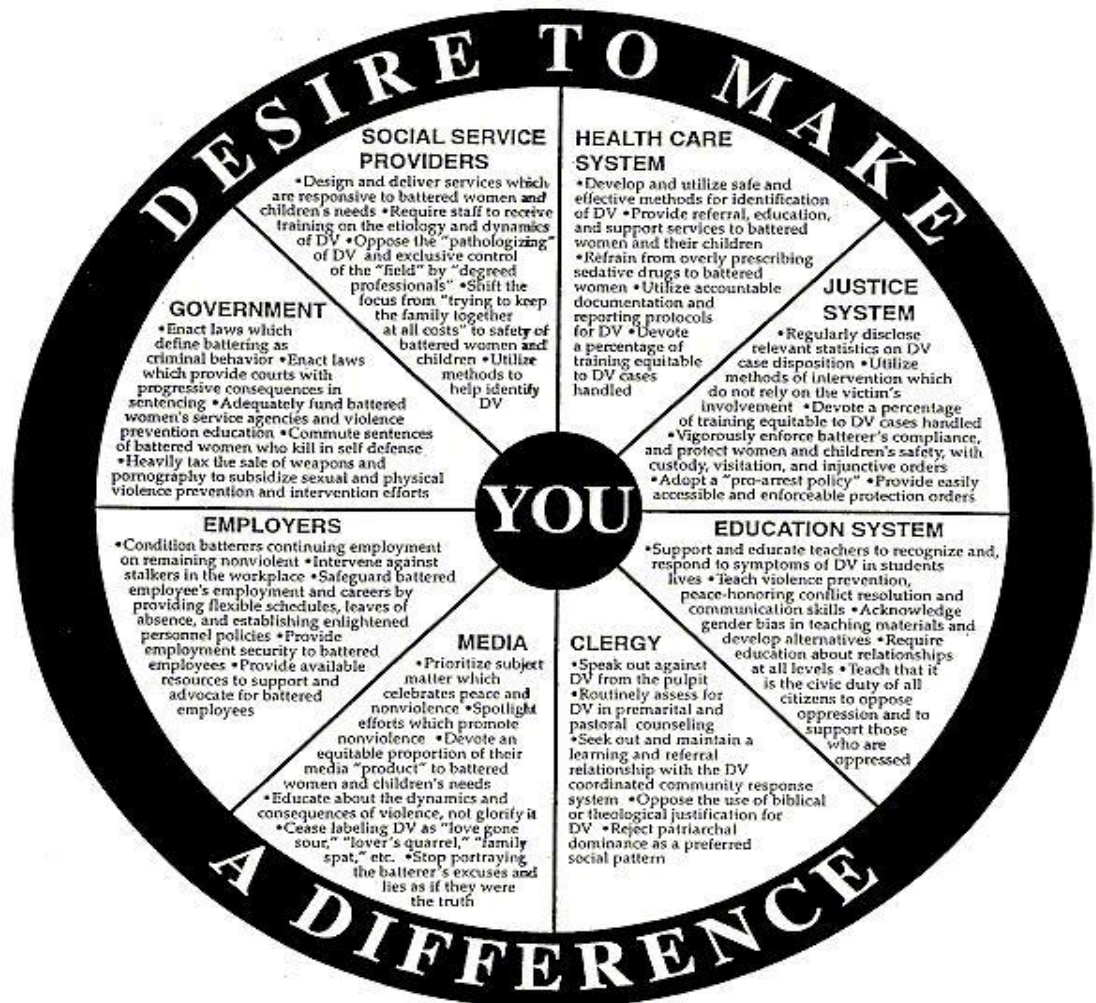


Figure 2.4 Coordinated Community Action Model (Jackson & Garvin, 2003)



Incidence and Prevalence of IPV Among Women of Childbearing Age

Currently, there is no national surveillance system to track IPV in the United States. Therefore, statistics on IPV are based on the original National Family Violence Surveys collected in 1975 and 1985; population based surveys (Strauss, Gelles, & Steinmetz, 1980; Tjaden & Thoennes, 1998); and the National Violence Against Women survey (collected November 1995 - May 1996). Multiple studies have shown that pregnancy represents the most critically vulnerable time for triggering an initial episode

and/ or exacerbating the severity and frequency of existing intimate partner violence (Campbell, 1998; Campbell, Moracco & Saltzman, 2000). Estimates of the prevalence of intimate partner violence during pregnancy range from 3.9 percent to 8.3 percent (Gazmararian, et al., 1996). The highest incidence of non-fatal IPV occurs among women 16-24 years old (BJS, 2001) while the highest incidence of fatal IPV occurs among women 35-49 years old (BJS, 2001). Preliminary studies of IPV among military versus civilian families, suggest the incidence of IPV may be as much as five times higher among military spouses (Brannen, et al., 1999; Mercier & Mercier, 2000; Ortiz & Ford, 2005). Ninety-five percent of all reported perpetrators of IPV are male while 80-85 percent of all reported victims of IPV are female (CDC, 2003). The majority of male perpetrators become violent toward intimate partners in an attempt to exert power and control over their victim. In contrast, the majority of female perpetrators engage in violence toward intimate partners as a matter of self-defense.

It is shocking to note that the leading cause of death among otherwise healthy women of reproductive age in the United States is homicide by an intimate partner (Olausson, Haglund, Weitoft, & Cnattingius, 2004; Sharps, et al., 2001). Homicide of a woman that is committed by a man is more specifically known as femicide, a term that was first introduced to the public in 1976 (Russell & Van de Ven, 1976). The definition of femicide has since been further refined by family violence researchers as it describes violence against women that results in death (Campbell, 1981; Campbell & Runyan, 1998; Radford & Russell, 1992). In the 1990's, several federal and state laws were developed to prevent abusers from obtaining firearms (Violence Policy Center, 2008). It is also of interest to note that The Unborn Victims of Violence Act, more commonly

known as Laci and Conner's Law, was implemented in 2004, making it possible to prosecute the perpetrator for double homicide instead of one case of femicide. According to a recent analysis of national 2006 homicide data, there was an average of 1.29 per 100,000 women resulting in 1,836 females murdered by males in single victim/single offender incidents (Violence Policy Center, 2008). The ten states with the highest rates of femicide per 100,000 women during 2006 include in rank order: Nevada (3.27/100,000 or 40 deaths), South Carolina (2.84/100,000 or 63 deaths), Alabama (2.20/100,000 or 52 deaths), Oklahoma (2.10/100,000 or 38 deaths), Louisiana (1.97/100,000 or 43 deaths), Vermont (1.90/100,000 or 6 deaths), Texas (1.82/100,000 or 214 deaths), Arkansas (1.74/100,000 or 25 deaths), Arizona (1.72/100,000 or 53 deaths), and Tennessee (1.70/100,000 or 53 deaths), (Violence Policy Center, 2008, p. 6).

IPV and adolescent pregnancy. Research indicates that IPV against childbearing women, especially pregnant adolescents, significantly increases the risk for negative maternal-fetal outcomes (Parker, McFarlane & Soeken, 1994). The rate of adolescent pregnancy rose by 3 percent from 2005-2006, marking the first increase in 15 years (CDC, 2007). Approximately "...three in ten adolescent girls get pregnant at least once before they reach age twenty..." resulting in nearly one million pregnancies in the United States each year (National Campaign to Prevent Teen Pregnancy, 2006). It has been further estimated that 22 percent of all teen births are a result of repeat pregnancy (National Campaign to Prevent Teen Pregnancy, 2006). Two-thirds of all pregnant adolescents are victims of statutory rape by adult men, age twenty-one and older (Harner, 2003; Kandaki & Smith, 2007). The majority of adolescent pregnancies occur among girls 15-19 years old. However, the majority of cases of IPV during adolescent

pregnancy have been documented among girls 14-17 years old (McFarlane, Parker & Moran, 2007; National Campaign to Prevent Teen Pregnancy, 2006) further complicating an already difficult situation.

Dual transition from adolescence to adulthood via pregnancy and parenthood creates many demands far exceeding the resources of most adolescents. As a result, about 500,000 adolescent pregnancies in the US end in abortion or miscarriage (Wheeler & Austin, 2001). For the remaining 500,000 pregnant adolescents who opt to make parenting or adoption decisions each year, “Common medical problems among adolescent mothers include poor weight gain, pregnancy induced hypertension, anemia, sexually transmitted diseases, and cephalopelvic disproportion” (National Campaign to Prevent Teen Pregnancy, 2006) and depression. As a result, children born to adolescent mothers suffer higher rates of prematurity and low birth weight, raising the probability of infant death, blindness, deafness, chronic respiratory problems, mental retardation, mental illness, and cerebral palsy (Vargo & Trotter, 2002). All of these problems may be exacerbated by any combination of socio-demographic characteristics including adverse childhood experiences (ACEs) (Hillis, et al., 2004), criminal activity (Gessner, 2006; Hufft, 2004), poverty, young age, low education level, race (Bohn, Tebben & Campbell, 2004), and homelessness (Dong, et al., 2005; Meadows-Oliver, 2006). As previously stated, ACEs increase the risk of IPV for pregnant teens, which also contributes to substance abuse, both known factors in poor pregnancy and birth outcomes (Vargo & Trotter, 2002). According to Hillis, et al., (2004), Tan and Quinlivan (2006), and Francisco, et al., (2008) the relationship between adverse childhood experiences (ACEs) (physical, emotional, sexual, and substance abuse) and adolescent motherhood/

adolescent fatherhood is strong and increases with the number of ACEs. Furthermore, when compared to nonvictims, pregnant adolescents with a history of violence in their lives are twice as likely to exhibit serious patterns of substance abuse that may include alcohol, tobacco, or illicit drug use (Martin, Clark, Lynch, Kupper & Cilenti, 1999; and Velez, et al., 2006). Ongoing research to explore healthcare providers knowledge of the need for and intent to implement an IPV assessment protocol is essential to promoting positive outcomes not just for adolescents but for all women of childbearing age.

IPV and military culture. Many civilian and military health care providers are responsible for the care of childbearing women, who are either active duty members of the military themselves or married to spouses on active duty in the military. Therefore, it is important to address the potential influence of military culture on the presence of IPV among women of childbearing age. An early landmark study indicated that 95% of violence among military families occurs in the home and 43% of victims reported that children witnessed the abuse (Wasileski, Callahan-Chaffee, & Chaffee, 1982). Overall, it has been suggested that one-third of all military spouses experience abuse during their marriage (Brannen, et al., 1999; Heyman & Neidig, 1999). Based on the limited available IPV data that has been reported, researchers estimate the incidence of IPV may be as high as five times greater among military families compared with civilian families (Mercier & Mercier, 2000). Most recently and more specifically, the prevalence of IPV among the pregnant military population has been reported at 14.5% (Lutgendorf, et al., 2009).

Stressors unique to the military family that may increase their risk for IPV and child abuse include frequent separations, financial pressures, frequent relocations,

isolation from family/peer support groups, and single/dual parent deployments for combat, peacekeeping or humanitarian efforts. In contrast, protective factors unique to the military family include stable assistance with basic needs such as food, housing, medical care and education possibly mediating against other variables often associated with IPV, including poverty and substance abuse. Entry into the military also requires candidates to pass literacy and aptitude tests and to be in good health (Cronin, 1995; Lutgendorf, et al., 2009; Mercier & Mercier, 2000; Newby, et al., 2005; Rentz, et al., 2006).

Consequently, it remains unclear whether a military environment contributes to increased spousal violence or whether individuals prone to abusive behavior are more likely to join the military (Mercier & Mercier, 2000). The majority of research studies have examined data on family violence in military families from army and air force only (Forgey & Badger, 2006; Rentz, et al., 2006). Overall, there has been less focus on spouse abuse compared to child maltreatment among military families. Reported cases of child maltreatment in military families, in rank order of substantiated cases, include physical abuse, neglect, sexual abuse, and emotional abuse (Forgey & Badger, 2006; Rentz, et al., 2006). Reported cases of spouse abuse, in rank order of substantiated cases, include physical abuse, emotional abuse, sexual abuse and neglect (Forgey & Badger, 2006; Rentz, et al., 2006).

For more than three decades, a lack of available IPV data among the military population has been attributed to fear of career damage when the perpetrator is a military officer; fear of financial instability when the perpetrator is an enlisted soldier; fear of embarrassment; fear of increased abuse; and a general military legitimization of violence

within the army, navy, marines, and air force (Gielen, et al., 2006; Mercier & Mercier, 2000). In 1981, the military created its own Family Advocacy Program (FAP) making healthcare providers and advocacy services for victims of child maltreatment and spouse abuse available within one agency (DOD, 1981). In 2001, the department of defense task force on domestic violence (DTFDV) was initiated to address issues of IPV in the military (DTFDV, 2001). Implementation of the DTFDV recommendations includes training for all military services and specialized training for command at all levels to alleviate the negative impact of women's disclosure on their safety and careers (DTFDV, 2001, 2002, 2003).

Most recently, the military has implemented a "restricted reporting" policy regarding domestic abuse, allowing victims to access FAP services without involvement of command or legal investigation and allowing military physicians to maintain patient confidentiality while making referrals to local resources (DOD, 2006; Chapin & Mackie, 2007). Victims may still opt for "unrestricted reporting" involving the military member's command, ensuring intervention services without resorting to criminal or civil court proceedings otherwise customary in the civilian community (DOD, 2006; Chapin & Mackie, 2007). Consistent with civilian literature, the military's priority focus for IPV prevention is currently targeting younger wives, lower income families, and families with previous incidents of IPV (Newby, et al., 2005). Despite the recent DTFDV recommendations, staff barriers toward screening for IPV in the general military population as well as screening practices in military prenatal settings have been identified as similar to those found in civilian environments including a lack of effective intervention(s), education, time constraints, and privacy (Ortiz & Ford, 2005).

Universal Screening/Assessment for IPV

Multiple position statements on universal screening for intimate partner violence among all women have been published by the American Medical Association (AMA, 2002), the American College of Nurse Midwives (ACNM, 1997), the American College of Obstetricians and Gynecologists (ACOG 1999; ACOG, 2002), the American Nurses Association (ANA, 2001), the Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN, 2006; Campbell & Furniss, 2003), the American Academy of Pediatrics (1998), the Emergency Nurses Association (ENA, 2003), Healthy People 2010 (USDHHS, 2000), the International Association of Forensic Nurses (IAFN, 2008), the March of Dimes (McFarlane, Parker & Moran, 2007), the Nursing Network on Violence Against Women, International (NNVAWI, 1985), the United States Preventative Services Task Force (USPSTF, 2004), and the World Health Organization (Krug, et al., 2002).

Numerous screening methods and guidelines have been suggested for intimate partner violence (Brown, Lent, Schmidt, & Sas, 2000; Campbell, 1998; Campbell, Moracco & Saltzman, 2000; Canterino, et al., 1999; Cohn, Salmon, & Stobo, 2002; FVPPF, 2004; Kimberg, Bilbao, & Marjavi, 2005; MacMillan, et al., 2006; McCord-Duncan, et al., 2006; McFarlane, Parker & Moran, 2007; Salber & Taliaferro, 2006; USPSTF, 2004). The most current compilation of *Intimate Partner Violence And Sexual Violence Victimization Assessment Instruments For Use In Healthcare Settings* is available online (Basile, Hertz, & Back, 2007). Each of these instruments has specific instructions for implementation. However, routine screening for intimate partner violence remains a controversy given that the CDC has been unable to endorse any specific IPV guidelines or screening instrument, citing a lack of conclusive research

(USPSTF, 2004). In an effort to address this controversy, a group of family violence researchers recently conducted a systematic review of the psychometric properties for existing IPV screening tools (Rabin, Jennings, Campbell, & Fair-Merritt, 2009). Results of this review revealed the most frequently tested IPV screening tools include the Hurt, Insult, Threaten, and Scream (HITS); the Woman Abuse Screening Tool/Woman Abuse Screening Tool-Short Form (WAST/WAST-SF), the Partner Violence Screen (PVS), and the Abuse Assessment Screen (AAS). The shortest of these instruments is the PVS (three items) and the longest of these instruments is the WAST (eight items). The scoring system for the HITS is the most involved and scoring may also take longer for the WAST due to the length of this instrument, possibly making these two instruments less desirable to implement in clinical practice. Additionally it is crucial to note that not all screening methods are comprehensive for assessing all types of intimate partner violence (physical, sexual, and emotional) and/or for use during pregnancy. In this regard, Rabin and colleagues reported the WAST and the AAS offered the most comprehensive IPV definition (physical, emotional and sexual abuse) including threats and fear. However, the AAS, which has five items, was uniquely noted to be the only instrument that specifically screens for IPV during pregnancy (Curry, et al., 2006; McFarlane, et al., 1997; McFarlane, Soeken, & Wiist, 2000; McFarlane, Parker, & Moran, 2007; Rabin, et al., 2009). While not addressed by Rabin and colleagues (2009), the Danger Assessment (Campbell, 2004) is often used as a companion instrument when results of the AAS are positive to determine if the IPV victim's life is in immediate danger. Both the AAS (McFarlane & Parker, 1994a, 1994b) instrument and the Danger Assessment (DA) (Campbell, 2004) were inspired by Dutton's model of empowerment and both are readily

available in English and Spanish. Furthermore it is important to note that these instruments are currently endorsed in several continuing education modules and guidelines on care of victims of IPV for nurses and other health care professionals (AWHONN, 2002; Campbell & Furniss, 2003; Berlinger, 2004; Dienemann, et al., 2002; FVPPF, 2004; McFarlane, Parker & Moran, 2007; Schwartz, 2007). It is also of interest to note that both the IOM (Cohn, Salmon, & Stabo, 2002) and the *National Consensus Guidelines* promote use of the Abuse Assessment Screen (AAS) and the Danger Assessment (DA) instruments (FVPPF, 2004).

Rabin and colleagues (2009) found three limitations in their systematic review precluding any conclusive recommendations regarding the effectiveness of IPV screening instruments. First, psychometric testing of the four most common instruments, HITS, WAST/WAST-SF, PVS, and the AAS is limited to the results of three to six studies of each instrument in a health care setting. Second, there is no gold standard by which to make comparison measures across multiple studies, testing the sensitivity and specificity of IPV screening instruments. Third, due to the variability in comparison measures, there was a wide variation in sensitivities and specificities. Overall, initial studies to establish validity and reliability are positive, however no single IPV screening instrument was found to have well-established psychometric properties (Rabin, et al., 2009).

Given the combined overall abundance of evidence-based research regarding many of the existing instruments; the fact that major medical organizations are mandating routine screening; the prevalence of IPV; and the relatively low cost of screening, the USPSTF recognizes the potential value in routine screening/assessment for IPV among known high risk populations. Ultimately the goal of screening/assessing for IPV "...is to

identify hidden morbidity in the general population and conduct preventive education” (Ambuel, Hamberger, & Lahti, 1996).

Multiple confidential survey studies have been conducted to identify nurses’ and physicians’ attitudes and barriers toward routine screening and assessing for IPV (Elliott, Nerney, Jones, & Friedman, 2002; Ellis, 1999; Moore, Zaccaro, & Parsons, 1998; Ortiz and Ford, 2005; Parsons, Zaccaro, Wells, & Stovall, 1995; Smith, et al., 2008; Sugg, 1992; Sugg & Inul, 1999; Waalen, et al., 2000). The majority of these studies involved large sample populations randomly selected from public directories of agencies and providers in the United States, including one study that recruited subjects from two army community hospitals (Ortiz & Ford, 2005). Sample populations primarily included nurses and physicians employed in family practice, emergency care, internal medicine, obstetrics and gynecology, maternal-newborn, and public health settings. Attitudes and barriers were similar across practice sites. Overall, respondents who had received some form of IPV training within the past year were more likely to screen their patients for IPV. However, respondents in public health settings were the most likely to have received IPV training and were more likely to screen for IPV and to intervene, offering educational materials, emergency numbers for safety and counseling and to further explore for child abuse in the home. Common barriers to screening patients for IPV predominantly included lack of education, time constraints, lack of confidence, inadequate strategies to assist victims, fear of offending, powerlessness, blaming the victims, and feelings of loss of control. Less frequently reported barriers included respondents’ fear for personal safety and underestimating the prevalence of IPV in respondents’ respective areas of practice. It is noteworthy that many respondents also

reported having a history of personal or family abuse (Elliott, Nerney, Jones, & Friedman, 2002; Ellis, 1999; Moore, Zaccaro, & Parsons, 1998; Ortiz & Ford, 2005; Parsons, Zaccaro, Wells, & Stovall, 1995; Smith, et al., 2008; Sugg & Inul, 1992; Sugg, et al., 1999; Waalen, et al., 2000).

IPV Curriculum in Medical and Nursing Schools

Training in family violence has not been a consistent priority across or even within the educational curriculum preparation for health care professionals (Cohn, Salmon, & Stobo, 2002). Furthermore the challenge of developing curricular content or pedagogical strategies has been compounded by an absence of both educational research and evaluation research for existing IPV screening/assessment methods and training guidelines (Cohn, Salmon, & Stobo, 2002). “Despite national interest in IPV issues, effort in U. S. medical schools to increase IPV screening and prevention have not achieved saturation” (Frank, et al., 2006, p. 1071).

Meanwhile, researchers strongly support engaging medical students and nursing students in IPV training while they are in professional school and then continuing their training upon entering the health care arena (Short, Johnson, & Osattin, 1998; Woodtli, 2000; Woodtli & Breslin, 2002). “Curricula should be multidisciplinary and should provide information, promote clinical skills, and effectively link providers with resources” (Short, Johnson, & Osattin, 1998, p. 283). The UCLA School of Medicine has conducted a comprehensive evaluation of its IPV instruction, IPV training implementation, and learning outcomes to determine the effectiveness of their module in assisting medical students to develop skills in screening patients for IPV. Results indicated that students and faculty were satisfied with the course overall. However, three

common areas of improvement were identified: 1) students' need for more opportunity to practice skills and receive feedback during the module; 2) need for consistency across classes in what is learned; and, 3) need for better tutor preparation sessions (Short, Cotton, & Hodgson, 1997). Overall medical students reported an increase in self-efficacy related to working with IPV victims following participation in IPV curriculum (Short, Cotton, & Hodgson, 1997). More recently, Short and colleagues developed and tested a comprehensive tool for measuring physician readiness to manage intimate partner violence (PREMIS) (Short, Alpert, Harris, & Suprenant, 2006). This tool is publicly available and consists of a comprehensive 15-minute survey specifically designed to measure the effectiveness of IPV educational programs in preparing physicians to respond to victims of IPV (Short, Alpert, Harris, & Suprenant, 2006). Additionally, *The Physician's Guide to Intimate Partner Violence and Abuse* (Salber, & Taliaferro, 2006) is now available. This guide is written in narrative that primarily addresses physicians but could be adapted as a reference for all health care professionals.

IPV experts also believe that nurses play a vital role in combating violence requiring action at primary, secondary and tertiary levels of care in addition to nursing education and health policy development (Woodtli, 2001). "Essential aspects of all nursing interventions with battered women include not only attitudes of respect for the woman's personal dignity and right to make her own decisions but also recognitions of the need for a holistic approach to violence within the family unit" (Woodtli, 2001). Research on incorporating IPV education into the standard nursing curriculum has stressed the importance of first addressing students' feelings towards survivors and perpetrators of IPV in order to dispel any negative attitudes (Campbell, 1992; Woodtli,

2000, 2001; Woodtli & Breslin, 1996, 1997, 2002). Once students have had time to compare and contrast personal and professional values, roles and functions, they should be given the opportunity to practice their new knowledge base and skills regarding IPV. For example, it has been recommended that faculty intentionally engage students in advocacy projects, facilitating development of communication skills necessary to implement the concept of empowerment among actual victims of family violence (Campbell, 1992; Woodtli, 2000).

Within the discipline of nursing, several self-study continuing education modules and guidelines for teaching nurses to assess for intimate partner violence have been made available through The March Of Dimes (McFarlane, Parker, & Moran, 2007); the Association for Women's Health, Obstetric and Neonatal Nurses (AWHONN, 2002; McFarlane & Furniss, 2003) and others (Berlinger, 2004; Dienemann, et al., 2002; FVPPF, 2004; Krieger, 2008; Schwartz, 2007). However, the availability of a structured curriculum does not necessarily translate into improved practice or implementation with the targeted population (Hinderliter, et al., 2003; Schoening, et al., 2004). It is imperative that further research be conducted to evaluate the efficacy of existing training guidelines.

Training Healthcare Providers to Screen/Assess For IPV

The Joint Commission on Accreditation of Health Care Organizations (JCAHO) (1992, 1995, 2004) and the Institute of Medicine (Cohn, Salmon, & Stobo, 2002) have mandated that all health care institutions adopt screening protocols and provide education to train healthcare workers for the purpose of screening/assessing for preventing and treating intimate partner violence. The Joint Commission guidelines related to IPV training are focused more on secondary intervention (Appendix A) while the guidelines

set forth by the Institute of Medicine have a greater focus on primary intervention (Appendix B). Due to the complexity and breadth of victims, perpetrators and first responders, the IOM proposes that responding to and preventing family violence is a societal responsibility that must be shared by professionals both inside and outside the health care arena (Cohn, Salmon, & Stobo, 2002).

Around this same time period, the Agency for Healthcare Research and Quality (AHRQ) developed a consensus-driven quality assessment tool for evaluating hospital-based domestic violence programs (AHRQ, 2002; Coben, 2002). However, no universal data repository was found to substantiate providers' compliance with the recommendation for training, and if so, what specific instruments or teaching curriculum were being used. As previously stated, implementing this mandate is complicated by the fact that numerous IPV screening methods and guidelines for IPV training have been suggested.

A compilation of IPV training guidelines for health care providers was recently published by the IOM (Cohn, Salmon, & Stobo, 2002). Many of these training guidelines were developed by a specific institution/organization. Recommendations for length, content, settings and evaluation designs of these training guidelines varied widely, making it extremely difficult to make any sort of systematic evaluative comparison of their efficiency and effectiveness. To date there has been no universal means for establishing and comparing effectiveness of the training guidelines. Meanwhile, health care providers continue to under-diagnose IPV, with as few as 5 percent of these women being appropriately identified (AWHONN, 2006) and as many as 50 percent of those

who are identified, going unreported to legal authorities and appropriate referral resources (Kimberg, Bilbao & Marjavi, 2005).

The IOM conducted a meta-search of available quantitative research studies regarding training of healthcare professionals on IPV, that were either published or in press from 1983 through November 2000. Four bibliographic databases were searched including, MEDLINE, PsycInfo, ERIC, and Sociological Abstracts, using the following search terms: family violence, domestic violence, and intimate partner violence coupled with training, assessment, evaluation, detection, and identification as both subject terms and text words. Published bibliographies and reference lists of chosen articles were also reviewed for additional studies. Thirty studies were found that met the following three inclusion criteria: 1) relevant training population; 2) formal training intervention; and 3) quantitative outcome measure(s). These studies were primarily conducted among nurses, physicians, and social workers in hospital or clinic settings and reported study outcomes in three categories including 1) knowledge, attitudes, and beliefs outcomes; 2) outcomes related to clinical intervention practices; and 3) screening, identification, and detection of IPV outcomes (Cohn, Salmon, & Stobo, 2002). Twenty-one of the thirty studies reported results related to screening, identification, and detection of IPV outcomes. Sixteen of the thirty studies reported results related to knowledge, attitudes, and beliefs outcomes. Eight of the thirty studies reported results of outcomes related to clinical intervention practices. However, only four of the studies reported outcomes in all three categories (Campbell, et al., 2001; Harwell, et al., 1998; Short, Hadley, & Bates, 2002; Thompson, et al., 2000).

Adjusting for the dates (December 2000 through July 2009) this researcher attempted modeling the original search criteria used by the IOM, however no results were found in this manner. Therefore it was necessary to alter the search criteria. Four databases including CINAHL, Medline, Ovid, and PsycINFO and the search engine, Google Scholar, were searched in July 2009. Broad keywords for the search included intimate partner violence, domestic violence, training, self-efficacy, and evaluation with limits restricting the results to peer reviewed journals, English language and research or clinical trial. Reference lists of selected articles were carefully reviewed for any additional studies. Authors' names (i.e. L. Bacchus, J. Campbell, J. McFarlane, L. Short, J. Silverman, N. Sugg, & R. Thompson) with prolific publications in the content area of IPV were also searched one at a time in combination with the keywords. A total of six additional studies (Gadomski, et al., 2001; Hamberger, et al., 2004; Knapp, et al., 2006; Wong, Wester, Mol, & Lagro-Janssen, 2006; Bacchus, et al., 2007; Brackley, 2008) were identified using these search methods and the same inclusion criteria: 1) relevant training population; 2) formal training intervention; and 3) quantitative outcome measure(s). Collectively, the four most comprehensive studies previously identified by the IOM (1982-November 2000) and the six studies identified from December 2000-July 2009 by this researcher, were selected for more in-depth discussion in this literature review because they most closely resemble the overall purpose, variables, desired outcomes and measures of the feasibility study. All ten of the studies specified use of a standard definition of IPV similar to the definition that was used in the feasibility study. Given the use of multiple search strategies undertaken to identify this group of ten studies it is noteworthy that overall two studies listed medical subject headings (MeSH) (Harwell, et

al., 1998; Thompson, et al., 2000) and four studies listed key words (Campbell, et al., 2001; Short, Hadley, & Bates, 2002; Wong, Wester, Mol, & Lagro-Janssen, 2006; Knapp, et al., 2006; Hamberger, et al., 2004) while two studies offered no specific search identification terms (Gadomski, et al., 2001; Brackley, 2008). This variation may inadvertently have a negative influence on the timely dissemination of IPV research needed for evidence-based practice and future research.

Harwell and colleagues (1998) conducted a study with a one group cohort design (n = 108) involving 3-6 hours of IPV training for staff from four community health centers including physicians (41), nurses or physician assistants (46), and social workers or psychologists (21). The majority of participants were females (81%) younger than 40 years of age (57%). The number of years the participants were employed by the community health center ranged from 1 month to 32.5 years (median = 2 years). The purpose of this study was to evaluate the multifaceted RADAR training model (Massachusetts Medical Society, 1992), an acronym for Routine screening; Ask direct questions; Document your findings; Assess patient safety; and Review patient options and referrals. The RADAR training program is designed to train all staff within large community health centers, combining trauma theory with family violence assessment for a body-mind-spirit approach to understanding the effect of IPV on victims. Additionally the RADAR training program provides tailored follow-up support as needed by community health centers using this model for approximately two years after the initial training. Specific content of the RADAR training includes: an explanation of trauma theory; a video demonstrating the emotional impact of IPV; an introduction to IPV; introduction to the use of RADAR; modeling RADAR; a survivor's story; and lastly, a

question and answer period with the community agency representatives. Participants in this study received the RADAR training program as facilitated by a team of physicians, social workers, IPV survivors, police and IPV community agency representatives and lasting from three to six hours in length (Harwell, et al., 1998).

Major outcomes included knowledge of IPV (measured by self-report), attitudes and comfort with IPV (measured by self-report), percent of all cases with completed safety assessments, body injury maps, and in-house or outside resource referrals (measured by chart reviews), and percent of cases involving screening, suspicion and confirmation of IPV (measured by chart review). The outcomes evaluation was conducted in two phases. In the first phase of evaluation, researchers assessed participants' perceived knowledge and comfort via self-administered surveys at pre-training, post-training, and three months follow-up. These survey instruments were designed specifically for this study. Findings from phase one suggest the RADAR intervention was effective in preparing CHC staff to respond to IPV victims. There was no mention of any instrument for participants to evaluate the training program content (Harwell, et al., 1998).

In the second phase of the evaluation, the impact of participating in the RADAR training on participants' rate of screening, suspicion of abuse, and internal/external referrals for IPV was determined via chart reviews. Findings from phase two indicated that the RADAR training program is an effective tool for increasing the numbers of women who are screened for IPV, assessed for safety, and given referrals outside the CHC for additional support in the community. The rate of screening for IPV (25% vs. 5%), suspicion of IPV (6% vs. 2%), completion of safety assessments (17% vs. 5%), and

referrals (4% vs. 0%) increased significantly between the training intervention and baseline time frames. However the RADAR training program did not effectively increase documentation of IPV in the chart, supporting the need for further training on the importance of documentation. It is of interest to note that while the overall number of women screened for IPV increased following participation in the RADAR training, chart reviews revealed that 75% of the women seeking care during the intervention period were not screened. Major limitations of this study included: a limited response rate at the 3 month follow-up (35%); inability to distinguish between individual effects of content versus application components of the training; inability to discern individual participants' rate of screening; and, sample size which may have limited ability to detect differences in identification of IPV and documentation rates following participation in the training (Harwell, et al., 1998).

Thompson and colleagues (2000) conducted a randomized control trial study using two groups (group randomized) involving two half-day training sessions over twelve months (September 1995 to August 1996) for five primary care clinics (n = 179) from the Group Health Cooperative (GHC) of Puget Sound, a large health maintenance organization (HMO). The intervention group (two clinics) received training based on the PRECEDE-PROCEED model of behavior change (Thompson, et al., 2000). This approach describes behavior change in terms of: 1) predisposing factors including knowledge, attitudes, and beliefs; 2) enabling factors including skills, resources, and self-efficacy; and, 3) positive or negative reinforcing factors influencing sustainability of behavior such as feedback, social support, peer influences, and personal feelings regarding the behavior (Green & Kreuter, 1991). The comparison group (3 clinics) had

access to the “usual or available training” consisting of a manual on IPV previously developed by the Group Health Cooperative. Staff knowledge of the manual was reported as “limited” at initiation of the study. Additionally, an article on IPV was published in an internal publication at the onset of the project however, no other system-wide training was made available to participants in the control clinics (Thompson, et al., 2000).

It is unclear what the exact contents of the training program included. However, the authors describe the training intervention as being focused on skill building and empowerment among providers to increase screening for IPV at all exam visits and to become familiar with system/environmental enablers such as question/assessment cue cards for health care providers, IPV wall posters, and IPV brochures in women’s restrooms. Major outcomes included self-efficacy in detecting IPV, system support, victim blaming, fear of offending, and safety concerns (measured by self-report), percent of cases whose quality of care was interpreted as good or excellent (measured by chart review), percent of patients asking about IPV (HCP self-report), percent of patients who were screened for IPV and who were confirmed victims of IPV (measured by chart review). Participants’ knowledge, attitudes, and beliefs (KAB) were measured using a pre-existing survey (Maiuro, et al., 2000) at pre-training, at 9-10 months, and 21-23 months following the initial training session (Thompson, et al., 2000). The final KAB survey consisted of 39 items divided in six domains: self-efficacy (7 questions), system support (4 questions), blaming-the-victim (7 questions), fear of offense/ role resistance (7 questions), victim/ provider safety (8 questions), and perceived frequency of asking (6 questions). The complete questionnaire included an additional 32 questions that were not

associated with the any of the six domains for a total of 71 items. There was no mention of any instrument for participants to evaluate the training program content (Thompson, et al., 2000).

While the total number of participants in the two groups was unclear, the pre-training response rate across the five clinics was 86% (179/208) including physicians (66), physician assistants (13), nurse practitioners (4), nurses (44), and other (52). The response rates at 9 months was 79% (150/190) and 82% (140/171) at 21 months following the initial training. Group characteristics related to attrition over time were not reported. There were no differences found among intervention and control groups by gender, length of service or job type. Findings indicated there were differences in recorded asking among those patients who had physical exams and a screening questionnaire. There was no significant change in the intervention effect related to provider characteristics. Response scores on four of the six domains significantly improved from pre-training to nine months following initiation of the training, including self-efficacy, fear offense, safety concerns, and perceived asking about IPV. With the exception of perceived asking about IPV these positive changes were sustainable at 21-23 months following initiation of training and were largely attributed to the implementation of system/environmental enablers previously discussed. No significant differences were noted in the six domains among control group participants. Study limitations were not discussed however the researchers cautioned others to keep the concept of “intervention impact” (efficacy or effectiveness x reach) in mind when planning and evaluating interventions to balance the cost and effort with potential benefits (Thompson, et al., 2000).

Campbell and colleagues (2001) conducted an experimental study using two groups (group randomized) involving two days of IPV training and planning for emergency department staff (nurses, physicians, and social workers). Twelve hospitals were randomly selected from a list of 39 hospitals, six located in Pittsburgh, Pennsylvania and six located in San Francisco, California. All of these hospitals had reported no previous IPV training and indicated that they would be interested in participating in IPV training prior to being selected to participate in this study. The intervention group participated in a two-day training and planning program that was designed and implemented by the FVPF and the Pennsylvania Coalition Against Domestic Violence (PCADV) known as, *Best Practices: Innovative Domestic Violence Programs in Health Care Settings* (Nudelman, Durburow, Grambs, & Letellier, 1997). This model focused on systems change, coalition building, provider attitudes and skill building (Nudelman, Durburow, Grambs, & Letellier, 1997). The training content was presented to the participants in teams consisting of a physician, nurse, social worker, and hospital or emergency department administrator and one local IPV agency representative who agreed to work with each team. Each team was requested to meet one time prior to the training and to commit to meeting again soon after the training to implement their action plan created at the training session (Campbell, et al., 2001).

The first day of training consisted of didactic instruction on the background dynamics of IPV; appropriate responses including assessment, documentation, and referrals; role playing assessment and intervention; legal mandates; and beginning team planning. The second day of training was devoted to each team's development of a written action plan for adoption of protocols and training the rest of the emergency

department staff. Cultural sensitivity and culturally competent care were emphasized throughout the training. The comparison group received training described as “usual or available” training (Campbell, et al., 2001).

Major outcomes included knowledge and attitudes about IPV (measured by self-report), percent of identified IPV cases with appropriate interventions (chart review), patient satisfaction with care (patient self-report), commitment of emergency department providers to screening and treating IPV victims (researcher ratings), percent of patients who asked about IPV (measured by patient self-report), percent of self-identified IPV victims (measured by chart review). Participants’ knowledge and attitudes were measured using an adapted version of a pre-existing survey known as the SAS or Staff Attitudinal Survey (Saunders, Lynch, Grayson, & Linz, 1987) administered to a total of 649 emergency department (ED) staff (nurses and physicians) at pre-training (n = 336) and at the end of the study (n = 313). The adapted version of the SAS included five core items concerning attitudes toward battered women, in addition to twelve items covering critical knowledge domains and ten items addressing common myths about IPV from the training manual. Four questions were deleted due to ambiguity leaving a total of 23 items with an internal consistency of 0.73. The higher the score, the more favorable the responses regarding blaming attitudes towards victims and more knowledge about IPV and roles of the health care provider in addressing IPV. Findings revealed that participant responses at the experimental hospitals were significantly higher than participant responses at the control hospitals on staff knowledge and attitude measures ($F = 5.57, p = 0.019$); “culture of the ED” ($F = 5.72, p = 0.04$); and patient satisfaction ($F = 15.43, p < 0.001$) following participation in the training intervention (Campbell, et al.,

2001). However there was no significant difference in documented identification rates of victims of IPV (Campbell, et al., 2001) suggesting that changes in clinical practice are more difficult to accomplish than changes in knowledge or attitudes, and may be influenced by hospital policies (Campbell, et al., 2001).

Limitations addressed by this study included: possible influence of heightened awareness of IPV related to the O. J. Simpson trial; implementation of two new IPV related laws in California; insufficient sample size for significance; and use of medical record reviewers who were not blinded to hospital treatment status during the process of data collection. Additionally the closing/merging of 9% of California's 398 emergency departments resulted in unusual staff turnover/uncertainty that may have negatively influenced both participants and data collectors in this study. It is also noteworthy that JCAHO made several improvements to the standards regarding IPV, that were strengthened each year from 1992-1995, possibly leading to increased awareness of IPV as participating hospital's accreditation was up for renewal (Campbell, et al., 2001).

Short, Hadley and Bates (2002) conducted a longitudinal, quasi-experimental study using two groups (one comparison group) involving training of undisclosed length for emergency department and perinatal hospital staff. The intervention group was trained using the WomanKind model, an in-house non-profit health care based program for victims of IPV unique to Fairview Health Systems in Minneapolis, Minnesota (Hadley, Shore, Lezin, & Zook, 1995). Components of the WomanKind training program include: overall scope and incidence of IPV; dynamics, myths, realities and the cycle of violence; routine screening and assessment; indicators for identification; intervention through health care; victim's process of behavior change; documentation in

the medical record; and community connections. Data were collected at three time points over a two-year period at three intervention and two comparison hospitals located in Minneapolis, Minnesota (Hadley, Short, Lezin, & Zook, 1995; Short, Hadley, & Bates, 2002).

The purpose of the study was to evaluate participants' knowledge, attitudes, beliefs, and behaviors (KABB) related to identifying IPV and willingness to initiate a positive change in the system through referral to WomanKind in-house services. The effectiveness of raining for the WomanKind volunteer advocates and staff was also evaluated. During the time of the study, initial patient contacts for the three intervention hospitals, included 1,298 patients, and combined with repeat and follow-up contacts included over 2, 832 patients. Major outcomes included knowledge, attitudes, and behavioral intentions about IPV (measured by self-report), understanding of abusive relationships, beliefs about staff preparation and ability for addressing IPV issues, victim autonomy for decisions, staff responsibility to address domestic violence, self-efficacy for detecting IPV and interacting with victims, self-efficacy for referral and services, and own behaviors regarding screening and documentation (all measured by self-report), percent of cases with documentation of confirmed or suspected IPV, percent of all cases identifies as IPV (measured by chart review). Participants' knowledge, attitudes, beliefs and behaviors (KABB) were measured using an adapted version of a pre-existing survey designed for medical students at UCLA (Short, Cotton, & Hodgson, 1997; Short, Alpert, Harris, & Suprenant, 2006) that was administered by a staff person, selected to serve as a study coordinator for each department participating in the study. A two-page chart review protocol was created to abstract necessary information from emergency

department records addressing the following items: presenting problem, identification of definite or suspicious IPV, social history, questioning about IPV, notation of injuries, patient referral, and type of referral made. Records were reviewed by eight reviewers (96% reliability) for all female patients over 12 years of age (Short, Hadley, & Bates, 2002).

Findings indicated that participants in the WomanKind training program demonstrated significantly higher KABB than those from the comparison group. Chart reviews indicated that IPV documentation in patient records was two times higher for the intervention group than the comparison group. These results suggest that specialized training such as the WomanKind Program coupled with on-site client services have an overall positive influence on the KABB of health care providers. Study limitations were not addressed by the authors (Short, Hadley, & Bates, 2002).

Gadomski and colleagues (2001) conducted a train the trainer study using a cohort design involving three hospitals and nineteen clinics in a rural health network. Training for the trainers was provided by the New York State Office for the Prevention of Domestic Violence and was based on a pre-existing empowerment model promoting IPV victims' safety (Warshaw, 1997). Twenty trainers were trained one day per week over a five week period including: five attending physicians, three nurse practitioners, nine registered nurses, one physician assistant, one social worker, and one medical office assistant. These trainers then provided two one-hour training sessions and an IPV public awareness campaign. Outcome measures to document the effectiveness of this campaign included the participants' knowledge, attitudes, beliefs, behaviors measured before (fall 1997) and after (fall 1999) the training (self-report survey). This self-report survey

involved a pre-existing knowledge, attitudes, beliefs, and barriers (KABB) survey (Short, Cotton, & Hodgson, 1997; Short, Alpert, Harris, & Suprenant, 2006). Response rates for the pre-training survey were 67% (n = 380) and 56% (n = 273) for the post-training survey (Gadomski, et al., 2001).

Overall findings suggested that IPV training programs are effective for increasing awareness of IPV in primary care settings. Findings based on the complete data sets (n = 232) revealed significant improvement across all thirteen subscales. Nine of the thirteen demonstrated significant improvement from the pre-training to the post-training survey including: screening, workplace resources, making referrals, provider self-efficacy, victim autonomy, victim understanding, legal requirements, staff preparation, and fewer people responded they were too busy or couldn't help (Gadomski, et al., 2001).

However, the authors were unable to attribute any of the positive changes to any particular element of the training intervention or demographic characteristics of the participants. It is also unknown if there was any relationship between results of the self-report survey and outcomes among the IPV victims determined by the medical record audit. There was little change in the rates for IPV victim identification between the pre and post surveys reflecting a possible disconnect over the two-year time lapse between training and measurement, degree of training and participant experience, time required to change providers' behaviors, and avoidance of the subject of IPV. Such relationships could only be determined by follow-up studies with the IPV victims who were seen during the period of data collection for this study. The authors attributed low response rates to the length of the KABB survey, sensitivity of the issue of IPV, and time

constraints to complete the survey while also providing patient care. No other specific study limitations were discussed (Gadomski, et al., 2001).

Hamberger and colleagues conducted a study to test four hypotheses following a three hour IPV training program among 752 health care providers who were divided into groups of 20 for the training. The majority of participants were female (72%) and consisted of registered or licensed practical nurses (66%). Other participants included medical assistants, radiology technicians, laboratory technicians, social workers, and physicians. Participants were employed in multiple settings including emergency departments, pediatrics, surgery, intensive care units, internal medicine, perinatal unit, inpatient and outpatient behavioral health and family medicine. Approximately half the employees worked full time (47%) and about half were between 0.5 and 0.9 effort employees (45%) and all participants received paid time off to attend training (Hamberger, et al., 2004). This training intervention involved implementation of the Family Peace Project guidelines that were modified to meet local needs (Ambuel, Hamberger, & Lahti, 1997) and incorporated Bandura's theory of self-efficacy (Bandura, 1979, 1982). The Family Peace Project is a comprehensive approach designed to: provide learners with a common knowledge about IPV definitions, dynamics, incidence and prevalence; facilitate learner attitudes towards IPV as both a public health and individual matter requiring health care screening and intervention skills; and, specific skills needed to provide IPV victims with screening, support, education, safety planning and local resources (Ambuel, Hamberger, & Lahti, 1997).

Major outcome measures included hypotheses one through three which stated that training would be result in: 1) increased self-efficacy related identification and helping

IPV victims; 2) increased endorsement of the health care provider's role and health care environment for assisting IPV victims; and 3) increased comfort making appropriate community agency referrals for IPV victims. Hypothesis 4 stated that the effects of the training intervention would be influenced by participants' prior training or prior experience in working with IPV victims. Data were collected to test the four hypothesis at three time points including pre-training, post-training, and six months follow-up (self-report survey). This self-report survey involved a pre-existing knowledge, attitudes, beliefs, and barriers (KABB) survey (Short, Cotton, & Hodgson, 1997; Short, Alpert, Harris, & Suprenant, 2006). A demographic form is included with the KABB survey to collect information regarding participants' professional training and discipline, years experience, work department, age sex, prior IPV training (coded as present or absent) and prior experience working with IPV victims. There was no outcome measure to monitor the quality or fidelity of the training intervention. However the team of trainers met weekly to discuss their progress and to problem-solve as needed (Hamberger, et al., 2004).

Findings revealed there were significant positive changes in participant responses across all subscales from pre-training to post-training. Overall median scores increased by four points for self-efficacy, referral, and screening; and by three points for health care role and workplace support. Participants who had no prior training had significantly higher responses for self-efficacy (5 points vs. 3; $p < 0.001$), referral (5 vs. 3 points; $p < 0.001$), and workplace support (3 points vs. 2; $p < 0.001$) in comparison to those who had any amount of prior training. Significantly greater increases in scale responses for self-efficacy, referral, health care role, and screening subscale items were also documented in

the group who reported no IPV victim identification in the past year. Findings from the six months follow-up survey showed that all five subscales remained significantly increased from pre-training to six months follow-up. However three of the subscales had dropped significantly from post-training to six month follow-up results including self-efficacy, referral, and screening ($p < 0.01$). Overall these data suggest that IPV training is effective in creating desirable changes in health care providers' self-efficacy judgments. The authors discussed several study limitations including vulnerability to Type I error in statistical analyses (i.e. rejecting the null hypothesis when it is true), lack of randomization, low participant response rate at six months follow-up (45%) and only 106 surveys could be matched with the original surveys, inability to evaluate actual screening behaviors of participants (Hamberger, et al., 2004).

Knapp and colleagues (2006) conducted a study with a one group cohort design (n = 79) involving 2 hours of IPV training for pediatric emergency department staff at the Children's Mercy Center Hospitals and clinics in Kansas City, Missouri, consisting of physicians, nurses, and social workers who volunteered to participate in the study. The training intervention involved participation in a 2-hour training program, entitled *It's Time to Ask*. The *It's Time to Ask* curriculum was created by the authors of this study and involved presentation of content in three modules. The first module included basic concepts related to definitions and IPV related to a pediatric health care setting. The second module involved recognition of barriers to IPV screening and intervention related to health care providers' attitudes, beliefs and behaviors. The third module addressed use of a model protocol for identification of IPV in a pediatric acute care environment (Knapp, et al., 2006). The authors stated,

“Self-efficacy is defined as a person’s belief in his or her ability to perform a designated task. Self-efficacy affects a person’s willingness to attempt a task, the degree of anxiety during the task performance, the amount of effort used, and the persistence in performing a task in the face of difficulties. Self-efficacy – related barriers to screening for IPV include feelings of inadequate training, poor confidence in ability to screen appropriately, concerns about lack of resources for identification and intervention, and fears that a parent will be angry or offended if screened” (Knapp, et al., 2006, p.114).

Outcome measures to document the effectiveness of the *It’s Time to Ask* curriculum included the participants’ demographic characteristics (self-report survey), attitudes and beliefs, self-efficacy, and reported behaviors/clinical practice (all measured by self-report survey), and training evaluation (self-report survey). This self-report survey involved adaptation of a 39-item pre-existing instrument (Maiuro, Vitaliano, & Sugg, 2000) administered at pre-training (n = 79), immediate post-training (n = 87) and at six months follow-up (n = 48). Only 35 of the original 39 survey items were included on the pre-training/post-training survey. Based on the pre/post surveys, the six months follow-up survey was reduced to a total of 22 items regarding attitudes and beliefs (11 items), self-efficacy (7 items), and behaviors/clinical practice (4 items). Survey results were not matched by individual participants at each time point. Final data analysis included only the 22 items that were included across all time points and only the surveys for those participants who completed the *It’s Time to Ask* training were analyzed. Mean scores and standard deviations were calculated for participant responses at the three time points. Independent *t*-tests were used to determine significance for any changes among pre-training, post-training and six months follow-up scores across time (Knapp, et al., 2006).

Findings indicated there were consistent positive changes in attitudes following participation in the *It's Time to Ask* training that persisted at the six month follow-up for five of eleven items on the survey: "There is not enough time in a pediatric visit to talk about IPV with parents/ caregivers", "Asking parents/caregivers about IPV is an invasion of privacy", "It is demeaning to parents/caregivers to question them about IPV", "It is not my place to interfere with how people choose to resolve conflicts," and "I am afraid of offending a parent/caregiver if I ask about IPV" (Knapp, et al., 2006, p. 112). Significant positive changes were noted for five of the seven items related to self-efficacy at immediate post-training and the remaining two of the seven items showed significant positive change at the six months follow-up survey. Two of the four statements related to behavior/clinical practice showed significant changes toward positive agreement and these differences were only noted in comparison of the pre-training with the six month follow-up surveys including, "In the past year, I have seen a parent/caregiver with an injury and have asked about IPV," and "In the past year, I have seen an abused child and have asked about IPV" (Knapp, et al., 2006, p. 114). There were no mean differences noted among participant demographic characteristics including age, profession, gender, or number of years in respective field. Results of the course satisfaction survey indicated the majority of participants would recommend the *It's Time to Ask* training to other health care providers. The fact that only certain attitudes, beliefs, and behaviors changed over time at pre-training and/or at six months follow-up while others did not, warrants further exploration. For example, the statement, "I feel confident that we are identifying as many victims of IPV as we can in my work setting," did not reflect significant change

until the six month follow-up survey. This supports the need for experience and practice to gain confidence in screening and identifying IPV victims (Knapp, et al., 2006).

The authors addressed several limitations related to the study population including the small sample size, possible bias inherent to the voluntary nature of subject recruitment, and inability to track individual participant responses over time. The authors also recognized the six months follow-up time interval was relatively short and that findings may not persist over longer periods. Additionally, the findings were unique to a pediatric emergency department and may not be generalized to other settings. Finally, it is noteworthy that a separate IPV screening program was instituted at the pediatric emergency department following presentation of the *It's Time to Ask* training and prior to the six month follow-up, making it impossible to measure only the effects of the *It's Time to Ask* training at the six months follow-up (Knapp, et al., 2006).

Wong and colleagues (2006) conducted a randomized control trial using a stratified sample in the Netherlands at Rotterdam. Participants were initially numbered and subsequently stratified into groups by a list of criteria including gender, district served (wealthy, mixed, deprived), and type of practice (solo-group practices, or health center). Each group was identified by a letter and its members were linked together as a team. Research assistants were blinded to the criteria that formed the basis of each team's formation. This study sought to answer the following research questions: "Will training be effective in stimulating family doctors to question women more actively about partner abuse when they suspect it and will identification increase?" and "Can doctors' awareness of the possibility of partner abuse in patients presenting non-obvious sign increase through training?" (Wong, Wester, Mol, & Lagro-Janssen, 2006, p. 250). Thus,

the aim of this study was to investigate differences among physicians' awareness and active questioning of patients regarding IPV following a 1.5 day IPV training session and focus group attendance versus focus group only. Contents of the 1.5 day IPV training created for this study addressed attitudes, IPV theory and background, IPV epidemiology, consultation skills incorporating role play with screening, IPV resource information, legal aspects of IPV, and pre/post testing of written vignettes. Three groups were formed in this study involving a training and focus group (n = 23) who cared for 87 patients, while the focus group only (n = 14) cared for 30 patients and the control group (n = 17) cared for a total of 14 patients for the duration of the study period. The IPV training and focus group (n = 24) was subdivided into two smaller groups of twelve (one lost due to illness) to minimize participant discomfort in discussing sensitive issues regarding IPV (Wong, Wester, Mol, & Lagro-Janssen, 2006).

Physician performance was identified as the dependent variable with the primary outcome measure being the number of reported cases where IPV was discussed or suspected. The secondary outcome measure was described as being the number of cases with non-obvious signs leading physicians to suspect and discuss IPV with their patients. Data collection for both the primary and secondary outcome measures involved use of an incident reporting instrument (created by the authors) whereby patient cases of identified or suspected IPV were anonymously recorded on numbered incident reporting forms. Cases qualified to be reported if they met one of the following three conditions: 1) when the physician suspected and questioned the patient regarding IPV regardless of whether or not IPV was confirmed; 2) when the physician suspected but chose not to question the patient regarding IPV for safety reasons (i.e. partner or child present at exam); and 3)

when the patient self-disclosed IPV victimization. Each case was reported only one time (Wong, Wester, Mol, & Lagro-Janssen, 2006).

Findings indicated that all study participants were physicians and the majority were described as young females, working part-time in a group practice. None of the study participants had received any prior training regarding IPV in their medical school curriculum or in their professional practice. No differences were found between the two subgroups who participated in both training and focus group sessions therefore the data were analyzed together. The total number of IPV cases reported over the six month study period was 131. A total of 11 cases where the women were questioned did not confirm abuse. These cases were eliminated from the final group comparison data analysis process. Final outcomes identified comparison of the full training and control groups had an IPV identification rate ratio of 4.26 (95% CI = 2.35 to 7.74 , $p < 0.001$); comparison of the focus group only team and the control group had an IPV identification rate ratio of 2.35 (95% CI = 1.19 to 4.66, $p = 0.014$); and comparison of the full training and focus group only team had an IPV identification rate ratio of 1.81 (95% CI = 1.31 to 2.90, $p < 0.014$) suggesting a positive significant effect for the IPV training overall. Participants emphasized the positive influence of tools provided during the training. Participants also reflected that the number of cases reported may have been negatively influenced by the summer holidays when physicians were off on vacation during the study period. Overall, findings revealed that a 1.5 day IPV training program for family physicians successfully increased their awareness and identification of IPV in female patients up to 4.5 times, and active questioning in the absence of obvious indicators of IPV increased up to 6 times. These results suggest that the training had a positive effect in helping physicians to

overcome existing barriers including lack of knowledge and negative attitudes towards victims of IPV (i.e. feeling powerless, and fear of offending). While the effect of the focus group only session was lacking the components of knowledge, information, and skills practice, it doubled the rate of active questioning, demonstrating a significantly increased awareness among those participants (Wong, Wester, Mol, & Lagro-Janssen, 2006).

Limitations of this study included the small sample size and specific focus on physicians unique to Rotterdam who volunteered to participate in this study that may have biased the positive results. The authors also noted the likelihood that training physicians who care for a population with a naturally high prevalence of IPV and low baseline for victim recognition prior to the study would be more likely to yield positive effects from training and focus group sessions. There was no instrument to measure changes in participants' knowledge, attitudes and barriers. However the researchers assumed there were positive changes in knowledge, attitudes and barriers based on the number of cases of abuse reported following the training and focus group sessions and the focus group only sessions in comparison with the control group (Wong, Wester, Mol, & Lagro-Janssen, 2006).

Bacchus' research team from King's College London, Florence Nightingale School of Nursing and Midwifery, conducted a landmark longitudinal study among a purposeful sample of multidisciplinary health professionals in maternity and genitourinary medicine services who participated in a one-day training session regarding identification and response to victims of IPV (2007). Evaluation of training in this study was based on data collected for trained staff between June 2005 and September 2006. A

total of 37 training sessions were presented and attended by a total of 230 student midwives, midwives, and consultants in maternity service, as well as 44 nurses and doctors working in genitourinary medicine. These trainees were primarily white British females, younger than 40 years of age, and had less than 5 years of experience in their respective professions (Bacchus, et al., 2007).

Since there were no existing reliable and valid measures, items selected for development of the questionnaires regarding health care providers' knowledge, confidence (self-efficacy) and attitudes were based on a systematic review of the literature (Cohn, Salmon, & Stobo, 2002; Maiuro, et al., 2000; Ramsay, et al., 2002; Short, Alpert, Harris, & Suprenant, 2006). The resultant *Instructional Measurement Subscale* questionnaires regarding participants' knowledge, confidence (self-efficacy), and attitudes toward identifying and responding to victims of IPV were administered at three points in time: pre-training, post-training, and six months following the training. Reliability test results indicated the questionnaires were internally consistent based on Cronbach's alpha for the initial items on the health care professionals' *Confidence In Implementing Routine Enquiry* subscale (Cronbach's alpha = 0.78), *Attitudes Towards Routine Enquiry* subscale (Cronbach's alpha = 0.64), and the *Attitudes Towards Victims Of Abuse* subscale (Cronbach's alpha = 0.63) (Bacchus, et al., 2007, pp. 64-65). Exact response rates for the pre-training and immediate post-training questionnaires were unclear but reported as "high" compared with a "low" response rate for the six months follow-up. Researchers were able to match seventy-two percent of the six month follow-up questionnaires (n = 49) with their respective pre-training questionnaires. However the

remaining respondents had not completed a pre-training questionnaire so there was nothing to match them with (Bacchus, et al., 2007).

In addition to these pre-training and post-training *Instructional Measurement Subscales*, researchers also conducted focus groups, interviews, audits of medical records and review of the database from referrals to an in-house IPV victim advocacy program, known as *MOZAIC*. The meaning of the acronym *MOZAIC* was not specified. The *MOZAIC* client database contained information such as sociodemographic characteristics of the patient, length and nature of abuse, agencies and health services attended by the patient prior to receiving *MOZAIC* services in addition to any resources accessed by the patient in between each meeting. A total of six focus groups were conducted following the training between October 2005 and January 2007. Focus groups included: health advisors (n = 4) at six months post-training, nurses (n = 2) at three months post-training, two groups of midwives (both n = 4) at 3 months post-training, and two groups of midwives (n = 6 and n = 5) at six months post-training. Focus groups were conducted by a trained facilitator, in a safe room at the hospital, and lasted approximately one hour each. Participants were required to sign a written consent form prior to participation in the focus group and were identified by a color name (i.e. “Red said...”). All focus groups were tape-recorded and transcribed verbatim. Qualitative content analyses from the focus groups was used in identification of concepts associated with each of the quantitative research questions (Bacchus, et al., 2007).

Findings revealed that reproductive health service and sexual health service areas are both appropriate and acceptable points of early intervention among victims of IPV. Pregnant women in particular were found to be at a turning point in breaking the silence

regarding their victimization out of direct concern for their unborn baby. Other turning points for victims revealing the abuse included escalation of severity of abusive episodes, fearing for their life, public humiliation, and or physically noticeable injuries. Interview data revealed that when health care providers make it a common practice to screen for abuse, women were more likely to change their perception of being abused as normal behavior. Overall, IPV victims viewed the HCP's as most trustworthy when they were knowledgeable, skilled and confident in their jobs and when they followed-up on things they said they would do. Breaches of confidentiality or inappropriate information sharing by HCP's who were ill-prepared regarding legal issues surrounding IPV resulted in a loss of trust with the victim. Findings regarding the effects of training on knowledge of IPV were inconclusive from the pre-training to the six months post-training, although there was an improvement, differences were only significant for the non-matched group. Overall, attitudes towards routine enquiry were positive following the training but participants reported the need for more focus on case studies with role play and skills practice. Routine enquiry for IPV was introduced in both maternity and genitourinary clinic services following the training intervention but was not consistently performed or documented in either area (47% and 58% respectively). This was largely attributed to persistent barriers related to anxiety and lack of confidence in responding to victim's disclosure of IPV, lack of privacy, and lack of comfort in separating the patient from her partner or family. However, there was a steady increase in patient referrals to *MOZAIC* over the study period. Additionally, provision of the in-house *MOZAIC* IPV victim advocacy services provided a unique opportunity for health care providers who were victims of IPV to access support. However, employees also shared anxiety about how

revealing abuse may affect their future. These findings strongly suggest the need for workplace policies for dealing with employees as victims or perpetrators of IPV as part of a comprehensive approach to addressing IPV. The authors discussed several limitations of the study including inability to match individual responses, attrition and changes in staff as well as study trainers over time (Bacchus, et al., 2007).

Brackley (2008) studied the implementation of an existing training model, known as the *Safe Family Project* (Swenson-Britt, Thornton, Hoppe, & Brackley, 2001), designed to educate hospital staff for the purpose of improving care to victims of domestic violence. This was accomplished through a campus partnership based on the *Achieving Outcomes Logic Model* (USDHHS, 2002) allowing for a needs and assets assessment, capacity building, program selection, implementation and assessment, and a final evaluation process. The *Safe Family Project*: “established a collaborative working group of health care providers and community agencies; assessed the needs and resources within the institution and community; built institutional support and involvement; developed a referral network and a Web site; and, generated administrative commitment to the project” (Brackley, 2008, p. E17). The needs and assets assessment revealed the need for hospital staff training regarding identification, intervention, and treatment for patients who are victims or perpetrators of IPV. Eight-hour train-the-trainer workshops were conducted for 85 health care providers in a large University Health System (UHS) of Texas. Participants in the train-the-trainer workshops included nurses, social workers, and technicians. Contents of the train-the-trainer sessions included an introduction to IPV; overview of interpersonal violence; IPV statistics and facts; IPV myths and misperceptions; workplace violence; JCAHO and Texas state law; compassion fatigue;

health care provider's role; working with new UHS documents; working with batterers; community resources; and learning more about peace and violence. On their respective units, trainers then provided training over a six week time period in the format of 30 minute inservices for emergency and obstetrical-gynecological staff. These inservices were repeated eleven times per week for a total of 66 inservices and involving a total of 631 staff participants. The aim of this training was to improve the identification, safety, treatment, and referral/follow-up of victims and perpetrators of IPV (Brackley, 2008).

Outcome measures included use of a demographic questionnaire, including the following items: race/ethnicity; age; gender; job duty/role; background; training; professional experience with domestic violence; and personal experience as a victim, witness, or perpetrator of violence. Outcome measures also included use of a pre-existing knowledge, skills and attitudes survey (Doepel, Connel & Hoff, 1994), administered to the emergency and obstetrical-gynecological staff immediately pre and post-training. Individual scores were not matched between pre-training and post-training surveys. Therefore only aggregate composite scores calculated from the sum of the scales could be reported for pre-training and post-training data (Brackley, 2008).

Findings revealed that participants in the train-the-trainer workshop reported a favorable composite mean score of 3.5 on a scale of 4. Prior to the staff training sessions, staff documented patient education regarding IPV 42% of the time. After the training, chart audits were conducted to determine the number of referrals made and anecdotal notes from reports of community agency partners receiving patient referrals were also reviewed. Female victims overwhelmingly reported feelings of empowerment following the health care providers participation in IPV training, whereas before they felt blamed.

“The percentage of staff with domestic violence training rose from 56% to 93%. Staff knowledge on domestic violence improved from 4.7 to 6.5 on ten items... The staff also improved on the ten skill items with scores rising from 5.4% to 6.4% (Brackley, 2008).” Conversely, participants’ aggregate scores related to attitudes toward victims decreased slightly from 126 to 119 on a 7-point Likert response scale of 26 items. Overall there was a positive change in documentation of domestic violence by nurses and social workers and it was also reported that 100% of the identified cases of domestic violence had documentation for referrals and patient education. However, in cases where substance abuse was involved providers failed to recognize any possible relationship with domestic violence and to intervene accordingly (Brackley, 2008). Findings from this study strongly suggest that hospitals must engage in staff development to assure that health care providers have the necessary knowledge, attitudes, and skills to care for victims of domestic violence. Limitations of this study were not addressed by the author (Brackley, 2008).

Over the past decade researchers have identified several trends in the efficacy of training regarding IPV. Previous quantitative research attempts to substantiate changes in healthcare providers’ attitudes after participation in training have failed due to inadequate measures of myths regarding IPV (Lazanblatt, Thompson, & McMurray, 2005; Short, Alpert, Harris, & Suprenant, 2006). Recent studies continue to suggest that some health care providers are prejudiced and have negative attitudes toward and difficulty expressing empathy for victims of IPV, especially those who choose to maintain a relationship with their perpetrator (Bacchus, et al., 2007; Lavis, Horrocks, Kelly, & Barker, 2005; Nicolaidis, Curry, & Gerrity, 2005). However, there is a newly emerging body of

evidence suggesting that training does increase short-term knowledge based on differences in pre/post-training measures (Bacchus, et al., 2007; Davis, et al., 1999; Ernst, Houry, Weiss, & Szerlip, 2000; Harwell, et al., 1998; Knight & Remington, 2000; McCauley, Jenckes, & McNutt, 2003).

Additionally, researchers have found that the likelihood of screening/ assessing clients for IPV has been shown to increase following participation in training on IPV (Bacchus, et al., 2007; Hamberger, et al., 2004; Harwell, et al., 1998; Knight & Remington, 2000; Thompson, et al., 2000). Healthcare professionals short-term level of comfort and confidence in screening/ assessing for and detecting victims of IPV has also been shown to improve following training but was not maintained based on results of follow-up measures (Hamberger, et al., 2004; Harwell, et al., 1998; McCauley, Jenckes, & McNutt, 2003; Thompson, et al., 2000). No studies were found to substantiate that victims increased self-disclosure of IPV following providers' participation in training sessions (Harwell, et al., 1998; Thompson, et al., 2000).

Qualitative researchers have stressed the need to account for contextual differences posed by individual institutional environments (Minsky-Kelly, et al., 2005; Stayton & Duncan, 2005; Wong, Wester, Mol, & Lagro-Janssen, 2006). In general, cumulative findings suggest a need for future training programs on IPV to focus more time in these five areas: strategies to ensure privacy, maintaining confidentiality, reporting laws/ information sharing, safety planning and documentation of findings of IPV (Cohn, Salmon, & Stobo, 2002; Protheroe, Green, & Spiby, 2004; Ramsay, et al., 2002; Short, Johnson, & Osattin, 1998; Taft, Broom, & Legge, 2004; Thurston & Eisener, 2006). Additionally, Cohn, Salmon, and Stobo, have encouraged the use of

designated champions; multidisciplinary partnerships; ready access to guidelines, protocols for screening/assessment and resources for both healthcare providers and victims (2002).

Previous researchers have identified the most successful aspects of training including didactic content on incidence and prevalence of IPV, screening and identification of IPV victims, legal issues of reporting and documentation of IPV, and referrals to empower victims' ongoing safety plan management (Bacchus, et al., 2007; Brackley, 2008; Campbell, et al., 2001; Gadowski, et al., 2001; Hamberger, et al., 2004; Harwell, et al., 1998; Knapp, et al., 2006; Short, Hadley, & Bates, 2002; Thompson, et al., 2000; Wong, Wester, Mol, & Lagro-Janssen, 2006;). Based on extensive review of the literature it has been recommended that training for staff should include: survivors perspectives; cultural competency; dynamics of victimization and perpetration; physical and mental health consequences of IPV on victims and children exposed; how to assess, intervene, support and document appropriately; interactive role playing and modeling of assessment and response techniques; information on where employees in abusive relationships can access assistance; and boundary setting and self care (FVPPF, 2004, p. 57). Additional research is needed to improve the healthcare provider's response to screening/assessment of IPV.

Theoretical Underpinning of the Feasibility Study

Review of the literature suggested that health care providers' development of the knowledge, cultural competence, confidence (self-efficacy), and attitudes related to identifying and responding to victims of IPV may be understood using a framework of self-efficacy (Anderson & Kras, 2005; Benight & Bandura, 2003; Hamilton, 2008).

Bandura's Social Cognitive Learning Theory supported the researcher's decision to conduct a feasibility study, and informed selection of outcome measurement instruments (Bandura, 1977a, 1977b, 1986, 1997). According to Bandura, self-efficacy is based on one's self-generated judgements of how well one can perform certain skills (Bandura, 1982). Self-efficacy is influenced by four primary sources of information: mastery experiences (verbal persuasion), vicarious experiences (modeling), social persuasion (skill performance appraisal), and somatic and emotional states (physiological states) (Bandura, 1977a, 1977b). The Family Violence Prevention Fund's, *Improving the Health Care Response to Domestic Violence* (Ganley, 1998) is a comprehensive training program designed to provide didactic information, modeling and skill rehearsal through a combination of PowerPoint, videos, case scenarios, demonstration, role play, collaborative dialogue and reflection (Appendix F). Bandura's research has shown that favorable self-efficacy judgments were related to increased skill performance (Bandura, 1977a, 1977b, 1982). Therefore, the feasibility study has significant value, for testing the effect of the FVPF training program, *Improving the Health Care Response to Domestic Violence* (Ganley, 1998), and making recommendations for ongoing research.

Chapter Three

Methodology

Intimate partner violence (IPV) is a global problem, costing billions of dollars and impacting millions of families. JCAHO requires health care providers to screen for IPV and to provide intervention if needed. The Center for Disease Control (CDC) makes no recommendation in the use of one particular IPV screening/ assessment instrument and/ or training curriculum due to insufficient evidence (USPSTF, 2004).

The *National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization* (FVPF, 2004) have been endorsed by JCAHO to help health care organizations comply with the mandated training. Based on this endorsement, the researcher decided to conduct a feasibility study exploring the efficacy of *Improving the Health Care Response to Domestic Violence* (Ganley, 1998), as a training program intervention designed to train health care providers in the use of the *National Consensus Guidelines* (FVPF, 2004). The purpose of the *Improving the Health Care Response to Domestic Violence* training program was to improve health care providers' perceived knowledge, cultural competence, confidence (self-efficacy), and attitudes related to identifying and responding to victims of IPV. Recommendation for a randomized control trial would be the next step pending favorable results and analysis of the feasibility study.

Social Cognitive Learning Theory (Bandura, 1977a, 1977b, 1986, 1997) provided important concepts for researching training programs related to screening and assessing for IPV. Bandura proposed that human functioning results from interplay among personal factors, behaviors, and internal/external environmental influences (Bandura, 1986). "People's level of motivation, affective states, and actions are based more on

what they believe than on what is objectively true” (Bandura, 1997, p. 2). Personal characteristics are more predictive of behavior than knowledge. Influencing personal characteristics, such as cultural competence, confidence (self-efficacy), and attitudes can enhance the attainment and practice of knowledge. Overall, it was hypothesized that participation in educational training regarding IPV would increase the Children First Program nurse home-visitors’ perceived level of knowledge, cultural competence, confidence (self-efficacy), and attitudes related to identifying and responding to victims of IPV.

Subjects

Because this was really a program evaluation with no real risk to the participants, an exempt IRB through Indiana University, Purdue University, Indiana and Clarian Institutional Review Board was obtained. The researcher also secured permission from Human Resources at the selected Health Department in Tulsa, Oklahoma, prior to data collection (Appendix C). After obtaining institutional review board (IRB) approval from the Indiana University IRB, the researcher selected a convenience sample for this feasibility study composed primarily of nurse home-visitors, (with varying levels of responsibility such as intake nurse, case manager, supervisor, training coordinator), who visit low-income, first-time mothers enrolled in the Children First Program within the city-county health department of a large mid-western city (population 400,000) in Oklahoma. This sample population was selected based on: subject availability to participate; capacity as first responders while working with individuals in the home environment where IPV is most likely to occur; and, positive regard for the Children First Program. Registered nurses and other professionals (i.e. social workers, professional

students and interns) working through the Children First Program were eligible to participate in the study. A total of 23 registered nurse home-visitors and 1 master's level social work intern participated in the study. Attendance at the training was mandatory for the Children First Program nurses, however, participation in the study was optional.

Recruitment

Two weeks in advance a letter advertising opportunity to participate in a study and a presentation of the training program, *Improving the Health Care Response to Domestic Violence* (Ganley, 1998) was sent via E-mail to the Director of the Children First Program. The E-mail was forwarded to the employees' individual department E-mail addresses. The training was mandatory; participation in the study was voluntary. One week in advance and again two days prior to the mandatory training time, a mass voice mail and E-mail reminders of the topic, date, time and location of the training were sent out by the Director of the Children First Program to individual employees to remind them of required attendance at the program and voluntary participation in the study.

Procedure

Participants were verbally informed prior to the training session that completion of the study instruments would constitute informed consent to participate as subjects in the study. Each participant received a training binder that included an agenda, handouts, and the study's instruments. Participants were informed that all answers would be confidential. Participants were also informed that it might be possible to recognize individual answers in any publication. Therefore all participants were instructed that they were not to complete the forms if they had any concerns regarding anonymity.

Employees consenting to participate as subjects in the study completed the *Plunkett Demographic Questionnaire* and the *Instructional Measurement Subscales* prior to the presentation. Following the training, subjects completed the *Training Program Evaluation* and the *Instructional Measurement Subscales*. The researcher had no knowledge of those who chose to participate as subjects in the study until the training was completed. Six Weeks later, the researcher met with the participants at a mandatory monthly staff meeting to complete the follow-up *Instructional Measurement Subscales*.

To ensure confidentiality, participants were asked to identify themselves using a self-selected six-digit code (i.e. parent's birthday). Forms for each participant were then matched by their six-digit code numbers. Each set of forms was filed individually and stored in a locked cabinet, in a secure location away from the training site. Pre/Post Training and Six Weeks Follow-Up *Instructional Measurement Subscales* forms were color-coded to insure that participants had completed all forms. Pre training forms were pink. Post training forms were blue. Six Weeks Follow-Up forms were green. There was no monetary expense or compensation to the subjects. However, the researcher provided the binders, certificates of attendance, lunch, and refreshments for attendees.

Training Intervention

The training intervention was delivered in a single day, Monday, March 2, 2009, from 8:30 a.m. to 5:00 p.m., allotting time for sign-in, breaks, participation in the training intervention and completion of study instruments. A follow-up session was conducted on Monday, April 13, 2009, from 9:00 a.m.-9:45, exactly six weeks following the training. Both the training program and the follow-up session were conducted in the same large

auditorium (seating capacity 150) with level rows of tables and chairs arranged in a semi-curved formation facing a large screen and podium. The room was equipped with multimedia equipment and a cordless microphone. The selected training intervention for the feasibility study was *Improving the Health Care Response to Domestic Violence* training program (Ganley, 1998), promoting implementation of the *National Consensus Guidelines On Identifying and Responding to Domestic Violence Victimization* (FVVPF, 2004). The guidelines were in the public domain and the FVVPF supplied support materials to the researcher: trainer's manual, resource manual, *Voices of Survivors* DVD, *Screen to End Abuse* DVD, intervention wallet card, and template to create a local resource pamphlet.

This training program consisted of five modules enumerated in Appendix F (Ganley, 1998). Within the trainer's manual, each of the five modules is organized into seven sections: 1) allotted teaching time; 2) goals and objectives; 3) specific training tips; 4) presentation content outline; 5) talking points to stimulate dialogue and question/answer time with participants; 6) participant handouts; and 7) suggested materials for PowerPoint slides. The training program incorporated application of the intimate partner violence Abuse Assessment Screening (AAS) instrument (Appendix D) and the Danger Assessment (DA) tool (Appendix E). Ideally, the FVVPF suggests a two-day training format with ninety minutes of teaching-learning time for each module but no less than forty-five minutes of teaching-learning time per module. The feasibility study allowed sixty minutes of teaching-learning time per module for a one-day format. Goals and objectives provided for each module within the trainer's manual were used to create the *Training Program Evaluation* for the study. The other sections and materials

provided in the FVPPF training manual were used to create PowerPoint presentations and handouts for each module. Participants were also provided with an agenda for the workshop (Appendix G) and a certificate of attendance. The teaching format consisted of several teaching-learning strategies including interactive PowerPoint presentations, that were used to engage participants in dialogue regarding talking points, question and answer time, case studies, personal stories, videos, demonstration, role play, and reflection.

The researcher provided a binder containing the five training modules, with training materials for each attendee. Module 1: *The Dynamics of IPV and its Impact on a Victim's Health* addressed content related to knowledge, cultural competence and attitudes. Module 2: *Cultural Competency in Responding to IPV Victims* addressed content related knowledge and cultural competence. Module 3: *Specific Clinical Strategies for IPV Screening, Assessment, Intervention* addressed content related to knowledge, cultural competence, and confidence (self-efficacy). Module 4: *Practical Applications of Screening, Assessments, and Intervention Strategies* addressed content related to knowledge, cultural competence, confidence (self-efficacy), and attitudes. Module 5: *Legal Issues and Community Resources for IPV Victims* addressed knowledge, cultural competence, confidence (self-efficacy), and attitudes. Note that concepts of knowledge and cultural competence were integrated throughout all five modules. One copy of the FVPPF folio for nurses, *A Call To Action: The Nursing Role in Routine Assessment for Intimate Partner Violence* (FVPPF, 2004) was also included in the binders. Each folio contained a tear-off, prepaid postcard for each attendee to order their own individual copy of the *National Consensus Guidelines on Identifying and*

Responding to Domestic Violence Victimization (FVPPF, 2004). The postcards were completed by each attendee at the beginning of the training and collected by the Children First Program Supervisor who placed them directly in the outgoing mail at the first break. The *Voices of Survivors* DVD (30 minutes) and *Screen to End Abuse* DVD (32 minutes) were watched during lunch prior to Module 3.

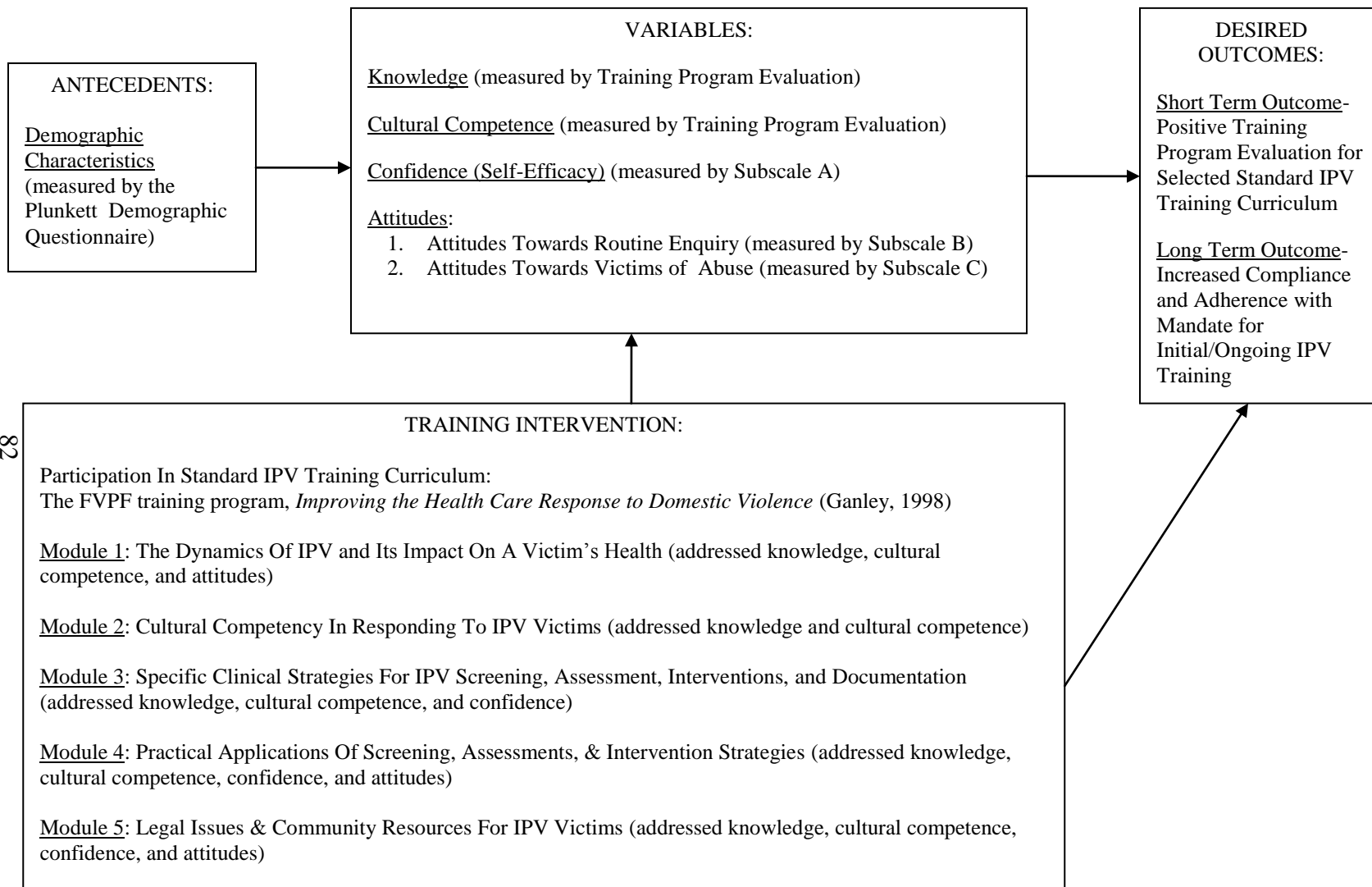
Instruments

A total of three evaluation instruments were used in the study, including the *Plunkett Demographic Questionnaire* (Appendix H); a *Training Program Evaluation* (Appendix I) for *Improving the Health Care Response to Domestic Violence* (Ganley, 1998); and the *Instructional Measurement Subscales* (Bacchus, et al., 2007) (Appendix J). The *Instructional Measurement Subscales* were used at three time points: pre-training, post-training, and six weeks follow-up.

A sample of “Children First Program” perinatal nurse home-visitors’ were assessed at three time points: pre-training, immediate post-training, and six weeks after training. Variables measured in the study included antecedents (demographic characteristics), knowledge, cultural competence, confidence (self-efficacy), and attitudes of the sample population regarding identification of and response to victims of intimate partner violence. The short term outcome for a “Positive Training Program Evaluation” was also addressed by the feasibility study (Figure 3.1).

Demographic characteristics were measured using the *Plunkett Demographic Questionnaire*, a survey consisting of 11 fill-in-the-blank and check-list items. The Questionnaire was designed by the researcher to ascertain socio-demographic antecedents of the sample population that might influence acquisition of knowledge, cultural

Figure 3.1 Testing the Efficacy of a Standard IPV Training Program



competence, confidence (self-efficacy) and attitudes toward IPV and its victims. The questionnaire requested data regarding professional role, employment status, educational preparation, age, gender, and race.

Participants' perception of knowledge and cultural competence variables was measured using the *Training Program Evaluation*. The *Evaluation* consisted of 15 items and was administered immediately after the training program. Module objectives were divided as follows:

- Module 1: The Dynamics of IPV and its Impact on a Victim's Health (5 objectives);
- Module 2: Cultural Competency in Responding to IPV Victims (3 objectives);
- Module 3: Specific Clinical Strategies for IPV Screening, Assessment, Interventions, and Documentation (2 objectives);
- Module 4: Practical Applications of Screening, Assessment, and Intervention Strategies (3 objectives); and,
- Module 5: Legal Issues And Community Resources For IPV Victims (2 objectives).

All 15 objectives were rated on a 5 point Likert response scale and numerically coded as follows: Strongly Disagree (1), Disagree (2), Neither Agree nor Disagree (3), Agree (4), and Strongly Agree (5). The higher the participant's score on each of the five modules in the Training Program Evaluation, the more favorable the perception of the level of knowledge and cultural competence and the more positive the evaluation of the training program.

The *Instructional Measurement Subscales* (Bacchus, et al., 2007) were used to measure confidence (self-efficacy) and attitudes. The three subscales were designed to measure changes in participants' *Confidence in Implementing Routine Enquiry*, *Attitudes Towards Routine Enquiry*, and *Attitudes Towards Victims of Abuse* (Appendix I). The

first subscale, *Confidence in Implementing Routine Enquiry*, measured confidence (self-efficacy) and consisted of 8 items rated on a 5 point Likert response scale, numerically coded as follows: Strongly Agree (5), Agree (4), Neither Agree nor Disagree (3), Disagree (2), and Strongly Disagree (1). The second subscale, *Attitudes Towards Routine Enquiry*, consisted of 5 items, and the third subscale, *Attitudes Towards Victims of Abuse*, consisted of 8 items rated on a 5 point Likert response scale. Both the second and third subscales measured participants' attitudes and were numerically coded as follows: Strongly Agree (1), Agree (2), Neither Agree nor Disagree (3), Disagree (4), and Strongly Disagree (5). The higher the score on each of the three subscales, the more confidence (self-efficacy) and the more positive the attitudes. As previously discussed in Chapter Two, existing factor analysis substantiated use of the Instructional Measurement Subscales (Bacchus, et al., 2007). The Instructional Measurement Subscales were administered at three time points, including pre-training, immediate post-training, and at six weeks after training.

It was anticipated that health care providers who lacked appropriate knowledge, cultural competence, and attitudes to assess and treat IPV would also have low confidence (self-efficacy) to screen, assess and assist victims of IPV (Bandura, 1986). Subjects with low confidence (self efficacy) for identifying and responding to victims of IPV, prior to the training, were expected to show greater changes in confidence (self-efficacy) and attitudes, as measured by the post-training and six week follow-up Instructional Measurement Subscales. Subjects with high confidence (self efficacy) for identifying and responding to victims of IPV, prior to the training, were expected to show

smaller changes in confidence (self-efficacy) and attitudes, as measured by the post-training and six week follow-up Instructional Measurement Subscales.

Data Analysis

A data base was created to analyze results of the feasibility study (n=24). All measurement items were numerically coded using the software, *Statistical Package for the Social Sciences* (SPSS) version 16.0 (SPSS, 2008). Results of the data analysis were organized and reported for each of the four hypotheses statements as follows.

Hypothesis 1. There will be an overall increase in healthcare providers' perceived level of knowledge and cultural competence following participation in the FVPPF training program, *Improving the Health Care Response to Domestic Violence* (Ganley, 1998). The Training Program Evaluation was used to evaluate the hypothesis.

The *Training Program Evaluation* consisted of five modules with a total of fifteen objectives that were rated on a 5-point Likert response scale. Participants' responses were numerically coded so that the higher the score, the more favorable the response related to level of knowledge and cultural competence. Minimum, maximum, mean and standard deviations were reported for each of the five modules in addition to mean composite scores for each module. Participants' narrative comments written at the bottom of the Training Program Evaluation were also reported.

Hypothesis 2. There will be an overall increase in healthcare providers' perceived level of confidence in implementing routine enquiry following participation in the training program, *Improving the Health Care Response to Domestic Violence* (Ganley, 1998). The hypothesis was evaluated by *Instructional Measurement Subscale A* (Items 1-8), named *Confidence in Implementing Routine Enquiry* (Appendix I). The 8 items were

rated on a 5-point Likert response scale, numerically coded so that the higher the score, the more favorable the participant's confidence in implementing routine enquiry. Minimum score, maximum score, mean score and standard deviations in addition to mean composite scores were reported for each time of administration (pre-training, post-training, and six weeks follow-up). Repeated measures ANOVA was conducted to compare mean composite scores over time. Paired samples Pearson correlations and dependent t-tests were calculated to show which pairs were significantly different over time. Cronbach's alpha reliability coefficient, was calculated to measure internal consistency of the items within the subscale for each of the three times.

Hypothesis 3. There will be an overall positive change in healthcare providers' attitudes towards routine enquiry following participation in the FVPF training program, *Improving the Health Care Response to Domestic Violence* (Ganley, 1998). The hypothesis was measured by *Instructional Measurement Subscale B* (Items 9-13), named *Attitudes Towards Routine Enquiry* (Appendix I). The 5 items were rated on a 5 point Likert response scale, numerically coded so that the higher the score, the more favorable the participant's attitudes towards routine enquiry. Minimum score, maximum score, mean score and standard deviations in addition to mean composite scores were reported for each point of administration (pre-training, post-training, and six weeks follow-up). Repeated measures ANOVA was conducted to compare mean composite scores over time. Paired samples Pearson correlations and dependent t-tests were calculated to show which pairs were significantly different over time. Cronbach's alpha reliability coefficient was calculated to measure internal consistency of the items within the subscale for each of the three times.

Hypothesis 4. There will be an overall positive change in healthcare providers' attitudes towards victims of abuse following participation in the FVPPF training program, *Improving the Health Care Response to Domestic Violence* (Ganley, 1998). The hypothesis was measured by *Instructional Measurement Subscale C* (Items 14-21), named *Attitudes Towards Victims Of Abuse* (Appendix I). The 8 items were rated on a 5-point Likert response scale and numerically coded so that the higher the score, the more favorable the participant's attitudes towards victims of abuse. Minimum score, maximum score, mean score and standard deviations in addition to mean composite scores were reported for each time of administration (pre-training, post-training, and six weeks follow-up). Repeated measures ANOVA was conducted to compare mean composite scores over time. Paired samples Pearson correlations and dependent t-tests were calculated to show which pairs were significantly different over time. Cronbach's alpha reliability coefficient, was calculated to measure internal consistency of the items within the subscale for each of the three times.

Lastly, the data were analyzed to explore for any relationships among the variables measured. Length of employment at Children First and the participants' age ranges were correlated with items on the *Instructional Measurement Subscales*, using Spearman's rho coefficients. Items on the *Instructional Measurement Subscales* were correlated with items on the *Training Program Evaluation*, using Pearson *r* coefficients. Table 3.1 consists of a summary of instruments and statistics used to test the hypotheses. Because the sample size was small (n=24), the statistics used for evaluation did not meet criteria for psychometric testing.

Table 3.1 Description of Study Instruments, Purpose, and Corresponding Data Analysis

Instrument	Variable Measured	Item Description	Reliability & Validity	Point Of Admin	Allotted Time	Data Analysis
Plunkett Demographic Questionnaire: (Appendix H)	Measures Demographic Characteristics Variable	11 Items: Fill In Blank & Check-List	Not Available- Devised By Researcher For This Study	Administered Immediate Pre Instruction	5 Min	Descriptive Statistics; & Spearman's <i>rho</i> Correlation With Instructional Measurement Subscales
Training Program Evaluation: (Appendix I) <u>Module 1 (5 Obj):</u> The Dynamics Of IPV & Its Impact On A Victim's Health <u>Module 2 (3 Obj):</u> Cultural Competency In Responding To IPV Victims <u>Module 3(2 Obj):</u> Specific Clinical Strategies For IPV Screening, Assessment, Intervention, & Documentation <u>Module 4 (3 Obj):</u> Practical Applications Of Screening, Assessment, & Intervention Strategies <u>Module 5 (2 Obj):</u> Legal Issues & Community Resources For IPV Victims	Measures Knowledge & Cultural Competence Variables	Total Of 15 Obj. All Rated on 5 Pt Likert Response Scale	Not Available	Administered Immediate Post Instruction	10 Min	Descriptive Statistics; & Pearson Correlation with Instructional Measurement Subscales
Instructional Measurement Subscales: (Appendix J) <u>Subscale I (8 Items):</u> Confidence in Implementing Routine Enquiry <u>Subscale II (5 Items):</u> Attitudes Towards Routine Enquiry <u>Subscale III (8 Items):</u> Attitudes Towards Victims Of Abuse	Measures Confidence (Self-Efficacy) & Attitudes Variables	Subscales I, II & III: Total Of 21 Items. All Rated On 5 Pt Likert Response Scale	Cronbach's alpha: Subscale I (0.78), Subscale II (0.64), & Subscale III (0.63). y (Bacchus, et al., 2007)	Administered Immediate Pre & Post Instruction, & at Six Week Follow-Up Post Instruction	20 Min Each Time Point	Descriptive Statistics; Item Analysis With Cronbach's Alpha; Repeated Measures ANOVA & Paired Samples Pearson Correlation & Paired Samples Dependent T-Tests; & Pearson Correlation with Training Program Evaluation

Limitations and Potential Threats to Methodology

Traditionally, researchers have promoted use of the randomized clinical trial (RCT) as a hallmark or gold standard for establishing rigor in generating and assessing evidence for best practices through quantitative research. Historically, RCT's also require greater investments of time, energy and funding. A RCT may be conducted in four phases as follows: Phase I of a RCT usually involves development of the best and safest treatment (intervention) possible. Phase II seeks to gather preliminary evidence of effectiveness for a particular treatment (intervention). Phase III involves collection of evidence to support whether one treatment (intervention) is more efficacious or preferred over another treatment (intervention). Phase III RCT's usually require large, multi-site sample populations to avoid limiting findings to a single setting. Finally, Phase IV RCT's require studying the effectiveness of a given treatment (intervention) in the general population. As previously discussed in Chapter One of this dissertation, the CDC makes no specific recommendation in the use of one particular IPV screening/assessment instrument and/or training curriculum over another due to insufficient supporting evidence. The *National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings* have been endorsed to help health care providers comply with the mandate for training set forth by JCAHO (FVVPF, 2004). Based on this endorsement, the researcher determined the next step was to conduct a feasibility study to determine the effect of the FVVPF training program, *Improving the Health Care Response to Domestic Violence* (Ganley, 1998), as a standard training curriculum toward implementation of the *National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization* (FVVPF, 2004).

Recommendation for a Phase III RCT would be the next step pending favorable results and analysis of the feasibility study.

As previously discussed, the *Plunkett Demographic Questionnaire* was designed for this study. The *Training Program Evaluation* was developed using the objectives for each training module. However, initial reliability and validity of the psychometric properties for the *Instructional Measurement Subscales* have been established (Bacchus, et al., 2007). According to Cook and Campbell (1979) potential threats to internal validity for the feasibility study may have included history, maturation, testing, and mortality. In terms of history, the researcher recognized that unplanned events may have coincided with the training intervention. For example subjects may have felt sick or stressed as opposed to focused and energetic which could affect their results. Maturation refers to changes in subjects that occur naturally over time. For example subjects who are newly employed by the Children First Program would naturally become more confident in their job role over six weeks of orientation/experience. The pre/post instruction testing procedure could alter the subjects' confidence and attitudes simply through repetition of exposure to the item content whereby participants may become test-wise or develop test-fatigue. Mortality (dropout) may have posed a threat if subjects did not complete the entire day of training or did not participate in the six weeks follow-up post instruction instrument. For example this could have lead to group inequivalence in matching pre to post to six weeks follow-up results. Potential threats to internal validity related to instrumentation, regression to the mean, selection or assignment errors were not applicable to the study.

Anticipated Challenges to Methodology

The training took place at the health department, in a large room designed to accommodate up to 150 people. Prior to the training the researcher was informed by the Children First Program director, that Mondays are the usual timeframe allotted for planned general health department employee meetings. The researcher implemented the training from 8:30 A.M.-5 P.M. and the six weeks follow-up session from 9 A.M.-9:45 A.M. on two selected Mondays, (March 2, 2009 and April 13, 2009, respectively).

Confronting the challenge of time management was crucial to success of the training. The FVPF training program, *Improving the Health Care Response to Domestic Violence* (Ganley, 1998), consisted of five modules, each ideally designed to be presented over 90 minutes but no less than 45 minutes. Due to the time constraints, the researcher was limited to 60 minutes for each module presentation. Secondly, incentive to participate on a Monday may have been burdensome to some employees. Children First nurses' attendance was mandatory. However it was stressed that the opportunity to participate in the study was optional. Ironically, the fact that attendance was mandatory may have accentuated the urgency of the need for such training possibly enhancing willingness to participate in the study. The researcher provided all training materials at no cost to participants in addition to lunch and refreshments which may have encouraged attendance for some participants.

The researcher anticipated that although many of the participants may have worked with this subject matter routinely, it was possible that they might feel some discomfort at participating in the training and or completing the evaluation instruments.

The researcher recognized that presentation of the *Voices of Survivors* DVD, *Screen to End Abuse* DVD, and case studies may have triggered personal recall.

To lessen the likelihood of personal recall becoming overwhelming and blocking learning, the researcher paced and limited the number of case studies, stories and visual images throughout the five training modules. The researcher was also prepared to adjust the presentation as needed based on the group's input/response during the actual training session. To minimize presentation bias, the researcher provided a historical overview and stated rationale for the chosen training in addition to resources for access to other known training guidelines and screening/assessment instruments. The researcher responded to the anticipated diversity of learning styles among participants by using a variety of teaching/learning strategies throughout each of the five training modules (Appendix G).

Health care providers may have exposure to IPV as a result of personal experience (i.e. self, friend, relative, client) but lack formal education about IPV and its resultant health consequences. As a result, special issues for the health care provider working with victims of intimate partner violence may include vicarious traumatization (also known as compassion fatigue), physical revenge by their client's perpetrator, and attitudes and values of the professional "concerning emotional intimacy and management of interpersonal power in relationships may impact heavily" on the health care provider's style, and victimization history of the professional (Dutton, 1992, p. 144). Special efforts to minimize these issues included incorporating information during the training modules regarding supervision, self-nurturance, personal therapy/employee assistance programs, diversifying professional responsibilities, and engagement in political activism (Dutton, 1992, pp. 151-153; Ganley, 1998).

Chapter Four

Results

The purpose of the feasibility study was to test the efficacy of a standard training program on participants' perception of knowledge, cultural competence, confidence (self-efficacy), and attitudes related to identifying and responding to victims of intimate partner violence (IPV). The desired short-term outcome of the feasibility study, was a positive *Training Program Evaluation* for the selected IPV training program, *Improving the Health Care Response to Domestic Violence* (Ganley, 1998). Knowledge about IPV and cultural competence were integrated throughout the five training modules. Additionally, the concept of confidence (self-efficacy) was addressed in Modules 3, 4, and 5; and the attitude concepts were addressed in Modules 1, 4, and 5 (Appendix F).

The feasibility study involved 24 participants and addressed four hypotheses in addition to the short term outcome. Results of the three study instruments: the *Plunkett Demographic Questionnaire*; the *Training Program Evaluation*; and, the *Instructional Measurement Subscales*, were used to evaluate the four hypotheses and the short term outcome of the study. The Training Program Evaluation and the Instructional Measurement Subscales were numerically coded so the higher the participants' scores, the more favorable their responses. This chapter is organized in three sections: collation of findings by instrument, hypothesis testing, and ancillary findings.

Collation of Findings by Instrument

Plunkett Demographic Questionnaire. Demographic characteristics of the sample, including discipline, educational preparation, gender, race, age, length of employment at Children First, and total years of experience in the discipline, are reported in Table 4.1 as frequencies and percentages. The feasibility study included 24 participants, all of whom were female, including 23 registered nurses home-visitors and 1 master's-prepared social work intern. Seven of the 23 registered nurse home-visitors also included the following roles: supervisors (2), case managers (2), intake nurse (1), program manager (1), and state training coordinator (1). Participants attained their professional degrees from 1976 (4.2%) through 2005 (8.3%). Professional education included Associate Degree in Nursing (n = 3, 12.5%), Bachelor of Science in Nursing (n = 18, 75%), Master of Science in Nursing (n = 1, 4.2%), Master of Social Work (n = 1, 4.2%), and one Bachelor of Arts (n = 1, 4.2%). Additional professional certifications of the participants included one each of the following: breastfeeding educator, community health education specialist, sexual assault nurse examiner, elementary teaching certificate, and Nursing Child Assessment Satellite Training (NCAST). Race of the participants included 19 Whites (79.2%), 2 Blacks (8.3%), 1 Hispanic (4.2%), 1 Native American (4.2%), and 1 Asian (4.2%). Twenty-two participants (91.7%) were employed full time and 2 participants (8.3%) were employed part time. Excluding the Social Work Intern, the participants' length of time employed by the Children First Program ranged from "Less than 6 months" to "Between 10 and 15 years" with the median length of employment being "Between 5 and 10 years" (29.2%). The modal length of employment was "Between 1 and 5 years" (37.5%). Participants' ages varied from "26-30 years"

(8.3%) to “66-70 years” (4.2%) with the median age falling between two age groups; “41-45 years” (12.5%) and “46-50 years” (16.7%).

Table 4.1 Summary of Demographics for the Sample

Item	Frequency	Percentage
Professional Role:		
Registered Nurse Home-Visitor	23	95.8%
Social Work Intern	1	4.2%
Educational Degree:		
ADN	3	12.5%
BSN	18	75.0%
Diploma Nurse + BA	1	4.2%
MSN	1	4.2%
MSW	1	4.2%
Length Of Time Employed By CFP		
Less Than 6 Months	1	4.2%
Between 1 & 5 Years	9	37.5%
Between 5 & 10 Years	7	29.2%
Between 10 & 15 Years	6	25.0%
Student/Intern	1	4.2%
Age:		
26-30 Years	2	8.3%
31-35 Years	4	16.7%
36-40 Years	3	12.5%
41-45 Years	3	12.5%
46-50 Years	4	16.7%
51-55 Years	3	12.5%
56-60 Years	3	12.5%
61-65 Years	1	4.2%
66-70 Years	1	4.2%
Gender:		
Female	24	100.0%
Male	0	0.0%
Race:		
White	19	79.2%
Black	2	8.3%
Asian	1	4.2%
Hispanic	1	4.2%
Native American	1	4.2%

Training Program Evaluation. The *Training Program Evaluation* was comprised of five module evaluations corresponding with the training module learning objectives designed to measure participants' perceived level of knowledge and cultural competence in identifying and responding to IPV victims (Appendix I). There were a total of 15 module objectives divided as follows:

- Module 1: The Dynamics of IPV and its Impact on a Victim's Health (5 objectives).
- Module 2: Cultural Competency in Responding to IPV Victims (3 objectives).
- Module 3: Specific Clinical Strategies for IPV Screening, Assessment, Interventions, and Documentation (2 objectives).
- Module 4: Practical Applications of Screening, Assessment, and Intervention Strategies (3 objectives).
- Module 5: Legal Issues and Community Resources for IPV Victims (2 objectives).

All 15 module objectives were rated on a 5-point Likert response scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree). The higher the participant's score on each of the fifteen module objectives in the Training Program Evaluation, the more favorable the response related to their level of perceived knowledge and cultural competence (Table 4.2). The evaluation was completed once, immediately after the training.

The minimum scores reported for all fifteen module objectives varied from 2 (Disagree) to 4 (Agree). However the maximum scores reported for all fifteen module objectives were 5 (Strongly Agree), indicating the majority of participant responses clustered around the 4 and 5 rating options. Module results indicated that the actual minimum to maximum response range for each of the modules was significantly lower than the possible ranges by at least 25% (Table 4.3). Module 2 had the greatest overall range of minimum to maximum responses (9 of 12 possible; 75%) while Module 4 had

the lowest overall range of minimum to maximum responses (3 of 12 possible; 25%).

The percentage of the mean composite score to the maximum possible score for each module was 87.5% or higher for Modules 2 and 5; 91.7% or higher for Modules 1, 3, and 4; and 91.9% for all 5 modules combined.

Table 4.2 Descriptive Statistics of the Training Program Evaluation

Module & Objective	Min Score	Max Score	Mean Score	Std Dev
Module 1: The dynamics of IPV and its impact on a victim's health				
1. Establish that IPV is a primary health issue facing clients, their families, and health care professionals.	4	5	4.71	.464
2. Correct misinformation about IPV that typically blocks effective responses by health care professionals, and introduce the definitions and causes of IPV, as well as perpetrator and victim issues.	3	5	4.58	.584
3. Illustrate the importance of developing and implementing culturally appropriate responses to IPV.	3	5	4.46	.658
4. Provide brief, concrete examples of changes in professionals' and health systems' approaches that can be made to improve the response to IPV victims.	4	5	4.50	.511
5. Motivate health care professionals to improve their response to IPV victims and their children.	3	5	4.67	.565
Module 1 Composite Results	19	25	22.92	2.28
Module 2: Cultural competency in responding to IPV victims				
1. Define the terms "culture" and "cultural competency" as they apply to IPV.	2	5	4.33	.816
2. Increase health care professionals' awareness of culture and how to interact within different cultural perspectives when responding to IPV victims.	2	5	4.25	.847
3. Provide a practice model that promotes a response to IPV that is free of discrimination and committed to cultural competency.	2	5	4.54	.721
Module 2 Composite Results	6	15	13.13	2.17
Module 3: Specific clinical strategies for IPV screening, assessment, intervention, and documentation				
1. Review with health care professionals that IPV is a significant health issue requiring response from the health care system.	4	5	4.79	.415
2. Educate professionals about simple, concrete, culturally appropriate ways to improve their response to IPV victims through routine screening, assessment, intervention, and documentation.	2	5	4.58	.717
Module 3 Composite Results	7	10	9.38	.97
Module 4: Practical applications of screening, assessment, and intervention strategies				
1. Provide models of effective screening, assessment, and intervention procedures for responding to IPV victims.	4	5	4.79	.415
2. Provide an educational setting where participants have the opportunity to apply their knowledge about IPV and cultural issues to case examples.	4	5	4.71	.464
3. Increase professionals' use of culturally competent screening, assessment, and intervention procedures with IPV victims.	2	5	4.46	.779
Module 4 Composite Results	12	15	13.96	1.37
Module 5: Legal issues and community resources for IPV victims				
1. Increase awareness of the legal options available to IPV victims so health care professionals can discuss these with clients and facilitate their access to potentially lifesaving resources.	3	5	4.46	.588
2. Review legal requirements and considerations for health care professionals and institutions that may be important for the care of victims of IPV and the practice of good risk management.	2	5	4.33	.816
Module 5 Composite Results	6	10	8.79	1.25

Scale Coded: 1=Strongly Agree, 2=Disagree, 3=Neither, 4=Agree, and 5=Strongly Agree

Table 4.3 Composite Module Summary of the Training Program Evaluation

Training Program Module (Likert Response Scale 1-5)	Possible Composite		Actual Composite		Mean Comp Score	Std Dev	Percentage of Mean Comp Score to the Max Possible Score
	Min-Max Score	Range	Min-Max Score	Range			
Module 1 (5 objectives)	5 - 25	20	19 - 25	6 (6/20 = 30%)	22.92	2.28	22.92/25 = 91.7%
Module 2 (3 objectives)	3 - 15	12	6 - 15	9 (9/12 = 75%)	13.13	2.17	13.13/15 = 87.5%
Module 3 (2 objectives)	2 - 10	8	7 - 10	3 (3/8 = 37.5%)	9.38	0.97	9.38/10 = 93.8%
Module 4 (3 objectives)	3 - 15	12	12 - 15	3 (3/12 = 25%)	13.96	1.37	13.96/15 = 93.1%
Module 5 (2 objectives)	2 - 10	8	6 - 10	4 (4/8 = 50%)	8.79	1.25	8.79/10 = 87.9%
Total Training Program Evaluation Score for all Modules	15 - 75	60	57 - 75	18 (18/60 = 30%)	68.21	6.298	68.21/75 = 91.9%

All 24 participants offered narrative comments on the *Training Program Evaluation*. The narratives included 8 positive comments regarding learning to use the Abuse Assessment Screen and the Danger Assessment tools; 6 positive comments regarding increased knowledge of local resources for victims of IPV; 5 positive comments regarding the use of the video clips and case studies to “make it (IPV) more real”; and 5 positive comments regarding use of facts about IPV and communication techniques for improved response to victims of IPV. Additionally there were four comments offering constructive feedback to include more information regarding 1)

barriers to change; 2) education for boys and, men related to IPV; 3) special considerations for victims of IPV who have disabilities; and 4) “How can we get Oklahoma from number 4 to number 50?” in the ranking for female homicides due to IPV. Participants verbally requested additional resources related to training in the use of the Danger Assessment tool and culturally specific health care resources.

Instructional Measurement Subscales. The *Instructional Measurement Subscales* instrument (Appendix J) included three subscales designed to measure potential changes in participants’ perceived level of *Confidence in Implementing Routine Enquiry*, *Attitudes Towards Routine Enquiry*, and *Attitudes Towards Victims of Abuse*, administered at pre-training, post-training, and six weeks follow-up. Descriptive statistics including minimum score, maximum score, mean score, standard deviation, and mean composite score were reported for each subscale for each time of administration. The higher the participant’s score on each of the three subscales, the more favorable the response related to their confidence (self-efficacy) and attitudes. Additional statistical tests included repeated measures ANOVA, paired samples Pearson correlations with dependent *t*-tests, and Cronbach’s alpha coefficient calculations for each of the subscales at each of the times of administration.

Subscale A: *Confidence in Implementing Routine Enquiry* (Table 4.4) consisted of 8 items rated on a 5-point Likert response scale ranging from 5 (Strongly Agree) to 1 (Strongly Disagree). Minimum scores reported at pre-training ranged from 2 (Disagree) to 3 (Neither). Minimum scores at both post-training and six weeks follow-up varied from 2 (Disagree) to 4 (Agree). Maximum scores were rated at a response of 5 (Strongly Agree) across pre-training, post-training, and six weeks follow-up implying that

participants' perceived level of *Confidence in Implementing Routine Enquiry* was already high prior to the training for some participants and improved over time for others. Mean scores at post-training were greater than 4 (Agree) for all items except item 6 ("I am confident that dealing with disclosures of abuse won't produce any emotional distress for me."), rated greater than 3 (Neither). All participants' scores were greater than 4 (Agree) for all items on Subscale A: Confidence in Implementing Routine Enquiry, at Six Weeks Follow-Up. Minimum scores on the mean composite score for Subscale A increased from 25 at (pre-training), to 28 at post-training, and to 29 at six weeks follow-up. The maximum mean composite score for Subscale A was stable across pre-training, post-training, and six weeks follow-up, reported at 40 of 40 points possible. The overall mean composite score for Subscale A increased from 32.54 at pre-training to 34.79 at post-training to 35.17 of 40 points possible at six weeks follow-up.

Subscale B: *Attitudes Towards Routine Enquiry* (Table 4.5) consisted of 5 items rated on a 5- point Likert response scale ranging from 1 (Strongly Agree) to 5 (Strongly Disagree). Minimum scores reported at pre-training and post-training) varied from 1 (Strongly Agree) to 3 (Neither). Minimum scores reported at six weeks follow-up varied from 1 (Strongly Agree) to 2 (Agree). For pre-training, maximum scores were rated 5 (Strongly Disagree) for all items except items 9 and 13, that were rated a 4 (Disagree), at pre-training. Maximum scores were rated at a response of 5 (Strongly Disagree) for all items at post-training. At follow-up, maximum scores were rated 5 (Strongly Disagree) for all items except item 9, ("If asked, most clients who are currently in an abusive relationship will deny everything."), rated 4 (Disagree). Mean scores were greater than 2 (Agree) or 3 (Neither) for all items across all time points except item 12 ("Routine

enquiry will probably result in abusive partner directing their violence towards health care providers.”) with a mean score greater than 4 (Disagree) at post-training. Minimum scores on the mean composite score for Subscale B increased from 11 at pre-training, to 12 at post-training, and then decreased to 10 at six weeks follow-up. The maximum mean composite score for Subscale B increased from 20 at pre-training to 25 at post-training and then decreased to 21 of 25 points possible at six weeks follow-up. The overall mean composite score for Subscale B increased from 14.71 at pre-training to 17.29 at post-training and then decreased to 16.88 points of 25 points possible at six weeks follow-up, still a significant increase from pre-training.

Subscale C: *Attitudes Towards Victims of Abuse* (Table 4.6) consisted of 8 items rated on a 5-point Likert response scale ranging from 1 (Strongly Agree) to 5 (Strongly Disagree). Minimum scores reported at pre-training varied from a response of 1 (Strongly Agree) to 2 (Agree) for all items except item 20 (“I think in my practice there is not enough time to ask about intimate partner violence.”), rated a 4 (Disagree). Minimum scores reported at post-training varied from a response of 1 (Strongly Agree) to 2 (Agree) for all items except for items 19 (“Intimate partner violence is a private matter that should be resolved primarily by the couple themselves.”), and 20 (“I think in my practice there is not enough time to ask about intimate partner violence.”), both rated a 4 (Disagree). Minimum scores reported at six weeks follow-up ranged from 1 (Strongly Agree) to 2 (Agree) except item 20 (“I think in my practice there is not enough time to ask about intimate partner violence.”), rated a 4 (Disagree). Maximum scores were rated at a response of 5 (Strongly Disagree) for all items across all time points. Mean scores were greater than 2 (Agree) or 3 (Neither) for all items across all time points except item

12 (“Routine enquiry will probably result in abusive partner directing their violence towards health care providers.”), rated greater than 4 (Disagree) at post-training. It is of interest that participants consistently rated item 21 (“Women who have suffered intimate partner violence in the past tend to seek out abusive partners.”) lower (agreed with the statement) than any of the other items on all three subscales across all time points. For item 21, the minimum score was rated a 1 (Strongly Agree). However, the mean score for item 21 was only slightly greater than 2 (Agree) across all time points and the standard deviation was also greater than 1 across all time points. Minimum mean composite scores for Subscale C increased from 20 at pre-training, to 24 at post-training, and then decreased to 21 at six weeks follow-up. The maximum mean composite score for Subscale C increased from 35 at pre-training to 40 points of 40 points possible at post-training and six weeks follow-up. The overall mean composite score for Subscale C increased from 28.96 at pre-training to 31 at post-training and then slightly decreased to 30.33 of 40 points possible at six weeks follow-up.

Composite *Instructional Measurement Subscale* results (Table 4.7) indicate that actual minimum to maximum response ranges for each of the subscales over three time points were lower than the possible ranges by at least 40.66%. Subscale C: *Attitudes Towards Victims of Abuse*, at six weeks follow-up, had the greatest overall range of minimum to maximum responses (19 of 32 possible; 59.34%) while Subscale A: *Confidence in Implementing Routine Enquiry*, at six weeks follow-up, had the lowest overall range of minimum to maximum responses (11 of 32 possible; 34.38%).

Table 4.4 Descriptive Statistics of Instructional Measurement Subscale A: Confidence in Implementing Routine Enquiry

Subscale A: Confidence In Routine Enquiry (8 Items)	Pre-Training				Post-Training				Six Weeks Follow-Up			
	Min Score	Max Score	Mean Score	Std Dev	Min Score	Max Score	Mean Score	Std Dev	Min Score	Max Score	Mean Score	Std Dev
1. I am comfortable talking with clients who tell me they are being abused by their partner	3	5	4.21	.658	3	5	4.50	.590	3	5	4.46	.658
2. I am confident I can document IPV accurately and confidentially	2	5	4.00	.834	4	5	4.50	.511	3	5	4.42	.584
3. I am confident I can make the necessary referrals to help female victims	3	5	4.25	.794	4	5	4.58	.504	4	5	4.58	.504
4. I am confident I will not react adversely towards partners I know are abused	3	5	4.25	.676	4	5	4.54	.509	3	5	4.42	.717
5. I am confident I have the necessary communication skills to facilitate women disclosing their experiences of IPV	2	5	4.04	.859	3	5	4.33	.565	4	5	4.29	.464
6. I am confident that dealing with disclosures of abuse won't produce any emotional distress for me	2	5	3.54	1.103	2	5	3.75	.944	2	5	4.12	.797
7. I am confident I can manage to see clients alone without their partners/family prior to asking about IPV	2	5	3.92	.929	2	5	4.17	.761	3	5	4.25	.737
8. I feel comfortable asking my patients about partner abuse	3	5	4.33	.565	3	5	4.42	.584	4	5	4.63	.495
Subscale A Composite Results (40 points possible)	25	40	32.54	4.881	28	40	34.79	3.647	29	40	35.17	3.559

Scale Reverse Coded: 5=Strongly Agree, 4=Agree, 3=Neither, 2=Disagree, 1=Strongly Disagree

Table 4.5 Descriptive Statistics of Instructional Measurement Subscale B: Attitudes Towards Routine Enquiry

Subscale B: Attitudes Towards Routine Enquiry (5 Items)	Pre-Training				Post-Training				Six Weeks Follow-Up			
	Min Score	Max Score	Mean Score	Std Dev	Min Score	Max Score	Mean Score	Std Dev	Min Score	Max Score	Mean Score	Std Dev
9. If asked, most clients who are currently in an abusive relationship will deny everything	2	4	2.75	.897	2	5	3.13	1.076	1	4	3.13	1.035
10. Asking about IPV may seem offensive to most clients	2	5	3.25	1.032	2	5	3.71	.955	1	5	3.42	.974
11. Clients' different cultural beliefs and values can impede asking about IPV	1	5	2.33	.963	1	5	2.75	1.260	1	5	3.00	1.285
12. Routine enquiry will probably result in abusive partner directing their violence towards HCP's	3	5	3.83	.637	3	5	4.21	.588	2	5	3.83	.761
13. Routine enquiry can put abused clients in more danger	2	4	2.54	.779	2	5	3.50	1.022	1	5	3.50	.885
Subscale B Composite Results (25 points possible)	11	20	14.71	2.678	12	25	17.29	3.629	10	21	16.88	2.968

Scale Coded: 5=Strongly Disagree, 4=Disagree, 3=Neither, 2=Agree, 1=Strongly Agree

Table 4.6 Descriptive Statistics of Instructional Measurement Subscale C: Attitudes Towards Victims of Abuse

Subscale C: Attitudes Towards Victims Of Abuse (8 Items)	Pre-Training				Post-Training				Six Weeks Follow-Up			
	Min Score	Max Score	Mean Score	Std Dev	Min Score	Max Score	Mean Score	Std Dev	Min Score	Max Score	Mean Score	Std Dev
14. Women’s actions can be the cause of violence	2	5	3.83	.963	2	5	4.42	.776	2	5	4.33	.761
15. It’s understandable that a woman decides to stay in an abusive relationship because of her children’s need of a father	1	5	2.75	1.032	1	5	3.04	1.083	1	5	3.17	1.090
16. Events of IPV are normal amongst couples going through marital difficulties	2	5	4.25	.794	2	5	4.46	.721	1	5	4.29	1.122
17. Women’s emotional and economic dependence upon their partners leads to abuse	2	5	3.38	.970	2	5	3.67	1.239	1	5	3.58	1.100
18. In many cases the victim stays in the relationship because she doesn’t really want to change the present situation	2	5	3.37	1.135	2	5	3.46	1.250	1	5	3.71	1.083
19. IPV is a private matter that should be resolved primarily by the couple themselves	2	5	4.54	.721	4	5	4.67	.482	4	5	4.62	.495
20. I think in my practice there is not enough time to ask about IPV	4	5	4.46	.509	4	5	4.67	.482	1	5	4.33	.917
21. Women who have suffered IPV in the past tend to seek out abusive partners	1	5	2.37	1.013	1	5	2.63	1.209	1	5	2.29	1.083
Subscale C Composite Results (40 points possible)	20	35	28.96	3.862	24	40	31.00	4.118	21	40	30.33	4.082

Scale Coded: 5=Strongly Disagree, 4=Disagree, 3=Neither, 2=Agree, 1=Strongly Agree

Mean composite scores were highest for Subscale A and lowest for Subscale B. The percentage of the mean composite score to the maximum possible score for Subscale A was 81.35% at pre-training, 86.9% at post-training, and 87.93% six weeks later. The percentage of the mean composite score to the maximum possible score for Subscale B was 58.84% at pre-training, 69.16% at post-training, and 67.52% six weeks later. The percentage of the mean composite score to the maximum possible score for Subscale C was 72.40% at pre-training, 77.50% at post-training, and 75.83% six weeks later.

Repeated measures ANOVA was conducted to compare mean composite scores over time (Table 4.8) on each of the three Instructional Measurement Subscales at Time 1 (pre-training), Time 2 (post-training), and Time 3 (six weeks follow-up). Additionally, Wilks' Lambda, F-test statistic, and partial eta squared were reported for each of the subscales (Table 4.8). Results were significant and substantiated acceptance of the four hypotheses. For the *Confidence In Implementing Routine Enquiry* subscale, there was a significant positive effect over time [Wilks' Lambda=.663, $F(2, 22) = 5.603$, $p < .0005$, partial eta squared = .337]. For the *Attitudes Toward Routine Enquiry subscale*, there was a significant positive effect over time [Wilks' Lambda = .486, $F(2, 22) = 11.622$, $p < .0005$, partial eta squared = .514]. For the *Attitudes Toward Victims of Abuse* subscale, there was a significant positive effect over time [Wilks' Lambda = .743, $F(2, 22) = 3.883$, $p < .0005$, partial eta squared = .257].

Table 4.7 Summary of Instructional Measurement Subscales Composite Results

Subscale/Time Of Administration	Min Comp Score	Max Comp Score	Range	Mean Comp Score	Std Dev	Percentage of Mean Score to Max Score Possible
Subscale A: Confidence in Implementing Routine Enquiry (8 Items, 8 - 40 Points Possible, Range 32)						
Pre-Training Composite Results	25	40	15 (15/32 = 46.88%)	32.54	4.881	32.54/40 = 81.35%
Post-Training Composite Results	28	40	12 (12/32 = 37.50%)	34.79	3.647	34.79/40 = 86.98%
Six Weeks Follow-Up Composite Results	29	40	11 (11/32 = 34.38%)	35.17	3.559	35.17/40 = 87.93%
Subscale B: Attitudes Towards Routine Enquiry (5 Items, 5 - 25 Points Possible, Range 20)						
Pre-Training Composite Results	11	20	9 (9/20 = 45%)	14.71	2.678	14.71/25 = 58.84%
Post-Training Composite Results	12	25	13 (13/20 = 65%)	17.29	3.629	17.29/25 = 69.16%
Six Weeks Follow-Up Composite Results	10	21	11 (11/20 = 55%)	16.88	2.968	16.88/25 = 67.52%
Subscale C: Attitudes Towards Victims of Abuse (8 Items, 8 - 40 Points Possible, Range 32)						
Pre-Training Composite Results	20	35	15 (15/32 = 46.88%)	28.96	3.862	28.96/40 = 72.40%
Post-Training Composite Results	24	40	16 (16/32 = 50%)	31.00	4.118	31.00/40 = 77.50%
Six Weeks Follow-Up Composite Results	21	40	19 (19/32 = 59.34%)	30.33	4.082	30.33/40 = 75.83%

Table 4.8 Repeated Measures ANOVA of Instructional Measurement Subscales

Composite Scores

Subscale	Wilk's Lambda	F	df	Sig	Partial Eta Squared
Subscale A: Confidence In Implementing Routine Enquiry	.663	5.603	(2, 22)	.011	.337
Subscale B: Attitudes Towards Routine Enquiry	.486	11.622	(2, 22)	.001	.514
Subscale C: Attitudes Towards Victims Of Abuse	.743	3.803	(2, 22)	.038	.257

Paired samples Pearson correlations and dependent t-tests showed which pairs in each subscale were significant over time (Table 4.9). For each subscale, Pair 1 was composed of pre-training and post-training results; Pair 2 was composed of post-training and six weeks follow-up results; and Pair 3 was composed of pre-training and six weeks follow-up results. Pearson correlations showed moderate relationships among all pairs in both Subscale A: *Confidence in Implementing Routine Enquiry*; and, Subscale B: *Attitudes Towards Routine Enquiry*, all significant at the .05 level or higher. However, only the Pearson correlation for Pair 1 (pre-training with post-training) showed any relationship significance for Subscale C: *Attitudes Towards Victims of Abuse*, significant at the .05 level. Paired samples t-tests were calculated for Subscale A, Subscale B, and Subscale C to compare the mean pre-training score with the mean post-training score (Pair 1); to compare the mean post-training score with the mean six weeks follow-up score (Pair 2); and to compare the mean pre-training score with the six weeks follow-up score (Pair 3). Results were significant and supported acceptance of the four hypothesis.

For Subscale A: *Confidence Towards Routine Enquiry*, mean scores and standard deviations were as follows: pre-training = 32.54 (sd = 4.881); post-training = 34.79 (sd = 3.647); and six weeks follow-up = 35.17 (sd = 3.559). A significant increase was found from the pre-training to the post-training ($t(23) = -2.990, p < .05$); and from the pre-training to the six weeks follow-up ($t(23) = -3.225, p < .05$). No statistically significant difference was found from post-training to six weeks follow-up ($t(23) = -.579, p > .05$).

For Subscale B: *Attitudes Towards Routine Enquiry*, mean scores and standard deviations were as follows: pre-training = 14.71 (sd = 2.678); post-training = 17.29 (sd = 3.629); and six weeks follow-up = 16.88 (sd = 2.968). A significant increase was found from the pre-training to the post-training ($t(23) = -4.294, p < .001$); and from the pre-training to the six weeks follow-up ($t(23) = -4.344, p < .001$). No significant difference was found from post-training to six weeks follow-up ($t(23) = .774, p > .05$).

For Subscale C: *Attitudes Towards Victims of Abuse*, mean scores and standard deviations were as follows: pre-training = 28.96 (sd = 3.862); post-training = 31 (sd = 4.118); and six weeks follow-up = 30.33 (sd = 4.082). A significant increase was found from the pre-training to the post-training ($t(23) = -2.590, p < .05$). No significant differences were found from post-training to six weeks follow-up ($t(23) = .603, p > .05$) or from pre-training to six weeks follow-up ($t(23) = -1.510, p > .05$).

Cronbach's alpha reliability coefficient, was calculated to measure internal consistency of the items within each subscale for each of the three time points (Table 4.10). The closer the Cronbach's alpha reliability coefficient is to a value of 1.00, the better the internal consistency of the items within each subscale. Scales with less than 10 items have lower Cronbach's alpha values. Cronbach's alpha reliability coefficients for

Subscale A: *Confidence in Implementing Routine Enquiry* (8 items) were as follows: pre-training (.886); post-training (.863); and six weeks follow-up (.856). Cronbach's alpha reliability coefficients for Subscale B: *Attitudes Towards Routine Enquiry* (5 items) were as follows: pre-training (.586); post-training (.771); and six weeks follow-up (.536). Cronbach's alpha reliability coefficients for Subscale C: *Attitudes Towards Victims of Abuse* (8 items) were as follows: pre-training (.633); post-training (.650); and six weeks follow-up (.617).

Table 4.9 Instructional Measurement Subscales Paired Samples Summary

Subscale Correlation/Paired Sample (n=24)	Paired Samples		Paired Differences		Paired Samples Test		
	Pearson Correlation	Sig	Mean	Std Dev	t	df	Sig (2-tail)
Subscale A Correlations: Confidence in Implementing Routine Enquiry							
Pair 1 Pre Confidence with Post Confidence In Implementing Routine Enquiry	.661*	.0001	-2.250	3.686	-2.990	23	.007*
Pair 2 Post Confidence with 6 Weeks F-U Confidence In Implementing Routine Enquiry	.612*	.001	-.375	3.173	-.579	23	.568
Pair 3 Pre Confidence with 6 Weeks F-U Confidence In Implementing Routine Enquiry	.593*	.002	-2.625	3.987	-3.225	23	.004*
Subscale B Correlations: Attitudes Towards Routine Enquiry							
Pair 1 Pre Attitudes with Post Attitudes Towards Routine Enquiry	.600*	.002	-2.583	2.948	-4.294	23	.0001*
Pair 2 Post Attitudes with 6 Weeks F-U Attitudes Towards Routine Enquiry	.698*	.0001	.417	2.636	.774	23	.447
Pair 3 Pre Attitudes with 6 Weeks F-U Attitudes Towards Routine Enquiry	.630*	.001	-2.167	2.444	-4.344	23	.0001*
Subscale C Correlations: Attitudes Towards Victims Of Abuse							
Pair 1 Pre Attitudes with Post Attitudes Towards Victims Of Abuse	.533*	.007	-2.042	3.862	-2.590	23	.016*
Pair 2 Post Attitudes with 6 Weeks F-U Attitudes Towards Victims Of Abuse	.127	.555	.667	5.419	.603	23	.553
Pair 3 Pre Attitudes with 6 Weeks F-U Attitudes Towards Victims Of Abuse	.370	.075	-1.375	4.461	-1.510	23	.145

* Correlation is significant at the 0.05 level or better (2-tailed)

Critical value of *t* at the 95% CI=1.714 (1-tailed, df= 23), 2.069 (2-tailed, df=23)

Table 4.10 Instructional Measurement Subscales Item Analysis Over Time

Subscales/Time Of Administration	N Of Items	Cronbach's Alpha
Subscale A: Confidence in Implementing Routine Enquiry		
Pre-Training	8	.886
Post-Training	8	.863
Six Weeks Follow-Up	8	.856
Subscale B: Attitudes Towards Routine Enquiry		
Pre-Training	5	.586
Post-Training	5	.771
Six Weeks Follow-Up	5	.536
Subscale C: Attitudes Towards Victims of Abuse		
Pre-Training	8	.633
Post-Training	8	.650
Six Weeks Follow-Up	8	.617

Hypothesis Testing

All four hypotheses were tested as stated below. Overall, results of the hypotheses testing supported a positive evaluation for the selected standard IPV training program used in the study. Therefore the short term outcome for the study was also accomplished. The relationship of these findings to previous studies and the implications for future research are discussed in Chapter Five.

First Hypothesis. Results of the *Training Program Evaluation* were used to evaluate Hypothesis 1: There will be an overall increase in healthcare providers' perceived level of knowledge and cultural competence following participation in the FVPPF training program, *Improving the Health Care Response to Domestic Violence*

(Ganley, 1998). The minimum scores reported for all fifteen module objectives on the *Training Program Evaluation* varied from 2 (Disagree) to 3 (Neither) to 4 (Agree). However the maximum scores reported for all fifteen module objectives were greater than 4 (Agree), indicating the majority of participant responses clustered around the 4 (Agree) and 5 (Strongly Agree) rating options for each of the five training modules. Therefore, Hypothesis 1 was accepted.

Second Hypothesis. Results of the *Instructional Measurement Subscale A: Confidence in Implementing Routine Enquiry*, were used to address Hypothesis 2: There will be an overall increase in healthcare providers' perceived level of confidence (self-efficacy) in implementing routine enquiry following participation in the FVPF training program, *Improving the Health Care Response to Domestic Violence* (Ganley, 1998). The overall mean composite score for Subscale A increased from 32.54 at pre-training to 34.79 at post-training to 35.17 of 40 points possible at six weeks follow-up. These results were significant as previously indicated by repeated measures ANOVA and paired samples *t* tests. Therefore Hypothesis 2 was accepted.

Third Hypothesis. Results of the *Instructional Measurement Subscale B: Attitudes Towards Routine Enquiry*, were used to address Hypothesis 3: There will be an overall positive change in healthcare providers' attitudes towards routine enquiry following participation in the FVPF training program, *Improving the Health Care Resposne to Domestic Violence* (Ganley, 1998). The overall mean composite score for Subscale B increased from 14.71 at pre-training to 17.29 at post-training and then decreased to 16.88 points of 25 points possible at six weeks follow-up. However there was still an increase from pre-training (14.71) to six weeks later (16.88). These results

were significant as previously indicated by repeated measures ANOVA and paired samples *t* tests. Therefore Hypothesis 3 was accepted.

Fourth Hypothesis. Results of the *Instructional Measurement Subscale C: Attitudes Towards Victims Of Abuse*, were used to address Hypothesis 4: There will be an overall positive change in healthcare providers' attitudes towards victims of abuse following participation in the FVPF training program, *Improving the Health Care Response to Domestic Violence* (Ganley, 1998). The overall mean composite score for Subscale C increased from 28.96 at pre-training to 31 at post-training and then slightly decreased to 30.33 of 40 points possible at six weeks follow-up. These results were significant as previously indicated by repeated measures ANOVA and paired samples *t* tests. Therefore Hypothesis 4 was accepted.

Ancillary Findings

Correlations among demographic data were calculated. Participant age significantly correlated with "length of time employed by the Children First Program" (Spearman's rho = .532) at the .05 level ($p = .007$). Three items from the *Plunkett Demographic Questionnaire*, "length of time employed in your field", "length of time employed by the Children First Program" and participant "age" were correlated with the three Instructional Measurement Subscales using Spearman's rho correlation. "Length of time employed by the Children First Program" significantly correlated with pre-training scores on Subscale A: *Confidence in Implementing Routine Enquiry* (Spearman's rho=.613) at the .05 level ($p=.001$). All items on the Instructional Measurement Subscales were correlated with all items on the Program Evaluation Modules using Pearson correlations (Table 4.11). Two correlations indicated a possible relationship at

the .05 level including pre-training results in Subscale A (*Confidence in Implementing Routine Enquiry*) with the Program Evaluation Module 5 (Legal issues and community resources for IPV victims - Pearson $r = .440$) and post-training results in Subscale A with the Program Evaluation Module 1 (The dynamics of IPV and its impact on a victim's health - Pearson $r = .416$).

Table 4.11 Correlation of Instructional Measurement Subscales with Program Evaluation

Subscale/Time	Program Evaluation Module					
	PE-Mod 1 Dynamics Of IPV	PE-Mod 2 Cultural Competency	PE-Mod 3 Clinical Strategies	PE-Mod 4 Practical Applications	PE-Mod 5 Legal Issues & Resources	
Subscale A: Confidence in Implementing Routine Enquiry						
PreConf	r	.238	.096	.075	.277	.440*
	sig	.262	.656	.729	.190	.032
PostConf	r	.416*	-.024	.023	.199	.162
	sig	.043	.911	.915	.352	.450
6WkConf	r	.285	-.126	-.019	.136	.272
	sig	.176	.556	.930	.528	.199
Subscale B: Attitudes Towards Routine Enquiry						
PreAttEnq	r	.202	-.277	-.073	.020	-.032
	sig	.344	.189	.734	.925	.882
PostAttEnq	r	.334	-.396	-.119	-.076	-.091
	sig	.111	-.055	.580	.723	.671
6WkAttEnq	r	.306	-.166	-.074	-.130	-.195
	sig	.145	.438	.732	.545	.362
Subscale C: Attitudes Towards Victims Of Abuse						
PreAttAbuse	r	.059	-.243	-.251	-.124	-.029
	sig	.785	.253	.237	.564	.893
PostAttAbuse	r	.217	-.350	-.196	-.178	.017
	sig	.307	.094	.359	.406	.938
6WkAttAbuse	r	.124	-.397	-.099	.010	.031
	sig	.562	.055	.646	.962	.885

Correlation is significant at the 0.05 level

Chapter Five

Discussion of Findings

This researcher studied the effect of a national training curriculum on health care providers' perceived knowledge, cultural competence, confidence (self-efficacy), and attitudes as first responders to victims of IPV among women of childbearing age. For the purpose of the feasibility study the family violence literature including state of the research on IPV screening/ assessment and IPV training programs was reviewed. Despite the development of IPV training guidelines by The Joint Commission (TJC) and the Institute of Medicine (IOM), it was argued in the literature that there was insufficient evidence for the CDC to endorse implementation of routine IPV screening/ assessment and IPV training. However, it was found that routine IPV screening/ assessment was endorsed by multiple health care agencies and governing bodies. It was found that multiple IPV screening/ assessment instruments and IPV training programs have been developed; however, no gold standard for testing or comparison has emerged. On the basis of the overall literature review, it was concluded that the feasibility of a national curriculum to train health care providers in screening/ assessment for IPV had not been tested. The short term outcome of the feasibility study was a positive training program evaluation and the study addressed four hypotheses. Collectively, it was hypothesized that participation in educational training regarding IPV would increase health care providers' knowledge, cultural competence, confidence (self-efficacy), and attitudes related to identifying and responding to victims of IPV.

In order to address the four hypotheses statements, the following research was conducted. Twenty-three nurse home-visitors, and one social work intern, at the Children

First Program participated in a one-day IPV training program from 8 a.m. to 5 p.m. Participants were asked to complete three evaluative measures: The 11-item Plunkett Demographic Questionnaire (pre-training), a 15-item Training Program Evaluation (post-training), and a 21-item Instructional Measurement Subscales (pre-training, post-training, and six weeks follow-up). All items were numerically coded so the higher the score, the more favorable the response. All hypotheses were supported. Overall, findings of the feasibility study supported previous research: barriers to routine screening/ assessment for IPV can be overcome and that positive changes can persist over time as a result of participation in a standard IPV training program (Bacchus, et al., 2007; Brackley, 2008; Campbell, et al., 2001; Gadowski, et al., 2001; Hamberger, et al., 2004; Harwell, et al., 1998; Knapp, et al., 2006; Short, Hadley, & Bates, 2002; Thompson, et al., 2000; Wong, Wester, Mol, & Lagro-Janssen, 2006). The discussion of findings was organized in four sections: hypothesis statements; ancillary findings; limitations and strengths; and, summary and future research directives.

Hypothesis Statements

Hypothesis 1. There will be an overall increase in healthcare providers' perceived level of knowledge and cultural competence following participation in the FVPPF training program, *Improving the Health Care Response to Domestic Violence* (Ganley, 1998). The Training Program Evaluation was used to evaluate the hypothesis. The majority of participant responses clustered around the 4 (Agree) and 5 (Strongly Agree) rating options for each of the modules indicating participants perceived an overall increase in knowledge and cultural competence following participation in the training program. Consequently the short term outcome for a positive training program evaluation was also

implied by the percentage of mean composite score to the maximum composite score (91.9%) for all five modules combined. Module 2: *Cultural competency in responding to IPV victims* had the highest overall percentage range of minimum to maximum responses (75%) indicating participant responses to this module were most varied overall. Module 4: *Practical applications of screening, assessment, and intervention strategies* had the lowest overall percentage range of minimum to maximum responses (25%) indicating participant response to this module was least varied overall. However, the third objective, “Increase professionals’ use of culturally competent screening, assessment, and intervention procedures with IPV victims” had the lowest mean score (4.46) and highest standard deviation (.779) in Module 4, warranting additional attention in future training sessions. It is important to remember that cultural competence was integrated throughout all training modules and composite results of the *Training Program Evaluation* were significantly favorable. However, as noted in Chapter Four, partially disappointing results of Modules 2 and 4 may be explained by the fact that allotted time for role play and practical application was limited. Participants’ narrative comments at the end of the Training Program Evaluation were positive regarding learning to use the Abuse Assessment Screen (AAS) and Danger Assessment (DA) tools; knowledge of local resources; use of videos and case studies; and integration of facts about IPV with communication techniques for improved responses to victims of IPV. Findings supported predictions made by the application of Bandura’s self-efficacy framework that is based on one’s judgements of how well one can perform certain skills (Bandura, 1977a 1977b, 1982). Participants’ favorable perceptions of post-training and six weeks follow-up measures of confidence (self-efficacy) and attitudes towards routine enquiry on the

Instructional Measurement Subscales implied increased knowledge and cultural competence as measured by the Training Program Evaluation.

Participants also verbally requested additional resources related to training in the use of the Danger Assessment (DA) tool and culturally specific health care resources to supplement what was already provided in the training program. A handout with a list of professional websites regarding certification in the use of the DA and culturally specific health care resources was provided at the six weeks follow-up session. These findings are consistent with the literature review about the cultural context of IPV being one of the most challenging in successful prevention and intervention of IPV (Dutton, 1992; FVVPF, 2004; McFarlane, Parker, & Moran, 2007).

Hypothesis 2. There will be an overall increase in healthcare providers' perceived level of confidence in implementing routine enquiry following participation in the training program, *Improving the Health Care Response to Domestic Violence* (Ganley, 1998). The hypothesis was evaluated by *Instructional Measurement Subscale A* (Items 1-8), named *Confidence in Implementing Routine Enquiry* (Appendix I). Mean scores at pre-training were greater than 4 (Agree) with the exception of item 6, "I am confident that dealing with disclosures of abuse won't produce any emotional distress for me," and item 7, "I am confident I can manage to see clients alone without their partners/ family prior to asking about IPV". The mean score for item 6 improved but remained less than 4 (Agree) at post-training and improved to greater than 4 (Agree) six weeks later. The mean score for item 7 improved to greater than 4 (Agree) at post-training and again six weeks later. Composite results for Subscale A imply that participants' perceived level of *Confidence in Routine Enquiry* was primarily positive prior to training and continued to

improve following participation in the training. Results for statements 6 and 7 are consistent with the literature findings regarding barriers and myths (Elliot, Nerney, Jones, & Friedman, 2002; Ellis, 1999; Gadowski, et al., 2001; Lazenblatt, Thompson & McMurray, 2005).

Hypothesis 3. There will be an overall positive change in healthcare providers' attitudes towards routine enquiry following participation in the FVPPF training program, *Improving the Health Care Response to Domestic Violence* (Ganley, 1998). The hypothesis was measured by *Instructional Measurement Subscale B* (Items 9-13), named *Attitudes Towards Routine Enquiry* (Appendix I). There was overall improvement in participants' *Attitudes Towards Routine Enquiry* from the pre-training to the post-training to the six weeks follow-up. However, participants' responses to the five items in Subscale B had lower mean scores across all time points in general, especially when compared with participant responses on Subscales A and C, suggesting that *Attitudes Towards Routine Enquiry* are generally more negative and possibly more difficult to change. Item 9, "If asked, most clients who are currently in an abusive relationship will deny everything," had mean scores including 2.75 (pre-training), 3.13 (post-training), and 3.13 (six weeks later). Item 10, "Asking about IPV may seem offensive to most clients," had mean scores including 3.25 (pre-training), 3.71 (post-training), and 3.42 (six weeks later). Item 11, "Clients' different cultural beliefs and values can impede asking about IPV," had mean scores including 2.33 (pre-training), 2.75 (post-training), and 3.00 (six weeks later). Item 12, "Routine enquiry will probably result in abusive partner directing their violence towards health care providers," had mean scores including 3.83 (pre-training), 4.21 (post-training), and 3.83 (six weeks later). Item 13, "Routine enquiry can

put abused clients in more danger,” had mean scores including 2.54 (pre-training), 3.50 (post-training), and 3.50 (six weeks later). These results are congruent with the current debate among providers and researchers regarding endorsement of routine screening for victims of IPV (FVVPF, 2009; MacMillan, et al., 2009; McFarlane, Parker, & Moran, 2007; Moracco & Cole, 2009; Bell & Orcutt, 2009; USPSTF, 2004).

Hypothesis 4. There will be an overall positive change in healthcare providers’ attitudes towards victims of abuse following participation in the FVVPF training program, *Improving the Health Care Response to Domestic Violence* (Ganley, 1998). The hypothesis was measured by *Instructional Measurement Subscale C* (Items 14-21), named *Attitudes Towards Victims Of Abuse* (Appendix I). Mean scores across all time points indicated participants disagreed (favorably responded) with four items in Subscale C including:

- Item 14, “Women’s actions can be the cause of violence.”,
- Item 16, “Events of IPV are normal amongst couples going through marital difficulties.”,
- Item 19, “IPV is a private matter that should be resolved primarily by the couple themselves.”, and,
- Item 20, “I think in my practice there is not enough time to ask about IPV.”

In contrast, mean scores across all time points were low on the remaining four items in Subscale C, indicating participants agreed (unfavorably responded) with the following:

- Item 15, “It’s understandable that a woman decides to stay in an abusive relationship because of her children’s need of a father.”,
- Item 17, “Women’s emotional and economic dependence upon their partners leads to abuse.”,
- Item 18, “In many cases the victim stays in the relationship because she doesn’t really want to change the present situation.”, and,
- Item 21, “Women who have suffered IPV in the past tend to seek out abusive partners.”

It is important to note that items 15, 17, 18, and 21 are all related to the most pervasive myth among health care providers and the victims themselves, that the victim is the one to blame for the IPV. Review of the literature clearly supports that the perpetrator is the one responsible for the IPV (Campbell, Moracco, & Saltzman, 2000; Dutton, 1992; Dutton, 1995; McFarlane, Parker, & Moran, 2007). Health care providers and victims must be educated to collaborate across disciplines to hold perpetrators accountable to stop the cycle of violence (Campbell, Moracco, & Saltzman, 2000; Dutton, 1992; Dutton, 1995; McFarlane, Parker, & Moran, 2007). Meanwhile, victims of IPV must be empowered to seek care for injuries and to implement a safety plan to prevent future trauma (Dutton, 1992; McFarlane, et al., 1997; McFarlane & Parker, 1994a, 1994b; McFarlane, Parker, & Moran, 2007; McFarlane, Parker, Soeken, & Bullock, 1992; McFarlane, Soeken, & Wiist, 2000). One possible explanation for the negative results on these statements is simply that the most pervasive myth regarding blaming the victim of IPV may also be the most difficult to change. A second explanation is that participants may have misinterpreted the wording of the statements. Lastly, there may have been some participants who were victims of IPV and responded to these statements from a personal perspective of self-blame that is common among IPV victims. The Plunkett Demographic Questionnaire contained no items related to participants' previous professional or personal experiences with IPV victimization, which may have posed a risk for a personal sense of vulnerability. However, given the general knowledge that 1 in 4 women experience IPV in their lifetimes (BJS, 2001), it was plausible there were approximately six victims of IPV among the all female sample (n = 24), negatively skewing the outcome of Subscale C.

Ancillary Findings

Non-parametric testing using Spearman's rho revealed a significant correlation between participants' age and the length of employment by the Children First Program. The older the participant the longer they were employed by the Children First Program, suggesting employees experienced job satisfaction and were loyal to their employer as evidenced by their longevity. Length of time employed by the Children First Program significantly correlated with pre-training scores on Subscale A: *Confidence in Implementing Routine Enquiry*. The longer the participant had been employed by the Children First Program, the more positive their pre-training perception of confidence (self-efficacy) in routine enquiry for IPV. However, individual scores for these participants revealed that while their responses on Subscale A remained favorable, their scores slightly decreased over time. The findings imply participants who were employed longer may have been confident initially, and later realized they may not have known as much as they originally perceived. Additionally, Pearson's correlations identified possibly significant relationships between Subscale A pre-training results and the Training Program Evaluation Module 5, *Legal Issues and Community Resources for IPV Victims*; and between Subscale A post-training results and the Training Program Evaluation Module 1, *The Dynamics of IPV and its Impact on a Victim's Health*. These findings further support the notion that some participants may have been over confident prior to the training but that ultimately, learning occurred following participation in the training program.

Limitations and Strengths

Findings of the literature review regarding specific IPV training program research studies should be interpreted in light of the following limitations. Despite the researcher's attempts at conducting a systematic search, it is possible that eligible papers were excluded. Determining eligibility criteria was subject to the researcher's bias. However multiple data bases and search strategies were implemented to reduce the risk of such bias. Given the use of multiple search strategies undertaken to identify the ten IPV training program studies discussed in Chapter Two, it is noteworthy that there were important differences in the way the studies were listed by medical subject headings (MeSH), key words, or a complete lack of specific search identification terms. The possible omissions may have contained elements crucial to the success of a training program.

Limitations of the feasibility study may have included at least four factors: economic, educational and racial disparities related to geographic location, small sample size, time constraint for the presentation, and the fact that all participants were employed by a nurse home-visitation program specifically targeting low-income first time mothers. Economic, educational, and racial disparities of the sample, in comparison with the general population of nurses working with at-risk first-time pregnant mothers is a limitation. While the demographics of the general population are unknown, one may assume that the demographics of the feasibility study sample do not match those of the general population. In fact, economic, educational and racial factors may not have the influence that professional and personal experience with IPV might have had on the results of the study. The second limitation was sample size. The sample population was

small (n = 24) and limited to participants employed by the Children First Program, preventing generalizability to other populations. The third limitation was time constraint for the presentation. The FVPF training program, *Improving the Health Care Response to Domestic Violence* (Ganley, 1998), consisted of five modules, each designed to be presented over 90 minutes but no less than 45 minutes. The feasibility study was limited to 60 minutes for each module presentation. To maximize time, the *Voices of Survivors* DVD and *Screen to End Abuse* DVD were viewed during lunch after all participants had time for a restroom break, had selected their food, and returned to their seats in the auditorium. The researcher observed that participants attentively listened and watched the videos indicating commitment to the “working lunch” period as part of the training program agenda. Effects of time constraints were evident in the previous discussion of study results related to each of the four hypotheses. Overall, participants’ written comments on the *Training Program Evaluation* indicated a desire for more practice in use of the *Abuse Assessment Screen* and the *Danger Assessment* tool. Despite the time constraints, results suggested that participants were engaged in the one-day training. Furthermore, there was evidence of improved perception of knowledge, cultural competence, confidence (self-efficacy) and attitudes toward identifying and responding to IPV victims that was sustained from pre-training to six weeks later. This finding indicated that the one-day training was a viable alternative and may even be preferred when compared with the time required for the two-day training.

Participants verbalized multiple group and individual expressions of gratitude throughout the day for the researcher’s time and presentation, indicating they were eager and appreciative for the IPV training program opportunity. There was no mortality

(drop-out) noted. All participants completed the entire day of training and were present for the six weeks follow-up session. Additionally all participants correctly recorded their self-selected, six-digit identification number resulting in 24 completely matched sets of evaluation instruments. The researcher observed that participants utilized the full allotted time for completion of the study instruments. Furthermore, visual inspection of the completed study instruments revealed that all participants' responses had individual check marks on the forms for each of the items. Participants' use of the allotted time to complete the forms combined with the absence of any continuous or "running" tally marks down a single column or multiple responses for any of the instrument items, implied that participants made thoughtful responses and suffered no test-fatigue.

Future Research Directives

The feasibility study found that a one day IPV training curriculum using teaching methods focused on improving knowledge and cultural competence, and attitudes and building confidence (self-efficacy) in skills regarding routine enquiry for IPV was well accepted by participants. Family violence researchers have progressed in the use of standard definitions for family violence, including IPV. Results of the feasibility study are consistent with those presented by previous training studies in the review of the IPV training program research (Bacchus, et al., 2007; Brackley, 2008; Campbell, et al., 2001; Gadowski, et al., 2001; Hamberger, et al., 2004; Harwell, et al., 1998; Knapp, et al., 2006; Short, Hadley, & Bates, 2002; Thompson, et al., 2000; Wong, Wester, Mol, & Lagro-Janssen, 2006).

The feasibility study employed a sample of convenience. Implications for future studies would include recruiting more subjects to allow for more in-depth analysis and

generalizeability to diverse populations. The researcher should consider recruiting a more diverse population from multiple areas of the United States in order to account for potential economic, educational and racial disparities and/ or biases. Sample size may be increased by recruiting professional employees from additional health care facilities including both inpatient and outpatient. Increasing time for the presentation from sixty minutes to ninety minutes per training module would allow for more interactive participation and greater opportunity to role play application of the Abuse Assessment Screen and Danger Assessment instruments. The researcher also recommends increasing the follow-up measure from six weeks to at least six months or one year. Future studies with larger, random samples, are needed to confirm the results of the feasibility study. The feasibility study suggested that the FVPPF training program, *Improving the Health Care Response to Domestic Violence* (Ganley, 1998), promoting implementation of the *National Consensus Guidelines On Identifying and Responding to Domestic Violence Victimization* (FVPPF, 2004), has the potential to effect health care providers' perceptions of knowledge, cultural competence, confidence (self-efficacy) and attitudes related to identification and responding to IPV victims. Given a larger, more diverse, sample the researcher could perform more rigorous data collection and analysis including psychometric testing of instruments and regression analyses of participant responses to evaluative measurement instruments, exploring for potential contextual relationships. Field notes of the feasibility study revealed a need for additional emphasis on provision of culturally specific health care resources; further exploration of participants' initial and ongoing training regarding IPV victims; and personal experiences with victimization or perpetration.

Since the feasibility study was conducted, new publications have emerged fueling the controversial debate among family violence researchers regarding implementation of routine screening/ assessment and training programs for IPV (FVVPF, 2009; MacMillan, et al., 2009; Moracco & Cole, 2009; Bell & Orcutt, 2009). Both clinical practice and research are impeded by the lack of conclusive evaluation of the psychometric properties of existing IPV screening/ assessment instruments and lack of randomized clinical trials involving known IPV training programs. Ongoing research testing the efficacy of a standard IPV training program on health care providers' perceived level of knowledge, cultural competence, confidence (self-efficacy) and attitudes related to identifying and responding to victims of IPV, among diverse populations, is needed to establish gold standards of comparison for IPV screening/ assessment instruments and IPV training programs to settle the debate. Future studies are needed to compare the feasibility of one-day versus two-day training sessions with booster group sessions and follow-up for sustainability of changes at varied time intervals (i.e. six months, 1 year, 2 years). Ultimately, the impact of such intervention research must be considered in terms of its effectiveness multiplied by the breadth of health care providers trained and IPV victims served.

Implications for Nursing Education and Practice

The FVVPF IPV training program provides a comprehensive overview of core content regarding IPV that nurse educators could use to introduce and engage students in application of concepts of care for victims of IPV (Ganley, 1998). Results of this feasibility study also support use of the *National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization* (FVVPF, 2004). Ongoing quantitative

and qualitative research regarding IPV training is needed to facilitate development of clinical simulation scenarios, case studies, online training modules, and the availability of electronic resources at the point-of-care (i.e. online screening and assessment instruments, safety templates, advocacy and referral resources). In recent years, there has been a call for reform, promoting quality and safety in education for nurses (QSEN), (Cronenwett, et al., 2007; Diekelmann & Diekelmann, 2009; Finkelman & Kenner, 2009; IOM, 2001, 2002, 2003). Additionally, key initiatives and regulatory agencies have emphasized the integration of health information technology into the nursing curriculum (NCSBN, 2010; NLN, 2008; NLN-AC, 2008; TIGER, 2006). Diekelmann and Diekelmann (2009) have also promoted reform in nursing education through the use of narrative pedagogy and nine concernful practices: presencing, assembling, gathering, caring, listening, interpreting, inviting, questioning, retrieving, and preserving (p. 343). Collectively, these trends in nursing education and practice suggest that nurses have an extended role and versatile capacity to serve as first responders to victims of IPV via telehealth services and service learning in addition to caring for victims of IPV in acute care clinics and nurse-family partnership programs. Ultimately, this researcher aspires to collaborate with the FVPPF in the development of an online IPV training program based on Ganley's original IPV training curriculum (1998) that was used in the feasibility study.

Appendices

Appendix A

Elements of Performance for the Revised JCAHO Standard PC.3.10

www.jointcommission.org and www.endabuse.org

1. The organization develops or adopts criteria for identifying victims in each of the following situations: (physical assault, rape, sexual molestation, domestic abuse, elder neglect or abuse, and child neglect or abuse).
2. Staff is educated about abuse and neglect and how to refer as appropriate.
3. A list of private and public community agencies that provide or arrange for assessment and care of abuse victims is maintained to facilitate appropriate referrals.
4. Victims of abuse or neglect are identified using criteria developed or adopted by the organization at entry into the system and on an ongoing basis.
5. The organization's staff refers appropriately or conducts the assessment of victims of abuse or neglect.
6. All cases of possible abuse, neglect, or exploitation are reported to appropriate agencies according to organization policy and law and regulation.
7. All cases of possible abuse, neglect, or exploitation are immediately reported in the organization.

Appendix B

IOM Recommendations for IPV Training (Cohn, Salmon, & Stobo, 2002):

Recommendation 1: The secretary of the U. S. Department of Health and Human Services should be responsible for establishing new multidisciplinary education and research centers with the goal of advancing scholarship and practice in family violence. These centers should be charged with conducting research on the magnitude and impact of family violence on society and the health care system, conducting research on training, and addressing concerns regarding the lack of comparability in current research. The ultimate goal of these centers will be to develop training programs based on sound scientific evidence that prepare health professionals to respond to family violence (p. 152).

Recommendation 2: Health professional organizations-including but not limited to the Association of American Medical colleges, the American Medical Association, the American College of Physicians, the American Association of Colleges of Nursing, the Council on Social Work Education, the American Psychological Association, and the American Dental Association-and health profession educators-including faculty in academic health centers-should develop and provide guidance to their members, constituents, institutions, and other stakeholders. This guidance should address: (1) competency areas for health professional curricula on family violence, (2) effective strategies to teach about family violence, (3) approaches to overcoming barriers to training on family violence, and (4) approaches to promoting and sustaining behavior changes by health professionals (p. 156).

Recommendation 3: Health care delivery systems and training settings, Particularly academic health care centers and federally qualified health clinics and community health centers, should assume greater responsibility for developing, testing, and evaluating innovative training models or programs (p. 157).

Recommendation 4: Federal agencies and other funders of education programs should create expectations and provide support for the evaluation of curricula on family violence for health professionals. Curricula must be evaluated to determine their impact on the practices of health professionals and their effects on family violence victims. Evaluation must employ rigorous methods to ensure accurate, reliable, and useful results (p. 158).

Appendix C



IUPUI and Clarian IRB and Subcommittees Reviews
Indianapolis, Indiana

February 9, 2009

Dear Reviewers:

This letter is to confirm that Sarah E. Plunkett has been granted approval for her dissertation feasibility study at the Tulsa Health Department, Children First Program, in Tulsa, Oklahoma. We have received a copy of her dissertation prospectus and presentation overview. Mrs. Plunkett's proposed study has been reviewed by our administrative office and she has our full support. Pending final approval by the IUPUI and Clarian IRB. Mrs. Plunkett is tentatively scheduled to present the National Consensus Guidelines on Identifying and Responding to Domestic Victimization in March on a regularly scheduled training day for our Children First Program nurses. She is also tentatively scheduled to return in April for a brief six-week follow-up with these same nurses. We look forward to the opportunity of participating in this study.

Sincerely,

Cathy Sullivan, RN
Tulsa Health Department
Children First Program, Manager



INDIANA UNIVERSITY

OFFICE OF RESEARCH ADMINISTRATION

Date: February 26, 2009

To: Dr. Janice Buelow
Nursing
NU 415

From: Regina Winger
Research Compliance Administration, IUPUI
UN 618

Subject: IUPUI/Clarian Institutional Review Committee - Exempt Review of
Human Study

Study Number: EX0902-62B

Study Title: "Does Participation in Education Regarding Intimate Partner Violence
Increase Nurses' Self-Efficacy Related to Identifying and Responding to
Victims of Intimate Partner Violence"

Your application for approval of the study named above has been accepted as meeting the criteria of exempt research as described by Federal Regulations [45 CFR 46.101(b), paragraph 2]. A copy of the acceptance is enclosed for your file.

Although a continuing review is not required for an exempt study, prior approval must be obtained before change(s) to the originally approved study can be initiated. When you have completed your study, please inform our office in writing.

If the research is conducted at or funded by the VA, research may not be initiated until approval is received from the VA Research and Development Committee.

Please contact the Office of Health Care Billing and HIPAA Programs at 317-278-4891 for information regarding a Data Use Agreement, if applicable.

Enclosures: Copy of acceptance

Appendix D
Abuse Assessment Screen

www.nnvawi.org

1. **WITHIN THE LAST YEAR**, have you been hit, slapped, kicked, or otherwise physically hurt by someone? YES NO

If YES, by whom? _____

Total number of times _____

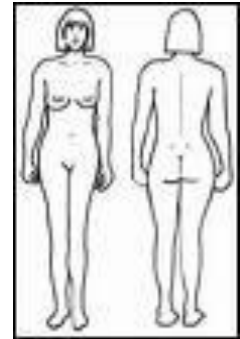
2. **SINCE YOU'VE BEEN PREGNANT**, have you been hit, slapped, kicked, or otherwise physically hurt by someone? YES NO

If YES, by whom? _____

Total number of times _____

MARK THE AREA OF INJURY ON THE BODY MAP SCORE EACH INCIDENT ACCORDING TO THE FOLLOWING SCALE:

- 1 = Threats of abuse including use of a weapon
- 2 = Slapping, pushing; no injuries and/or lasting pain
- 3 = Punching, kicking, bruises, cuts and/or continuing pain
- 4 = Beating up, severe contusions, burns, broken bones
- 5 = Head injury, internal injury, permanent injury
- 6 = Use of weapon; wound from weapon



If any of the descriptions for the higher number apply, use the higher number.

3. **WITHIN THE LAST YEAR**, has anyone forced you to have sexual activities? YES NO

If YES, by whom?

Total number of times _____

Developed by the Nursing Research Consortium on Violence and Abuse. Readers are encouraged to reproduce and use this assessment tool.

Appendix E
Danger Assessment (DA) tool
J. Campbell, © 2003, www.dangerassessment.org

Several risk factors have been associated with increased risk of homicides (murders) of women and men in violent relationships. We cannot predict what will happen in your case, but we would like you to be aware of the danger of homicide in situations of abuse and for you to see how many of the risk factors apply to your situation.

Using the calendar, please mark the approximate dates during the past year when you were abused by your partner or ex partner. Write on that date how bad the incident was according to the following scale:

1. Slapping, pushing; no injuries and/or lasting pain
2. Punching, kicking; bruises, cuts, and/or continuing pain
3. "Beating up"; severe contusions, burns, broken bones
4. Threat to use weapon; head injury, internal injury, permanent injury
5. Use of weapon; wounds from weapon

(If **any** of the descriptions for the higher number apply, use the higher number.)

Mark **Yes** or **No** for each of the following. ("He" refers to your husband, partner, ex-husband, expartner, or whoever is currently physically hurting you.)

- ___ 1. Has the physical violence increased in severity or frequency over the past year?
- ___ 2. Does he own a gun?
- ___ 3. Have you left him after living together during the past year?
3a. (If have *never* lived with him, check here___)
- ___ 4. Is he unemployed?
- ___ 5. Has he ever used a weapon against you or threatened you with a lethal weapon? (If yes, was the weapon a gun?___)
- ___ 6. Does he threaten to kill you?
- ___ 7. Has he avoided being arrested for domestic violence?
- ___ 8. Do you have a child that is not his?
- ___ 9. Has he ever forced you to have sex when you did not wish to do so?
- ___ 10. Does he ever try to choke you?
- ___ 11. Does he use illegal drugs? By drugs, I mean "uppers" or amphetamines, "meth", speed, angel dust, cocaine, "crack", street drugs or mixtures.
- ___ 12. Is he an alcoholic or problem drinker?
- ___ 13. Does he control most or all of your daily activities? For instance: does he tell you who you can be friends with, when you can see your family, how much money you can use, or when you can take the car? (If he tries, but you do not let him, check here: ___)
- ___ 14. Is he violently and constantly jealous of you? (For instance, does he say "If I can't have you, no one can.")
- ___ 15. Have you ever been beaten by him while you were pregnant? (If you have never been pregnant by him, check here: ___)
- ___ 16. Has he ever threatened or tried to commit suicide?
- ___ 17. Does he threaten to harm your children?
- ___ 18. Do you believe he is capable of killing you?
- ___ 19. Does he follow or spy on you, leave threatening notes or messages on answering machine, destroy your property, or call you when you don't want him to?
- ___ 20. Have you ever threatened or tried to commit suicide?

- ___ Total "Yes" Answers

Thank you. Please talk to your nurse, advocate or counselor about what the Danger Assessment means in terms of your situation.

Appendix F
Improving The Health Care Response to Domestic Violence: A Training Program

Module	Goals And Objectives	Teaching/Learning Strategies
I. The dynamics of IPV and its impact on a victim's health. (Addressed knowledge, cultural competence, and attitudes).	<ol style="list-style-type: none"> 1. Establish that IPV is a primary health issue facing clients, their families, and health care professionals. 2. Correct misinformation about IPV that typically blocks effective responses by health care professionals, and introduce the definitions and causes of IPV, as well as perpetrator and victim issues. 3. Illustrate the importance of developing and implementing culturally appropriate responses to IPV. 4. Provide brief, concrete examples of changes in professionals' and health systems' approaches that can be made to improve the response to IPV victims. 5. Motivate health care professionals to improve their response to IPV victims and their children. 	<p>Presentation of specific facts and information: PowerPoint and handout</p> <p>Talking points for dialogue, Q & A</p>
II. Cultural competency in responding to IPV victims. (Addressed knowledge and cultural competence).	<ol style="list-style-type: none"> 1. Define the terms "culture" and "cultural competency" as they apply to IPV. 2. Increase health care professionals' awareness of culture and how to interact within different cultural perspectives when responding to IPV victims. 3. Provide a practice model that promotes a response to IPV that is free of discrimination and committed to cultural competency. 	<p>Presentation of specific facts and information: PowerPoint and handout</p> <p>Case studies and personal stories</p> <p>Talking points for dialogue, Q & A</p>
III. Specific clinical strategies for IPV screening, assessment, intervention, and documentation. (Addressed knowledge, cultural competence, and confidence).	<ol style="list-style-type: none"> 1. Review with health care professionals that IPV is a significant health issue requiring response from the health care system. 2. Educate professionals about simple, concrete, culturally appropriate ways to improve their response to IPV victims through routine screening, assessment, intervention, and documentation. 	<p>Visual experience: <i>Voices of Survivors</i> DVD and <i>Screen to End Abuse</i> DVD (during lunch prior to this module)</p> <p>Presentation of specific facts and information: PowerPoint and handout</p> <p>Demonstration, role play and reflection</p> <p>Talking points for dialogue, Q & A</p>

Appendix F continued
 Improving The Health Care Response to Domestic Violence: A Training Program

Module/Topic	Goals And Objectives	Teaching/Learning Strategies
IV. Practical applications of screening, assessment, and intervention strategies. (Addressed knowledge, cultural competence, confidence and attitudes).	1. Provide models of effective screening, assessment, and intervention procedures for responding to IPV victims. 2. Provide an educational setting where participants have the opportunity to apply their knowledge about IPV and cultural issues to case examples. 3. Increase professionals' use of culturally competent screening, assessment, and intervention procedures with IPV victims.	Presentation of Specific Facts and Information PowerPoint Handout Demonstration, role play and reflection Talking points for dialogue, Q & A
V. Legal issues and community resources for IPV victims as well as the legal and reporting issues for health care professionals. (Addressed knowledge, cultural competence, confidence and attitudes).	1. Increase awareness of the legal options available to IPV victims so health care professionals can discuss these with clients and facilitate their access to potentially lifesaving recourses. 2. Review legal requirements and considerations for health care professionals and institutions that may be important for the care of victims of IPV and the practice of good risk management.	Presentation of Specific Facts and Information PowerPoint Handout Demonstration, Role Play and Reflection Talking Points for Dialogue, Q & A

Appendix G

Training Program Agenda

Improving the Health Care Response to Domestic Violence (Ganley, 1998)
promoting implementation of the *National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization* (FVPPF, 2004)

A One-Day Workshop
Presented By Sarah E. Plunkett, PhD(c), RNC-NIC, CNS, CNE
For The
Tulsa Health Department, Children First Program
March 2, 2009

08:00-09:00 AM	Check-In (Light Breakfast)
09:00-09:15 AM	WELCOME!
	Complete Study Forms Plunkett Demographic Questionnaire Instructional Measurement Subscales (pre-training)
09:15-10:15 AM	<u>Module 1:</u> The dynamics of IPV and its impact on a victim's health
10:15-10:30 AM	Break
10:30-11:30 AM	<u>Module 2:</u> Cultural competency in responding to IPV victims
11:30-12:45 PM	Lunch Provided (Enjoy!) (Watch Videos: Voices Of Survivors & Screen To End Abuse)
12:45-01:45 PM	<u>Module 3:</u> Specific clinical strategies for IPV screening, assessment, interventions, and documentation
01:45-02:45 PM	<u>Module 4:</u> Practical applications of screening, assessment, and intervention strategies
02:45-03:00 PM	Break (Light Refreshments)
03:00-04:00 PM	<u>Module 5:</u> Legal issues and community resources for IPV victims
04:00-05:00 PM	WRAP-UP: Question/Answer Time & Thank-You!
	Complete Study Forms Training Program Evaluation Instructional Measurement Subscales (post-training)

Appendix H
Plunkett Demographic Questionnaire (Thank You!)

1. Professional Title: _____
2. Role At The Children First Program: _____
3. Are You Employed: _____ Full Time _____ Part Time (_____ hrs/wk)
4. Educational Degree (s): Year Of Attainment:

5. Professional Certification (s): *(if applicable)* _____

6. Length Of Time Employed In Your Field: *(months or years)* _____
7. Length Of Time Employed By The Children First Program:

_____ Less than 6 months _____ 6 months to 1 year
_____ Between 1 & 5 years _____ Between 5 & 10 years
_____ Between 10 & 15 years _____ Between 15 & 20 years
_____ Between 20 & 25 years _____ Student/Intern
8. What Is Your Age In Years:

_____ 20-25 years _____ 26-30 years
_____ 31-35 years _____ 36-40 years
_____ 41-45 years _____ 46-50 years
_____ 51-55 years _____ 56-60 years
_____ 61-65 years _____ 66-70 years
_____ 71-75 years _____ 76-80 years
9. What Is Your Gender: _____ Female _____ Male
10. What Is Your Race:
_____ Black
_____ White
_____ Hispanic
_____ Native American
_____ Asian
_____ Other
11. Is there anything else you want me to know about you or your work in The Children First Program? (Please use back of page if needed)

Appendix I

Training Program Evaluation

Improving the Health Care Response to Domestic Violence (Ganley, 1998), promoting implementation of the *National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization* (FVVPF, 2004)

Sarah E. Plunkett, PhD(c), RNC-NIC, CNS, CNE
IUPUI, Doctoral Dissertation Study
Monday, March 2, 2009

Please select one response to evaluate how well the training met each of the objectives.	1 Strongly Disagree	2 Disagree	3 Neutral	4 Agree	5 Strongly Agree	N/A
Module 1: The dynamics of IPV and its impact on a victim's health						
1. Establish that IPV is a primary health issue facing clients, their families, and health care professionals.						
2. Correct misinformation about IPV that typically blocks effective responses by health care professionals, and introduce the definitions and causes of IPV, as well as perpetrator and victim issues.						
3. Illustrate the importance of developing and implementing culturally appropriate responses to IPV.						
4. Provide brief, concrete examples of changes in professionals' and health systems' approaches that can be made to improve the response to IPV victims.						
5. Motivate health care professionals to improve their response to IPV victims and their children.						
Module 2: Cultural competency in responding to IPV victims						
1. Define the terms "culture" and "cultural competency" as they apply to IPV.						
2. Increase health care professionals' awareness of culture and how to interact within different cultural perspectives when responding to IPV victims.						
3. Provide a practice model that promotes a response to IPV that is free of discrimination and committed to cultural competency.						
Please select one response to evaluate how well the training met each of the objectives.	1	2	3	4	5	N/A

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	
Module 3: Specific clinical strategies for IPV screening, assessment, intervention, and documentation						
1. Review with health care professionals that IPV is a significant health issue requiring response from the health care system.						
2. Educate professionals about simple, concrete, culturally appropriate ways to improve their response to IPV victims through routine screening, assessment, intervention, and documentation.						
Module 4: Practical applications of screening, assessment, and intervention strategies						
1. Provide models of effective screening, assessment, and intervention procedures for responding to IPV victims.						
2. Provide an educational setting where participants have the opportunity to apply their knowledge about IPV and cultural issues to case examples.						
3. Increase professionals' use of culturally competent screening, assessment, and intervention procedures with IPV victims.						
Module 5: Legal issues and community resources for IPV victims						
1. Increase awareness of the legal options available to IPV victims so health care professionals can discuss these with clients and facilitate their access to potentially lifesaving resources.						
2. Review legal requirements and considerations for health care professionals and institutions that may be important for the care of victims of IPV and the practice of good risk management.						

Comments: _____

Appendix J
Instructional Measurement Subscales For Measuring

Confidence In Implementing Routine Enquiry, Attitudes Toward Routine Enquiry and Attitudes Towards Victims Of Abuse

(administered at pre-training, post-training, and six weeks follow-up)

Please Respond To Each Of The Following Statements					
Confidence in implementing routine enquiry	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree
1. I am comfortable talking with clients who tell me they are being abused by their partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I am confident I can document intimate partner violence accurately and confidentially	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I am confident I can make the necessary referrals to help female victims	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I am confident I will not react adversely towards partners I know are abused	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I am confident I have the necessary communication skills to facilitate women disclosing their experiences of intimate partner violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I am confident that dealing with disclosures of abuse won't produce any emotional distress for me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I am confident I can manage to see clients alone without their partners/ family prior to asking about intimate partner violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I feel comfortable asking my patients about partner abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please Respond To Each Of The Following Statements

Attitudes towards routine enquiry	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree
9. If asked, most clients who are currently in an abusive relationship will deny everything	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Asking about intimate partner violence may seem offensive to most clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Clients' different cultural beliefs and values can impede asking about intimate partner violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Routine enquiry will probably result in abusive partner directing their violence towards health care providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Routine enquiry can put abused clients in more danger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attitudes towards victims of abuse	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree
14. Women's actions can be the cause of violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. It's understandable that a woman decides to stay in an abusive relationship because of her children's need of a father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Events of intimate partner violence are normal amongst couples going through marital difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please Respond to Each of the Following Statements					
Attitudes towards victims of abuse (continued)	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree
17. Women's emotional and economic dependence upon their partners leads to abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. In many cases the victim stays in the relationship because she doesn't really want to change the present situation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Intimate partner violence is a private matter that should be resolved primarily by the couple themselves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. I think in my practice there is not enough time to ask about intimate partner violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Women who have suffered intimate partner violence in the past tend to seek out abusive partners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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- Woodtli, M. A., & Breslin, E. T. (1996). Violence-related content in the nursing curriculum: A national survey. *Journal of nursing education*, 35(8), 367-374.
- Woodtli, M. A., & Breslin, E. T. (1997). Violence and the nursing curriculum: Nurse educators speak out. *Nursing and health care perspectives*, 18(5), 252-259.
- Woodtli, M. A., & Breslin, E. T. (2002). Violence-related content in the nursing curriculum: A follow-up national survey. *Journal of nursing education*, 41(8), 340-348.
- World Health Organization (2004). *A guide to implementing the recommendations of the "World report on violence and health"*. Geneva, Switzerland: World Health Organization.
- Young, M. (1986). History of the victims' movement. In Ochbery, F. (Ed.), *Victims of violence* (pp. 311-321). New York, New York: Harper and Row.

Curriculum Vitae

Sarah Elizabeth Plunkett

Education:

Ph.D. Dec. 2009	Indiana University/Purdue University Major: PhD in Nursing Science Minor: Advanced Nursing Education	Indianapolis, Indiana
M.S.N. May 1989	Oral Roberts University Clinical Role: Maternal-Child Health Nursing for the Family Functional Role: Nursing Education and Clinical Nurse Specialist	Tulsa, Oklahoma
B.S.N. May 1982	Pittsburg State University	Pittsburg, Kansas

Certifications:

July 2007 National League for Nursing, Certified Nurse Educator (CNE).

1999-present National Neonatal Intensive Care Nurse Certification (RNC-NIC), The National Certification Corporation (NCC) for the Obstetric, Gynecologic and Neonatal Nursing Specialties.

1988-present American Heart Association, Healthcare Provider CPR Instructor

1999-present American Heart Association, Neonatal Resuscitation Protocol (NRP) Certification.

1996-present Breastfeeding Educator Certification

1999 American Cancer Society, Certification in Breast Cancer Screening, "Triple Touch Facilitator".

Professional Experience:

Teaching

01-00 to Present	Tulsa Community College, Tulsa, Oklahoma: Associate Professor of Nursing, Nursing for the Childbearing Family and Introduction to Nursing Informatics.
08-93 to 5-00	The University of Tulsa, Tulsa, Oklahoma: Faculty, OB/Pediatrics, Community and Fundamental Nursing, Course coordinator NSG 3164 and NSG 2254.
08-88 to 12-88	Langston University at U.C.T. Tulsa, Oklahoma: Part Time Faculty, OB Clinical.

- 08-88 to 11-88 Tulsa Junior College, Tulsa, Oklahoma: Part Time Faculty, Responsible for team teaching Fundamental Skills of Nursing in a lab setting.
- 01-88 to 04-88 O.R.U. Anna Vaughn School Of Nursing: Teaching Practicum in partial fulfillment of graduate course work, O.R.U., Tulsa, Oklahoma. Responsible for team teaching undergraduate pediatrics theory and clinical course: Nursing of Children.
- Clinical
- 11/30/92 to Present St. John Medical Center, Tulsa, Oklahoma: Flex Staff Nurse II, 36 bed Level III NICU.
- 05/18/92 to 11/24/92 Hillcrest Medical Center, Tulsa, Oklahoma: Charge Nurse, 20 bed Level II SCN.
- 03/13/90 to 01/24/92 Kaiser Permanente, Fontana, California: NICU Clinical Nurse Specialist, 20-bed Level IIA NICU. Responsible for staff/family education program development, case management, and coordination of NICU High Risk Discharge Follow-Up Program. Assisted in development of Regional NICU Core Curriculum and Quality Improvement Programs. American Academy of Pediatrics Neonatal Resuscitation Regional Trainer.
- 01-06-88 to 01-09-90 Hillcrest Medical Center, Tulsa, Oklahoma: Charge Nurse, 20 bed Level II SCN.
- 05-15-89 to 08-04-89 City of Faith Hospital, Tulsa, Oklahoma: Chief Nurse, Childbirth Center. Responsible for management of 50+ staff in L/D, ABC, Level II NICU, Well Baby Nursery, and Postpartum that involved unit budgeting, QI, scheduling, interviewing/ hiring/ terminating staff, and day-to-day problem solving in the center. Conducted employee performance appraisals.
- 07-12-87 to 12-31-87 Muskogee Regional Medical Center, Muskogee, Oklahoma: Staff Nurse. Responsible for direct primary care in areas of L/D, Postpartum, GYN Surgery, Well Baby Nursery and Pediatrics with a focus on discharge teaching.
- 08-19-85 to 08-14-87 McAlester Regional Hospital, McAlester, Oklahoma: Charge/Staff Nurse, L/D, Nursery, Postpartum, GYN Surgery and Pediatrics.
- 06-01-82 to 07-28-85 Mercy Health Center, Oklahoma City, Oklahoma: Team/ Assistant Team Leader, Staff Nurse, 36 bed Level III NICU.

Podium Presentations:

- 2010 Selected for podium presentation to Tulsa Registered Nurse Community Volunteers campaign to increase awareness of the co-occurrence of intimate partner violence and child abuse and how to respond as a community, January 22, 2010.
- 2009 Podium presentation, "When Love Hurts... Intimate Partner Violence During Pregnancy." The University of Oklahoma State of the Science on Prematurity Conference, October 2, 2009.
- 2009 Podium presentation, "When Love Hurts... Intimate Partner Violence During Pregnancy." Catholic Charities Volunteers, Tulsa, Oklahoma, July 1, 2009.
- 2009 Podium presentation, "Best Practices for Identifying and Responding to Victims of Intimate Partner Violence Among Childbearing Women and their Families." The annual Oklahoma Commission Against Domestic Violence and Sexual Assault (OCADVSA) Conference, Tulsa, Oklahoma, June 19, 2009.
- 03/28/09 Podium Presentation: Park Plaza Church of Christ, Tulsa, Oklahoma, Memorial Service Eulogy for Ann Anthony, PhD(c), RN, former Associate Dean of Nursing, TCC.
- 12/03/08 Non-Violent Communication Strategies: an interactive presentation for Teen Dads Pointers On Parenting Support (POPS) at the Margaret Hudson Program, Alternative High School for pregnant/ parenting adolescents, Tulsa, OK.
- 09/27/08 Podium Presentation: SOS on Intimate Partner Violence Among Women of Childbearing Age. 2007-2008 Nurse Fellows Mentoring 2008-2009 Nurse Fellows, SOS on Prematurity and Low Birthweight, OU, Oklahoma City, OK.
- 09/25/08 Podium Presentation: Intimate Partner Violence Among Women of Childbearing Age and Neonatal Outcomes, AWHONN Oklahoma Chapter Meeting
- 04/18/08 Podium Presentation: New Hope For Victims Of Intimate Partner Violence. AWHONN Oklahoma Section Conference. The Culture Of Poverty: Many Voices, One Mission
- 11/5-7/06 Joint PowerPoint Presentation of TCC's Learning Enhancement Program as a Prototype for student retention, National Organization for Associate Degree Programs (NOADN) 2006 Conference: 20 Years of Setting the Pace, Charlotte, NC.

- 09/15/05 RSV: A Clinical Update for The Tulsa Healthy Families Coalition, Community Service Council, Tulsa, OK.
- 08/29/05 Using Internet Resources, Learning to Read for Success and Test Taking Strategies for Level 3 Nursing Students; Seminar at TCC, Tulsa, OK.
- 02/07/05 Using Internet Resources and Test Taking Strategies for Level 3 Nursing Students; Seminar at TCC, Tulsa, OK.
- 08/30/04 Using Internet Resources and Test Taking Strategies for Level 3 Nursing Students; Seminar at TCC, Tulsa, OK.
- 08/13/04 TCC Nursing Division Learning Enhancement Committee Workshop Presenter: Anecdotal Notes Documentation, Legibility and Legality With OBN Updates Regarding Student Charting.
- 05/2002 TCC Nursing Division Pinning Ceremony: Level 3 Faculty Speaker.
- 12/2001 TCC Nursing Division Pinning Ceremony: Keynote Speaker.
- 11/2001 TCC Best Teaching Practices Presentation on Collaborative Testing in Level 3 NUR 2423 Nursing Care of the Childbearing Family course.

Poster Presentations:

- 2009 Doctoral Dissertation poster presentation, "Training Health Care Providers to Identify and Respond to Victims of Intimate Partner Violence: A Feasibility Study." Sigma Theta Tau International Nursing Honor Society Biennial Convention, October 31-November 4, 2009, Indianapolis, IN.
- 03/12-13/09 Poster Presentation: Oklahoma Association of Community Colleges (OACC), Great Ideas For Teaching (G.I.F.T.). Joint poster presentation with colleague, Gwenn Hurlbut, "Collaborative Testing-Cooperative Learning" (Received \$250 Award)
- 10/30-31/08 Poster Presentation: Educating Healthcare Providers to Assess for Intimate Partner Violence Among Pregnant Adolescents. Oklahoma Nurses Association Regional State Conference, Tulsa, OK.
- 09/26/08 Poster Presentation: Educating Healthcare Providers to Assess for Intimate Partner Violence Among Pregnant Adolescents. SOS on Prematurity and Low Birthweight, OU, Oklahoma City, OK.

10/11/07 Poster session on intimate partner violence and substance abuse during pregnancy related to prematurity and low birthweight outcomes: “Windows of Opportunity”, Nurses Nurturing Nurses, Oklahoma Nurses Association, Annual Convention, OKC, OK.

10/3-4/07 Poster session on intimate partner violence and substance abuse during pregnancy related to prematurity and low birthweight outcomes, State of the Science on Prematurity, OKC, OK.

Research:

09/16/09 Doctoral Dissertation Defense, IUPUI School of Nursing, Indianapolis, Indiana. “Training Health Care Providers to Identify and Respond to Victims of Intimate Partner Violence.” A feasibility study in partial fulfillment of doctoral course work for IUPUI, Indianapolis, Indiana. Conducted at the Children First Program in Tulsa, OK.

04/13/09 IUPUI Doctoral Dissertation Phase II data collection (six weeks follow-up survey) completed at the Tulsa Health Department, Children First Program, Tulsa, OK.

03/02/09 IUPUI Doctoral Dissertation Phase I data collection completed: Presented One-Day National IPV Training Curriculum from the Family Violence Prevention Fund (FVPPF), “Improving the Health Care Response to Domestic Violence (Ganley, 1998)” promoting implementation of the “National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization (FVPPF, 2004),” for the Tulsa Health Department, Children First Program, Tulsa, OK.

02/11/09 IUPUI Doctoral Dissertation Proposal Defense completed and IRB Submitted for “Training Health Care Providers to Identify and Respond to Victims of Intimate Partner Violence.” A feasibility study in partial fulfillment of doctoral course work for IUPUI, Indianapolis, Indiana. Conducted at the Children First Program in Tulsa, OK.

04/30/08 IUPUI Nursing D752 Pilot Study. “Will Participation In The March Of Dimes Learning Module, ‘Abuse During Pregnancy: A Protocol For Prevention And Intervention (3rd ed)’ (McFarlane, Parker, and Moran, 2007) Increase Knowledge Of And Intent to Implement An Abuse Assessment Screening Protocol For Intimate Partner Violence?” A pilot study in partial fulfillment of doctoral course work for IUPUI, Indianapolis, Indiana. Conducted for the multidisciplinary team at the Margaret Hudson Program, Tulsa, Oklahoma (an alternate high school for pregnant adolescents).

- 11/2007 Stress And Coping Experiences During Adolescent Pregnancy. Non-Experimental, Descriptive Research Query Of Five Pregnant Adolescents Attending An Alternate High School For Pregnant Adolescents.
- 07/24/06- (Student) 2006 Summer Research Institute for Community Based
07/26/06 Participatory Research, UCLA, School of Nursing. LA, CA.
- 03/31/06- 30th Annual MNRS Research Conference. Linking Research and
04/03/06 Practice: A Roadmap for the Future. Milwaukee, WI.
- 1991-1992 Data collector for pilot study on use of sucrose water in the neonate during
invasive procedures. NICU, Kaiser Permanente, Fontana, California.
- 1990-1992 Data collector for investigational new drug therapy: surfactant replacement.
NICU, Kaiser Permanente, Fontana, California.
- 1990-1992 Data collector for the March of Dimes regional study on birth defects
related to environmental exposures in Southern California. NICU, Kaiser
Permanente, Fontana, California.
- 1989 Master's Thesis: "Coping Patterns Of Families To Infant Death
Experience".

Publications:

Author of two chapters: Newborn Screening for Genetic Disorders, and Sickle Cell Disease, Mosby's Pediatric Nursing Reference, 6th ed. Betz, Cecily L. and Sowden, Linda A. (Eds), Mosby Yearbook Publications: October, 2007.

Consultant and Co-Developer, Childbearing and Childrearing Syllabi, Oklahoma Wesleyan University, Bartlesville, Oklahoma: May-July, 2006.

Dreams Come True Contest entry: "Why Me?" Contest sponsored by the National Association of Neonatal Nurses (NANN). Story published in archives online at www.NANN.org

TCC Pinning Ceremony Keynote Address, December 2001, published on TCC Nursing Division Home Page.

"Original Teaching Innovations In Maternity Health Care" for Maternity Minutes, a quarterly publication. Entry accepted for publication, Winter 2000 edition. Awarded maternity nursing educational video (produced in conjunction with AWHONN).

Contributor/ author of Chapter 14 , Child Abuse and Neglect (pp.73-81); and Chapter 63, Otitis Media (pp.410-417), Mosby's Pediatric Nursing Reference, 4th ed. Cecily L. Betz and Linda A. Sowden (Eds.), Mosby Yearbook Publications: 2000.

Master's Thesis: "Description Of Coping Patterns Of Families To Infant Death Experience", April 1989. National Microfiche Data Base; Ann Arbor, Michigan.

Professional Activities:

Organizations

Academy of Neonatal Nursing (ANN)

American Heart Association: Member, SJMC Community Training Center for Healthcare Provider CPR Instructor

American Nurses Association (ANA)/ Oklahoma Nurses Association (ONA); Dual membership. ONA representative to Oklahoma Healthy Mothers- Healthy Babies Coalition (OHMHBC) and Oklahoma Infant Alliance (OIA)

Association of Women's Health, Obstetrics and Neonatal Nurses (AWHONN); Tulsa, Oklahoma Chapter

Greater Tulsa, Families And Communities Empowered for Safety (f.a.c.e.s.). Professional Community Advisory Board Member

Midwestern Nurses' Research Society

National Association of Neonatal Nurses (NANN); Northeastern Oklahoma Chapter (NEOANN)

National League for Nurses

Oklahoma Healthy Mothers-Healthy Babies Coalition (OkHMHBC) and Oklahoma Infant Alliance (OIA)

Sigma Theta Tau, Zeta Delta Chapter-At-Large Charter Member; 2009 Delegate to Biennial Convention, TU Faculty Counselor 1997 & 1998, Nominating Committee 1995 & 1996; Dual membership in Alpha Chapter

Committees

IUPUI, Indianapolis, Indiana, Graduate Online Nursing Program Accreditation Report Committee, Doctoral Student Reviewer/Editor, 2008-2009

TCC Nursing Division, Curriculum Committee Chair, 2009-2011.

TCC Metro Campus Faculty Delegate to the 2007-2008 Leadership Development Academy II

TCC Nursing Transition Committee Chair, Coordinated Multidisciplinary Level I and Level II Nursing move from MC to SEC Fall 2006 (ie. nursing, LRC, advisement, testing, media, bookstore, etc.)

TCC Learning Enhancement Committee, Level 3 Faculty Representative, 2002-Spring 2007

TCC Students Matter Committee, Level 3 Faculty Representative, 2000-Spring 2006

TCC Metro Campus Faculty Delegate to the 2004-2005 Leadership Development Academy I (selected by Metro Campus Deans and Provost)

TCC Nursing Faculty Mentor for new faculty on Level 3, 2002-present

TCC Creative and Alternative Teaching (CAT) pilot faculty, 2002-2004 (Appointment by dean, peers and special consultant)

TCC Faculty Matters Committee, Level 3 Faculty Representative, 2001-2003 (Peer selected by secret ballot)

TCC Nursing Curriculum, Level 3 Faculty Representative, 2000-2001

TCC Nursing Process Blue Ribbon Task Force, faculty volunteer, 2000-2001

Registered Nurse Community Volunteers of Tulsa, Oklahoma; Continuing Education Committee 1998

TU Nursing Program Accreditation Report Committee, 1993-2000

Honors, Awards, Fellowships:

2009 Mauerman Doctoral Nursing Faculty Scholarship Recipient, Tulsa Community College, Tulsa, OK.

2009 National League for Nursing (NLN), Health Information Technology Scholar (HITS) Program.

2009 Oklahoma Association of Community Colleges (OACC), Great Ideas For Teaching (G.I.F.T.) joint poster presentation with TCC colleague, "Collaborative Testing-Cooperative Learning" \$250 Award

2008-09 Neonatal Foundation for Research and Education (NFRE) Doctoral Scholarship

2007-09 Tulsa Community Foundation, Community Leader's Scholarship for Nursing

2007-09 IUPUI, SON Florence Nightingale Memorial Scholarship

2007-09 IUPUI, Andrew S. Cebula Memorial Scholarship.

Midwestern Nursing Society Annual Conference, Tuition Scholarship Recipient, Student Volunteer Exchange Program.

Tulsa Community College, Metro Campus Faculty Delegate To The Leadership Development Academy II

Nurse Fellow, University of Oklahoma/March of Dimes State of the Science on Prematurity and Low Birthweight Conference and Mentorship Program

2007-08 Nurses Educational Funds (NEF) Scholarship for Leadership

2007-08 IUPUI, SON Kristen Pettijohn Memorial Scholarship

2007-08 IUPUI, SON Julie White Memorial Scholarship

September 2007, IUPUI, T670 Doctoral Coursework, Exemplar Nursing Philosophy

2007-08 TCC Leadership Development Academy II; Metro Campus Delegate

July 2006 UCLA Summer Research Institute \$250 Scholarship.

June 2006, IUPUI, D701 Doctoral Coursework, Exemplar Professional Strengths Paper.

April 2006 AWHONN Scholarship for Outstanding Academic Achievement and Contributions to the Health of Women and Infants.

2005-06 TCC Nursing Division Faculty Sponsor for the Pinning Ceremony Committee.

2004-05 TCC Leadership Development Academy I; Metro Campus Delegate (selected by deans and provost).

TCC Pinning Ceremony, Level 3 Faculty Program Representative (student selected), Fall 2000, Spring 2001, Spring & Fall 2002, Spring & Fall 2003, Spring 2004.

TCC Nursing Division, Students Matter Committee, Level 3 Faculty Representative (student selected), Fall 2000-Spring 2007.

The University Of Tulsa, College Of Business, "Mayo Teaching Excellence Award" Nominee, 1999-2000 (Ineligible to receive actual award twice; see below).

Winning entry of "Original Innovations in Maternity Health Care" for Maternity Minutes, a quarterly publication. Entry accepted for publication in Winter 2000 edition. Awarded a maternity nursing educational video of choice (produced in conjunction with AWHONN, \$400 value).

First Place, City of Tulsa, First Annual “Caring For Others Christmas Ornament Contest” sponsored by JoAnn's Fabric and Craft Stores in conjunction with the The Susan G. Komen Foundation , Nov-Dec, 1999. All proceeds donated to breast cancer research.

First Place, Decorating Contest, Education Banner Display for Breast Cancer Awareness, “National Lee Denim Day”, October, 1999, School of Nursing, College of Business, The University of Tulsa, Tulsa, Oklahoma.

Conference Scholarship Award, National Oncology Nursing Society/National Cancer Institute, “Cancer Among African Americans: Issues and Challenges in Cancer Prevention and Early Detection”, and The American Cancer Society, breast cancer prevention, “Triple Touch Facilitator” certification, Atlanta, Georgia, April 24-26, 1999.

The University Of Tulsa, College Of Business, “Mayo Teaching Excellence Award” Recipient, 1997-1998. (First Nursing Faculty to Ever Receive This Award)

The University Of Tulsa, School Of Nursing, “Outstanding Nursing Faculty Member”, 1997-1998.

Dr. Tomine Tjelta Award Of Excellence In Nursing Research for The Class of 1989 “Outstanding Graduate Thesis” (Description Of Coping Patterns Of Families To Infant Death Experience), April 1989.

Oklahoma Physicians Manpower Training Scholarship for Graduate Nursing Education, 1987-1988.

McAlester, Oklahoma Chapter Of Professional Business Women’s and Philanthropic Organization Scholarship for Graduate Nursing Education, 1986-1988.