NURSING STUDENTS' ATTITUDES TOWARD VICTIMS OF DOMESTIC VIOLENCE AS PREDICTED BY SELECTED INDIVIDUAL AND RELATIONSHIP VARIABLES

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(ABSTRACT)

Abused women are frequent users of health care services. Yet, battered women often do not identify the health care delivery system as a resource. The present study surveyed 155 female associate and baccalaureate degree nursing students from three mid-Atlantic universities in order to examine how selected personal and relationship variables affected their attitudes toward battered women.

It was hypothesized that those students who had an early exposure to family violence combined with high levels of egalitarianism and perceived control over life events would be more sympathetic toward battered women than those who did not. Instruments used to measure the chosen variables included the Sex-Role Egalitarianism Scale, the Conflict Tactics Scale, the Family Violence Scale, the Perceived Control Scale, and the Inventory of Beliefs about Wife-Beating. Data were collected via

anonymous self-report questionnaires and analyzed through the use of correlation and hierarchical regression procedures.

Nursing students with more egalitarian sex role beliefs and perception of control over their life events were more sympathetic to battered wives than those students with more traditional sex role attitudes and less perceived control over their life. Sex role egalitarianism was found to be the best predictor of attitudes toward victims of domestic violence. Contrary to expectations, there appeared to be little relationship between the level of violence experienced by students in their families of origin or in their current relationships and sympathy for battered wives.

Findings from this study will add to the current nursing knowledge base regarding attitudes of one group of health care professionals toward victims of domestic violence by exploring those attitudes and by identifying which of the chosen variables was most predictive of those attitudes. Implications for nursing education include an examination of the impact of gender issues on personal and professional behavior as well as the importance of empowering nursing students through the use of a competency based practice model.

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INTRODUCTION

Overview

Although family violence is wide-spread, the acceptance of wife battery/spouse abuse as a major social, economic, and health problem has grown slowly. Pressure from the women's movement, starting in the late 1960s, has enlarged researchers' initially narrow focus on child abuse to include all types of abuses against family members (Fontaine, 1991; Tilden & Shepherd, 1987). "Of all the forms of family violence, wife battering now ranks second, following child abuse, in terms of the attention it receives in public, professional, and scientific communities" (Margolin, Sibner, and Gleberman, 1988, p. 89). This attention seems rightly focused, as violence in families is not evenly distributed between all family members, but disproportionately directed toward women (Dobash & Dobash, 1979). Estimates of physical abuse of women in the United States range from 1.8 to 4 million incidents yearly (Hotaling, Finkelor, Kirkpatrick, & Straus, 1988; Straus, Gelles, & Steinmetz, 1980), and of these, approximately one in five involves not just an isolated incident, but a series of batterings (Harlow, 1991).

In addition, marital rape occurs in 30% to 50% of

domestic violence incidents (Frieze, 1983; Russell, 1982; Weingourt, 1990). These estimates are assumed to be low since many women, due to socialization, do not identify that they have been raped and do not consider marital rape to be domestic violence. In general, women are reluctant to report being raped and/or battered. The most recent report by the National Crime Survey (NCS) indicates that only 56% of victimizations were reported to the police. Two-thirds of the victims reported intimate violence to the NCS but not to the police because a) they believed that violence was a private or personal matter, b) they took care of the problem themselves, or c) they were afraid of reprisals (Harlow, 1991).

The health implications of spouse abuse are stunning. Violent family interactions seem to be particularly dangerous to a woman's emotional and physical health. More than one million women seek medical help for injuries inflicted by what police call "partner assault" and between two thousand and four thousand women die annually from spouse abuse (McCarthy, 1991; Straus, 1986). Abused women are frequent users of a variety of health care services. As Stark and his associates wrote:

> "Battered women comprise a significant percentage of rape victims, suicide attempts, psychiatric patients, mothers of abused children, alcoholics, and women who miscarry or abort. Finally....battered women make multiple visits to

> the medical and psychiatric services for general health problems that are as much a part of the battering syndrome as physical injury but are not recognized as related to assault" (1988, p.v).

Further studies support Stark's contention that battering compromises a woman's health in a variety of ways, but is often unidentified, misidentified or totally ignored by the health care system (Drake, 1982; Helton, McFarlane, & Anderson, 1985; Hilberman & Munson, 1978; Hillard, 1988; Kurz, 1987; Warshaw, 1989). "The medical system is a crucial point in the identification and prevention of abuse, yet, abuse remains virtually unrecognized by the medical system" (Stark & Flitcraft, 1981, p. vii).

These health problems also carry a heavy economic cost. In addition to the direct cost of treating both acute and chronic sequelae of beatings, "abused women are more likely to lose their jobs or lose time from work than nonabused women" (U.S. Department of Health and Human Services, 1991, p. 18).

Statement of the Problem

Despite the fact that family violence has been increasingly identified as an appropriate focus of health care personnel (Bohn, 1990; Browne, 1992; Novello, 1992; Stark & Flitcraft, 1988; Sugg & Inui, 1992; Tilden, 1987),

and the growing realization as to the importance of the initial response given to the victim of domestic violence by helping professionals (Limandri, 1987), "the medical response to abuse has been slow and sporadic" (Kurz & Stark, 1987, p. 249). Health care professionals often respond to battered women with ignorance, disbelief, inattention, or blame (Hilberman, 1980). Clinical research has demonstrated that health professionals persistently failed to question the source of a woman's injury, ignored cues that domestic violence was occurring, or labeled and denigrated the woman if abuse was revealed (Drake, 1982; Goldberg & Tomlanovich, 1985; Helton, 1986; Kurz, 1987; Sugg & Inui, 1992; Warshaw, 1989; Weingourt, 1990). In turn, battered women do not identify the health care delivery system as a resource, nor find the help offered by physicians and nurses particularly useful (Brendtro & Bowker, 1989; Helton, 1986). In fact, none of the twelve battered women interviewed by Drake (1982) reported positive feelings about the health care they received. They felt that they were treated "impersonally, insensitively, and received minimal to no support from the providers" (p. 45).

Prior to the middle 1970's, there was little research examining the frequency with which battered women used medical and/or psychological services or how effective

these services were. Early research studies tended to use small samples in a single clinical setting making generalizations difficult. In addition, often the researchers did not delineate between doctors and nurses as members of the health care team, a point noted specifically by Brendtro and Bowker (1989). Initial research in this area seemed directed at increasing the sensitivity of the health care workers to the presence and characteristics of the domestic violence problem in health care settings (Bullock, McFarlane, Bateman, & Miller, 1989; Stark, Flitcraft, Zuckerman, Grey, Robinson, & Frazier, 1981; Goldberg & Tomlanovich, 1984). Only recently has the research focus shifted to include an examination of the attitudes and behavior of helping professionals. This is an important shift in that "a growing literature demonstrates how health professionals reinforce sexual, racial, and economic inequities through their individual attitudes and practices" (Stark, Flitcraft, Zuckerman, Grey, Robinson, & Frazier, 1981, p. viii). However, minimal attention (especially outside the nursing profession itself) has been paid to the attitudes and behavior of nurses and nursing students in the assessment and treatment of this major health problem.

Of all members of the health care team, nurses have the numbers, the access, and the opportunities to make

significant inroads in the prevention, detection, treatment, and scholarly investigation of the problem of domestic violence. Nursing also views health more as a "lived experience" and emphasizes prevention, early treatment and client involvement in health care. Such an approach validates and values each client's experiences and lays the foundation for empowerment (McBride & McBride, 1982).

Literature supports the fact that a nurse's perceptions and attitudes toward patients are considered to be of extreme importance. The "therapeutic nurse-patient relationship" and the "nursing process", both cornerstones of professional nursing practice, begin with an examination of the nurse's own reaction to the client. Negative feeling responses and attitudes can interfere with a nurse's objectivity and ability to provide effective and competent nursing care. In general, nurses appear to dislike and label as difficult patients that in some way make them feel powerless and ineffective (Ganong, Bzdek, & Manderino, 1987; Podrasky and Sexton, 1988). Victims of domestic violence, because of their repeated pattern of help seeking, would appear to fit this category.

Numerous authors have stressed the critical need for nurses to be aware of and in control of their own feelings

and attitudes toward violence in general and victims of domestic violence in particular (Brendtro and Bowker, 1989; Lichenstein, 1981; Sherman, 1980; Valenti, 1979). However, only three studies have examined the impact of such issues as gender, professional role, and amount of contact with battered women on health care professionals' attitudes toward victims of domestic violence (Drout, 1987; Rose, 1984; Shipley & Sylvester, 1982).

There also appears to be a void in research that examines the attitudes or perceptions of nursing students toward victims of domestic violence despite the belief that attitudes and perceptions are formed early in life and these attitudes and perceptions are assumed to influence a nurse's behavior toward patients. Several studies have examined the impact of selected personal beliefs on an individual's attitudes toward victims of domestic violence (Kristiansen & Guilietti, 1990; Stith, 1990) but these studies did not include nurses or nursing students in their samples. Many attributional studies focus on factors external to the respondent, such as the characteristics of the victim or the context of the situation. There is a need for further research designed to examine the relationship between personal characteristics and beliefs and attitudes toward victims of domestic violence, especially in those professions

where individuals have ample opportunity to intervene in the problem and to serve as advocates for the victims.

Purpose Statement

The purpose of this study was to examine the relationship between selected individual and relationship variables and nursing students' attitudes toward victims of domestic violence. An ancillary purpose was to determine which of the selected individual and family variables or combination of variables best predicted these attitudes. The specific variables of interest for this study consisted of:

1. Sex-role egalitarianism
2. Childhood involvement with family violence
3. Current involvement with domestic violence, and
4. Feeling of control or lack of control over life events

Research Questions

The general and ancillary purposes of this study generated the following research questions:

1. What is the relationship between nursing students' attitudes toward victims of domestic violence and each of the following variables?

    a) Sex role egalitarianism

b) Childhood involvement with family violence

c) Current involvement with domestic violence

d) Feeling of control or lack of control over life events

2. Which of these selected individual and relationship variables or combination of variables was the best predictor of nursing student attitudes toward victims of domestic violence?

Conceptual Framework

This study was grounded in the social psychology perspective of symbolic interactionism. Symbolic interactionism focuses on the interaction between human beings and the manner in which these human beings interpret or define each other's actions instead of merely reacting to them (Blumer, 1969; Charon, 1989). Symbolic interactionists believe that it is the individuals themselves who give behavior meaning; the meaning of any given situation can only be understood from the perspectives of the participants. Since this is so, symbolic interactionism is concerned with the process by which people derive meanings from social interaction, interpret those experiences, and choose their own position or actions (Oleson & Whittaker, 1968). Thus, symbolic interactionists view men and women as complex, dynamic,

thoughtful, and interactive human beings, actively creating their own reality, rather than more simplistically as reactive subjects whose behavior is stimulated either internally (by their own personality characteristics) or externally (by the environment or social situations).

Symbolic interactionism postulates that humans live in a symbolic as well as a physical environment, but it is to the symbolic stimuli which they are the most responsive (Charon, 1989). In family interactions for example, complex sets of meanings are learned that allow family members to communicate, share experiences, and involve two or more persons in a social process (Peterson & Rollins, 1987). Whenever there is an interaction between family members, there is shared meaning, an exchange of perspectives. With each additional interaction, family members develop a perspective as to what is real and how they should act toward that reality (Charon, 1989). As a result of this learning, family members develop a culture that guides their behavior. This culture, comprised of past experiences, socialization, interactions and current definitions of self, guide and define interactions in the present. In violent families for example, depending on the culture of the individual participants, specific interactions in the present may be seen as violent and

abusive, or ordinary, and so just more of the same.

Nursing students are also learning complex sets of meanings as they are socialized to the nursing culture via continual interactions with other members of the health care delivery system. It is through these interactions that the students select and develop perspectives, values, and behaviors related to their roles as nurses. In addition, they bring with them to their nursing education a legacy of symbols developed through past interactions with others in myriad social contexts. Memories from the students' past are applied to situations they encounter in the present. "Significant other, reference groups, perspective, knowledge, and feelings from our past are all used as social objects to work through the present situation" (Charon, 1989, p. 127-128).

Thus, when a nurse (or nursing student) and a victim of domestic violence interact, each is guided by his\her own culture and definition of self. Each has certain expectations of themselves and the other. Nurses' perspectives of the victim of domestic violence are influenced by their own personal cultures (family interactions) and by the culture of the health care delivery system, both highly symbolic systems. "It is through thinking with symbols that each individual is able to create his or her own world beyond the physical,

develop highly individual interpretations of reality, and respond uniquely to that reality" (Charon, 1989, p. 60). Individuals learn how to view reality through interacting and learning the perspectives of others.

Because nurses (and nursing students) are educated to examine the interactions between themselves and their clients in order to plan and deliver effective and appropriate nursing care, this symbolic interactionist perspective, with its emphasis on self, mind, and role-taking, seems quite appropriate for a study of nursing students' attitudes. Unless the students can take the role of the victim of domestic violence, they cannot clearly understand her perspective and needs. "Real concern for others, being able to give to others, to respond to their needs, demands first and foremost that we understand the other" (Charon, 1989, p. 108). The interaction then, provides each with the opportunity to "take on the role of the other". It is this ability to get outside of the "self", to see the world from the perspective of the battered woman that allows the nurse to see both self and client more objectively. In fact, inaccurate role-taking might explain the tendency of the battered woman not to disclose and the health care worker to disbelieve or minimize any injuries or complaints of violence. Due to inaccurate role-taking, nurses may

respond to what clients represent or symbolize rather than respond to the actual clients themselves.

Need for the Study

Spouse abuse is a major public health problem in the United States. Despite heightened awareness of the medical, economic, and sociological impact of domestic violence and despite educational and research data attesting to the importance and efficacy of increased knowledge in this area, many nursing school curriculums include little content on the subject. Therefore, the results of this study could be used to provide support for the inclusion of such material in nursing school curriculums. The results of this study might also be useful to those individuals in the health care system who design and provide continuing education programs on the topic of domestic violence. An additional result might be the identification of the existence of a proportion of nursing students who carry a legacy of family violence with them into their nursing careers. Such a legacy could affect both the self-esteem of the student and clinical work with a variety of patient groups. The results of this study might then be used to help both nursing faculty and nursing students themselves identify and address the impact of this debilitating legacy. Such an increased

awareness could begin to counteract personal prejudices and societal myths concerning domestic violence and help nursing and other health professions recognize that such problems exist among themselves.

Definition of Terms

The following are operational definitions of terms relevant to this study:

Domestic Violence: An intentional act, or series of acts between social partners or relatives that has the potential to physically harm one of the participants.

Battered Woman: A female who has experienced more than one assault from an intimate partner and is involved in an on-going abusive relationship with that individual. A battering relationship typically encompasses a life-threatening history of injury and psychosocial problems as well as a history of help seeking marked by neglect and inappropriate and punitive responses (Stark & Flitcraft, 1988).

Nursing Student: Individuals eighteen years of age or older who are currently enrolled either full or part-time in an associate or baccalaureate degree nursing program.

Limitations

1. The sample for this study is one of convenience, rather than random, thus the generalizability of the study will be affected.

2. One instrument (the Family Violence Scale) measures retrospective information, so recall might be affected by maturation and memory.

3. The topic under study, i.e., domestic violence, is so much in the media at this point in time that this might have some impact on the participants' attitudes toward victims of domestic violence.

4. Data will be collected through self-report measures; therefore they will be subject to the inherent limitations of such instruments.

5. All subjects will be students attending summer classes; as such, they may not be representative of the general university\nursing student population.

6. The motivation of each participant to carefully read and respond to the items is beyond the control of the investigator, as is the overall physical and psychological condition of the participants at the time of the testing.

Organization of the Study

Chapter one consists of an introduction, background

and conceptual framework for the study, statement of the problem and purpose statement. The research questions, need for the study, definitions, and limitations are also included.

Chapter two provides a review of the literature on the negative impact of domestic violence on women's health, the response of health care professionals to victims of domestic violence, the impact of sex-role egalitarianism, personal experiences with violence, and perceived control over events in one's life on attitudes toward victims of domestic violence, and studies examining attitudes toward victims of domestic violence.

Chapter three describes the research design and methods to be used. Chapter four presents the results and the data analysis. Chapter five presents a summary of this study, the conclusions, and recommendations.

CHAPTER 2

REVIEW OF THE LITERATURE

Introduction

The general purpose of this study is to examine the relationship between selected individual and relationship variables and nursing students' attitudes toward victims of domestic violence. The variables under scrutiny include sex-role egalitarianism, perceived control over life events, family violence experienced as a child and current involvement in a violent relationship. The preceding chapter presented evidence that domestic violence affects a substantial percentage of our nation's population and extracts a huge toll on the health of the individual victim. Despite this fact, the health care community has been markedly slow to respond and intervene effectively in this major health problem.

This chapter will take a more detailed look at the attitudes of one group of health care professionals (specifically nurses) to the problem of domestic violence. In order to do this, the chapter will be divided into three sections. The first section will provide an overview of the negative impact of domestic violence on women's health as well as the response of the health care delivery system to this problem. The second section examines attitudes and attributions regarding victims of

domestic violence, with a special focus on nursing attitudes toward this population. The third section presents a review of the literature related to the specific variables of interest. This review of the literature will be grounded in both nursing and domestic violence literature.

Domestic Violence: A Negative Health Factor

Spouse abuse is a growing and significant health problem causing major morbidity and mortality. One study found violence to be the second leading cause of injuries to women, and the leading cause of injuries to women ages 15 through 44 years (Grisso, Wishner, Schwarz, Weene, Holmes & Sutton, 1991). Compared to nonabused women, battered women are five times more likely to attempt suicide, fifteen times more likely to abuse alcohol, nine times more likely to abuse drugs, and three times more likely to be diagnosed as depressed or psychotic (Stark & Flitcraft, 1988). Assaults to women account for trauma injuries ranging from black eyes, cuts, multiple bruises and contusions, broken bones, concussions, detached retinas (Browne, 1992; Hilberman & Munson, 1978) to gunshot and knife wounds (Harlow, 1991). Abused women are also more likely than other trauma (accident) victims to have multiple injuries (Burge, 1989). Sexual assaults and

rapes within the context of the battering are also common (Stark, Flitcraft, Zuckerman, Grey, Robinson, & Frazier, 1981; Russell, 1982; Weingourt, 1990), "with women describing being beaten and raped in front of the children" (Hilberman & Munson, 1978, p. 462). Finally, women report permanent, but less obvious, injuries such as joint damage, partial loss of vision or hearing, and scars from burns, bites and gunshot or knife wounds (Browne, 1992).

Close examination of the domestic violence phenomenon has demonstrated that, frequently, the assaults and victimization are repetitive in nature and escalate in severity over time. Data collected by the National Crime Survey (NCS) from 1979-1987 indicate that one in five women had been assaulted at least three times in a six month period by spouses or ex-spouses; another 15% of women were assaulted repeatedly by violent boyfriends or ex-boyfriends (Harlow, 1991). Given these statistics and the fact that over half the victims of domestic violence sustain injuries from assaults, with almost one quarter receiving medical care for their injuries (Harlow, 1991), it is obvious that abused women may visit physicians repeatedly with increasingly severe physical and psychological trauma. Stark and his colleagues (1981) found that although battered women accounted for just 25%

of their sample, they accounted for almost half of the visits to the emergency surgical service, and presented a trauma history of approximately seven years.

Consistently, although some battered women report a prior history of trauma, both physical and psychological health problems seem to increase and intensify once the abuse starts (Stark & Flitcraft, 1988). Obviously then, early diagnosis and treatment is necessary to interrupt escalating health problems, as well as prevent severe injury or death (Browne, 1992; Sugg & Inui, 1992). In addition, despite practitioners' beliefs to the contrary, evidence suggests that victims of domestic violence want to be asked about their abuse (Drake 1982; Friedman, Samet, Roberts, Hudlin & Hens, 1992; Rath & Jarratt, 1990) and believe that physicians could help with medical and psychological problems stemming from abuse (Friedman, Samet, Roberts, Hudlin & Hens, 1992).

Victims' Use of Health Services

Abused women are frequent users of emergency, gynecological, and psychiatric health care services (Appleton, 1980; Carmen, Reicker, & Mills, 1984; Drake, 1982; Helton, 1986; Hilberman & Munson, 1978; Hillard, 1985; Goldberg & Tomlanovich, 1985). In studies of emergency department visits, 22% to 35% of women presenting with any complaint were there because of

symptoms related to partner abuse (Randall, 1990). One of the earliest studies in this area estimated that 21% of all women using emergency surgical services were there for sequelae of domestic violence, one half of all injuries presented by women occurred in the context of partner abuse, and over half of all rapes of women over 30 had been perpetrated by an intimate partner (Stark, Flitcraft, Zuckerman, Grey, Robinson, & Frazier, 1981).

Abuse during pregnancy was first addressed by Gelles (1975) who found that 23% of the violent families he interviewed reported this phenomenon. Bohn (1990), reviewing the literature on domestic violence and pregnancy, found an incidence of abuse during pregnancy in approximately half of all battered women. "Abuse often begins during pregnancy and may result in pregnancy loss, pre-term labor, low birth-weight, fetal injury and fetal death" (Bohn, 1990, p. 86). Many women report changes in the pattern of violence during pregnancy (Hilberman & Munson, 1978; Hillard, 1988). For some women, the abuse increases, with the abdomen becoming the target for battering; for some women the abuse decreases.

Lastly, clinicians and researchers are only just beginning to appreciate the fact that victims of domestic violence may suffer both immediate and long-term trauma from on-going abuse. Physical violence has been found to

play "a central causative role in paralyzing anxiety and (psychiatric) symptom formation" for battered women (Hilberman & Munson, 1978, p. 460). One follow-up study of battered women by Hilberman (1980) revealed both catastrophic acute reactions and persistent chronic disability in a significant proportion of victims. In addition, those psychiatric patients, both in-patient and out-patient, with a history of abuse reported higher levels of interpersonal sensitivity, depression, anxiety and hostility, averaged longer hospital stays, evidenced significant difficulty with anger, aggression, self-image, and trust, and were frequently given more punitive psychiatric diagnoses than those psychiatric patients reporting no history (Carmen, Reicker, & Mills, 1984; Herman, 1986; Surrey, Swett, Michaels, & Levin, 1990; Weingourt, 1990).

Indeed, wife battering is such a health problem that the U.S. Department of Health and Human Services reported that "severe spouse abuse is the single major cause of injury for which women seek medical attention; it is more common than auto accidents, mugging, and rape combined" (1991, p.5).

Response of the Medical Community

The medical community, like the criminal justice system, constitute a frontline in the identification and

intervention of domestic violence (Browne, 1992). Yet, the medical community has been markedly slow to rise to the challenge. Studies conducted over the past fifteen years in a variety of medical settings reveal a continued pattern of nonassessment and nondetection. Analysis of records from one hospital emergency service showed that 18.9% of 3,676 randomly selected cases were classified by researchers as abused women, but clinicians only correctly associated 4.5% of the injuries with violence, and only classified 1.8% of 3,717 trauma episodes as battering (Kurz & Stark, 1988). Campbell's (1992) review of nursing literature on battering found that at least 10%-22%, perhaps as high as 25% of women using emergency services were battered, yet only 2%-8% were correctly identified. Helton, McFarlane and Anderson (1987) found that while 36% of the 290 prenatal patients in their study had been battered or were at risk for battering, not one of these women had been assessed for abuse by their health care providers.

In addition, the bulk of the current research points to the medical practitioners' focus, not on the victimization or its causes, but on the victim's presenting physical symptom or organic problem (Hillard, 1986; Kurz, 1987; Warshaw, 1989; Sugg & Inui, 1992). Commonly women are never asked specifically about the

possibility of abuse. If and when women do disclose their victimization to health care professionals, typically they are ignored, denigrated, and blamed for their abuse or given responses that are often insensitive and not particularly helpful (Drake, 1982; Brendtro & Bowker, 1989; Kurz, 1987; Lichtenstein, 1981; Sugg & Inui, 1992; Warshaw, 1989). Thus, while domestic violence puts a victim's health increasingly at risk in a variety of ways, the rate of identification of victims by the medical community remains abysmally low.

Not surprisingly, in a survey that asked 1000 participants to rate the effectiveness of a variety of professionals in addressing their abuse, health professionals ranked lowest, judged less effective than battered women's shelters, lawyers, social service workers, police and clergy (Brendtro & Bowker, 1989).

Difficulties in Identification and Treatment

Complex reasons account for this ineffective and often inappropriate response on the part of the medical community. First, health care professionals are often unaware that they routinely see victims of domestic violence. Not all battered women sustaining injuries from beatings by intimate partners seek medical assistance (Bowker & Maurer, 1987; Dobash & Dobash, 1979; Harlow, 1991).

Battered women who do seek medical treatment for injuries they receive from beatings frequently wait to seek this treatment until physical injuries become so severe they can no long be self treated (Bowker & Maurer, 1987; Drake, 1982) or involve a pregnancy or a child (Bowker, 1983; Bowker & Maurer, 1987; Hillard, 1988; Goldberg & Tomlanovich, 1985). Even then, battered women often disguise the actual problem and appear reluctant to aggressively seek help for the abuse (Campbell, 1989; Drake, 1982; Hillard, 1988; Hilberman & Munson, 1978; Goldberg & Tomlanovich, 1985).

Domestic violence has been called "a health care problem in disguise" (Drake, 1982). Domestic violence victims frequently present to health care providers with physical injuries and psychological problems that are nonspecific enough to escape being obviously identified as the result of battery (Anderson, 1984; Campbell, 1989; Hillard, 1988; Hilberman & Munson, 1978). Although a substantial number of battered women present to hospital emergency departments with obvious physical injuries, victims of domestic violence also seek medical attention for primary care health problems that are less obviously related to their abuse and victimization (Browne, 1992; Campbell, 1989; Hillard, 1988; Hilberman & Munson, 1978; Goldberg & Tomlanovich, 1985). Primary care complaints

include chronic headaches, hyperventilation, or dizziness, (Hilberman & Munson, 1978; Hillard, 1988), muscle aches, abdominal pains, recurrent vaginal infections, sleeping and eating disorders, and depression (Browne, 1992).

Finally, due to the fact that battered women may turn to alcohol and drug use as a way of coping with the violence, many may initially be seen following an attempted suicide or as a substance abusing patient (Goldberg & Tomlanovich, 1985; Stark & Flitcraft, 1988). Such disguised health problems further obfuscate the problem of domestic violence for health care providers. Brendtro & Bowker (1989) conclude that "because most battered women do not seek medical help and because many who come into contact with physicians and nurses conceal the etiology of their injuries, the experiences of most health care personnel lead them to underestimate the extent of wife abuse (as a problem)" (p. 170).

Structure and Culture of the Medical System

Another reason for the ineffective medical response may be the structure and culture of the health care delivery system itself. Although wife-battering qualifies as an event of epidemic proportions simply due to the numbers of women involved, "domestic battery is not treated as an "epidemic" because it does not fit into the individually oriented, physiologically based medical model

of care" (Germain, 1984, p. 26). In this model, clinicians respond to women as "sick" and in need of help, rather than as "survivors" in need of empowerment (King & Ryan, 1989; Kurz & Stark, 1987). This linear, reductionistic medical model tends to limit both the perception of what is wrong with the woman and the caregivers' choice of interventions.

In addition, busy clinics, physicians' offices, and emergency rooms almost guarantee that the health professional will spend minimal amounts of time with the victim of domestic violence, thus helping to hide the victimization (Dobash & Dobash, 1979; Sugg & Inui, 1992; Walker, 1984; Warshaw, 1989). In fact, the majority of primary care physicians (71%) interviewed by Sugg and Inui (1992) for their qualitative study on physician's attitudes toward victims of domestic violence identified the time constraints of a busy practice as the major deterrent for asking about violence in the home. These physicians felt that domestic violence was of such low prevalence in their patient population that pursuing it was not a good investment of time.

Lack of an Appropriate Knowledge Base

In a system such as this, staff often lack enough knowledge about spouse abuse to correctly identify either the problem or the victim. Apart from mandatory child

abuse reporting, content on domestic violence is infrequently presented in professional school curriculums (King, 1988; McKenna, 1989; Randall, 1992; Sheridan, 1987), so that physicians and nurses lack the knowledge and training that would help them correctly identify and interpret signs and symptoms of abuse.

Efforts at Change

Early research findings that domestic violence was a leading cause of women's trauma injuries coupled with practitioners' growing realization of how little they really knew about this phenomenon led many in the medical community to question their own attitudes toward and treatment of battered women (Pagelow, 1992; Randall, 1990). First examined was the care given victims of domestic violence in hospital emergency rooms (Flitcraft, 1992). Many hospitals began developing and implementing protocols for identifying battered women in emergency departments. Sporadic efforts were also begun to train health care workers in the dynamics of intrafamily violence.

Impact of Protocols

There is some empirical evidence that protocols and increased staff training in the dynamics of domestic violence do increase the rate of identification of victims. One study showed an increase in identification,

after protocol training, from 5.6% before to 30% after (McLeer & Anwar, 1989). These researchers designed a pilot study to see if the use of a protocol in a hospital emergency department, with direct questions about whether injuries were caused by battering, would increase the percentage of battered women identified. Utilizing the classification system for identifying women at risk for battering developed by Flitcraft (1977), McLeer and Anwar retrospectively reviewed the records of all female trauma victims (exclusive of motor vehicle accidents and natural disasters) who presented to the emergency department in a large mid-Atlantic hospital in 1976. Risk for battering was identified as positive, probable, or suggestive of a battering incident as documented in emergency room intake data. They then classified as positive for battering any case where a woman directly stated that her injuries were caused by an assault by someone with whom she was or had been intimately involved.

These researchers found that only 5.6% of the 359 female trauma patients were identified in their case records as having injuries caused by battering (1989). Another 10.9% of patients were classified as probable cases of battery and 9.2% as suggestive of abuse by these researchers. Following the introduction of the protocol which encouraged providers to ask questions which elicited

a trauma history and to directly ask women if they had been injured by someone, the percentage of women identified positively as victims of domestic violence jumped 24.5% (McLeer & Anwar, 1989). In addition, McLeer and Anwar (1989) found that the majority of women, regardless of battering status, responded readily to the questions and the women who had been abused appeared relieved that someone had directly asked how they had been hurt (a point also made by Drake's 1982 research study).

In a similar study, Tilden and Shepherd (1987) used a time series quasi experiment to demonstrate a significant increase in nurses' documentation of wife battering after staff training and implementation of an abuse-victim protocol. As did Anwar and McLeer, these researchers used the classification system developed by Flitcraft (1977) in reviewing the records of all adult female trauma patients (N=447) seen in a northwestern university affiliated hospital emergency department during a four month period. They were looking for documentation of battering in the nurses' notes. They found documentation either positive, probable, or suggestive of battery in 72 of these cases. Yet, nursing staff documented spouse abuse in only seven of these cases (9.72%) (Tilden & Shepherd, 1987). Following the introduction of the protocol and staff training in its use, the rate of identification of cases

positive for abuse rose to 22.97% (17 cases out of a possible 74). However, staff was still missing almost 77% of the women identified by the researchers as still at risk for abuse (Tilden & Shepherd, 1987).

These two studies, while indicating that increased knowledge in the dynamics of domestic violence does significantly increase the rate of identification of victims, also demonstrate the probability that other factors beyond cognition influence health care providers' response to victims of domestic violence. Even in the presence of obvious signs and symptoms of abuse, with knowledge of the underlying cause of the trauma, and structural supports in place (i.e. protocols), many physicians and nurses fail to respond to battering. Several studies examined this phenomenon to better understand caregivers' responses. Two studies in particular will be discussed in some detail here.

Warshaw (1989) examined emergency room records in one hospital emergency room that had a formal protocol for identifying and treating women at risk for abuse. Her review of the records clearly indicated that 52 women were being treated for injuries deliberately inflicted by another person. In the majority of cases, the injured women either directly admitted being battered or gave very strong clues about being at risk for abuse. These clues

included mention by the patient of such things as marital difficulties, vague psychosomatic complaints, abortion, miscarriage or premature labor; substance abuse, and\or suicide attempts, all phenomena previously associated with women at risk for abuse. This information was recorded in the chart, but was rarely expanded upon by the caregiver (Warshaw, 1989).

Analysis of the records demonstrated that even when women had clearly been deliberately injured by an intimate, they were rarely asked any questions by the physicians that indicated an awareness of potential or actual abuse (Warshaw, 1989). In over 90% of the cases, the physician failed to obtain a psychosocial history, failed to ask about past sexual or physical abuse, failed to ask about the woman's living arrangements, and failed to address the woman's safety. Finally, in every case, despite explicit information about abuse (i.e. patient statements about the abuse) or very strong clues recorded by the nurse or physician, the physician's discharge diagnosis specifically reflected this victimization in only 8% of the cases.

Physicians in this study infrequently followed the existing protocol for working with women at risk for abuse (Warshaw, 1989). Despite a formal protocol that specifically calls for psychiatric and social work

consultations in identified cases of domestic violence, there was no psychiatric consult in 96% of the cases reviewed and no social work consult in 92%.

Warshaw (1989) found no major differences between the nurses and the doctors in their recording of explicit information about abuse; however, she did find that physicians tended to obscure information already recorded by the nurse rather than to elaborate on it. She speculated that overwork and understaffing for both nurses and doctors may have overridden any expected gender differences in responsiveness.

In the second study, Kurz (1987) examined the reactions of emergency department staff to battered women in four hospitals in a large metropolitan area. Utilizing a variety of data collection methods - direct observation of interactions between battered women and staff, informal interviews with Emergency Department staff, and a review of medical records, she compared staff reactions in three of these hospitals where there had been one-time efforts to educate staff about battering to a fourth hospital which had in place on-going intervention efforts.

Staff responses were rated as positive, partial or nonresponsive. Positive staff responses were seen as supportive and sympathetic. In these cases, in addition to providing medical care, staff noted battering on the

case record, spoke to the women about what happened, assessed for safety, and attempted to provide some appropriate assistance. Staff were more likely to be sympathetic and offer positive responses if they thought the woman to be in immediate danger and actively trying to extricate herself from the abusive situation.

Partial responses, while similar to positive responses, such as discussing the women's situation or offering a hotline card were typically time-limited and businesslike. These responses were most often explained by staff as reactions to women they perceived to be evasive, irresponsible, or uninterested in being helped. This assumption was often associated with their belief in a personal inability to assist the women in changing their victimization.

Nonresponsive staff offered the battered women only medical treatment, citing many of the same reasons given for the partial responses. Also mentioned were lack of time and the view that battering was not a legitimate medical concern. In general, Kurz (1987) found staff's negative perceptions and misconceptions of battered women to be the primary factor in their lack of responsiveness. Battered women were frequently seen as a source of frustration and personally responsible for their own abuse.

While reasons for responses were similar across the four hospitals, rates of response were markedly different. The hospital with the on-going intervention efforts employed a physician's assistant who believed that battered women were victims not only of their abusers, but also of sexist institutions and practices. She served as an advocate for victims of domestic violence and reframed as signs and symptoms of abuse many of the patient behaviors that her colleagues found troubling. In this hospital, researchers found that staff took battering seriously 47% of the time, viewing it as a legitimate medical concern. In contrast, battered women seen in the other three hospitals fared less well, eliciting a positive response from staff in only 11% of the cases. Similarly, in the hospital with the activist physician's assistant, only 21% of staff responses were partial and 32% were nonresponsive, as compared to 49% and 40% respectively in the other three hospitals. Therefore, it appears that the attitudes of these medical personnel significantly influenced their response to the battered women they attended.

While Kurz and Warshaw drew different conclusions as to the reasons for medical nonresponsiveness to victims of domestic violence, both studies demonstrate this continued pattern. Both studies also document the continued pattern

of "decontextualization" of abuse by the medical community. Even in the face of obvious victimization on the part of the woman and the existence of the formal protocol for handling such cases, health care providers continue to avoid exploring the context of abuse. For the most part, they continue to focus on the victim's obvious trauma injury or presenting symptom and confine their attention and energy to this domain.

Domestic Violence: Attitudes Toward Victims

Societal Attitudes

As highlighted by Kurz's study, the domestic violence literature increasingly suggests that there is another reason for this lack of effective response on the part of health care workers. Researchers have begun to identify that it is an individual's socialized attitudes rather then his or her cognitive style or knowledge level that most determine response to victims of violence (Eisikovits, Edleson, Guttman, & Sela-Amit, 1991; Flitcraft, 1992; King & Ryan, 1989; Tilden, 1989; Tilden & Shepherd, 1987).

Numerous studies conducted over the past two decades indicate that societal attitudes toward domestic violence are complex and varied. Survey data generated from the general population during these years revealed disturbing

levels of acceptance of violence against wives, with between 16.6% and 27.6% of respondents indicating that hitting a spouse was justified, and at times, even necessary (Dibble & Straus, 1980; Gentemann, 1984).

Although males\husbands are allocated the majority of responsibility for violence between intimates, females\wives are held responsible under certain circumstances. Gentemann (1984) found that nearly 19% of the 400 adult females she surveyed felt that wife-beating was justified in situations where the wives were perceived to be flirting or nagging or drunk. Similarly, research by Kalmuss (1979) demonstrated that while 73% of her respondents attributed primary or total responsibility for any violence to the husband\perpetrator, 23.7% attributed equal responsibility to both participants, and 3.3% attributed primary or total responsibility for any violence to the wife\victim. Kalmuss found that a sizeable minority of respondents attributed less responsibility to the husband when the abuse was seen as justified (i.e. husband and wife arguing prior to the abuse) and when the physical consequences to the wife were low (i.e. black eyes versus internal injuries). Sugarman and Cohn's (1986) examination of attribution of responsibility for wife abuse demonstrated that while males\husbands were overwhelmingly held responsible for

the origin of the violence, females\wives were likely to be held responsible for solutions to the violence.

Health Care Attitudes

Attitudes or personal biases concerning domestic violence are thought to be particularly problematic for those in the medical community. Identified as a source of concern more than a decade ago (Stark, Flitcraft, Zuckerman, Grey, Robison, & Frazier, 1981) medical and nursing research continue to demonstrate that physicians and nurses are influenced by societal and personal misconceptions about domestic violence (King & Ryan, 1989; Shipley & Sylvester, 1982; Sugg & Inui, 1992) and that these misconceptions compromise medical and nursing care (Drake, 1982; Hilberman & Munson, 1978; King & Ryan, 1989; Kurz, 1987; Lichtenstein, 1981; Podrasky & Sexton, 1988; Stark & Flitcraft, 1988; Sugg & Inui, 1992).

A growing literature shows how health care professionals stereotype, label and derogate battered women (Davis, 1984; Drake, 1982; Kurz, 1987; Stark & Flitcraft, 1988). While attitudes toward domestic violence victims are just recently becoming a focus of nursing researchers, a critical review of research on stereotyping by nurses and nursing students conducted by Ganong, Bzdek and Mandarino (1987) presents some evidence that nurses stereotype other people based on sex, age,

attractiveness, personality, diagnosis, social class, and family structure. However, the researchers, citing methodological errors in many of the studies reviewed, cautioned against drawing firm conclusions from the results. The majority of the studies reviewed were descriptive in nature, used convenience or other non-probability sampling, used researcher-developed instruments lacking in reliability and validity, and refrained from addressing any possible social desirability problems.

Additional studies have indicated that nurses and nursing students label as difficult alcoholic patients (Harlow & Goby, 1980; Schmid & Schmid, 1973), psychiatric patients (Behymer, 1953; Belknap, 1956), patients who were obese, abused drugs or smoked cigarettes (Fernicola, 1982), were time-consuming, demanding, complaining, unreasonable and uncooperative, or were female (Podrasky & Sexton, 1988). In general, nurses appear to dislike and label as difficult patients that in some way make them feel ineffective and powerless (Ganong, Bzdek, & Manderino, 1987; Podrasky & Sexton, 1988).

Podrasky and Sexton's (1988) investigation found that the label "difficult patient" was more likely to be used when the participants were confronted with patient behaviors or characteristics seen as in some way under

patient control than when they were confronted by characteristics or behaviors that were seen as inborn and so essentially beyond patient control. This was interpreted as an indication that nurses had less tolerance for negative traits or behaviors that were learned because the patient was expected to have some control over them. This same study found that difficult patients frequently elicited feelings of anger and frustration from their care-givers (Podrasky & Sexton, 1988). Indeed, when faced with difficult patients, research indicates that health care professionals not only label these individuals, but actually blame them for their problems, particularly if these problems involve self-destructive life-styles or chronic complaints (Lorber, 1975).

When faced with a difficult patient, rather than attempting to determine the reason for the negative behavior or respond therapeutically to it, nurses frequently exhibit the classical fight or flight response. They take out their anger either directly on the patient (Newburn, 1987) or on a third party or object (Podrasky & Sexton, 1988) or they avoid and ignore the patient (Flaskerud, Halloran, Janken, Lund, & Zetterlund, 1979; Janken, 1974). Stereotyping or labelling of patients limits the nurses' ability to see beyond the label and

examine all aspects of the presenting problem (DeVellis, Wallston, & Wallston, 1980; Fischelis, 1961; Janken, 1974), thus limiting their ability to provide appropriate and quality nursing care (King & Ryan, 1989; Podrasky & Sexton, 1988).

Nursing Attitudes

Numerous authors have punctuated the critical need for nurses to be aware of and in control of their own feelings and attitudes toward victims of domestic violence (Brendtro & Bowker, 1989; Lichenstein, 1981; Sherman, 1980; Valenti, 1979; Weingourt, 1985) warning that the nurse who is not, in effect, "fuses with the violent family" (Foley & Grimes, 1987, p. 943).

Attitudes of nurses toward victims of domestic violence have been explored by King (1988) and compared to other health professionals by Shipley and Sylvester (1982) and Rose and Saunders (1986). Drout (1987) expanded this comparison beyond health care personnel to include other professionals who often interact with victims of domestic violence (i.e. lawyers, social workers, police officers).

In one of the earliest nursing studies to examine professional attitudes toward victims of domestic violence, Shipley and Sylvester (1982) randomly surveyed 450 health care professionals at a large metropolitan medical center. Their purpose was to identify the present

attitudes of various groups of health care workers toward both victims and perpetrators of domestic violence. While the study was exploratory in nature and the return rate small (27%, N=122), the study did generate some interesting findings. The majority of health care professionals agreed that there were complex social and intrapersonal factors that contributed to family violence. Yet, the data indicated that these same professionals shared some societal myths and misconceptions about this phenomenon. Specifically, both physicians and nurses expressed beliefs that domestic violence was more prevalent in certain ethnic backgrounds than others and that abusive persons tend to be mentally ill.

Rose and Saunders (1986) used an expost facto survey design to study the attitudes of two groups of health care workers toward victims of domestic violence. Eighty-six physicians (84% of the sample) and 145 nurses (81% of the sample) responded to a two page mailed questionnaire. The questionnaire consisted of two instruments, one to measure attitudes toward women and one to measure beliefs about wife-beating. The instrument used to measure the beliefs about wife-beating consisted of three subscales measuring such constructs as wife-beating is justified, wives should prevent beatings, and wives should be helped. Because of their position in the medical hierarchy, Rose and Saunders

predicted that a) nurses would have more sympathetic attitudes toward battered women than physicians; and b) professional roles, rather than gender would explain any attitudinal differences.

Univariate analysis was used to compare nurses and physicians both across and within gender for differences in their beliefs about women abuse and their attitudes toward women. These researchers found that while both groups believed some myths about battered women, including that women were somewhat responsible for their victimization, nurses (as a group) were more sympathetic toward battered women than were physicians. Nurses were less likely to believe that beatings were justified or to believe that women were responsible to prevent beatings. However, contrary to their initial hypothesis, they found that gender and not professional socialization, was the differentiating factor in these beliefs (Rose & Saunders, 1986). Female nurses and physicians held more liberal attitudes than male nurses and physicians. Male nurses (who represented just 2% of the nurse group) showed the least opposition to wife-beating. Nurses and physicians with the most liberal attitudes toward women's roles were the least likely to blame victims.

Physicians and nurses were united in their belief that battered women should be offered help for their

victimization (Rose & Saunders, 1986). The authors speculated that this finding occurred because the items measuring this construct may have not been specific enough to differentiate between the two groups. In addition, the codes of ethics in both medical and nursing professions mandates that all patients be given care regardless of situation or individual characteristics.

In the expanded comparison study, Drout (1987), using a sample of 92 professionals (including police officers (N=29), public health nurses (N=20), social workers (N=22), and lawyers (N=20), examined attribution of blame for battering. These professionals responded to written scenarios in which the researcher manipulated various characteristics of both the victim and the batterer (specifically marital and economic status). She anticipated that those professionals, regardless of professional role, who had the most extensive contact with battered women or who had received training would be more sympathetic toward battered women. This would be evidenced by a) attribution of responsibility to the batterer, b) positive character evaluations of the battered woman, and c) recommendations for substantial corrective action following abuse.

Overall, the professionals viewed the unmarried victim more negatively than the married victim and the

dependent victim more negatively than the independent victim. However, this researcher found that both professional role and amount of contact with battered women played a differentiating role in attribution of blame. Drout found that nurses and police officers held the victim more responsible for the battering and the perpetrator less responsible than did social workers or lawyers. In addition, nurses, as a group, were more likely to evaluate the victim's character negatively and attribute blame to the victim's personality. Nurses were also less likely than the other professionals to envision encouraging battered women to call the police and press charges.

Differences in attribution of responsibility were explained by differences in amount of contact with battered women (i.e. the greater the contact, the less likely the professional would be to hold the victim responsible). Those professionals with infrequent contact with victims of domestic violence, defined by the investigator as fewer than one to five contacts per year, (i.e. police officers and nurses), tended to hold the victim more responsible and the batterer less responsible for the victimization than those professionals with more frequent contact with victims (i.e. social workers and lawyers). Interestingly, this last finding, that more

contact with victims increases sensitivity, while supported by Shipley and Sylvester (1982), is in direct contrast to Snyder and Newberger's (1986) findings that increased clinical contact decreased sensitization toward victims of violence in their sample of nurses.

The last study on nursing attitudes reviewed is also the most recent. King's 1988 study proposed to a) determine the perceived helping model preferred by nurses in their interventions with battered women and b) determine those factors in the nurses' educational and clinical experiences which affect this preference. Utilizing a self-administered questionnaire containing the Help Orientation Test and an educational/experience questionnaire, she obtained data from 116 registered nurses, 57 emergency room nurses plus 59 nurses who had attended a three day national nursing conference on violence against women. The Help Orientation Test (HOT) identifies several different helping models. These include: a) the compensatory helping model - where individuals are not responsible for problem cause, but are seen as responsible for problem solution; b) the enlightenment helping model - where individuals are seen as responsible for problem cause but not for problem solution; c) the medical helping model - where individuals are seen as responsible for neither problem cause nor

problem solution; and d) the moral helping model - where individuals are seen as responsible for both problem cause and problem solution. The educational/experience questionnaire contained two items directly questioning respondents on attribution of responsibility for problem and solution.

The results of the study show the inclination of nurses, regardless of their educational background, practice setting, or clinical experiences, to use the medical model of helping in which the client is attributed low responsibility for both problem cause and solution rather than a more empowering model of helping. In the medical model individuals are expected to get well by seeking and utilizing the help of expert practitioners, rather than attempting to solve the problem themselves (King, 1988). The second most popular choice for both groups of nurses was the moral model of helping. While this model holds the woman responsible for her abuse, it also holds her responsible for solving her problems. King (1988) concluded that the choice of this helping model, while disappointing in that it still held women responsible for their own abuse, was more related to the empowerment approaches identified as helpful to battered women as it rested on the premise that the women were also responsible for solving the problems.

While all respondents chose a medical model in response to the HOT test, direct questioning of the respondents through two short questions on the educational\experience questionnaire indicated a difference in attribution of problem responsibility between the two groups of nurses. None of the Conference Attendee Nurses thought that the women were totally responsible for their abusive situations while 4% (N=2) of the Emergency Room Nurses attributed total responsibility to the victim. Seventy-eight percent (N=45) of the Conference Attendee Nurses thought that the victim was totally not responsible for her abusive situation while only 39% (N=22) of the Emergency Room Nurses thought that she was totally not responsible. The majority of the nurses in this latter group (58%, N=33) were neutral on this question.

When asked directly whether or not they thought battered women were responsible for extricating themselves from their abusive situation there was no significant differences between the groups. Neither group thought that the women were not responsible for problem solution. While the majority of all the nurses (54.7%, N=62) were neutral in response to this question, 40% (N=45) of the nurses thought that battered women had high responsibility for getting themselves out of their abusive situation.

This is in direct contrast to their choice of the medical model as their preferred model of helping, since in this model the woman is attributed low responsibility for problem solution.

Most nurses in the study, while reporting significant clinical and personal contact with battered women, reported little specific training on the topic. In addition, 18% of the nurses reported personal experience with either physical or emotional abuse (King, 1988). This particular finding led King to conclude that personal experiences, attitudes and beliefs strongly influenced the nurse's reaction to battered women. "This personal experience often leads to repression of feelings or knowledge of abuse and leaves one unwilling to look at the pain and prevalence of abuse" (King & Ryan, 1989, p. 48). In a later article growing from this study, King and a colleague highlighted numerous personal and societal beliefs about abused women subscribed to by the nurses in her study. For example, many of the nurses surveyed believed that a) violence was a private matter, b) battering occurred more frequently in certain racial and cultural backgrounds, c) women who live in abusive relationships tend to become helpless, d) alcohol causes battering, and e) the abuse suffered by these women could not be all that bad or the woman would leave.

King's work is important because it is the first nursing study to postulate that it is personal care-giver beliefs and attitudes rather than lack of skill or education that impedes efforts at appropriate intervention with abused women.

In summary, these studies suggest that while specific training on abuse continues to be important for nurses and nursing students, examination of personal beliefs about intrafamily violence and its victims is equally, if not more, important. Yet, as can be seen, studies of nurses' attitudes toward victims of domestic violence are limited in number. There appears to be a void in studies examining the attitudes or perceptions of nursing students toward victims of domestic violence despite the belief that attitudes are believed to be formed as a result of experience and exert a dynamic influence on the individual's response to situations and people (Allport, 1967). While Rose and Saunders' study examined respondents' attitudes toward women as they impacted on attitudes toward wife-beating, many attitudinal studies focus on factors external to the respondent, such as characteristics of the victim or context of the situation. There are few studies which examine personal characteristics or experiences of these groups of care-givers as they relate to attitudes toward victims of

domestic violence. Therefore, this study proposes to examine the relationship between selected personal and relationship characteristics and experiences of nursing students and their attitudes toward victims of domestic violence.

Specific Variables Impacting on Attitudes toward Victims

Sex Role Egalitarianism

The literature on family violence suggests that the sexist structure of the family and of society encourages women-battering by promoting expectations of male dominance and authority and female dependency and submission. In such a structure, the use of force against wives and female partners both protects male authority and is justified by the existence of male authority (Straus, 1976). The sociocultural analysis of spouse abuse views sex role socialization, which results in aggressive, dominant, authoritarian men and passive, dependent, self-sacrificing women, as one vital social mechanism for the creation and legitimization of an ideology that supports this male dominance and the need to maintain power through whatever means are deemed necessary (Finn, 1986).

A number of authors have suggested that stereotypical sex role ideology is a critical variable in supporting marital violence (Dobash & Dobash, 1979; Steinmetz, 1977;

Straus, 1976). While several investigations involving clinical populations have demonstrated an association between sex role stereotyping and marital violence (Bernard & Bernard, 1984; Coleman, 1980; Telch & Lindquist, 1984), with batterers tending to be less egalitarian and more traditional than nonbatterers, conflicting results have been reported. Hotaling & Sugarman (1986) reported that only two of the eight studies they reviewed found that batterers held more traditional sex role expectations than nonbatterers. They concluded that "male dominant expectations may be so pervasive that it is not possible to differentiate violent males from nonviolent males on this dimension" (Hotaling & Sugarman, 1986, p. 114). These same researchers report conflicting results from studies they reviewed which examined the hypothesis that women socialized to hold traditional sex role expectations or to accept male-dominant family relationships may be more likely to experience violence in their adult relationships. Three of the studies reported a positive relationship between sex role traditionalism and victimization, while three studies found no relationship. Hotaling & Sugarman (1986) conclude that sex role traditionalism cannot discriminate victims of wife abuse from women in nonviolent, but highly conflictual relationships.

However, studies involving nonclinical populations suggest a similar relationship between sex role egalitarianism and marital violence. Gentemann (1984) surveying a cross-section of 400 adult females, found that those individuals with traditional sex role attitudes were significantly more likely to justify wife abuse than those individuals with egalitarian sex role attitudes. One of the first empirical studies to directly explore the association between sex-role attitudes and attitudes toward marital violence in a nonclinical population was done by Finn in 1986. He surveyed 300 male and female college undergraduates at two Southern universities and found that the majority of these students held egalitarian sex-role beliefs and disapproved of the use of physical force in marriage. However, further analysis indicated that men held significantly more traditional sex role attitudes than women and were more likely to hold attitudes that endorsed the use of force in marriage. Finally, use of a multiple regression analysis revealed that attitudes toward sex roles accounted for the largest proportion of explained variance in attitudes toward force in marriage and was therefore the most powerful predictor of those attitudes (Finn, 1986).

Stith (1990) has utilized both clinical and nonclinical samples to investigate this relationship

between sex role egalitarianism and marital violence. Her first study utilizing this construct was an effort to determine how individual and family characteristics influenced the male police officer's responsiveness to domestic violence. Seventy-two male police officers were asked to respond to three vignettes in which husbands assaulted their wives. Utilizing these vignettes, two exogenous variables (level of sex role egalitarianism and level of marital stress) and two endogenous variables (approval of marital violence and use of violence in marriage), Stith developed and tested a multivariate causal model to predict three different possible police responses (i.e. mediating response, arrest, and antivictim response).

In order to determine the impact of the total model on police response to marital violence, Stith conducted three separate analyses using the different vignette measures of police response. The results demonstrate that neither arrest nor mediation was significantly predicted from combining the four variables. However, the model was significantly able to predict antivictim response and came close to predicting arrest. The model accounted for 19% of the variance in the antivictim response and 11% of the variance in the arrest response. Sex role egalitarianism, by itself, approached significance in predicting

antivictim response (B= -.21, p=.01), demonstrating that as the officers' egalitarianism decreased, their tendency toward an antivictim response increased. Stith (1990) concluded that the model, including the officer's use of violence in his own marriage, marital stress level, marital violence attitude and egalitarianism was related to the officer's use of hostility toward victims, but was not significantly related to his use of arrest, or mediating responses in domestic violence situations.

In another study, Crossman, Stith and Bender (1990) explored the relationship between sex role egalitarianism and marital violence in a clinical sample of men enrolled in either substance abuse programs (N=71) or in anger management programs (N=44). The men were questioned about their approval of marital violence, their conflict tactics, their sex role egalitarianism, and their problems with alcohol. Use of regression analyses on the data generated from the combined groups demonstrated that egalitarianism was explained by severe violence, minor violence, and attitudes approving of marital violence. Thus, 18% of the variance in egalitarianism was accounted for by these three variables. The best predictor of egalitarianism was approval of marital violence (B=-.31, p=.01). Severe violence also explained a significant amount of the variance in egalitarianism (B=-.27, p=.02)

whereas, minor violence did not.

Much has been written regarding the sexist bias of most health care delivery systems. Lovall (1981) in fact asserts that the obvious sexism of the medical profession is not incidental, nor merely a reflection of societal attitudes, but a stronghold historically designed to control women. As health care providers, nurses often feel confined by an externally imposed structure and value system reflective of these attitudes and biases. In such an oppressive environment, nurses are treated "as objects to be acted upon rather than as human beings capable of action" (Lovell, 1988, p. 216). Ehrenreich and English (1973) concluded that oppression of nurses was inextricably linked to their oppression as women, with nursing a workplace extension of the female roles as wives and mothers. Studies conducted in the last decade which explored the characteristic of nurses (and nursing students) found that these individuals frequently conform to societal expectations of women, both in personality characteristics and in behavior (Haddad, 1989; Loo, 1983; Rendon, 1987). However, no studies have examined the relationship between the sex role egalitarianism of nursing students and their attitudes toward victims of domestic violence.

Based on this review of the literature, the following

hypothesis regarding nursing student attitudes toward victims of domestic violence was proposed:

A positive relationship exists between nursing students' level of sex role egalitarianism and their sympathy towards victims of domestic violence.

Personal Experience with Family Violence

Family violence has been shown to exert a life-long influence on its victims, both directly and indirectly (Walker, 1984). In fact, witnessing parental conflict has been consistently identified by researchers as an extremely stressful event for children (Brown, O'Keefe, Saunders, & Baker, 1986; Dibrell & Yamamoto, 1986; Lewis, Seigel, & Lewis, 1984; Yamamoto, 1979). Both anecdotal (Hilberman & Munson, 1978) and empirical studies (Davis & Carlson, 1987; Goodman & Rosenberg, 1987; Jaffe, Wolfe, Wilson, & Zak, 1986) indicate that observation of marital violence adversely effects children causing problems in the areas of health, socioeconomic development, and interpersonal behavior. The empirical studies also found some evidence that the combination of being a witness and being a victim of family violence has more serious consequences for the child.

In a secondary analysis of a survey conducted for the Commission on the Causes and Prevention of Violence, Owens

and Straus (1975), reported a strong association between exposure to violence, either as an observer or as a victim of violence during childhood, and violent behavior as an adult. Later research suggests that the opposite might be true, with observation of parental conflict more consistently associated not with perpetrating violence, but with being victimized by violence, especially for women (Hotaling & Sugarman, 1986). Thus, this intergenerational transmission of violence theory has undergone several evolutions, with recent literature continuing to report conflicting results.

For example, Cappell and Heiner (1990) found that both men and women who witnessed spousal aggression in their family of origin were less likely to direct aggression toward their spouses and more likely to become victims of such violence in their adult relationships. Cappell and Heiner (1990) analyzed a sub-sample of the 2143 married or cohabiting couples interviewed for the NSPVAF (1976) (Straus, 1980). In that survey, one person from each couple was interviewed and questioned about the presence of violence in both his\her current family and family of origin. The sub-sample analyzed (N=888, 487 females, 401 males) included only those couples with one or more children living at home.

To gather data about the presence of violence in

families of origin, respondents were asked how often they 1) were hit by either parent during adolescence (variable labelled parental aggression in the family of origin) and 2) witnessed or knew about one parent hitting another (variable labelled spousal aggression in the family of origin). The Conflict Tactics Scale (CTS) (Straus, 1979) was used to measure the incidence of aggression in the respondent's current family. Multivariate models of analysis were used to examine the relationships between the different forms of violence in the two generations of families and to ascertain the affect of one form of aggression on another form.

Cappell and Heiner (1990) found that reported aggression between the spouses in the family of origin was associated with reported aggression between the parents and the respondents. Males reported being hit by their parents in their families of origin more often than did females. However, most interestingly, the researchers found that both men and women who witnessed spousal aggression in their family of origin were not more likely to direct aggression toward their spouses. Rather women and men who reported having witnessed spousal aggression in their families of origin were more likely to have reported that they were the targets of aggression from their spouses. Cappell and Heiner concluded that men and

women apparently did not learn the role of perpetrator of aggression in their families of origin, but rather learned vulnerability to aggression. "Contrary to popular belief, knowing whether aggressive relations were present in the family of origin will be more useful in predicting whether the respondent is the target of aggression than in predicting whether the respondent is the perpetrator" (Cappell & Heiner, 1990, p. 149, 150). While they confessed to be ignorant of exactly what mechanisms were involved in this intergenerationally transmitted vulnerability, Cappell and Heiner (1990) postulated that "vulnerability might involve learning to tolerate violence" in some manner (p. 147). Such a learned tolerance could render these individuals less sensitive to intrafamily violence as adults.

Utilizing a survey format, Alexander, Moore, and Alexander (1991) attempted to answer the following questions about dating violence: 1) what is the effect of observing childhood violence on dating violence?, 2) what is the effect of witnessing marital violence on one's own attitudes toward women?, and 3) what are the effects of attitudes toward women on dating violence? Their sample consisted of 380 individuals (152 males, 228 females) not presently married, but involved in a dating relationship of at least six months duration. Data on relationship

violence was collected via the verbal aggression and violence subscales of the Conflict Tactics Scale (CTS) and a separate questionnaire examining the frequency with which various types of family violence occurred both in their families of origin and in their current dating relationship. The Attitudes toward Women Scale (AWS) was used to measure the views of respondents regarding the roles and rights of women in contemporary society. In addition, the respondents completed a second questionnaire describing their partner's presumed attitudes toward women and their own attitudes toward women. Hierarchical regression analysis was used to evaluate the three research questions.

Alexander, Moore, and Alexander (1991) found that males were more likely than females to report being verbally abused, being verbally abusive, being physically abusive, and being physically abused by their partner if they have been severely abused by their father. In contrast to Cappell and Heiner (1990), these researchers found that witnessing marital violence between one's parents was not predictive of either extending or receiving verbal and physical abuse in the dating relationship, nor was being physically abused by one's mother. However, physical abuse by one's father was highly predictive of a man's extending and receiving both

verbal abuse and physical abuse in a dating relationship.

Alexander, Moore, & Alexander III (1991) found that the witnessing of parental abuse had a powerful effect on the enculturation of values in children. These researchers found that males who witnessed marital violence were conservative in their attitudes toward women, while females who witnessed such conflict generally espoused more liberal views. Finally, Alexander, Moore, and Alexander (1991) found that individuals with conservative attitudes toward women were more likely to report being verbally and physically abusive if their partners' attitudes were seen as liberal. Conversely, these individuals were less likely to report being verbally and physically abused than were those individuals with liberal attitudes toward women if their partners' attitudes were seen as conservative.

Personal experience with family violence may also influence the attitudes and helping responses of health care professionals toward victims of domestic violence. Recent literature indicates that physicians and nurses are not immune to family violence (Dotterer, 1992; King & Ryan, 1989; Sugg & Inui, 1992). Both King and Ryan and Sugg and Inui commented on how the diagnosis and treatment of abuse might be hindered when nurses and physicians too closely identify with abused patients due to their own

experience with violence. Eighteen percent of the nurses interviewed for King's (1988) study reported personal experience with either physical or emotional abuse. Sugg and Inui found that 14% of the male physicians and 31% of the female physicians in their study acknowledged personal experience with abuse in their family of origin or physical violence with an intimate partner.

Several researchers have attempted to examine this phenomenon and its impact on clinical assessment of violent situations. Herzberger and her colleagues explored the responses of both lay (college students) and mental health professional populations to a series of vignettes depicting moderate to severe disciplinary actions. In the first study (Herzberger & Tennen, 1985) young adults were asked to read descriptions of disciplinary actions and judge a) the severity and appropriateness of the parents' behavior and b) the emotional impact of this discipline on the child's future behavior. Herzberger & Tennen report that lay people who had been severely disciplined\abused as children view the abuse of others as less serious than those who had not been abused. In addition, participants with similar backgrounds believed the punishment would be less likely to harm the child's future development and more likely to decrease future misbehavior.

In a follow up study, Howe, Herberger, & Tennen (1988) examined the effect of a personal history of abuse on clinicians' judgments about an allegedly abusive situation. Contradictory to the earlier study surveying a lay population, Howe, Herzberger, & Tennen (1988) found that clinicians with a personal history of abuse viewed abuse of others as more serious and having a more adverse affect on the individual's subsequent development than did those without such a history. Consistent with previous research (Herzberger & Tennen, 1985a; Snyder & Newberger, 1986) these researchers also found gender differences. Female clinicians believed that the disciplinary actions depicted were more severe and had a more deleterious affect on the individual that did their male counterparts.

While there has been little research which directly examined the impact of personal experience with domestic violence on nurses' attitudes, nursing literature supports the idea that personal experiences and family expectations and\or attitudes strongly influence both nurses' attitudes and their behavior. For example, studies show that nurses' inferences about patient suffering are directly or indirectly influenced by their own psychological characteristics and acquired beliefs about suffering (Dudley & Holm, 1984; Holm, Cohen, Dudas, Medema, & Allen, 1988; Mason, 1982). In fact, a major finding of the Holm

et al study was that assessment of patient's pain is significantly influenced by the intensity of the nurse's personal experience with pain (1988). The authors found that nurses who had experienced intense pain themselves were generally more sympathetic to the patient in pain than those who had not.

Based on this review of the literature, the following hypotheses regarding nursing student attitudes toward victims of domestic violence were proposed:

A positive relationship exists between the level of violence nursing students experienced in their family of origin and their sympathy toward victims of domestic violence.

A negative relationship exists between the level of violence nursing students experience in their current relationships and their sympathy toward victims of domestic violence.

Feeling of Control over Life Events

This variable was chosen because "the issue of power and powerlessness is a probable cause or at least a contributing factor to violence in the family..."(Pagelow, 1984, p. 87). Finkelor concurs and further states that "abuse tends to gravitate to the relationships of the greatest power differential" (1983, p. 17). Men who see

themselves as relatively powerless in the environment beyond the home often attempt to compensate for these feelings\perceptions by exerting absolute power in the family (Pagelow, 1984). Walker (1984) has also studied this phenomenon but from the perspective of the victim, not the batterer. Researchers have begun examining this concept of powerlessness not just in terms of violent family dynamics, but also as a factor in the development of attitudes and perceptions about wife abuse.

Attributions and perceptions about wife abuse are derived from several differing theoretical perspectives and these differing perspectives about violence toward women frequently yield competing hypotheses. For example, both defensive attribution theory and balance theory suggest that females and those with more favorable attitudes toward women will blame and derogate victims of violence less than males and those whose attitudes toward women are more negative. In contrast, the just world hypothesis suggests that, among those who believe the world is just, a woman who provokes her own abuse should be blamed or derogated more than an innocent victim. In order to test the feasibility of these competing hypotheses Kristiansen and Guillieti (1990) examined the effects of gender, attitudes toward women and just world beliefs on perceptions and attributions about both the

perpetrator and victim in domestic violence cases. Surveying 157 college students (97 males, 60 females) Kristiansen and Guillieti collected data via instruments that measured the students' attitudes toward women and their belief in a just world. Participants were also asked for their responses to vignettes depicting various domestic violence scenarios, one in which the victim might be perceived to have provoked the abuse and one in which she did not.

Hierarchical regression analysis conducted on both sets of data revealed two patterns of results, each differentially associated with participants' gender. Men's perceptions and attributions regarding wife abuse appear to be a function of their attitudes toward women. Male participants blamed the victim more as their attitudes toward women became less favorable. In contrast, women's perceptions and attitudes about wife abuse appear to be contingent on both their attitudes toward women and their need for control. Females with positive attitudes toward women blamed the victim more as their just- world beliefs became stronger. This finding was interpreted by Kristiansen and Guilietti (1990) to suggest that women may blame a victim of domestic violence in an effort to gain perceived control over the possibility of their own potential victimization. Thus,

these researchers found that the need to maintain an illusion of invulnerability by blaming the victim for the abuse was greatest among those female students who not only felt more vulnerable themselves, but also had the greatest need to maintain an illusion of control. Kristiansen and Guilietti (1990) suggest that efforts to change perceptions of wife abuse must consider not only peoples' attitudes toward women, but also their gender and need for control.

Nursing has long been identified as a stressful profession. In nursing, becoming overwhelmed by stress (or burned out) has been linked to a perceived sense of powerlessness (Keane, Ducette, & Adler, 1985). Furthermore, feeling out of control and powerless has been linked with personal physical problems, emotional distress, poor patient care and low morale (Hickman, 1985; Halsey, 1985; Williamson, Turner, Brown, Newman, Sirles, & Selleck, 1988). It is not unusual to find nurses who feel frustrated, guilty, angry or anxious when patients do not respond to proffered nursing care. In fact, it has been speculated that some helpers "burn out" as a result of repeated failures in intervening with certain clients (Maslach, 1978). Attempts to find appropriate and\or effective alternative nursing interventions may cause the nurse to end up trying to control the patient. Such

attempts at control lead to further failure and accompanying feelings of confusion and anxiety (Janken, 1974). Nurses who feel out of control and powerless themselves, on the one hand, would seem to replicate the role of numerous client populations, but especially that of the victim of domestic violence. One implication of this replication of roles is the idea that nurses can identify the domestic violence problem, but cannot identify any solutions due to this parallel processing. On the other hand, it has been shown that nurses can become abusive themselves as a way to deal with their own frustration and perceived sense of powerlessness (Newburn, 1987). Either response to these feelings of powerlessness has the potential to revictimize the victim of domestic violence.

While no studies have been located which examine the impact of perceived control on nursing students' attitudes toward victims of domestic violence, one recent qualitative study examined primary care physicians' attitudes toward this particular client population. Sugg and Inui (1992) conducted semi-structured, open-ended interviews with 38 primary care physicians. Those interviewed were asked to describe domestic violence cases they had managed. During the one hour, audiotaped interview, the researchers asked specific probe questions

concerning the physician's role in identifying and intervening in domestic violence cases as well as questions concerning any personal experiences with abuse.

Fifty percent of the physicians voiced feelings of frustration and inadequacy when discussing their ideas about appropriate interventions in domestic violence. Many of these physicians pointed to the complexity of the problem, likening it to "a big morass which we will never escape" (Sugg & Inui, 1992, p. 3159). Sugg and Inui (1992) commented on the strong sense of powerlessness expressed by physicians as they described their inability to "fix" the problem, with many of the respondents bemoaning their lack of "tools". Sixty-one percent of the physicians revealed that they had neither training on domestic violence in medical school nor continuing education courses on the topic. Only 8% of the respondents indicated that they had good training in this area.

Forty-two percent of the physicians expressed frustration that although they would intervene with advice or referrals to resources, ultimately control was in the hands of the patients. Many physicians were frustrated by their inability to control the patient's behavior and the patient's inability to control their own life circumstances. In fact, this need to gain control and

expedite the problem was one of the major obstacles to the physicians' willingness to address domestic violence. Physicians, especially female physicians, were troubled by their lack of control when faced with the repetitive nature of domestic violence.

Based on this review of the literature, the following hypothesis regarding nursing student attitudes toward victims of domestic violence was proposed:

A positive relationship exists between nursing students' perception of control over life events and their sympathy toward victims of domestic violence.

Lastly, in a an effort to identify which of these variables, or combination of variables, best predicted attitudes toward battered women, and based on this review of the literature, the following hypothesis regarding nursing student attitudes toward victims of domestic violence was proposed:

Nursing students' attitudes toward victims of domestic violence are predicted by the students' level of experienced violence in their families of origin, sex-role egalitarianism, perceived control over life events, and current involvement in a violent relationship.

Summary

This chapter initially reviewed the literature

regarding the impact of violence on women's health, as well as the health care community's response to victims of such violence. The literature shows that violent family interactions compromise women's health in a variety of ways. Yet, the response of the health care delivery system toward battered women has been neither timely nor appropriate. Studies have shown that attitudes and personal biases concerning domestic violence are particularly troublesome for health care providers such as physicians and nurses.

The second section of the literature review examined attitudes and attributions regarding victims of domestic violence. It provided a detailed look at the attitudes of one group of health care professionals (specifically nurses) to the problem of domestic violence.

The final section provided a review of the literature related to the specific variables of interest. Based on this literature review, the proposed hypotheses and the proposed theoretical model for this study were developed.

CHAPTER 3

METHOD

The general purpose of this study was to examine the relationship between selected individual and relationship variables and nursing students' attitudes toward victims of domestic violence. The variables under scrutiny included sex-role egalitarianism, perceived control over life events, family violence experienced as a child and current involvement in a violent relationship. This chapter provides a discussion of the instruments used to measure these variables, as well as a description of the procedures used in data collection and analysis.

This was a descriptive exploratory study in which the data were collected by means of a survey questionnaire. The questionnaire consisted of the following instruments: the Family Violence Scale, the Conflict Tactics Scale, the Sex-Role Egalitarianism Scale, the Perceived Control Scale, an abbreviated Marlowe-Crowne Social Desirability Scale, and the Inventory of Beliefs about Wife-Beating, as well as questions concerning pertinent demographic data (see Variables and Measures, p. 76).

Population and Sample Selection

The sample for this study consisted of both male and

female nursing students currently enrolled in baccalaureate and associate degree nursing programs at three mid-Atlantic universities. These particular universities were chosen in order to include participants from a variety of cultures as well as from both public and private nursing programs. Each university enrolls between 250 and 300 undergraduate nursing students. The population of nursing students at all three universities was multi-cultural, consisted of both males and females, and ranged in age from 18 to 55.

The sample was one of convenience rather than random due to limitations of both time and money. However, there was no reason to suspect that students attending these particular nursing programs were markedly different from other individuals currently seeking degrees in nursing in either public or private universities in the larger metropolitan areas of the United States.

Procedure

The designated schools of nursing were contacted and permission requested to administer the questionnaires to their nursing students. Initial contact was made to the Dean of each school via an introductory letter describing the proposed research study. A second contact via telephone followed approximately one week later. At two of

the schools of nursing, the Dean acted directly upon the researcher's request; at the third, the request was forwarded by the Dean to the nursing school's research committee for evaluation and action.

In requesting permission to conduct the study, a research packet was submitted to the appropriate individuals or committees. The packet contained the following (see Appendix D):

1. A letter of introduction from the researcher which briefly explained the study, requested cooperation, and assured anonymity.

2. The survey questionnaire, including a coversheet which gave directions for completing the questionnaire.

3. A copy of the consent form to be signed by each participant.

4. A copy of the form granting exemption from human subjects committee review from Virginia Tech. (One university also required an exemption from human subjects review from its own Office of Research. This was obtained and included in the packet for that particular site.)

Once permission was given to proceed, individual nursing instructors were contacted and permission requested to administer the questionnaires to students in their nursing classes. All students were asked for their

voluntary participation in a study designed to determine how life experiences relate to the formation of health care perspectives. In order to safeguard their privacy and encourage their cooperation, the students were asked to anonymously complete the survey questionnaire.

At two sites, the completed questionnaires and consent forms were returned directly to the researcher. At the third site, questionnaires, consent forms and directions were given to the students in class. Following an explanation of the study, participants returned the signed consent forms directly to the researcher and were requested to return the completed questionnaires by mail. Stamped, pre-addressed envelopes were provided to these respondents. The signed consent forms were kept entirely separate from the questionnaires.

Data collection took place from May 22, 1992 through August 15, 1992. The return rate for the questionnaires administered and collected directly by the investigator was 93%; the return rate for the questionnaires returned by mail was 63%. Overall return rate was 83%.

Variables and Measures

Individual Level Variables

Sex-Role Egalitarianism

The sex-role egalitarianism construct is defined as

"an attitude that enables one to respond to another individual independently of that other individual's sex" (Beere, et al, 1984, p. 564). In order to measure this construct, each nursing student was asked to complete an abbreviated form of the Sex-Role Egalitarianism (SRE) Scale (Beere, King, Beere & King, 1984). This scale measures the attitudes of both men and women toward nontraditional role behaviors. Low SRE scores indicate traditional sex-role attitudes and expectations, while high SRE scores indicate a tolerance for men and women behaving in ways that are not typically or traditionally associated with their respective sexes.

The complete instrument consists of 95 statements concerning the roles of adult men and women divided into five categories: marital roles, parental roles, employment roles, social-interpersonal-heterosexual roles and educational roles. A single score is generated for the total instrument. The complete SRE has demonstrated an internal consistency of .97 and evidence of both construct and concurrent validity (King & King, 1983). An abbreviated form of the SRE was used in this study. This 25 item instrument consists of five items from each of the five categories with the highest item-total correlations (Rosenfeld & Jarrard, 1985). King (1990), in examining this shortened form of the SRE for its psychometric

properties, demonstrated an alpha coefficient of .94, stability coefficient of .88, and equivalence reliability of .87. The reliability of each instrument and subscale used in this study was established using Cronbach's alpha. The alpha coefficient of the shortened form of the SRE used for this study was .88.

Construct validity for both the long and short forms of this instrument has been confirmed in a number of studies analyzing the moderating effect of sex-role egalitarianism (Brabeck & Weisgerber, 1989; King & King, 1983) as well as the correlation between the SRES and both life roles (Mosick-Feldis, 1990) and marital adjustment (Li & Caldwell, 1987). Further support for the reliability and validity of this form are provided by Stith (1990) and Crossman, Stith & Bender (1990).

A sample item is included for each category: marital roles, "The husband should be the head of the family"; parental roles, "It should be the mother's responsibility, not the father's, to plan the young child's birthday party"; employment roles, "Women are just as capable as men to operate a business"; educational roles, "Home economics courses should be as acceptable for male students as for female students"; social-interpersonal-heterosexual roles, "It is worse for a woman to get drunk than for a man". A copy of the complete 25

item instrument is included in Appendix A.

Sense of Control

For this study, sense of control was defined as perceiving oneself in control over or responsible for both the good and bad things that happen in one's life. In order to measure this sense of control, each nursing student was asked to complete the Perceived Control Measure developed by Mirowsky and Ross (1991). This eight item instrument assesses the student's perceived control and lack of control over both good and bad outcomes. Each participant was asked to respond to the four perceived control questions and the four lack of control questions using a 5 point Likert response scale ranging from 1 (strongly disagree) to 5 (strongly agree). This Likert scale measure had an alpha reliability of .68 (Ross, 1991). Despite the moderate alpha coefficient, this scale has an advantage over other similar mastery or locus of control scales in that it includes and balances control over good and bad outcomes and is not biased by self-defense (Mirowsky & Ross, 1990, 1991). Mirowsky and Ross also demonstrate evidence of content and construct validity (1991). The alpha reliability for the Perceived Control Measure in this study was .65.

Typical items in this scale are: "Most of my problems are due to bad breaks"; "I am responsible for my own

success". A copy of the complete instrument is included in Appendix A.

Social Desirability

Social desirability is defined as the tendency of people to conform to social stereotypes in order to gain approval from others (Crowne & Marlowe, 1964). In order to measure the tendency of subjects to choose socially desirable answers to questions, the Marlowe-Crowne Social Desirability Scale was included in the questionnaire. The original instrument consisted of 34 items and possessed an internal consistency of .88 (Crowne & Marlowe, 1964). The 10 item version of this instrument, using 5 point Likert scale responses, was used for this study. This abbreviated scale possesses high internal reliability (alpha coefficient .90) (Greenwald & Satow, 1970). The alpha coefficient for the abbreviated scale used in the current study was .73.

Participants were asked their agreement with such statements as: "No matter who I'm talking to, I'm always a good listener" or "I sometimes try to get even, rather than forgive and forget". A complete copy of this ten item instrument is included in Appendix A.

Demographic Data

Certain background information was collected from each of the participants in the study. This background

information consisted of questions concerning age, gender, ethnic and religious affiliations, marital status, educational program type and educational level, parental marital status and current occupation, amount and type of contact with battered women, and amount of training or education in the identification and treatment of battered women. These particular areas were chosen either because they appear to parallel\support the question being researched or the literature indicates that these variables appear to have some impact on attitudes toward victims of domestic violence. A copy of the demographic data questionnaire is included in Appendix A.

Relationship Level Variables

Family of Origin Violence

Family of origin violence is defined for this study as any intentional act carried out by individuals in the participant's family during his or her childhood that had the potential to physically or psychologically harm others. This construct was measured by use of the Family Violence Scale developed by Bardis (1973). Participants were asked to respond to a 25 question instrument using a 5 point Likert response scale ranging from 1 (never) to 5 (very often). One score was assigned for the complete scale. The higher the score on this scale, the more

family violence experienced by the participant during childhood. Research on this scale conducted by its author found test-retest reliability to be .87 and split half reliability to be .93. Bardis (1973) also reports evidence of construct validity. The alpha coefficient of the Family Violence Scale for this study was .88.

Typical of the sample questions are the following: "Did you fight physically with other children?"; "Did your father beat your mother?"; "Did your mother throw things in anger?". A complete copy of this scale can be found in Appendix B.

Current Involvement with Violence

Each nursing student was also asked to complete the Conflict Tactics Scale (CTS) developed by Straus (1979). This scale measures the current use of reasoning (items one through four), verbal aggression (items five through nine), and violence (items ten through fourteen) within the student's marriage or current dating relationship. The CTS attempts to examine how often, during the past year, each respondent used a variety of tactics to resolve conflicts with his or her spouse or dating partner. Each participant was asked to respond to the 14 item scale twice; once to report on violence instigated by them toward their partner and once to report violence sustained by them from their partner. Each participant responded to

the 14 items using a 5 point response scale ranging from 1 (never) to 5 (frequently done). Scores were computed by adding the response code values for the items making up each CTS scale.

The internal consistency the CTS was examined via item analysis to determine the correlation of the items making up the CTS with the total score (Straus, 1979). The item-total correlations for the reasoning scale = .74, the verbal aggression scale = .73 and the violence scale = .87. All three scales demonstrate reliability coefficients above .70, so appear to have satisfactory reliability. Stith (1990), in a study of police response to domestic violence, demonstrated an alpha reliability of .84 for the violence scale. The alpha reliability for the violence subscales in this study were .87 (violence used by self) and .93 (violence used by partner).

Validity has been illustrated in a number of analyses in studies of violent relationships (Bulcraft & Straus, 1975; Steinmetz, 1977; Walker, 1984). A copy of the instrument is included in Appendix B.

Dependent Level Variable

Sympathy for Battered Wives

For the purpose of this study, wife-beating was defined as hitting in order to inflict physical pain. In

order to assess beliefs about wife-beating, each participant was asked to complete the Inventory of Beliefs about Wife-Beating developed by Saunders, Lynch, Grayson, & Linz (1987). The development of this instrument parallels earlier efforts to develop scales concerning attitudes and\or beliefs about rape. The 31 item inventory is comprised of five sub-scales derived through factor analysis: 1) wife-beating is justified, 2) wives gain from beatings, 3) help should be given, 4) offender should be punished, and 5) offender is responsible. The first three subscales were used in this study because only these three pertain to victims of domestic violence. Due to intercorrelations among the factors used to develop the first three subscales of this inventory, Saunders (1987) provides justification for combining these subscales into a larger one, called "sympathy for battered wives". The alpha coefficient for this larger subscale is .89. This larger subscale was used in this study and one score was generated for this scale. The alpha coefficient for this larger subscale in the current study was .85.

Twelve statements measure the first factor "wife-beating is justified". This factor reflects the attitude that wife-beating is justified either in general or as a result of specific victim behaviors and has an alpha coefficient of .86. Using this subscale in a study of

physicians and nurses, Rose (1984) achieved an alpha coefficient of .73. A sample statement from this subscale is the following: "A husband has no right to beat his wife even if she breaks agreements she has made with him".

Seven statements measure the second factor, "wives gain from beatings". This factor reflects the attitude that victims are somehow responsible for their beatings and derive some sort of sympathy or attention from the abuse. This subscale has an alpha coefficient of .77, and includes such statements as: "Battered wives are responsible for their abuse because they intended it to happen".

The third subscale "help should be given" contains five statements and emphasizes interventions by bystanders and social agencies. This subscale has an alpha coefficient of .67. In the study of physicians and nurses by Rose (1984), this coefficient was a bit higher (.72). A sample statement from this subscale would be the following: "Social agencies should do more to help battered women".

Saunders et al (1987) also demonstrated substantial evidence of construct validity as well as low social desirability bias. The construct validity of the total scale was shown through correlation with theoretically relevant constructs. As in attitudes toward rape,

negative attitudes toward victims of domestic violence were linked with traditional views of women's roles and gender. Finally, the scale differentiates between groups known to have opposing attitudes toward wife beating (i.e., batterers and advocates for the women). A copy of the complete 24 question instrument is included in Appendix C.

Analysis of Data

The data collected from the participants' responses to the six instruments were analyzed through the use of correlation and multiple regression techniques. Although this was an exploratory study, both literature review and logic provided a theoretical basis for determining a specific sequence for entering the independent variables into the regression equation, so a hierarchical strategy for entering these variables was used. In hierarchical analysis, the choice of sequential entry of the variables into the regression equation is determined in advance (a priori) based on the hypothesized relationships. This leads to an ordering of the variables that reflects their presumed causal priority.

Because conflict tactics learned as children in one's family of origin precede the development of attitudes as adults, this variable (Family Violence) was entered first

into the regression analysis. A set of variables, Sex-Role Egalitarianism and Perceived Control over Life Events was entered into the equation next. Both Sex Role Egalitarianism and Perceived Control are assumed to be acquired as one matures, so would logically occur next in the model. These two variables were entered as a set because neither could be assumed to precede the other. Lastly, a set of variables involving current exposure to violence, Personal Conflict Tactics and Partners' Conflict Tactics, were entered into the regression equation. Again, these variables were entered as a set because neither could be assumed to precede the other (See Figure I).

In order to test the proposed hypotheses, several types of calculations were used. First, frequency distributions and descriptive statistics were employed to review the demographic characteristics of the individuals and scales used in the study.

Next, scatterplots were graphed to obtain a visual pattern of relationships between variables, as well as the strengths of those relationships. The data collected from the participants' responses to the six instruments were screened to look for any problems that might interfere

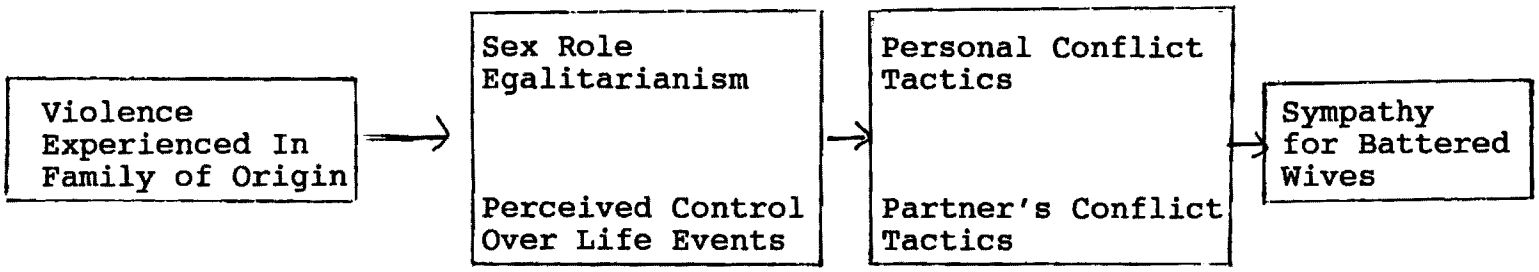

Figure 1

Proposed Theoretical Model

with the appropriate use of regression techniques (i.e. ratio of cases to independent variables, normality, outliers, and multicolinearity). Finally, correlation and multiple regression techniques were utilized to examine the contribution of each variable, or set of variables, in the model. Data analysis was done by means of The Statistical Package for the Social Services (SPSS Inc., 1988). It was anticipated that these analyses would provide information about which of the independent variables was related to the dependent variable (sympathy for battered wives) as well as the strength of each independent variable in predicting the nursing students' attitudes toward victims of domestic violence. A discussion of these findings follow in Chapter Four. These analyses were performed to determine which nursing student characteristics might be most important to focus on in developing both classroom and clinical experiences to assist the students in becoming more aware of, sensitive to, and clinically effective with victims of domestic violence.

Summary

Responses to questionnaires received from nursing students attending three mid-Atlantic universities were analyzed to test proposed hypotheses concerning predictors

of attitudes toward victims of domestic violence. The scales were described and statistical anaysis procedures used to evaluate the model were presented.

CHAPTER 4

RESULTS

The general purpose of this study was to examine the relationship between selected individual and relationship variables and nursing students' attitudes toward victims of domestic violence via a series of hypothesized correlations and a hypothesized hierarchical regression model. The specific individual variables under scrutiny included sex-role egalitarianism and perceived control over life events; the specific relationship variables included exposure to family violence as a child and current involvement in a violent relationship. The variables were entered sequentially into the regression model based on the hypothesized relationships. This chapter presents the results of the data analyses. Descriptive data concerning the respondents are provided and the results of the statistical analysis specific to each hypothesis is presented.

Sample

Out of the original 221 questionnaires distributed, 183 were returned, for an overall response rate of 82.8% (see Table 1). The return rate for the questionnaires administered and collected directly by the investigator was 92.8% (N = 129); the return rate for the

Table 1

Response Rate and Distribution of Subjects

Collection Method	Number Distributed	Number Returned	%
by Investigator	139	129	92.8%
by Mail	82	54	65.8%
Total	221	183	82.8%
Distribution of Returns (N = 183)		**Number**	**%**
Male Respondents		23	12.6%
Female Respondents		155	84.6%
Gender Unknown		5	2.8%

questionnaires returned by mail was 65.8% (N = 54).

While 155 female nursing students returned the questionnaire, only 23 male nursing students it. Thus, only 12.6% of the nursing student sample was male. However, 23 is too small a number for useful between group comparisons. Also, because differences are likely to exist between male and female experiences with and attitudes about family violence (Finn, 1986; Kristiansen & Guillieti, 1990; Rose & Saunders, 1986), including these 23 males in the analyses could unduly influence or confound the results. Comparison of mean scores between males and females supported this concern (see Appendix E). While the mean scores of the males were within one standard deviation of the female scores, male respondents reported more traditional sex-role attitudes (M = 4.21) than did female respondents (M = 4.50). Male respondents also reported less sympathy for battered women (M = 4.47) than did female respondents (M = 4.67). In addition, male respondents reported more violence in their current relationships (M = 1.58) than did female respondents (M = 1.41) as well as more family of origin violence (M = 1.78) than did female respondents (M = 1.42). Therefore, the decision was made to limit the analyzed sample to the 155 female nursing students. Five questionnaires were also excluded due to undesignated gender. The data from the

additional questionnaires were used to provide expanded descriptive information about the survey participants and to help in interpreting the survey results.

Sample of Interest

This sample consisted of 155 female nursing students attending either associate degree or baccalaureate degree nursing programs at three mid-Atlantic universities (see Table 2). The mean age of the respondents was 32 years (sd = 7.9), with a range from 19 to 55 years. As shown in Table 2, 66% of the students were non-Hispanic Caucasians, while 34% were of minority background. A slight majority of the sample was married (52.5%). Of the unmarried respondents, 51% were not currently involved in a serious relationship (nor had ever been).

The sample appeared to be highly educated, with the majority (91%) having completed some college courses. Twenty-seven percent had already earned a baccalaureate degree prior to entering nursing school and 9% had completed some graduate courses or achieved a master's degree in some field outside of nursing.

A large number of the respondents (73%, N = 108) personally knew women who had been battered (see Table 3). Eighteen of the respondents (12.1%) had been victimized themselves, while three (or just 2%) identified themselves

Table 2

Demographic Characteristics of Participants

Characteristic	Category	Number	Percentage
Age N = 155	19 - 28 29 - 38 39 - 48 49 - 55	58 60 31 6	37.4% 38.4% 20.0% 3.9%
Ethnic Background N = 152	White, non-Hispanic African American Other Asian Hispanic American Indian	100 22 13 10 1 6	65.8% 14.5% 8.6% 6.6% 3.9% .6%
Marital Status N = 154	Married Unmarried, not in a relationship Unmarried, in a serious relationship Unmarried, living with partner Other	81 37 30 5 1	65.8% 24.0% 19.5% 3.2% .7%
Mother's Marital Status N = 155	Married, first marriage Widowed Other, deceased Remarried Divorced Separated	89 22 15 14 11 4	57.4% 14.2% 9.7% 9.0% 7.1% 2.6%
Father's Marital Status N = 155	Married, first marriage Other, deceased Remarried Divorced Widowed Separated	83 36 18 9 6 3	53.5% 23.2% 11.9% 5.8% 3.9% 1.9%

Table 2 (Continued)

Demographic Characteristics of Participants

Characteristic	Category	Number	Percentage
Educational Program N = 155	Baccalaureate Degree	93	60.0%
	Associate Degree	57	36.8%
	Graduate Degree	5	3.2%
Previous Education N = 155	High School	14	9.0%
	Some College	54	34.8%
	Baccalaureate	42	27.1%
	Some graduate credits	8	5.2%
	Master's	6	3.9%
	Other (Associate)	31	20.0%
Nursing Courses Taken N = 149	One	7	4.7%
	Two	18	12.1%
	Three	27	18.1%
	Four	7	4.7%
	Five	24	16.1%
	Six	16	10.7%
	Seven	10	6.7%
	Eight	10	6.7%
	Nine	30	20.2%

Table 3

Participants' Experiences with Domestic Violence

Participants N = 148	**Number**	**Percentage**
Respondents who themselves were involved in domestic violence:		
As Victims	18	12.2%
As Instigators	3	2.0%
Respondents who knew battered women	108	72.9%
Category of battered women known N = 108		
Friends	59	54.6%
Relatives	45	41.7%
Acquaintances	39	36.1%
Clients/Patients	36	33.3%
Co-Workers	31	28.7%
Neighbors	30	27.7%
Parents	8	7.4%

as instigators of violence. Of those who reported knowing battered women, many had friends (54.6%) and relatives (41.7%) who had been victims of domestic violence. Nearly 28% of the sample who knew battered women had neighbors who had been victimized (N = 30), while 28.7% knew co-workers (N = 31) and 36.4% had acquaintances who had been beaten (N = 39). Finally, a third of these respondents (33.3%) had cared for clients or patients who were battered.

A slight majority of the sample (54.7%) had some sort of training in domestic violence (see Table 4). The main vehicle for this training appeared to be either lecture content (59.2%) or journal articles (38.3%), with smallest percentage (16%) acquired via direct clinical contact with battered women (either involving a clinical observation or a specific clinical rotation). Further details of the sample characteristics are presented in Tables 2 - 4.

Data Screening

Prior to running the regression analyses, the data were screened to determine if there were any potential problems. The results of the screening were as follows:

Ratio of cases to Independent Variables: There were 142 cases used in the regression analysis and 5 independent variables. Thirteen cases were dropped due to

Table 4

Participants' Domestic Violence Training

Participants N = 149	**Number**	**Percentage**
Respondents who had some training in domestic violence	81	55%
Category of domestic violence training N = 81		
Lecture	48	59.2%
Journal Articles	31	38.3%
Workshop or Conference	21	25.9%
Other Sources	12	14.8%
Clinical Observation	9	11.1%
Clinical Rotation	4	4.9%

missing data. Thus the ratio of cases to independent variables equalled 28.4:1. This ratio is appropriate for use of regression, and exceeds the minimum requirement of 15 or 20 to one (Tobachnik & Fidell, 1989).

Normality: The data in several scales were not normally distributed. The distributions of two of the scales (Sex-Role Egalitarianism and Sympathy for Battered Wives) were negatively skewed (more high scores than low ones); a third (Family Violence Scale) was positively skewed (more low scores than high scores). Because these three scales differed substantially from normal, a log transformation was done. However, when the transformed data were analyzed, the model provided no further explanatory power, nor any improvement in significant correlations. So, the original untransformed data were used in the analyses for this study.

Multicollinearity: If the tolerance of an independent variable (1-squared multiple correlation of the variable) is too low, the variable does not enter into the analysis (Tobachnik & Fidell, 1989, p. 88). The tolerance levels for the five independent variables ranged from .93 to .76, indicating no serious multicollinearity problems with the variables.

Outliers: Multivariate outliers were sought by considering the Mahanalobis distance of each case to the

centroid of all the cases (Tobachnik & Fidell, 1989, p. 175). Three multivariate outliers were identified and were isolated from the remainder of the sample. A visual scan of these specific cases showed that these respondents differed from the rest of the respondents in that they reported markedly more violence in their family of origin (i.e. Family Violence scores). The mean of these three cases (2.92) was more than four standard deviations from the mean (1.39) of the rest of the sample. However, when the correlations and regressions were run omitting these three cases, there were practically no differences in the results. Therefore, these three cases, while outliers, were deemed not influential and left in the analyzed sample.

Social Desirability: In order to measure the tendency of the respondents to provide socially desirable answers, each participant of this study was asked to complete an abbreviated form of the Marlowe-Crowne measure of social desirability. As indicated in Table 5, this instrument was significantly correlated with two independent variables, SRE ($r = .16$) and PERCON ($r = .23$) as well as the dependent variable, DOMVIO ($r = .21$). Thus, it appears that as the tendency to answer in socially desirable ways increases, nursing students' sex role egalitarianism, perceived control over life events, and

Table 5

Correlation of Marlowe-Crowne Measure of Social Desirability with the Independent and Dependent Variables

Variable	Marlowe-Crowne
SRE = Sex-Role Egalitarianism Scale	.16*
PERCON = Perceived Control Scale	.24**
CTSY = Control Tactics Scale (personal)	-.14
CTSYP = Control Tactics Scale (your partner's)	-.14
FAMVIO = Family Violence Scale	-.10
DOMVIO = Sympathy for Battered Wives	.21**

*p < .05; **p < .01

sympathy for battered wives may also increase slightly. However, while these relationships were significant, they were relatively weak. Thus, the results of the scales may be taken at face value for the most part, with little concern that respondents tended to answer in socially desirable ways.

Scale Descriptions

In order to assess the effectiveness of each instrument in this sample, the initial step in the data analysis was to obtain the means, standard deviations and ranges of scores for each scale. In addition, to determine the internal consistency reliability of each scale for the sample, Cronbach's (1951) alpha was calculated.

Alpha reliabilities for all of the scales were in the acceptable range (alpha .65 or higher). Table 6 contains the means, standard deviation, and the range for each scale and indicates the result of the reliability analysis.

Relationships Between Variables

Correlations were used to examine the bivariate relationships between the variables in the proposed hypotheses (see Table 7). Six significant correlations out

Table 6
Means, Standard Deviation, Range, and Reliability for Independent and Dependent Variables

Variables	# of Items	M	SD	Range	Cronbach's Alpha
Independent Variables					
SRE	25	4.50	.43	2.9 - 5.0	.88
PERCON	8	4.05	.51	2.5 - 5.0	.65
CTSY	6	1.41	.71	1.0 - 4.3	.87
CTSYP	6	1.50	.89	1.0 - 5.0	.93
FAMVIO	25	1.42	.42	1.0 - 3.0	.88
Dependent Variable					
DOMVIO	24	4.67	.39	3.2 - 5.0	.85

* All scores had a possible range from 1 to 5.

SRE = Sex-Role Egalitarianism Scale
PERCON = Perceived Control Scale
CTSY = Conflict Tactics Scale (personal)
CTSYP = Conflict Tactic Scale (your partner's)
FAMVIO = Family Violence Scale
DOMVIO = Sympathy for Battered Wives Scale

Table 7

Relationships Among the Variables

	SRE	PERCON	CTSY	CTSYP	FAMVIO	DOMVIO
SRE	1.000	.43**	-.004	-.13	.08	.65*
PERCON		1.000	-.07	-.14	.02	.39**
CTSY			1.000	.46**	.23**	-.08
CTSYP				1.000	.18*	-.09
FAMVIO					1.000	-.01

SRE = Sex-Role Egalitarianism Scale
PERCON = Perceived Control Scale
CTSY = Conflict Tactics Scale (personal)
CTSYP = Conflict Tactics Scale (partner's)
FAMVIO = Family Violence Scale
DOMVIO = Sympathy for Battered Wives Scale
* $p < .05$; ** $p < .01$

of a possible 15 were found. Less than one correlation would be expected to be significant by chance (at the .05 level of significance). Thus, the number of significant correlations is greater than the number expected by chance.

Two correlations were found to be both significant and relevant to the proposed hypotheses. This section will present results from the correlation procedures specific to each of these hypotheses.

Hypothesis: A positive relationship exists between nursing students' levels of sex role egalitarianism and their sympathy towards victims of domestic violence.

As expected, there was a significant positive relationship between sex-role egalitarianism and sympathy toward battered women ($r = .65$). This hypothesis was supported, indicating that increased egalitarianism is related to sympathy for battered wives.

Hypothesis: A positive relationship exists between nursing students' perception of control over life events and their sympathy for victims of domestic violence.

This second hypothesis was also supported by the data collected. Perceived control over life events was positively and significantly related to sympathy for battered women ($r = .39$). Thus, for these nursing students, as perception of control increased, sympathy for

battered wives increased.

Hypothesis: A positive relationship exists between the level of violence nursing students experienced in their families of origin and their sympathy towards victims of domestic violence.

This hypothesis was not supported by the data collected. Contrary to expected results, in this study there appears to be little relationship between experiencing family violence in one's formative years and attitudes toward victims of domestic violence ($r = -.01$).

Hypothesis: A negative relationship exists between the level of violence nursing students' experience in their current relationships and their sympathy for victims of domestic violence.

Two correlations were computed to test this hypothesis. Also contrary to expected results, there appears to be little relationship between the use of violent conflict tactics, either personal ($r = -.08$) or one's partner's ($r = -.09$) and sympathy toward victims of domestic violence.

Thirteen additional correlations were examined which were not related to the proposed hypotheses. Of these, four were significant. Sex-Role Egalitarianism was positively and significantly correlated with perceived control ($r = .43$). That is, high levels of egalitarianism

were related to increased feelings of personal control over life events. In fact, Perceived Control was more related to Sex-Role Egalitarianism (r = .43) than to the dependent variable Sympathy for Battered Wives (r = .39), indicating a possible multicollinearity problem. However, since the data screening found no such problem with the variables, the correlation between these two independent variables, while maybe confounding, was not critical to the analyses.

In addition, other significant relationships were noted. Personal conflict tactics was significantly and positively correlated with both partner's conflict tactics (r = .46) and family violence (r = .23). That is, adults who used violent conflict tactics were more likely to have come from families with increased levels of violence and have partners who used the same type(s) of violent conflict tactics. Family violence was significantly and positively correlated with partner's conflict tactics (r =.18). Thus, individuals who were exposed to increased levels of violence in their families of origins were more likely to have partners who used physical violence.

Model Testing

In order to evaluate the final hypothesis, a hierarchical regression model was developed (Figure 1,

Chapter 3) and regression procedures were run. Although the initial sample was composed of 155 female nursing students, the regression analysis was run using data from 142 respondents. Thirteen of the original 155 respondents either were not currently, or had never been, involved in a serious relationship, and so, had not completed the Conflict Tactics Scale(s). Thus, their cases were deleted from the regression analysis. This section presents results from statistical analyses of each step in the regression model.

Hypothesis: Nursing students' attitudes toward victims of domestic violence are predicted by the students' level of experienced violence in their families of origin, level of sex role egalitarianism, perceived control over life events, and current level of violence in their relationship.

Following the hypothesized hierarchical regression model, the variable family violence (FAMVIO), was entered into the regression equation first. Alone, FAMVIO explained a quite minimal amount of the variance in the dependent variable DOMVIO. FAMVIO had a non-significant R^2 of .00001.

The set of variables (SRE and PERCON) was entered into the regression equation next. This set of independent variables produced an R^2 of .42, significant

at the .001 level, with an R^2 change of .42. Thus, this second set of independent variables explained almost all of the variance in the dependent variable at this point in the analysis.

The set of conflict variables (CTSY and CTSYP) was entered into the equation last. This produced an insignificant R^2 change of .004. The addition of this set of independent variables explained very little additional variance in the dependent variable DOMVIO. Table 8 displays the beta scores, the R^2, the change in R^2 , the change in F, and the p value for each of the independent variables.

After step three, with all the independent variables in the equation, multiple R = .65, R^2 = .43, adjusted R^2 = .41, F (5,137) = 20.40, p = .000. Thus, the entire model accounts for 43% of the variance in the dependent variable DOMVIO (Sympathy for Battered Women). However, almost all the variance is explained by the set of independent variables (SRE and PERCON). The other three independent variables (FAMVIO, CTSY and CTSYP) explain minimal amounts of the variance.

In order to test the individual explanatory power of SRE and PERCON, these two variables were entered into the regression model in two separate runs. On the initial run, PERCON was entered first, followed by SRE. Then the

Table 8

Results of Hierarchical Regression Analysis

Step	Beta	R^2	ΔR^2	ΔF	p
1. FAMVIO	-.04	.0001	.0001	.001	.9743
2. SRE PERCON	.60 .11	.42	.42	50.83	.000
3. CTSY CTSYP	-.07 .04	.43	.004	.53	.59

FAMVIO = Family Violence Scale
SRE = Sex-Role Egalitarianism Scale
PERCON = Perceived Control Scale
CTSY = Conflict Tactics Scale (personal)
CTSYP = Conflict Tactics Scale (partner's)

procedure was repeated with the entry sequence of the variables reversed. When entered into the regression equation first, PERCON explained 13.5% of the variance in DOMVIO (R^2 =.135), with SRE explaining an additional 28.4% (R^2 =.419). However, when the sequence was reversed, PERCON lost much of its explanatory power. SRE entered into the regression equation first explained 40.8% of the variance in the dependent variable DOMVIO (R^2 = .408). PERCON only explained an additional 1.1% of the variance (R^2 =.419). Thus, sex-role egalitarianism appears to be the best predictor of attitudes toward victims of domestic violence. SRE and PERCON together explain much of the same variance in the dependent variable (DOMVIO).

Summary

Statistical and descriptive findings were presented in this chapter. A description of the analyzed sample and the explanation of the reasons for limiting the analyzed sample to female nursing students were provided. Relationships between nursing students' egalitarianism, perceived control over life events, exposure to family violence as a child, current involvement in a violent relationship and attitudes toward victims of domestic violence were explored.

Hypotheses were tested by means of both correlation

and hierarchical regression analyses and the results discussed. Results of these analyses were presented and the most useful predictors of attitudes toward victims of domestic violence were identified. Sex role egalitarianism and perceived control over life events were identified as useful predictors, while level of violence experienced in one's family of origin and current use of nonviolent conflict tactics were not. Further analysis indicated that sex role egalitarianism was the most useful predictor of attitudes toward victims of domestic violence.

Chapter Five presents conclusions based on these findings along with recommendations and suggestions for further study.

CHAPTER 5

SUMMARY, DISCUSSION, CONCLUSIONS and RECOMMENDATIONS

Summary

Abuse against women appears to have reached epidemic proportions in the United States. Researchers estimate that 1.8 to 4 million women a year are involved in incidents of physical abuse (Hotaling, Finkelor, Kirkpatrick, & Straus, 1988; Straus, Gelles, & Steinmetz, 1980). Violent family interactions are known to compromise women's health in a wide variety of ways (Bohn, 1990; Browne, 1992; Stark & Flitcraft, 1988; Weingourt, 1990). One recent study found violence to be the leading cause of injuries to women ages 15 through 44 (Grisso, Wishner, Schwarz, Weene, Holmes & Sutton, 1991). Yet, historically, the response of the health care system toward battered women has been neither timely, appropriate, nor effective. Researchers examining this phenomenon have documented a continuing pattern of nonassessment, nondetection, and nonintervention (Campbell, 1992; Helton, McFarlane & Anderson, 1987; Kurz & Stark, 1988; McLeer & Anwar, 1989). In return, battered women have found the health care community to be insensitive and not particularly helpful (Brendtro & Bowker, 1989; Drake, 1982).

Research conducted in the past fifteen years has delineated a variety of possible reasons for this poor performance, ranging from an inadequate knowledge base to socialized attitudes. Attitudes or personal biases concerning domestic violence are thought to be particularly problematic for those in the health care community. Recent studies continue to demonstrate that physicians and nurses are influenced by societal and personal misconceptions about battered women (King & Ryan, 1989; Sugg & Inui, 1992). Only four nursing studies have examined the impact of issues such as gender, professional role, amount of contact, and personal biases toward women on health care professionals' attitudes toward victims of domestic violence (Drout, 1987; King, 1988; Rose, 1984; Shipley & Sylvester, 1982). There appears to be a void in research that examines the attitudes or perceptions of nursing students toward victims of domestic violence despite the belief that attitudes and perceptions are formed early in life and are assumed to influence a nurse's behavior toward patients.

Therefore, the purposes of this study were to explore the relationship between specific individual and relationship variables and nursing students' attitudes toward victims of domestic violence and to determine which of these selected variables, or combination of variables

was the best predictor of these attitudes. These purposes generated specific research questions. They were:

1. What is the relationship between nursing students' attitudes toward victims of domestic violence and each of the following variables?

a) Sex role egalitarianism

b) Family violence experienced as a child

c) Current involvement in a violent relationship

d) Feeling of control over life events

2. Which of these selected individual and relationship variables or combination of variables is the best predictor of nursing student attitudes toward victims of domestic violence? These research questions formed the basis for the development of five hypotheses which will be discussed in detail in the next section of this chapter.

This was a descriptive exploratory study in which the data were collected by means of a survey questionnaire. The questionnaire consisted of the following instruments: the Family Violence Scale, the Conflict Tactics Scale, the Sex-Role Egalitarianism Scale, the Perceived Control Scale, an abbreviated Marlowe-Crowne Social Desirability Scale, and the Inventory of Beliefs about Wife-Beating, as well as questions concerning pertinent demographic data.

The data for this investigation came from questionnaires which were distributed to two hundred

twenty-one baccalaureate and associate degree nursing students from three mid-Atlantic universities. One hundred eighty-three questionnaires were returned for a response rate of 82.8%. The final sample consisted of 155 female nursing students. Participants were eliminated based on gender and\or their never having been in an intimate relationship.

The programmed statistical package, SPSSX, was used to analyze the data. Frequency distributions, descriptive statistics, scatterplots, data screening procedures, correlation and regression procedures were run.

Discussion of the Findings

Although no demographic variables were included in the primary statistical analyses, the descriptive statistics procedures run on the demographic data revealed some interesting results. A great majority of the females in this sample appeared to be involved in non-violent significant relationships. Seventy-five percent of the sample was either married or involved in a serious relationship. Only 12% (N = 18) of these nursing students reported that they themselves had been a victim of domestic violence. In addition, the majority of these women appeared to come from families characterized by non-violent, stable relationships. Almost 60% of their

mothers and over half of their fathers had been married only once. Lastly, these respondents reported that only 5.4% (N = 8) of their parents had been victims of marital violence.

Table 4 (see Chapter 4) which presented the means, standard deviations and ranges for the variables used in the study provided additional data attesting to the generally low level of violence associated with this sample. For the most part, respondents themselves used non-violent conflict tactics (M = 1.41) as did their partners (M = 1.50). Respondents also reported low levels of violence in their families of origin (M = 1.42).

However, almost three-fourths (N = 108) of the sample personally knew a victim of domestic violence. Fifty-five percent of the sample had received some sort of training in domestic violence. Of those who had some training in this area, it appears that much of it occurred in the course of their nursing education. Almost 60% of those respondents with training acquired it from some type of nursing lecture. An additional 16% of this training was acquired through clinical contact with the victim, either caring for a victim in a clinical rotation (4.9%) or through some sort of clinical observation (11.1%). These results were somewhat inconsistent with fairly recent literature reports concerning the relative lack of content

on domestic violence presented in professional school curricula (King, 1988; McKenna, 1989; Randall, 1192; Sheridan, 1987). Perhaps, as mentioned in Chapter 1, the fact that domestic violence has become the target of widespread media attention and has been identified as a problem meriting nationwide attention has raised the consciousness of the health care community. Certainly, the participants in this sample were highly sympathetic toward victims of domestic violence (M = 4.67).

The present study found a significant positive relationship between sex role egalitarianism and perceived control. As nursing students' egalitarianism increased, their perception of control over life events increased. Perhaps individuals who are unconfined by traditional beliefs about sex roles also feel more in control of other aspects of their lives. Participants in this study were, for the most part, mature, educated women with egalitarian beliefs who perceived themselves to be in control of their lives. Many had earned degrees and\or been employed prior to beginning nursing education. On the face of it, these participants' choice of nursing as a profession would seem inconsistent with the stereotypic notion of nursing as strictly "women's work". Perhaps, nursing is no longer stereotypically seen as a female ghetto, and so, is again attracting thoughtful, competent individuals. Another

reason for this seeming inconsistency might pertain to characteristics of the participants themselves. Perhaps individuals who have experienced previous success in academic and employment domains, as well as accumulated a certain amount of practice living, feel increasingly responsible for personal successes and failures. Thus, these women feel more in control of their lives and so are comfortable making a career choice that seems to run counter to cultural expectations.

However, as was noted in Chapter 4, this positive relationship between egalitarianism and feelings of control, while not critical to the analysis, was perhaps confounding to the study. It appears that these variables explain much of the same variance in nursing students' sympathy for battered wives.

Despite the low level of violence reported by this sample, the present study found that adults who used violent conflict tactics were significantly more likely to have come from families with high levels of violence and have partners who use the same type of violent conflict tactics. Previous studies which examined the relationship between witnessing and/or experiencing violence in one's family of origin and violence in adult relationships have produced conflicting results. Alexander, Moore, & Alexander (1991) found that witnessing marital violence

between one's parents was not predictive of either extending or receiving abuse in adult relationships, nor was being physically abused by one's mother. However, physical abuse by one's father was highly predictive of both, especially in males. Cappell & Heiner (1990), on the other hand, found that aggressive relationships in the family of origin were more useful in predicting targets rather than perpetrators of aggression in adult relationships. The findings from the present study, while not differentiating between perpetrators or types of abuse, also show a significant relationship, albeit a weak one, between aggression in one's family of origin and victimization as an adult. However, findings from this study show a slightly stronger relationship between aggression in one's family of origin and use of violence as an adult. This suggests that in this study at least, growing up in a violent family is slightly more likely to result in one's learning aggressive behavior rather than vulnerability to aggression.

As mentioned earlier in this chapter, the two original research questions generated five hypotheses which were tested in the present study. Three of the five hypotheses were either fully or partially supported.

A strong positive relationship existed between nursing students' egalitarian sex-role attitudes and their

sympathy for battered women. As nursing students' egalitarian sex-role attitudes increased, their sympathy toward victims of domestic violence also increased. This finding is consistent with previous research reports involving non-clinical populations that individuals with more egalitarian sex-role attitudes were more sympathetic toward victims of domestic violence than individuals holding more traditional sex-role attitudes (Finn, 1986; Gentemann, 1984; Stith, 1990). The respondents in this study, similar to the respondents in Finn's 1986 study, held highly egalitarian sex-role beliefs (M = 4.50) and were quite sympathetic toward victims of domestic violence (M = 4.67).

A positive relationship existed between nursing students' perception of control over life events and their sympathy for victims of domestic violence. Participants in this study generally felt themselves to be in control of their lives (M = 4.05). As students' perception of control over life events increased, their sympathy toward victims of domestic violence increased also. This finding is consistent with previous research reports that individuals who felt more in control over events in their lives were more sympathetic toward victims of domestic violence (Kristiansen & Guilietti, 1990; Newburn, 1987; Sugg & Inui, 1992). Participants in Sugg & Inui's 1992

study described how their strong sense of powerlessness impacted on their responses to victims as well as their search for appropriate interventions in domestic violence. Kristiansen & Guilietti (1990) found that even females possessing positive attitudes toward women tended to blame victims of domestic violence more as their own perception of control over life events decreased. These researchers interpreted the findings to indicate that women may blame battered women for their own abuse in an effort to gain control over their own possible victimization. The findings in this study appear to support the belief that women who feel in control over their lives are less troubled by potential victimization and so are able to be sympathetic toward victims.

The present study offered partial support for the hypothesized hierarchical regression model which anticipated that nursing students' sympathy for victims of domestic violence was predicted by the students' level of experienced violence in their families of origin, sex role egalitarianism, perceived control over life events, and current involvement in a violent relationship. The entire model explained 43% of the variance in nursing students' sympathy for battered wives. However, sex role egalitarianism and perceived control over life events together accounted for 42% of this variance. The other

variables, or combination of variables, explained nonsignificant, minimal amounts of the variance. Further analysis of the individual explanatory power of the significant predictors found that egalitarianism appeared to be the best predictor of attitudes toward victims of domestic violence. This finding is consistent with previous research noting the important relationship between sex role attitudes and sympathy for victims of domestic violence (Finn, 1986; Rose & Saunders, 1986; Stith, 1990). Stith (1990) found that sex role egalitarianism approached significance in predicting antivictim response, demonstrating that as police officers egalitarianism decreased, their tendency toward antivictim response increased. Similar to Finn's 1986 study, the present study found that attitudes toward sex roles accounted for the largest proportion of explained variance in sympathy for battered wives, and therefore was the most powerful predictor of those attitudes.

Two hypotheses were not supported by the data. Contrary to expectations, the present study found that the level of violence experienced by nursing students in their childhood was not related to their sympathy for battered women. Also contrary to expectations, the present study found that there was little relationship between the level of violence nursing students experienced in their current

relationships and their sympathy for victims of domestic violence.

These findings are inconsistent with previous studies which support the idea that observation of marital violence has a powerful enculturating influence (Alexander, Moore, & Alexander, 1991, Cappell & Heiner, 1990). While there is no literature directly linking exposure to childhood violence with sympathy for battered women, the results of this study are inconsistent with this implied relationship. In addition, these findings are at odds with nursing research which reports that personal experience with pain increases one's sympathy for others in pain (Holm, Cohen, Dudas, Medema, & Allen, 1988). The same relationship does not appear to hold with personal victimization and sympathy toward battered women. One explanation for the lack of significant relationships is the fact that these participants reported a low level of violence in their childhood and in their current relationships. It is possible that there was not enough variance on these measures to find a significant relationship. Future studies with larger samples may uncover this relationship.

Conclusions

The major conclusions of the study can be summarized

as follows:

1.) Sex role egalitarianism is significantly and positively related to attitudes toward victims of domestic violence.

2.) Perceived control over life events is significantly and positively related to attitudes toward victims of domestic violence.

3.) Sex role egalitarianism and perceived control together account for a substantial amount of the variance in nursing students' attitudes toward victims of domestic violence.

4.) Sex role egalitarianism is the best predictor of sympathy toward battered wives.

5.) Violence experienced in one's family of origin does not appear to be related to sympathy for battered wives.

6.) The level of violence experienced in current relationships and sympathy for battered wives do not appear to be related.

The above conclusions, if generalized beyond this population, need to be viewed with caution because of the limitations of the study.

Generally speaking, participants in this study reported low levels of violence, both in their families of origin ($M = 1.42$) and in their serious personal

relationships (M = 1.41). Despite the relatively high return rate, due to the sensitive nature of the subject matter, it might be that respondents who did not return questionnaires experienced more violence in their lives than did those who returned the questionnaires.

Another limitation might be the fact that the sample for the present study was limited to females. Research has consistently shown that men hold significantly more traditional sex role attitudes than women and are more likely to hold attitudes that endorse the use of force in marriage (Finn, 1986; Rose & Saunders, 1986). In addition, research indicates that males report being hit in their family of origin more often than do females (Alexander, Moore & Alexander, 1991; Cappell & Heiner, 1990). Although male respondents were not included in the analyzed sample (for reasons previously explained in Chapter 4), a comparison of the few available male responses with those of female respondents indicated that males reported higher levels of family of origin violence, less egalitarianism, and less sympathy for battered women than did female respondents. In addition, males reported more violence in current relationships than did females. This is consistent with research findings of both Cappell & Heiner (1990) and of Rose & Saunders (1986). Male participants in both studies reported higher acceptance of

violence toward battered women.

A third limitation might be the instrumentation in the study used to measure violent behavior. Language used in the Family Violence Scale might be ambiguous, stereotypic, and not particularly sensitive. This scale was first developed by Bardis in 1973 and does not appear to have been updated. For example, several questions in this instrument ask questions about having been "beaten". Kelly (1988) notes that assumptions that researchers and subjects share a common definition of such terms as rape or battering often are not valid. "The terms beating and battering tend to be understood in terms of severe, frequent physical violence" (Kelly, 1988, p. 120). Participants responding to the questions might have varying ideas as to what constitutes a beating and tend to disqualify or minimize other less physically violent acts committed by family members.

Several instruments (the Family Violence Scale and the Conflict Tactics Scale) measure retrospective information, so recall might be effected by memory and maturation.

Another flaw in the instrumentation is that the CTS and the Family Violence Scale were used to measure participants' perceptions of and experience with violence in past and present relationships at only one point in

time, when the questionnaire was answered. However, due to the impact of violence on individuals and due to the manner in which society defines violence, a single measurement of participants' experience with and perception of violence may not accurately reflect what is really occurring in those relationships.

In a study concerning women's perceptions of their violent experiences, Kelly (1988) found that 60% of the women who had been raped and 62% of the women who had been incestuously abused forgot their experiences for a period of time. While over 60% of these women did not initially define their experiences as a form of abuse, almost 70% changed their definition over time, almost always in the direction of relabeling the incident as abuse. Kelly (1988) concluded that it was impossible to accurately assess the incidence of violence with survey questionnaires that were distributed at a single point in time. Research designs that allow for repeated contact with queries about violence may trigger information for participants that would have been forgotten and/or minimized with only one contact with the researcher. Kelly stresses the importance of an interactive design when attempting to elicit information about abusive experiences.

In summary, the CTS and the Family Violence Scale may

be limited for a number of reasons. Both instruments survey participants about a limited number of specifically defined events a single time in their lives. The instruments fail to measure changes in the definition and perception of violence over time, and they fail to measure the experiences women may have had that felt abusive to them, but were not included in the scales. Due to these limitations, the present study may have failed to identify some women who experienced abusive or violent acts, either in their families of origin or in their current relationships that were not included in the questionnaires. In addition, the study may have failed to identify women who minimized or forgot violent episodes or experiences.

Implications for Future Research

While findings from the present study have provided support for certain aspects of previous research regarding attitudes toward victims of domestic violence, they have also raised questions suggesting further study. Future research could proceed along two different paths. First, further work should be done with the data collected for the present study. Literature suggests the existence of cultural differences in attitudes toward abuse (Torres, 1991). Approximately 33% of the respondents in the

present study were from minority backgrounds. Future research should examine this data for any cultural differences in relationships between the chosen variables and sympathy for battered wives.

The present study used a combined subscale, called Sympathy for Battered Wives (Saunders, 1987), to measure the dependent variable. The participants in this study were very sympathetic toward victims. Further research might examine the relationships between each of the independent variables and the original three subscales (Wife-Beating is Justified, Wives Gain from Beatings, and Help Should be Given) using canonical correlations. Such research might find one or more of the non-significant independent variables to be more highly correlated to an individual subscale than to the larger composite scale.

Future research could also include the use of a focus group interview to inform and enhance the findings. Presentation of data findings to selected groups of nursing students for discussion might lead to an increased understanding of these findings. In this way both quantitative and qualitative research techniques could be used synergistically to broaden understanding of nursing students' attitudes toward victims of domestic violence.

Secondly, future research might include studies growing from specific questions or concerns raised by the

present study. The present study noted gender differences in relationships between the independent and the dependent variables. Future research might replicate the present study utilizing only male nursing students. While this might be difficult, the sample could be enlarged to include all associate and baccalaureate nursing programs in the state of Virginia.

The present study noted some limitations in the instrumentation used to measure violent behavior and\or experiences. Future research might involve the creation and testing of more sensitive, less stereotypic violence measures. According to Kelly "the kinds of questions we ask must facilitate exploration of events that women are unsure of how to define, but that they experienced as abusive" (1988, p. 129). More sensitive violence measurement may narrow the existing gap between stereotypic definitions and what women are actually experiencing as abusive behavior.

The present study found that nursing students' attitudes toward victims of domestic violence were generally quite favorable despite previous research which suggests the opposite. Future research might examine these attitudes over time to see if they change, especially once the students are employed full-time in nursing. In addition to paper and pencil measures,

systematic observation of nurses in the workplace would provide an opportunity to examine the relationship between attitudes toward battered wives and actual behavior toward these women. Future research might use a multi-method approach, including questionnaires, systematic field observations, and interviews with both nurses and victims of domestic violence.

Implications for Education

The findings from this study have implications for the education of nursing students, specifically in relationship to their attitudes toward a specific patient population, but also in a much broader sense. The findings of this study point to the importance of egalitarianism in predicting attitudes toward battered wives, yet, nursing education and practice oftentimes exist in settings permeated with traditional sex role beliefs. Educating nursing students about gender issues, both at the societal and the practice level, would appear to be of some importance. Medicine has historically been seen as an overwhelmingly patriarchal and this paternalism exists today. Most nurses practice in settings highly influenced by the medical model. Helping nursing students see the gender biases rampant in the health care community will make them more aware not only of the impact of this

on their patients and practice, but also on themselves and their professional choices. Nurses who question the societal tendency to frame health and illness in sexist terms are more likely to redefine health problems and see previously hidden solutions. Such education may be done in a variety of ways. Nursing faculty could introduce gender issues as specific modules in each specialty area in nursing. In this way, students could examine the ways in which these issues permeate the definition of disease, the description of symptoms, and the choices of treatment. Nursing educators might assign students observational experiences where they could examine family\system dynamics for those ideas, behaviors and interactional sequences which support and maintain power inequities or stereotypic gender roles. They could help students define family health problems in terms of power differentials and stereotyped expectations and behaviors.

Because nursing educators work in a largely female environment and one strongly influenced by the medical model, they need to be aware of their own gender specific beliefs, attitudes and behaviors. Inability to understand and question their own role in this patriarchal medical system just perpetuates that system with each succeeding class of graduates. Finally, because nursing educators practice in a primarily female environment, they need to

serve as gender role models for their students and treat all women respectfully, whether patient, colleague or student. Nursing educators need to take their students seriously and encourage them to ask questions. They should counteract the tendency of their women students to invalidate or apologize for themselves or to present themselves as helpless and inadequate.

Although much has been written in nursing literature about the importance of autonomous practice, oftentimes the means for accomplishing that feat are not made specific in educational programs. While the findings of this study point to the importance of nursing students perceiving themselves to have control over their lives, many time nurses discount the power and control they do possess. They do this by discrediting their ability to be in charge of their lives, discrediting their ability to think or allowing others to think for them and by considering their own needs less important than the needs of others. Nursing educators could counteract this tendency in their students by providing opportunities for students to practice more autonomously, to be successful, and then, to acknowledge that success. They could remind students of their own resources and competencies. They could search for contexts in which each student feels or demonstrates competence and then help the student

recognize and process that experience. Finally, nursing educators could provide their students an expanded lens through which to observe and understand both their own and their patient's behavior. Such a paradigm shift, from the more traditional linear to a systems or interactional understanding would go a long way to enhance and energize each student's view of self and practice.

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APPENDICES

Appendix A

1. The Sex Role Egalitarianism Scale
2. The Perceived Control Scale
3. A Demographic Data Form
4. A Social Desirability Scale

Below you will find a series of statements about men and women. Read each statement carefully and decide the extent to which you agree or disagree with each. I am not really interested in what society says; I am interested in your personal opinions.
For each statement, circle the number which seems to best describe your opinion.

Strongly Disagree	Disagree	Neutral or No Opinion	Agree	Strongly Agree
1	2	3	4	5

	Strongly Disagree				Strongly Agree
1. Home economics courses should be as acceptable for male students as for female students.	1	2	3	4	5
2. Women have as much ability as men to make major decisions in a large business or organization.	1	2	3	4	5
3. High school counselors should encourage qualified interested women to enter technical fields such as physics or engineering.	1	2	3	4	5
4. Cleaning up the dishes should be the joint responsibility of husbands and wives.	1	2	3	4	5
5. A husband should leave the care of young babies to his wife.	1	2	3	4	5
6. The family home will run more smoothly if the father rather than the mother is responsible for establishing rules for the children.	1	2	3	4	5
7. It should be the mother's responsibility, not the father's, to plan the young child's birthday party.	1	2	3	4	5
8. When a child awakens at night, it should be the mother's responsibility to take care of the child's needs.	1	2	3	4	5
9. Men and women should be given equal opportunities for professional training.	1	2	3	4	5
10. It is worse for a woman to get drunk than for a man.	1	2	3	4	5

	Strongly Disagree				Strongly Agree
11. When it comes to planning a social gathering, women are better judges of which people to invite.	1	2	3	4	5
12. The entry of women into traditionally male jobs should be discouraged.	1	2	3	4	5
13. Expensive vocational and professional training should be given primarily to men.	1	2	3	4	5
14. The husband should be the head of the family.	1	2	3	4	5
15. It is wrong for a man to enter a traditionally female career.	1	2	3	4	5
16. The important decisions about career-related issues should be left to the husband.	1	2	3	4	5
17. A woman should be careful not to appear more intelligent than the man she is dating.	1	2	3	4	5
18. Women are more likely than men to gossip about their acquaintances.	1	2	3	4	5
19. A husband should not meddle with the domestic affairs of the household.	1	2	3	4	5
20. It is more appropriate for a mother rather than a father to change their baby's diapers.	1	2	3	4	5
21. When two people are dating, it is generally best if their social life is based around the man's friends.	1	2	3	4	5
22. Women are just as capable as men to operate a business.	1	2	3	4	5
23. When a married couple is invited to a party, the wife, not the husband, should be responsible for the RSVP.	1	2	3	4	5
24. Both men and women should be treated equally when applying for student loans.	1	2	3	4	5

	Strongly Disagree				Strongly Agree
25. Equal opportunity for all jobs regardless of sex is an ideal we should all uphold.	1	2	3	4	5

The statements below also concern personal attitudes and traits. Please assess honestly your personal reaction to these items by circling the number that best desribes you.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
	1	2	3	4	5
			Strongly Disagree		Strongly Agree
11.	I am responsible for my own successes.....	1	2	3	4	5
12.	I can do just about anything I set my mind to.....	1	2	3	4	5
13.	My misfortunes are the results of mistakes I have made....	1	2	3	4	5
14.	I am responsible for my failures.....	1	2	3	4	5
15.	The really good things that happen to me are mostly luck.....	1	2	3	4	5
16.	There's no sense planning a lot -- if something good is going to happen, it will...	1	2	3	4	5
17.	Most of my problems are due to bad breaks.....	1	2	3	4	5
18.	I have little control over the bad things that happen to me.....	1	2	3	4	5

I would like to ask you for some general information about yourself. This information will not be used to identify you, but will be helpful to me in interpreting the results of my study.

1. What was your age on your last birthday? _____ (years)

2. What is your sex? (circle number)
   1. Female
   2. Male

3. Which one of the following best describes your racial or ethnic identification? (circle number)
   1. African-American
   2. American Indian
   3. Asian\Pacific Islander
   4. Hispanic
   5. White, Non-Hispanic
   6. Other; please specify _____

4. What is your current marital status? (circle number)
   1. Single, not in a relationship
   2. Single, in a serious relationship
   3. Married
   4. Living with partner
   5. Divorced
   6. Widowed

5. What is your religious affiliation? (circle number)
   1. Agnostic or atheist
   2. Catholic
   3. Jewish
   4. Protestant
   5. Other; please specify _____

6. What is your current educational program? (circle one)
   1. Associate Degree
   2. Baccalaureate Degree

7. Prior to entry into this nursing program, what was the highest level of education that you had completed? (circle number)
   1. High school degree
   2. Some college
   3. Bachelor's degree
   4. Some graduate credits
   5. Master's degree
   6. Other; please specify _____

8. What is the current marital status of your parents? (circle number for each parent)

Mother	Father
1. Married (first marriage)	1. Married (first marriage)
2. Remarried	2. Remarried
3. Separated	3. Separated
4. Divorced	4. Divorced
5. Widowed	5. Widowed
6. Other (please specify)	6. Other (please specify)
_____	_____

9. Please describe the usual occupation of each of your parents. (If retired or deceased, describe the usual occupation before retirement or death.)

   Mother _____

   Father _____

10. Please circle all of the following categories in which you personally knew women to have been hit or beaten up by their partner.
    1. No one
    2. Neighbor
    3. Acquaintance
    4. Client\patient
    5. Co-worker
    6. Friend
    7. Relative
    8. Parent
    9. Self as victim
    10. Self as instigator
    11. Other; please specify

11. What is your specific student training or continuing education in the identification and\or treatment of battered women? (please circle all the categories that apply)
    1. None
    2. Lecture, lab, or grand round
    3. Clinical rotation in a family violence treatment center
    4. Clinical observation in a family violence treatment shelter
    5. Workshop or conference
    6. Journal articles; please specify approximate number read
       _____
    7. Other; please explain _____

Listed below are a number of statements concerning personal attitudes and traits. Read each item and decide how much each statement describes you personally. Please circle the number that indicates how strongly you agree or disagree with each statement.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	2	3	4	5

		Strongly Agree				Strongly Disagree
1.	No matter who I'm talking to, I'm always a good listener.	1	2	3	4	5
2.	I have sometimes taken unfair advantage of another person.	1	2	3	4	5
3.	I am always courteous, even to people who are disagreeable .	1	2	3	4	5
4.	I sometimes try to get even, rather than forgive and forget.	1	2	3	4	5
5.	I am quick to admit making a mistake.	1	2	3	4	5
6.	I sometimes feel resentful when I don't get my own way.	1	2	3	4	5
7.	I am always willing to admit when I make a mistake.	1	2	3	4	5
8.	There have been occasions when I have taken advantage of someone.	1	2	3	4	5
9.	I would never think of letting someone else be punished for my wrongdoing.	1	2	3	4	5
10.	At times, I have wished that something bad would happen to someone that I disliked.	1	2	3	4	5

Appendix B

1. The Family Violence Scale
2. The Conflict Tactics Scale

As children grow up in families, they are exposed to a variety of parental behaviors. Following is a list of questions related to how the people in your own family handled conflicts or disagreements during your childhood. Please read all the questions carefully and respond to them honestly. Circle the numbers that apply.

Never	Very Seldom	Seldom	Often	Very Often
1	2	3	4	5

	Never		Seldom		Very Often
1. Did your father beat you?.....	1	2	3	4	5
2. Did your mother approve of physical violence in general (i.e. war against enemy countries, necessary violence against criminals, and the like)?.....	1	2	3	4	5
3. Did your father seriously threaten physical violence against you?.....	1	2	3	4	5
4. Did your mother use really violent language in dealing with your father?.....	1	2	3	4	5
5. Did your father use really violent language with you?	1	2	3	4	5
6. Did your mother seriously threaten physical violence against people outside your family?.....	1	2	3	4	5
7. Did your father approve of physical violence in general (i.e. war against enemy countries, necessary violence against criminals, and the like)?.....	1	2	3	4	5
8. Did your mother throw or break things in anger?...	1	2	3	4	5
9. Did you fight physically with other children?.....	1	2	3	4	5
10. Did your father throw or break things in anger?	1	2	3	4	5
11. Did your mother encourage you to use physical force against other children?..	1	2	3	4	5

	Never		Seldom		Very Often
12. Did your father seriously threaten physical violence against your mother?....	1	2	3	4	5
13. Did your mother use really violent language in dealing with you?.....	1	2	3	4	5
14. Did your father use really violent language in dealing with your mother?.....	1	2	3	4	5
15. Did your mother seriously threaten physical violence against your father?.....	1	2	3	4	5
16. Did your father encourage you to use physical violence against other children?.....	1	2	3	4	5
17. Did your mother beat your father?.....	1	2	3	4	5
18. Did you seriously threaten physical violence against other children?.....	1	2	3	4	5
19. Did your father beat your mother?.....	1	2	3	4	5
20. Did your mother seriously threaten physical violence against you?.....	1	2	3	4	5
21. Did your father seriously threaten physical violence against people outside your family?.....	1	2	3	4	5
22. Did your mother beat you?	1	2	3	4	5
23. Did your father use physical violence against people outside your family (other than in war)?.....	1	2	3	4	5
24. Did your mother use use physical violence against people outside your family (other than in war)?.....	1	2	3	4	5
25. How often did physical violence take place in your neighborhood?.....	1	2	3	4	5

The following list of things you might have done when you had a conflict or disagreement with your spouse or dating partner. If you are not currently married or in a dating relationship, think about the most serious relationship that you've ever been in and answer the questions based on that relationship. (Please circle the numbers to the right and left of each of the items to indicate your response).

Never Done	Threatened Only	Rarely Done	Occasionally Done	Frequently Done
1	2	3	4	5

You						Your Partner				
1	2	3	4	5	tried to discuss the issue relatively calmly	1	2	3	4	5
1	2	3	4	5	did discuss the issue relatively calmly	1	2	3	4	5
1	2	3	4	5	got information to back up my side of things	1	2	3	4	5
1	2	3	4	5	brought someone else in to settle things (or tried to)	1	2	3	4	5
1	2	3	4	5	argued heatedly but short of yelling	1	2	3	4	5
1	2	3	4	5	yelled and\or insulted	1	2	3	4	5
1	2	3	4	5	sulked and\or refused to talk about it	1	2	3	4	5
1	2	3	4	5	stomped out of the room	1	2	3	4	5
1	2	3	4	5	threw something (but not at my partner) or smashed something	1	2	3	4	5
1	2	3	4	5	threatened to hit or throw something at her or him	1	2	3	4	5
1	2	3	4	5	threw something at my partner	1	2	3	4	5
1	2	3	4	5	pushed, grabbed or shoved my partner	1	2	3	4	5
1	2	3	4	5	hit (or tried to hit) my partner, but not with anything	1	2	3	4	5
1	2	3	4	5	hit (or tried to hit) my partner with something hard	1	2	3	4	5

Appendix C

1. The Inventory of Beliefs about Wife-Beating

Below you will find a series of statements about husbands and wives. Please read each statement carefully and decide the extent to which you agree or disagree with each. I am not interested in what society says; I am interested in your personal opinions.

For each statement, circle the number which seems to best describe your opinion. Please do not omit any statements. Remember to circle only one of the seven possible choices for each statement.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5
		Strongly Disagree		Strongly Agree

1. A husband has no right to beat his wife even if she breaks agreements she has made with him.....	1	2	3	4	5
2. Even when a wife's behavior challenges her husband's manhood, he's not justified in beating her.....	1	2	3	4	5
3. A wife doesn't deserve a beating even if she keeps reminding her husband of his weak points.....	1	2	3	4	5
4. Even when women lie to their husbands, they do not deserve to get a beating.....	1	2	3	4	5
5. A sexually unfaithful wife deserves to be beaten.....	1	2	3	4	5
6. Sometimes it is OK for a man to beat his wife.....	1	2	3	4	5
7. It would do some wives good to be beaten by their husbands.....	1	2	3	4	5
8. Occasional violence by a husband toward his wife can help maintain the marriage..	1	2	3	4	5
9. There is no excuse for a man beating his wife.....	1	2	3	4	5
10. A woman who constantly refuses to have sex with her husband is asking to be beaten.....	1	2	3	4	5

	Strongly Disagree				Strongly Agree
11. Episodes of a man beating his wife are the wives fault.....	1	2	3	4	5
12. Wives could avoid being beaten by their husbands if they knew when to stop talking.....	1	2	3	4	5
13. Battered wives are responsible for their abuse because they intended it to happen.....	1	2	3	4	5
14. Wives who are battered are responsible for the abuse because they should have foreseen that it would happen.....	1	2	3	4	5
15. Battered wives try to get their partners to beat them as a way to get attention from them.....	1	2	3	4	5
16. When a wife is beaten, it is caused by her behavior in the weeks before the battering.....	1	2	3	4	5
17. Most wives secretly desire to be beaten by their husbands.....	1	2	3	4	5
18. Wives try to get beaten by their husbands to get sympathy from others.....	1	2	3	4	5
19. Women feel pain and no pleasure when beaten by their husbands.....	1	2	3	4	5
20. If I heard a women being attacked by her husband, it would be best that I do nothing.....	1	2	3	4	5
21. If I heard a woman being attacked by her husband, I would call the police.....	1	2	3	4	5
22. Wife beating should be given a high priority as a social problem by government agencies.....	1	2	3	4	5
23. Social agencies should do more to help battered women.....	1	2	3	4	5

	Strongly Disagree				Strongly Agree
24. Women should be protected by law if their husbands beat them.....	1	2	3	4	5

Appendix D

1. Sample Letter to Deans
2. Cover Letter to Nursing Students
3. Informed Consent Statement Read to Participants
4. Informed Consent Form Signed by Participants

February 27, 1992

Dorothy Powell, Ed.D
Dean, College of Nursing
Howard University
2400 6th St. N.W.
Washington, D.C. 20059

Dear Dr. Powell,

My name is Jean Coleman. I am a psychiatric nurse currently enrolled in the doctoral program in counselor education at Virginia Polytechnic Institute and State University. My research interests are in the field of women's mental and physical health. I am particularly interested in understanding the formation of nurses' attitudes toward battered women.

Abused women are frequent users of emergency, gynecological, and psychiatric services. Yet, these women do not identify the health care delivery system as particularly helpful or useful to them. Little research has been directed toward understanding why this situation exists. My dissertation research will attempt to develop a preliminary understanding of attitude formation in one group of health care professionals (i.e., nurses) by examining the relationship between selected individual and family variables and attitudes toward victims of domestic violence.

I would like to include some of the nursing students at Howard University in my research sample. The study will involve the use of survey techniques and the students' participation would be entirely voluntary and anonymous.

I will be calling you within the next seven days to answer any questions that you may have. I look forward to a positive response.

Sincerely,

Jean U. Coleman MSN, RN, CS
806 N. Ivy St.
Arlington, Va. 22201

Dear Nursing Student:

Thank you very much for agreeing to take part in this research study. The study itself is designed to develop a beginning understanding of nursing student attitudes toward battered women. I believe that the study will contribute to the nursing knowledge base about such issues as the impact of personal experiences and current behavior on attitude formation regarding this specific health care population. I anticipate that this questionnaire will take you approximately 15 to 20 minutes to complete.

There are **three** points that I would like to emphasize:

1. Your participation is entirely **voluntary**. There is no penalty for not participating and you may withdraw from the study at any time and for any reason.

2. Your responses are **completely anonymous**. Please **do not** put your name or social security number anywhere on this survey. The results will describe group trends rather than individual responses.

3. You have to be 18 years of age or older to participate.

To clarify the instructions, they are as follows:

Please read the questions as well as the responses very carefully. Question format and the way responses are presented will vary from one section to another.

There are no right or wrong answers. It is not necessary to spend very long on any question. Mark your answer quickly and go on to the next item. Be sure to mark how you actually feel about the statement, not how you think you should feel.

It is important for you to complete all the items on each of the pages.

Since these questionnaires have been distributed to a number of nursing classes, if you have already completed one, please do not complete a second, but return the questionnaire.

Again, thank you very much for taking part. If you have any questions about this study or would like to know the results, please feel free to contact me at the (local) phone number below.

Sincerely,

Jean Coleman
(703) 698-6033

INFORMED CONSENT

STATEMENT TO BE READ TO CLASS

1. Introduce myself and explain that this research is part of a doctoral dissertation study examining how life experiences relate to the formation of health care perspectives.

2. Participation in this research is voluntary. Refusal to participate will involve no penalties and it will not adversely affect your grade in this course. Participation can be terminated at any time and for any reason.

3. Participants will be asked to carefully complete a series of short surveys.

4. There are no known risks involved and no costs to you.

5. Your responses are anonymous; you will not be asked to identify yourself in any way on these questionnaires. The results will describe group trends rather than individual responses.

6. You will be asked to sign a participant informed consent form indicating that you understand the conditions for your partipation in this study and agree to take part. This form will be handed out separately from the questionnaire itself and cannot be used in any way to identify your individual questionnaires.

ADD: a brief cover letter which reiterates the purpose of the study; thanks them for their participation; and has my signature and a phone number where I can be reached if there are any further questions.

INSTRUCTIONS TO PARTICIPANTS:

Please read the questions as well as the responses very carefully. There are a number of different surveys and the manner in which questions and responses are presented for each varies from one survey to the next.

There are no right or wrong answers. It is not necessary to think over any item very long. Mark your answer quickly and go on to the next statement.

Be sure to mark how you actually feel about the statement, not how you think you should feel.

It is important that you complete all the items on each of the surveys.

Thank you.

Statement of Informed Consent

I understand that the purpose of this study is to develop a beginning understanding of nursing student attitudes toward battered women. I further understand that the study is being conducted by Jean Coleman as part of her doctoral dissertation under the supervision of Drs. Charles Humes and Sandra Stith of Virginia Polytechnic Institute and State University in Falls Church, Va.

I have read the instructions for completing this questionnaire and understand the conditions for my participation in this study.

I understand that my responses will be completely anonymous and that the results will describe group trends rather than individual responses.

I understand that my participation is entirely voluntary, that there is no penalty for my refusing to participate, and that I may terminate my participation at any time and for any reason.

I understand that there are no costs to me for participating in this study.

I understand that I must be 18 years of age or older to participate.

I understand that I have the option not to answer any question that makes me uncomfortable. Further, if any of the questions make me uncomfortable, I understand that I can talk with Jean Coleman privately about my discomfort, either directly or by telephone. She can be reached by phone at 703/698-6033.

I have read this form, understand my rights and my role with regard to this research, and agree to participate.

_____ _____

Participant's Signature Date

Appendix E

Table 9

Mean Frequencies and T Test Comparisons Between Males and Females on Independent and Dependent Variables

Table 9

Mean Frequencies and T Test Comparisons
Between Males and Females on
Independent and Dependent Variables

Independent Variables	Females X	Males X	T	p
SRE df = 176	4.50 (.43)	4.21 (.60)	-2.82	.005**
PERCON df = 176	4.05 (.51)	4.08 (.46)	.27	.787
CTSY df = 165	1.41 (.71)	1.58 (.75)	1.35	.179
CTSYP df = 166	1.50 (.89)	1.64 (.94)	1.53	.128
FAMVIO df = 174	1.42 (.42)	1.77 (.91)	3.02	.003**
Dependent Variable				
DOMVIO df = 176	4.67 (.39)	4.47 (.54)	-2.25	.025*

Note: Standard deviations are given in parentheses below mean values.
* $p < .05$
** $p < .01$

VITA

JEAN URBAN COLEMAN

EDUCATION

Ed.D, College of Education
Virginia Polytechnic Institute and State University
Blacksburg, Virginia
Major: Counselor Education

Post Master's Certificate in Marriage and Family Therapy (1989)
Virginia Polytechnic Institute and State University
Northern Virginia Graduate Center

Master of Science in Nursing (1974)
University of North Carolina
Chapel Hill, North Carolina
Major: Psychiatric Nursing

Bachelor of Science (1970)
Boston College
Chestnut Hill, Massachusetts
Major: Nursing

OTHER EDUCATION

Post Graduate Training Program in Family and Systems Theory and Family Psychotherapy (1977-1979)
Georgetown Family Center
Georgetown University Medical Center
Washington, D.C.

PROFESSIONAL EXPERIENCE

Associate Director, Center for Family Services (August 1992-present)
Department of Family and Child Development,
Virginia Polytechnic Institute and State University

Adjunct Professor/Supervisor (1989-August 1992)
Center for Family Services, Virginia Polytechnic Institute and State University

Chair, Local Human Rights Committee (May 1992)
Northern Virginia Mental Health Institute
Fairfax, Virginia

Assistant Professor of Nursing (1982-1991)
Tenured 1985
Instructor (1976-1979)
Marymount University
Arlington, Virginia

Nurse Therapist (1980-1981)
Chapel Hill, North Carolina

Nurse Clinician (1974-1975)
Arlington County Substance Abuse Program
Arlington, Virginia

Staff Nurse (1970-1972)
Psychiatric Unit
North Carolina Memorial Hospital
Chapel Hill, North Carolina

PROFESSIONAL CREDENTIALS

Licensed as professional nurse in Massachusetts (1970); currently licensed in Virginia

American Nurses' Association certification in Adult Psychiatric and Mental Health Nursing (1990)

HONORS AND AWARDS

Nominated by Marymount University for the Virginia Outstanding Faculty Award (1989)

Selected for inclusion in Who's Who in Professional Nursing (1987)

Research Mini-Grant Award by

American Association for Teacher Education
Finished product was chosen as one of the three best (out of twenty grants awarded).

Johnston Scholar (1972-1974)
University of North Carolina
Chapel Hill, North Carolina

Member of Sigma Theta Tau (1970-present)

Graduated magma cum laude from Boston College
(1970)

PRESENTATIONS

"The Female Gender: Untapped Opportunities for Energizing Self, Practice and Systems" paper presented at the Fourth Annual Public Mental Health Nursing Conference
Williamsburg, Virginia (November, 1992)

"Cultural Considerations in Advanced Practice for Psychiatric Nurses" paper presented to the Northern Virginia Psychiatric Nurses'Professional Practice Group
Dominion Hospital
Falls Church, Virginia (June, 1992)

"The Role of Culture in Mental Health and Mental Illness" paper presented at the Third Annual Public Mental Health Nursing Conference
Williamsburg, Virginia (November, 1991)

"The Role of Culture in Mental Health and Mental Illness" presented as part of an in-service series
Northern Virginia Mental Health Institute
Falls Church, Virginia (October, 1991)

"Ethical Dilemmas in Educating the Handicapped" paper presented at the 8th Annual Conference of the Council for Exceptional Children
Alexandria, Virginia (November, 1986)

"Ethical Dilemmas in the Lifecycle of the Handicapped Individual"; poster presentation
Conference on Nursing Ethics
George Washington University Hospital
Washington, D.C.

Jean Urban Coleman

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Date