Nurses' Attitudes Toward Survivors and Perpetrators of Domestic Violence

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Domestic violence is of special concern to nurses, as they are often the first health care professionals to interact with battered women. The purpose of this study was to explore and describe nurses' attitudes toward the survivors and perpetrators of domestic violence. A holistic ecological health promotion framework guided this qualitative investigation. Thirteen participants expert in the care of abused women were interviewed using semistructured questions to describe nurses' attitudes toward survivors and perpetrators. Significant statements were identified, clustered, and placed into categories of response. Findings included identification of general themes and specific categories related to attitudes nurses have about battered women and those who abuse and injure them. The significance of this research underscores the importance of nurses' attitudes as influencing factors in their interactions with women and families involved in domestic violence. Application of a health promotion framework encourages a holistic perspective of care for this vulnerable population.

Violence in the United States is now described as both a major health problem and a criminal justice problem. The risk for violence does not escape any segment of society, regardless of race, age, gender, economic status, or lifestyle (Hotaling & Sugarman, 1990). Reduction in violence is a major goal of Healthy People 2010 (U.S. Public Health Service, 1999) and is targeted as a public health priority by the World Health Organization (1997). The role of nurses in countering violence is one that involves action at all levels of care: primary, secondary, and tertiary prevention, as well as professional education and health policy

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arenas. National nursing organizations, including the American Nurses Association (1991) and the American Association of Colleges of Nursing (AACN, 1999), have issued position statements that highlight the problem from a nursing perspective, identify the profession's commitment to address violence as a nursing issue, and provide recommendations for nursing action.

Domestic violence against women is of special concern to many nurses because it affects large numbers of women and has implications for children, elders, and partners. Domestic violence includes physical, sexual, and psychological violence, all of which can result in acute and long-term physical and emotional injury, disability, and death. The statistics are frightening—battering affects at least 2 million women each year (Poirier, 1997); the annual rate of physical attacks on women by family members in 1992-93 was 9.4 per 1,000 women but only 1.4 per 1,000 men (Bachman & Saltzman, 1995); 7.4% to 20% of women experience abuse in the 12 months prior to their pregnancy (Campbell & Parker, 1992; McFarlane, Parker, Soeken, & Bullock, 1992); one in six women is subjected to intimate partner violence during pregnancy (Datner & Ferroggiaro, 1999); and 31% of female homicide victims were killed by intimate partners (Federal Bureau of Investigation, 1993). The annual cost of partner abuse in the United States has been estimated at $67 billion (Miller, Cohen, & Wiersema, 1998). In addition, the documentation and processing of reports of abuse by intimate partners presents a significant burden on police departments and the court system (Cochran, 1998).

Because a nurse is the first health care professional to interact with a battered woman in the emergency room, physician's office, clinic, or women's shelter, it is important that nurses are adequately prepared to identify women who have been battered (Woodtli & Breslin, 1997). The percentage of women identified as battered increased from 5.6% to 30.0% following staff training along with institution of protocols in the emergency room (Olson et al., 1996). Nurses continue to care for survivors of domestic violence episodes in hospital rooms, rehabilitation centers, outpatient clinics, shelters, and in the home. Essential aspects of all nursing interventions with battered women include not only attitudes of respect for the woman's personal dignity and right to make her own decisions but also recognition of the need for a holistic approach to violence within the family unit.

Attitudes are based on one's values and beliefs, not just on one's knowledge (Hoff & Ross, 1995). The attitudes nurses have about survivors and perpetrators of domestic violence may affect their ability

to establish positive nurse-client relationships and achieve expected nursing outcomes. The effect that nurses' attitudes have on their therapeutic effectiveness in caring for women survivors and their families, including the perpetrators, is unknown. Although findings of many studies on violence-related issues have been reported, few have focused on nurses' attitudes toward either the survivors or perpetrators of domestic violence. A first step in understanding the relationship between nurses' attitudes and nursing outcomes is to explore nurses' attitudes toward the women who are battered as well as those who batter.

The purpose of this article is to report the findings of a qualitative study focused on attitudes nurses have about survivors and perpetrators of domestic violence. These findings are one part of a larger qualitative study that explored the feelings nurses have about domestic violence and described the essential knowledge and skills nurses need to provide care to those involved in domestic violence (Woodtli, 2000).

Literature Review

Although findings of many studies on violence-related issues have been reported, this literature review is limited to findings with specific reference to nurses' attitudes. As early as 1979, Gelles confirmed the importance of helpers (e.g., nurses) in determining the outcomes of violent relationships. However, Rose and Saunders (1986) were the first to compare attitudes of nurses and physicians toward woman abuse. They found that female nurses and physicians were more sympathetic toward battered women and were less likely to believe victims are responsible for the abuse than were male nurses or physicians. In one of the few reports of physician attitudes toward domestic violence, Sugg and Inue (1992) found that physicians referred to questioning women about domestic violence episodes as "opening Pandora's Box." They identified feeling discomfort in asking questions, fear of offending the patient, and feeling powerless over the treatment and outcome. These attitudes were perceived as barriers to intervening in situations in which they suspected domestic violence.

In an effort to refute commonly held attitudes based on the beliefs that women are helpless and that battering occurs more frequently in certain racial or cultural groups, King and Ryan (1989) were among the first to suggest that nurses in advanced practice be change agents

to correct these misconceptions. Tilden et al. (1994) explored factors that influenced 1,521 clinicians' assessments and management of family violence. Of the 1,521 participants, 241 were nurses. The researchers were troubled to find that (a) only about a third of participants in each of the six disciplines thought mandatory reporting of suspected elder abuse was effective; (b) about 50% of physicians, psychologists, and social workers and 37% to 39% of dentists, dental hygienists, and nurses thought mandatory reporting of child abuse effective; and (c) nearly half of the dentists and dental hygienists, 15% of physicians, and 13% of nurses viewed themselves as not responsible for dealing with family violence. However, a majority (55%-76%) of the disciplines, except psychologists, thought mandatory reporting laws for spouse abuse should be enacted. The researchers also found that participants with previous education on child, elder, or spouse abuse were more likely to suspect the presence of abuse among their patients than those without education. In a subsequent study, Limandri and Tilden (1996) examined the responses of the sample of the 241 registered nurses. They reported that (a) 87% of nurses agreed that health professionals were responsible to help those experiencing family violence; (b) 93% agreed that family violence was more a health problem than a legal problem; and (c) 76% agreed that reporting spouse abuse should be mandatory. In a qualitative study described in the same article, the authors reported findings related to responses of 9 of the 241 nurses. The nurse interviewees believed violence should not be used but "could be provoked" in cases of spousal abuse, stated that "the abused person should not allow the situation to become violent and should leave when it does," and showed "little tolerance for adults perceived as participating in their own abusive situation" (p. 251).

Sword, Carpio, Deviney, and Schreiber (1998) reported that despite limited instruction about woman abuse in their nursing curriculum, 150 Canadian nursing students were sympathetic in their attitudes about woman abuse. The authors suggested that to enhance student learning and improve their interactions with abused women, students must first be encouraged to explore their own attitudes about woman abuse and identify their misconceptions.

In summary, attitudes about abused women were found to be related to gender; women and nurses generally agreed that the abused person was not responsible for the abuse, although abusive behavior could be provoked. Nurses and other health care professionals were encouraged to confront their attitudes toward woman abuse with the intent that subsequent interactions with abused women

would be more effective. There was little empirical evidence that education changed attitudes, but findings demonstrated that identification of abused women did increase after exposure to educational programs. Little data-based evidence was found related to either nurses' attitudes toward the survivor and the perpetrator of woman abuse or to nurses' expectations of care outcomes. Therefore, the research findings reported here attempt to fill the need for empirically based data in the nursing and domestic violence literature on attitudes of nurses toward the survivor and perpetrator of domestic violence as perceived by nurses and others who are identified as expert practitioners in the field of domestic violence.

Conceptual Orientation

The importance of ecological models is "that they view behavior as being affected by and affecting the social environment" (McLeroy, Bibeau, Steckler, & Glanz, 1988, p. 354). For nurses, this view is important because it provides an opportunity to design a range of health promotion strategies targeting multiple levels within the social environment. The holistic view of behavior proposed by ecological models permits nurses to focus attention on different types of social influences for which they can develop appropriate interventions to modify health-related behaviors. The interventions may range from those directed at the individual or family to those aimed at communities or public policy. To decrease the incidence of violence and promote the health of individuals, families, communities, institutions, and the society as a whole, interventions, including those of nurses, must be directed at multiple social levels. An ecological perspective directs attention to both the behavior and its individual and environmental determinants. This view is congruent with a holistic perspective of nursing care.

The Ecological Model for Health Promotion (McLeroy et al., 1988) guided this research study and is useful for studying domestic violence. From a health promotion perspective, the model is based on the assumption that behavior is influenced by five factors: intrapersonal, interpersonal, institutional, community, and public policy. It supports the holistic dimensions of nursing interventions that have the potential to be implemented at each level. Nurses' attitudes related to each of the factors could guide their interventions and enhance the effectiveness of health promotion techniques available within a holistic

framework. In summary, this ecological model, with its emphasis on the effects of several levels of social factors on behavior, provides a holistic grounding for research focused on the social and health problems related to domestic violence against women.

This conceptual orientation guided the design of this qualitative study. Findings related to the analysis of the participants' responses to two of the seven questions are reported here: What are your attitudes about the survivor of domestic violence, and what are your attitudes about the perpetrator of domestic violence? Additional information related to participant attitudes is included in a section entitled "Additional Comments."

METHOD

Sample

Using a network sampling technique, the researcher identified a purposive sample of 13 health care providers who agreed to participate in individual interviews focused on their experiences, attitudes, and expectations of outcomes related to abuse against women. Members of the health professional community in a large southwestern city recommended the informants to the investigator because of their experience and expertise in caring for survivors of domestic violence. Each informant was contacted by telephone and invited to participate in the interview session after the purpose of the study had been explained. All informants agreed to participate, and individual meeting times were arranged. Each participant was assigned a code number; the list of names with the corresponding code number was known only to the research assistant and kept in a locked file. After the completion of the 13th interview, the investigator and research assistant agreed that data saturation had occurred and no additional participants were contacted.

Procedure

Interviews with participants took place at locations determined by the participant and lasted from 1 to nearly 3 hours. All interviews were audiotaped and conducted by a graduate student completing her master of science degree in nursing. Using the interview guide, the investigator and the graduate student, an experienced nurse, role

played simulated interviews and discussed potential interviewer responses. Field notes taken during the interview were supplemented and completed immediately following the interview. The interviews were transcribed by a third person not connected with the research study. The written transcripts were compared to the audiotaped interviews to ensure accuracy.

Four of the 13 participants were randomly selected and agreed to be interviewed a second time. Again, these interviews were individually scheduled to last 1 hour. The purpose of the second interview was to "feedback the findings" that emerged from the analysis of the 13 interviews to help assure the conformability of the findings (Guba, 1981). Miles and Huberman (1984) recommend conducting feedback sessions after the final analysis of the data rather than during data collection so that the researcher can provide feedback in a more systematic format and at a higher level of inference. The participants agreed with the findings and were verbal in their supportive comments confirming the accuracy of the report. During the second interview, the participants emphasized the need for education in domestic violence and all types of abuse as part of the formal curriculum for nursing students and continuing education for all nurses. They voiced their opinion that education (a) may help change attitudes of some nurses, (b) would enhance assessment and identification of battered women and those at risk, (c) might increase the frequency and effectiveness of nursing interventions, and (d) would hopefully improve outcomes.

Instrument

Although the instrument consisted of seven structured questions and one open-ended question, only responses to the two questions focused on nurses' attitudes are addressed in this article. Questions were based on research findings in two previous studies (Woodtli & Breslin, 1996, 1997). The questions were reviewed and discussed with a doctorally prepared women's health nurse practitioner, researcher, and educator whose methodological focus is primarily qualitative. Minor changes in words and in sequence of questions were suggested and implemented. The structured questions targeted responses to the stated purposes of the study; the open-ended question encouraged participants to add information or insights they believed were relevant. The research assistant conducted a pilot interview with one nurse to test the clarity of the questions. The content of this interview was not included in the analysis of findings. No revision of the

questions or format was indicated, but the hour of time allocated for the interview was exceeded. This extended length of interview time proved to be repeated for all but one of the participants.

Analysis

The transcript copies were reviewed independently by the investigator and the research assistant. The responses to each question were aggregated and significant statements identified. Together the investigator and research assistant compared the significant statements by question for similarities and differences. When differences emerged, they reviewed the transcripts and field notes together, discussed the differences in interpretation, and came to consensus. They then independently analyzed the significant statements by question and placed the statements into categories. Again, they compared categories and came to consensus. Together, they abstracted the categories of response into the general themes for each question. The data from the open-ended question are included in a separate category. No significant differences were discovered in analyzing the responses to the open-ended question. Likewise, no substantive changes occurred during the second interview to modify the response categories or themes. Participant responses to the second interview primarily confirmed, expanded on, and provided additional rationale for the results of the analysis.

Results

The study findings reported here are related to the attitudes of nurses toward survivors and perpetrators of domestic violence. Comments focusing on nurses' attitudes related to nursing outcomes resulting from their care are included in the section "Additional Comments."

Sample

Of the 13 participants, 11 were registered nurses, 1 was a social worker, and 1 a counselor. The 2 non-nurses had worked extensively with nurses in their respective professional roles and had many opportunities to observe, cooperate with, and collaborate with nurses in the care and referral of domestic violence survivors, their children,

and the perpetrators. The investigator used these "outsider" views and experiences of knowledgeable professionals external to nursing as comparison data to the "insider' views of the 11 nurses. Analysis of the 2 non-nurse interviews did not differ significantly in attitudes from those expressed by the nurse participants. In fact, the non-nurse participants praised the genuine concern nurses showed for battered women, the expert direct care they provided, and nurses' commitment to refer the domestic violence dyad and children to other professionals and organizations for additional help and assistance. Both of the outsiders commented favorably on nurses' attitudes toward those involved in and affected by the dynamic, complex, and very difficult physical and emotional aspects of domestic violence situations. In summary, the observations of the 2 non-nurse participants confirmed the findings expressed by nurses about their attitudes toward survivors and perpetrators of domestic violence.

The 11 nurse participants were all registered nurses who ranged in educational preparation from diploma to master's degree. Ten nurses were female; 1 was male. All were currently practicing in various health care specialties and settings including pediatrics, maternity, mental health, public health, doctor's office, adult care home, emergency room, and urgent care. Ten were working in a metropolitan area; 1 worked in a small community hospital. Several participants stated they had previously contacted Child Protective Services and Adult Protective Services. One participant was a trained sexual assault nurse on call when her services were needed, one had participated in an outreach rural domestic violence program, one was a victim witness volunteer, two volunteered at women's shelters, and another volunteered at a shelter for perpetrators only. One nurse identified herself as an abuse survivor of 18 years, and another confided that her daughter was currently in an abusive relationship.

Findings

Question 1: What Are Your Attitudes About the Survivor?

Three categories emerged from the analysis of responses to this question: attitudes about the survivor, nurses' responses to the survivor, and nurses' role in caring for the survivor. The general theme derived from the three categories of participants' responses to this question is, The Survivor Is Crying for Help.

Attitudes about the survivor. Participants said that the survivor is an individual who "is crying for help." Yet, they said, "survivors are adults who have options and choices" about their lives and how they choose to live. Participants described the survivor as a woman who is often dealing with other complex issues, such as children, finances, and multiple other family problems that limit the choices, at least in the survivor's mind, that are open to her. They emphasized their concerns that the survivor is "always in potential danger" of even more violent episodes as the violence escalates. Most stated that the survivor has "low self esteem and feels isolated from others," including her family and friends. Participants believed that these issues and personal characteristics coupled with the survivor's "lack of insight" into the dynamics of violence, and especially into her own unique situation, constituted barriers that resulted in her experiencing great difficulty leaving the situation and indeed often prevent her from leaving.

Nurses' interactions with the survivor. Participants stated that nurses' attitudes toward the survivor should be caring and empathetic "wherever the victim is in the violence cycle." They emphasized the need for nurses' interactions to demonstrate "respectful attitudes" toward the survivor's person, feelings, and right to decide. They stressed the need for nurses' interactions to reflect attitudes that are objective, without bias, and some participants even used the word "neutral." Participants said that nurses' attitudes and interactions with the survivor should reflect the knowledge that survivors belong to all socioeconomic groups, can be both males and females, and represent all cultures and ethnicities. One participant said nurses' responses and interactions should reflect the attitude of "arm them with facts but touch them emotionally."

Nurses' role in caring for the survivor. Participants were quite emphatic about the "do and don'ts, the cans and cannots" of the professional role. They distinguished between appropriate nursing role behaviors and those clearly outside the role. Participants believed that nurses can and should make emotional contact with each survivor in ways that convey caring and respect. Nurses, one said, must treat each survivor as "a unique individual in a unique situation with a unique set of problems." Participants stressed that "getting the victim help is the focus" of what nurses can do. They described *help* as first recognizing the problem and then providing information, knowledge, support, resources, and especially, safety. Several

participants said that nurses must accept the fact that, although "they can offer help, the survivor has the right to decide not to accept it." On the other hand, participants clearly described what nurses cannot do. They cannot own the problem, make choices or decisions for the survivor, rely on stereotypes, act on their biases, or "take personally the anger that is sometimes projected onto them."

Question 2: What Are Your Attitudes About the Perpetrator?

The participants discussed nurses' attitudes about the perpetrator within the same three categorical types they used in their responses to the survivor question. Again, three categories of participants' responses emerged from the data: attitudes about the perpetrator, nurses' interactions with the perpetrator, and nurses' role in caring for the perpetrator. The general theme taken from three categories of responses to this question is, The Criminal Justice System Judges, The Nurse Does Not.

Attitudes about the perpetrator. All participants stated that "the perpetrator is dangerous," can repeat the violent episode, or can become even more violent. They stressed that nurses always need to be aware of the "potential for violence." Several participants said that perpetrators may need to be jailed but may be "protected from the police by their families and the survivor herself." Participants characterized perpetrators as usually lacking in self-esteem and often dealing with issues of power and control. One participant said she grew up in a violent home and "at times feels sorry" for the perpetrator. Others suggested that perpetrators may themselves "be victims of a violent society," such as child abuse, gangs, or violent family dynamics, and that they need help as well. Participants viewed the perpetrator as "part of the problem but also part of the solution." They stressed his need for help as a member of the dyad or family. Many of their comments reflected the holistic perspective of family, not just focusing on the survivor or the perpetrator. Participants also warned against assuming there is just one perpetrator. In domestic situations, they said, violence may be mutual with both partners engaging in violent behaviors toward the other. There may be "two perpetrators and two survivors."

Nurses' interactions with the perpetrator. Again, the participants stressed the need for nurses to be nonjudgmental and "neutral" in

their attitudes. They urged nurses to recognize their own feelings. "It's easy to feel anger toward the perpetrator," but nurses need to "put their anger on the back burner" and not let their biases or negative attitudes get in the way of care for the survivor or their recognition that the perpetrator needs care as well. They stated that the nurse needs to recognize that the survivor often sees the perpetrator as the one whom "she loves" and to whom she "is connected" or who is the "father of her kids." In contrast, participants also reported that some survivors see the perpetrator as a "monster" or as a person whom she fears but is "afraid to leave." Participants suggested that nurses' responses to the perpetrator be guided by viewing the perpetrator within a "larger context" in which the social or cultural environment may permit or encourage violent acts toward women or view the perpetrator within the framework of the cycle of violence, family history, or childhood abuse. However, participants also stressed that nurses' interactions with the perpetrator must ensure safety for themselves and for others in the environment. Some participants were quite explicit about nurse-perpetrator interactions (e.g., "Don't get into an argument"; "Don't let them get between you and the door"; "Make sure you are able to call security"). Most participants identified the need for nurses to respond to the perpetrator in ways that reflect a more holistic view of the domestic violence dyad: the survivor and the perpetrator rather than the survivor or the perpetrator. As one participant said, "It's not that simple."

Nurses' role in caring for the perpetrator. The participants stressed that the immediate focus of the nurses' role is directed toward "care of the survivor." Nevertheless, they said, nurses need to deliver appropriate care to the perpetrator and treat the perpetrator as a "human being." They indicated that appropriate referrals needed to be made for the perpetrator as part of the plan of care and stated that the collaboration with other health providers, such as social workers, was an essential part of treatment of the whole family: children, perpetrator, and survivor. The participants spoke about the need for nurses to know when and how to refer and who on the care team could best manage the follow-up care. They emphasized that it was unrealistic and inappropriate in the current interdisciplinary health care delivery environment to expect that the nurse can "do it all." They stated that the nurses' role also included ensuring protection for themselves, the survivor, and others involved in the domestic violence episode. Several of the participants emphasized that "the law's role is to judge the

criminality of the act" and that the nurses' role is to practice within the "legal and ethical standards of the profession."

Question 3: Additional Comments

Participants added many comments to those they had already expressed in their responses to the two "attitude" questions. First, they talked about their attitudes related to the long-term effects of nursing care on the survivor. They said that they hoped one result of interactions with a nurse would be that the survivor would ultimately be able to "leave the violent situation and remain safe," but if she chose to remain, she would be more aware of the increased danger to herself and family and would follow up on the referrals. Participants expressed their hope that violence-related education would change the attitudes of some nurses and result in increased identification of abuse, earlier intervention, collaboration with other health professionals, and more referrals. Participants expressed the hope that positive nurse attitudes would encourage nurses to become strong advocates for social and health services such as rape crisis teams, women's shelters, violence prevention programs in schools, and increased funding for violence prevention programs at all levels. Participants also suggested that a positive outcome of survivors' interactions with nurses would be an attitude of nurses as their advocates, as people who provide health care for the abused and those in danger of being abused. Finally, participants stated that they hoped an outcome of nursing care would be that survivors would use the information and insights they gained to become advocates for themselves and for other women and children involved in violent relationships.

Discussion

Attitudes about the survivor were first identified in terms of the survivor herself and then in terms of the nurses' attitudes toward her. The dichotomy is curious from the perspective of the perceived differences, at least in these participants' views, about the survivor as the person "who is" and the survivor as a person "for whom" the nurse provides care. In the first instance, the survivor as the person "who is," it seemed as if the participants were discussing the characteristics of a battered woman from a fairly objective, if not impersonal,

perspective. For example, this is a woman who is an adult, has choices, has low self-esteem, and feels isolated. However, in the second instance, nurses' attitudes about the survivor as a woman "to whom I give care," the participants seemed to be giving themselves permission to express their own feelings about the ways nurses *should* view the survivor, attitudes nurses *should* hold. For example, nurses should be respectful, caring, empathetic, and not stereotype. It was as if the participants were describing two aspects of the survivor: an adult woman who has experienced a terrible violent assault to her personhood and a woman patient about whom nurses should have specific attitudes in order to provide professional nursing care.

It is interesting that in nearly every instance, the participants referred to the battered woman as "victim" despite consistent use of the word "survivor" by the interviewer. The use of the word *survivor* by the interviewer was deliberately chosen to indicate the strengths or potential strengths of a woman who (a) had endured a violent physical assault, (b) had the persistence and the will to endure and carry on, (c) was an adult with the right to make her own decisions, and (d) had the potential to use her personal strengths to achieve a safe and satisfying life. Participants did not question their own use of the word *victim* when they talked about this woman who survived. They did not seem to perceive the dissonance: their description of person as victim, as one who is crying for help, always in danger and isolated from family and friends, often afraid to leave the situation, and their expectation that this victimized person behave as an adult, logically consider options, and take responsibility for her choices. This is an area that needs to be investigated in more detail; that is, what is the difference, if any, between the attitudes of nurses who perceive the battered woman as a victim and those who perceive her as a survivor? Does the difference influence nursing interactions and/or interventions? Are the values on which attitudes are based different between those who view the battered woman as a victim and those who view her as a survivor?

Despite these two inconsistencies, the nursing care participants identified was congruent with their verbalized attitudes of caring, respect, and survivor autonomy. Most important, participants emphasized that nursing care be carried out within the context of psychological support and practical knowledge. The need for nurses to "touch emotionally" was mentioned repeatedly as participants identified the first priority of care as providing help and safety, followed

by providing information, resources, and support. The dual focus of emotional comfort and tangible support was reflected in their concern for the survivor, the family, and the perpetrator.

The participants' attitudes toward the perpetrator portrayed a combination of compassion for the perpetrator and fear, not just for the survivor but for nurses and other caregivers. They seemed to deal with their fear by emphasizing the need for safety measures and other behavioral precautions. They demonstrated their compassion by their attempts to understand the perpetrator's actions, to find a reason to explain this terrible behavior—maybe it was society's fault, maybe it was his own history of childhood abuse, maybe it was his family or his neighborhood. The need to understand the perpetrator in the larger context of the social and cultural environment was reflected in their discussions about what the nurses' attitudes toward the perpetrator should be. At times, this perspective of perpetrator seemed to contrast with the participants' views of the survivor, in which participants characterized the survivor as an autonomous person, an individual adult responsible for her decisions and actions. There seemed to be little attempt to widen the context of her behavior with no discussion of the potential influences of social, family, or community factors as contributing to either her survivor status or her victim role. Again, this is an area for further research.

In their response to the question "Anything else?" participants' answers reflected the five components of the Ecological Model of Health Promotion (i.e., intrapersonal, interpersonal, institutional, community, public policy) that framed this study (McLeroy et al., 1988). Survivor outcomes reflecting the intrapersonal perspective included an increase in self-esteem, empowerment, and a heightened awareness of the choices available to her. These suggestions support Noonan's (1997) position that nurses can apply self-care concepts within a case management model to increase female survivor's self-care capabilities, including self-esteem and empowerment. Interpersonal factors include outcomes such as the survivor bringing her insights and information to others in her family, friends, or neighbors and acting as advocate for other survivors and their children. Institutional factors were reflected in the participants' desire that survivors perceive nurses as advocates, confirming the opinion expressed in the classic work of Gelles in 1979. Participants also called for educational institutions to increase their curricular content on violence-related

issues and service institutions to provide staff development and continuing education programs. Recognition for the need for curricular attention to violence has been recognized by several nurse educators and researchers (AACN, 1999; Hoff & Ross, 1995; Kerr, 1992; McBride, 1992; Sword et al., 1998; Tilden et al., 1994; Woodtli & Breslin, 1996, 1997). Community factors were represented by the overwhelming demand for more community action, support, and resources to prevent violence and meet the physical, psychological, and safety needs of those involved in violent episodes. The need to collaborate with community organizations to deal effectively with violence and abuse is recognized (Schroeder & Weber, 1998). Finally, from a public policy perspective, participants called for more funding for violence prevention and treatment programs at all levels of government and for stronger laws that ensure both treatment and punishment. Their emphasis on society's responsibility in prevention and treatment of domestic violence echoes that of Walker (1984) who, more than 15 years ago, claimed that domestic violence survivors fall victim to two systems, the family and society.

Limitations

Several limitations of this study prevent generalization of findings. First, the sample is confined to one city in one part of the country. The opinions of these 13 participants may not be those of participants in other geographical areas or members of other health care disciplines. Another limitation may be the sampling of nurses who typically work with domestic violence. Nurses who do not focus on this area of practice may hold different opinions and attitudes. Additional limitations include the subjective and perhaps selective retrospective recollections of participants. Finally, although rigorous attention was given to maintaining standards for authenticity and confirmability of data, other researchers may have reached different conclusions. Therefore, these findings cannot be generalized without additional research in different settings with other participants. A quantitative study based on the opinions and attitudes expressed in these qualitative findings would provide an opportunity to examine the reliability and validity of these data and contribute additional information and insights.

Conclusions

From their analysis of their long and varied experiences with domestic violence survivors and perpetrators within several health care arenas, the 13 participants were a credible resource for examining nurses' attitudes toward survivors and perpetrators of domestic violence. As practitioners in the field and as willing respondents to broad questions about survivors and perpetrators, they provided a rich "insider's" and "outsider's" view to attitudes that could not have been elicited through more structured measures.

Specifically, participants provided insights about survivor's intrapersonal feelings and fears; nurses' respectful, caring, and objective attitudes; and nurses' role behaviors within boundaries of "should do and should not do." They provided insights into their own dilemmas and conflicts by defending the survivor's autonomy and right to decide but consistently referring to her as victim. They provided insights into perpetrators as dangerous, protected, and victimized by family history or social forces/context and defined nurses' attitudes as "letting the criminal justice system judge them." They provided insights into short- and long-term survivor outcomes and identified expected outcomes across a range of activities. Categories and themes that emerged from their discussions incorporated implications for nursing education, nursing practice, and nursing policy.

Analysis of participants' attitudes supports the need to facilitate nurses' and nursing students' recognition of their personal attitudes, based on their beliefs and values about domestic violence, its survivors, and perpetrators. Participants clearly supported the role of nursing educators to prepare students for professional practice and of continuing education to facilitate ongoing professional development in areas related to domestic violence and abuse. They emphasized the advocacy role of nurses that motivates them individually and as a professional group to initiate, support, and promote social and health policy changes.

Finally, findings from this study support the Ecological Model for Health Promotion as a valid holistic framework that can guide the study and research of nurses as they examine their multiple roles in assisting clients in violent relationships at several levels of intervention. As nurses and the profession search for frameworks to guide their research, education, and practice, ecological models, such as the one used in this study, provide a holistic approach that has the potential to advance both the science and the practice of nursing.

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