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Evaluation of an Intimate Partner Violence Curriculum in a Pediatric Hospital

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Abstract

OBJECTIVE. Intimate partner violence harms victims as well as families and communities. Many barriers account for limited intimate partner violence screening by nurses. The purpose of this study was to measure how participation in a curriculum about screening parents for intimate partner violence, at a pediatric hospital, affects a nurse's knowledge, attitudes, behaviors, and self-efficacy for intimate partner violence screening.

METHODS. In this interventional, longitudinal study, data were collected before participation in an intimate partner violence screening curriculum, after participation, and 3 months later. The measurement tool was adapted from Maiuro's (2000) Self-efficacy for Screening for Intimate Partner Violence Questionnaire.

RESULTS. Sixty-eight pediatric nurses completed all aspects of the study. At baseline, 18 (27%) nurses self-reported seeing a parent with an injury, and of those only 7 (39%) followed up with intimate partner violence screening. Factor analysis was performed on the baseline Self-efficacy for Screening for Intimate Partner Violence Questionnaire by using varimax rotation. Five factors were identified: conflict, fear of offending parent, self-confidence, appropriateness, and attitude. Only fear of offending parent was significantly different from times 1 to 3, indicating that nurses were less fearful after the training. Cronbach's α value for the total questionnaire at baseline was .85. Nurses reported significant improvement (baseline to 3-month follow-up) in several self-efficacy items.

CONCLUSIONS. Participation in a 30-minute curriculum on intimate partner violence screening was associated with improvements in self-efficacy and significantly lower fear of offending parents 3 months after training. Nurses also showed improvement in the perception of resources available for nurses to manage intimate partner violence. Thirty-minute hospital-based curriculums that include victim testimonial video and practice role-playing to simulate parent interactions are recommended.

Keywords

domestic violence, intimate partner violence, evaluation, self-efficacy, nurses

Identification of and intervention with victims of intimate partner violence (IPV) are important injury-prevention strategies for children, because children are more likely to be abused when there is IPV in the home.¹ IPV, also known as domestic violence, is defined as actual or threatened physical, sexual, or psychological harm by a current or former partner or spouse.^{2,3} IPV impacts victims, families, friends, and communities,⁴ with ~29% of women and 22% of men identified as victims during their lifetime.⁵ Successful interventions for addressing or averting IPV are complex. Interventions include (1) screening to identify victims, (2) coordination of resources, and (3) empowerment and initiation of change in the identified population.

The first step of any successful IPV intervention is effective screening. Although multiple health care practitioners are in a position to screen for IPV,⁶ it is likely that nurses have the best opportunity to

screen, because nurses interact closely with the parents of hospitalized children. Screening is complex in and of itself. A number of barriers arise that may limit screening. Practical barriers may include a lack of privacy,⁷ time constraints,⁶⁻⁸ and multiple demands on nurses, including interruptions and looking for supplies.⁹ Knowledge and attitude barriers include not knowing how to ask about domestic violence^{6,7} and not knowing what to do with the information once it is obtained.⁶ Communication barriers related to the interactions between nurses and parents may include fear of offending or scaring a parent,⁶ the belief that IPV is not a pediatric problem,^{6,8} a lack of confidence in their skills,¹⁰ and feelings of inadequate training.⁶ Nurses also fear confrontation and may think attempting intervention may be ineffective.¹¹ Victims may hesitate to disclose IPV because of fears for their safety, a lack of knowledge regarding sources for support and protection, and concerns about losing custody of their children.¹² Consequently, nurses must be prepared to answer each of these concerns and to feel confident about the interaction during screening.

Despite receiving education in nursing school about screening for violence, and existing hospital screening policies, there is a potential inconsistency between knowledge and attitudes and actual screening behavior,¹³ as evidenced by relatively few physicians¹⁴ or nurses¹³ screening for IPV. As a result, the Joint Commission has addressed this issue nationally with a safety goal to screen for personal safety.¹⁵ However, individual organizations' responses to this Joint Commission goal may vary in approach and effectiveness.

Effective education for physicians and nurses incorporates simulation and promotes self-efficacy. Physicians with high self-efficacy about screening are known to be more likely to screen.¹⁶ Nursing students showed a significant increase in their self-efficacy before and after simulation activities about health teaching.¹⁷ Knapp et al⁶ reported that emergency department staff showed consistent positive changes in attitudes and self-efficacy after a 2-hour IPV curriculum. Their 2-hour self-efficacy theory-based IPV training session was perceived as quite long.⁶

With this study we sought to describe how participation in an IPV curriculum impacted nurses' knowledge, attitudes, behaviors, and self-efficacy. Self-efficacy is defined as a person's belief in his or her ability to perform a designated task.¹⁸ We hypothesized that there would be improvements in knowledge, attitudes, and self-efficacy for IPV screening after the curriculum and that these improvements would be maintained after 3 months.

METHODS

Educational Intervention

The curriculum for IPV screening included 4 effective instructional strategies: (1) relevant information; (2) demonstration of the knowledge, skills, and attitudes; (3) practice opportunities; and (4) feedback.¹⁹ We also based the curriculum on self-efficacy theory.¹⁸ In this theory, mastery experience, vicarious experience, emotional states, and social persuasions from others are believed to account for feelings of competence and confidence about performing a specific task. How people behave can often be best predicted by the belief individuals have about their capability. Self-efficacy perceptions help determine what people do with the knowledge they obtain.²⁰

As part of the educational session, nurses in groups of 2 or more viewed a 20-minute hospital-produced video about IPV, read through a scripted role-play, and had a discussion. The wording of the screening question and the appropriate nurse response was derived from the Agency for Healthcare Research and Quality's clinical pathway for IPV disclosure.²¹ The screening question was: "Because violence is an issue for so many families, and can be harmful to children, we ask everyone about their exposure to violence. Do you have concerns about your safety, your child's, or your family's safety?"

Study Design

The study used presurvey and postsurvey methodology to evaluate the impact of the required hospital IPV curriculum. Approval was obtained from the hospital's institutional review board. The coinvestigators used standardized study procedures for recruitment, enrollment, informed consent, and survey techniques. Registered nurses employed at a freestanding tertiary care Midwestern children's hospital were asked if they would like to volunteer for the study before the required education. Excluded from the sample were nonnursing health care providers such as physicians, social workers, physician assistants, and nursing assistants.

Sample

Subject sampling was by convenience. In a sample of 64, there was at least 80% power to detect a difference of 0.5, with an effect size of 0.42, between the prestudy and poststudy scores of the "attitudes/beliefs" and "self-efficacy." For this calculation, an SD of 1.2, a significance level (α) of .017 corrected by using the Bonferroni method for 3 outcomes, and a 2-sided 1-sample *t* test were assumed.

Study Instruments

Nurse Demographics

A demographic information sheet was used to collect data on all participating nurses (gender, age, race, years of experience, years of employment at the hospital, highest degree, other departments worked, previous education in IPV, and education about child abuse).

IPV-Screening Questionnaire

We used the Knapp et al⁶ modified version of the longer 39-item tool created by Maiuro et al²² to study health care provider attitudes, knowledge, behaviors, and self-efficacy related to screening for IPV. The Knapp et al questionnaire included 24 items. Maiuro et al²² reported a Cronbach's α value of .88. The perceived self-efficacy domain accounted for 20% of the variance in the 39-item tool. Criterion validity was established with the use of a control group. An expert panel created the terms on the questionnaire, thus establishing content validity.

The self-report summated rating scale uses a 5-point Likert scale format (1 = strongly disagree and 5 = strongly agree). The center of the scale was labeled "neutral." Two subscales developed by Knapp et al⁶ include (1) attitudes and beliefs (questions [Q]1–Q11), Cronbach's α = .760 and (2) self-efficacy (Q12–Q18), Cronbach's α = .765. The maximum score on the attitudes subscale of the IPV-screening questionnaire is 55, with lower scores indicating more desirable attitudes. The maximum score for the self-efficacy subscale is 35, with lower scores reflecting higher self-efficacy (Q12, Q13, and Q15–Q18 reverse scored). The behavior items (Q19–Q24) were yes/no items.

Procedure

The nurse demographics form was completed before the education form along with the first study questionnaire. There were at least 48 hours between the first and second study questionnaires and a 3-month time lapse before the final questionnaire. The questionnaires were completed on paper or on the hospital's computer learning platform according to participant preference. This preference was noted on a contact form that contained their name and their e-mail address or mail station. E-mail reminders were sent to the nurses with a link to the follow-up surveys on the computer learning platform. Those who chose the paper option were given the questionnaire in an envelope to return. All forms were coded with a study participant number. All contact information was kept separate from the questionnaire, in a locked drawer, and was then shredded once the third questionnaire was completed. No data on participation (or nonparticipation) were shared with hospital administration or Human Resources. Thus, there was no risk of potential reprisal for nonparticipation. Participating nurses were told that they did not have to answer any question that they did not wish to answer and that they could leave the study at any time.

SPSS 14.0²³ (SPSS Inc, Chicago, IL) was used for all analyses. Data were entered by a trained research assistant. Descriptive statistics were calculated for the nurses. Four missing observations were removed and not considered in any additional analyses. Frequencies were calculated for baseline behaviors. Analyses were conducted by using paired *t* tests for the individual questions on the attitudes/beliefs and self-efficacy subscales of Maiuro's (2000) Self-efficacy for Screening for Intimate Partner Violence Questionnaire. Factor analysis was performed for 18 questions on attitude/beliefs and self-efficacy by using the varimax rotation method for only baseline data. All *P* values reported are uncorrected for multiple comparisons.

RESULTS

Sixty-eight nurses completed all 3 questionnaires (see Table 1). The majority of the participants were white (94%) and female (96%), held bachelor degrees (74%), had >5 years' nursing experience (65%), and had <5 years' hospital experience (57%). Participating nurses were a wide range of ages and worked in a variety of hospital departments. Only 29% recalled previous IPV education, but 72% recalled previous child abuse education.

TABLE 1 Sample Characteristics

Characteristic	Frequency, <i>n</i> (%)
Gender	
Female	65 (96)
Male	3 (4)
Age, y	
18–29	25 (37)
30–39	19 (28)
40–49	14 (21)
50–59	10 (14)
Race	
White	64 (94)

Black/African American	1 (1.5)
Hispanic	2 (3)
Asian	1 (1.5)
Time as a nurse, mo	
<12	12 (18)
13–24	2 (3)
25–60	10 (14)
61–120	12 (18)
>120	32 (47)
Previous IPV education	
Yes	20 (29)
No	48 (71)
Time at institution, mo	
<12	20 (29)
13–24	4 (6)
25–60	15 (22)
61–120	6 (9)
>120	23 (34)
Highest degree obtained	
Associate	9 (13)
Diploma	1 (1)
Bachelors	50 (74)
Masters	4 (6)
Other	4 (6)
Participant work setting	
Acute care	21 (31)
Outpatient/clinic	3 (4)
Emergency department	11 (16)
Other (PICU, NICU, surgery)	14 (210.8)
Combination	18 (27)
Missing	1 (1)
Previous child abuse education	
Yes	49 (72)
No	19 (28)

Behaviors at baseline (see Table 2) showed a discrepancy between seeing a parent with an injury, depression, or anxiety, or an abused child and then following up with the IPV-screening question. Only 7 (39%) of the 18 (27%) nurses who self-reported seeing a parent with an injury followed up with IPV screening. Fifty two (84%) of the nurses reported seeing parents with depression or anxiety; however, of these, only 3 (6%) of the nurses reported screening these parents for IPV. A larger number of nurses ($n = 26$ [42%]) reported seeing an abused child in the previous year. Of these, only 9 (35%) of the nurses screened the parent for IPV. Behavior frequency was reported for the baseline questionnaire only as missing data after training, and follow-up ranged from $n = 51$ (71%) to 61 (85%).

TABLE 2 Baseline Behaviors

Behavioral Experience (Q19–24)	Frequency, <i>n</i> (%)
In the past year I have seen a parent with:	
An injury	18 (27)
If yes, asked about IPV	7 (39)
Depression/anxiety	52 (84)
If yes, asked about IPV	3 (6)
An abused child	26 (42)
If yes, asked about IPV	9 (35)

Questionnaire results for attitudes/beliefs and self-efficacy are reported in Table 3. Mean scores for Q8, “I am afraid of offending a parent/caregiver if I ask about IPV,” showed a statistically significant improvement after the curriculum when compared with baseline ($P = .012$) that was sustained at 3 months ($P = .006$). Posttest results also indicated statistically significant positive changes for nurses in Q12, Q13, Q15, Q16, and Q17 on the self-efficacy scale ($P < .001$) that was sustained at 3 months ($P < .001$).

TABLE 3 Baseline/Posttraining and Follow-up Questionnaire Results

Statement	Baseline (<i>N</i> = 68), Mean (SD)	Posttraining After Training (<i>N</i> = 68), Mean (SD); Comparison With Baseline, Mean Difference (95% CI), <i>P</i>	Follow-up (<i>N</i> = 68), Mean (SD); Comparison With Baseline, Mean Difference (95% CI), <i>P</i>
Attitudes and beliefs			
1. There is not enough time in a pediatric visit to talk about IPV with parents/caregivers	2.5 (1.1)	2.4 (1.1); (-0.23 to 0.38), .63	2.4 (1.0); (-0.17 to 0.43), .38
2. People are only victims if they choose to be	1.5 (0.7)	1.4 (0.6); (-0.06 to 0.27), .21	1.5 (0.7); (-0.15 to 0.21), .74
3. When it comes to domestic violence victimization, it usually "takes two to tango."	1.7 (0.9)	1.6 (0.9); (-0.08 to 0.25), .29	1.6 (0.8); (-0.09 to 0.30), .29
4. Asking parents/caregivers about IPV is an invasion of their privacy	1.9 (0.8)	1.9 (0.7); (-0.17 to 0.17), 1.0	1.9 (0.6); (-0.13 to 0.28), .47
5. It is demeaning to parents/caregivers to question them about IPV	1.9 (0.7)	1.8 (0.6); (-0.12 to 0.20), .58	1.8(0.6); (-0.15 to 0.20), .74
6. It is not my place to interfere with how people choose to resolve conflicts	2.0 (0.8)	2.0 (0.7); (-0.22 to 0.16), .76	2.0 (0.7); (-0.27 to 0.12), .46
7. I think that trying to determine the cause of a parent/caregiver's injury is not part of a pediatric emergency or hospital care	1.9 (0.8)	1.8 (0.7); (-0.09 to 0.36), .24	1.8 (0.7); (-0.12 to 0.29), .39
8. I am afraid of offending a parent/caregiver if I ask about IPV	2.7 (1.2)	2.3 (1.0); (0.07 to 0.55), .012	2.3 (1.0); (0.11 to 0.63), .006
9. If parents/caregivers do not reveal abuse to me, then they must feel it is none of my business	2.1 (0.9)	1.9 (0.8); (0.002 to 0.47), .05	1.9 (0.8); (-0.04 to 0.43), .11
10. It is inappropriate to ask about IPV in the pediatric setting	1.9 (0.8)	1.7 (0.7); (-0.004 to 0.45), .05	1.8 (0.8); (-0.13 to 0.33), .37
11. Even if the child is not in immediate danger, I am mandated to report an instance of a child witnessing IPV to child protective services	3.7 (1.0)	3.1 (1.3); (0.24 to 0.88), .001	3.6 (1.1); (-0.21 to 0.35), .60
Self-efficacy			
12. I have ready access to information describing management of IPV	2.9 (0.9)	2.1 (0.9); (0.55 to 1.12), <.001	2.1 (0.8); (0.56 to 1.14), <.001

13. There are strategies I can use to help victims of IPV change their situation	2.5 (0.9)	1.9 (0.8); (0.37 to 0.86), <.001	2.1 (0.7); (0.25 to 0.75), <.001
14. If I ask a parent/caregiver who has not been abused about IPV, he/she will get very angry	2.3 (0.8)	2.1 (0.6); (-0.01 to 0.33), .06	2.1 (0.7); (0.03 to 0.42), .03
15. I feel confident that I can make appropriate referrals for victims of IPV	2.9 (0.9)	2.0 (0.7); (0.70 to 1.12), <.001	2.2 (0.9); (0.50 to 0.97), <.001
16. I feel confident that we are identifying as many victims of IPV as we can in my work setting	3.7 (0.8)	3.2 (0.9); (0.20 to 0.65), <.001	3.2 (0.9); (0.20 to 0.66), <.001
17. There are measures I can take to minimize the risk to a victim's safety when he/she discloses IPV	2.4 (0.9)	1.9 (0.5); (0.34 to 0.72), <.001	2.0 (0.6); (0.24 to 0.67), <.001
18. I feel comfortable asking parent/caregivers about the possibility of IPV	3.1 (1.0)	3.3 (1.3); (-0.62 to 0.09), .14	2.9 (1.2); (-0.15 to 0.50), .28

CI indicates confidence interval.

Factor analysis was performed for the 18 questions on attitude/beliefs and self-efficacy by using the varimax rotation method for only baseline data. After performing factor analysis, it was found that all questions can be classified into 5 groups (factors), and each group (factor) consists of the following questions: factor 1 is the combination of Q4, Q5, Q6, and Q14. The correlation of Q4, Q5, Q6, and Q14 is shown in Table 4. Factor 2 is the combination of Q8 and Q18. The correlation of Q8 and Q18 is .71. Factor 3 is the combination of Q12 and Q15. The correlation of Q12 and Q15 is .56. Factor 4 is Q10. Factor 5 is Q3.

TABLE 4 Correlation Among Q4, Q5, Q6, Q7, and Q14

	Q4	Q5	Q6	Q7	Q14
Q4	1	0.8	0.54	0.44	0.5
Q5	0.8	1	0.52	0.53	0.59
Q6	0.54	0.52	1	0.31	0.36
Q7	0.44	0.53	0.31	1	0.4
Q14	0.5	0.59	0.36	0.4	1

Q1, Q2, Q7, Q9, Q11, Q16, and Q17 are not included in any factors. The eigenvalues of the 5 factors are 14.51, 3.93, 1.74, 1.42, and 1.134, respectively. The hypothesis for testing 5 factors is sufficient. On the basis of the above-listed results, factors 1 through 5 can be regarded as the measures of “conflict,” “fear of offending,” “self-confidence,” “appropriateness,” and “attitude,” respectively.

The data on posttraining versus baseline, and follow-up versus baseline, including *t* tests, on the basis of these 5 factors weighted are reported in Tables 5, 6, and 7. Paired *t* tests were conducted on the weighted sum of Q4, Q5, Q6, and Q14, the weighted sum of Q8 and Q18, and the weighted sum of Q12, Q15, Q10, and Q3 on the baseline data versus posttraining data. The same *t* tests were conducted on the baseline data versus follow-up data. The results of all *t* tests are given in given in Table 7. Only factor 2 (fear of offending parent) ($t_{67} = 2.43, P = .0176$) was significantly different from times 1 to 3, indicating that nurses were less fearful after the training. Cronbach's α value for the total questionnaire at baseline was 0.85. Nurses reported significant improvement (baseline to 3-month follow-up) in several self-efficacy items. One example is having ready access to information describing management of IPV ($M = 2.9$ [SD: 0.9]) to follow-up ($M = 2.1$ [SD: 0.8]); (95% confidence interval: 0.56–1.14, $P < .001$).

TABLE 5 The Weighted and Unweighted Variance According to Factors

Factor	Weighted	Unweighted
1	17.0311726	3.07717408
2	17.3487443	2.01519906
3	6.8057313	1.73731398
4	5.0854143	1.35502829
5	0.9077238	1.23770141

TABLE 6 Pre, Post and Follow-up Training Factor Statistics

Difference	N	Lower CI, Mean	Mean	Upper CI, Mean	Lower CI, SD	SD	Upper CI, SD	SE	Minimum	Maximum
Statistics (baseline vs posttraining)										
Factor 1	68	-0.08	0.044	0.1675	0.4366	0.5103	0.6141	0.0619	-1	1.5432
Factor 2	68	-0.161	0.0584	0.2773	0.7741	0.9047	1.0888	0.1097	-1.873	2
Factor 3	68	-0.324	-0.121	0.0827	0.7195	0.8409	1.012	0.102	-2	2.8261
Factor 4	68	-0.004	0.2206	0.4452	0.794	0.9279	1.1167	0.1125	-3	3
Factor 5	68	-0.078	0.0882	0.2541	0.5864	0.6854	0.8248	0.0831	-2	2
Statistics (baseline vs follow-up)										
Factor 1	68	-0.078	0.0638	0.2053	0.4999	0.5842	0.7031	0.0708	-2.234	1.3309
Factor 2	68	0.0511	0.2842	0.5172	0.8238	0.9628	1.1587	0.1168	-2.437	2.1266
Factor 3	68	-0.369	-0.176	0.0175	0.6835	0.7989	0.9614	0.0969	-2	2
Factor 4	68	-0.127	0.1029	0.3325	0.8116	0.9485	1.1415	0.115	-4	3
Factor 5	68	-0.089	0.1029	0.2952	0.6797	0.7944	0.956	0.0963	-2	3

CI indicates confidence interval.

TABLE 7 Pre, Post, and Follow-up Training *t* Tests

Baseline vs Posttraining				Baseline vs Follow-up			
Difference	df	t	Pr > t	Difference	df	t	Pr > t
Factor 1	67	0.71	0.4799	Factor 1	67	0.9	0.3707
Factor 2	67	0.53	0.5965	Factor 2	67	2.43	0.0176
Factor 3	67	-1.19	0.2402	Factor 3	67	-1.81	0.074
Factor 4	67	1.96	0.0541	Factor 4	67	0.89	0.374
Factor 5	67	1.06	0.2922	Factor 5	67	1.07	0.2891

df indicates degrees of freedom. Pr indicates p-value.

Cronbach's α analysis for the baseline data was also performed to detect the internal consistency and the validity and reliability of the questionnaire. The overall raw α value of .85 suggests that the internal reliability of this questionnaire is acceptable. Moreover, the Cronbach coefficient α with each variable deleted was performed as well. We found that Q11 had the lowest item-total correlation value (.029), and it was much smaller than others. This indicates that Q11 was not measuring the same construct as the rest of the items in the questionnaire.

DISCUSSION

Screening parents for IPV in the pediatric hospital setting is clearly an important pediatric injury-prevention strategy. In our sample at baseline, the nurses self-reported poor follow-up screening behavior in the face of IPV predictors including parent injury, depression, anxiety, and child abuse. Screening for IPV is difficult, as clearly reflected in the behaviors in the survey results. The behavioral results substantiate the Joint Commission¹⁵ safety-goal initiative and the IPV-curriculum intervention.

Poor screening behaviors could be related to a lack of knowledge or a belief or attitude or poor self-efficacy about screening for IPV. Past research has shown that self-efficacy regarding screening seems to be the key variable that accounts for the highest amount of known variance for behaviors about screening for IPV.¹⁸ Knapp et al⁶ reported barriers that affect self-efficacy, including feelings of inadequate training, poor confidence about screening, concerns about a lack of resources, and fears of offending the parent. Teaching methods and strategies used during training are thought to help overcome these barriers. Therefore, our curriculum was designed with these factors in mind.

The "It's Time to Ask" curriculum of Knapp et al⁶ served as a starting reference for the creation of our hospital-produced, 30-minute curriculum. We incorporated the teaching strategies of Salas and Cannon-Bowers¹⁹ and self-efficacy theory,¹⁸ including knowledge about "red flags," vicarious experience, role-play opportunity, and chance for feedback addressing the participants' emotional states. The hospital-created IPV educational video included footage of 2 IPV victims with children who tell their stories and plead with nurses to screen. This footage was a compelling testimonial and served to educate nurses that victims tend not to admit the violence until a nurse asks. It dispels the myth about offending a parent by IPV screening.

We were not able to compare the behaviors subscale because of missing data in the postscreening and 3-month follow-up screening for behaviors. Ultimately, an improvement in screening behaviors is the goal. However, belief in one's ability best predicts behavior.²⁰

There was improvement in the self-efficacy items on the questionnaire that addressed practical barriers to screening such as ready access to information describing the management of IPV, strategies to help victims, confidence to identify victims, and making referrals. Overcoming practical barriers is necessary in our current health care environment. A nurse's day is filled with many tasks, operational failures, and multiple interruptions that limit the time nurses have for interacting with patients and families.⁹ In the pediatric setting, the opportunity for screening is also limited by the presence of children accompanying the patient and parent. The screening question is only asked when there is not a child older than 2 years of age or a spouse present.

Screening for IPV requires interaction skills by a skilled nurse and a parent. Learning the skill of interacting about a sensitive subject as well as fitting the interaction into the busy day require practice. Our strategy was to provide a scripted screening question and practice a response to a parents' disclosure during the role-play. Interaction-related barriers are difficult to overcome. In our study, the fear-of-offending factor captured the barrier related to offending parents and the comfort level of the nurse for talking with the parent. However, within 48 hours of the IPV education, there was no statistically significant change in the perceptions related to interacting with parents in our sample; at the 3-month follow-up there was a statistically significant change in this perception. It could be that the chance to practice the screening with real parents made the difference. The nurses may not have been confident that this would be the case when they completed the 48-hour follow-up.

Limitations in this study should be considered. We cannot conclude that the intervention alone was responsible for the changes that resulted. We did not have a control group for comparison, because this was a required education program for all nurses. Data collected were self-reported rather than an objective measure. There were missing data for behaviors after the intervention and at the 3-month follow-up. Q11 assessed knowledge of mandated reporting of IPV. The answer to this question varies from state to state. Although physicians and social workers also screen for IPV, we only sampled nurses. The nurses we sampled represented a wide variety of departments, ages, and levels of experience. Although we focused on nurses, it may be that the same findings apply to other health care providers. A follow-up study that objectively measures behaviors is recommended.

CONCLUSIONS

Evaluation of the 30-minute IPV curriculum showed statistically significant self-reported changes in knowledge and attitudes and self-efficacy regarding screening for IPV sustained at the 3-month follow-up. Additional findings include the improvements in parent-nurse interactions about IPV screening and overcoming perceived practical barriers such as screening in today's busy hospital environment. Improvement in the fear-of-offending factor 3 months after the curriculum is an important finding. Education alone is a necessary but insufficient condition to impact IPV-screening behavior. Practice is necessary to develop the belief that one can be effective at screening.

Footnotes

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What's Known on This Subject

Nurses have an opportunity to screen parents for IPV when parents bring their children to pediatric hospitals. Past research has shown that health care professionals often fail to complete the screen even though it is a Joint Commission standard.

What This Study Adds

Evaluation of a 30-minute, self-efficacy theory-based curriculum on screening parents for IPV showed improvements in nurse self-efficacy for screening and a decreased fear of offending parents by screening.

IPV—intimate partner violence • Qn—question number

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