Health Canada Santé Canada

Nursing Education and Violence Prevention, Detection and Intervention

Canada

Our mission is to help the people of Canada
maintain and improve their health.
Health Canada

Nursing Education and Violence Prevention, Detection and Intervention
was prepared by **Margaret M. Ross** for the Family Violence Prevention Unit, Health Canada.

Également en français sous le titre : *Enseignement infirmier et prévention, détection et prise en charge de la violence*

This publication may be provided in alternative formats upon request.

For further information on family violence issues, please contact:

National Clearinghouse on Family Violence
Family Violence Prevention Unit
Healthy Communities Division
Population and Public Health Branch
Health Canada
Address Locator: 1907D1
7th Floor, Jeanne Mance Bldg., Tunney's Pasture
Ottawa, Ontario K1A 1B4 CANADA

Telephone: 1-800-267-1291 or (613) 957-2938
Fax: (613) 941-8930
TTY: 1-800-561-5643 or (613) 952-6396
Web Site: http://www.hc-sc.gc.ca/nc-cn
E-mail: national_clearinghouse@hc-sc.gc.ca

Cat. H72-21/185-2002E
ISBN 0-662-31541-3

Nursing Education and Violence Prevention, Detection and Intervention

A Report Prepared for
Health Canada
Family Violence Prevention Unit
Healthy Communities Division

by
Margaret M. Ross, R.N., Ph.D.
Professor of Nursing and
Ontario Ministry of Health Career Scientist

Acknowledgements

The author acknowledges the assistance of Katalin Kennedy and Lynn Austin in the conduct of this project. In addition, the input of Lee Ann Hoff and Judy Wuest was invaluable.

Table of Contents

Executive Summary

Interpersonal violence is a major societal problem with consequences for health and well-being. There are approximately 250,000 Registered Nurses, 75,000 Registered Practical Nurses and 5,500 Psychiatric Nurses in Canada. The vast majority are in practice in institutional, community and home-based settings where they are in close contact with a large segment of the population that is vulnerable to violence. Nurses often provide the first line of contact with the health care team and are well situated to mobilize resources and the initial intervention. They are in an ideal position to contribute to the prevention and detection of violence among children, women and older adults and to intervene sensitively and effectively in the care of survivors. The education of nurses, however, is central to their participation. There is both anecdotal and research evidence that nurses feel ill-prepared to face the difficulties of problem solving and decision making in situations of actual and potential violence. Interpersonal violence occurring between individuals has been a relatively invisible dimension of pre-service and continuing education curricula.

This document presents an overview of the recent literature (1995-2000) on the education of nurses in the area of violence prevention, detection and intervention. The goal is to inform educators, researchers and policy makers about gaps in educational services and areas of needed research.

On-line searches were conducted of CINAHL, Medline, Sociofile and Psychfile, large bibliographic databases, using OVID as the search engine and key words. Reference lists were hand searched for additional recently published articles and for articles published before 1995 that seemed particularly important to nursing education. Letters of inquiry were also distributed to the Centres of Excellence for Women's Health, the Research Centres on Family Violence and Violence Against Women, deans and directors of university schools of nursing, and the Canadian Association of Schools of Nursing for unpublished documents and reports related to the education of nurses in the area of violence. A draft report was distributed to a panel of experts in the field of violence prevention for critical appraisal, and refinements were made as recommended.

The findings showed that the literature on the education of nurses in the area of violence prevention, detection and intervention is limited. Responses to letters of inquiry revealed collaboration among researchers at the Centres of Excellence for Women's Health, the Research Centres on Family Violence and Violence Against Women, and faculty members of university schools of nursing. With one exception, involving a study conducted by students, there were no ongoing or unpublished projects reported that related to the education of nurses.

The literature, in large measure, focuses on

- the importance of a theoretical and conceptual basis for nursing education and research,
- the importance of experiential learning, and
- the integration of concepts from a variety of disciplines.

Conclusions and Recommendations

1. Nurse educators need to ensure that all students acquire a solid foundation in knowledge and skill development about violence prevention, detection and intervention. This will enable them to respond sensitively and effectively to survivors of violence.

2. A systematic approach to teaching and learning that emphasizes both didactic and experiential strategies and evidence-based practice is important. Such an approach will lead to a better understanding of violence and more sensitive and effective care of survivors than an approach that is incidental or hit and miss.

3. The creation of a supportive learning environment (in particular, a clinical learning environment where students feel comfortable testing out their knowledge and skill in practice) will lead to feelings of self-esteem and confidence in students' abilities to respond sensitively and effectively to survivors of violence.

4. It is highly recommended that educators use the "feeling" level as a starting point in educating student nurses about violence prevention, detection and intervention. Exploring individual attitudes about violence is essential in helping students recognize their attitudes and understand the values and beliefs on which they are based.

5. A solid theoretical foundation is important for the development of a discipline. With few exceptions, the literature on the education of nurses in the area of violence prevention, detection and intervention is largely a-theoretical. Given that nursing is essentially a practice-based discipline, it is important to ground the theoretical underpinning of educational programs and research endeavours in concepts from the social sciences and the humanities, victimology, ethics, as well as feminist and critical theory.

6. The preparedness of faculty members varies. Many educators are expected to teach about violence prevention, detection and intervention with minimal experience in working with survivors of violence. There is a need for curriculum development, train the trainer, and program evaluation workshops directed toward faculty members who are charged with teaching and role modelling in this area of practice.

7. Given that nursing education is grounded in knowledge and skill development that is derived from experience with clients, the process of curricular development and implementation will be enriched by involving grass roots workers and activists in the field of violence prevention. Whenever possible, the involvement of survivors in the development and implementation of learning programs should also be encouraged. Students can benefit greatly by learning from survivors and front line workers who are experienced in the area of violence prevention, detection and intervention.

8. The literature on the curricular inclusion of issues related to violence prevention, detection and intervention is in its infancy. Nurse educators and researchers should be encouraged to write about their approaches to teaching and learning, and submit them to health professional journals.

9. Research on the education of nurses in the area of violence is also in its infancy, and it is largely descriptive in nature. Studies are needed on the inclusion of issues related to violence in the curricula of schools of nursing; on the best ways of supporting faculty members who strive to teach in an area where many are under-prepared; and on the effectiveness of educational approaches, including those of a didactic and experiential nature, on perceptions, the acquisition of knowledge, and skill development. Studies are also needed on the effects of nursing education in the area of violence on the health and well-being of survivors.

10. Given the high incidence of violence directed toward the general female population and the fact that the majority of students in nursing are women, it is probable that some students will have histories of abuse. Indeed, they may currently be living in abusive situations. Research is needed to determine the prevalence of violence experienced by students and to identify how they are responding to this reality in their lives.

11. Given that the problem of violence against women, children and older adults requires collaboration among health and social service providers, it is crucial that nursing students learn to work with members of other disciplines to prevent, detect and intervene effectively in situations of actual or potential violence. Without the opportunity to work together as students, it is unrealistic to expect that, upon graduation, nurses and other health and social service providers will automatically come together in collaborative and effective working relationships.

12. Curriculum guides have been created that can provide direction for nurse educators in the development and implementation of programs for students at all levels of practice. Many of these guides are Canadian in origin and were developed with federal and provincial funding. They are now, however, widely known by nurse educators. Efforts should be made to ensure that these documents are widely disseminated to all concerned with the pre-service and ongoing education of nurses.

13. There is evidence that curricular goals are directed, at least to some extent, toward ensuring that students and nurses are prepared to write registration and certification examinations. Those educators and administrators who are charged with such examinations should incorporate questions that relate to violence. This is a way of recognizing the importance of this issue to health and well-being and the role of nursing in its prevention, detection and intervention.

14. The Canadian Nurses Association and many of the provincial nursing associations have developed policy statements, ethical guidelines, and standards of practice that support the sensitive and effective response of nurses to survivors of violence. The Canadian Association of Schools of Nursing (CASN) and the Colleges of Applied Arts and Technology (CAATs), in collaboration with deans, directors, leaders from professional nursing organizations, and experts in the field, should be encouraged to work together to develop educational policies and guidelines that support the education of nurses in the area of violence.

15. The Centres of Excellence for Women's Health and the Research Centres on Family Violence and Violence Against Women, which are located across the country and which are in collaborative relationships with faculty members from Schools of Nursing, should be encouraged to collaborate on research efforts to investigate the influence of educational outcomes on nursing and other health and social services in the prevention and detection of and intervention in violence.

16. Securing adequate funding is a crucial factor in initiating and maintaining educational programs on violence that are systematic, relevant to various types of students, and offer content that is both discipline-specific and relevant to working with other disciplines. As curriculum content tends to be crowded, and human and material resources may be lacking in global budgets, they are typically dependent on extramural funding. Federal and provincial ministries should consider the possibility of allocating funding for such programs, to help ensure that nurses are well prepared to prevent, detect and intervene in this prevalent public health problem.

17. This review did not investigate in-service and ongoing educational programs on violence prevention, detection and intervention that have been developed for staff by hospitals and community health agencies, other than those that have been documented in the literature. Responses to the letters of inquiry sent to deans and directors of university schools of nursing and to the executive directors of the Centres of Excellence for Women's Health and the Research Centres on Family Violence and Violence Against Women suggested that such organizations should be surveyed to develop a more complete picture of the education of nurses in this area of service delivery.

Purpose

The purpose of this project was to conduct an overview of the recent literature addressing the education of nurses in the areas of violence prevention, detection and intervention. The ultimate goal was to inform policy makers, educators and researchers about gaps in educational services and areas of needed research.

Background

The education of nurses in the areas of violence prevention, detection and intervention is central to their effective participation in the care of survivors of violence. The topic of violence presents a greater than average challenge to most nurse educators charged with teaching and role modelling.

In addition to conveying information about the complexities of health care, the educator needs to sensitize students about the linkages between values and traditions, which in turn relate to ways of living and social interaction. It further needs to be explained that values and traditions are considered to be sacred by many, but can be perceived to be dangerous by others. How these messages become interpreted and applied later, when students address cases involving those who are vulnerable to abuse – including women, children and older adults – will depend on how effectively educators conveyed them. Practice and research-based evidence indicate that nurses face difficulties regarding problem solving and decision making in situations of actual or potential violence. Preparing future nurses to address violence prevention, detection and intervention is an essential role for nurse educators, but it is a difficult role.

The problem of violence is of concern to all levels of government. At the federal level, over the past 15 years, there have been a number of initiatives related to violence against women, children and older adults. Among these, the 4-year federal Family Violence Initiative (1991-1995) provided $136 million to address the problems of family violence. In 1993, the Canadian Panel on Violence Against Women prepared its final report, which listed more than 500 recommendations on a range of issues and included a plea for mandatory education of health professionals to ensure that they are prepared with the necessary knowledge, skills and attitudes to work effectively with survivors of violence. Through the National Clearinghouse on Family Violence, many new publications have been developed, some of which are intended specifically for the health and social services sector. This report builds on these and other efforts.

Preparing Future Nurses

In 1989, Brendtro and Bowker reported that, despite the involvement of health care workers, including nurses, in the care and treatment of survivors of violence, they were viewed as the least helpful of all professional sources. The literature suggests that even well-informed practitioners have limited direction and support in the struggle to assess and intervene effectively when there is concern for the physical, emotional or material safety and well-being of women, children and seniors. This is problematic for both nursing education and nursing practice.

In the United States, McBride (1992) noted that violence against women has been a relatively invisible dimension of curricula topics and urged that, in the future, it be viewed as a major area of study in nursing education programs. She also advocated that violence against women be considered a major initiative in developing a nursing research agenda. She urged nurse researchers to assume leadership in pursuing research that

targets treatment-related questions. McBride believed that the way to get students motivated, energized and empathic in their practice with survivors of violence is by their getting to know these women as people, like themselves. To fulfil their potential, students must be made aware of the prevalence of violence and be provided with the opportunity to develop their knowledge, skills and judgement to facilitate a sensitive and effective response to this serious public health problem.

Nursing's Potential

Nurses are in an ideal position to contribute to violence prevention, detection and intervention. Their sheer numbers, the variety of their practice locations, and the nature of their practice mean that they are in close contact with a large segment of the population at risk for violence and its consequences. There are 256,544 Registered Nurses, 75,000 Registered Practical Nurses, and 5,500 Psychiatric Nurses in Canada (Statistics Canada, 2000). The vast majority of these nurses are in practice. In addition to their widespread presence in traditional health care agencies and community settings, nurses work in public schools and, most importantly, in people's homes. They often provide the first contact with the health care team, and they are well situated to mobilize resources and initial interventions.

The broad scope of nursing practice (education, research, policy, administration and service) is congruent with intervention at the primary (prevention), secondary (treatment) and tertiary (rehabilitative) levels of prevention (Ross and Hoff, 1995). At the primary level, nurses are in a strategic position to engage in educational programs that heighten public and professional awareness of violence against women, children and seniors. They can participate in establishing policies and procedures that protect the rights of individuals and families within community and care facilities. Nurses can also engage in research aimed at determining the antecedents and consequences of conflict and violence, testing the validity and reliability of assessment tools and evaluating the efficacy of clinical interventions on behalf of survivors. At the secondary level, nurses can establish screening programs for individuals at risk, participate in the medical treatment of injuries resulting from violent episodes, and coordinate community services to provide continuity of care. At the tertiary level of prevention, nurses can facilitate the healing and rehabilitation process by counselling individuals and families, providing support to groups of survivors, and assisting them to achieve their optimum level of safety, health and well-being.

Methods

On-line Searches

The search strategies entailed on-line and hand searches of selected reference lists. Using OVID as the search engine, an on-line search was conducted of CANSIM, CINAHL, Current Contents, MEDLINE, Sociofile and Psychfile, large bibliographic databases, for articles, papers and reports published between 1995 and 2000. The following keywords were used individually and in combination: violence prevention, detection, intervention, violence against women, children, older adults, battered women, child abuse, rape, sexual assault, suicide, crisis intervention, conflict resolution and nursing education.

Letters of Inquiry

Letters were distributed to the executive directors of the Canadian Association of Schools of Nursing, the Centres of Excellence for Women's Health, the Research Centres on Family Violence and Violence Against Women, and all university schools of nursing

in search of unpublished documents and reports and papers emanating out of these organizations on the topic of nursing education and violence against women, children and seniors. Inquiry was also made about whether graduate programs in nursing offered students the opportunity to specialize in the area of violence prevention, detection and intervention either through course work or thesis production.

Screening

All articles identified through the on-line search and letters of inquiry were initially screened to determine their relevance to this review. A screening tool guided the selection of manuscripts for review. Relevance criteria determined whether the paper was published since 1995; was related to the education of nurses in one or more areas of violence; was the product of a research project, program development/implementation program, or a personal experience/opinion piece. Reference lists from selected articles were hand searched for articles published before 1995 that might be of relevance to this project. Only the articles that dealt with nursing education in the area of violence prevention, detection and intervention and that were available from the University of Ottawa, Algonquin College and Queen's University were selected for review and included in the overview.

Validation and Evaluation

A draft of the overview was distributed to a panel of experts on violence prevention, detection and intervention and the education of nurses for validation and evaluation. Criteria for evaluation included clarity, comprehensiveness, appropriateness of the search strategy, appropriateness of the screening criteria, relevance of the review for policy makers and nursing educators and researchers, and overall quality. After validation and evaluation, feedback from the panel members was reviewed and incorporated into the overview, which was then finalized.

Overall Findings

The literature on the education of nurses in the area of violence prevention, detection and intervention is limited. In 1996, Woodtli and Breslin reported that a review of the published literature revealed few publications describing the inclusion of content about violence against women, children or seniors in health care curricula. Since then, there has been little change. Thirty-five articles have been selected for inclusion in this report, as they met established criteria and were considered directly relevant to the project. In addition, a few documents published before 1995 have been included as they hold particular significance for the education of nurses in the area of violence. The majority of authors were American in origin with the remainder primarily Canadian and British.

Although responses to the letters of inquiry from the Centres of Excellence for Women's Health and the Research Centres on Family Violence and Violence Against Women revealed collaboration between researchers of these centres and faculty members at schools of nursing, no ongoing or unpublished projects relating to the education of nurses were identified at the time of inquiry. Deans and directors of schools with graduate programs reported that students had the opportunity to conduct their thesis research in the area of violence as long as there were faculty members available for thesis supervision. They also reported that their undergraduate programs contained content that related to violence, particularly in pediatrics, psychiatry and gerontology. One school reported that students had conducted a study (Theriault, 1995) relating to their personal experiences with violence and abuse within the context of their educational

program. In addition, the responses of deans and directors indicated a small increase in the content offered in undergraduate education over the past few years. All schools provide opportunities for learning about violence against women, children and older adults in their curricula. When faculty members are available for supervision, graduate students also have the opportunity to focus their studies and/or research in the area of violence against women, children and seniors.

Program Development

Theoretical and contextual issues

There has been considerable debate about the theoretical underpinnings of violence against women, children and seniors (Hoff, 1994). The approach in much of the literature is to place violence within the context of social acts that have far-reaching effects on personal and public health, for which perpetrators are considered to be morally accountable. Such violence is seen to be learned in a milieu permeated with social inequities based on age, ethnicity and gender. Images of physical and emotional force appear to be the dominant method of conflict resolution. Although there are many references in the literature to family violence, there are cautions against using this term as it obscures the socio-cultural roots of abuse that extend beyond the family. These roots are seen to be deeply embedded in cultural values and traditional social structures that disempower women and older people (Hoff and Ross, 1993; Ross and Hoff, 1995). The term "family violence" is also inadequate for addressing abuse by health care professionals in and outside of institutions. Similarly, much of the literature refers to "victims" of violence rather than to "survivors", which is a more empowering term (Hoff, 2001).

There are also indications that educational approaches emphasizing the principles of primary health care are well suited to establishing nursing practice within the realities and complexities of survivors' experience (Ross and Hoff, 1995). Such principles include maximum participation in identifying survivors' needs, decision making about the types of services that will best meet these needs, and accessibility to responsive, user-friendly and cost-effective services.

Educational approaches are also needed that go beyond traditional models and that improve prospects for survivors to increase control over their situations, thus improving the quality of their lives. According to Campbell (1992; 1998), a focus on the principles of advocacy, mutuality, critique, and transformation will help to ensure that nurses can provide care for survivors of violence that is empowering and emancipating. Woodtli and Breslin (1996) and Woodtli (2000) advocated the use of an ecological model for health promotion as the theoretical underpinning of educational programs for nurses on domestic violence. Such a model allows for intervention at the personal, interpersonal, institutional, community, and public policy levels. In addition, it is crucial that the use of technology and inter-disciplinary and inter-sectoral collaboration be improved. The challenge for nurse educators is to develop curricula that are relevant to the social and political realties of survivors of violence and to incorporate approaches that ensure the systematic sensitization of pre-service and practising nurses to these realities.

Key features of professional education

Nursing education embodies features that are central to the teaching and learning process, including the centrality of experiential learning and the integration of content from a variety of disciplines (Ross and

Hoff, 1995). These features provide the structure within which curriculum development and implementation occur.

The centrality of experiential learning

Nursing is an applied discipline. Much of the knowledge associated with nursing is generated from interaction with individuals, families and groups in a variety of institutional and community-based settings. Such knowledge, which is embedded in practice, accrues over time in the practice of an applied discipline (Benner, 1984; Ross and Hoff, 1995). Students encounter patients and clients, they engage in decision making and carry out tasks and interventions under the supervision of specialists in education and practice. Expertise develops by testing and refining propositions, hypotheses and principle-based expectations in actual practice. Within the context of such experiential learning, it is crucial that students have the opportunity to learn the clinical culture and interact with other nurses and health care providers. It is also crucial that the clinical experiences selected for students have the potential to reveal the concepts that students are expected to learn, and that they have the opportunity to test out in practice their knowledge and skill with respect to these concepts.

With regard to violence, it is important that students have the opportunity to encounter in their practice women and children who are survivors of abusive episodes or who are at risk for being abused. Such encounters should move beyond traditional health care settings and include the home setting, crisis centres, battered women's shelters, etc.

Urbancic, Campbell and Humphreys (1993) described a clinical practicum during which students were given a placement in shelters for battered women that allowed them to function as advocates, advisors, case managers, and health care teachers, and to focus on the broad concerns of daily living. The authors concluded that such experience provides students with opportunities to learn about interpersonal violence and to develop empowering and caring skills.

Educators should also invite into the classroom survivors who are willing and able to share their experience so that students can learn first hand about the dynamics and traumatic results of abuse (Brandt, 1997). It is also important for educators to use learning resources such as videos, films and self-directed learning packages, which are increasingly available on the market.

The integration of concepts from a variety of disciplines

There are suggestions in the literature that the curriculum should not be free-standing but, rather, that knowledge about violence should be integrated into existing courses and clinical experiences, especially those concerned with mental health, primary care, community health, emergency care and the health of women, children and seniors (Brandt, 1997). Students bring to the curriculum knowledge from the biomedical and psychosocial sciences as well as the arts and humanities. They also bring varying levels of professional knowledge and varying degrees of critical analysis. Students are supported in their learning by peers, teachers and health care personnel, who help them relate to and cooperate and collaborate with others in the provision of care. Throughout their program of learning, selected courses, content or concepts from other disciplines are sequenced so as to be relevant to the dimensions of the profession being studied at any point in the curriculum.

Although it is beyond the scope of this paper to discuss all the content required by nurses to respond appropriately to survivors, without sensitivity to gender issues as well as knowledge of the health and social consequences of violence, students will be at a

major disadvantage in their practice. Finally, since no one discipline holds the key for solving the problems and meeting the needs of women, children and seniors who are abused, the principles of interdisciplinary practice must be integrated into curricular initiatives related to violence prevention, detection and intervention.

Elements of Curriculum Development

The development of a conceptual framework

Curriculum design involves developing a framework within which disparate topics, empirical studies and theoretical explanations can be linked. The challenge lies in combining areas that reflect different degrees of abstractness, levels of analysis and sophistication in theory and practice. Ross and Hoff (1995) proposed a curricular framework that is eclectic, interdisciplinary and draws on concepts from human growth and development, socio-cultural analysis, crisis theory, victimology, life event research and feminist scholarship. Such a framework will help to ensure that although the substantive focus of content will be dynamic and changing, a consistent theoretical approach will be applied. In addition, Ross and Hoff suggested that an inclusive framework ensures that issues are not exclusively from more traditional perspectives, such as pathological models that focus their placement of abuse within the context of personality dysfunction. Furthermore, these authors believe that violence cannot be understood and responded to effectively until health professionals take into account such sociological and political factors as increased longevity, patterns of frequent migration across vast geographic regions, poverty, ageism, unequal access to care, and other social and political realities.

The determination of core content

The principles of relevance, applicability, integration, and diversity provide guidance for the determination of content on the topic of violence prevention, detection and intervention for nursing students (Ross and Hoff, 1995).

Relevance
Nurses live in a pragmatic world. Concepts are useful, insofar as they provide direction and make a difference in nurses' ability to practice. While theoretical concepts contribute to knowledge of a phenomenon, practice-based concepts facilitate the application of knowledge.

Applicability
Concepts must be presented in ways that clearly demonstrate their application to practice.

Integration
Concepts related to violence must be linked to other concepts from the biomedical and psychosocial sciences and the humanities.

Diversity
Nursing education occurs in a variety of settings and at varying levels (pre-service and continuing education). Curricular initiatives must, therefore, include concepts, methods and resources that have utility for varied programs and levels of practice.

Core Content

A core curriculum encompasses those courses or learning units required of all students graduating from an educational institution, without which the educational goals would not be met. Such learning involves knowledge, attitude and skill development at several levels of education (Ross and Hoff, 1995; Brandt, 1997).

Knowledge

There are two broad categories of essential concepts that nurses must master: 1) concepts explicitly concerned with violence prevention, detection and intervention and the physical and emotional consequences of violence; and 2) concepts related to violence that are already addressed in the curriculum but that require explicit elaboration in order to be relevant to violence prevention, detection and intervention. For example, concepts like stress, trauma, primary prevention, crisis, social change and cultural variation, though not unique to people who have experienced violence in their lives, are important in responding to this population. Key concepts also relate to the theoretical underpinnings of health status and health service delivery. These include the problem, incidence, and socio-cultural context of violence; issues related to prevention and protection; and concepts related to clinical practice.

The problem, incidence and socio-cultural context of violence

Epidemiological data and demographic correlates of violence and victimization such as age, sex, class, race, sexual identity, physical ability/disability, immigrant status, and geographic location are central to a comprehensive understanding of violence. It is also crucial that students learn about the connection of violence to economic disparity and other disadvantages such as those based on age, ethnicity, and gender relations. Knowledge of family dynamics, role theory, sex-role stereotyping, and power disparities, including feminist analysis and social change theory, is a prerequisite for students in order to situate violence within the larger context of power relationships underlying violent situations. Students also need to understand concepts related to multiculturalism, cultural relativism and cross-cultural patterns and differences in violence, victimization, and healing in order to respond appropriately in situations that are different from those that nurses bring to their learning and clinical practice. The phenomenon of stigmatization and bias and their potential for creating a climate that activates violence are also important aspects of knowledge development related to the socio-cultural context of violence.

Violence prevention

Knowledge of the principles of primary, secondary and tertiary prevention is central to the prevention of violence and to the protection of people from abuse, as well as to the appropriate response of nurses to survivors of abuse. In addition, it is crucial that nurses are well-versed in basic ethical and legal issues (e.g. legal protections, limits of legal restraint, mandatory reporting, "duty to warn", rights and accountability of defendants) that serve as the underpinnings of health care practice, aimed at the prevention and reduction of violence.

Clinical concepts

The prevention of and response to situations of violence involve an understanding of the dynamics of violence, including social, cultural, economic, psychological, behavioural and biophysical ramifications. It also involves an understanding of the links of violence and victimization with substance abuse, physical health status, depression, suicidal risk and other mental health sequelae. Nursing students must appreciate the experience of traumatic stress and its implications for self-esteem, health and well-being. They need to be knowledgeable about the criteria for identifying survivors of abuse in health and social service entry points

(triage) and for assessing victimization trauma, including the potential of violent episodes to escalate to homicide. The theory behind crisis intervention and social support strategies for survivors, families and assailants, including appropriate referral to community-based resources, is also central to appropriate action by nurses in their response to survivors of violence (Hoff, 2001).

Attitudes

It is important for educators to confront attitudes and not just teach facts. If nursing students are expected to prevent violence and intervene on behalf of survivors, a first step in their education is to provide opportunities to learn about human growth and development, including their own. It is also important to develop a sensitivity to political and societal precepts that often devalue women, children, and seniors. Nurses, like others, can be influenced by dominant societal values, which have consistently exacerbated the plight of survivors. Clarification of values both at the personal and societal level is critical to the training of nurses as professionals who contribute to the care of survivors of violence (Hoff, 1994).

A second underlying assumption is the recognition by faculty members that the traditional stance of assuming professional objectivity or neutrality towards issues like violence no longer holds. Feminist and multicultural critiques make it clear that scientists and nurses are not immune from the values of the culture in which they reside, teach and practice (Hoff, 2001). It is important to acknowledge that the influence of values and ideology applies to nursing practice specifically as well as to societal violence generally. A survey of Ontario schools of nursing (Hoff and Ross, 1995) underscored the challenge of examining attitudes and values with regard to violence. Survey findings revealed the parallels between the topics addressed in nursing education and societal responses to violent situations. Compared with child abuse and wife battering, abuse of older adults had the least coverage and was the only topic covered by more than one respondent "only in readings" rather than more formally within the course or program structure. The authors concluded that, compared with knowledge and skills, attitudinal content that necessitates a major departure from deeply held values regarding abuse of older adults presents the greatest challenge to both teachers and learners.

Skills

Essential skills required to implement strategies for the care of violence survivors include the techniques of crisis care, i.e. identification, assessment (including victimization trauma and the risk of suicide and/or violence toward others), planning, implementation and evaluation (Hoff and Adamowski, 1998). Other required skills include communicating by listening actively, questioning discreetly, responding empathetically, and advising and directing appropriately. Additional important skills for nurses include the following:

- educating people to recognize symptoms of stress,
- teaching survivors to assess assault/abuse,
- learning to name the problem and its source, and avoiding self-blame.

It is also crucial that nursing students learn to advise violence survivors of their basic legal rights and to link them to legal resources that will help them avoid re-victimization. They need to learn to mobilize safety, legal, and community resources effectively (e.g. arranging admission to a shelter, finding translators for immigrants, providing support for caregivers). Also needed are the skills to implement

agency policy regarding mandated reporting and maintenance of accurate records, so that they cannot be used against survivors but, rather, can assist them in legal action later. Students also need to learn to use the consultative process, i.e. knowing whom to call under what circumstances and, in fact, doing so. Finally, additional skills for nurses should include learning to complete the steps of crisis management and follow-up referral while not judging or imposing their values on the survivor, implementing health promotion and illness prevention strategies, and working with community organizations.

Levels of Education

Nursing education occurs at many levels. There is some direction in the literature with respect to the education of nurses and other heath care providers at different levels of practice. Hoff (1994) provided direction for class/seminar planning. She divided the global curriculum content required for knowledgeable and skilful health care providers into three levels of professional education (beginning, intermediate, and advanced). At the beginning level, the emphasis is on description and primary prevention in personal and student-role behaviours. Students are introduced to the topic and sensitized to the issue of violence in a way that does not overwhelm them but conveys that they have an important role to play in violence prevention. At the intermediate level, the emphasis is on analysis, clinical application, and a critique of clinical performance based on principles described in the literature. The focus is on students' understanding and application of assessment and intervention strategies in a variety of clinical settings. It is assumed that not all students will encounter each type of survivor; rather, they will learn the basic strategies through their own research, study and other learning experiences. At the advanced level, the emphasis is on the synthesis of concepts and the refinement of skills learned at previous levels of education. This level assumes that students have grasped essential concepts of crisis intervention and treatment on behalf of survivors, and have planned opportunities to work with people in actual or potential situations of violence.

Brandt (1997) advocated different levels of education for varying levels of practitioners: general, nurse practitioner, specialty practice, and consultants, investigators and educators. The author described the goals and objectives of courses designed for different levels of practice. A core course focuses on generalist practice and emphasizes attitude development, core knowledge and skills development related to effective screening, diagnosis, and referral. A second level course focuses on specialty practice and emphasizes intensive, targeted, specialty-focused assessment and intervention with survivors of violence. Barriers to professional practice are explored, as are the legal aspects of care. A third level course focuses on research and educational issues related to violence and the skills required for the consultation role.

Woodtli (2000) recommended an intra-personal or "feeling" level of education as a starting point in educating nursing students about domestic violence. She suggested that exploring attitudes about domestic violence is essential in helping students to recognize their own attitudes and to understand the values and beliefs on which their attitudes are based. An interpersonal level of education focuses on theory-based interventions, including disclosure, in sensitive domestic violence situations. This author also referred to core and specific knowledge and skills development. Core knowledge and skills are needed by all nurses, no matter what the situation, and specific knowledge and skills are required by nurses in specific situations of domestic violence.

Interdisciplinary Practice

Most experts in the field of violence confirm the need for an interdisciplinary approach to the prevention of violence and treatment programs for those in need of care (Hoff, 1994, 2001; Ross and Hoff, 1995; Woodtli, 2000). This view, however, is not always actualized in practice. In addition, the health professions usually act independently in developing and implementing curricula despite the many commonalities in their knowledge, attitudes, and skills (Brandt, 1997). This approach may work well in some situations of learning but it does not work in the area of violence. The challenges of establishing interdisciplinary training programs have been described by others (Byrne, 1991; Hanvey and Rowe, 1997). Although it is beyond the scope of this paper to detail the literature on the interdisciplinary education of nurses and other health professionals, the results of a Canadian study of five health science centres will be reported. The results of this study by Ross et al. (2000) revealed that

- the majority of student respondents (78%) reported content on interdisciplinary practice in their program of studies;
- two-thirds of the nursing students (66%) and over half of the medical students (60%) reported the inclusion of such content in their curriculum; and
- a greater proportion of dental and oral health students (85%), pharmacy (92%) and rehabilitation science students (92%) reported exposure to such content.

Despite these encouraging findings, the number of hours devoted to this content was not substantial. Only a minority of respondents (41%) reported more than four hours of instruction, the remainder estimating the number of hours of instruction to be three (12%), two (13%), or one (9%). Nine percent reported that issues related to interdisciplinary practice were covered in readings only. The program content was primarily didactic and dealt with issues such as team structure, team process, disciplinary values, conflict resolution, and problem solving within groups. Students were provided with few opportunities to test out their knowledge and skills in practice with health professionals from other disciplines.

Nurse educators can be guided in their efforts to ensure that students are well able to work together with other health and social service providers by the work of Laschinger and Weston (1995). They described how collaborative practice requires multiple interactive skills, including advanced communication abilities, astute negotiation skills, and a keen understanding of the form and function of professional disciplines. In addition, Weilichowski et al. (1999) described a model for collaborative nursing and medical education within the context of family violence that provides specific examples of program objectives and teaching methods.

Personal Histories of Students

Since the incidence of physical and/or sexual abuse among the general female population is high (Statistics Canada, 1993) and the majority of students in nursing are women, it is logical to deduce that abuse histories exist among students and faculty members. In addition, some of them may currently be in abusive situations themselves. If trauma from abuse has not been worked through, potentially disturbing course content may trigger unanticipated responses. For such individuals, barriers to their effective intervention with survivors of violence may surface. Early in their education, nursing students should receive an introduction to potentially disturbing topics such as violence and its possible connection to their own personal histories. Such an introduction may

motivate students to seek counselling for unresolved problems. When such an approach fails, crisis intervention and referral by faculty members for distressed students is appropriate.

A recent study (Theriault, 1995) highlighted the experience of nursing students with violence and abuse in schools of nursing across Canada. Respondents described a culture of high expectations, personal feelings of powerlessness, low self-esteem and lack of confidence in their clinical competence as well as remote relationships with faculty, all contributing to their feelings of vulnerability. A number of recommendations for curricular change emerged. Among them were enhancing the self-esteem of students, improving student-faculty-preceptor relationships, and ensuring a supportive clinical learning environment.

Violence in the Workplace

Violence is a problem for both nurses and patients. Violence directed at health care providers, including nurses and nursing students, is reported as endemic and considered an occupational hazard (Calvert, 1996; Whitly, Jacobson and Gawrys, 1996). A recent study of nurses' experience of violence while working in hospitals in British Columbia and Alberta (Duncan, Estabrooks and Reimer, 2000) revealed that close to half (46%) of all nurses had experienced one or more types of violence in the previous five shifts that they had worked. An alarming 70% had not reported the abuse. Emotional abuse (37.6%), threats of assault (19%), and physical assault (18.1%) were the most common types of abuse experienced by the nurses. In the vast majority of cases, patients were the perpetrators; however, physicians and co-workers were identified as significant sources of emotional abuse.

The bulk of the literature on violence in the workplace focuses on psychiatric, emergency, long-term care, and home nursing (Brown, 1998; Featherstone, 1999; Lewis and Dehn, 1999; Rice, 1998; Rose, 1997; Fédération des infirmières et infirmiers du Québec, 1995). Increasingly, the safety of nurses and nursing students is emerging as a critical concern to the profession (Whitly, Jacobson and Gawrys, 1996). These authors provided a review of the literature focusing on the incidence of violence toward nurses, factors that correlate with the occurrence of violence, the management of violence in potentially violent situations, and the effects of violence on nurses.

Williams (1995) conducted a survey of violence in the workplace, revealing that 64% of registered nurses reported personal experience with harassment of a sexual nature. Perpetrators were most often patients (72.8%) followed by physicians (57.9%). Nurses who worked in community home health (64.7%) and occupational health (60.7%) were most often harassed. In hospital settings, harassment occurred most frequently in the operating room, medical-surgical area, and the emergency room. About one-third of those who had been sexually harassed had also been physically assaulted. Less than 40% (38.5%) of respondents knew that their employer had a policy on sexual harassment; about half (47.6%) were unsure. The author concluded that educational programs must be developed to help nurses deal with issues of violence and sexual harassment in the workplace.

A Canadian Nurses' Association policy statement (1996) advocated that nurses increase their knowledge and skills regarding the issue of violence and that they take a proactive stance in refusing to tolerate violence and harassment. The policy identified as important the ability to assess potentially violent situations and to defuse or cope with escalating situations. Nurses also need to be

knowledgeable about institutional policies and, where none exist, to be able to work with administrative personnel to develop them. The College of Nurses of Ontario subsequently developed an educational tool for nurses entitled *Abuse of Nurses: A Guide to Prevention and Management* (1999).

Violence is also perpetrated by nurses. A 1997 survey of 1,000 nurses by the College of Nurses of Ontario found that 48% had witnessed at least one incident of patient abuse within the previous three years, and another 11% had heard about one or more incidents. The most common form of abuse was embarrassing or offensive comments, rough treatment, or yelling and swearing. The College of Nurses of Ontario recently updated a widely acclaimed educational program entitled *One is One Too Many* (1999) aimed at preventing the abuse of patients by nurses. Standards of practice and ethical guidelines that have been developed by the Canadian Nurses Association (1992; 1996) and many other nursing associations, including the Registered Nursing Association of Nova Scotia (1997) and the Ontario Nurses' Association (1995), provide direction for education with respect to the nurse-patient relationship. By providing direction on the nature of the nurse-patient relationship, these standards and guidelines help to prevent abusive relationships and serve to ensure that the nurse-patient relationship is therapeutic and not harmful.

Curricular Implementation

Methods for curriculum implementation are varied and include the use of formal didactic sessions and small informal group seminars, workshops and tutorials (Ross and Hoff, 1995). Traditional approaches involve the use of single and/or optional courses. Although this method may be particularly attractive, curricula are already overcrowded and it has disadvantages for students who do not have the theoretical or practical grounding to cope with the content. Furthermore, the use of optional courses does not address the need to ensure the systematic coverage of content for all students. The curriculum thread approach corrects some of the disadvantages of single courses. However, this approach requires total faculty involvement and vigilance in order to avoid losing ground between the single course and the curriculum thread, somewhere along the line.

A series of short courses, representing a middle ground between the single course and the curriculum thread, offers a compromise. These courses focus on particular components of core content (knowledge, attitudes and skills), levels of practice (introduction, elaboration and synthesis), and practice setting (community, home, institution). A problem-based learning approach, which is used in some schools of nursing, can present essential content in the form of required case studies. These case studies are dealt with in small groups with tutors and through clinical experience in diverse settings. This approach has the advantage of being learner-centred and interactive (Hoff, 1994). In addition, problem-based learning is highly accessible for continuing education programs and when time is at a premium.

Discussion of actual cases of violent episodes is another method of expanding exposure to assessment and intervention dilemmas. Medical and nursing rounds and case conferences with other health care workers provide opportunities for reviewing survivors' situations. Whatever the method, it is crucial that nursing students be provided with the best research and clinical material available on the topic.

Guidelines, persuasion, and incentives rather than mandates and sanctions are the preferred methods for engaging nurse educators in the development of learning programs that focus on violence prevention, detection and intervention (Brandt, 1997). The support of key professional organizations (the Canadian Nurses' Association, provincial nursing associations, the Canadian Association of Schools of Nursing, the Colleges of Applied Arts and Technology) and institutional support among deans and administrators are also key in driving the development and implementation of curricular reforms within schools of nursing. In the United States, the American Association of Colleges of Nursing (AACN) issued a position paper to assist nurse educators to address violence-related content in all nursing curricula (AACN, 1999). The development of pilot projects in a few key schools where the curriculum can be tested and refined is also encouraged. In addition, material about violence should be incorporated into registration and specialty certification examinations.

Responses of Students

Many students have had little educational exposure to violence (Theriault, 1995; Sword et al., 1998). With few exceptions, there is little in the literature that describes the outcomes for students of learning about violence prevention, detection and intervention. Mandt (1993) described the response of one student to a course on violence. This student described how she never felt that it was any of her business to ask a woman directly whether a spouse or partner had beaten her up. She just thought that if the woman wanted to tell her, she would. This course taught her otherwise. Another student talked about what she had learned in a shelter for battered women. From this experience, she came to understand how women go through a grieving process and how hard it is for them to leave their abusive situation permanently. She noted how many women feel completely helpless, have no jobs, have no way to support themselves, and do not see themselves as having any power to change their situation. They just keep buying into the promise that the man will change.

In a study of nursing students' opinions on interpersonal violence, Kiner (1995) found that students with work experience in health care tended to agree that research, education, and legislation could help reduce violence; however, students without such experience disagreed with this premise. Sword et al. (1998) reported that most students have very little exposure to issues of violence, in particular woman abuse, in their formal curriculum. Nevertheless, their responses were sympathetic. Data from 155 nursing students (19-55 years of age) revealed that students with more egalitarian sex-role beliefs and with a greater sense of control over life events were more sympathetic to battered women than were those with less egalitarian sex-roles and less control over life events.

Research

Tilden et al. (1994) conducted a regional study of 1,571 practising clinicians in six disciplines, including nursing. They found that more than one-third of the subjects reported no educational content on spouse, child, or older adult abuse in their educational programs. The investigators concluded that a need exists to expand curricula on family violence.

Kingston, Penhale and Bennett (1995) investigated the relative proportion of child abuse, domestic violence, and older adult abuse in social work, nursing and medicine curricula. The response from nursing schools showed that 98% dealt with child abuse, 81% taught about older adult abuse, and 60% included issues related to domestic violence in general in their curricula. A majority of faculty members (65%) believed that it was very important to include the topic of

domestic violence in the curriculum. The range of topics varied among programs, but they usually included the incidence and prevalence of domestic violence in general; physical, social and psychological indicators of abuse; family conflict; societal attitudes; ethnicity and abuse; communication strategies; and health authority policy.

Hoff and Ross (1995) reported the results of a survey of schools of nursing in Ontario to determine curricular approaches to content on abuse and violence, and to identify the curriculum development needs of faculty. The response rate was 93%, representing several program types: eight baccalaureate, 32 diploma and three master's programs. All of the schools reported that they included content on violence issues in their curriculum, if only in readings. Three-quarters reported that planned clinical instruction was incidentally rather than systematically included as part of the curriculum. The majority of respondents believed that the topic of violence was not adequately addressed because there was not enough time, when other curriculum requirements had to be taken into consideration. In addition, they identified a lack of faculty expertise in this area of practice as problematic to the inclusion of violence-related content. The authors also identified several strategic issues that they considered central to the curriculum development process, and described a series of six workshops held throughout Ontario to assist nurse educators with the task of systematically addressing violence in nursing curricula. The workshop participants included faculty members, clinical preceptors and community-based experts in victim/survivor care. The authors indicated that the workshops are an initial step in addressing the inclusion of violence content in nursing curricula.

Woodtli and Breslin (1996) conducted a survey of schools of nursing in the United States to examine the extent, placement and faculty members responsible for curricular content on abuse and violence against women, children and older adults. This national study was grounded in an ecological framework that focused on intra-personal, inter-personal, institutional, community, and public policy factors. A 35 item mailed questionnaire, modelled on a questionnaire developed by Hoff and Ross (1995), included demographic, course content, and curriculum development items. The questionnaire was completed by 298 (48%) of the programs surveyed. Findings showed that most programs included issues related to woman, child and older adult abuse; each content area was presented in two hours or less; and clinical practice opportunities were primarily coincidental. Fifty-three percent of respondents believed that content was adequately addressed, and 68% recommended curriculum development workshops to address curricular issues relating to violence. In a follow-up study, Woodtli and Breslin (2002) found very little evidence of progress among nurse educators in addressing violence-related content in nursing curricula.

Lachapelle and Forest (1997) evaluated the outcomes of a mandatory course on the social aspects of violence offered at the University of Quebec at Rimouski. The course aimed to promote a change of attitudes and develop intervention abilities for nurses who might come in contact with domestic violence. The results showed that before taking the course, nurses viewed domestic violence as an individual problem; by the end of the course, students increasingly acknowledged the social dimensions of violence. The authors concluded that training on domestic violence can modify perceptions and help nurses develop the competencies to intervene.

Sword et al. (1998) surveyed 150 nursing students at McMaster University on their level of exposure and attitudes to survivors of violence. Students responded to the "Student Exposure to Woman Abuse Questionnaire" and the "Inventory of Beliefs about Wife Beating". They reported that they had had very limited exposure to woman abuse in formal curricular activities; nevertheless, they were sympathetic in their attitudes. The authors concluded that it is important for students to explore their own attitudes toward woman abuse, and that the curriculum be designed to enhance knowledge and skills in specific content areas, including detection, intervention and referral.

Ross, Hoff and Coutu-Wakulczyk (1998) presented the findings of a national survey of schools of nursing in Canada (n = 155) conducted in 1995, which determined the extent to which violence-related content was addressed in nursing curricula. The study yielded a response rate of 88%. Theoretical content related to violence against women and children, and suicide as a response to abuse formed part of the curriculum, if only in readings, in all schools of nursing. Child abuse (4.0 hours) and suicide (4.0 hours) received the greatest number of hours of instruction, followed by woman abuse (3.6 hours), sexual assault (3.4 hours), and older adult abuse (2.7 hours). University schools of nursing provided more hours of instruction on woman abuse (4.8 hours) than other types of schools (community colleges: 3.5 hours; cegeps*: 3.5 hours; hospitals: 3.7 hours). On average, schools in western Canada (4.3 hours) and Atlantic Canada (4.3 hours) provided more hours of instruction on woman abuse than those in other regions of the country (Ontario: 3.5 hours; Quebec: 3.1 hours). The majority of university schools of nursing (62%) provided experiential instruction in the area of violence, but the other types of schools provided very little such instruction. The authors concluded that although the findings indicated a sensitivity to the importance of including content on violence in nursing curricula, the approach was usually incidental and largely dependent on faculty interests.

Robinson (1999) conducted a series of interviews with psychiatric nursing students in London, England, to evaluate the adequacy of course content on the prevention and management of violence. Students felt that they had been adequately prepared from a content perspective but lacked the skills to manage violent situations. They recommended an increased focus on the topic of violence, greater liaison between education and service providers, and a period of experience with survivors in a secure setting.

Woodtli (2000) conducted interviews with 13 key informants to identify and describe the essential knowledge and skills needed by nurses to provide competent and sensitive care in cases involving domestic violence. She emphasized the potential impact of nurses' feelings on nursing actions and questioned the ability of nurses to intervene effectively when personal negative attitudes formed the basis of their perspectives about survivors and perpetrators. The informants acknowledged the need to prepare students for interdisciplinary practice; coordinate and manage care for vulnerable populations; and incorporate professional standards, advocacy and accountability into practice. Findings from the interviews provide data that can form the empirical basis for the review of current curriculum content and strategies, which can in turn serve as a basis for curriculum development.

* cegeps = Collèges d'enseignement général et professionnel

Ross, Hoff and Bunn (2000) conducted a study of five health sciences centres across Canada to determine the extent to which violence prevention, detection, and intervention were included as a component of the curricula for future health care providers. They also gathered data about planned opportunities to learn about interdisciplinary practice. The disciplines surveyed included nursing, medicine, human kinetics, occupational therapy, physiotherapy, pharmacy, and social work. Nursing rated very favourably when compared with other disciplines: the majority of student nurses reported content in their curriculum on child abuse (77%), woman abuse (91%), older adult abuse (84%), sexual assault (57%), suicide/self destruction (93%), conflict resolution (71%), crisis intervention (71%), and interdisciplinary practice (66%). Only a small proportion, however, reported planned clinical instruction in this area of practice.

An interesting finding was the disparity between the responses of faculty members and students about the curricular inclusion of content about violence. Faculty members consistently reported less content than did students. It may be that faculty members are familiar with the content they include in their own courses but are unfamiliar with the content in other courses that form part of students' curriculum. The authors suggested that it is important for faculty members to be well versed about the entire curriculum and how their particular courses articulate with the curriculum as a whole. The findings of this study extended those of other studies by gathering information about specific intervention strategies, such as crisis intervention and conflict resolution.

Courses, Texts and Other Curriculum Resources

Courses

Beech (1999) described a three day unit instruction program on aggression and violence offered for all pre-service students in nursing and midwifery at Keele University, in the UK. Robinson (1999) described a mandatory course on domestic violence offered at the University of Quebec at Rimouski.

Brandt (1997) developed three courses on family violence for nurses, physicians, and dentists. Family Violence 101 conveys a body of core knowledge, attitudes, and skills that every health care professional should master as an undergraduate, irrespective of profession, specialty, or scope of practice. Family Violence 201 is conceptualized as postgraduate education and training for primary and specialty care. The emphasis shifts from the acquisition of core knowledge, attitudes, and skills to more detailed competencies with respect to diagnosis, treatment, and referral. Family Violence 301 facilitates the expert incorporation of the knowledge, attitudes and skills necessary for health professionals who will specialize or become leaders, teachers, and scholars in the field of family violence. Interdisciplinary faculty development and public policy efforts are key elements for inclusion at this level.

Ireland and Powell (1997) described an introductory course on child protection, developed at a British school of nursing and midwifery. They described the collaborative work that led to the establishment of the course and outlined its benefits. The course has attracted participants from a range of

health care settings, and it has proved to be oversubscribed and well-evaluated. Practitioners who attended the course reported that they returned to their work settings with an increased awareness of child mistreatment and an understanding of the need for a proactive approach to child protection.

Mandt (1993) developed a course entitled Nursing and Crisis Intervention for Victims of Family Violence as a senior level clinical course for post Registered Nurse (RN) students. Its focus was on the integration of bio-psycho-social and nursing concepts and principles that would enable nurses to deliver care to those experiencing crises in family violence. The didactic portion of the course emphasized theories of violence, grief, and crisis intervention integrated with nursing theory. Students applied these theories in a variety of nontraditional settings, including shelters for battered women and their children, sexual abuse centres, and telephone crisis centres. Given the highly emotional impact of the content, a significant amount of time was devoted to group discussion. In addition, students conducted independent research and engaged in group presentations on selected topics related to family violence.

Kerr (1992) described the incorporation of content about violence against women into an undergraduate curriculum at Capital University. She identified ten curriculum objectives and described two courses, Human Growth and Development and Psychosocial Nursing, in which violence against women was addressed. Kerr reported that clinical sites included an acute inpatient psychiatric setting, outpatient settings such as a safe house for abused women and their children, a safe house and crisis intervention centre for runaway teens, and a family-centred inpatient and outpatient treatment program for chemical abuse. Teaching methods included selected reading materials and videotapes, clinical discussions, conferences, role playing, journal entries, and a visit to a student-selected community agency. Evaluation of curriculum goals showed how important goals are to the classroom and to clinical experiences and learning. The author concluded that it is essential for nursing students to learn about abuse and appropriate intervention strategies because the nurse is often the first health care member to recognize abuse and initiate care for the victims.

Texts

Parsons and Moore (1997) evaluated major texts in nursing, obstetrics, gynecology and primary care for content in the area of family violence, including domestic violence, rape, child abuse, sexual abuse in pregnancy and older adult abuse. The study included 19 nursing texts that had been published between 1990 and 1996. A domestic violence content score was established with a maximum score of 12. They found that 63% of nursing texts included some content on violence, although only 10% achieved scores ranging from 9 to 12. The authors concluded that the availability of information on family violence is limited in nursing and other professional texts. There are, however, additional ways of introducing students to the topic of violence. Campbell (1992) suggested using novels as a method of exposing students to the realities of violence, before they encounter actual survivors. In this way, they can learn about violence while still being able to distance themselves, by putting the book down as necessary. She recommended the following novels: *The Color Purple* (Walker, 1982), *Beloved* (Morrison, 1987), *The Handmaid's Tale* (Atwood, 1986) and *The Prince of Tides* (Conroy, 1986).

Hoff's (2001) interdisciplinary text, in several editions, addresses violence issues in two chapters within the framework of comprehensive crisis care. The theoretical framework informing this work is based on

in-depth research with abused women. Clinical scenarios illustrate the essentials for nurses and other practitioners in the prevention, detection, intervention, and follow-up care indicated in abusive and critical situations across the life course.

Other curriculum resources

Curriculum Guide for Nursing: In 1991, the Ministry of Colleges and Universities of the Province of Ontario allocated $1.8 million for initiatives related to the prevention of violence against women. The University of Ottawa School of Nursing was successful in its submission of a proposal to develop *A Curriculum Guide for Nursing* (Hoff and Ross, 1993). A first in health education nationally and internationally, the *Guide* identifies theoretical (stress, conflict, gender) and practice issues (assessment, problem solving, intervention) that are relevant to nursing and the care of victimized women and children. The *Guide* also provides direction for the integration of victimology content into the curricula of schools of nursing.

The conceptual framework is eclectic, interdisciplinary, and grounded in concepts from crisis theory, victimology, feminism, and socio-cultural analysis. It identifies broad concepts from disciplines such as sociology, political science, women's studies, and economics and links them to nursing frameworks. The *Guide* highlights the essential knowledge, attitudes, and skills required by nurses to sensitively and effectively respond to women and children who have been abused. Because nursing education occurs in a variety of settings, the *Guide* includes concepts, methods, and resources applicable to a variety of programs and levels of nursing, including in-service and continuing education programs. The *Guide* discusses the potential of nursing in violence prevention and the care of victims/survivors and their families. A central theme is the discovery and sharing of guidelines and resources to assist nurse educators in both academic and clinical settings with the systematic, rather than incidental, inclusion of violence and victimization content in their teaching and learning programs.

Interdisciplinary Curriculum Guide: Under the auspices of Health Canada through the Family Violence Initiative, Hoff (1994) developed an inter-disciplinary guide entitled *Violence Issues: An Interdisciplinary Curriculum Guide for Health Professionals*. This interdisciplinary guide extended the *Curriculum Guide for Nursing* (Hoff and Ross, 1993) to other health professionals. The *Interdisciplinary Curriculum Guide* underscores the central factor that violence in all its forms, and as it affects all age groups, is the business of all health care workers. It provides curriculum direction for specific health care disciplines, including nursing, as well as illustrations of how members of interdisciplinary teams work collaboratively on behalf of violence survivors. Ethnographic examples of abuse situations are provided along with their implications for educational programs. Implementation strategies focus on curriculum design, and formal and practicum instruction. Despite its wide distribution to health science educators across Canada, a recent study revealed that few faculty members were aware of the *Interdisciplinary Curriculum Guide* (Ross et al., 2000). Of those who had used it, the majority reported that they found it to be extremely useful.

Principles of Effective Anti-violence Education:
Burkell and Ellis (1995) outlined the development of anti-violence programs based on principles that have proven to be successful. They conducted a review of the evaluation of primary prevention programs in a variety of areas, including violence against women, substance abuse, sexual assault prevention, and health promotion. Some general principles identified include links between knowledge, attitudes and behaviour, personal relevance, and anecdotal evidence. School-based prevention, college/university programming and programming for professional groups and community intervention are discussed. Some of the recommendations for the development of anti-violence education programs are that

- all educational programs should have an evaluation component,
- programs should be designed to maximize personal relevance,
- material should be matched to interest level, and
- explicit behavioural skills training should be included.

Finally, the authors suggest that anti-violence programs would be enhanced by having a theoretical basis.

Violence Education: Towards a Solution:
Although designed for family physicians, this manual (Hendricks-Matthews, 1992) can serve to provide direction for nurse educators and other health professional educators. The chapters deal with gender issues, battered women, men who batter, sexual assault, adult survivors of sexual assault, child sexual abuse, child psychological abuse, child physical abuse, older adult abuse, African-American homicide, anti gay/lesbian violence, violence and substance abuse, violence and corporal punishment, prevention, and the emotional impact of working with victimized patients. Each chapter provides an analysis of important sociological, psychological and medical factors, advice to physicians on assessment of and response to violence, a chapter outline, and a teaching guide.

Woman Abuse Curriculum: A Multidisciplinary and Community Based Approach to Knowledge Facilitation for Students in Health Science and Social Work:
This document was developed by the Women's Health Office, Faculty of Health Sciences, McMaster University, in 1994. It aims to sensitize students in professional programs to the needs of women assaulted by their partners and to the service and practice implications of their experiences. The project was grounded in women's experience of violence and in their assessments of their own needs, rather than in professionals' assumptions about them.

A Case Study for Problem Based Learning:
Developed by Bishop and Lent (1993) at the University of Western Ontario, this case study was developed as part of the work for "Educating Future Physicians for Ontario" and for integrating women's health issues into the undergraduate medical curriculum. Although developed for physicians, this case study provides direction for nurses and nurse educators.

One is One Too Many:
The College of Nurses of Ontario (CNO) produced an educational program that aims at raising awareness among nurses of patient abuse. The program focuses on helping nurses to recognize warning

signs and on their obligation to intervene when they witness patient abuse. Originally developed in 1994 in response to a government requirement for all health colleges to provide member information on abuse, the program was revised in 1999. The new version takes into consideration CNO research on abuse and includes a number of improved tools for nurses to learn about and use in order to prevent abuse. It also includes a new guide to aid in preventing the abuse of nurses themselves. The program contains three components: a video, a workshop facilitator's guide, and a self-directed learning guide. The video is a docudrama that uses actual nurses and patients as well as actors to illustrate causes of abuse. It contains powerful scenarios and provides valuable commentary from nurses about their own experiences and best practices. The program has been widely used across the province of Ontario and is highly regarded by both educators and nurses.

Creating Excellence in Crisis Care: Drawing on the best practices from the United States and Canada, Hoff and Adamowski (1998) provide vivid examples that clearly demonstrate how a holistic, interdisciplinary, and collaborative approach is the most practical response to the challenges of working with people in crisis. The comprehensive text offers a field-tested framework and systematic method for including crisis content – critical life events, violence, victimization, suicide and psychiatric emergencies – in the formal training of health and other human services professionals. The book also describes the criteria for developing programs and practice protocols that address the social, psychological and medical needs of people in distress.

In addition to offering guidance on training and program development, the authors make a unique contribution to the literature by emphasizing the inter-connectedness between normal yet stressful life events and catastrophic experiences like serious emotional and mental disorders, violence and disaster. They demonstrate how this knowledge can help create a more effective approach to crisis care. Written as a guide for educators, administrators, supervisors, and clinical trainers, *Creating Excellence in Crisis Care* contains a wealth of information and resources on a wide range of topics, including diversity, policy setting, certification, fundraising, international standards, networking and much more.

Policy and Practice Implications

The following recommendations derive from the above review of the literature:

1. Nurse educators need to ensure that all students acquire a solid foundation in knowledge and skill development relating to violence prevention, detection and intervention. This will enable them to respond sensitively and effectively to survivors of violence.

2. An approach to teaching and learning that is systematic in nature and emphasizes both didactic and experiential strategies as well as evidence-based practice is important. Such an approach will lead to a better understanding of violence as well as to more sensitive and effective care of survivors than an approach that is incidental or hit and miss.

3. The creation of a supportive learning environment (in particular, a clinical learning environment in which students feel comfortable testing out their knowledge and skill in practice) will lead to feelings of self-esteem and confidence in students' abilities to respond sensitively and effectively to survivors of violence.

4. It is highly recommended that educators use the "feeling" level as a starting point in educating student nurses about violence prevention, detection and intervention. Exploring individual attitudes about violence is essential to helping students recognize their attitudes and understand the values and beliefs on which they are based.

5. A solid theoretical foundation is important for the development of a discipline. With few exceptions, the literature on the education of nurses in the area of violence prevention, detection, and intervention is largely a-theoretical in nature. Given that nursing is essentially a practice-based discipline, it is important to ground the theoretical underpinning of educational programs and research endeavours in concepts from the social sciences and the humanities, victimology, ethics, as well as feminist and critical theory.

6. The preparedness of faculty members varies. Many educators are expected to teach about violence prevention, detection, and intervention with minimal experience in working with survivors of violence. There is a need for curriculum development, train the trainer, and program evaluation workshops directed toward faculty members who are charged with teaching and role modelling in this area of practice.

7. Given that nursing education is grounded in knowledge and skill development that is derived from experience with clients, the process of curricular development and implementation will be enriched by involving grass roots workers and activists in the field of violence prevention. Whenever possible, the involvement of survivors in the development and implementation of learning programs should also be encouraged. Students can benefit greatly by learning from survivors and front line workers who are experienced in the area of violence prevention, detection, and intervention.

8. The literature on the curricular inclusion of issues related to violence prevention, detection, and intervention is in its infancy. Nurse educators and researchers should be encouraged to write about their approaches to teaching and learning, and submit them to health professional journals.

9. Research on the education of nurses in the area of violence is also in its infancy, and it is largely descriptive in nature. Studies are needed on the inclusion of issues related to violence in the curricula of schools of nursing; on the best ways of supporting faculty members who strive to teach in an area where many are under-prepared; and on the effectiveness of educational approaches, including those of a didactic and experiential nature, on perceptions, the acquisition of knowledge, and skill development. Studies are also needed on the effects of nursing education in the area of violence on the health and well-being of survivors.

10. Given the high incidence of violence directed toward the general female population and the fact that the majority of students in nursing are women, it is probable that some students will have a history of abuse. Indeed, they may currently be living in abusive situations. Research is needed to determine the prevalence of violence experienced by students and to identify how they are responding to this reality in their lives.

11. Given that the problem of violence against women, children and older adults requires collaboration among health and social service providers, it is crucial that nursing students learn to work with members of other disciplines to prevent, detect and intervene effectively in situations of actual or potential violence. Without the opportunity to work together as students, it is unrealistic to expect that, upon graduation, nurses and other health and social service providers will automatically come together in collaborative and effective working relationships.

12. Curriculum guides have been created that can provide direction for nurse educators in the development and implementation of programs for students at all levels of practice. Many of these guides are Canadian in origin and were developed under the auspices of federal and provincial governments. They are not, however, widely known by nurse educators. Efforts should be made to ensure that these documents are widely disseminated to all concerned with the pre-service and ongoing education of nurses.

13. There is evidence that curricular goals are directed, at least to some extent, toward ensuring that students and nurses are prepared to write registration and certification examinations. Those educators and administrators who are charged with such examinations should incorporate questions that relate to violence. This is a way of recognizing the importance of this issue to health and well-being and the role of nursing in its prevention, detection and intervention.

14. The Canadian Nurses Association and many of the provincial nursing associations have developed policy statements, ethical guidelines, and standards of practice that support the sensitive and effective response of nurses to survivors of violence. The Canadian Association of Schools of Nursing (CASN) and the Colleges of Applied Arts and Technology (CAATs) in collaboration with deans, directors, leaders from professional nursing organizations, and experts in the field should be encouraged to work together to develop educational policies and guidelines that support the education of nurses in the area of violence prevention, detection, and intervention.

15. The Centres of Excellence for Women's Health and the Research Centres on Family Violence and Violence Against Women, which are located across the country and which are in collaborative relationships with faculty members from schools of nursing, should be encouraged to collaborate on research efforts to investigate the influence of educational outcomes in nursing and other health and social services on the prevention and detection of and intervention in violence.

16. Securing adequate funding is a crucial factor in initiating and maintaining educational programs on violence that are systematic, relevant to various levels of students, and offer content that is both discipline-specific and relevant to working with other disciplines. Since curricula tend to be crowded, and human and material resources may be lacking in global budgets, they are typically dependent on extramural funding. Federal and provincial ministries should consider the possibility of allocating funding for such programs, to help ensure that nurses are well prepared to prevent, detect and intervene in this prevalent public health problem.

17. This review did not investigate in-service and ongoing educational programs on violence prevention, detection, and intervention that have been developed for staff by hospitals and community health agencies other than those that have been documented in the literature. Responses to the letters of inquiry sent to deans and directors of university schools of nursing and to the Executive Directors of the Centres of Excellence for Women's Health and the Research Centres on Family Violence and Violence Against Women suggest that such organizations should be surveyed to develop a more complete picture of the education of nurses in this area of service delivery.

References

American Association of Colleges of Nursing. *Position Paper: Violence as a Public Health Problem*. Washington, D.C., 1999.

Atwood, M. *The Handmaid's Tale*. Boston, MA: Houghton Mifflin, 1986.

Beech, B. "Sign of the times or the shape of things to come? A 3 day unit of instruction on aggression and violence in health settings for all students during pre-registration nurse training", *Nurse Education Today*, 19, 8 (1999): 610-16.

Benner, P. *From Novice to Expert*. Menlo Park, CA: Addison-Wesley, 1984.

Bishop, J, B. Lent. *Woman Abuse Case for Problem Based Learning*. London, ON: Faculty of Medicine, University of Western Ontario, 1993.

Brandt, E.N. Jr. "Curricular principles for health professions education about family violence," *Academic Medicine*, 72, 1 Suppl (1997): S51-58.

Brendtro, M. and H.I. Bowker. "Battered women: How can nurses help?" *Issues in Mental Health Nursing*, 10 (1989): 169-80.

Brown, L. "Workplace violence: experiences of nursing home workers," *Journal of the Ontario Occupational Health Nurses Association*, 18, 2 (1998): 4-10.

Burkell, J. and K. Ellis. *Principles of Effective Anti-Violence Education: A Review of Prevention Literature.* London, ON: Centre for Research on Violence Against Women and Children, 1995.

Byrne, C. "Interdisciplinary education in undergraduate health sciences," *Pedagogue Program for Educational Development,* 3, 3 (1991): 1, 3-8.

Calvert, W.J. "The effects of violence in society upon nursing curriculum imperatives," *ABNF Journal*, 7, 5 (1996): 124-28.

Campbell, J.C. "Ways of teaching, learning and knowing about violence against women," *Nursing and Health Care*, 13, 9 (1992): 464-70.

Campbell, J.C., ed. *Empowering Survivors of Abuse: Health Care for Battered Women and their Children*. Thousand Oaks, CA: Sage, 1998.

Canadian Nurses Association. *Family Violence: Clinical Guidelines for Nurses*. Ottawa, 1992.

Canadian Nurses Association. *Policy Statement on Violence in the Workplace*. Ottawa, 1996.

Canadian Panel on Violence Against Women. *Final Report of the Canadian Panel on Violence Against Women: Changing the Landscape: Ending Violence – Achieving Equality*. Ottawa: Supply and Services Canada, 1993.

College of Nurses of Ontario. *Abuse of clients by registered nurses and registered nursing assistants: Report to council on results of Canada Health Monitor Survey of Registrants*. Toronto: College of Nurses of Ontario, 1993: 1-11.

College of Nurses of Ontario. *Abuse of Nurses: A Guide to Prevention and Management.* Toronto, 1999.

College of Nurses of Ontario. *One is One Too Many*. Rev. ed., Toronto, 1999.

Conroy, P. *The Prince of Tides*. Boston, MA: Houghton, 1986.

Duncan, S., C.A. Estabrooks and M. Reimer. "High rates of violence against nurses: findings of the Alberta nurse survey," *Alberta RN,* March/April 2000.

Featherstone, R. "Alone on the road: safety tips for community nurses," *ONA Vision,* 26, 2 (1999): 27-29.

Fédération des infirmières et infirmiers du Québec. *Research Report on Violence Against Nurses in the Workplace*. Quebec, 1995.

Hanvey, L. and W. Rowe, eds. *Building a Bridge: challenges and opportunities in interdisciplinary HIV/AIDS education. November 30 to December 2, 1996, Ottawa: conference proceedings.* Ottawa: Association of Canadian Medical Colleges, 1997.

Hendricks-Matthews, M., ed. *Violence Education: Toward a Solution*. Kansas City, MO: Society of Teachers of Family Medicine, 1992.

Hoff, L.A. *People in Crisis: Clinical and Public Health Perspectives*. San Francisco: Josey-Bass, 2001.

Hoff, L.A. "Interpersonal violence," In: *Critical Issues in Global Health Care*. Edited by C.E. Koop, C.E. Parsons and M.R. Schwarz. San Francisco, CA: Josey-Bass, 2000.

Hoff, L.A. and K. Adamowski. *Creating Excellence in Crisis Care*. San Francisco, CA: Josey-Bass, 1998.

Hoff, L.A. *Violence Issues: An Interdisciplinary Curriculum Guide for Health Professionals*. Ottawa: Health Canada, 1994.

Hoff, L.A. and M. Ross. "Violence content in nursing curricula: strategic issues and implementation," *Journal of Advanced Nursing,* 21, 1 (1995): 137-42.

Hoff, L.A. and M. Ross. *Violence Against Women and Children: A Curriculum Guide for Nursing*. Ottawa, ON: University of Ottawa, School of Nursing, 1993.

Ireland, L.M. and C. Powell. "Development of an introductory course in child protection," *British Journal of Nursing,* 6, 12 (1997): 686-90.

Kerr, R. "Incorporating violence against women content into the undergraduate curriculum," In: *Violence Against Women: Nursing Research, Education, and Practice Issues.* Edited by C.M. Sampsella, New York, NY: Hemisphere, 1992.

King, M.C. and J. Rya. *Violence Against Women: A Family Health Issue*. *Proceedings of the International Family Nursing Conference*. Calgary, AB: University of Calgary, 1988: 100.

Kiner, H.P. Nursing students' opinions on interpersonal violence. *Journal of Nursing Education*, 34, 7 (1995): 325-31.

Kingston, P., B. Penhale and G. Bennett. "Is elder abuse in the curriculum? The relative contribution of child abuse, domestic violence, and elder abuse in social work, nursing and medicine qualifying curricula," *Health and Social Care in the Community*, 3, 6 (1995): 353-62.

Lachapelle, H. and L. Forest. "Educating nursing students on domestic violence," *The Canadian Nurse*, 93, 9 (1997): 39-44.

Laschinger, H.K. and W. Weston. "Role perceptions of freshman and senior nursing and medical students' attitudes toward collaborative decision making," *Journal of Professional Nursing,* 11, 2 (1995): 119-28.

Lewis, M.L. and D. Dehn. "Violence against nurses in outpatient mental health settings," *Journal of Psycho-social Nursing and Mental Health Services,* 37, 6 (1999): 28-33.

Mandt, A.K. "The curriculum revolution in action: nursing and crisis intervention for victims of family violence," *Journal of Nursing Education,* 32, 1 (1993): 44-6.

McBride, A. "Violence against women: overreaching themes and implications for nursing's research agenda," In: *Violence Against Women: Nursing Research, Education and Practice Issues.* Edited by C.M. Sampsella. New York, NY: Hemisphere, 1992.

Morrison, T. *Beloved*. New York, NY: Alfred A. Knoph, 1987.

Ontario Nurses' Association. *Violence in the Workplace: A Guide for ONA Members*. Toronto, 1995.

Parsons, L.H. and M.L. Moore. "Family violence issues in obstetrics and gynecology, primary care and nursing texts," *Obstetrics and Gynecology,* 90, 4Pt1 (1997): 596-99.

Registered Nursing Association of Nova Scotia. *Violence in the Workplace: A Resource Guide.* Halifax, 1997.

Rice, R. "Home visit safety," *Geriatric Nursing*, 19, 4 (1998): 241-42.

Robinson, S. "Learning about violence: eperiences and views of psychiatric nursing students," *NT Research,* 4, 2 (1999): 101-15.

Rose, M. "A survey of violence toward nursing staff in one large Irish accident and emergency department," *Journal of Emergency Nursing,* 23, 3 (1997): 214-19.

Ross, M.M., L.A. Hoff and H. Bunn. *Discipline Specific and Interdisciplinary Education of Health Professions in the Area of Violence Prevention, Detection and Intervention: A Study of Canadian Faculties of Health Sciences*. Ottawa: University of Ottawa, 2000.

Ross, M.M., L.A. Hoff and G. Coutu-Wakulczyk. "Nursing curricula and violence issues," *Journal of Nursing Education,* 37, 2 (1998): 53-60.

Ross, M. and L.A. Hoff. "The education of health professionals: interdisciplinary curriculum guidelines related to abuse and neglect of older Canadians," In: *Abuse and Neglect of Elderly Canadians.* Edited by M. MacLean. Toronto: Thompson Publishing Co., 1995.

Ryan, J. and C. King. "Woman abuse: educational strategies to change nursing practice," *Clinical Issues,* 4, 3 (1993): 483-92.

Statistics Canada. "The Violence Against Women Survey," *The Daily,* 1993.

Statistics Canada. *CANSIM – Statistical Database Canada 2000* [Online]. Statistics Canada. [cited 1 October 2001]. Available on Internet: <URL: http://www.cna-nurses.ca/pages/resourcesstats/stats_99.htm>.

Sword, W.B., B. Carpio, L. Deviney, et al. "Research brief. Woman abuse: enabling nursing students to respond," *Journal of Nursing Education*, 37, 2 (1998): 88-91.

Theriault, C.A. *Nursing students caught in the oncoming headlights: nursing students describe their experiences with violence and abuse while in nursing school: preliminary report.* Fredericton, NB: Canadian Nursing Students Association, 1995.

Tilden, V.P., T.A. Schmidt, B.J. Limandri, et al. "Factors that influence clinicians' assessment an management of family violence," *American Journal of Public Health,* 84, 4 (1994): 628-32.

Urbancic, J., J. Campbell and J. Humphries. "Student clinical experiences in shelters for battered women," *Journal of Nursing Education,* 32, 8 (1993): 341-46.

Walker, A. *The Color Purple*. New York, NY: Washington Square Press, 1982.

Whitly, G.G., G.A. Jacobson and M.T. Gawrys. "The impact of violence in the health care setting upon nursing education," *Journal of Nursing Education,* 35, 5 (1996): 211-18.

Wielichowski, L., C. Knuteson, B. Ambuel, et al. "A model for collaborative nursing and medical education within the context of family violence," *Journal of Nursing Education,* 38, 1 (1999): 13-16.

Williams, M. "The prevalence and impact of violence and sexual harassment of registered nurses in the workplace," *Chart,* 92, 4 (1995): 5-6.

Woman's Health Office. *Woman abuse curriculum: a multidisciplinary and community-based approach to knowledge facilitation for students in health services and social work*. Hamilton, ON: Faculty of Health Sciences, McMaster University, 1994.

Woodtli, M.A. "Domestic violence and the nursing curriculum: tuning in and tuning up," *Journal of Nursing Education,* 39, 4 (2000): 173-82.

Woodtli, M.A. and E. Breslin. "Violence related content in the nursing curriculum: a national study," *Journal of Nursing Education,* 35, 8 (1996): 367-74.

Woodtli, M.A. and E. Breslin. "Violence-related content in the nursing curriculum: a follow-up national survey," *Journal of Nursing Education,* 41, 8 (2002): 340-48.