ATTITUDES OF A SELECTED POPULATION OF COMMUNITY HEALTH NURSES TOWARD PARENTS OR GUARDIANS WHO PHYSICALLY ABUSE CHILDREN

by

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ABSTRACT

A replication of Reilly's study (1980) was conducted in order to describe the attitudes of community health nurses who work with parents and children toward child abusers; to determine the relationship between the attitudes of the community health nurses and selected social and professional variables; to compare the attitudes of these nurses to the attitudes of the registered nurses studied by Reilly (1980); to compare the attitudes of the community health nurses in the randomly selected group with the attitudes of the community health nurses in the convenience group; and last, to describe the data presented by the community health nurses in regard to their experiences with child abuse.

The population consisted of community health nurses. One sample population of one hundred and fifty-seven subjects was randomly selected from the community health nurses employed by the British Columbia Ministry of Health. A second sample population of fifteen subjects was self-selected from the community health nurses employed in two of the Health Units of Metropolitan Health Services of Greater Vancouver. The attitudes of the community health nurses toward child abusers were measured by a Likert-type Attitudinal Instrument developed by Reilly (1980). Information regarding the selected social and professional variables was obtained by a biographical data sheet also developed by Reilly (1980). Data regarding the community health nurses' experiences with child abuse were collected by open-ended questions. The correlated data from the attitude scores and the background data sheet were analyzed

through the process of inferential analysis and descriptive statistics. Data regarding the subjects' experiences with child abuse were summarized by the process of content analysis and descriptive statistics.

The results of the study revealed that the community health nurses' attitudes toward child abusers were more favorable than unfavorable. This finding substantiated Reilly's (1980) finding regarding registered nurses' attitudes toward child abusers. In addition, it was shown that the variable, whether the subjects have seen an abused child, significantly affected the attitude scores of the community health nurses in the randomly selected group. The study did not support Reilly's (1980) findings that the subjects' present level of education and whether the subjects have met an abusing parent or detected a case of child abuse significantly affected the attitude scores.

The study also found that community health nurses experience a multitude of frustrations in the management of child abuse. In addition, it was found that a significant percentage of the nurses expressed a need for further instruction regarding the treatment of child abuse.

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CHAPTER I

INTRODUCTION

Problem Area

In the last decade, Canadian health care professionals have become increasingly concerned with the prevention of child abuse. The early identification and reporting of the problem have been viewed as the primary means to prevention (McKittrick, 1981). As a direct result of the process of identification and reporting, measures can be taken to assure the child's safety and facilitate the family's entry into a rehabilitative program.

Community health nurses who work with parents and children are in a key position to identify the occurrence of child abuse. The success of community health nurses in the identification of child abuse, however, is dependent, in part, upon their ability to effectively communicate with the abusive parents or guardians.

An objective attitude on the part of the professional toward the abusive parent or guardian is believed to promote effective communication (Helfer & Helfer, 1968; McAnulty, 1975). In contrast, the expression of an unfavorable attitude by a professional is not only detrimental to the communication process, but is also contributory to future abuse of the child (Lipner, 1975).

At this time, there are no available research studies which describe the attitudes of community health nurses toward abusive parents or guardians. It is, therefore, not known whether the attitudes of the

community health nurses tend to facilitate the identification of child abuse.

The literature does describe the subjective views of some authors in regard to registered nurses' attitudes toward child abusers. To illustrate, Kliot (1977) proposed that, generally, registered nurses experience difficulty in dealing with their feelings toward child abusers. Golub (1968) stated that, due to their negative feelings, registered nurses have difficulty in maintaining a professional attitude toward child abusers. Further, it has been pointed out that although registered nurses know that a sympathetic and understanding attitude is important in the management of child abuse, they admit to feeling enmity and antipathy toward child abusers (McAnulty, 1975; Neill & Kaufman, 1976).

In order to determine the attitudes of the registered nurses toward child abusers, Reilly (1980) conducted a research study with registered nurses employed in hospitals in New York City. The findings of this study refute the statements in the literature regarding registered nurses' attitudes. Reilly found that the registered nurses' attitudes toward child abusers were more favorable than unfavorable. In addition, it was found that the registered nurses' attitudes were significantly affected by specific social and professional factors (nurse's present level of education, nursing experience).

What then are the attitudes of community health nurses who work with parents and children toward child abusers? A replication of Reilly's (1980) study will be conducted with a sample population of community health nurses in order to ascertain their attitudes. In addition, the study will examine the significant relationship of selected social and professional factors to the attitudes.

Statement of the Problem

What are the attitudes of community health nurses who work with parents and children toward child abusers?

Purposes of the Study

1. To describe the attitudes of community health nurses who work with parents and children toward child abusers.

2. To determine the relationship between the attitudes of community health nurses toward child abusers and selected social and professional variables.

3. To compare the attitudes of community health nurses who work with parents and children to the attitudes of registered nurses who work in hospital settings, as studied by Reilly (1980).

4. To compare the attitudes of community health nurses toward child abusers in the random group with the attitudes of community health nurses in the convenience group.

5. To describe data presented by the community health nurses in regard to their nursing experiences with child abuse.

The Implications of the Study

This study could have implications for nursing education and service. The research findings will determine attitudes which may indicate a need for inservice education programs for the improvement of nurses' performance in the management of child abuse. These education programs could significantly influence the prevention of child abuse. The attitude instrument could be used a second time to measure changes in the attitudes of nurses after an educational program (Reilly, 1980, p. 108).

As well, the research findings could have implications for curriculum development in schools of nursing.

Justification for the Replication of the Study

The Research Design and Data Analysis of the Study "Attitudes of a Selected Population of Registered Nurses Toward Child Abusers" (Reilly, 1980)

Reilly conducted an exploratory survey in order to (1) describe the attitudes of registered nurses toward child abusers, and (2) measure the relationship between the registered nurses' attitudes and selected social and professional variables.

The sample population of three hundred and eighty-five subjects was drawn from registered nurses employed in seven clinical areas of four hospitals in New York. A stratified, weighted random sampling method was used to select proportionate numbers of registered nurses from the selected clinical areas in the different hsopitals.

The data were collected by the attitude scale developed by Reilly and a background data sheet. This attitude scale is described in detail in a later chapter.

The data were analyzed by a one-way analysis of variance. Using a F-test, a significance level of .05 was used for rejection of the null hypothesis. Scheffe's multiple range tests for comparisons were used to locate pairs of mean scores affecting significantly different variables.

The data analysis indicated that registered nurses' attitudes toward child abusers were generally more favorable than unfavorable. As well, the data revealed that four of the social and professional variables, included in the study, had a significant effect on the subjects' attitudes: present level of education, nursing experience in a psychiatric

setting, and whether the subjects had met an abusing parent or detected a case of child abuse. Attitudes were more favorable for the registered nurses who had a higher level of education (baccalaureate or master's degree), who had nursing experience in a psychiatric setting, and who had met an abusing parent or detected a case of child abuse.

Difference Between the Present Study and Reilly's (1980) Study

The present study differs in the following ways.

First, the sample population of registered nurses is drawn from community health nurses who work with parents and children and who are employed in British Columbia.

Second, the study compares the attitudes of community health nurses in a randomly selected group to the attitudes of the community health nurses in a convenience group.

Third, a comparison of the attitudes of community health nurses who work with parents and children to the attitudes of registered nurses working in hospital settings is included as well.

Fourth, the study presents a description of community health nurses' experiences with child abuse.

Fifth, and last, two questions in the background data sheet developed by Reilly are deleted from the background data sheet used in this study. The two questions that are deleted relate to the registered nurses area of clinical practice and nursing title. These questions were not appropriate to the present study since all subjects work in the community and have the same nursing title (community health nurse).

The Value of the Replicated Study

A replication of Reilly's (1980) study is of value in the following ways. The research findings will describe, with reliability, community health nurses' attitudes toward child abusers. The findings will determine the relationships between the attitudes and the social and professional variables; they may further substantiate Reilly's findings; and data may indicate a need for in-service education programs for improvement in the management of child abuse. Finally, data will be collected regarding community health nurses' experiences with child abuse.

The Use of Reilly's (1980) Instrument in the Proposed Study

Reilly's attitudinal scale and background data sheet were selected for the present study due to the instrument's acceptable level of reliability. Although the instrument has been used with a sample population of registered nurses in New York City, it should be effective in eliciting the atttitudes of a sample population of community health nurses in British Columbia.

Definition of Terms

Attitude: is the summated measure of individual feelings toward parents or guardians who physically abuse their children, as measured by a Likert-type scale (Reilly, 1980).

Registered Nurse: is one who is employed full-time as a registered professional nurse in British Columbia.

Community Health Nurse: is one who is registered full-time as a professional nurse in British Columbia and who is employed by either the Ministry of Health or the Metropolitan Health Services of Greater Vancouver.

Child Abuser: is a parent or guardian who inflicts or allows to be inflicted serious injury upon a child less than 18 years of age or creates or allows to be created a substantial risk of serious physical injury.

Assumptions of the Study

Registered Nurses have attitudes toward child abusers.

Registered Nurses will express truthfully their attitudes toward child abusers.

The Likert-type scale (Reilly, 1980) accurately measures attitudes.

Limitations of the Study

Due to the small sample population, generalizations are confined to the population of community health nurses in British Columbia. The external validity is limited.

CHAPTER II

LITERATURE REVIEW

The literature review contains three parts. The first part presents the definitional, epidemiological, and etiological aspects of the problem. The second presents a discussion of the need for nurses to have an objective attitude toward child abusers as well as the factors which qualify community health nurses to identify child abuse. The third part presents a discussion of attitude as a concept, and three research studies which examine professionals' attitudes toward child abusers.

Definitional Aspect

Kempe (1971) viewed child abuse as the extreme form of a spectrum of non-accidental injury or deprivation of children. It is considered that at one end of the spectrum is the child who is physically abused and has repeated and serious injuries (fractured long bones or a subdural hematoma); at the other end is the child who is passively rejected by deprivation of physical and/or emotional nurturance.

Gil has defined the phenomenon just described, as:

> the intentional, non-accidental use of physical force, or the intentional, non-accidental acts of omission on the part of the parent or other caretaker interacting with the child in his care aimed at hurting, injuring or destroying the child. (p. 6)

As defined, child abuse appears in a range of forms: physical abuse, physical neglect, emotional abuse, and emotional neglect. The focus of the present discussion is limited to physical abuse of children.

It follows from the definition that in determining whether or not a child has been physically abused, one must consider three distinct variables: the physical and emotional appearance of the child, the circumstances accompanying the injury, and the intention of the parent or guardian. Usually, the child's appearance does not provide sufficient evidence to support a diagnosis of child abuse. In this case, the circumstances of the injury must be discussed to determine whether the injury was actually the consequence of an abusive act or an accident. Did the parent or guardian, for example, willfully cause the harm or allow the harm to occur? Did the injury occur through an omission by the parent or the guardian? Also, in determining the cause of the child's injury, one must consider the parent's or guardian's intentions. Was the injury the result of abuse or the use of physical force as a disciplinary measure? If the injury was the result of a disciplinary measure, was the physical force within socially acceptable limits for discipline (Reilly, 1980)?

This information, gathered through the questions developed from the guidelines of the definition, is not the only factor to be considered in assessing whether the parent's or guardian's behavior toward a child is abusive; the professional's judgement concerning the information is crucial to a differentiation between an abusive and accidental injury.

Manifestations of physical child abuse. Child abuse is manifested in the child's physical and behavioral appearance. The physical manifestations include bruises, welts, burns, long bone fractures, dislocations, lacerations, poisoning, depressed skull fractures, hematomas,

brain damage, neurological problems, chronic illness, and death (Gil, 1970; Kempe, 1971; McKittrick, 1981; Maden & Wrench, 1977). These of course are the easiest to assess. Behavioral manifestations which often take less recognizable forms have been observed in many studies. Numerous authors concur that a significant proportion of children who have experienced physical abuse have impaired cognitive functioning and significant social and psychological problems (Maden & Wrench, 1974). One study (Behsid, 1981) found that abused children have lower intelligence, experience more anxiety and depression, and develop less adequate social and personal adjustments than non-abused children. Martin (1980), in a study of a group of fifty children who had been abused, found that thirty of these children had an impaired ability for enjoyment; thirty-one had signs of emotional turmoil (enuresis, poor peer relationships); twenty-six showed obviously low self-esteem, twelve were withdrawn, fearful, and had a low tolerance of frustration; twelve showed resistive tendencies; eleven were hypervigilant toward their surroundings; eleven had marked compulsivity, ten demonstrated pseudo-adult behavior; and nine of thirty-four children had learning problems. (Children with neurological problems, or not yet in school, were not included in this last category.) McKittrick (1981) stated that behavioral manifestations of abuse include indiscriminate seeking of affection, establishment of superficial relationships, emotional and social withdrawal, aggression, and an inadequate self-concept.

The age and sex distribution of physically abused children. At one time, it seemed as though child abuse occurred primarily with infants. Studies have shown that, in fact, abuse occurs through

childhood to the adolescent years. They have also shown that boys are more frequently abused than girls until adolescent years, after which girls are more frequently abused. These findings are presented by a number of authors (Frazer, 1973; Habbish, 1981; Maden & Wrench, 1977). In 1979 in British Columbia, there were 791 reported cases of probable child abuse. In 158 cases, the victims were under 3 years of age; in 319 cases, the victims were 3 to 10 years of age; and in 314 cases, the victims were 11 years and older (Report of the Social Service Ministry, B.C., 1980).

Parents and guardians who physically abuse children. Gil (1970) found that 86 percent of the children studies were abused by a parent or guardian with whom the child was living. Many authors suggest that stepparents, adoptive parents, foster parents or companions, as well as natural parents, physically abuse children (Maden & Wrench, 1977). Matthews (1981) added that teachers, nurses and babysitters may also physically abuse children.

Epidemiological Aspect

There are no accurate national statistics regarding the occurrence of child abuse in Canada. However, based on American statistics, Mary Van Stolk (1973) estimated that approximately 250 children are physically abused per year in Canada. Habbish (1981) also suggested that approximately 250 children per million are physically abused by caretakers each year. In 1977 in British Columbia, there were 791 reported cases of probable child abuse. Furthermore, it is suggested that these figures do not actually reflect the true incidence of the problem: many of the cases are not reported. Reasons for the failure of professionals to report suspected cases of child abuse have been offered by several

authors. Chisholm (1980) has identified five reasons for the failure to report, the foremost being the lack of a standard, useable definition of child abuse. Practically, this means that the types of injuries identified as abuse vary among the Canadian provinces. For example, some provinces regard emotional and physical neglect as abusive; others identify only physical abuse, and yet others suggest that abuse and neglect can occur without a physical injury. The second reason she presents is the variation among the provinces in the reporting systems; 9 of the twelve provinces and territories have a mandatory reporting system, but three provinces have only a monitoring system program. The third reason is the lack of consistent procedures in dealing with child abuse once it is reported. Professionals' uncertainties regarding the procedures and the possible consequences to the family are cited as being a deterrent to reporting. A fourth explanation is a failure to recognize (or acknowledge) child abuse. Lastly, Chisholm mentions the need for professional education regarding the problem.

McKittrick (1981) adds to these explanations her understanding of the factors which hinder professional involvement in child abuse. McKittrick contends that professionals fear that reporting will cause further injury to the child; that they believe that action will not be taken even if the case is reported, especially if abuse has happened in the past; that they are hesitant to assume a change in professional responsibility once a case is reported; that they believe that reporting will impair their relationship with the client by destroying a trust; and that they fear legal entanglements.

Helfer (1975) has also discussed various reasons for physicians' reluctance to become involved in cases of child abuse and, as Reilly

(1980) suggested, these could also apply to the reluctance of other health care providers. Helfer suggested that physicians do not always have the knowledge and skill required to diagnose and treat the problem. In addition, physicians usually do not have training in the interpersonal skills required to investigate suspected child abuse. Also, cases of child abuse may not have been reported because frequently there are inadequate community resources for the treatment of the problem. Physicians, like other professionals, are fearful of a court hearing. Lastly, Helfer suggested that physicians have rarely been trained as change agents and, although some have been effective in promoting change, most try to maintain a positive image in the community by conservatism and support of the status quo.

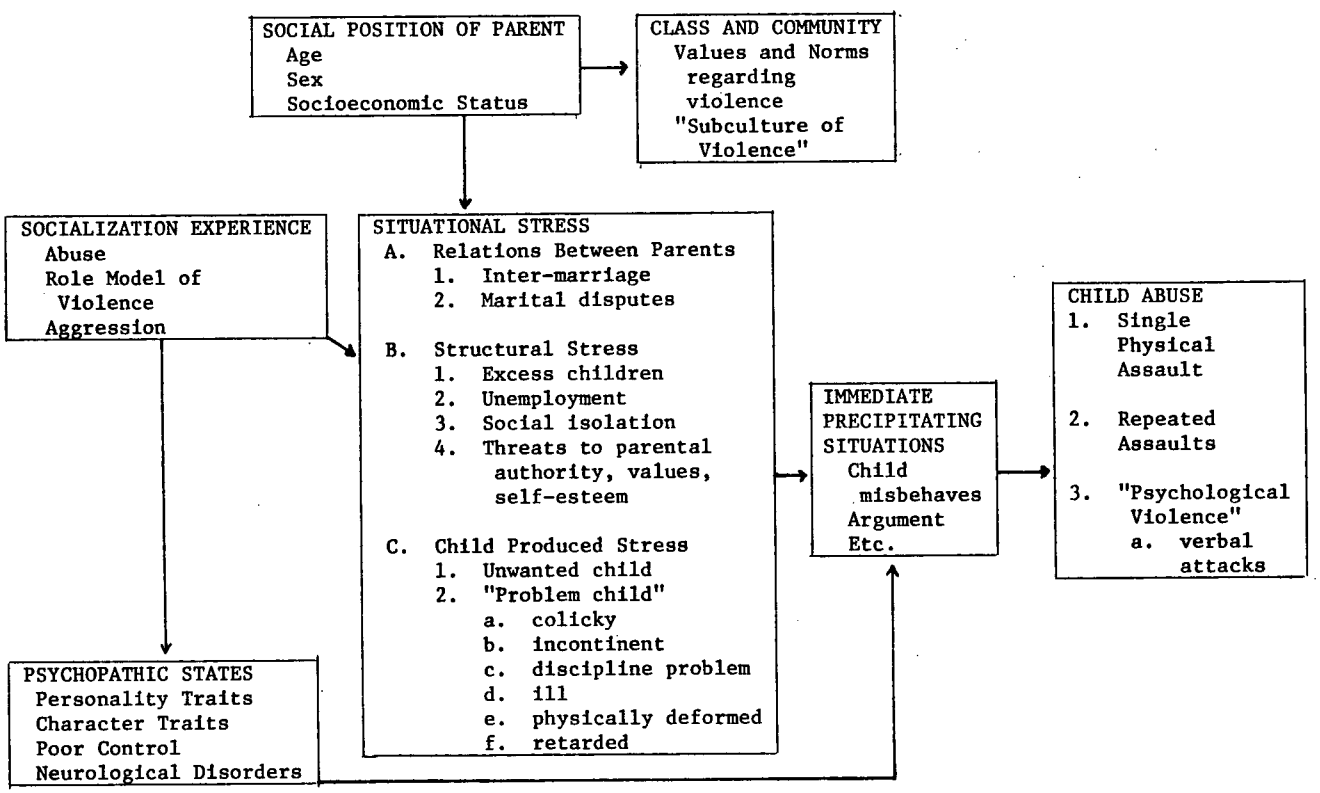
Etiological Aspect

Before initiating a discussion of the etiological factors of child abuse, generalizations found in the literature must first be qualified. For several reasons, the data do not demonstrate the real extent of the problem of child abuse. First, not all of the actual cases are reported or seen in clinical settings. Second, since almost all of the research on child abuse is ex post facto, the analysis of the underlying dynamics of abusive behavior is restricted. Finally, few studies attempt to compare abusive and non-abusive families and, without such a comparison, it is difficult to know with certainty which factors are significant (Spinetta & Rigler, 1972).

Within the restrictive limitations of the data, however, many theories have been formulated to explain the dynamics of the problem. It seems appropriate, therefore, to select a model from Gelles (1973),

Figure 1

Gelles' Social Psychological Model
of the Causes of Child Abuse



Gelles, Richard J. "Child Abuse As Psychopathology: A Social Critique and Reformulation." American Journal of Orthopsychiatry, July 1973, 43 (4).

who in turn has relied on Gil's (1970) empirical research and theoretical formulations in its development. Although the etiological factors and relationships which Gelles' social-psychological model delineates are postulates, it has been adopted as the most suitable, since it permits an examination of the multidimensions of the problem.

It is understandable, in view of Gil's sociological perspective in regard to the causal factors of child abuse, that the social position of the parents (top left box of Figure 1) is prominently recognized. Gil (1970) concluded that "the educational and occupational levels of the abusive parents were very low" (Gil, 1970, p. 860). Indeed, according to several authors, limited education and employment problems are primary causes of abusive behavior (Baldwin & Oliver, 1975; Galdston, 1965; Young, 1964). Gil proposed that the stress of poverty generates frustrations which are vented through the physical abuse of children. Although many support Gil's view, some are less inclined to regard the deprivations caused by poverty as the primary causal factors of child abuse. Steele and Pollock (1968) and Wasserman (1967), for example, found similar abusive behavior in middle and upper class families. Further, Pelton (1978) suggested that abusive behavior toward children occurs in all socio-economic groups; there is, however, a higher incidence of reporting in the lower groups.

Also to be noted, within the social position, are the sex and age of the abusing parent. Generally speaking, studies have shown that more women than men physically abuse children (Bennie & Sclare, 1979; Gil, 1970; Resnick, 1969; Steele & Pollock, 1968), perhaps because normally women have extended caregiving contact. Gil suggested that when the fathers are the caretakers and the women are the financial providers,

then the fathers abuse more frequently. Zalba (1971) found, however, that an equal number of men and women abuse children, regardless of which parent has the most contact.

Gil noted that for women who abuse the average age is twenty-six, and for men it is thirty. Frazer (1973) found that the average age for women is twenty-two, and for men, twenty-eight. However, Reilly (1980) cited a study (Roberts & Adler, 1974) which found that approximately as many adults under twenty years of age abused their children as all other adults together.

According to Gil, "the subculture of violence" prevalent in the lower socio-economic communities lends approval to aggression and violence. This "subculture of violence" is set forth within the class and community factor (top right box of Figure 1). Gil reasoned that because of this cultural value the physical abuse of children is more prevalent among the lower socio-economic groups and contended, again, that poverty generates stress which results directly in child abuse. He suggested also that corporal punishment is used more frequently by parents in the lower classes for discipline, where reason is used by parents in the middle class. Other studies indicated, however, that the corporal punishment of children is equally pervasive among lower and middle class families (Steinmetz, 1974; Strauss, 1971); and, while some authors agreed with his second point (Satlin & Miller, 1971), others (Paulsen & Blake, 1969) disagreed with his emphasis on financial income, educational background and occupational position as primary causal factors in child abuse.

Several authors have shown that the personality traits of the abusive adult are the primary causal factors of the problem (Fontana,

1968; Kempe, 1971; Steele & Pollock, 1968; Wasserman, 1967). These authors suggested that an abusive adult has personality traits which, in the presence of stress, allow for an uncontrollable physical expression of feeling, in the form of child abuse. While this may be true, the literature does indicate that a disproportionate number of reported cases do come from the lower socioeconomic groups. It seems, therefore, that further research is required to determine the significance of the relationship between poverty and child abuse (Maden & Wrench, 1977).

The fact that the majority of families who live in poverty do not abuse their children suggests that environment conditions alone do not adequately account for child abuse; Gelles has therefore included the socialization experience of the parents (middle left box of Figure 1) as an integral aspect of the phenomenon. Studies indicated that a significant number of abusive parents were themselves physically or emotionally abused as children (Fontana, 1973; Gil, 1970; Steele & Pollock, 1968). Consequently, the abusive adult has as a role model a parent who used aggression or violence as a means to resolve a conflict or to discipline children (Spinetta & Rigler, 1972). It seems that abusive parents have learned, through their own childhood experiences, to communicate as adults in an aggressive, abusive manner with children. Also, within this factor of socialization are the adult who abuse their children not so much because they were actually abused but because they have never experienced ". . . sensitive, generous and individualistic care" (Kempe, 1971, p. 30). In either case, child abuse is recognized as a pattern of interaction which is intergenerational.

Possibly due to the interest of physicians in child abuse, the

causal factors have also been described in terms of psychopathology (bottom left box of Figure 1). Early investigators believed child abuse was due to neurotic and psychiatric behavior (Miller, 1959; Woolley & Evans, 1955). In the last two decades, however, the thinking regarding the presence of psychopathology has changed. Kempe, for example, found that approximately only five percent of the cases involve psychosis, either of a delusional or depressive type, and approximately only five percent of the parents are described as psychopathic. Most authors, in fact, support the view that only a small percentage of abusive parents suffer mental illness (Spinetta & Rigler, 1972). Instead, they associate the psychodynamic of child abuse with personality traits which impair the adult's ability to parent effectively. Morris and Gould (1963), for example, found a role reversal between the parent and child, in which the parent was dependent on the child for reassurance, security and love; Steele and Pollock (1968) found that abusive parents have unrealistic expectations for the child and little empathy for its needs and abilities.

On the whole, then, child abuse is regarded as a physical expression of the frustration and anger of a parent when his/her emotional needs are not fulfilled by the child.

Adults and guardians who physically abuse their children. One single, coherent, abusive personality has not been identified. However, the following characteristics have been recognized as common among abusive parents: unmet dependency needs (Green et al., 1974; Melnick & Hurley, 1969; Steele & Pollock, 1968); lack of identity (Elmer, 1967; Green et al., 1974; Steele & Pollock, 1968); impaired impulse control (Cohen, 1966; Smith & Hanson, 1975); rigid or inadequate defenses

(Melnick & Hurley, 1969; Steele & Pollock, 1968); role reversal between spouses (Galdston, 1965).

In an effort to reduce the phenomenon to simple and explicable terms, attempts have been made to cluster the personality characteristics and to evolve a psychodynamic within each cluster. The first endeavor to develop such a typology, and the most frequently quoted, was developed by Merrill (1962). The typology has been summarized and presented by Smith (1976).

Merrill identified three clusters of characteristics found to be true of abusing mothers and fathers, and a fourth found to be true of fathers. The first group of abusive adults was characterized by a continual and pervasive hostility and aggression. The second group was identified by rigidity, compulsiveness, lack of warmth, lack of reasonableness, and a lack of pliability in thinking and belief; these parents were self-righteous regarding their abusive behaviors. The third group showed strong feelings of passivity and dependence; they tended to be depressed and immature. The fourth group was composed of fathers who were young, intelligent and unemployed; the majority remained at home as caretakers. Merrill suggested that the frustration experienced in this arrangement led to the abuse.

Gelles (1973) proposed that the elements of the parents' social position, class and community, socialization experiences and personality traits weave together to produce a potentially abusive situation in which the situational stress (centre box of Figure 1) is only an intensifier. He has delineated situations which could produce stress and his findings are supported by many authors (Ellis & Milner, 1981; Frodi, 1981; Garbarios & Sherman, 1980; Maden & Wrench, 1977; Zalba, 1967).

The last etiological factor to be included is the immediate precipitating situation (right box of Figure 1). For example, a child's refusal of food, or highpitched crying over an extended time, may trigger a crisis which results in an abusive attack. As stated earlier, however, the crisis is secondary to the various factors presented in the model which interrelate to produce the potentially abusive situation.

In order to explain the development of an abusive incident, Reilly (1980) cited an abbreviated summary of events which hypothetically cause child abuse. The citation was developed by Steele (1977) and is as follows:

> As all parents know, crises are a fact of life. . . . Self-confidence, ingenuity, and useful knowledge of how to seek help are necessary to cope with crises. Abusive parents do not have these abilities and any crisis has a greater impact on them. If a crisis cannot be coped with adequately it lasts longer, becomes more distressing, and can develop into an even more serious crisis. Eventually the situation may become disastrous and unmanageable. Parents become pushed beyond their strength, feel desperately helpless and end up abusing the child. (p. 54)

It is clear that there are many controversial problems to be resolved in order to establish the etiological factors of child abuse. Further research is required in order to accomplish this task.

Nurses Need to Have an Objective and Professional Attitude toward Child Abusers

The identification of child abuse is dependent, in part, upon the relationship a nurse develops with an abusive parent or guardian (Helfer & Helfer, 1968). An objective and professional attitude on the nurse's part is critical to the development of the relationship with the parent or guardian.

Helfer (1968) identified the advantage of an objective and professional attitude. He suggested that the abusive parent is usually willing

to co-operate in a discussion of the problem when a professional talks in an open and non-judgemental manner. Understandably, an abusive parent or guardian would feel encouraged to talk more openly if a professional conveyed a sense of understanding and acceptance. In contrast, for example, an abusive parent or guardian, who already felt distrustful and lonely, might well withdraw emotionally and socially from a situation in which a professional expressed, either verbally or non-verbally, an unfavourable attitude. In the latter case, of course, communication is distorted or impeded and the identification of the problem hindered.

Hayes (1981) supported this view by stating that a professional and nurturing attitude facilitates the breakdown of the family's isolation, and thereby promotes communication between the nurse and the parent regarding the problem and the means to its resolution.

Ebeling (1981) proposed that one of the most important steps in the development of this attitude is an understanding of, and an ability to cope constructively with, one's attitudes and feelings toward the family and the problem of child abuse.

Heindl (1981), likewise, suggested that before nurses are prepared to provide quality nursing care to these families, they must first identify their feelings toward the child and the parents, and then recognize and cope with the factors which contribute to their emotional responses.

Even though anger may be a natural response to child abuse (Alexander, 1972), nurses have a responsibility to communicate with a parent or guardian in a professional manner which is based on an insight regarding one's emotions and self-discipline.

To summarize, as Ebeling stated:

> The way we deal with our emotions—and whether or not we maintain objectivity—play a crucial part in being able to help these seriously troubled families. If we are to be helpful, we cannot indulge ourselves by acting upon angry feelings, natural as they might be, towards a parent. (p. 8)

The Qualifications of Community Health Nurses to Identify Child Abuse

Community health nurses who work with parents and children are in a key position to contribute to the prevention of child abuse through the early identification of the phenomenon. Grindley (1981) stated that the nurse is one of the health professionals who is frequently in contact with abused children and their families, and is the logical person to be closely involved in the prevention of child abuse.

There are distinct professional characteristics of community health nurses which qualify them to identify child abuse. The discussion which follows will consider some of these characteristics.

Community health nurses, by virtue of their education, have the ability to assess the needs, the problems, and the coping patterns of individuals and families. That is to say, for example, that these nurses have the ability to judge the normalcy of a child's physical growth and intellectual, emotional, and social development; the age and situational appropriateness of the family's interactional pattern; and, the family's stress level and means of coping. The information gathered from such an assessment by a nurse provides sufficient evidence for her/him to make a decision regarding potential or actual child abuse. In potentially abusive situations, the problems can be corrected before a crisis develops, thus preventing the occurrence of child abuse. In the event that child abuse has occurred, future attacks can be prevented

by therapeutic interventions initiated by the nurse's assessment and identification of the problem.

Community health nurses have a positive image in the community. Heindl (1981) suggested that generally nurses are seen as helping professionals and, therefore, gain a rather immediate acceptance by families who tend to view other professionals with scepticism. One would think, then, that this kind of image and acceptance would facilitate the development of a relationship in which the abusive adult or guardian could discuss, with confidence, the problems which give rise to child abuse. In fact, McKeel (1978) pointed out that the nurse's role in the abusive family cannot be overestimated because of the usefulness of these relationships in the prevention of child abuse.

Reilly (1980) noted that the communication between clients and nurses tends to be natural and positive. She suggested, further, that the minimal tensions of such a relationship promote the constructive interaction necessary to any therapeutic endeavor.

In addition, community health nurses make frequent home and school visits over an extended time. This creates the opportunity for nurses to develop relationships and to make comprehensive individual and family assessments. To illustrate, community health nurses have the opportunity to assess levels of stress for a mother during postpartum visits to the home or to assess a child's social and emotional adjustment during school visits.

Community health nurses have access both to consultative services of professionals in allied disciplines and to the resources of the community. In addition, community health nurses can facilitate the families' utilization of these professional and community resources.

Community health nurses are recognized as being qualified to identify child abuse. Frazer (1973) strongly recommended that community health nurses be requested by physicians to follow children who were suspected of having been abused but where such abuse was not yet proven. Newberger (1975) recommended that nurses' observations should be taken into account in decisions related to the management of child abuse. Lalonde (1974-76) stated that the important role of the public health nurse in identifying child abuse must be recognized, and appropriate measures be taken to ensure that adequate numbers of nurses are available to provide the constant services and surveillance required in the communities they serve (p. 45).

In summarizing the discussion of community health nurses' qualifications, it seems to be suitable to refer to McAnulty who stated:

> A nurse's accurate assessment and acceptance of her responsibility to aid the family and to communicate appropriately with other professionals is crucial to the early diagnosis and treatment of these troubled families. Indeed, the nurse's skilled appraisal and her sensitivity to the situation may determine the speed and efficiency of the family's entry into a system of helping structure . . . (p. 70)

Attitude as a Concept

An attitude is the intensity of a positive or negative feeling toward a psychological object. A psychological object is any symbol, item, person, slogan or phrase toward which individuals can respond differently in regard to positive or negative feelings (Thurstone, 1946).

What then is the composition of an attitude? Shaw and Wright (1967) stated that an attitude is composed of an affective component which is based on a cognitive process. In addition, it is antecedent

to behavior. Rosenberg (1960) illustrated this definition in the following. An individual who encounters a group, and perceives their actions with distrust, develops negative feelings toward the group which, in turn, motivates the individual to avoid the group in the future. Accordingly, the term attitude applies to this positive or negative dimension of the motivation-producing affective reaction (Shaw & Wright, 1967).

It is also important to differentiate between attitudes and beliefs. Beliefs are regarded as an evaluation of a truth or falsehood and, therefore, express a degree of acceptance or rejection. Attitudes, on the other hand, while also evaluative, do not express acceptance or rejection but, rather, express feelings. The expression of feelings is not a component of beliefs (Shaw & Wright, 1967).

"Attitude, in this study, has a unidimensional focus. It solely denotes likes or dislikes" (Reilly, 1980, p. 45). Given that an attitude is composed of feelings toward a psychological object, and not acceptance or rejection, it is unnecessary to attempt an exploration of the subjects' beliefs. In fact, as Thurstone (1946) has pointed out, it is irrelevant whether all subjects even attach the same cognitive meaning to the object in discussion.

Attitudes Toward Child Abuse

Attempts have been made to examine the attitudes of the public and selected professionals toward child abusers. Although, as Reilly (1980) has stated, while purporting to study attitudes the researchers have actually only studied perceptions and beliefs.

The earliest attempt to examine the public beliefs was made by Gil (1970) in his sample survey of the total noninstitutional population, twenty-one

years of age and older in the United States. In the study Gil posed this one question in regard to child abusers: "What should be done with the perpetrators of child abuse?" The analysis indicated that 27.1 percent chose to jail the adult or punish in some other manner; 66.4 percent believed that treatment and close supervision was required; 4.4 percent preferred to leave the family alone, given that the child's injuries were not serious; 1.5 percent of the subjects interviewed disagreed with all of the suggested alternatives, and .4 percent admitted that they did not know what was appropriate. Based on this data it is clear that the public, as represented, has a favorable attitude toward child abusers.

Frazer (1973), in consultation with Gil, studied professional beliefs regarding child abusers. In one aspect of the study, Frazer explored the responses of 128 nurses who practiced in community health or pediatrics to the following two questions. The first question posed was: "What should be done about parents or others who have intentionally injured a child in their care, the first time it is reported?" Slightly more than 15 percent chose to punish the parents with a fine or jail sentence or to remove the child from the home; approximately 39 percent believed that the parents should receive a warning or that the incident should be investigated; and 42 percent recommended that the family receive therapy and supervision. The second question posed was: "What should be done about parents or others who have intentionally injured a child in their care, if it is repeated?" Almost 47 percent chose to punish the parents with a fine or jail sentence, or to remove the child from the home. This response rated almost three times higher than the response to the first question. The percentage of nurses who believed that the parents should receive a warning or that the incident should

be investigated decreased to only seven percent, and the percentage of those who recommended that the family receive therapy and supervision decreased slightly to 37 percent. Obviously, the repetition of injury significantly changes some nurses' beliefs regarding the approach to be used in the management of the problem.

Reilly (1980) also cited a report in which the attitudes of hospital staff toward child abusers (Burns, 1973) were presented. The actual purpose of the report was to evaluate the reporting procedures for child abuse in one county of New York State. As a result of the interviews the attitudes of staff were compiled. The hospital staff included in the interviews were the chief radiologist, directors of nursing, emergency room nurses, maternal-child supervisors and medical and social workers of six hospitals. The attitudes were described as cautious and respectful toward child abusers of the middle socio-economic groups, but angry and punitive toward child abusers from lower socio-economic groups. Furthermore, in summary, the authors of the report concluded from the behavior of the staff that "abused children from lower socio-economic families receive considerable personal attention whereas the parents are deliberately avoided, as if to deny them further responsibility for their children" (p. 48).

The final study (Chang, 1976) to be presented in this discussion was designed to examine physicians' beliefs regarding child abuse and neglect. A nine-item questionnaire was administered to 1367 physicians. Two of the questions were related to beliefs about child abusers. The findings indicated that 29 percent of the physicians who responded believed that a police or social service agency should remove a physically abused child from the parents. Fifty percent believed that a

judicial hearing should be held before taking such action. In the end, however, as Reilly stated, it is not really known whether the responses are more a comment regarding the agencies mandated to protect children's rights, or the rights of parents or guardians who physically abuse children.

CHAPTER III

METHODOLOGY

This study was conducted in order to describe the attitudes of community health nurses who work with parents and children toward child abusers; to determine the relationship between the attitudes of the community health nurses and selected social and professional variables; to compare the attitudes of these nurses to the attitudes of the registered nurses studied by Reilly (1980); to compare the attitudes of the community health nurses in the randomly selected group with the attitudes of the community health nurses in the convenience group; and to describe the data presented by the community health nurses in regard to their experiences with child abuse.

An exploratory descriptive research design (Brink & Wood, 1978) was selected for this study, due to the dearth of literature regarding registered nurses' attitudes toward child abusers. This chapter describes four parts of the methodology - the instrument, sample selection, data collection, and data analysis.

The Instrument

A Likert-type Attitude Scale, developed by Reilly (1980), which measures attitudes toward child abusers, was employed in this study. The scale was composed of thirty-six statements in regard to child abusers. Each statement was followed by a Likert-type five point rating scale (Strongly Agree to Strongly Disagree). Subjects were asked

to respond to each statement by assigning a numerical value to the statement. The numerical values were summated.

A background data sheet accompanied the scale. The data sheet collected information in regard to social and professional variables.

In addition, four open-ended questions were posed in order to provide the subjects with the opportunity to express any of their experiences with child abuse which they considered to be important to the study.

The Development of the Attitude Scale (Reilly, 1980)

Reilly believed that a Likert-type scale of summated scores was most suitable for the task of measuring attitudes toward child abusers since this type of scale permitted a variety of statements to be included, and "the statement used . . . supposedly related and reflected the same attitude" (p. 51).

The scale was generated from two sources: the literature on child abuse, and the responses of forty-five registered nurses to three representative case studies of physical child abuse. After each case, the nurses wrote approximately three sentences which described their feelings toward the child abuser. Respondents also completed the following sentences: (1) "It's a shame child abusers . . ."; (2) "I can't understand why child abusers . . ."; (3) "Seeing a child abuser, I would . . ."; (4) "Speaking to a child abusing parent . . ." (Reilly, 1980, p. 52).

From both of these sources, a pre-pilot instrument of eighty related statements was composed. Approximately half of the statements were worded positively and half worded negatively.

To determine the content validity of each item, the instrument was submitted to ten judges. The judges were requested to rate each statement as to whether it was positive or negative, according to a specific scale.

Based on the statistical analysis of their responses, eighteen positive statements, and eighteen negative statements, which discriminated between favorable and unfavorable attitudes, were compiled.

The instrument was then prepared for a pilot study. The statements were randomly ordered. The positive statements were labeled as sympathy and helpfulness and the negative as enmity and apathy. The response scale was structured as: strongly agree, agree, undecided, disagree, and strongly disagree. A favorable attitude was indicated by a low score: a numerical value of one was assigned to "strongly agree" with successive values assigned to the remaining choices up to five for "strongly disagree". The scores were reversed for the negative statements. Subjects with the most favorable attitudes received a summated score of thirty-six and those with the most unfavorable received one-hundred and eighty.

The Development of the Background Data Sheet (Reilly, 1980)

This questionnaire was developed to obtain data on various social and professional variables. The data in regard to these variables were correlated with the subjects' attitudinal scores to ascertain significant effects of the variables on the attitudinal scores.

The variables were selected from the literature. Four clusters of variables were then formed. The first cluster of questions was related to demographic data, i.e. age, marital status, ethnic background, and

family size. Family background, including childhood religious background and parents' education were included in the second cluster. The questions posed in the third cluster referred to nursing career. And, in the last cluster, fixed dichotomous answers were structured for eight questions regarding experience with child abuse.

The Report of the Pilot Study (Reilly, 1980)

A pilot study was conducted in order to test the reliability of the attitude scale and the clarity of the background data sheet. Two reliability techniques were used. A reliability coefficient of .82 was computed by the split-half method, corrected by the Spearman-Brown Prophecy Formula. In the other, the coefficient alpha was .86. "In addition, an item analysis indicated that the instrument discriminated among persons with high total scores and those with low total scores" (p. 55). The study showed, in addition, that the questions in the background data sheet were understood.

Sample Selection

A sample population of one-hundred and ninety-seven subjects was selected from the registered nurses currently employed as community health nurses in British Columbia. A random sample of one-hundred and fifty-seven community health nurses was selected from the three hundred and fourteen community health nurses employed by the British Columbia Ministry of Health. The names of the nurses were obtained from the Ministry of Health. A convenience sample of thirty community health nurses was self-selected from the community health nurses employed in two of the Health Units of the Metropolitan Health Services of Greater Vancouver. This sample was included as a result of an initial contact made with the Health Units during an early phase in the planning of the study.

Data Collection

One-hundred and fifty-seven instruments and explanatory letters, addressed to individual community health nurses, were mailed directly to the nursing supervisors of the community health nurses employed by the Ministry of Health. The nursing supervisors were asked to forward the instruments to the community health nurses whom they supervised, and to whom the instruments and explanatory letters were addressed.

At the same time, thirty instruments and explanatory letters were mailed directly to the two nursing supervisors of the community health nurses employed by the Metropolitan Health Services of Greater Vancouver. The nursing supervisors were asked to distribute the instruments to the community health nurses interested in participating in the study. The community health nurses who agreed to participate in the study formed the convenience group.

A separate sheet containing the four open-ended questions regarding the community health nurses' experiences with child abuse was attached to and distributed with each instrument. All of the subjects involved in the study received the same instrument and explanatory letters.

The subjects were requested to complete the questionnaire and then forward it directly to the investigator.

Data Analysis

The data obtained from the data background sheet were presented descriptively (Appendix C). Means and standard deviations of the attitude scores are presented for each variable as well as the absolute and relative frequency of responses for each category within the variables.

Significant differences in the attitude scores were computed by a one-way analysis of variance. Using an F-test, a significance level of

.05 was set for rejecting the null hypothesis. Scheffe's multiple range tests for comparisons were used to locate pairs of means scores affecting significantly different variables.

The data collected by the open-ended questions have been summarized by content analysis. The findings for each question have been organized into categories. The frequency of responses to each question, the categories, and the range of remarks within the categories have been tabulated (Appendix D).

CHAPTER IV

DATA ANALYSIS

Chapter IV is divided into two sections. The first section contains an inferential analysis of the data collected by the attitude scale and the biographical data sheet. An analysis for both the random and convenience group is included. The second section presents a description of the data collected by the open-ended questions that were posed regarding experiences with child abuse.

Section I

Eighty-four percent of the subjects in the random group responded to the questionnaire, and fifty percent of the subjects in the convenience group responded. For the total sample in the random group, the mean attitude score was calculated as 71.37 with a standard deviation of 12.57. Individual scores had a range 73 with a median of 71.25. The mean attitude score for the subjects in the convenience group was calculated as 71.53 with a standard deviation of 10.81. Individual scores had a range of 35 with a median of 70.7. In Reilly's (1980) study, the mean attitude score was calculated as 83.34 with a standard deviation of 14.98. The individual scores had a range of 96 with a median of 82.95.

To analyse the data, a one-way analysis of variance, using an F-test, was calculated for each of the nineteen social and professional variables to determine if the mean attitude scores for the various categories

(within the variables) were significantly different at or below the .05 level. Scheffe's multiple testsfor comparisons were used to locate pairs of mean scores affecting significantly different variables.

In addition, descriptive analysis was computed for both groups. The analysis provided the means and standard deviations of the attitude scores, and the frequency and relative frequency of responses to the fixed alternative answers to the nineteen variables. The data was tabulated, and for details refer to Appendix C.

A presentation of the inferential analysis will be made. Headings, corresponding to the nineteen variables, will be used.

Age

Table 1

Analysis of Variance of Raw Scores on the Attitude Scale According to Age (N= 132)

Variable	Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-test
Age	Between Groups	497.8681	4	124.4670	0.778
	Within Groups	20160.3037	126	160.0024	
	Total	20658.1720	130		

To determine if there was a statistically significant difference in the attitude scores of the subjects in the various age categories, a one-way analysis of variance was computed. The results, as shown in Table 1, indicated that there was no significant difference.

Table 2

Analysis of Variance of Raw Scores on the Attitude Scale According to Age (N = 15)

Variable	Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-test
Age	Between Groups	97.4066	4	24.3517	0.158
	Within Groups	1540.3330	10	154.0333	
	Total	1637.7395	14		

As shown in Table 2, the analysis of variance indicated that, at the time of testing, there were no significant differences in the attitude scores of the subjects in the convenience group, according to age.

Reilly (1980) found, as well, that there were no significant differences in the attitudes scores of subjects in the various age categories.

Marital Status

Table 3

Analysis of Variance of Raw Scores on the Attitude Scale According to Marital Status (N = 132)

Variable	Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-test
Marital Status	Between Groups	188.5713	4	47.1428	0.292
	Within Groups	20528.2423	127	161.6397	
	Total	20716.8130	131		

The test for significance, as found in Table 3, revealed that the attitude scores for the subjects in the random group were not significantly different at or below the .05 level, according to marital status.

Table 4

Analysis of Variance of Raw Scores on the Attitude Scale According to Marital Status (N = 15)

Variable	Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-test
Marital Status	Between Groups	221.2711	4	55.3178	0.391
	Within Groups	1416.4641	10	141.6464	
	Total	1637.7351	14		

The results of the analysis, as shown in Table 4, indicated that there is no significant effect of marital status on the attitude scores.

Reilly, likewise, found that the subjects' marital status had no significant effect on the attitude scores.

Ethnic Background

Table 5

Analysis of Variance of Raw Scores on the Attitude Scale According to Ethnic Background (N = 132)

Variable	Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-test
Ethnic Background	Between Groups	902.4385	4	225.6096	1.446
	Within Groups	19814.3730	127	156.0187	
	Total	20716.8120	131		

As evident in Table 5, the test for significance revealed that the attitude scores of the subjects in the random group were not signficantly different at or below the .05 level.

Table 6

Analysis of Variance of Raw Scores on the Attitude Scale According to Ethnic Background (N = 15)

Variable	Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-test
Ethnic Background	Between Groups	32.8003	1	32.8003	0.266
	Within Groups	1604.9275	13	123.4559	
	Total	1637.7278	14		

As with the subjects in the random group, the test for significance indicated that the attitude scores of the subjects in the convenience group were not significantly different at or below the .05 level, Table 6.

Reilly found as well that the subjects' ethnic background had no significant effect on the attitude scores.

Children

Table 7

Analysis of Variance of Raw Scores on the Attitude Scale as to Whether Subjects Have Children (N = 132)

Variable	Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-test
Do You Have Any Children?	Between Groups	17.9998	1	17.9998	0.113
	Within Groups	20698.8083	130	159.2216	
	Total	20716.8083	131		

The data, shown in Table 7, revealed that the variable, children, had no significant effect on the attitude scores.

Table 8

Analysis of Variance of Raw Scores on the Attitude Scale as to Whether Subjects Have Children (N = 15)

Variable	Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-test
Do You Have Any Children?	Between Groups	121.1516	1	121.1516	1.038
	Within Groups	1516.5884	13	116.6606	
	Total	1637.7400	14		

The results of the analysis, as revealed in Table 8, indicated that as in the random group, the variable, do you have any children, had no significant effect on the attitude scores.

Reilly also found that there was no significant difference in attitude score according to this variable.

Number of Children

Table 9

Analysis of Variance of Raw Scores on the Attitude Scale As to the Number of Children (N = 132)

Variable	Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-test
Number of Children	Between Groups	61.6127	3	20.5376	0.134
	Within Groups	8554.3214	56	152.7557	
	Total	8615.9342	59		

The test for significance, Table 9, determined that the differences in attitude scores between the two categories was insignificant.

Table 10

Analysis of Variance of Raw Scores on the Attitude Scale As to the Number of Children (N = 15)

Variable	Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-test
Number of Children	Between Groups	510.8750	3	170.2917	1.694
	Within Groups	402.0000	4	100.5000	
	Total	912.8750	7		

The test results, Table 10, indicated that there was no significant differences in the attitude scores, according to the variable, number of children.

When Reilly performed the one-way analysis of variance, according to this variable, the differences among the groups were not significant.

Childhood Religious Background

Table 11

Analysis of Variance of Raw Scores on the Attitude Scale According to Childhood Religious Background (N = 132)

Variable	Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-test
Childhood Religious Background	Between Groups	216.5169	3	72.1723	0.448
	Within Groups	20307.9469	126	161.1742	
	Total	20524.4640	129		

When the analysis of variance was computed for the random group, Table 11, it was determined that the scores did not differ significantly according to the subjects' religious background.

Table 12

Analysis of Variance of Raw Scores on the Attitude Scale According to Childhood Religious Background (N = 15)

Variable	Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-test
Childhood Religious Background	Between Groups	68.9718	1	68.9718	0.572
	Within Groups	1568.7683	13	120.6745	
	Total	1637.7400	14		

As in the random group, there were no significant differences in the attitude scores in the convenience group, Table 12.

Reilly found also, that childhood religious background did not significantly effect the attitude scores.

Father's Education

Table 13

Analysis of Variance of Raw Scores on the Attitude Scale According to Father's Education (N = 132)

Variable	Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-test
Father's Education	Between Groups	1090.5759	6	181.7626	1.160
	Within Groups	19275.7036	123	156.7130	
	Total	20366.2800	129		

The data, Table 13, indicated no significant difference in attitude scores.

Table 14

Analysis of Variance of Raw Scores on the Attitude Scale According to Father's Education (N = 15)

Variable	Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-test
Father's Education	Between Groups	570.4921	6	95.0820	0.713
	Within Groups	1067.2500	8	133.4063	
	Total	1637.7419	14		

The test of significance, Table 28, revealed that this variable had no significant effect on the attitude scores.

Reilly's study also indicated that there was no such significant effect on attitude scores.

Mother's Education

Table 15

Analysis of Variance of Raw Scores on the Attitude Scale According to Mother's Education (N = 132)

Variable	Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-test
Mother's Education	Between Groups	1090.5759	6	181.7626	1.160
	Within Groups	19275.7036	123	156.7130	
	Total	20366.2800	129		

The results of the one-way analysis of variance, as given in Table 15, indicate no significant difference in the attitude scores.

Table 16

Analysis of Variance of Raw Scores on the Attitude Scale According to Mother's Education (N = 15)

Variable	Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-test
Mother's Education	Between Groups	583.2421	5	116.6484	0.996
	Within Groups	1054.4998	9	117.1666	
	Total	1637.7419	14		

The analysis of variance, Table 16, computed that there was no significant differences in the attitude scores of the subjects in the various age categories.

Reilly's findings revealed the same result for the sample population of registered nurses.

Educational Preparation for Registration

Table 17

Analysis of Variance of Raw Scores on the Attitude Scale According to Educational Preparation for Registration (N = 132)

Variable	Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-test
Educational Preparation for Registration	Among Groups	50.3465	1	50.3465	0.317
	Between Groups	20666.4630	130	158.9728	
	Total	20716.8100	131		

As evident in Table 17, the subjects' educational preparation prior to registration had no signficiant effect on the attitude scores.

Table 18

Analysis of Variance of Raw Scores on the Attitude Scale According to Educational Preparation for Registration (N = 15)

Variable	Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-test
Educational Preparation for Registration	Among Groups	10.6810	1	10.6810	0.085
	Between Groups	1627.0549	13	125.1581	
	Total	1637.7358	14		

The analysis of variance revealed that the educational preparation of the subjects in the convenience group had no significant effect on the attitude scores, Table 18.

Reilly's study indicated as well that differences in attitude score were not significant at the .05 level, according to educational preparation prior to registration.

Present Level of Education

Table 19

Analysis of Variance of Raw Scores on the Attitude Scale According to Present Level of Education (N = 132)

Variable	Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-test
Present Level of Education	Between Groups	689.4457	4	172.3614	1.085
	Within Groups	20021.7038	126	158.9024	
	Total	20711.1490	130		

For the subjects in the random group, the one-way analysis indicated that their present level of education did not significantly effect the attitude scores, Table 19.

Table 20

Analysis of Variance of Raw Scores on the Attitude Scale According to Present Level of Education (N = 15)

Variable	Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-test
Present Level of Education	Between Groups	101.4033	1	101.4033	0.858
	Within Groups	1536.3325	13	118.1794	
	Total	1637.7356	14		

As shown in Table 20, the subjects' present level of education did not significantly effect the attitude scores.

Reilly found however, that the subjects' present level of education had a significant effect on the attitude scores at the .05 level. The results of the Scheffe test indicated that there was a significant difference between the attitude scores of the registered nurses with a diploma, and the registered nurses with a baccalaureate degree or higher. "As the amount of higher education in nursing increased, the average attitude toward child abusers became more favourable" (pp. 70-71).

Years of Nursing Experience

Table 21

Analysis of Variance of Raw Scores on the Attitude Scale According to Years of Nursing Experience (N = 132)

Variable	Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-test
Years of Nursing Experience	Between Groups	597.1004	4	149.2751	0.942
	Within Groups	20119.7127	127	158.4229	
	Total	20716.8130	131		

Analysis of variance determined that for the subjects in the random group, differences in attitude scores were not significant, Table 21.

Table 22

Analysis of Variance of Raw Scores on the Attitude Scale According to Years of Nursing Experience (N = 15)

Variable	Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-test
Years of Nursing Experience	Between Groups	105.6677	2	52.8338	0.414
	Within Groups	1532.0663	12	127.6722	
	Total	1637.7339	14		

For the subjects in the convenience group, as well, the analysis of variance determined that the differences in attitude scores were not significant, Table 22.

Reilly had the same finding in her study.

Formal Instruction in Child Abuse

Table 23

Analysis of Variance of Raw Scores on the Attitude Scale According to Formal Instruction in Child Abuse (N = 132)

Variable	Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-test
Formal Instruction in Child Abuse	Between Groups	64.5564	1	64.5564	0.403
	Within Groups	20645.2927	129	160.0411	
	Total	20709.8520	130		

The data, Table 23, indicate that the attitude scores do not differ significantly according to whether the subjects received formal instruction in child abuse.

Table 24

Analysis of Variance of Raw Scores on the Attitude Scale According to Formal Instruction in Child Abuse (N = 15)

Variable	Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-test
Formal Instruction in Child Abuse	Between Groups	32.0234	1	32.0234	0.259
	Within Groups	1605.7131	13	123.5164	
	Total	1637.7366	14		

As evidenced in Table 24, the attitude scores did not differ significantly.

Reilly's study also indicated that the attitude scores did not differ significantly according to the variable, formal instruction in child abuse.

Having Seen an Abused Child

Table 25

Analysis of Variance of Raw Scores on the Attitude Scale According to Having Seen an Abused Child (N = 132)

Variable	Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-test
Seen an Abused Child	Between Groups	1309.6731	1	1309.6731	8.773
	Within Groups	19407.1398	130	149.2857	
	Total	20716.8130	131		

The data presented in Table C-25, Appendix C indicates that the subjects who have seen an abused child have a more favourable attitude toward child abusers. There is an almost twelve point difference in the mean attitude scores of the subjects in the two categories; have seen an abused child, and have not seen an abused child. The one-way analysis of variance, Table 25, determined that the differences in the attitude scores was significant.

Table 26

Analysis of Variance of Raw Scores on the Attitude Scale According to Having Seen an Abused Child (N = 15)

Variable	Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-test
Seen an Abused Child	Between Groups	14.0432	1	14.0432	0.112
	Within Groups	1623.6914	13	124.8993	
	Total	1637.7346	14		

In the convenience group, there was no significant difference in the subjects' attitude scores, Table 26.

Reilly's study also indicated no significant difference in scores according to this variable.

Physically Abused As a Child

Table 27

Analysis of Variance of Raw Scores on the Attitude Scale As to Whether Subjects Were Physically Abused As a Child (N = 132)

Variable	Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-test
Physically Abused As a Child	Between Groups	327.5791	1	327.5791	2.089
	Within Groups	20389.2367	130	156.8403	
	Total	20716.8160	131		

According to the results of the analysis of variance, the differences in attitude scores were not significant, Table 27.

Table 28

Analysis of Variance of Raw Scores on the Attitude Scale As to Whether Subjects Were Physically Abused As a Child (N = 15)

Variable	Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-test
Physically Abused As a Child	Between Groups	60.8113	1	60.8113	0.501
	Within Groups	1576.9277	13	121.3021	
	Total	1637.7390	14		

For the subjects in the convenience group, the variable, physically abused as a child, had no significant effect on the attitude scores, Table 28.

Reilly found as well, that there was no significant difference in the attitude scores for the two categories.

Nursed an Abused Child

Table 29

Analysis of Variance of Raw Scores on the Attitude Scale As to Whether Subjects Have Provided Nursing Care to an Abused Child (N = 132)

Variable	Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-test
Nursed an Abused Child	Between Groups	9.0190	1	9.0190	0.057
	Within Groups	20707.7935	130	159.2907	
	Total	20716.8130	131		

The results, Table 29, indicate no significant difference in attitude scores.

Table 30

Analysis of Variance of Raw Scores on the Attitude Scale As to Whether Subjects Have Provided Nursing Care to an Abused Child (N = 15)

Variable	Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-test
Nursed an Abused Child	Between Groups	6.5388	1	6.5388	0.052
	Within Groups	1631.1992	13	125.4769	
	Total	1637.7380	14		

The analysis of variance, Table 30, indicates that for the subjects in the convenience group as well, the variable, nursed an abused child, had no significant effect on the scores.

Reilly determined that differences in scores, according to this variable, were not significant.

Contact With a Child Abuser

Table 31

Analysis of Variance of Raw Scores on the Attitude Scale As to Whether Subjects Have Had Contact With a Child Abuser (N = 132)

Variable	Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-test
Contact With a Child Abuser	Between Groups	127.2058	1	127.2058	0.803
	Within Groups	20589.6078	130	158.3816	
	Total	20716.8140	131		

One-way analysis of variance, Table 31, determined that there was no difference in the scores.

Table 32

Analysis of Variance of Raw Scores on the Attitude Scale As to Whether Subjects Have Had Contact With a Child Abuser (N = 15)

Variable	Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-test
Contact With a Child Abuser	Between Groups	277.5423	1	277.5422	2.653
	Within Groups	1360.1912	13	104.6301	
	Total	1637.7334	14		

As for the subjects in the random group, the test for significance indicated no difference in the attitude scores of the subjects in the convenience group, Table 32.

Reilly found, however, that the difference in attitude scores was significant at the .01 level.

Detected Child Abuse

Table 33

Analysis of Variance of Raw Scores on the Attitude Scale As to Whether Subjects Have Detected Child Abuse (N = 132)

Variable	Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-test
Detected Child Abuse	Between Groups	15.9341	1	15.9341	0.099
	Within Groups	20693.9136	129	160.4179	
	Total	20709.8480	130		

The data in Table 33 indicates that there is no significant effect of the variable, detected child abuse, on the attitude scores of the subjects in the random group.

Table 34

Analysis of Variance of Raw Scores on the Attitude Scale As to Whether Subjects Have Detected Child Abuse (N = 15)

Variable	Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-test
Detected Child Abuse	Between Groups	12.8444	1	12.8444	0.103
	Within Groups	1624.8884	13	124.9914	
	Total	1637.7327	14		

Again, the results indicate no significant difference in attitude scores between the two categories, Table 34.

Reilly found that according to whether subjects had detected child abuse there was a significant difference in attitude scores at the .05 level.

Reported Child Abuse

Table 35

Analysis of Variance of Raw Scores on the Attitude Scale As to Whether Subjects Had Reported Child Abuse (N = 132)

Variable	Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-test
Reported Child Abuse	Between Groups	7.1854	1	7.1854	0.045
	Within Groups	20709.6291	130	159.3048	
	Total	20716.8140	131		

The data indicated no significant difference in attitude scores, Table 35.

Table 36

Analysis of Variance of Raw Scores on the Attitude Scale As to Whether Subjects Had Reported Child Abuse (N = 15)

Variable	Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-test
Reported Child Abuse	Between Groups	58.8036	1	58.8036	0.484
	Within Groups	1578.9314	13	121.4563	
	Total	1637.7349	14		

The data reveal that the variable, reported child abuse, had no significant effect on the attitude scores of the subjects in the volunteer group, Table 36.

Reilly also found that this variable had no significant effect.

Court Hearing in Regard to Child Abuse

Table 37

Analysis of Variance of Raw Scores on the Attitude Scale As to Whether Subjects Have Been Involved in a Court Hearing in Regard to Child Abuse (N = 132)

Variable	Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-test
Court Hearing in Regard to Child Abuse	Between Groups	248.2785	1	248.2785	1.577
	Within Groups	20468.5331	130	157.4503	
	Total	20716.8120	131		

There was no significant effect in the attitude scores of the subjects

in the random group, according to subject's involvement in a court hearing in regard to child abuse, Table 37.

And, the test for significance performed on the subjects in the convenience group showed the same result, Table 38.

Table 38

Analysis of Variance of Raw Scores on the Attitude Scale As to Whether Subjects Have Been Involved in a Court Hearing in Regard to Child Abuse (N = 15)

Variable	Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-test
Court Hearing in Regard to Child Abuse	Between Groups	0.5203	1	0.5203	0.006
	Within Groups	1022.2490	11	92.9317	
	Total	1022.7693	12		

Reilly, likewise, found that involvement in a court hearing in regard to child abuse had no significant effect on the attitude scores.

In addition, Reilly performed a one-way analysis of variance according to the variables; clinical areas of nursing, years of practice in the clinical area (of current practice), and nursing title. The results of the test indicated that registered nurses practicing in a psychiatric setting have the most favorable attitudes, and that the registered nurses' titles (Head Nurse, Staff Nurse) and years of clinical practice had no significant effect on the attitude scores.

Section II

This section of the chapter presents the content analysis of the open-ended questions. The presentation includes both the frequency of responses to each question plus the categories derived through the analysis of the responses. For further details regarding the analysis refer to Appendix D.

As previously indicated, the questions were posed in order to provide the community health nurses with the opportunity to express any of their experiences in regard to child abuse, which they considered valuable to this study.

The Content Analysis Derived From the Responses of the Subjects in the Random Group (N = 132)

Frustrations Experienced by the Community Health Nurses in Dealing with Child Abuse

Eighty-five percent of the subjects responded to this question. Twelve categories were identified in regard to the source of the frustration. The following is a list of the categories: the need for education of the public and allied professionals regarding child abuse; communication problems; inadequate provision of professional treatment and community resources; limitations in the child protection laws and problems related to the judicial system; factors related to the families; general beliefs regarding the right of parents and child-rearing practices; professional attitudes and feelings that hinder management of the problem; limitations in the role of the community health nurse; need for preventative programs for child abuse; reluctance of neighbors to report suspected child abuse; reluctance of professionals to report suspected child abuse; and, the fact that child abuse is difficult to prove.

The Agencies Identified as the Most Helpful in Assisting the Community Health Nurses in the Management of Child Abuse

Eighty-one percent of the community health nurses identified the agencies that they considered to be the most helpful in the management of child abuse. Since many of the communities throughout British Columbia do not have some of the agencies identified by the subjects, the response rate for each agency will not be presented. The agencies are as follows: Ministry of Human Resources; Child Abuse Team; Mental Health Centre; school personnel; police; family physicians; social workers; colleagues in community health nursing; counsellors; Help Line for Children; Transition Houses; Home Maker Services; Crisis Centres; Parents-In-Crisis; Family Life Association; Volunteer Groups; churches; Child Development Centre; other Ministry of Health personnel; Health Units; hospital; Family Support Systems; Post-partum Depression Group; Local Youth Services Group; Day Care with Parent Group Training.

Community Health Nurses' Perceptions Regarding Whether They are Adequately Informed on Child Abuse for the Management of the Problem

Eighty-three percent of the community health nurses responded to this question. Thirty-four percent of the respondents indicated that they were adequately informed for the fulfillment of present nursing responsibilities. Forty-one percent indicated the opposite. Fifteen percent of the subjects suggested that they were informed regarding child abuse, but would require assistance in order to provide nursing care to an abused child and the family. Eighteen percent of the subjects suggested that they were informed, but could use more information on the subject. And, one community health nurse was undecided.

Comments

Forty percent of the community health nurses included comments. The categories that were identified in the content of the responses are as follows: the need for a standard definition; need for a team approach; need for preventative measures; need for professional education; need for research; perceived difficulties in assisting families; child abuse perceived as a social worker's problem; need for a specialized worker; the problem of sexual abuse; the problem of emotional abuse and neglect; need for community resources; need for mandatory reporting; and remarks regarding the questionnaire.

Content Analysis Derived from the Responses of the Subjects in the Convenience Group (N = 15)

Frustrations Experienced by the Community Health Nurses in Dealing with Child Abuse

Seventy-five percent of the community health nurses responded to this question. Seven categories were identified in the content of the responses. The categories are as follows: communication problems; inadequate provision of professional treatment and community resources; public and professional attitudes toward children and child abuse; need for preventative programs for child abuse; behavior and attitudes of family toward treatment; and, the fact that child abuse is difficult to prove.

The Agencies Identified as the Most Helpful in Assisting the Community Health Nurses in the Management of Child Abuse

Sixty-nine percent of the community health nurses responded to this question. The agencies identified are as follows: Ministry of Human Resources; Child Abuse Team; Mental Health Centres; Parents-in-Crisis;

Health Units; Family Services; Ministry of Education; Chesterfield House; Schools; Carefree Society; Home Maker Services; Children's Aid Society; and Family Support Workers.

Community Health Nurses' Perceptions Regarding Whether They are Adequately Informed on Child Abuse for the Management of the Problem

This question was answered by one hundred percent of the subjects. Almost fifty-three percent indicated that they were adequately informed to fulfil present nursing responsibilities. Twenty-three percent indicated the opposite. Twenty-three percent indicated that they were fairly well informed.

Comments

Twenty-three percent of the subjects included comments. The categories identified in the content of the responses are as follows: the role of the community health nurse in the treatment of child abuse; a need for qualified professionals; and, remarks regarding the questionnaire.

The categories identified by the community health nurses in the random group and the convenience group are similar. Based on this data, it would seem that there is no appreciable difference between the experiences of the subjects in the two groups.

CHAPTER V

SUMMARY, DISCUSSION, CONCLUSIONS AND IMPLICATIONS

Summary and Discussion

An exploratory descriptive study was conducted to describe the attitudes of community health nurses who work with parents and children toward child abusers, and to determine the relationship of selected social and professional variables to the attitudes. In addition, the findings of the present study were compared to Reilly's (1980) study and the data concerning the community health nurses' experiences regarding child abuse was described and tabulated.

A sample population of one-hundred and ninety-seven subjects was selected from the registered nurses currently employed as community health nurses in British Columbia. A random sample of one-hundred and fifty-seven community health nurses was selected from the community health nurses employed by the British Columbia Ministry of Health. A convenience sample of thirty community health nurses was self-selected from the community health nurses employed in two of the Health Units of the Metropolitan Health Services of Greater Vancouver.

The attitudes of the selected community health nurses were measured by the Likert-type attitudinal scale and background data sheet developed by Reilly (1980). Four open-ended questions were posed in order to collect data related to the community health nurses' experiences with child abuse.

Almost seventy-five percent of the community health nurses responded

to the questionnaire. This suggests that the issue addressed in this study is regarded by the community health nurses as relevant to the practice of nursing in the community.

The reliability of the instrument (Reilly, 1980) with the sample of community health nurses was found to have a coefficient alpha of 0.88. This indicated that the instrument was consistently measuring the attitudes that it was designed to measure.

The Findings of the Inferential and Descriptive Analysis for Both the Random and Convenience Groups

The research findings determined that the attitudes of community health nurses toward parents or guardians who physically abuse their children were more favorable than unfavorable. This was found to be true for the community health nurses in both the random and convenience groups. This finding refuted the statement in the literature which suggested that registered nurses feel enmity and antipathy toward child abusers.

The study also determined that there was a significant relationship between the variable, whether subjects have seen an abused child, and the attitude scores. That is, the scores of the subjects in the random group who had seen an abused child were significantly more favorable than the scores of the subjects who had not seen an abused child. The experience of seeing an abused child influenced, in a positive direction, the development of the community health nurses' attitudes toward child abusers.

It is interesting to note that, in comparison, three variables - education prior to registration, present level of education, and formal instruction regarding child abuse - did not significantly affect the

attitude scores. That is, these educational experiences did not significantly influence the development of the community health nurses' attitudes toward child abusers.

The differing effects of these educational experiences (seeing an abused child and, for example, education prior to registration) in regard to the development of attitudes is appreciable when it is recalled that Shaw and Wright (1967) stated that an attitude is composed of an affective component that is based upon a cognitive process. Accordingly, it is reasonable to think that a more favorable attitude toward child abusers would be shaped by educational experiences that address the affective domain of learning (seeing an abused child). In essence, this finding supports the belief that learning through experiences that address the affective domain is a more powerful means to the development of attitudes than learning through experiences that address only the cognitive domain.

Specific information regarding the nature of this experience in relation to the development of favorable attitudes toward child abusers is required. This information would be useful to educators in planning learning experiences for students in nursing.

For the convenience group, the test for significance computed that there were no significant relationships between the variables and the attitude scores.

The Finding of the Descriptive Analysis of the Attitude Scores and the Variables

Three interesting observations were made, based on the descriptive analysis of the correlated data from the attitude scores and the biographical data.

First, there was a wide variation in the attitude scores of the seven subjects in the random group who had been physically abused as children. It would seem that the impact of this childhood experience has either a noticeably positive or negative effect upon the community health nurses' attitudes toward child abusers. Variables yet to be identified could also account for the wide variation.

Second, a considerable proportion of the community health nurses have detected and/or reported child abuse (Table C-32-35, Appendix C). This strongly supports the belief that community health nurses are in a key position to identify child abuse. It would be reasonable to suggest that their attitudes toward child abusers have facilitated the identification of the problem.

Third, it was found that although community health nurses are actively involved in the detection and/or reporting of child abuse, only a small percentage (Table C-36, Appendix C) have been involved in a court hearing. This raises a question as to the exact contributions made by the role of the nurse in the decision-making process within the formal legal system (i.e. court hearing).

Comparison of the Findings of the Present Study to the Finding of Reilly's (1980) Study

This study further substantiated Reilly's finding that the registered nurses' attitudes toward child abusers are more favorable than unfavorable. In fact, the attitude scores for the community health nurses were more favorable than the attitudes of the registered nurses studied by Reilly.

A twelve point difference separated the mean attitude scores for the two samples of registered nurses. (The attitude scores of the

subjects' random and convenience groups were the same.) The difference in the scores could be a function of demographics, or variations in the experiences of registered nurses in community and hospital settings.

The findings of the present study differ from Reilly's study in two respects. First, Reilly found that the subjects' present level of education had a significant effect on the attitude scores. To explain, registered nurses who had received a baccalaureate degree had a more favorable attitude toward child abusers than the registered nurses who had received a diploma. With the sample investigated in the present study, it was computed that the community health nurses who had received a diploma had the same attitude score as the community health nurses who had received a baccalaureate degree. The discrepancy in the findings of the two studies could be viewed as a function of differences in the educational experiences of the two samples. For example, opportunities for experiential learning in regard to treatment of abusive children may have been provided for a significant proportion of the subjects in Reilly's study. The discrepancy could also be a function of differences in the two groups of registered nurses.

Second, Reilly found that the attitude scores of the registered nurses were significantly more favorable when the subjects had met an abusive parent or detected a case of child abuse. In the present study, however, these relationships were found to be not significant. Further data is required in order to understand this difference in the findings of the studies.

Descriptive Findings of the Open-Ended Questions

The data provided information regarding the community health nurses' experiences with child abuse. The content of the experience for the

subjects in the random and convenience groups was essentially the same. Therefore, the summary reflects the experiences of the subjects in both groups.

Eighty-six percent of the community health nurses have clearly identified a variety of concrete factors which they have perceived as the primary sources of frustration in the management of child abuse.

Examples of the factors included the following: the need for education of the public, allied professionals and abusive families regarding the phenomenon of child abuse; the unavailability or inaccessibility of adequate professional treatment and community resources for the families; communication problems between health care professionals; limitations in the role of nursing regarding treatment of the problem; and frustration arising from a lack of monetary resources.

The content of these responses conveyed to the author a sense of powerlessness on the part of the community health nurses in response to the frustrations.

An examination revealed that the community health nurses' frustrations are based not only on these factors considered in isolation, but also on varying combinations of these factors as they interact. Furthermore, it is clear that these factors also hinder the prevention and treatment of child abuse. In recognition of this, the significance of the factors identified by the community health nurses assume an additional weight.

In an attempt to alter effectively the impact of the community health nurses' role in the prevention of child abuse, a critical investigation is required to ascertain more precisely the issues and problems experienced by the nurses in the management of child abuse.

The community health nurses identified the agencies that have been the most helpful in the management of child abuse. The Ministry of Human Resources was frequently regarded as helpful in that the investigation of reported cases of child abuse is within the mandate of this Ministry. Mental Health Centres, Parents-in-Crisis and school personnel were also frequently cited as helpful.

Also, more than one-half of the community health nurses indicated that formal instruction regarding therapeutic approaches to the problem of child abuse would be necessary if they were to assume additional responsibility in the treatment of these families (i.e. counselling).

Eight percent of the subjects provided comments on the structure of the questionnaire. These comments were predominantly related to the fact that a definition of child abuse had not been included. The belief was expressed by these subjects that more precise responses to the statements may have been possible if a specific abusive situation could have been visualized through a definition. It seems necessary at this time to examine the validity of this comment in relation to the findings of the study. It will be recalled from earlier discussion that Thurstone (1946) clearly indicated that it is irrelevant, in the measurement of a group's attitude, whether the issue in discussion has the same cognitive meaning for each of the subjects. Thus, although the subjects in this study may have had a range of visions in relation to the statements, the attitude scores do reflect the subjects' likes and dislikes regarding child abusers, as intended by the design of the instrument.

Conclusions

Based on these findings, the researcher concluded the following points:

1. The attitudes of the community health nurses toward child abusers were more favorable than unfavorable.

2. A significant relationship exists between the subjects' attitude scores and the variable, whether the subjects have seen an abused child.

3. Community health nurses are, in fact, in a key position to identify child abuse since a high percentage have detected and reported child abuse.

4. The community health nurses experience various frustrations in the management of child abuse.

5. The factors that cause the frustrations for the community health nurses may also hamper the prevention and treatment of child abuse.

6. Many community health nurses require additional formal instruction in order to provide comprehensive nursing care to these families.

Implications for Nursing Education

The research findings have implications for the development of nursing curricula and nursing in-service education programs.

The study found that the experience of seeing an abused child signifcantly affected the development of favorable attitudes on the part of the community health nurses toward child abusers. This finding directs attention to the need for nurse educators to plan learning experiences that expose students in nursing or community health nurses to clinical services that provide treatment for abused children and their families. Such exposure should provide learning experiences that would foster development of an objective attitude toward child abusers.

An appreciable proportion of the community health nurses expressed the need for additional formal instruction regarding the management of child abuse. This implies the need for nursing in-service education programmers to focus attention on the preventative and treatment aspects of child abuse; also, specific attention should be directed to the modes of nursing practice in the prevention and treatment of the problem.

It is known that the presence of an objective attitude toward child abusers is crucial to the prevention and treatment of child abuse. Further, it is recognized that the development of an objective attitude has its beginnings in a planned educational process. Nurse educators therefore have a particular responsibility to begin and nurture the development of such attitudes.

Implications for Nursing Research

The research findings have the following implications for future nursing research.

First, the study indicated that the experience of seeing an abused child affected the attitude scores. This finding has implications for nursing education in regard to the planning of learning experiences which effectively foster the development of favorable attitudes toward child abusers. Prior to planning these experiences, however, additional information is required in regard to the specific aspects of the experience of seeing an abused child which are critical to the development of a favorable attitude toward child abusers. Further study regarding this experience will be needed to obtain this information.

Second, the community health nurses experience a multitude of frustrations in relation to the management of child abuse which often hinder

the prevention and treatment of child abuse. In order to alter the role of the community health nurse in the management of child abuse, and thereby facilitate prevention and treatment of the problem, a critical investigation is required to determine precisely the issues and problems experienced by community health nurses in the management of child abuse.

As a final remark, the author reinforces the value of a replicated study. As a consequence of this study, research findings (Reilly, 1980) have been substantiated and light has been shed upon further dimensions of the phenomenon under study. The benefit of this study to the quality of nursing care delivered to abused children and their families depends upon the utilization of these findings in nursing research, education and practice.

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APPENDIX A

ATTITUDE SCALE TOWARD PARENTS OR GUARDIANS
WHO PHYSICALLY ABUSE THEIR CHILDREN

The purpose of this questionnaire is to determine nurses' feelings toward parents or guardians who physically abuse their children. The findings of the study could have implications for the nursing management of child abuse.

Instructions

Please circle the number on the attached Answer Sheet which best represents your feelings regarding each statement. All statements concern parents or guardians who physically abuse their children. Please try to avoid the undecided category unless this clearly represents your feelings.

The numbers on the Answer Sheet correspond to the following:

1 = Strongly Agree
2 = Agree
3 = Undecided
4 = Disagree
5 = Strongly Disagree

1. Parents who have physically abused their children should be given a life sentence.
2. Helping child abusers would be satisfying work.
3. Given the opportunity, I would verbally attack an abusive parent.
4. Child abusers deserve as much help as anyone else.
5. One can sympathize with the parent who physically abuses his or her child.
6. Child abusers enjoy hurting their kids.
7. Given the chance, I would help a parent stop abusing his or her child.
8. Child abusers don't deserve to have children in the first place.

1 = Strongly Agree
2 = Agree
3 = Undecided
4 = Disagree
5 = Strongly Disagree

9. It is impossible to sympathize with an abusive parent.

10. With a little help, abusive parents can resume normal parental duties.

11. One could say, "Once a child abuser, always a child abuser."

12. Parents who abuse their children are psychotic.

13. Child abusing parents can be helped successfully.

14. Child abusers should be locked up.

15. I would not apeak to someone who has physically abused a child.

16. Abusive parents need as much loving care as their physically abused child.

17. Child abusers sincerely want to stop hurting their children.

18. Child abuse is sinful.

19. Child abusers don't want any help.

20. Child abusers are only doing what was done to them as children.

21. I would help abusive parents work out their problems.

22. What child abusers do to their children is unforgiveable.

23. Stiff legal penalties should be imposed on abusing parents.

24. You have to feel sorry for the child abuser.

25. One could offer comfort to a child abuser.

26. Parents who abuse their children should be treated as criminals.

27. Child abusers don't know how to show their love for their children.

28. Child abusers should be made to feel that they can ask for help without being criticized.

29. Child abusers won't stop hurting their children unless you have them arrested.

1 = Strongly Agree
2 = Agree
3 = Undecided
4 = Disagree
5 = Strongly Disagree

30. Child abusers should be made to feel worthwhile.

31. It's a shame that child abusers don't receive more understanding.

32. Once physically abused, a child should be permanently removed from the home.

33. Child abusers should be sterilized.

34. Helping abusive parents would be a worthwhile experience.

35. A child abuser should not be made to feel like a criminal.

36. It is pointless to help abusing parents.

ANSWER SHEET

Attitude Scale Toward Parents or Guardians
Who Physically Abuse Their Children

1 = Strongly Agree
2 = Agree
3 = Undecided
4 = Disagree
5 = Strongly Disagree

(1)	1	2	3	4	5	(19)	1	2	3	4	5
(2)	1	2	3	4	5	(20)	1	2	3	4	5
(3)	1	2	3	4	5	(21)	1	2	3	4	5
(4)	1	2	3	4	5	(22)	1	2	3	4	5
(5)	1	2	3	4	5	(23)	1	2	3	4	5
(6)	1	2	3	4	5	(24)	1	2	3	4	5
(7)	1	2	3	4	5	(25)	1	2	3	4	5
(8)	1	2	3	4	5	(26)	1	2	3	4	5
(9)	1	2	3	4	5	(27)	1	2	3	4	5
(10)	1	2	3	4	5	(28)	1	2	3	4	5
(11)	1	2	3	4	5	(29)	1	2	3	4	5
(12)	1	2	3	4	5	(30)	1	2	3	4	5
(13)	1	2	3	4	5	(31)	1	2	3	4	5
(14)	1	2	3	4	5	(32)	1	2	3	4	5
(15)	1	2	3	4	5	(33)	1	2	3	4	5
(16)	1	2	3	4	5	(34)	1	2	3	4	5
(17)	1	2	3	4	5	(35)	1	2	3	4	5
(18)	1	2	3	4	5	(36)	1	2	3	4	5

BACKGROUND DATA SHEET

Instructions

Please answer each of the following questions with a check mark (√) next to the appropriate response.

1. Age:

_____ 19 and under

_____ 20-29

_____ 30-39

_____ 40-49

_____ 50-59

_____ 60 and above

2. Marital Status:

_____ Single

_____ Married

_____ Widowed

_____ Separated

_____ Divorced

3. Ethnic Background:

_____ Caucasian

_____ Black

_____ Oriental

_____ Hispanic

_____ Other

4. Do you have any children?

_____ Yes _____ No

5. If yes, how many?

_____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ More

6. Childhood Religious Background:

_____ Protestant

_____ Catholic

_____ Jewish

_____ Other

_____ None

7. What is the highest level of education achieved by your father?

_____ 1. Completed less than 7 grade

_____ 2. Completed 7 grade but less than 10 grade

_____ 3. Completed at least 10 grade but less than 12

_____ 4. Graduated from high school

_____ 5. Completed at least 1 year of college but less than 4

_____ 6. Completed four years of college, received a bachelor's degree

_____ 7. Completed graduate or professional education leading to a graduate degree

8. What is the highest level of education achieved by your mother?

_____ 1. Completed less than 7 grade

_____ 2. Completed 7 grade but less than 10 grade

_____ 3. Completed at least 10 grade but less than 12

_____ 4. Graduated from high school

_____ 5. Completed at least 1 year of college but less than 4

_____ 6. Completed four years of college, received a bachelor's degree

_____ 7. Completed graduate or professional education leading to a graduate degree

9. What is your basic nursing education, leading to registration?

_____ Basic diploma

_____ Bachelor's degree

10. Which one of the following describes the highest level of education which you have now completed? (Please check one only.)

_____ No preparation beyond basic diploma

_____ Some post-basic credits toward a baccalaureate degree

_____ Baccalaureate degree in nursing

_____ Baccalaureate degree, other than nursing

_____ Master's degree

_____ Doctoral degree

11. How many years have you practiced as a registered professional nurse?

_____ up to 1 year

_____ 1-2 years

_____ 2-3 years

_____ 3-4 years

_____ 4-5 years

_____ more than 5 years

12. Have you ever received formal instruction regarding child abuse?

_____ Yes

_____ No

13. Have you ever seen a physically abused child?

_____ Yes

_____ No

14. Were you physically abused as a child?

_____ Yes _____ No

15. Have you ever given nursing care to an abused child?

_____ Yes _____ No

16. Have you ever been in contact with an abusing parent?

_____ Yes _____ No

17. Have you ever detected a case of child abuse?

_____ Yes _____ No

18. Have you ever reported a case of child abuse for further action?

_____ Yes _____ No

19. Have you ever been involved in a court hearing regarding a case of child abuse?

_____ Yes _____ No

QUESTIONS RELATED TO CHILD ABUSE

These questions are designed to give you an opportunity to write any of your thoughts, feelings or experiences about child abuse, which you consider valuable. Responding to the question is optional, however.

1. What frustrations have you had in dealing with child abuse?

2. What agencies have you found most helpful in assisting you with the management of child abuse?

3. Do you feel that you are adequately informed about child abuse for the management of child abuse?

4. Other comments:

APPENDIX B

April, 1982

Dear

I am a registered nurse in the Master's Program in Nursing at the University of British Columbia. I am interested in conducting a research study in regard to community health nurses' attitudes toward child abusers.

Recognizing the nature of the problem and the usual therapeutic approaches employed in the treatment of the family, I propose that a study of community health nurses' attitudes toward parents or guardians who physically abuse their children would be significant.

I would appreciate if you would complete the two (2) questionnaires enclosed. The questionnaires require fifteen minutes to complete. Responding to the open-ended questions is optional. You are not required to sign your name so that your anonymity and confidentiality is assured. Your participation in the study is voluntary. Completion of the questionnaire indicates your consent to participate. You are free to withdraw from the study at any time without jeopardizing your employment.

Please complete the attitude scale first, then proceed to the background data sheet. I would appreciate if you would return the questionnaire by May 10, 1982. Please find enclosed a self-addressed envelope. The findings of this research study will be available to you upon request. Thank you for your attention to this request.

Sincerely,

APPENDIX C

DESCRIPTIVE ANALYSIS

Table C-1

Means and Standard Deviations of Attitude Scores
As Well As Frequency and Relative Frequency
of Responses According to Age
(N = 132)

Variable	Mean	Standard Deviation	Frequency	Relative Frequency
Age:				
19 and under	-	-	-	-
20-29	68.9697	12.3250	33	25
30-39	71.5870	11.1347	46	34.8
40-49	74.1212	13.5272	33	25
50-59	69.5000	15.5177	16	12.1
60 and above	71.6667	11.2398	3	2.3
1 case missing			1	0.8

Table C-2

Means and Standard Deviations of Attitude Scores
As Well As Frequency and Relative Frequency
of Responses According to Age
(N = 15)

Variable	Mean	Standard Deviation	Frequency	Relative Frequency
Age:				
19 and under	-	-	-	-
20-29	70.5000	4.6547	4	26.7
30-39	76.0000	16.9706	2	13.3
40-49	69.3333	15.2927	6	40.0
50-59	74.0000	4.2426	2	13.3
60 and above	75.0000	0.0000	1	6.7

Table C-3

Means and Standard Deviations of Attitude Scores
As Well As Frequency and Relative Frequency
of Responses According to Marital Status
(N = 132)

Variable	Mean	Standard Deviation	Frequency	Relative Frequency
Marital Status:				
Single	70.7073	15.1001	41	31.1
Married	71.1842	10.7786	76	57.6
Widowed	75.3333	18.5023	3	2.3
Separated	75.8333	15.3547	6	4.5
Divorced	71.8333	12.8906	6	4.5

Table C-4

Means and Standard Deviations of Attitude Scores
As Well As Frequency and Relative Frequency
of Responses According to Marital Status
(N = 15)

Variable	Mean	Standard Deviation	Frequency	Relative Frequency
Marital Status:				
Single	73.0000	5.6569	2	13.3
Married	73.4286	11.1184	7	46.7
Widowed	64.0000	0.0000	1	6.7
Separated	60.0000	0.0000	1	6.7
Divorced	72.2500	14.6373	4	26.7

Table C-5

Means and Standard Deviations of Attitude Scores
As Well As Frequency and Relative Frequency
of Responses According to Ethnic Background
(N = 132)

Variable	Mean	Standard Deviation	Frequency	Relative Frequency
Ethnic Background:				
Caucasian	71.7540	12.5314	126	95.5
Black	62.5000	6.3640	2	1.5
Oriental	74.5000	12.0208	2	1.5
Hispanic	49.0000	0.0000	1	0.8
Other	57.0000	0.0000	1	0.8

Table C-6

Means and Standard Deviations of Attitude Scores
As Well As Frequency and Relative Frequency
of Responses According to Ethnic Background
(N = 15)

Variable	Mean	Standard Deviation	Frequency	Relative Frequency
Ethnic Background:				
Caucasian	71.9286	11.1111	14	93.3
Oriental	66.0000	0.0000	1	6.7

Table C-7

Means and Standard Deviations of Attitude Scores As Well As Frequency and Relative Frequency of Responses As to Whether Subjects Have Children (N = 132)

Variable	Mean	Standard Deviation	Frequency	Relative Frequency
Do You Have Any Children?				
Yes	70.9667	12.0844	60	45.5
No	71.7083	13.0454	72	54.5

Table C-8

Means and Standard Deviations of Attitude Scores As Well As Frequency and Relative Frequency of Responses As to Whether Subjects Have Children (N = 15)

Variable	Mean	Standard Deviation	Frequency	Relative Frequency
Do You Have Any Children?				
Yes	68.8750	11.4198	8	53.3
No	74.5714	10.0309	7	46.7

Table C-9

Means and Standard Deviations of Attitude Scores
As Well as Frequency and Relative Frequency
of Responses As to the Number of Children
(N = 132)

Variable	Mean	Standard Deviation	Frequency	Relative Frequency
Number of Children:				
None	71.7083	13.0454	72	54.5
One	69.0833	11.9731	12	-
Two	71.5714	11.7298	28	-
Three	70.8571	10.0679	14	-
Four	72.1667	19.7222	6	-
Five	-	-	-	-
More Than Five	-	-	-	-

Table C-10

Means and Standard Deviations of Attitude Scores As Well As Frequency and Relative Frequency of Responses As to the Number of Children (N = 15)

Variable	Mean	Standard Deviation	Frequency	Relative Frequency
Number of Children:				
None	74.5714	10.0309	8	46.7
One	77.0000	0.0000	1	6.7
Two	64.0000	9.6437	3	20.0
Three	65.0000	10.3923	3	20.0
Four	87.0000	0.0000	1	6.7
Five	-	-	-	-
More Than Five	-	-	-	-

Table C-11

Means and Standard Deviations of Attitude Scores As Well As Frequency and Relative Frequency of Responses As to Childhood Religious Background (N = 132)

Variable	Mean	Standard Deviation	Frequency	Relative Frequency
Childhood Religious Background:				
Protestant	71.5158	12.4754	95	72
Catholic	69.4545	12.1684	22	16.7
Jewish	-	-	-	-
Other	74.3000	15.7977	10	7.6
None	67.3333	12.7017	3	2.3
2 cases missing			2	1.5

Table C-12

Means and Standard Deviations of Attitude Scores As Well As Frequency and Relative Frequency of Responses As to Childhood Religious Background (N = 15)

Variable	Mean	Standard Deviation	Frequency	Relative Frequency
Childhood Religious Background:				
Protestant	70.6923	10.5149	13	86.7
Catholic	77.0000	15.5563	2	13.3

Table C-13

Means and Standard Deviations of Attitude Scores As Well As Frequency and Relative Frequency of Responses According to Father's Education (N = 132)

Variable	Mean	Standard Deviation	Frequency	Relative Frequency
Father's Education:				
Less than Grade 7	67.0000	11.5326	15	11.4
Less than Grade 10	71.4828	11.0215	29	22.0
Less than Grade 12	75.6111	11.8129	18	13.6
H. S. Diploma	71.9091	10.8185	22	16.7
1 Year of College	65.7000	14.4994	10	7.6
B.A.	73.4731	15.0347	19	14.4
M.A.	69.2941	14.1896	7	12.9
2 missing cases				1.5

Table C-14

Means and Standard Deviations of Attitude Scores As Well As Frequency and Relative Frequency of Responses According to Father's Education (N = 15)

Variable	Mean	Standard Deviation	Frequency	Relative Frequency
Father's Education:				
Less than Grade 7	88.0000	0.0000	1	6.7
Less than Grade 10	69.0000	0.0000	1	6.7
Less than Grade 12	68.0000	7.5277	4	26.7
H. S. Diploma	68.7500	8.4212	4	26.7
1 Year of College	81.0000	8.4853	2	13.3
B.A.	70.5000	24.7487	2	13.3
M.A.	66.0000	0.0000	1	6.7

Table C-15

Means and Standard Deviations of Attitude Scores As Well As Frequency and Relative Frequency of Responses According to Mother's Education (N = 132)

Variable	Mean	Standard Deviation	Frequency	Relative Frequency
Mother's Education:				
Less than Grade 7	70.9091	13.1107	11	8.3
Less than Grade 10	71.1492	13.1274	21	15.9
Less than Grade 12	69.0769	10.8048	13	9.8
H. S. Diploma	72.9737	10.8690	38	28.8
1 Year of College	71.9091	15.4482	33	25.0
B.A.	67.6000	13.1673	10	7.6
M.A.	71.0000	8.0623	5	3.8
1 missing case			1	0.8

Table C-16

Means and Standard Deviations of Attitude Scores As Well As Frequency and Relative Frequency of Responses According to Mother's Education (N = 15)

Variable	Mean	Standard Deviation	Frequency	Relative Frequency
Mother's Education:				
Less than Grade 7	88.0000	0.0000	1	6.7
Less than Grade 10	78.5000	13.4350	2	13.3
H. S. Diploma	69.7500	10.6201	8	53.3
1 Year of College	77.0000	0.0000	1	6.7
B.A.	66.0000	0.0000	1	6.7
M.A.	63.5000	9.1924	2	13.3

Table C-17

Means and Standard Deviations of Attitude Scores As Well As Frequency and Relative Frequency of Responses According to Educational Preparation for Registration (N = 132)

Variable	Mean	Standard Deviation	Frequency	Relative Frequency
Educational Preparation for Registration:				
Diploma	71.9437	12.4532	71	53.8
Baccalaureate Degree	70.7049	12.7872	61	46.2

Table C-18

Means and Standard Deviations of Attitude Scores As Well As Frequency and Relative Frequency of Responses According to Educational Preparation for Registration (N = 15)

Variable	Mean	Standard Deviation	Frequency	Relative Frequency
Educational Preparation for Registration:				
Diploma	70.5000	12.2597	6	40
Baccalaureate Degree	72.2222	10.4616	9	60

Table C-19

Means and Standard Deviations of Attitude Scores As Well As Frequency and Relative Frequency of Responses According to Present Level of Education (N = 132)

Variable	Mean	Standard Deviance	Frequency	Relative Frequency
Present Level of Education:				
Diploma	73.2000	12.0546	15	11.4
Credits to B.A./B.S.	73.1667	12.8656	30	22.7
B.S. (Nursing)	70.6625	12.6200	80	60.6
B.A. (Non-Nursing)	79.5000	14.8492	2	1.5
Master's Degree	61.7500	11.3248	4	3.0
Doctoral Degree	-	-	-	-
1 missing case				0.8

Table C-20

Means and Standard Deviations of Attitude Scores As Well As Frequency and Relative Frequency of Responses According to Present Level of Education (N = 15)

Variable	Mean	Standard Deviation	Frequency	Relative Frequency
Present Level of Education:				
Credits to B.A./B.S.	66.3333	11.7189	3	20
B.S. (Nursing)	72.8333	10.7097	12	80

Table C-21

Means and Standard Deviations of Attitude Scores As Well As Frequency and Relative Frequency of Responses According to Years of Nursing Practice (N = 132)

Variable	Mean	Standard Deviation	Frequency	Relative Frequency
Years of Nursing Practice:				
Up to 1 year	-	-	-	-
1-2 years	49.0000	0.0000	1	0.8
2-3 years	67.7500	15.2197	4	3.0
3-4 years	73.2500	15.0703	12	9.1
4-5 years	71.5556	5.8760	9	6.8
More than 5 years	71.4906	12.5927	106	80.3

Table C-22

Means and Standard Deviations of Attitude Scores As Well As Frequency and Relative Frequency of Responses According to Years of Nursing Practice (N = 15)

Variable	Mean	Standard Deviation	Frequency	Relative Frequency
Years of Nursing Practice:				
3-4 years	71.5000	7.7782	2	13.3
4-5 years	66.3333	5.5076	3	20.0
More than 5 years	73.1000	12.5206	10	66.7

Table C-23

Means and Standard Deviations of Attitude Scores As Well As Frequency and Relative Frequency of Responses According to Formal Instruction in Child Abuse (N = 132)

Variable	Mean	Standard Deviation	Frequency	Relative Frequency
Formal Instruction in Child Abuse:				
Yes	71.0187	12.5713	107	81.8
No	72.8333	13.0106	24	18.2

Table C-24

Means and Standard Deviations of Attitude Scores As Well As Frequency and Relative Frequency of Responses According to Formal Instruction in Child Abuse (N = 15)

Variable	Mean	Standard Deviation	Frequency	Relative Frequency
Formal Instruction in Child Abuse:				
Yes	71.1429	11.1138	14	93.3
No	77.0000	0.0000	1	6.7

Table C-25

Means and Standard Deviations of Attitude Scores As Well As Frequency and Relative Frequency of Responses According to Subjects Having Seen an Abused Child
(N = 132)

Variable	Mean	Standard Deviation	Frequency	Relative Frequency
Seen an Abused Child:				
Yes	70.4215	12.4075	121	91.7
No	81.8182	9.6625	11	8.3

Table C-26

Means and Standard Deviations of Attitude Scores As Well As Frequency and Relative Frequency of Responses According to Subjects Having Seen an Abused Child
(N = 15)

Variable	Mean	Standard Deviation	Frequency	Relative Frequency
Seen an Abused Child:				
Yes	71.1538	11.5675	13	86.7
No	74.0000	4.2426	2	13.3

Table C-27

Means and Standard Deviations of Attitude Scores As Well As Frequency and Relative Frequency of Responses As to Whether Subjects Were Physically Abused As a Child
(N = 132)

Variable	Mean	Standard Deviation	Frequency	Relative Frequency
Physically Abused As a Child:				
Yes	64.7143	21.0543	7	5.3
No	71.7440	11.9575	125	94.7

Table C-28

Means and Standard Deviations of Attitude Scores As Well As Frequency and Relative Frequency of Responses As to Whether Subjects Were Physically Abused As a Child
(N = 15)

Variable	Mean	Standard Deviation	Frequency	Relative Frequency
Physically Abused As a Child:				
Yes	64.0000	0.0000	1	6.7
No	72.0714	11.0137	14	93.3

Table C-29

Means and Standard Deviations of Attitude Scores As Well As Frequency and Relative Frequency of Responses As to Whether Subjects Have Provided Nursing Care to an Abused Child (N = 132)

Variable	Mean	Standard Deviation	Frequency	Relative Frequency
Provided Nursing Care to an Abused Child:				
Yes	71.1176	12.4763	68	51.5
No	71.6406	12.7732	64	48.5

Table C-30

Means and Standard Deviations of Attitude Scores As Well As Frequency and Relative Frequency of Responses As to Whether Subjects Have Provided Nursing Care to an Abused Child (N = 15)

Variable	Mean	Standard Deviation	Frequency	Relative Frequency
Provided Nursing Care to an Abused Child:				
Yes	72.0000	12.7279	10	66.7
No	70.6000	6.5803	5	33.3

Table C-30

Means and Standard Deviations of Attitude Scores As Well As Frequency and Relative Frequency of Responses As to Whether Subjects Have Been in Contact with an Abusing Parent (N = 132)

Variable	Mean	Standard Deviation	Frequency	Relative Frequency
Contact with an Abusing Parent:				
Yes	71.0902	12.6000	122	92.4
No	74.8000	12.3810	10	7.6

Table C-31

Means and Standard Deviations of Attitude Scores As Well As Frequency and Relative Frequency of Responses As to Whether Subjects Have Been in Contact with an Abusing Parent (N = 15)

Variable	Mean	Standard Deviation	Frequency	Relative Frequency
Contact with an Abusing Parent:				
Yes	69.8462	10.4071	13	86.7
No	82.5000	7.7782	2	13.3

Table C-32

Means and Standard Deviations of Attitude Scores As Well As Frequency and Relative Frequency of Responses As to Whether Subjects Have Detected Child Abuse
(N = 132)

Variable	Mean	Standard Deviation	Frequency	Relative Frequency
Detected Child Abuse:				
Yes	71.5288	12.5055	104	78.8
No	70.6667	13.2810	27	20.5
1 missing case			1	0.8

Table C-33

Means and Standard Deviations of Attitude Scores As Well As Frequency and Relative Frequency of Responses As to Whether Subjects Have Detected Child Abuse
(N = 15)

Variable	Mean	Standard Deviation	Frequency	Relative Frequency
Detected Child Abuse:				
Yes	70.7778	11.7237	9	60
No	72.6667	10.2502	6	40

Table C-34

Means and Standard Deviations of Attitude Scores As Well As Frequency and Relative Frequency of Responses As to Whether Subjects Have Reported Child Abuse
(N = 132)

Variable	Mean	Standard Deviation	Frequency	Relative Frequency
Reported Child Abuse:				
Yes	71.2941	12.8758	119	90.2
No	72.0769	9.7763	13	9.8

Table C-35

Means and Standard Deviations of Attitude Scores As Well As Frequency and Relative Frequency of Responses As to Whether Subjects Have Reported Child Abuse
(N = 15)

Variable	Mean	Standard Deviation	Frequency	Relative Frequency
Reported Child Abuse:				
Yes	72.7273	11.7140	11	73.3
No	68.2500	8.3016	4	26.7

Table C-36

Means and Standard Deviations of Attitude Scores As Well As Frequency and Relative Frequency of Responses As to Whether Subjects Have Been Involved in a Court Hearing in Regard to Child Abuse (N = 132)

Variable	Mean	Standard Deviation	Frequency	Relative Frequency
Involvement in a Court Hearing in Regard to Child Abuse:				
Yes	68.6667	13.3848	27	20.5
No	72.0667	12.3298	105	79.5

Table C-37

Means and Standard Deviations of Attitude Scores As Well As Frequency and Relative Frequency of Responses As to Whether Subjects Have Been Involved in a Court Hearing in Regard to Child Abuse (N = 15)

Variable	Mean	Standard Deviation	Frequency	Relative Frequency
Involvement in a Court Hearing in Regard to Child Abuse:				
Yes	71.0000	0.0000	1	6.7
No	71.7500	9.6401	2	80.0

APPENDIX D

Descriptive Analysis of the Community Health Nurses' Experiences with Child Abuse

Random Group
(N = 132)

Frustrations Experienced by the Community Health Nurses in Dealing with Child Abuse

Category	Range of Remarks		Frequency of the Remark
1. Need for education of the public and allied professionals regarding the phenomenon of child abuse	need for public awareness of the problem and the means to prevention		1
	need for teachers to know the emotional and physical indications of the problem		1
	need for social workers, lawyers, and registered nurses to have more education regarding the treatment of the problem		3
2. Communication problems	related to: the family and the nurse	development and continuation of a relationship with the family which will facilitate the identification and treatment of the problem	6
	the court and the "helping professionals"	insufficient evidence presented to the court regarding the home situation (child thereby sent home prematurely or the case is rejected)	4

Category	Range of Remarks		Frequency of the Remark
2. Communication problems (continued)	related to: the social workers from the Ministry of Human Resources and the community health nurses	lack of communication between the agencies regarding the management of the family	8
		the issue of confidentiality	1
		(the meaning of this remark was not explained)	
3. Inadequate provision of professional treatment and community resources	inadequate knowledge and skill, on the part of professionals, for the effective management of the problem		13
	lack of counselling services		6
	lack of support services		5
	insufficient number of professionals		1
	insufficient follow-up treatment and support		15
	irresponsibility of professionals		10
	need for a multidisciplinary approach to the treatment of the problem		4
	insufficient time to work therapeutically with the families		9
	lack of continuity in the treatment of the families (lack of co-ordination between the agencies)		12

Category	Range of Remarks	Frequency of the Remark
3. Inadequate provision of professional treatment and community resources (continued)	inability to provide the type of immediate treatment or support that is required by the family	2
	inadequate funding for community resources	5
	lack of support for the adolescent who is abused	1
	minimal professional help provided for child neglect and sexual abuse	2
	inadequate management of mental and emotional abuse	3
4. Limitations in the child protection laws	need for the revision of the legislation regarding the protection of children's rights	5
Problems related to the judicial system	rights of the parents are placed before the rights of the child	2
	children can be returned to the custody of the parents with only minimal provision made, by the court, for supervision of the home, or for a treatment plan for the family	6
	delays in court hearings	3
	unpredictability of court hearings	2
	a decision regarding a child's future placement should be made by more than one person (the judge)	1

Category	Range of Remarks	Frequency of the Remark
5. Factors related to the families	the parents insufficient or lack of awareness regarding their need for professional assistance (i.e. resistance)	7
	family's inadequate desire to change	6
	the family's disappearance from the community following the identification of the problem	2
	general social and personal problems that sometimes hinder change:	
	lack of money	1
	family history of child abuse	1
	parents' low self-esteem	2
	(father's) unemployment	2
	the "deep-rootness" of behavior patterns	4
	abusive behavior is regarded by parents as an acceptable form of discipline	3
	marital problems	2
	too many children in the family	1
	"difficult baby" to manage	1
	inadequate or lack of support systems	1
	alcohol dependency	1
	young motherhood	1
	unrealistic expectations of the baby	1
	unwanted children	1

Category	Range of Remarks	Frequency of the Remark
5. Factors related to the families which impede treatment (continued)	general social and personal problems that sometimes hinder change: (continued)	
	frequent moves (relocation) by the family	1
	no interests outside the home	1
	situations in which there is little hope for change, i.e. mother is mentally retarded or mentally ill and is unable to care for children	1
6. General beliefs regarding the rights of parents, and child-rearing practices	people have the right to parent as they wish	1
	that one (professional, neighbor) should not interfere with a parent's approach to child-rearing unless requested to do so by the parent	1
7. Attitudes and feelings of professionals that hinder management of the problem	the presence of a feeling of defeat, even before attempting to change the situation	2
	the belief that the child should remain with the parents: often this causes the child to suffer further abuse	1
	feelings of anger	1
	guilt (following the identification of the problem)	1
	rebuke	1
	frustration (due to the attitudes of allied professionals)	1

Category	Range of Remarks	Frequency of the Remark
7. Attitudes and feelings of professionals that hinder management of the problem (continued)	helplessness or hopelessness	2
	professionals' belief that one should not interfere in family matters, unless requested	1
	fear and anxiety for the children when the parents do not acknowledge their behavior as abusive	1
	working with abusive parents is emotionally draining	1
8. Limitations in the role of the community health nuse	the role of the community health nurse is not clearly identified	4
	limited input by community health nurses to the decision-making process regarding treatment of the problem	1
9. Need for preventative programs for child abuse	need for education of high school students regarding "parenting"	1
	need for parenting classes for parents who abuse their children	1
	need for an interdisciplinary approach to the problem	4
10. Reluctance of neighbors to report child abuse		3
11. Reluctance of professionals to report child abuse		3

Category	Range of Remarks	Frequency of the Remark
12. Child abuse - a difficult problem to prove	difficult to determine the occurrence of child abuse without being in the home extensively	1
	there may be evidence to support a suspicion, but not enough to prove the case	5
	often a crisis must develop before the abusive behavior is identified	1
	parents must first recognize the need for change	1
	difficult to distinguish an accidental and abusive injury	3
	need for physical marking before there is a case	1

Comments
(N = 132)

Category	Range of Remarks	Frequency of the Remark
1. Need for a definition of child abuse	need for a standard definition to be used by all professionals in the identification and treatment of child abuse	2
2. Need for a team approach		1
3. Need for preventative measures	Means: post-natal visits fathers involvement in pre-natal and parenting groups increased public awareness of the problem increased family awareness of the community resources	1

Category	Range of Remarks	Frequency of the Remark
3. Need for preventative measures (continued)	development of self-esteem, through schools	1
	high school preparation of adolescence for parenting	2
	parenting groups	2
	more supervision of high risk families	2
	public education regarding child abuse	1
4. Need for professional education	regarding the management of feelings, attitudes, beliefs that may hinder the provision of nursing care	4
	regarding the treatment of child abuse	2
	regarding the management of sexual abuse	2
5. Need for research	focus - the etiology and treatment of child abuse	1
6. Perceived difficulties in assisting families	parents' resistance (i.e. parents refuse help)	3
	difficult to identify the problem	1
	difficult to ensure the safety of the child while the family receives counselling	1
	treatment facilities are scarce	1
	professionals are hesitant to become involved	3
	insufficient time for social workers to investigate and follow-up cases	2

Category	Range of Remarks	Frequency of the Remark
6. Perceived difficulties in assisting families (continued)	lack of a screening tool for detection of the problem	1
	lack of a protocol for the management of child abuse to be used by all professionals	1
	inadequate communication between professionals	1
	home studies are inadequate for a court decision regarding the child's placement	1
	cultural differences in disciplining children	1
7. Child abuse perceived as a social worker's issue	child abuse is regarded as a social problem and, as such, should be dealt with by social workers	1
8. Need for specialized worker	a specialized worker in each health unit should have the responsibility of providing care to these families	1
9. The problem of sexual abuse	need for strict enforcement of legislation regarding incest	1
	increase public and professional awareness of this problem	1
10. The problem of emotional abuse and neglect	these problems are seldom treated professionally	1
11. Need for community resources	there is a need for volunteer groups and day cares	1 2

Category	Range of Remarks	Frequency of the Remark
12. The need for mandatory reporting	fines should be the punishment for the failure of a citizen or professional to report suspected or known child abuse	
13. Questionnaire	the questions were too general	4
	the questionnaire does not consider the differences that can be observed in child abuse	5
	sinful is not a word that can be used- the conditions of the parents, make it so, that one can forgive them for what they have done	1
	these statements may apply to a percentage of cases, but not all cases	1
	the questionnaire was difficult to answer because child abuse was not defined	5
	the questionnaire is not appropriate to the work of nurses - since they are not the front-line workers in child abuse	1
	most questions were easy to answer by the obviousness of the attitudes - being a trained professional, one can quickly see how one <u>should</u> be answering	1
	there is a difference in one's feelings dependent upon nature of the abuse	8
	multiple choice questions are difficult to answer since no answer fits	1

Category	Range of Remarks	Frequency of the Remark
13. Questionnaire (continued)	the responses (strongly agree to strongly disagree) were not appropriate for all questions, i.e. child abusers are only doing what was done to them as children	1

Descriptive Analysis of the Community Health Nurses' Experiences with Child Abuse

Convenience Group
(N = 15)

Frustrations Experienced by Community Health Nurses in Dealing with Child Abuse

Category	Range of Remarks	Frequency of the Remark
1. Communication problems	between the community health nurse and the family after the identification of a case of child abuse (issue of mistrust involved)	1
	between social workers from the Ministry of Human Resources and community health nurses	1
2. Inadequate provision of professional treatment and community resources	parents receive minimal counselling	1
	example not cited	3
3. Public and professional attitudes toward children and child abuse	child abuse is accepted in our society	1
	children are given low priority (example not cited)	1
	a punitive attitude toward child abusers exists in our society	1

Category	Range of Remarks	Frequency of the Remark
4. Need for preventative programs for child abuse	need for the preparation of high school students for parenting	1
	need for day care centres for children	1
5. Behavior and/or attitudes of family toward treatment	lack of co-operation from parents	1
6. Child abuse - a difficult problem to prove		

Comments
(N = 15)

Category	Range of Remarks	Frequency of the Remark
1. Need for education of professionals	professionals working with these families need to have formal training	1
2. The role of community health nurses in the prevention and treatment of child abuse	nurses need to take political action regarding the problem of child abuse through the R.N.A.B.C.	1
	nurses need to place the protection of children before the protection of self when interacting with allied professionals.	1
	need to develop a policy, within the health unit, for the recording of physical child abuse	1
3. Questionnaire	questions (many) poorly worded because of double negatives	1
	answers could have been different if the nature of the abuse had been identified	1