GUIDELINES FOR OBTAINING A SECONDARY ASSESSMENT OF ABUSED AFRICAN AMERICAN AND HISPANIC WOMEN IN PRIMARY CARE SETTINGS

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ABSTRACT

GUIDELINES FOR OBTAINING A SECONDARY ASSESSMENT OF ABUSED AFRICAN AMERICAN AND HISPANIC WOMEN IN PRIMARY CARE SETTINGS

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In this scholarly project, guidelines are presented for obtaining a secondary assessment of abused African American and Hispanic women in primary care settings. Secondary assessment is the data outcome of a comprehensive, cultural-based interview of a client who has been previously identified as being abused. The guidelines assist the advanced practicing nurse (APN) in recognizing her/his cultural beliefs, attitudes, and practices that may prevent abused African American and Hispanic women from receiving culturally appropriate care. APNs utilizing the provided guidelines will become skilled in obtaining a cultural-specific assessment of previously identified abused African American and Hispanic women in the primary care setting.

Cultural perspectives on abuse have been minimally used in research, theoretical frameworks and health care curricula. Unlike many current practices in gathering assessments, the provided cultural-based guidelines will enable APNs to obtain the client's unique perception of abuse.

ACKNOWLEDGEMENTS

I wish to convey special thanks to the family members and friends who gave me support and encouragement during the three years completing this scholarly project.

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Introduction

The American Medical Association states that one in four families is experiencing some form of violence (Sabatino, 1992). In 1991, the estimated annual cost for domestic violence was $44,393,760., as reported by Moss & Taylor (1991). The American Nurses Association and the American Medical Association have both declared that physical abuse is a crucial issue in women's health care (Campbell, 1992). It has been reported by Kirschbaum (1992) that up to one third of patients seen by a health care provider are victims of domestic violence.

Domestic violence has been a major health care concern for over a decade and continues to escalate as a costly health care issue. The number of women who are being abused continues to rise. Varied standards of care exist for abused women seeking health care across the country. Guidelines can help provide a preliminary step toward national standardization of health care for abused women. The general purpose of this scholarly project is to provide the advanced practicing nurse (APN) with secondary assessment guidelines for abused woman seeking health care.

Problem

Abused women present themselves in every health care setting, yet health care providers often fail to uncover violence when they conduct their assessments. Emergency

rooms are one of the health care settings that are not providing adequate abuse screening. Henderson (1992) revealed that approximately one third of women using emergency room services are seeking treatment for symptoms related to on-going abuse; yet, it is estimated that due to the provider's lack of information or health care workers' reluctance to assess for abuse, only 10% or less of these women are actually assessed for abuse.

Pregnant women seeking prenatal care in physicians' offices or primary care settings have not received adequate abuse assessments. Abuse assessments of women seeking prenatal care are often omitted or are not sensitive to the type of cultural community the health care facility serves (Taggart & Mattson, 1995). Parker, McFarlane, Soeken, Torres & Campbell (1993) estimated that 40-60% of battered women incur injuries while pregnant. Physical abuse during pregnancy has been recognized as a significant health risk to both mother and baby. APNs are in a vital position to provide culturally appropriate abuse screening for expectant mothers seen in primary care facilities.

Primary care settings can be considered the front line for screening, assessing, educating, and providing support for abused women. APNs care for many women in primary care settings. Practitioners are in a crucial position to diagnose, intervene with appropriate assessments, and develop management plans to help arrest the abuse cycle

(Wagner, Mongan, Hamrick & Hendrick, 1995). Abused women have reported that primary care providers, who include both physicians and nurses, are not supportive and are the least effective in caring for abused women (Hoff, 1990). One study revealed that only 3% of abused women reported ever being questioned by their primary care provider as to whether they were abused or not (Ferris & Tudiver, 1992). Some of the reasons for non-caring responses toward abused women seeking health care are that practitioners lack knowledge about abuse issues, are misinformed, biased, focus on medical models, or have time constraints (Moss & Taylor, 1991; Snugg & Innui, 1992).

The social, psychological, legal, and physical consequences of abuse have been studied and as a result have led to the subsequent development of various assessment screening tools and forms. However, cultural factors in relation to abuse in families have historically received the least attention (Campbell-Williams, 1993; Long, 1986). Since illness and health are linked to the sociocultural context of a person's identity and belonging, women's health care issues, such as domestic violence, can be more effectively treated by practitioners who operate from within a sociocultural framework (Rorie, Paine & Barger, 1996). APNs have an important provider role to deliver culturally appropriate and effective assessment techniques for abused women seen in the primary care settings.

Purpose of the Study

The overall purpose of this scholarly project is to provide guidelines for APNs to obtain a secondary assessment of African American and Hispanic abused women seen in a primary care setting. Initial screening or identification of abuse will have occurred previously within a primary care setting or other health care agencies.

The expected outcomes and/or goals are that the APN will be able to skillfully elicit disclosure and interpret specific information during interviewing. The resultant data from the interview will provide a baseline for culturally relevant and congruent management plans. This provides culture-specific care for abused African American and Hispanic women seen in the primary care setting.

Conceptual Terms

Five conceptual terms are important to this project: general definitions of abuse, cultural perceptions of abuse, cultural relevance, cultural congruency, and secondary assessment.

General Definitions of Abuse.

Abuse can be defined as acts ranging from harassments, psychological or emotional abuse, battery, to the ultimate homicide. Authors King, Torres, Campbell, Ryan, Sheridan, Ulrich, and McKenna (1993) have studied abuse extensively and formed a general definition of abuse that includes emotional abuse, verbal abuse, threats and coercion,

physical attacks, socioeconomic restrictions, sexual abuse, and threats or use of weapons including dangerous objects.

When defined as having been shoved or pushed, 38.8% of women reported lifetime abuse and 22.7% reported some form of physical assault by their partner during a period of one year prior to the reporting of the abuse (Hamberger, Saunders, & Hovey, 1992). The typical physical forms of abuse may include assault with a weapon, being slapped, thrown, choked, hit, punched, pushed, or kicked (AMA, 1992; Berrios & Grady, 1991). This project will incorporate these general abuse definitions into cultural perceptions of abuse.

Cultural Perceptions of Abuse.

For the purpose of this project, abuse will be defined as any physical, emotional, sexual, or psycho-social threat or assault to the well-being and safety of an individual African American or Hispanic woman. The client's own cultural perception of abuse is a unique definitive component that needs to be included with the general definition of abuse to fully define cultural perceptions of abuse. The APN then determines the extent of the abuse based upon objective observation of the client's physical, psychological and emotional status.

Definitions, perceptions, and responses about domestic violence can take on different meanings within different cultures and subcultures (Torres, 1991). Abused African

American and Hispanic women share many common experiences of abuse that women of other races experience. Historically, many abused African American women have perceived that interventions offered to them are based on values incompatible with their own cultural needs and beliefs (Saunders-Robinson, 1991; Schwartz & Mattley, 1993; Sullivan & Rumptz, 1994). Their perception of abuse does not differ in terms of the definitive types of abuse per se, but rather about the causes of abuse and about the experiences they have encountered in seeking and using services for abused women (Coley & Beckett, 1988). An example of a possible cause of abuse is discussed by Coley and Beckett (1988), who suggest that the displaced aggression of black males toward a dominant and unjust Anglo American society perpetuates abuse toward African American women. These authors further elaborate that, in turn, abused African American women feel that the abuse they suffered was caused indirectly by the Anglo American society which now offers help to them. This explanation should not be over-generalized, but may be considered as one of many perceived causes of abuse by some African American women.

Definitions of what constitutes abuse remains much the same for African American women as with other racial and ethnic groups. However, societal pressures that produce domestic violence and subsequent cultural adaptations to those pressures are some of the important factors that need

to be understood and considered when assessing many abused African American women.

Some abused Hispanic women's definition of abuse may have societal and cultural implications. Abused Hispanic women may share many of the same cultural issues with abused African American women. However, some cultural issues for many Hispanic women may have a unique property. Acculturation, confusion in role expectations, and possible language barriers are some of the unique elements that may affect how some Hispanic women may define abuse.

The perception of abuse by many Hispanic women becomes more problematic when they enter a society that defines abuse differently. Many Hispanic women may often feel a great sense of ambivalence as acculturation levels increase. They may perceive a sense of being torn between their traditional role of pleasing male partners and striving to fit in a society that encourages greater independence by women. This attempt to balance two cultures often is associated with marital discord and domestic abuse toward some traditional Hispanic women.

Although Anglo American and Hispanic women may share the same abuse experiences, their interpretations of them may differ (Torres, 1991). For example, Hispanic women may not consider slapping, pushing or shoving as abuse, providing it does not happen regularly (Taggart & Mattson, 1995). The first instance of emotional abuse held a stronger

significance for abused Hispanic women compared to Anglo American women, but if emotional abuse occurred on a regular basis, the Hispanic women became more tolerant of it (Torres, 1991). Perceptions and tolerance of abuse may be further exacerbated by the fact that Catholicism and its regulation of divorce can cause denial of abuse by many practicing Catholic Hispanic women (Mayo & Resnick, 1996). They may perceive the doctrine of the church to limit the abused woman's choices, often making tolerance the only perceived option. Thus, perception of what is considered abuse may also be seen as a cultural adaptation.

This scholarly project will focus on two cultural groups, abused African American and Hispanic women. With regards to the these cultural groups, conceptual terms presented are cultural relevance and cultural congruency. These conceptual terms were chosen because they are terms that help determine the level of cultural competency necessary for the APN to obtain a culturally appropriate secondary assessment.

Cultural Relevance.

In general, the nursing definition of culture is: a complex, integrated system that includes knowledge, beliefs, skills, morals, law, customs, and any other acquired habits and capabilities of a group of people (Barkauskas, Baumann, Allen, & Fisher, 1994). Leininger (1995) defines culture as the learned, shared, and transmitted values, beliefs, norms,

and lifeways of particular groups that guide their thinking, decisions, and actions, in patterned ways. The basis of cultural relevance is that cultures are unique and need to be evaluated according to their own values, beliefs, and standards (Haviland, 1993).

This author's definition of cultural relevance for this project is twofold. Cultural relevance has both a subjective and objective definitive component to help the APN determine the pertinence of cultural influence on the previously identified African American or Hispanic abused woman's life. The subjective component of cultural relevance is the acceptance of the client's expressed disclosure as verbatim. The client defines the relevance of culture on her life through her own cultural value system. Cultural relevance also has an objective component which is an interpretive process. This process is used by a skilled APN to obtain a secondary assessment. The APN's interpretive skill is fundamentally based on knowledge of the client's cultural heritage, in its entirety. The skilled APN needs to use the client's feedback in the application of this knowledge in order to be unbiased.

Cultural Congruency.

Leininger (1991) defines cultural congruency as those cognitive-based assistive, facilitative, supportive, enabling acts or decisions that are tailor-made to fit the client's cultural beliefs, values, and lifestyles in order

to facilitate or provide a supportive and meaningful health care service. Although these skills are associated more with actual nursing care interventions, they are also an integral part of a holistic, culture-specific assessment.

For the overall scope of this project, cultural congruency will be defined according to Leininger's definition as provided. For the specific focus of this project, cultural congruency is further defined by this author as the mutually-agreed upon culture-specific treatment goal established between the APN and client at the end of the secondary assessment process.

Secondary Assessment.

This author defines a secondary assessment as follows: a culture-based, comprehensive data composite obtained through interviewing the identified abused Hispanic or African American woman seen in the primary care setting. The subjective data will include cultural perception of abuse, and culturally relevant information about the client's sociocultural structure. The secondary assessment should also include the following: consideration of immediate safety/danger factors, psychosocial history and current status, and a complete physical history. Non-biased assessment tools which are language appropriate and include subjective perception of abuse can be used to aid or enhance a portion of a secondary assessment. These tools are not to be used in lieu of the practitioner-client interview.

Language appropriateness of an abuse assessment tool is determined by the APN. The client's familiar language and the level of comprehension of language used in the tool are important factors to determine before choosing the appropriate tool.

As primary care providers, nurse practitioners should ensure that abused women receive non-biased abuse assessments. An example of assessment tool bias is the failure to address the subjective perception of abuse. Victimization is largely a subjective experience. Abuse interpretations will vary from person to person and culture to culture. Misunderstanding created by language barriers is another bias to consider before using and applying assessment tools. Language appropriate tools are necessary to obtain accurate, culture-specific information.

Authors Long (1986); Mayo & Resnick (1996) state that varying ways in which cultures define abuse affect the manner in which abuse needs to be assessed and treated by practitioners. This culture/abuse concept, discussed a decade ago, continues to be recognized as a significant assessment approach. Thoughtful consideration of the context in which abuse occurs within a culture is essential to obtain a refined assessment that is a meaningful tool for subsequent appropriate interventions.

Lazzaro & McFarlane (1991) demonstrated the concept and definition of a multi-level comprehensive assessment and

intervention for abuse. Level I, or the initial assessment, is a screen that determines if abuse has occurred. Level II is a comprehensive assessment that is implemented when recent or present abuse is established. Level II's comprehensive assessment concept is similar to this project's secondary assessment concept; however, Level II is not a culturally based assessment. Level III is when a client presents with actual injuries, and crisis intervention is paramount.

Hoff (1989) stated that initial screening needs to be carried out in all entry points of health care and can be implemented by every professional. He further states that a comprehensive assessment needs a specialist to consider and carry out a holistic approach to effectively assess the abused woman. Such a specialist is an APN.

In consideration of the purpose of this scholarly project, a comprehensive assessment will be referred to as a secondary assessment. Physical and psychological status, social structure and history, and cultural factors need to be addressed during a secondary assessment. Such an assessment should be conducted within a holistic cultural framework that addresses cultural relevance of the client's abuse perception.

These complexities make it difficult to define and develop a precise method that will serve as a guide to prevent wide variations in health care providers' opinions

which may adversely effect the provision of culturally appropriate care to abused women. However, a non-biased assessment method will assist in providing more culturally relevant and congruent intervention options (Coley & Beckett, 1988; Hoff & Rosenbaum, 1994; Jibaja-Rutsth, Kingery, Holcomb, Buckner & Pruitt, 1994; Torres, 1991).

This author intends to provide guidelines that enable the APN to use skills in obtaining a culturally relevant and congruent secondary assessment from previously identified abused African American and Hispanic seen in a primary care setting. The APN skills will be based upon a culture-theory framework and applied during the secondary assessment interview process.

Theoretical Framework: Abused Women and Nursing

Historically, abuse has been studied by social workers, psychologists, behavioralists, and more recently by physicians and nurses, all using various psychosocial theoretical frameworks. Traditionally, the nursing field has taught and used family systems theory to understand problems of family abuse. Hoff & Ross (1994) state that the study of violence in nursing curricula focuses on the psychiatric frameworks. Most current curricula in nursing schools do not include in-depth teaching about problems such as domestic violence within a culturally diverse society (Sims & Baldwin, 1995).

The conceptual framework, most often used in nursing

colleges are Sister Callista Roy's adaptation model, Henderson's needs approach, followed by Orem's self-care model (Hoff & Ross, 1994). Nursing models are not often used in studies of abuse. Those that have been used most frequently are from the nursing theorists Sister Callista Roy and Dorthea Orem. In critiquing nursing models that have been used in abuse studies, there are apparent shortcomings that will be addressed briefly in order to substantiate the rationale for choosing Madeleine Leininger's theory and model for this project.

Sister Callista Roy's adaptation model defines a person as a biopsychosocial being. Coping and adaptation levels are responses to stimuli that can be adaptive or ineffective. The theory focuses on responses to stressors and adaptation to them. There is no specific inclusion of cultural influences on responses to stressors. Roy's model focuses more on the activity interventions of nursing and not on assessment. Roy's two-level assessment is centered around nursing goals and diagnosis, not centered around the client's cultural subjective input (Tomey, 1994).

Dorothea Orem's theory of self care strongly emphasizes an active role by the nurse to do for the client what the client can not (Tomey, 1994). Applications of Orem's model have not been used in primary care settings for abused women and do not include a cultural assessment of clients in general. The supportive and educational components of this

model would apply to interventions for abused women, but not in gaining a complex subjective assessment from abused women of various cultures.

As American society becomes increasingly culturally diverse, it is imperative that all health care providers use a sociocultural framework. Providing care using this framework facilitates an avenue toward more effective and successful outcomes (Price & Cordell, 1994). Primary care facilities are growing and serving larger populations from diverse cultures. As primary care providers, APNs need to be educated or formally trained in serving these populations and their health concerns. The escalating problem of violence in our society, and particularly domestic violence, is a growing health care issue. Therefore, APNs would better serve this population using theoretical frameworks that focus on cultural concepts. Based upon this rationale, this author has selected Madeline Leininger as the nursing theorist for this project.

Leininger's Transcultural Nursing Theory and the Sunrise Model.

In general, the purpose of transcultural nursing is to facilitate the discovery of a body of knowledge and then establish skills focused on transcultural care in order to assist nurses in giving culturally congruent and competent care to people of diverse cultures. The nature of transcultural nursing is a formal area of study and

practice. Transcultural nursing has and continues to focus upon comparative holistic culture care and health/illness patterns of individuals/groups, with respect to differences and similarities in cultural values, beliefs, and practices. The goal is to provide culturally sensitive, congruent, and competent nursing care to people of diverse cultures (Leininger, 1974; 1995).

Some of the key elements in Leininger's theory are cultural sensitivity, cultural congruence, and culture-specific care. For the purpose of this project, these terms may be combined into an umbrella term referred to as cultural competence. Cultural sensitivity is one's awareness of cultural differences and giving respect to those differences in providing care. Although awareness is a start in culture-specific care and should be practiced by all nurses in general, it does not in itself rise to the level of cultural competence (Rorie et al., 1996). Culture-specific care refers to tailored-care practices that are identified from a client of a particular culture in order to plan care that specifically fits the client's needs and lifeways (Leininger, 1995).

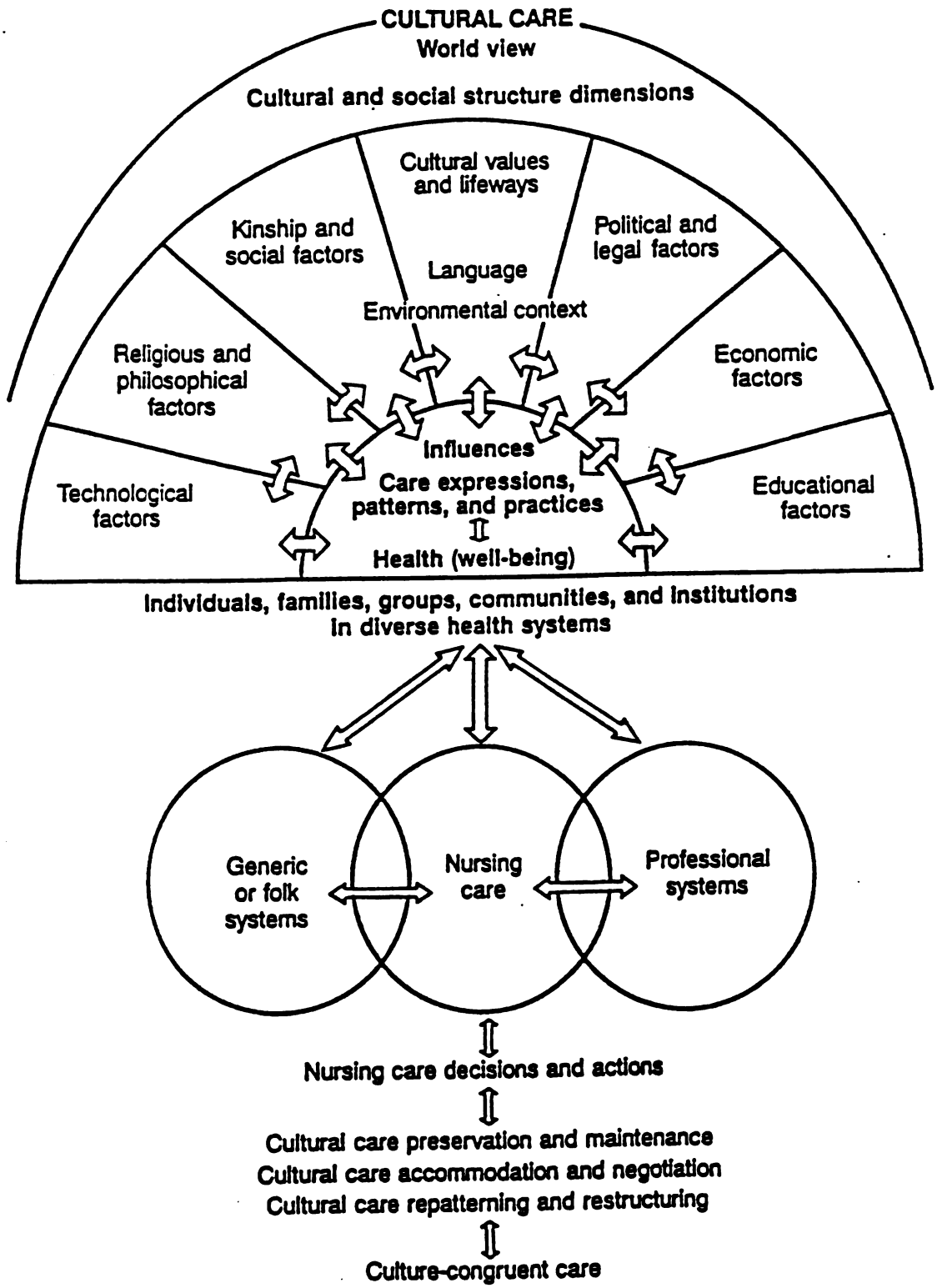
The two key concepts chosen for the purpose of this project are cultural relevance and cultural congruency, which have been defined previously. These two concepts are fundamental in developing culturally competent skills and provide an avenue toward providing culture-specific care of

previously identified abused Hispanic and African American clients seen in a primary care setting.

Practitioners need to expand their knowledge about cultures and care so that they understand specific needs of individuals and groups. Leininger's Sunrise Model can not be used as theory itself, but as a visual guide for the practitioner to focus on the components (concepts) of transcultural nursing theory. In general, it is a guide to help users envision a holistic perspective of the many influences of culture on clients, communities and different health care systems (Leininger, 1991). Practitioners can focus globally on all, or on individual domains of the Sunrise Model. An explanation of the model is needed to apply appropriate nursing skills in obtaining a culture-specific assessment. See Figure 1 for a diagram of Leininger's Sunrise Model.

The overall theoretical foundation of the Sunrise Model is based upon the premise that nurses should view clients in a holistic rather than a fragmented way. The discovery of clients' cultural backgrounds and their lifeways better serves them. The purpose of the holistic cultural approach is to understand clients' worldviews, religious (spiritual) beliefs, family relationships, home remedies, social ties and their many cultural values and beliefs. Ethnohistory and language are also important components in obtaining a holistic, culture-specific assessment. All these factors

SUNRISE MODEL



From Leininger, M. "Sunrise Model: M. Leininger's Theory of Nursing Cultural Care Diversity and Universality." *Nursing Science Quarterly* 1:157, 1988. Adapted with permission of the author and publisher.

Figure 1. Leininger's Sunrise Model

have a strong influence on clients' health care beliefs, practices, and needs.

In using the model, practitioners may begin with global "worldview" of the client, or the client's "cultural and social structure" components (see Figure 1). The worldview is the way the client tends to look out on the world to form a big picture. The cultural/social structure refers to the dynamic patterns and interrelatedness of factors of a particular culture which include religion, kinship, political, economic, educational, technological influences, cultural values, and ethnohistorical relevancy.

Starting the assessment with "generic" or folk systems and "professional" systems is also good (refer to Figure 1). Generic systems are lay practices APNs may employ, such as folk remedies, using healers, and cultural rituals. Although this mode of practice is unknown to most nurses, it is an important concept in providing culturally congruent care. Professional systems are formally taught/learned caring skills to serve clients. Beginning the cultural assessment process with generic or professional components/domains of the model may uncover other significant areas of inquiry.

The APN may find some of the components of the social structure more relevant than others. For example, when discovering a client's experience of barriers to receiving health care in the community, an APN may focus on the domain of "economic factors." The APN may then proceed to determine

cultural relevance in regards to the economic status of the abused client who has expressed monetary problems that may cause health care inaccessibilities.

The Sunrise Model is not a linear or systematic tool. The model should be used in a non-sequential manner to discover relevant subjective and objective information about the client's cultural world. The practitioner needs to be alert to cues from the client as to which component or domain in the model should be concentrated upon. The Sunrise Model allows a more flexible and creative guide in obtaining a culturally holistic assessment.

Leininger (1991) states that the central goal of doing culture-care assessments is to provide culturally congruent, specific and meaningful care to individuals, families, or special groups. The basis of this approach is to guide the practitioner in ways to establish trusting relationships in order to enter the client's world and discover cultural perspectives often concealed within family values, religious beliefs, economic factors or in other areas depicted in Leininger's culture-care model. Leininger (1995) defines cultural assessment as a complete identification of cultural beliefs, meanings, values, and practices of clients within a holistic perspective including worldview, life experiences, environment, ethnohistory, and social structure factors.

Obtaining a culture-specific assessment provides a clinical pathway toward making nursing decisions about care

and action. As part of the decision process, the practitioner decides if "preserving," "accommodating," or "repatterning" culturally relevant behaviors, practices or health care needs is appropriate (see Figure 1). The accomplishment of culture-congruent care needs to include this decision process. The inclusion of these concepts in the Sunrise Model are directed toward implementation and evaluation of care. The focus of this project is not on the entire care process including assessment, planning, implementation, and evaluation/outcomes. Rather, this project will be limited to focusing on pertinent concepts regarding assessment of abused African American and Hispanic women only.

The bridging of abuse and culture care is a concept not typically studied by the nursing profession. This project has attempted to bridge complex abuse and cultural assessment concepts by using Leininger's culture-care framework and Sunrise model. The purpose of this project is to provide cultural guidelines for APNs to obtain a secondary assessment of identified abused Hispanic and African American women seen in the primary care setting. Leininger's Sunrise Model will therefore be revised to focus only on relevant assessment processes and the concepts concerning abused Hispanic and African American women (see Figure 2 for the adapted model).

CULTURAL SPECIFIC ASSESSMENT

Worldview

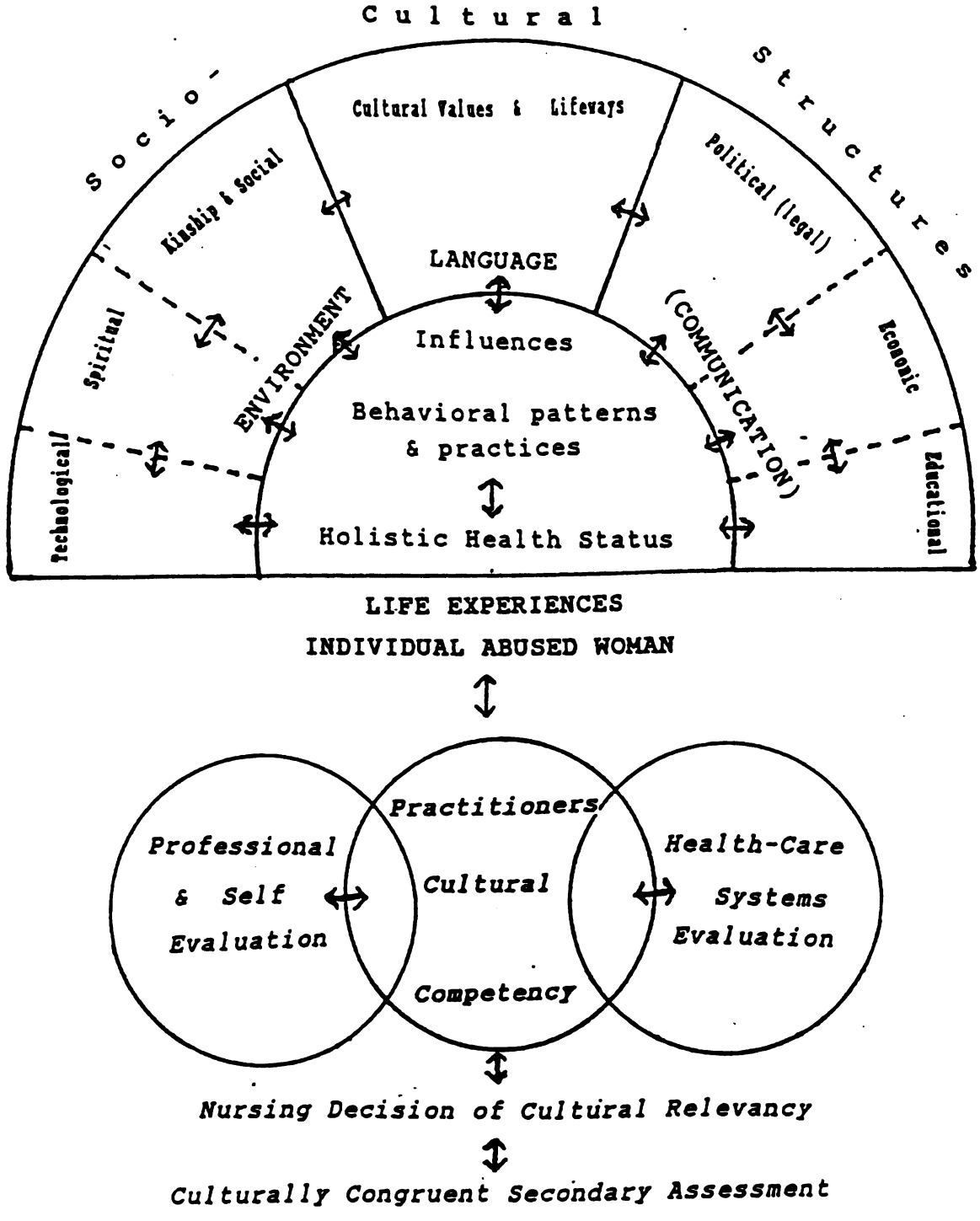


Figure 2. Adaptation of Sunrise Model

Literature Review

The literature review includes general health-related studies of abuse, assessment issues and abused women, abuse assessment tools, and cultural perspectives on African American and Hispanic abused women.

Health-Related Studies

Addressing abuse studies in general, nursing research has accumulated an impressive, but not as yet extensive body of scientific knowledge about domestic violence (Campbell, 1991). Recent long-term health issues prompted a few studies that are concerned with the battered woman's experience of suffering a tremendous amount of abuse and having more health problems and chronic illnesses (Cordoni, 1991; Saunders, 1995). Although little research has been done that examines long-term effects of abuse on women, authors agree that abuse is a critical health hazard (Abbott, Johnson, Koziol-McLain, & Lowenstein, 1995). Cordoni (1991) conducted a study to examine long-term physical effects on battered women. The results revealed that physical injuries from battering were primarily to the head area. Abused African American women especially suffered this trauma placing them at higher risk for neurological complications and related chronic disorders. This study used sheltered abused women only, which therefore limits general application of the results and its cultural relevancy.

Health care providers must be aware of subtle signs of

abuse, such as chronic psychosomatic complaints and various injuries that are inconsistent with explanations (Wagner et al., 1995). Multiple articles over many years have stated that abused women who enter the primary care facility present with chronic and vague complaints such as headaches, chronic pain, gastrointestinal complaints, insomnia, depressive symptoms and delayed prenatal care (Lion, 1977; Taggert & Mattson, 1995; Tilden & Shepard, 1987). These physical and emotional signs are often assessed and diagnosed as illnesses with unknown etiology and overlooked as manifestations of chronic abuse. Chronic somatic complaints may be indicative of abuse and depression. Such symptoms need to be thoroughly assessed by practitioners.

Some studies concur that battery may cause mental health problems as isolation, poor self-esteem, alcohol or drug abuse, and multi-psychosomatic symptoms (Hamberger et al., 1992; Plichta, 1992). Several studies place abused women who are battered at high risk for depression and suicide (Campbell, 1989; Cascardi & O'Leary, 1992; Goodman, Koss, & Russo, 1993). These authors did not mention the cultural relevancy of how different cultural groups may be emotionally affected by abuse, what ways they cope with abusive situations, or what specific ways they seek treatment for depressive illnesses.

A study by Bohn (1990), noted that emotional characteristics of abused women are shame, dependency,

guilt, entrapment, and helplessness. In contrast, Wagner et al.'s (1995) study is more culturally specific and found that African American women suffer fewer feelings of helplessness, indicating there is a cultural factor that may distinguish this group's coping style from other cultural groups of abused women. Another study of the psychological effects of abuse was conducted by Follingstad, Rutledge, Berg, Hause, & Polek (1990). These authors concluded that poor self-esteem is thought to be caused not only by physical abuse but by verbal abuse as well. Interestingly, a more culture-specific report on perceived abuse by Torres (1991) indicate that Hispanic women often do not consider verbal yelling and threats abusive acts. This contrast in findings is indicative of further need to study the psychological manifestations and perspectives of abuse within cultural frameworks.

The effects of abuse on emotional and psychological well-being are detrimental, but the extreme physical consequence and risk of battering is death. The AMA (1992) reported that 50% of all women who are murdered in the United States are killed by a male partner. Campbell (1992) stated an even higher percentage. She reported in her study that 75% of women killed are killed by a husband, lover, or ex-husband or ex-lover who abused them prior to the homicide. The study did not address any specific cultural groups. In 1991, homicide of women was the leading cause of

death for young African American women ages 15-34 (U.S. Department of Health and Human Services, 1991). These statistics are astounding and place abused women, particular young African American women, at high risk for homicide. A better means of early screening and thoroughly assessing all abused women is greatly needed to help prevent deaths from battering.

Although the focus of this project is on cultural assessments of identified abused African American and Hispanic women, there are special concerns regarding all abused expectant mothers. In contrast to few studies addressing abuse in a culturally sensitive context, there are many studies and articles on battered pregnant women. The studies share common findings such as poor prenatal care and high risk to both mother and baby. As primary care practitioners may see many expectant mothers, there are certain client risks APNs need to be aware of when treating abused pregnant women.

Physical violence toward women often begins or escalates during pregnancy, resulting in high risk for poor pregnancy outcomes (Sampselle, Peterson, Murtland, & Oakley, 1992). Risks of poor prenatal care and risk to the infant are often a result of abuse. Emotional stress from abusive relationships and the subsequent delay of prenatal care are associated with low-birth-weight infants (Bullock, McFarlane, Bateman & Miller, 1989). However, low birth

weight is only one outcome of abused pregnant women. Pregnant women who seek care for premature labor, bleeding, or other types of injuries and risks should be assessed for battering.

Women abused during pregnancy often have spontaneous abortions and stillbirths due to blows to the abdomen (Andrews & Brown, 1988). Unfortunately, many physical injuries, such as those to the torso, are not detected because they are not readily visible (Sheridan, 1993). Studies have not included the type of facility these women were examined at, nor what practitioner was responsible for the exam. Assessment for abuse can easily be incorporated during routine prenatal exams and can help prevent the oversight of abused pregnant women seen in the primary care settings.

McFarlane & Parker (1994), who have studied abuse during pregnancy, documented that their sample of 691 Houston and Baltimore pregnant women produced a finding of 1 in 6 women were abused. This study, however, did not focus on any particular socioeconomic group, nor on abused women in rural settings. Their findings were similar to a previous study by Berenson, Stiglich, Wilkerson, & Anderson (1991). Both studies found that abused Hispanic and African American women suffered less abuse during pregnancy than Caucasian women. This finding is in direct contrast with non-pregnant Hispanic women, in which higher abuse rates for Hispanic

woman than for Caucasian or African American women were found (Quillian, 1996; Straus & Smith, 1990). Cultural assumptions about how Hispanic women should be treated with more reverence during pregnancy could be one of the reasons for this conflicting finding (Taggart & Mattson, 1995; Torres, 1991). More cross-cultural studies are needed to examine cultural relevancy of abuse during pregnancy.

Regardless of culture, assessment for abuse during pregnancy must be carefully considered for all expectant mothers to help reduce risks to the mother and child. Screening and assessing for abused women who are seeking prenatal care are often omitted or are not sensitive to the type of cultural community the health care facility serves (Taggart & Mattson, 1995). Longevity studies in response to this finding are indicated and would possibly substantiate a greater need for cultural assessments.

Most studies, including those from a nursing perspective, are based on psychosocial frameworks. Psychological frameworks are medical models focusing on symptomology and psychological effects of abuse. Social models are concerned with the historical interdynamics of abused family members and the possible causes of abuse in our society, such as economic and educational deprivation. Actual coping styles and perception of what abuse is may be more related to cultural assumptions. Holistic cultural assessments of abused women are needed for more effective

treatment modalities and need to be used as baseline information for further abuse research.

Assessment Issues

Although there are no current studies on culturally based abuse assessments, the issue of providers not assessing for abuse or assessing inappropriately appears to be of increasing concern in the health care community. An American Nurses Association position paper addressed the issue of abused women (Campbell, 1993). It stated that health professionals needed heightened awareness as to their roles in assessment, intervention, and prevention of violence toward women. The primary care setting is a major entry point of abused women and APNs need to recognize and assess these women and subsequently provide appropriate treatment.

An impressive long list of articles have discussed the findings that health care providers are just not doing the job of discovering abused women in their facilities, or, when they do, ignoring the appropriate treatment or implementing inappropriate treatment (Chambliss, Bay & Jones, 1994; Chez & Jones, 1995; Ferris & Tudvier, 1992; Henderson, 1992; Hoff, 1990; Kurz, 1987; Moss & Taylor, 1991). These studies did not always state clearly what facilities or populations were included. It is commonly agreed that practitioners are not adequately assessing for abused woman and should be doing so.

Hamilton & Coates' (1993) study of 270 physically, emotionally, and sexually abused women used various service agencies and professionals represented in their study. The findings reported a range of what 270 abused women perceived as the least to most helpful professionals. It was discovered that health care providers were one of the most frequently encountered professionals by abused women. Other professionals were clergy, police, and various type of counselors. Health care providers were not perceived as being most helpful, however. Nurses were actually reported midway on the scale in providing helpful services and caring approaches. The lack of appropriate or sensitive interviewing techniques by the provider was a common complaint by these 270 abused women. The article did not state which facilities nurses represented, what type of nurses were included in the study, nor did it include racial or ethnic representation of the dissatisfied abused women. There is clearly a need for more abuse assessment research conducted by APNs.

There are common themes as to why health providers are not caring for abused women properly. The-most common cited reason for health professionals not identifying and assessing abused women appropriately is inadequate training and/or education about dealing with abuse (Campbell, 1992; Chambliss et al., 1994; Chez & Jones, 1995; Hamilton & Coates, 1993; Henderson & Erickson, 1994; Ryan & King, 1992;

Tilden, 1989). The answer to this problem varied among authors. Most concluded that education reform, training, exploration of the attitudes and beliefs held by providers, role clarification, administrative support, establishing standards of care protocols, and more research on domestic violence is needed. Such parameters and variables are familiar topics to most APNs. Although most authors agreed on the education/training needs of health care providers, there were few specifics about how to accomplish this. No authors mentioned development of a specific curricula to teach care providers skills to treat abused women. None of the authors included cultural considerations to be made when attaining comprehensive assessments of abused women.

Abuse Assessment Tools

There are few recent articles or studies regarding specific abuse assessment tools. Despite the growing need for comprehensive abuse screening methods to be implemented in all health care settings, literature continues to produce a plethora of articles on how to merely initiate screening methods (Lazzaro & McFarlane, 1991). There are a few tools that have been popularly used for many years, and there are several new tools that have stemmed from the parent ones. Tested, culture-specific abuse assessment tools are not currently available.

An issue in regards to obtaining assessments by using tools was addressed by McFarlane, Christoffel, Bateman,

Miller, & Bullock (1991). They stated that written self-reports of abuse do not encourage interactions and rapport between abused women and practitioners and hinder trust and honest disclosure. However, it is likely that if skillful interviews are used in conjunction with self-reports, trust and disclosure would not be jeopardized. More importantly, self-reports should not be used as the sole measurement of outcome in the assessment of abused women.

Authors Lazzaro & McFarlane (1991) proposed a step-by-step plan for assessing abused women using a crisis intervention framework. The authors conveyed that assessment of an identified abused women must also include intervention steps. They believed that the establishment of rapport and trust in a therapeutic relationship is imperative when abused women have been identified. This view did not address a preventative and early comprehensive assessment, which can provide a means of developing a trusting relationship between the abused woman and the provider before an actual crisis occurs.

Signs and symptoms of abuse are frequently neglected, as initial abuse screening is often only one question on a history intake form. Ryan & King (1992) provided a simplistic five-question assessment for abused women and suggested using it to assess all women who seek health care. The authors further stated that if the abused woman should answer "Yes" to any of those five questions, the

practitioners need to engage in an advocate role and use themselves as tools in empowering the abused women. This assessment approach did not consider subjective cultural perceptions of abuse and did not address all pertinent psychosocial issues regarding an abusive situation.

An assessment form developed by McFarlane (1993) uses a three-item questionnaire along with a body diagram in order to document bodily injuries. This form is in both English and Spanish and is widely used with pregnant women as a measurement of abuse. However, this tool assumes that some acts of physical assault, such as slapping, are always considered abusive. Contrary to this is infrequent slapping may not be perceived as abusive by all women (Torres, 1996). Such discrepancy may indicate bias. Studies of the effectiveness of this tool with different cultural populations are non-existent.

Another form developed by the Nursing Research Consortium on Violence and Abuse is similar to the tool developed by McFarlane, but includes time frames when the abuse occurred and perceived threat level. The tool takes into consideration what the abused woman perceives as threatening. (See Appendix A for this Violence and Abuse form.) However, there are no available studies regarding its use. Cross-cultural studies to examine cultural relevancy and abuse are needed.

Hoff & Rosenbaum (1994) stated that it is impossible to

develop abuse assessment tools that will precisely measure degrees of emotional trauma. The authors continued to say that developing tools that are comprehensive in range yet remain sensitive to distinct features of the abused woman is a very difficult challenge. These comprehensive assessments must include variables such as cultural milieu, age, and relationship factors. Hoff & Rosenbaum (1994) have developed a victimization tool to be used routinely by primary care providers to assess abused women. The purpose of the tool is to obtain a subjective report from the abused person. The report allows for a personal definition and perception of abuse by the abused client. This perception helps guide the practitioner to a more non-biased intervention approach. There were no available studies regarding this tool. Studies on cross-cultural perception of abuse are indicated.

The Danger Assessment Tool (DAS) developed by Campbell (1986) includes cultural considerations of abused women who are at high risk for suicide or homicide. This tool can be used conjunctively with an interview, if deemed appropriate, and it is not time consuming. Campbell's tool is specific, culturally adaptable and is nationally tested and widely used.

The Battered Woman Scale by Schwartz & Mattley (1993) measures the woman's personal gender role trait ascription. The tool is based on a feminist viewpoint regarding the causes of abuse toward women. The scale included cultural

groups but did not include women other than those from lower socioeconomic levels, thus general application of findings from such a tool is questionable.

The Conflict Tactics Scale (CTS) developed by Straus (1979) is the most widely used instrument for measuring severity and frequency of abuse. The validity and reliability of this tool has been long established nationally (Straus, 1979; 1989). It addresses violent acts and verbal aggression but does not address sexual or emotional abuse. The CTS has been viewed as narrow in focus by Rodenburg & Fantuzzo (1993), and they subsequently developed the Measure of Wife Abuse tool which includes empirical methods of construction to enable a broader range of wife abuse. Although it is a more comprehensive tool that addressed the CTS limitations, it is lengthy, which may deter its usage particularly in busy primary care settings.

The Index of Spouse Abuse (ISA) created by Hudson & McIntosh (1981), has been frequently used and has been nationally tested with favorable results. The tool is fairly comprehensive but limited to psychosocial parameters. The Survey on Family Violence by Teske and Parker (1982) examines the woman's perception of abuse but does not include emotional abuse.

There are many other psychosocial tools and questionnaires that have been developed and can be used for assessment of abused women. Some of the tools are: The

Family Violence Scale that quantifies the incidence of abuse by husbands (Bardis, 1973), The Measure of Courtship Violence (Makepeace, 1981), The Domestic Violence Assessment Form (Kuhl, 1982), and The Psychological Abuse Diagnostic Checklist (Hoffman, 1984).

Tools can be used in obtaining a secondary assessment of abused women; however, there are shortcomings in producing an effective outcome if they are used as the sole means of measuring abuse. Often when assessments are obtained, cultures and languages are not considered, or only minimally so. Without such considerations, abuse tools could be biased. Most instruments used for assessing abused women are insensitive to cultural influences on perception of abuse, coping mechanisms, and options regarding abusive situations.

Perspectives on African American and Hispanic Abused Women

The concept that cultural norms, beliefs, and values are related to the prevalence of domestic violence, as stated by Gelles & Cornell (1983), has been around for quite some time. However, recent literature that focuses on abuse within a cultural framework is very limited. Empirical studies on abused Hispanic and African American women are even more scant.

As reviewed earlier, there are many articles and studies on abused pregnant women in general. Reports vary in

findings regarding occurrence of abuse with Hispanic and African American pregnant women. No significant differences delaying prenatal care, which is common among abused women, were found between Hispanic, African American or Caucasian women in a study by Taggart & Mattson (1995). The indication of cause for the delayed care may be due more to socioeconomic factors and/or the possible embarrassment of having injuries discovered by health care providers, rather than to cultural reasons. The highest risk of homicide for abused pregnant Hispanic, African American and Caucasian women is found among the Caucasians (McFarlane, Parker, Soeken, & Bullock, 1992). Straus & Smith (1990) found higher rates of spousal abuse among non-pregnant Hispanic women as compared to Caucasian or African Americans. Other reports that studied pregnant women revealed a lower rate of abuse with Hispanic women (Berenson et al., 1991; McFarlane & Parker, 1994). One explanation is that Hispanic women may be more tolerant of certain forms of abuse or interpret abuse differently compared to other groups (Torres, 1987; 1991). Another possible explanation previously mentioned is there may be a certain cultural attitude of reverence toward expectant Hispanic mothers which does not typically occur during a non-pregnant state (Torres, 1991). This possible tolerance of abuse, perception of abuse, and change of attitudes toward many Hispanic expectant mothers should be considered when accumulating assessment data.

There may be special cultural issues with some Hispanic women. Many traditional Hispanic women may try to balance sociopolitical, cultural systems and values brought with them from their mother country, with the cultural systems in the United States (Mayo & Resnick, 1996). The acculturation process, with possible resultant interpersonal conflicts, may be a catalyst for abusive relationships (Torres, 1991). The culturally held belief that the Hispanic male is superior and that his needs are more important than the female is the concept of machismo. This traditionally held belief by many Hispanic females causes perception of abuse to be different than those of Anglo Americans, according to several authors (Mayo & Resnick, 1996; Torres, 1987, 1991). These studies reveal that culture has a significant effect on definition, perception, and tolerance of abuse.

The client's cultural perceptions of abuse needs to be a central component in obtaining a non-biased comprehensive assessment. These subjective data help to facilitate a culturally congruent treatment by developing a mutually agreed plan of care that includes the client's culture-specific abuse perception. The determination of acculturation level and its impact on many abused Hispanic woman should also be a component of the assessment process.

A study of how health care provider's perception of abuse can be biased or racist was done by Campbell (1992). The author found that nurses blame women more for their

abuse situation if the woman is of color, on government assistance, or has not left the abuser. The article did not differentiate what level of nurses were included, what kind of assessments were being used, nor did it discuss the socioeconomic level of the abused women.

The race of women may be a critical factor in deciding to disclose abuse (Dobash & Dobash, 1992). This article discussed abused African American women's sociocultural life experiences that influence trust level and decisions to disclose or not disclose abuse experiences to health care providers. This is indicative of how perceptions may differ in regards to causal factors of abuse, sociocultural conditioning, and the negative responses some abused African American women may have experienced. Such experiences and perceptions may be a cause of resistance toward disclosure by some abused African American women. Such resistance can seriously hinder the assessment process.

Wagner et al. (1995) found that the actual experience of abuse remains similar among African American, Caucasian, urban, and rural women, but methods of coping are different. This study found emotional abuse rates among rural African American women to be low and that rural Caucasian women received the highest levels of abuse. The study implied that rural African American abused women used coping mechanisms that demonstrated healthier self-esteem and assertion skills. However, coping with abuse may not be considered a

positive attribute if the abusive situation continues and/or escalates. This study was not clear on demographics, ages, socioeconomics, abuse longevity, and number of dependents, which are all variables affecting coping strategies. The cross-cultural aspects of coping with abuse need to be studied further.

There were few studies of abused African American women 10 years ago, and they are still very limited. Authors addressing African American abuse issues want more cultural theory applications to studies and research (Coley & Beckett 1988; Hampton & Gelles, 1994; Oliver, 1988). Campbell-Williams (1993) reported that application of Eurocentric interpretations of behavior and values in assessing abused African American women may lead to inappropriate assessments and interventions. She further suggested using a culture-based model and that the application of Afrocentric views would alleviate racial stereotyping. Furthermore, she suggested such culturally specific Afrocentric care could more appropriately address special needs and experiences of some abused African American women. However, the idea of Afrocentric views completely replacing Eurocentric views in treating abused African American women should not be over-generalized. This approach needs to be studied more closely as a potential treatment modality.

Cultural bias, racism and stereotyping, low self-esteem, the myth of the strong Black matriarch, and high

risk for being murdered in an abusive relationship are but a few issues written about abused African American women (Coley & Beckett 1988; Saunders-Robinson, 1991; Sullivan & Rumptz, 1994). Some abused African American women may face such political, social, and cultural issues and they should be considered as possibly relevant factors when attaining an abuse assessment. All these factors can have a serious impact on gathering culturally relevant assessment data.

Cultural perspectives in studies and research, cross-cultural educational systems, training health care providers, and culture-specific care for abused clients are being neglected. As our society becomes more culturally diverse it is even more imperative that health care professionals consider alternative approaches in caring for the populations they serve. Domestic violence occurs in many cultural groups. There is a great need to begin standardizing health care practices for abused women. Guidelines for obtaining a comprehensive cultural assessment of abused women is strongly indicated and may help to facilitate standardizing care and providing more appropriate abuse treatment modalities.

Guidelines

These guidelines contain the process for collecting culture-specific data from abused Hispanic or African American clients. The process includes skillful interviewing and utilizing a cultural framework provided by the Adapted

Sunrise Model (see Figure 2). The guidelines will enable the APN to use interpretive skills or strategies during the interview. This process will facilitate the collection of a culturally relevant and culturally congruent secondary assessment of previously identified abused Hispanic and African American women seen in the primary care setting. Psychosocial and physical assessment will be incorporated within the domains of the Adapted Sunrise model. As discussed earlier, the model does not need to be used in any logical or systematic order. The model is a flexible visual guide to ensure the cultural data collected is comprehensive and specific to the individual client during the interview process. An abbreviated outline of the guidelines in Appendix C can be used with the Adapted Sunrise Model (refer to Figure 2). The outline should not be applied in practice in lieu of reading this paper. Understanding the purpose, model, and concepts of the secondary assessment process will assist in attaining important skills and strategies to collect culture-specific data.

An introduction, statement of purpose, and concept review will be followed by a discussion of four guidelines' topics, which are: prepatory guidelines, initial interviewing, structured interview using Leininger's Sunrise Model, and assessment tools. The prepatory guidelines address checks for APNs to help determine their present level of cultural competency. The initial interview

guidelines will have subheadings related to Hispanic and African American cultural issues to be considered during the initial interview process. The third and main topic is the structured interview guidelines using the Sunrise Model. Review of the Sunrise Model's theory, significance of domains, and application of the Adapted Sunrise Model are the subheadings in this section. The application of the Adapted Sunrise Model and the interpretive skills needed during the structured interview process will be explained. Psychosocial and physical assessments are incorporated into the structured interview process. Guidelines using assessment tools with abused women is the fourth and concluding guideline's topic.

As previously discussed in the paper's introduction, abuse against women is one of the most prominent and growing health-related problems today. The lack of available studies that address current cultural issues facing many abused Hispanic and African American women is a significant reason for developing culture-based abuse assessments. Cultural assessments of abuse may provide a baseline so that future studies may explore more effective treatment of many abused women. Another reason for focusing on cultural approaches to treat abused women is the lack of cultural awareness by providers and how this negatively effects treatment of many abused Hispanic and African American clients.

The purpose of this scholarly project is to provide

guidelines for APNs to obtain a culturally holistic secondary assessment of previously identified abused African American and Hispanic women who are seen in the primary care setting. An adapted version of Leininger's Sunrise Model is used as a visual guide during the interview and will assist in obtaining a holistic cultural assessment. Through skillful interpretations during the interview the practitioner may facilitate the client's self disclosure, which can result in more successful interventions to care for abused Hispanic and African American women.

A brief review of the project's concepts/terms are as follows: definition of abuse, secondary assessment, cultural relevancy, and cultural congruency. As defined earlier, abuse is any physical, emotional, sexual, or psychosocial threat or assault to the well-being and safety of an individual African American or Hispanic woman. The client's perception of abuse and the practitioner's objective evaluation of the client's physical, psychological and emotional status are also part of defining what constitutes abuse. One important definitive component is the APN needs to allow the client to express her own cultural perception of abuse.

Secondary assessment is a culturally specific compilation of data obtained from previously identified abused Hispanic or African American women. A revised model based upon the Sunrise Model by Madeleine Leininger is used

as a guide during the data collecting interview (see Figure 2). The practitioner needs to include the client's subjective data, make an objective evaluation of the client's safety/danger factors, obtain a psychosocial status, and complete a physical history. Abuse assessment tools are to be used as a conjunctive means of assessing. As discussed previously, the abuse tools need to be screened for bias, be language appropriate, and include the client's perception of abuse.

Cultural relevance is the value of subjective cultural information provided by the client. Cultural relevance is also determined by the practitioner through interpretive skill. This skill is based upon knowledge of the client's entire cultural world, and should be void of bias.

Cultural congruence is an outcome based upon the action or decision a practitioner demonstrates to provide appropriate culture-specific care to the individual client. The outcome of these decisive acts is a culture-specific plan of care that is mutually agreed upon by client and practitioner.

Prepatory Guidelines

Cultural competence is not synonymous with cultural sensitivity. Cultural sensitivity is only an awareness of cultural differences. Cultural competence requires preparation beyond most nursing school curriculum. **The difference between sensitivity and competence needs to be**

distinguished when evaluating the practitioner's level of readiness in developing a culture-specific plan of care for abused women. The purpose of this project is not to instruct on just the awareness of cultural variables but to provide guidelines on what cultural skills are needed to begin developing a higher level of cultural competency in assessing. The prepatory guidelines contain a brief check list to help determine the practitioner's level of cultural competency prior to beginning a client interview. These guides are a summation of topics, comments, issues, and recommendations discussed in the paper's literature review and conceptual framework sections. These are prepatory guides only and are not the main focus of the project guidelines.

The following check list is a guideline to help determine the practitioner's current level of cultural competency: recognize cultural diversity in its entirety (including language), respect and accept people and their culture on their terms (even if unfamiliar to you), be cognizant of your own historical and current cultural beliefs, recognize cultural groups' definitions of health and illness, recognize and accept cultural practices of curing sickness and promoting health that may be different than your own, use interpretive skills in determining what practices are appropriate toward therapeutic interventions, understand there are subcultures within a culture who may

behave and believe in a different way from the main group, understand culture has a strong influence on behavior and may be difficult to change, be cognizant that there are similarities and differences in and between cultures, and be flexible in planning care for clients in keeping with their cultural beliefs.

The cultural environment of the health care facility is important to help establish good rapport with clients, and to demonstrate a higher level of cultural competency. Some guidelines to prepare a good cultural environment are: **have a quiet/private interview area without the barriers of exam tables or desks; posters/pictures, literature, or artifacts that are culturally in tune with the community should be displayed or available in the environment; allow ample time for the first interview -- at least 45 minutes.**

Initial Interviewing Guidelines

The process of gathering the secondary assessment data from previously identified abused women should begin with an interview. It has been established at this point that the client has been identified as an abused woman through some initial screening or through previous admission by her. The previous screening would have been perhaps a yes/no question on a health intake form, or perhaps the client's acknowledgement that she is or was abused.

Interviewing is a continuing process of cultural-data gathering and interpretation while obtaining the secondary

assessment information from the identified abused woman. **The interview process beginning with formal greetings and establishing names and titles is advisable for all clients.** Many African American and Hispanic women may view initial casual introductions by professionals as a sign of incompetence and or disrespect, which may hinder establishing good rapport (Galanti, 1991; Leininger, 1995). As part of the formal greeting **the APN should establish their experience as a professional and allow for questions. Familiarity with the client's language, correct pronunciation of names, and addressing clients with appropriate titles will help facilitate a better rapport.**

Open-ended questions asked during the beginning of the interview should be on an informal or relaxed pace between the practitioner and client. Resistance to self-disclosure and experiencing anxiety when asked too many questions too quickly, are commonly seen in abused women. Informal, open-ended questions will allow the client to take the lead in disclosure and provide an avenue for the practitioner to make initial uninterrupted visual and cognitive interpretive judgements of the client's overall status. This informal or relaxed approach will empower the client and allows venting subjective contributions that are imperative in the self-disclosure process of abused women. Through open-ended initial interviewing, the APN can determine the level of abuse the woman is able to acknowledge, prior to any attempt

to assess the abuse in detail. **It is very important to understand the abuse from the perspective of the abused woman before imposing a particular framework through the use of more structured cultural assessment modes.**

Initial open-ended interview questions should be asked of all abused women. The role of the practitioner during the initial interaction is a facilitator who is an active listener with heightened awareness to interpret the overall cultural relevance of information disclosed. This interaction provides understanding the abused woman's perspective about the violence, based on actual occurrences as she tells her story.

An example of some open-ended initial interview questions are: Can you tell me how you feel you are being mistreated? What specific acts of abuse have occurred? What have you used as methods of avoidance and self protection? What attempts to escape the abuse do you feel was successful or unsuccessful? Who or what do you believe is a support system? The initial objective is to examine perception of abuse, as well as determine what strategies the abused woman uses and their effectiveness with regards to her immediate safety. Open-ended questions are not based on any specific model or conceptual frame; it is the cultural interpretation of the answers to the questions that is the main focus of these guidelines. Open-ended questions help to get the interview going and will elaborate and enrich the interview

(Pedersen & Ivey, 1993). The initial self-disclosed information can be used later to compare or contrast with information given during the structured, culture-based interview.

Hispanic-Specific Issues.

There may be cultural issues to consider when conducting the initial interview with some abused traditional Hispanic women, such as language and acculturation levels. **All fluent languages and current acculturation level must be identified at the very beginning of the interview.**

Assuming that all Hispanic women speak Spanish is not appropriate. There are many countries and cultures represented within the Hispanic community. Language dialects and customs differ among these countries and cultures. **A basic knowledge of language differences in the community being served is a beginning toward cultural competency.** Learning the language or languages of the community will provide a means of learning about the cultural attitudes, including non-verbal communication (Pedersen & Ivey, 1993).

If language is determined as a relevant barrier in obtaining the assessment, an interpreter may be indicated. **Several interview guidelines in choosing an interpreter should be considered: choose one who shares the same cultural background, speaks the same dialect, is aware of sex/gender differences in the Hispanic culture, and has**

expertise in abuse issues. Introduce the interpreter and client and allow a little time for small talk; do not use the client's relatives or friends as interpreters; and plan for extra time when using an interpreter (Galanti, 1991; Perdersen & Ivey, 1993).

Using these guidelines in choosing an interpreter will assist in increasing the comfort level of the client. To use an interpreter in this fashion will promote more accurate disclosure and avoid misunderstandings or bias. This consideration will demonstrate to the client that the practitioner is culturally competent. Using an interpreter will help to avoid culture clash and enhance disclosure and trust building, which are extremely important in assessing and treating abused women.

Acculturation is generally defined as a process of integrating new cultural beliefs and patterns into the original cultural beliefs and patterns. **The APN must determine what specific language or languages the Hispanic woman speaks, what country she is originally from, at what age she came to the United States, and what cultural group she currently identifies with. Acculturation levels of the client may be determined by open-ended questions addressing these factors or by using an appropriate acculturation scale. A reference list of acculturation scales that can be used as an adjunctive tool is in Appendix B.**

Assessing current acculturation levels is important

because those levels can affect relationships, roles, perceptions, and behaviors. Conflicts may arise within relationships when changing or when differing acculturation levels occur between partners. These acculturation level changes can possibly incite an abusive cycle, affect an occurring abuse cycle, influence the Hispanic woman's perception of abuse, and may change her perceived options and responses to the abuse (Torres, 1987; 1991; Mayo & Resnick, 1996). All these factors in turn could seriously affect treatment.

As acculturation of the traditional Hispanic family increases, values may change accordingly. An example of this is role changes of females in traditional Hispanic families. Acquiring different cultural views may change role perception and status within the traditional Hispanic family, which in turn may cause dissension in the home. This strife over family members trying to maintain traditional female roles and status may meet with resistance by many Hispanic males and perhaps even by older family members who do not recognize the need for increasing acculturation levels and change in power status (Torres, 1991). This strife is often seen as a catalyst of domestic unrest and violence.

With increasing levels of acculturation of some traditional Hispanic women, there may be an introduction of more liberal religious teachings about their family role

when compared with religious teachings from the country of origin. This role change may in turn cause strife in many traditional Hispanic families. Also, there may be more choices in religions, providing more options to convert from traditional and predominant Catholicism to other denominations. Unlike traditional Catholicism, other denominations may recognize divorce as an option for women in an abusive relationship. This option to divorce or to leave the abusing partner may ultimately affect perception of abuse and tolerance levels in many abusive relationships.

The opportunity for employment and its influences on womens' roles, the opportunity for better or higher education, and a general disapproving attitude toward abusing women in the mainstream United States, are but a few more factors that may affect traditional roles within some Hispanic families. These changes in values through the acculturation process may challenge traditional Hispanic family power structures. This challenge of power status can and often does precipitate punitive reactions toward many Hispanic females (Torres, 1991).

Identifying acculturation levels can help facilitate openness in the practitioner-client relationship. **A client's acculturation level and language needs to be evaluated during initial contact.** Identifying acculturation level and language help to facilitate the client's self-disclosure and provides a more accurate baseline in care planning. Allowing

the client to identify her perceived cultural orientation leads to the creation of a culture-specific plan of care. An assessment without considering language and acculturation level would be a great disservice to many abused Hispanic women, and hinders provision of effective and quality care for them.

African-American Specific Issues.

Problems with self-disclosure or with interpretation of disclosure between practitioner and client may be an issue when interviewing some African American women. However, with some African Americans the type of language and acculturation issues that may arise are somewhat different than those of many traditional Hispanic women. The differences are that difficulty may arise between English language speakers; and, acculturation assumptions may occur about the client's cultural preference. Cultural issues related to many abused African American women may include: language/expressions, internal acculturation, and historic/ heritage influences on trust levels (Campbell-Williams, 1993; Coley & Beckett, 1988; Dobash & Dobash, 1992; Saunders-Robinson, 1991; Schwartz & Mattley, 1993; Sullivan & Rumptz, 1994).

Language problems can occur among English speakers. During the interview, the APN may experience client's usage of "street talk," words, sentences, syntax, or phonology that may be indicative of cultural or subcultural

influences. **Becoming familiar with the client's language can help determine possible subcultural influences on attitudes, beliefs, and behaviors** (Pedersen & Ivey, 1993). Familiarity with language differences may in turn help avoid difficulties in understanding the client's meanings and needs (Galanti, 1991).

It is generally viewed that practitioners who attempt to use "street talk" just to elicit self-disclosure may be considered as insincere by many African Americans. This type of interaction may hinder trust building and affect self-disclosure. Regardless of cultural or subcultural backgrounds, **it is more appropriate to just ask clients to make something more clear if the practitioner is in doubt, or is a novice in serving a community.** This straightforward approach serves as feedback and as a language learning process for the APN.

Encourage the client to use the language that is most comfortable for her in order to promote better disclosure and ascertain a more accurate assessment. Practitioners who use the client's language should do so if it is in proper context, if it is not contrived, and the client feels comfortable with the practitioner using the client's language. The basic step of recognizing and understanding differences in a community's cultural language and expressions is necessary to begin a meaningful and appropriate culture-specific assessment and plan of care.

Acculturation was previously discussed in reference to those Hispanics who relocate from country of origin to a different country. This acculturation is an external type. Internal acculturation is the process in which culture change occurs due to relocating (as moving from urban to rural areas), changing socioeconomic status, or personal preference of identifying with another culture (Galanti, 1991; Sue & Sue, 1990). **Assessing the internal acculturation of African Americans can help determine the client's identity with the dominant culture verses the client's identity with his/her own race** (Sue & Sue, 1990). **Understanding the process of internal acculturation can help alleviate any assuming of the client's cultural identification.**

Knowledge of a client's culture increases the practitioner's cultural competence level and may therefore ease the process of self-disclosure during the interview. A cultural barrier between practitioner and client could cause difficulty in the self-disclosure process and in providing an appropriate culture-specific plan of care. Mere observation and assumptions are not appropriate in determining the client's cultural group. **Ask the client direct, simple, open-ended questions to determine the client's cultural identity. An acculturation scale can be used as an accompaniment to help determine the client's cultural identification and acculturation level.**

If there is an internal acculturation issue, ask an open-ended question about how life experiences in past and present within the African American culture compare to those within the dominant culture. This example is an appropriate start in exploring and processing issues, and may help avoid the possibility of culture clash during the interview. It may also assist with identifying what cultural resources and supports are valued by the client, and to which new cultural resources the client may currently be receptive. **The client should identify what cultural group is most suited to her during the initial interaction.** Identification of what cultural group the abused woman perceives she is most familiar and comfortable with can help to disclose information that will help the practitioner move toward an individualized, culture-specific plan of care. Determining what the client identifies with is crucial in collecting early data.

Resistance to self-disclosure is common among many abused women in general. The differences in language and acculturation levels are two possible causes of cultural clashing and barriers in obtaining self-disclosure that may occur with some Hispanics or African Americans. **Knowledge of African American heritage and history can assist in understanding some possible barriers and resistance that the clinician may experience with some abused African American woman** (Campbell-Williams, 1993; Coley & Beckett, 1988;

Leininger, 1995; Rorie et. al, 1996; Saunders, 1995; Saunders-Robinson, 1991; Sullivan & Rumptz, 1994).

Culturally insensitive treatment may cause barriers between health-care provider and client. A common issue discussed earlier in this paper was that many abused African American women have often experienced treatment that was culturally insensitive. Insensitivities were perceived to be from racial discrimination, economic suppression, stereotyping of roles, lack of or poor services, and inadequate caregivers (Coley & Beckett, 1988; Saunders-Robinson, 1991; Sullivan & Rumptz, 1994). The feelings of mistrust may typically be seen in many abused women regardless of ethnicity. When these feelings are compounded with experiences of racial prejudice or cultural insensitivities, mistrust can become greatly magnified. Mistrust can be a barrier to disclosure and subsequently a barrier to obtaining an appropriate assessment that will be cultural-specific and individualized. As discussed in the acculturation section, the practitioner **through initial open-ended questions may uncover mistrust based on the client's past negative health-care experiences. Identifying barriers with the client needs to be done before gathering in-depth assessment data.** Campbell-Williams (1993); Saunders (1995) recommendation to possibly reduce barriers is that **understanding Afrocentric philosophy may assist in developing a culturally competent practice with some abused**

African American women.

Afrocentrism emphasizes African values and traditions which include the philosophy that there is a strong unity between nature, the spiritual world, and mankind, all of which make people responsible for one another (Saunders, 1995). This philosophy actually opposes many current concepts of individualism and that are stressed in mainstream Anglo culture. This belief of individualism and self-responsibility are basic psychosocial concepts used by many health care providers, and could be in direct conflict with Afrocentric philosophy.

If the client should identify with Afrocentrism, the Afrocentric philosophy can be used in planning care. Utilizing the Afrocentric philosophy may assist the practitioner through empowering some clients by **exploring with them community supports, healing options, and resources they identify with.** Knowledge of the Afrocentric philosophy may also help in understanding some abused African American women's perception of abuse and in knowing how cultural heritage may impact their perceptions.

Reducing barriers that arise from differences in language, assumptions of cultural identity, and experience of racial oppression and prejudice is not something that can be accomplished in the short term. **Strategies that involve self-exploration, community involvement, advanced learning, and application of cultural-care concepts are long-term**

commitments. The application of such knowledge in assessing many abused African American and Hispanic women can ensure effective interactions and enhance developing an appropriate culture-specific plan of care.

Structured Interview Guidelines Using Leininger's Model

Leininger's Sunrise model is the third and main topic in the guidelines. This topic addresses the application of Leininger's nursing theoretical framework by using the Adapted Sunrise Model as a structured visual guide during the interview of the identified abused woman (see Figure 2). The term "structured" guide is used only as a loose term in order for the practitioner to learn to cover all pertinent areas of the client's life and to ensure the accomplishment of accumulating enough assessment data to begin a culture-specific plan of care. **Use the model as a guide to ensure obtaining adequate and pertinent information, not as a rigid, systematic tool to control the interview process.**

As mentioned in the prepatory guidelines, the initial interview should not exceed 45 minutes. The initial interview with introductions, open-ended questions and considerations of any specific cultural issues has been accomplished. **The structured approach of the interview process may have to be scheduled at a later date. Extra time will be needed if instruments are going to be used consecutively with a structured interview. If the client is currently in distress or endangered, it is in her best**

interest to complete the assessment in one session. Continuing the assessment after the informal open-ended questions also depends on the willingness of both practitioner and client.

An overview of the structured interview section using Leininger's Sunrise Model is as follows: review of theoretical foundation of the Sunrise Model, significance of the components/domains, and application of the Adapted Sunrise Model.

Theoretical Foundation of the Sunrise Model.

As discussed in detail in the nursing theory section, Leininger's purpose in developing her Culture Care theory was to discover human care diversities and universalities and use the knowledge to provide culturally congruent nursing care as a pathway to health and well-being (Leininger, 1995). The development of the Sunrise Model was to provide a visual image to guide in conceptualizing the components of Leininger's Cultural Care theory. Using holistic cultural assessments assists in discovering what similarities and differences of expressions and lifeways there are among and between people.

The Sunrise Model can be applied to study Culture Care theory by using different components of the model (see Figure 1). The model helps to envision a holistic perspective of influences on culture care, which in turn influences the health and well-being of the client. The

model is not viewed as a theory but as components of the Culture Care theory. The practitioner may explore any area of the model, depending upon the client's identified needs and the influences upon her health and well-being.

Significance of the Model's Components/Domains.

The Sunrise model is to be used as a visual tool to inquire and to gather subjective and objective information toward culture care. Determining the beginning or focal point when using the model depends entirely upon the client's expressed needs, values, or greatest concerns. There is no logical or linear process when using the model. The practitioner moves with the client when exploring a situation and learns about the client's experiences within an environmental context. **Clients need to be encouraged to share openly and fully what they are experiencing.** Learning from clients within their own cultural environmental context is essential in culture care. The purpose is to allow the client to freely express her own needs and priorities. Facilitation is the main role of the practitioner.

Each component of the model needs to be studied in depth to identify cultural care aspects and understand how it relates to specific cultural groups. The skilled practitioner interprets meaning and explanations for the client's culturally learned behaviors and reflects upon the data received. The practitioner's interpretations are based upon the full knowledge of the particular cultural group

with which the client identifies. In doing a cultural assessment, practitioners can expand their understanding of the differences and similarities in and between cultural groups and discover alternate approaches for providing specific and culturally congruent care for clients.

When using the Sunrise model in assessing, the practitioner may begin with the client's perception of the world and reality (see Figure 1). A client's "worldview" is often governed by the significance or value level of specific "domains" (Galanti, 1991; Leininger, 1995). An example is: if a person highly values religion, his or her worldview will have religious foundations (see "religious & philosophical factors" domain in Figure 1). Understanding a client's worldview assists in understanding her behaviors and interpretations or perceptions of reality (Galanti, 1991; Leininger, 1995). **During the assessment, the practitioner needs to pay attention to language statements, the client's expressions, and revelation of any patterns/practices, all of which may hold covert values and influence the client's outlook on life and her well-being.** The interpretation of these covert discoveries are crucial in exploring a holistic plan of care with clients.

The practitioner may discover that some domains of the model's cultural and social structure dimensions may have more significance in some cultures compared to others (see Figure 1). A general example is: "religious / philosophical

factors" and "kinship / social factors" may be more significant for the client who practices Afrocentrism, and "technological" and "economic factors" may be more significant to Euro-Americans. Such a generalization would need to be thoroughly explored with the individual client before establishing its applicability.

The overall goal of the cultural assessment is to obtain a holistic assessment and to identify factors (domains) that have unique and significant importance to the individual client. The focus of Leininger's Sunrise Model is to ascertain an accurate holistic assessment, **paying particular attention to expressions, practices, and patterns that reflect the client's needs.** Thus, appropriate care decisions are made which are culture-specific and individualized. A culture-specific plan of care is more meaningful to the client and renders a more successful outcome.

Leininger's Sunrise Model is a culture-based assessment used mainly for medical diseases, illnesses, conditions, and situations related to such. The purpose of this project is to obtain an secondary assessment of identified abused African American and Hispanic women. The needs of abused women are typically related to emotional, psychological, sociological, and physical factors. An adaptation of the Sunrise Model was developed to accommodate the specific needs and issues of abused women and to address those needs

in a culturally based secondary assessment (see Figure 2).

Application of the Adapted Sunrise Model.

For the purpose of this project the Adapted Sunrise Model was developed, and will be explained. To visualize the differences between Leininger's original model and the adapted model compare Figure 1 with Figure 2. Both models have the same sociocultural domains, worldview, language, and environmental context. Alterations of Leininger's Sunrise Model were created to better address the specific needs of abused women.

One such alteration is the use of the concept "behavioral patterns," deleting the original Sunrise Model's "care expressions." This change was to concentrate on the abused woman's behaviors with emphasis on emotional/psycho-social status and not focus on the original model's care practices of disease, illnesses or related conditions. The deletion of "families, groups, communities and institutions" is in keeping with the purpose of this project, which is concentrating on assessing the individual abused woman. In addition, "culture care preservation, accommodation, and repatterning" are care goals that are focused beyond the assessment stage and are not applicable for the purpose of this project, and have been deleted. Determining cultural relevancy of assessment data, and establishing culture-specific care plans that both practitioner and client agree upon (cultural congruency) are

basic secondary assessment skills toward achieving cultural competency. "Cultural competency," cultural relevancy, and cultural congruency have been discussed previously. The "professional self evaluation" has also been discussed and should be a feedback process toward developing and maintaining cultural competency. Evaluating the cultural competency of "health care systems" needs to be on-going, paying particular attention to the primary care facility where the APN practices.

The Adapted Sunrise Model (see Figure 2) is to be used as a visual guide in order to ascertain a culture-specific secondary assessment of the identified abused client. As stated previously, there is no specific beginning point and the process should be a natural flow with the client. **When asking closed-type, structured questions to get specific information (on psychosocial or physical assessments), and to keep the interview on track, guidelines are as follows: identify facts about the client using "what" questions, identify issues or feelings about a problem by using "how" questions, identify or clarify detailed motives with "why" questions** (Pedersen & Ivey, 1993). Asking questions should not be at the pace of bombardment or done insensitively. **Timing and allowing the client to pace the interview are important. The questions should focus on the client's concerns. The structured questions should be goal directed and topic oriented, using the applicable domains of the**

model as a reference. These type of questions will help ascertain facts and limit any inferences which may be inaccurate. The questions will also allow revelation of emotional issues that are important to the abused client and reveal cognitive coping abilities with such problems and issues.

The psychosocial and physical assessments need to be incorporated in the structured interview using applicable domains from the Adapted Sunrise Model. When using the Adapted Sunrise Model the practitioner needs to incorporate a psychological assessment within the model's cultural framework. **The psychological status is an essential assessment component for all abused women. A psychological status that includes possible depression, danger levels (suicidal and or homicidal aspects), cognitive status, emotional status, and family psychological history should be part of an assessment for all abused women. Some of the psychological effects of abuse that need to be assessed, and that are applicable to many abused women in general include fear, anxiety, flashbacks and nightmares, difficulty concentrating, rage/anger, grief/depression/suicide, low self-esteem and shame, and cognitive changes (beliefs about the world and herself).**

The psychological evaluation incorporated throughout the entire interview needs to be based upon the client's subjective information and the APN's objective observation

of the client's behavior. The client's identified culture should be carefully considered in order to obtain an appropriate psychological assessment. Observation of the client's behavior needs to be evaluated in context of what is normal within the client's culture and environment. Accurately interpreting cultural relevance of the data collected is a vital objective for the practitioner. This skill will help avoid misinterpreting the client's patterns and behaviors as abnormal.

Some of the important components/domains (see Figure 2) to address while ascertaining a psychological status are: client's worldview, kinship/social factors, and cultural values/lifeways. Asking the client questions pertaining to these domain categories can help to obtain a comprehensive, psychological evaluation that is culture specific. Obtaining a family psychological history may help distinguish types of familial mental illnesses from behaviors considered normal within their culture. Asking questions about worldview may reveal sociocultural domains that are most significant in her life and can provide a picture of the client's overall cognitive status.

The practitioner needs to be aware that abused African American women who have expressed hardships with internal acculturation may exhibit psychological problems. As discussed previously, stressors from internal acculturation can be from socioeconomic changes, geographic changes, or

from experiencing the pressures of prejudice and racism within their own country. **These internal acculturation stressors can have a significant impact on many abused African American women's psychological well-being, and need to be explored with them.**

Homicide is a highly significant concern for many abused women, however, **APNs need to be aware that statistics reveal that many abused African American women are at a higher risk for homicide** (U.S. Department of Health and Human Services, 1991). **Danger of homicide needs to be part of the psychological screening for all abused women. It may be beneficial to use Campbell's (1986) Danger Assessment tool in addition to the interview process.**

Like many abused African American women, many abused Hispanic women have psychological manifestations that may be linked to their sociocultural conditions. **External acculturation, discussed in the open-ended interview segment, can be a great stressor for many traditional Hispanic women and needs to be evaluated by the practitioner.** The struggle between traditional roles and fitting into the mainstream of a highly technical society, places many Hispanic women at a crossroads. As discussed previously, this dilemma may cause role confusion and family strife, and thus possible social withdrawal and depression. **In regards to problems related to external acculturation that many abused Hispanic women may face, it is particularly**

important to screen for denial, depression, and danger levels.

Assessing both abused Hispanic and African American women's acculturation levels is imperative during the open-ended phase. Determining what this means in regards to the client's psychosocial adaptation needs to be given special consideration during the structured interview phase.

The sociological status is as important as the psychological status of all abused women. Often psychological and sociological information are entwined. A sociological status should address the client's perceived social supports and available resources. Some of the components/domains (see Figure 2) that can be used as a guide to obtain information in regards to the client's sociological status are kinship, economic/educational factors, lifeways, and spirituality.

Using an ecogram as part of a secondary assessment of abused women may be a very beneficial guideline. It can be used as reference to the kinship domain in the model. An ecogram is more in keeping with the purpose of a culture-based assessment. The ecogram, unlike a genogram, includes the client's definition of "extended" family and kinship. These extended family members may be highly significant to the client and more important to the abused woman than biological family members. When doing an ecogram, discussing the quality of relationships can address relationship

disturbances within the family. (The safety of children in the abusive home needs to be included in the sociological inquiry). A family's sociocultural history can also be incorporated into the ecogram.

In reference to the economic and educational domains of the model, it has been previously discussed that economic and educational status are not conclusively correlated with abuse. Abused women are from all socioeconomic levels. However, economic factors may cause sociological limitations, such as fewer choices in receiving quality health care or legal counsel. Similarly, abused women are from all educational backgrounds. Generally, educational factors are indicative of economic level, and thereby may affect availability of resources for the client. Educational level may also reflect the client's personal and cultural values, communication abilities, patterns of behaviors, and cognitive abilities. **Establishing the client's economic and educational status can help to explore appropriate and available resources.**

Obtaining information about the client's cultural lifeways (see Figure 2), is vital when obtaining sociocultural facts about the abused woman. Questions about lifeways can reveal general beliefs, values, and cultural relevancy of the overall subjective data. Questions about whether and how the client believes that her culture is a social support may yield important information toward

developing a culture-specific plan of care.

Kinship and religion/spirituality factors are areas of inquiry necessary for all comprehensive assessments of abused women. These domains can reveal longstanding social support systems, inner strengths, and deeper cultural values. Multiple articles and authors have indicated that both African American and Hispanic cultures have strong social ties and foundations to family and religion (Campbell-Williams, 1993; Coley & Beckett, 1988; Galanti, 1991; Leininger, 1995; Saunders, 1995; Torres, 1991).

Identifying family roles and family networks as social support or resource systems are imperative factors for a secondary assessment. As discussed previously, the traditional family role of many Hispanic women is one of submissiveness and tolerance, and the extended family of many Hispanic abused woman may be supportive of traditional roles. Therefore, family members could condone abuse toward a family member who is perceived as being disrespectful toward her traditional place and role in the family. **Social support systems need to be thoroughly explored with abused Hispanic women who take on traditional roles. Consideration of supportive organizations or people outside the family may be indicated.**

Generally, African Americans are often value strong, have protective bonds with those considered family, respect elders, and have independent spirits (Leininger, 1995).

APNs should be aware that members of the extended family and its kinship are often of great significance for African American women (Galanti, 1991; Leininger, 1995; Campbell-Williams, 1993). **Exploring who the extended family members are, their roles, and determining if they are considered a social support or resource is an important objective toward creating a culture-specific plan of care.**

Religion and spirituality may be a source of inner strength and social support for clients. A church can be an alternative or addition to family support. **A practical guideline is to assess whether the client is a member of a particular church and if the church has available economic and emotional supports.** It is generally known that many Hispanic people practice Catholicism and that divorce is not an option encouraged by the Catholic church. As previously discussed, **church law can perpetuate denial and increased abuse tolerance by many Hispanic woman. It is therefore indicated to obtain the client's experience with clergy and mutually determine if the church can be used as a resource in the plan of care.**

Like many Hispanics, African Americans may believe that religion is a principal part of daily living (Galanti, 1991; Leininger, 1995; Martinez, 1993). **The general guideline for assessing religious factors of clients is to determine their religious affiliation and what role the church may play in their lives. Explore the client's perception of whether the**

church or its members are considered part of the extended family. Inclusion of such recognized church members as part of a plan of care may lend to a more successful outcome with many African American clients.

Folk beliefs are often intertwined with religion for many Hispanics and African Americans (Galanti, 1991; Leininger, 1995; Martinez, 1993). **Explore family folk beliefs, practices, and their power in the client's life as a means of spiritual support and healing. Inclusion of the respected healers and folk practices can be integrated into the plan of care.** This inclusion may be very spiritually beneficial to many abused women who have related psychological, sociological, and physical problems.

Domains in the adapted model (see Figure 2) that can pertain to the physical history inquiry are cultural values and lifeways, technological factors, social factors, spiritual factors, and economic factors. As with all comprehensive assessments, obtaining the physical status of the client is imperative. **Obtaining a physical history from abused women should address the same areas, regardless of cultural orientation. Awareness of complications and potential health hazards commonly seen in abused women need to become part of the practitioner's physical assessment skills.**

Some manifestations of abuse that are seen as delayed physical complications are arthritis, hypertension, and

heart disease (Butler, 1995). Although these conditions may be seen in women who are not abused, the client's chronic abuse history may reveal a link to such physical complications. Common somatic complaints that abused women may have were discussed earlier. **Somatic complaints need to be assessed as valid physical complaints and collated with psychosocial findings to consider possible etiology.**

A serious health hazard for abused women is head injury. Head injury as discussed earlier, is a significant high risk for many abused African American women. **A neurological history and exam is strongly indicated for all battered women.** As already presented, perceptions of injury and its significance may have cultural implications. Minimizing or guarding injury may be a typical response by many abused women. **Regardless of reasons for minimizing injury, physical injuries need to be thoroughly assessed and documented.**

Some specific physical aspects to address using the Adapted Sunrise Model are history of client's and familial physical illnesses or conditions, economics and health care accessibility, dependencies on technological factors for health/wellness, cultural health care beliefs and practices, birth control and pregnancies, and religious or spiritual influences on health care practices.

Guidelines Using Assessment Tools

The last guideline's topic is about using abuse

assessment tools. **Using assessment tools is an option and should not be used as a sole means of assessing abused women.** Abuse assessment tools can be used if appropriate and used as a conjunctive means of data gathering. Self-reports and measurements have been presented in the conceptual terms and literature review sections. As reported, there are no available abuse assessment tools that have been tested within a cultural framework. **Selecting the appropriate tool depends upon the objective of the practitioner and should be based upon the individual client's needs.**

The APN may ask certain questions about the tool to determine its cultural validity. **A general guideline is to question if the tool takes into account language differences or barriers, cultural values and beliefs, and acculturation levels. Abuse assessment tools should include the client's cultural perception of abuse.** If these factors are not present, it is probably considered culturally biased. **Other questions to evaluate for bias-free tools proposed by Flaherty, Gaviria, Pathak, Michell, Wintrob, Richman & Birz (1988) are: Is the test relevant for the culture being tested? Is the meaning of each item the same cross-culturally? Would interpretations of all the variables remain the same when compared with each cultures norms? Is the test measuring the same context cross-culturally? Is the method of assessing the same cross-culturally? When using a Likert scale test, it is important for the APN to do a self-**

evaluation of biases and prejudices before interpreting results. Biases may not be related to any particular assessment technique or tool, but could occur from the prejudices and interpretive processes of the practitioner.

This concludes the guidelines for the project. An abbreviated guideline's outline in Appendix C may be used as a convenient reference. Implementation of these guidelines while interviewing the identified abused Hispanic or African American woman will need consistent and persistent practice and commitment. The opportunity for advanced practitioners to explore and evaluate the cultural approach in assessing abused women can be an interesting challenge.

Advanced Nursing Implications

A limitation of this project is that cultures are bountiful in the United States, and Hispanic and African American abused women represent only two of this country's cultural groups. To study abuse and culture care, inclusion of other groups are needed to begin improving care for all abused women. Another limitation is that this project focused on the interview process of assessing abused women and did not include intervention plans. In actual practice, assessments can not be separated from the process of interventions for abused women. Interventions are often simultaneously done when assessing people who are in crisis. Assessing, intervening, and evaluating the outcomes are dynamic elements of providing health care.

This project has attempted to bridge the complex concepts of culture-specific care and assessing abused women. Culturally based assessments are not typically used in the nursing profession. Traditional medical models representing psychosocial etiology and responses to abusive situations are more common. However, these medical models may represent a view that encapsulates many stereotypical inferences. Cultural and socioeconomic factors have a strong influence on many abused women. Research that focuses on cultural influences on abuse is scant. Cultural factors on abuse need to be studied further by APNs to help facilitate better outcomes in treating the growing population of culturally diverse abused women.

More research studies of abuse are needed to look at the chronic symptomology of abused women, which populations are at highest risk, and long-term health costs. Chronic abuse increases the risk for serious or chronic health care problems, thus may increase visits to primary health care facilities. The concepts of primary care and abuse have received some attention, but few are from a nursing perspective. There is a need for more nursing research on abuse and subsequent nursing-based approaches. Evaluation of health care facilities for cultural competency can be a good beginning baseline for research projects and for improving culture-specific care for abused clients. APNs working in primary care settings could easily provide an invaluable

contribution to improving care for abused women by researching culture and abuse.

Nurses may encounter abused women in their practice. Often abused women are seen in emergency rooms, psychiatric units, and in other crisis settings. It is often over-looked or underestimated how many abused women who suffer chronic health problems are seen in physicians' offices and primary care settings. As discussed, many abused women believe their caregivers are not sensitive to their needs, particularly if they are abused women of color. Cultural education and training of practitioners is imperative to obtain skills of cultural competency and to deliver culture-specific care to abused clients. The delivery of cultural care to abused women and their families is a highly specialized approach that is fitting for APNs who are in the primary care setting. Developing cultural competency training programs for primary care facilities would be a challenging experience for the advanced practitioner.

Although some nursing schools include culture and care in their curricula, they appear not to be addressing culture-care and the abused woman. Abuse of children and elderly are often included in educational curricula, but abused women are not typically studied. Since the abuse of women is a growing health care problem, studies of abused women need to be incorporated in nursing curricula and in clinical practice.

In practice, there are an abundance of abuse assessment tools based on medical models. APNs can alter these tools to a nursing model and incorporate culture-specific guidelines. Studies on the cultural validity of available abuse tools can also be a challenging project for APNs.

Advanced practicing nurses have an excellent opportunity to better serve their community by adopting a practice that incorporates culture care. Through self-study, practicing culture assessment techniques, and exploring the cultural competency within his/her practice, the APN can provide better care to many abused women.

Conclusion

The escalation of abuse in this country may be indicative of the failure in current health care practices. There is growing cultural diversity within our society. Abused women that represent all cultural groups frequent health care systems. Using cultural frameworks in obtaining health assessments from abused women is a beginning toward cultural competency for practitioners. Education and training of health care professionals need to include culture-specific curricula. Developing skills to obtain culture-specific assessments and to reach high levels of cultural competency is a beginning toward more effective care of abused women. Research to develop national standards of practice for all abused women is needed. Cross-cultural care of abused women is a research area befitting for APNs.

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APPENDIX A

ABUSE ASSESSMENT SCREEN

1. Have you <u>ever</u> been emotionally or physically abused by your partner or someone important to you? Yes ☐ No ☐

2. **WITHIN THE LAST YEAR,** have you been hit, slapped, kicked, or otherwise physically hurt by someone? Yes ☐ No ☐

   If YES, by whom?_____
   Total number of times _____

3. Since you've been pregnant, were you hit, slapped, kicked, or otherwise physically hurt by someone? Yes ☐ No ☐

   If YES, by whom?_____
   Total number of times _____

MARK THE AREA OF INJURY ON THE BODY MAP.
SCORE EACH INCIDENT ACCORDING TO THE FOLLOWING SCALE:

1= Threats of abuse including use of a weapon

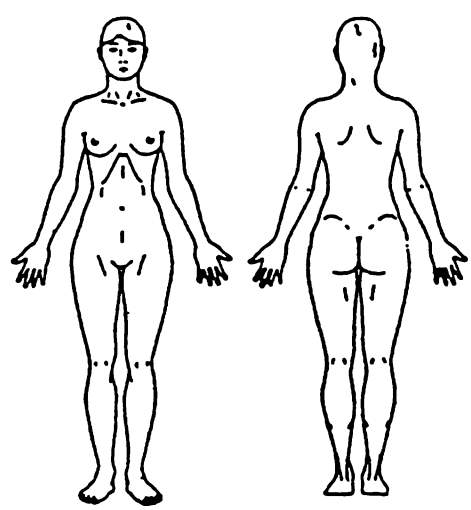
2= Slapping, pushing; no injuries and/or lasting pain

3= Punching, kicking, bruises, cuts and/or continuing pain

4= Beating up, severe contusions, burns, broken bones

5= Head injury, internal injury, permanent injury

6= Use of weapon; wound from weapon



SCORE

_____

_____

_____

_____

_____

_____

If any of the descriptions for the higher number apply, use the higher number.

4. **WITHIN THE LAST YEAR,** has anyone forced you to have sexual activities? Yes ☐ No ☐

   If YES, who? _____
   Total number of times _____

5. Are you afraid of your partner or anyone you listed above? Yes ☐ No ☐

Source: Developed by the Nursing Research Consortium on Violence and Abuse. Readers are encouraged to reproduce and use this assessment tool.

APPENDIX B

Acculturation Scales

Name of Scale	*Group*	*Reference*
Acculturation Questionnaire	Vietnamese, Nicaraguan refugees	Smither & Rodriguez-Giegling (1982)
Acculturation Rating Scale for Mexican Americans	Mexican Americans	Cuellar et al., (1980)
Acculturative Balance Scale	Mexican Americans, Japanese	Pierce, Clark, & Kiefer (1972)
Behavioral Acculturation Scale	Cubans	Szapocznik, Suopetta, Arnalde, & Kurtines (1978)
Children's Acculturation Scale	Mexican Americans	Franco (1983)
Cuban Behavioral Identity Questionnaire	Cubans	Garcia & Lega (1979)
Cultural Life Style Inventory	Mexican Americans	Mendoza (1989)
Developmental Inventory of Black Consciousness	African Americans	Milliones (1980)
Ethnic Identity Questionnaire	Japanese Americans	Masuda, Matsumoto, & Meredith (1970)
Multicultural Acculturation Scale	Southeast Asians, Hispanic Americans, Anglo Americans	Wong-Rieger & Quintana (1987)
Multicultural Experience Inventory	Mexican Americans	Ramirez (1984)
Racial Identity Attitude Scale	African Americans	Helms (1986)
Rosebud Personal Opinion Survey	American Indians	Hoffmann, Dana, & Bolton (1985)
Suinn-Lew Asian Self-Identity Acculturation Scale	Chinese, Japanese, Koreans	Suinn et al., (1987)

APPENDIX C

Guidelines for Obtaining a Secondary Assessment of Abused African American and Hispanic Women in Primary Care Settings

The following guidelines for obtaining a secondary assessment of abused African American and Hispanic women in primary care settings have been abbreviated and may be used as a reference. It is strongly recommended that the project contents be read before applying the guidelines in practice. It is important to understand the conceptual framework and model, as it provides a foundation for the application of the guidelines.

I) Prepatory Guidelines:

The "prepatory guidelines" is a check list for the determining of the practitioner's cultural competence level.

* Know the difference between culture-sensitivity and culture-competence
* Recognize cultural diversity in its entirety
* Accept client's culture on their own terms
* Be aware of own cultural beliefs and values
* Accept cultural health beliefs that differ from yours
* Utilize skills toward appropriate cultural interventions
* Be aware that subcultures may differ from the main group
* Understand the influence of culture on behavior
* Be aware of similarities and differences in and between cultures

(prepatory guidelines cont.)

* Be flexible in planning care to respect client's beliefs
* Provide quiet/private interview area without barriers
* Display pictures, literature and artifacts in keeping with community cultures
* Allow time for first interview (at least 45 minutes)

II) Initial Interviewing Guidelines

The initial interview is focused on establishing a good rapport and trust to facilitate self-disclosure. The APN uses interpretive skills to determine the cultural relevance of abuse assessment information obtained through open-ended questions of the client.

* Use formal greeting and establish titles and credentials
* Be familiar with client's language
* Ask open-ended questions (at a relaxed pace) of all abused women
* Understand client's perception of abuse
* Assume facilitator role with awareness of cultural relevancy of information received
* Use open-ended questions and interpret cultural significance as: can you tell me how you feel you are mistreated; what specific acts of abuse have occurred; what have you used as methods of avoidance and self-protection; what attempts to escape have been successful/unsuccessful; who or what do you believe is a support system

A) Hispanic-Specific Issues

* Identify client's fluent languages and acculturation level at beginning of interview
* Have basic knowledge of Hispanic language differences in the community
* Choose interpreter with same background and language dialect as client; who is aware of sex/gender differences; who is an expert in abuse; allow for extra time; and do not use client's relatives (Galanti, 1991; Pedersen & Ivey, 1993)
* Use open-ended questions to determine language; what country of origin; age arrived in this country; and what cultural group client currently identifies with
* Use acculturation scales if appropriate (Appendix B)

B) African American-Specific Issues

* Recognize client's language usage to help determine subcultural influences
* Ask client for clarity if words or meanings are unfamiliar
* Encourage client to use language that is comfortable for them
* Use client's language if it is in proper context and client feels comfortable
* Assess acculturation to help determine what culture client identifies with. Use open-ended questions
* Understand internal acculturation and its effects

(african american-specific issues cont.)

* Use internal acculturation scale if needed (optional)
* Ask how life experiences past/present within African American culture compare to those in dominant culture
* Establish what cultural group client identifies with during initial interview
* Be knowledgeable of African American history/heritage
* Identify any barriers of past negative health-care experiences before gathering in-depth data
* Understand Afrocentric philosophy and how to apply this in care plan if appropriate

III) Structured Interview Guidelines Using Leininger's Model

The structured interview is an approach to obtain a comprehensive culturally based assessment of the abused African American or Hispanic women. This requires using the Adapted Sunrise Model (see Figure 2). A psychosocial, and physical status is incorporated into the assessment.

* Use model as visual guide not rigid systematic tool
* Allow extra time for abuse assessment tools
* Complete assessment in one session if client is endangered
* Continue structured interview only with client's consent

A) Significance of the Model's Components/Domains

* Study model and its components with relation to different cultural groups
* Start assessment using the domain in model that correlates with the client's immediate concern

(significance of the model's components/domains cont.)

* Encourage client to disclose openly
* Begin with client's perception of "worldview", this is a good start in using the model
* Pay close attention to language, statements, expressions and patterns
* Remember the goal is to obtain holistic cultural assessment using all domains that are applicable

B) Application of Adapted Sunrise Model

* Use "what" questions to identify facts, "how" questions to identify feelings or issues, and "why" questions to identify or clarify motives (Pedersen & Ivey, 1993)
* Allow patient to pace interview, focusing on client's immediate concerns. Correlate concerns with appropriate domains.
* Incorporate psychosocial and physical assessment into structured interview, using appropriate domains
* Provide all abused women with a thorough psychological evaluation. Be objective.
* Be aware of signs and symptoms of depression, danger level, and cognitive/emotional disturbances
* Be aware of what normal behaviors are in different cultures
* Use worldview, kinship/social factors, and cultural values/lifeway domains when obtaining psychological

(application of adapted sunrise model cont.)

evaluation

* Obtain family psychological history to differentiate mental illness from cultural normalcy
* Be aware there may be psychological problems with some abused African American women who are having difficulty with internal acculturation
* Be aware there is high risk of homicide for many abused African American women
* Assess all abused women for danger level and homicide
* Be aware there may be psychological problems for many abused traditional Hispanic women such as denial and depression
* Be aware of psychosocial effect of external acculturation on many Hispanic women
* Address client's sociological status of perceived supports and resources
* Use kinship, economic/educational factors, lifeways, and spirituality domains for sociological assessment
* Be familiar with using an ecogram which can be used while discussing kinship and sociocultural family history
* Address safety of children in home
* Be aware that economic/education factors may reveal possible resources for client

(application of adapted sunrise model cont.)

* Ask questions about general values, beliefs and cultural relevancy of them in her life
* Inquire about kinship & religion of all abused women
* Identify family roles and networks as support/resource
* Explore support system outside family with abused Hispanic women, if appropriate
* Be aware that extended family is highly significant for many African American women and explore their roles
* Determine if client's church offers economic/emotional support
* Be aware that some abused traditional Hispanic women may have conflicts/issues with religious doctrines
* Determine if abused African American woman considers her church as part of extended family
* Explore family folk beliefs and practices as means of support and healing
* Use domains of cultural values & lifeways, technological factors, social factors, spiritual factors, and economic factors when obtaining physical assessment information
* Obtain thorough physical assessment of all abused women, documenting all injuries
* Be aware of complications, chronic conditions,

(application of adapted sunrise model cont.)

and health hazards of abused women

* Address all somatic complaints as valid
* Perform neurological exam for all battered women
* Be aware client's may minimize injuries, document
* Address family health history, economic/health care access, dependency on technology for health/wellness, cultural health care beliefs and practice, religious/spiritual influences on health care practices, pregnancy and birth control

IV) Guidelines Using Assessment Tools

* Use of abuse tools is optional and should be based on client's needs and objective of practitioner
* Question if tool considers language differences, cultural values, and acculturation levels. Needs to include client's cultural perception of abuse
* Question if tool is relevant for culture being tested, does each item have same meaning cross-culturally, would interpretation of all variables remain the same when compared with each cultures norms, is test measuring the same context cross-culturally, is method of assessing same cross-culturally (Flaherty, Gaviria, Pathak, Mitchell, Wintrob, Richman & Birz, 1988)
* Do self- evaluation of biases and prejudices before interpreting Likert scale tests

See guidelines in paper for examples and rational.