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Discourse

A Call to Focus Our "Passion for Substance" on Family Violence

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Why has family violence not been claimed by the Canadian nursing community as a vital issue for practice and research, when violence has affected the health of most Canadian individuals, families, and communities? The prevalence of family violence in Canada is well documented (Canadian Centre for Justice Statistics, 2000; Statistics Canada, 1993), and research supports the fact that family violence is a major health issue with grave consequences for physical, emotional, and social well-being (Butler, 1995; Campbell, 2000; Campbell, Harris, & Lee, 1995). Yet violence is not addressed widely in Canadian nursing education, research, or practice. In this discussion, we explore the conditions that have contributed to this apparent disregard of violence in the Canadian nursing agenda, and the consequences of this neglect for responsive research, theory, policy, and practice.

The Canadian Context

Canadian geography, history, and politics pose a unique set of challenges for dealing with violence and abuse. The vastness of the country and its relatively sparse population act as barriers to the formation of teams, networks, and a critical mass of researchers and practitioners concerned with violence, and to the provision of adequate services, particularly in rural settings.

Canada's history, founded on colonialism and immigration, provides an important backdrop to dealing with abuse by intimate

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partners. The historical oppression of First Nations people and racialized immigrant groups has created a legacy of violence and a particular context of health-care provision. Racialization interfaces with the dynamics of abuse in ways that may result in violence being seen as a problem for certain socially stigmatized groups and thus less worthy of investigation and action.

Current political trends in Canada, such as consolidation of right-wing factions, a more hard-line criminal justice response, and a favouring of "rights" over social responsibility, have had a profound impact on the social response (or lack thereof) to violence against women. In particular, the criminal justice system has dominated the social response. In addition, family justice systems have been increasingly involved. "Men's rights" and "fathers' rights" have provided an ideological platform for the use of the legal system as a tool of harassment, and abuse has extended into family courts where child custody and access has become an opportunity for continued abuse of women through their children (Bourque, 1995; Goundry, 1998; Reid, 1998; Taylor, Barnsley, & Goldsmith, 1996).

Finally, health care in Canada has recently undergone an unprecedented upheaval, with cost concerns driving a multiplicity of changes, including downsizing, reorganization, introduction of new information and biomedical technologies, and the systematic devaluing of nursing work (Armstrong & Armstrong, 1996; Canadian Nurses Association, 1998; Gregor, 1997; Nagle, 1999; Picard, 2000).

Within this unstable and often chaotic setting, concern for woman abuse has not had a significant profile in either nursing research or practice.

Violence Research in Canada

Nevertheless, research related to violence in Canada has become more visible in the past decade. The murder of 14 women at Montreal's École Polytechnique on December 6, 1989, shattered Canadians' complacency regarding the safety of their communities and moved violence to the forefront of social concern. In Canada, the strongest call for government initiatives to address violence came not from the health sector but from women's groups, based both in the community and in academia. The federal government extended its Family Violence Initiative and in 1992 funded each of five research centres for 5 years, to stimulate and support research on family violence and violence against women (Health Canada, 1999b).

Within these centres, the research thrust was interdisciplinary, community-based, and participatory (Health Canada, 1999b). In the 1990s, in fact, many national and provincial funding agencies began to require that proposals for research grants in all domains reflect significant efforts by researchers to work across disciplines and to partner with grassroots community groups and policy-makers. This requirement, when genuinely implemented, strengthens research efforts by increasing the relevancy of the research problems that are addressed, maximizing research expertise by bringing together diverse disciplines and sectors, and enhancing the usefulness of research in that both the research process and the findings have the potential to change the status quo. The research reports of the violence centres speak to the success of this approach (Health Canada, 1999a).

On the other hand, such collaboration requires consensus among participants, the negotiation of which takes much time and generally slows the research process. Further, the approach may not support the development of disciplinary knowledge since research problems identified by one discipline may not be seen as relevant to others. The centres focused on social welfare responses to violence and increasingly were drawn to the criminal and family justice systems; nursing and health were not major features of their work.

Development of Canadian Nursing Research in Violence

Harding (1991) argues that those who get to define what counts as a legitimate research problem play a powerful role in shaping the resultant view of the world. Although Health Canada was the leading agency in the violence initiative, the research centres were funded under the Social Science and Humanities Research Council (SSHRC), not the National Health Research and Development Program (NHRDP), an agency more familiar to nurse researchers. The driving forces transforming these violence research centres into functioning entities came from the social sciences rather than health. Funding of the violence research centres under SSHRC, the emphasis on social welfare and justice system responses, and the call for multidisciplinary, intersectoral approaches influenced how violence research was addressed, not only in the centres but within nursing as well.

Nurses interested in violence research often joined teams whose research concentration, while consistent with a social determinants of health perspective, often moved their research focus away from nursing concerns regarding violence. Indeed a review of the annotated research

reports of the five centres (Health Canada, 1999a) reveals that while many investigations were concerned with justice system responses, few studies explicitly addressed health and none directly addressed nursing. In addition, possibly because violence research was allocated to SSHRC, health research on violence did not emerge as a priority for other national health funding agencies such as NHRDP or the Medical Research Council of Canada (MRC). Unquestionably, these teams offered nurses a rich network of research colleagues based in both communities and academia, new insights into the complexity of family violence, and diverse opportunities to develop their research skills. On the other hand, nurse researchers were not always recognized for bringing to the team either a disciplinary perspective or research expertise. In Canada, nursing is not known publicly for its work in family violence, and many nurses who joined the teams were in the early stages of their research careers or were doctoral students. Hence, the power of nursing to influence was limited.

Another factor confounding the emergence of violence on the nursing research agenda was the development of nursing as an academic discipline. During this period the discipline was in transition, as Canada's first doctoral programs in nursing were being established. In justifying the need for such programs, nursing faculties were challenged by university and funding communities to delineate the uniqueness of nursing science vis-à-vis medicine or the social sciences. In this climate, violence, already claimed by the social sciences, did not emerge as a central issue for knowledge development in nursing. Faculty members were inclined to develop research programs that were more obviously aligned with nursing's paradigm, such as developmental transitions, health challenges, or diseases that presented evident challenges to nurses. Violence, close to invisible in nursing practice, remained so in research. Doctoral students were encouraged to carry out work relevant to their supervisors' interests and likely to garner training funds from provincial and national funding agencies. Indeed, in a November 1995 national symposium on nursing research priorities organized by the Canadian Nursing Research Group, the Canadian Nurses Association, and the Canadian Association of University Schools of Nursing, violence was barely mentioned. The consequence for nursing in Canada is that the cadre of nursing researchers interested in violence is small, few nursing doctoral students choose to study issues of violence because of the scarcity of mentors and funding, and opportunities for post-doctoral fellowships or career awards in violence research are few.

Implications for Policy and Practice

The limited attention to violence in Canadian nursing research has seriously limited nursing's contribution to health policy and practice. First, we have little research that addresses our unique context, and second, there is little uptake of the significant volume of nursing research done elsewhere. In Canada at present the nursing research and practice leadership concerned with violence is a handful of dedicated individuals who are primarily focused on violence as a substantive area of concern. While development of this cadre is critical, what is required is a larger critical mass and a broader, more integrated approach. Considering the likelihood that many nursing clients will have some experience with violence, nursing practice, and the theory that guides it, must be informed by knowledge of violence. For example, nurses who investigate, teach, and work in mental health and acute psychiatric care must be recruited to incorporate theory about violence in their work, and to contribute to the development of theories and practices related to violence. Similarly, nurses who teach and research family theory must be encouraged to integrate knowledge of abuse into their work. Rather than developing an isolated body of knowledge about violence, nursing knowledge in such areas as families, communication, mental health, health promotion, and caring should be imbued with what is known about violence. At present, little of what is known about violence is drawn through the core conceptual knowledge that directs our practice.

Work by nurses in other countries, most notably the United States, has created an awareness of abuse as a nursing issue and has contributed significantly to the conceptualization of abuse as a health issue. For example, the extensive work by nurses on abuse and pregnancy (e.g., Campbell, Soeken, Oliver, & Bullock, 1998; McFarlane, Parker, Soeken, & Bullock, 1992) has done much to unseat idealized views of pregnancy and motherhood, and has raised awareness of the issues. But how has this work been taken up in theory, policy, and practice? A similar prevalence of abuse in pregnancy has been documented in Canada (Stewart & Cecutti, 1993). But have the research findings been used in Canada to inform all practice areas in which pregnant women and mothers come into contact with nurses? Has this work been used to develop comprehensive programs of perinatal care infused with an understanding of abuse as a common and all-too-frequent feature of women's lives? Or has it only been used to support the occasional program to identify some women as abused?

The substantial body of work from other disciplines in Canada and other countries also provides sound direction. But this direction has not been acted upon. Despite numerous reports with comprehensive recommendations (e.g., British Columbia Task Force on Family Violence, 1992; Canadian Advisory Committee on the Status of Women, 1991; Canadian Public Health Association, 1994), there is little evidence of a meaningful social or health-care response to woman abuse, and most of the recommendations have never been implemented in policy or practice. Few resources have been provided to take action within nursing. It is difficult to estimate the impact of those few initiatives that have been taken within health care and nursing, because formal evaluation is rarely built into the project. For example, in 1994 Health Canada sponsored the publication of a curriculum guide for health professionals that provided direction for dealing with violence in a variety of ways (Hoff, 1994). However, no published data are available to evaluate the extent to which these recommendations have been taken up by nursing schools since Hoff and Ross conducted their 1992 study of nursing curricula (Hoff & Ross, 1995).

Where Do We Go From Here?

What can be done to begin building a nursing infrastructure to support nursing research in violence and the application of research findings in policy and practice? Ironically, the efforts of nurse investigators to collaborate with other disciplines and sectors may have isolated us from our nursing colleagues. An important step for us is to begin networking with each other, through vehicles such as the Nursing Network on Violence Against Women, International, an organization that held its first conference outside the United States in Vancouver in June 2000. As a group, we can develop strategies to bring violence into the mainstream of nursing research. One means of doing this is through partnerships across institutions among those already involved in research on violence. One such effort is underway in a program of research being conducted by nurses at the University of Western Ontario and the University of New Brunswick (see Happenings in this issue). Another strategy is to consider how violence can be integrated with other nursing research interests such as child health or health promotion, particularly in those areas seen as funding priorities. This tactic has been used effectively by our colleagues in the US, for example, in their development of a program of research focusing on abuse in pregnancy. Finally, nurse researchers face the opportunity and challenge of claiming violence as an important and fundable health issue by applying for grants, traineeships, and career awards from the new Canadian

Institutes of Health Research. Although there is no institute for violence, there are opportunities to demonstrate how violence fits the agenda of several of the planned institutes. It is critical that these arguments be made early in the life of these institutes, to ensure that violence research takes a legitimate place as a research priority.

Nursing now has an opportunity to envision, implement, and evaluate meaningful health-care approaches to abuse and violence. Without a strong nursing contribution to the development of violence research, opportunities to offer nursing alternatives to biomedical and epidemiological frameworks are limited. For example, nursing could complement calls for "universal screening" that arise from an epidemiological model with health promotion frameworks, relational frameworks, nursing theories, and family nursing theories. Core areas of nursing concern, such as growth and development, communication, mental health, and family theory, must be targeted for an infusion of theory regarding the dynamics of abuse. Without a strong claim by nursing that violence is a universal concern affecting a wide scope of practice, clinical problems will remain unexamined. For example, pediatric nurses may continue to deal with "non-accidental injury" without the benefit of understanding the relationship between child abuse and woman abuse.

In 1987 Meleis called for nursing to develop a "passion for substance," to focus knowledge development on the major phenomena central to nursing. She claimed that such passion would further our knowledge development and our potential for the generation of gender-sensitive and culture-sensitive theories. We claim that violence is a phenomenon central to nursing. Nursing's voice must be heard among the voices of social scientists, women, and communities calling for public policy and social action to address violence and abuse. This can happen only if the public is aware that violence is woven into the conceptual fabric of nursing practice. Nursing's presence in the interdisciplinary and intersectoral work that addresses violence must shift from that of supporting cast to leading role. We must make clear to others how our research and practice knowledge adds to and offers direction to current efforts to address this significant health problem. We invite you all to take up this challenge.

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