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Happenings

Making Connections: A Vehicle for Developing a Nursing Response to Violence Against Women and Children in Canada

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There can be no question that violence is a health issue affecting the lives of countless Canadian women and children (Canadian Centre for Justice Statistics, 2000). In the past decade we have witnessed a dramatic increase in public acknowledgement of the effects of violence in our society, due in large part to the influence of the mass media in providing vital information and reshaping attitudes. It is astonishingly clear, however, that, despite increased public awareness, nursing in Canada has been slow to systematically "adopt" violence as a health problem that falls within our domain.

There are isolated examples of nurses' involvement in innovative educational and service projects across the country (e.g., Hoff, 1994). A small number of Canadian nurses have made important contributions to our understanding of the nature of woman abuse, the processes of leaving an abusive relationship and healing, and the strength shown by women who have been abused (Eriksen & Henderson, 1998; Henderson, 1990, 1993, 1995; Merritt-Gray & Wuest, 1995; Varcoe, 1997), as well as the health effects of abuse (Kerouac, Taggart, Lescop, & Fortin, 1986; Ratner, 1993, 1995a) and societal responses to woman abuse (Ratner, 1995b). Also investigated have been children's experiences of witnessing abuse (Bennett, 1991; Berman, 1999a, 1999b; Erikson & Henderson, 1992; Henderson, 1990, 1993) and the effects of these experiences on their health and development (Kerouac et al, 1986;

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Onyskiw, 1999). What has been missing is a systematic, national response from the nursing community at large to the ever-present issue of abuse.

We have an opportunity to focus our attention on violence as a critical health issue and assume a leadership role in promoting an anti-violence agenda. This challenge will require effort on many fronts. Researchers can contribute by studying the health effects of abuse and the processes of healing and by developing and testing nursing interventions to support these processes. Innovative practice models for responding to abuse as well as violence-prevention programs must also be developed and evaluated. Nurse educators must find ways of integrating knowledge and clinical experience related to violence into already heavy undergraduate curricula and under-funded continuing education programs. Furthermore, we must use evidence from our successes in research, practice, and education to influence policy and service delivery at a broader level.

A critical first step is to build the infrastructure needed to support an anti-violence agenda within nursing. For researchers, the primary challenge lies in identifying a "community of scholars" — a network of nurses who are committed to an anti-violence agenda *and* who are capable of developing and carrying out research programs that systematically address key issues of national importance.

Given that there are relatively few Canadian nurses conducting violence-related research, this article will address strategies that might be used to build the communication networks and working relationships needed to establish nursing as part of the solution to the health problem of violence.

Connecting with Existing Networks: the Nursing Network on Violence Against Women, International

Canadian nurses interested in the issue of violence can use the Nursing Network on Violence Against Women, International (NNVAWI) to connect with each other and with nursing colleagues internationally. The NNVAWI was formed in 1985 to help nurses respond more effectively to the effects of violence in women's lives. It embraces an empowerment philosophy in which women are viewed as survivors and the nurse's role is to support each woman's process of leaving an abusive relationship on her own terms. The overarching goal of the organization, to ensure a nursing presence in the struggle to end violence in women's lives, has four components:

- to provide leadership and outreach to nurses and others in the sharing of knowledge and ideas necessary to support nurses in their work on violence against women
- to create supportive strategies to mitigate the effects of violence, abuse, and exploitation of women
- to sponsor international nursing conferences that bring together researchers, educators, providers, and advocates in the area of violence against women
- to network at other conferences attended by nurses, especially those that focus on women's health and on issues of violence.

In addition to publishing a quarterly newsletter and establishing a website, <www.nnvawi.org>, the NNVAWI sponsors an international conference every 18 months. The 10th conference, held in June 2000 in Vancouver, was the first to take place outside the United States. This trend reflects growing international interest and activity in the small and thriving organization, which currently has only 100 members but which represents five countries (Australia, Canada, China, Great Britain, and the United States).

Approximately 20 Canadian nurses are active members. Dr. Janet Eriksen of the University of British Columbia is Secretary of the Board of Directors. At the most recent conference, Canadian nurses from coast to coast presented papers on current or recently completed studies addressing a wide range of issues: children's responses to witnessing physical aggression in the family (Onyskiw, 2000), parenting support for mothers who have left abusive relationships (Henderson & Eriksen, 2000), the impact of woman abuse on the health promotion processes of single mothers and their children (Ford-Gilboe, Merritt-Gray, Berman, & Wuest, 2000), nurses' understanding of the lives of abused women (Henderson, 2000), clients' experiences with a specialized sexual-assault service (McIntosh et al., 2000), development and testing of a perinatal-abuse screening tool (Stewart & Midmer, 2000), and nurses' experience of workplace violence (Acorn, Wong, Hyndman, & Clarke, 2000).

Benefits of Membership

Issues of violence surpass national boundaries and regional interests. The NNVAWI already provides a venue for Canadian nurses to connect with colleagues, both in Canada and abroad, and to disseminate their work, but there is potential for greater participation. The nature of this small, open organization makes it an excellent forum for interacting and sharing ideas, obtaining feedback, gaining support, and forming

the alliances that are necessary for building a community of scholars and developing national and international research projects. Members have a variety of interests and areas of expertise as researchers, clinicians, and educators. This organizational strength contributes to enhanced dissemination and use of research findings and to the development of an integrated nursing response to violence. The NNVAWI has gained wide recognition as a force for change in the United States. In acknowledgement of its contributions to the advancement of nursing education, practice, research, and policy on violence, the NNVAWI was recently presented with the first Health Care and Domestic Violence Leadership Award by the Family Violence Prevention Fund. By joining the NNVAWI, Canadian nurses can help to increase the visibility of violence as a health issue and to open the door to change in Canada as American nurses have done in the United States.

Building Our Own Networks: Collaborative Research Teams

On a national level, nurses face at least two challenges in developing research programs related to violence. The first of these is to develop teams that build upon local expertise but cut across regional boundaries. Since relatively few Canadian nurses could be considered experts in this field, how can strong research teams be formed? The second challenge is to secure national research funding as a means of promoting awareness of violence as a health issue and fostering consideration of violence in national discourse and policy-making about health and allocation of health resources. Within the Canadian Institutes for Health Research (CIHR), violence has been specifically identified as a priority area in the recently formed Institute of Gender and Health. Given this opportunity, how can we begin to compete for funding at the national level?

An Example

The experience of one team of nurse researchers in developing two studies related to violence may serve to illustrate how the challenge of building a team and obtaining funding can be met. This team is conducting two 3-year concurrent studies in two provinces (Ontario and New Brunswick).

The first study, a feminist grounded theory investigation of the impact of woman abuse on the family health promotion processes of single mothers and their children (Ford-Gilboe, Berman, Merritt-Gray, & Wuest, 1997), is funded by the Medical Research Council of Canada.

The second, which uses a participatory action approach to explore the impact of public policy, both as it is written and as it is enacted at service-delivery levels, on health promotion within these families (Wuest, Berman, Ford-Gilboe, Merritt-Gray, & Kerry, 1998), is funded by the National Health Research Development Program (NHRDP). Families' descriptions of their experiences with the "system" provided in study #1 are being used as a basis for identifying relevant policy issues to explore with service providers and policy-makers. Findings and recommendations will be shared with stakeholders during policy fora as a means of fostering both policy and system change and will also be used to refine the theory developed in study #1.

Developing the research team. A number of factors can be credited with drawing the team together and developing trust and solidarity. Subgroups of the team at each site shared a history of successfully working together. Further, three of the investigators had been exposed to issues of violence as doctoral students at Wayne State University and had been mentored by Dr. Jacquelyn Campbell.

Although team members were conducting research in different areas using different methods, all of the work was grounded in a feminist/critical perspective. Initially, this shared perspective was helpful in establishing a common ground for viewing abuse and for developing respectful ways of sharing the work so that all voices could be heard and the strengths of individual members used to capacity. In Ontario, Berman's work focused on children who had witnessed violence and on the use of narrative analysis, while Ford-Gilboe was conducting research on health promotion in single-parent families using primarily quantitative surveys combined with qualitative family interviews. In New Brunswick, Wuest and Merritt-Gray had recently studied the process of leaving an abusive relationship and both had expertise in grounded theory methodology. Through discussion, a natural intersection in the collective expertise of the team that represented a gap in knowledge about abuse was identified and used to focus the first project. As the focus of the second study became clearer, Kerry, who had expertise in the policy arena, was invited to join the team. Early in the process of developing the team, the need for more than one investigator at each site was identified, in order to reduce isolation, provide flexibility, help track the emergent design, and provide the ongoing emotional support that is often necessary in research on sensitive topics.

Obtaining funding. The priorities of funding agencies and how to fit the interests of the team into these agendas were of primary importance. In the first study, violence was linked to health promotion and

the broader determinants of health — a novel approach based on the literature review. The second study's focus on public policy fit well with the NHRDP's identified research priority in health policy. However, as non-traditional approaches were being proposed in both studies, a particularly compelling and sound case needed to be made. Several strategies were used to present as tight a case as possible. These included: offering specific examples of how the emergent designs might develop; asking colleagues who were unfamiliar with the methods and/or content to critique the proposal; and repeatedly highlighting how the research was innovative, built on prior work in the field, and was being carried out by a team that had already done the necessary pilot work. For example, preliminary data from a survey of single-parent families (Ford-Gilboe, Berman, Laschinger, & Laforet-Fliesser, 2000) were used to document the significance of woman abuse for single mothers (i.e., 55–88% of mothers reported having experienced one or more types of abuse in a partner relationship). The use of two sites was identified as a strength rather than a limitation, and details were provided about how the team would conduct the work at a distance (via e-mail, teleconference, team meetings, etc.). The timing of the second proposal was also strategic in that a finite window of opportunity to access the sample in study #1 would be lost if funding was not obtained quickly. Thus, the first grant was used as leverage for the second.

These two studies represent small steps in developing a body of knowledge about the health effects of abuse and effective ways of responding to this issue. Nursing represents a wide range of interests that cross clinical populations and settings. If violence is seen as an important issue affecting the lives of countless women, children, and families, many opportunities can be found to integrate it into established research programs, in areas such as women's health, child health and development, family processes and transitions, healing, health promotion, decision-making, and stress and coping. The fact is that a team of relatively junior nurse researchers, located in two distant provinces, was successful in obtaining federal funding for non-traditional research. This may serve to encourage other researchers to consider how their particular interests and areas of expertise might fit with an anti-violence agenda, and to develop projects around these interests and submit them for funding.

An Invitation to Action

In speaking of the social mandate to support the development of healthy families, Hillary Rodham Clinton (Clinton, 1996) popularized

an ancient African proverb, "It takes a village to raise a child." The anti-violence agenda is not unlike a small child — early in its development and vulnerable to the effects of neglect by those who would dismiss it. It is not too late for the nursing community to adopt and nurture this child. Alone we are powerless, but collectively we can so do much to improve the health of women and children. Do you hear this call? How will you respond?

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