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GUEST EDITORIAL

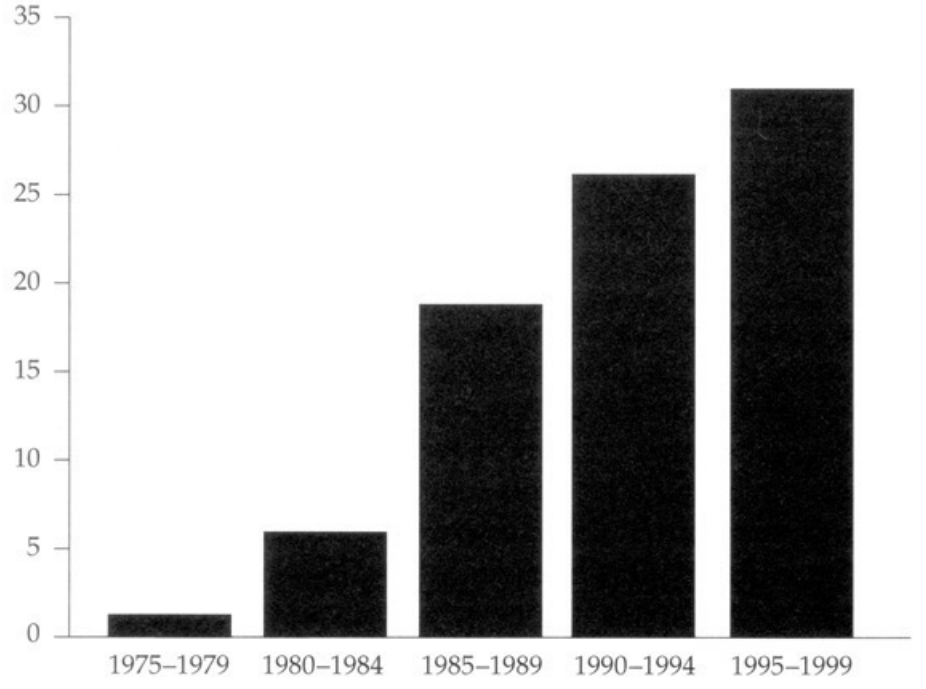
A Celebration of Nursing Research on Violence

Jacquelyn C. Campbell

I have been so excited and privileged to be able to work with the fine editor and staff of the *Canadian Journal of Nursing Research* as well as with all of the wonderful scholars who answered our request for manuscripts or made other contributions. It has been a wonderful process and, more importantly, we have together produced a volume that will be a significant contribution to the nursing science, and science in general, on violence. One of the most gratifying aspects of the process is that more quality manuscripts were received than could be published in this issue. As a result, there are several more on the topic of violence from the original solicitation that will be published in *CJNR* over the next year. I hope that this issue and the articles that follow will spark even more interest in nursing scholarship on the topic.

The growth in North American published nursing research on violence, especially violence against women, over the past 25 years has been phenomenal. See Figure 1 for a graphic representation of the impressive increase in the field of intimate-partner violence alone! Barbara Parker's epidemiological study of the risk factors for intimate-partner violence, which appeared in 1977 in the *American Journal of Public Health* (Parker & Schumacher, 1977), is the first published nursing research I have found on domestic violence and is, I believe, the first published health-care research on the subject except for a few very early psychiatric case studies. Four more articles were published between 1980 and 1984, and that small beginning grew to more than 30 data-based nursing studies (identified as such or published in a nursing journal) between 1995 and 1999. There are two very recent reviews of all of the nursing research in the domestic-violence field (Campbell & Parker, 1999; Humphreys, Campbell, & Parker, in press), as well as many excellent reviews of research on intimate-partner violence and various aspects of health, including abuse during pregnancy, that include nursing research (e.g., Gazmararian et al., 2000). Nursing scholars and practitioners interested in this field need to be directed to such

Figure 1 *Published Nursing Research on Intimate-Partner Violence, 1975–1999*



Source: Campbell & Parker, 1999.

references. It is discouraging to read clinical nursing articles, nursing research publications, and nursing theses and dissertations that review the literature on domestic violence without citing the important nursing scholarship in the field. The interdisciplinarity of the violence field is important and laudatory, but nursing also needs to cite the contributions of its own discipline.

The most outstanding in-depth contribution made by nursing scholars to a particular component of violence research has been in the area of abuse during pregnancy. One of the two earliest published studies of this phenomenon came from nursing scholars (Helton, McFarlane, & Anderson, 1987), followed by a decade of sustained, multiple studies using a variety of methodologies that have explored this area in all of its important facets. It is wonderful to see one of the earliest nursing scholars in the area of abuse during pregnancy, Linda Bullock (Bullock & McFarlane, 1989), represented in this issue, as she publishes the first known investigation of abuse and breastfeeding. This area is a natural for nursing research. Although this initial investigation did not show a relationship, more research is needed in this area,

especially in-depth studies using qualitative data. Abuse during pregnancy has not had the attention of enough Canadian nursing scholars to date, and I would love to see more research from them in that field. Especially ripe for nursing inquiry is testing of the Parker, McFarlane, Soeken, Silva, and Reel (1999) intervention for domestic violence in prenatal clinics. This is another example of nursing research breaking new ground, actually testing an intervention in a health-care setting. The initial research used a quasi-experimental design and found some evidence of increased safety behaviours and decreased violence. The intervention can be adapted to any kind of patient or setting — a perfect opportunity for further testing.

The books reviewed in this issue represent both the interdisciplinarity of the field and nursing contributions to these collaborations. Rebecca and Russell Dobash's *Changing Violent Men,* reviewed by Angela Henderson, demonstrates that batterer intervention programs can be effective in decreasing repeat domestic violence. The research reported in that book provides important information for practising nurses to use for informed referrals as well as demonstrating methodological advances in combining qualitative and quantitative data and measurement of violence. The second book, reviewed by Helene Berman, is an anthology of primary data on wife beating and battering from 15 small-scale societies, edited by two anthropologists and me. It demonstrates the rich range of research methods being used in violence research as well as formulating important messages for prevention of domestic violence and cultural competence in interventions.

This issue of *CJNR* is another such resource for nursing scholars and clinicians. It is particularly exciting in that it represents a fuller range of violence inquiry than has been true in much of the research recently published. More attention has been paid to intimate-partner violence than to the other areas of violence, in both nursing research and recent research from other disciplines. Although this attention is a commendable development, the other forms of violence are equally detrimental to the health of human beings. Recent research has demonstrated that childhood physical and sexual abuse have detrimental effects on women's health over and above those resulting from domestic violence (e.g., McCauley et al., 1997). Yet nursing investigations of these issues have been scarce. Rape continues to be a pervasive form of violence against women that, after Burgess and Holmstrom's (1974) groundbreaking nursing research in the field, has been relatively neglected by nursing scholars, even though clinical nursing as practised by forensic nurses and Sexual Assault Nurse Examiners has been increasingly recognized as important to the field. And although child

abuse with its clear long-term detrimental effects persists to a discouraging extent, with a nursing intervention shown to be the most effective in preventing it (Kitzman et al., 1997), nursing research has never been particularly notable in that area.

Even so, this issue of the Journal addresses a wide variety of violent acts from the perspectives of both the victim and nursing. I am honoured that Judith Wuest and Marilyn Merritt-Gray chose this forum to publish the third in their outstanding series of articles articulating their theory of women's process of leaving an abusive partner. This is an area to which nursing scholarship also has contributed significantly. The qualitative data analyses by nursing scholars such as Landenburger (1989, 1998), Taylor (1998), and Ulrich (1991, 1998), and my own longitudinal study (Campbell, Rose, Kub, & Nedd, 1998), have provided insights into this process, but Wuest and Merritt-Gray's theory has been articulated now in the most depth. In the article published here, they break new ground by fully articulating the process by which battered women reclaim their sense of self after an abusive relationship. This important work continues the trajectory of much of nursing scholarship that emphasizes the strengths of survivors of violence rather than pathology.

This issue is also noteworthy in representing a variety of exciting cutting-edge research methods, as has been true and commendable about most of the prior nursing research in the field. The Wuest and Merritt-Gray article exemplifies feminist grounded theory methodology, which is being further developed in the collaborative process described in Marilyn Ford-Gilboe's essay. Helene Berman's study of the effects of violence on a national scale on Bosnian youth is an important contribution in terms of both its landmark content and its use of photography as a qualitative method of inquiry, not so much as data but as a way for children to tell their stories. Nursing should be encouraged more to develop innovative research methods and also to take advantage of opportunities to shape existing methods and databases for nursing research, as Judee Onyskiw urges us to do in her methodological essay. Each of the articles both illustrates a variety of methods of inquiry well used in these studies and thoughtfully reflects on their limitations as well as their advantages.

As well as highlighting nursing's attention to the effects of violence on health, this issue of *CJNR* addresses the part that nurses play as intervenors and as victims themselves. Colleen Varcoe's study illustrates yet another methodological approach, an ethnographic combination of participant observation and in-depth interviews with nurses. As

the rest of us urge routine screening of patients for violent experiences and expert nursing interventions, Varcoe addresses the personal and system barriers that prevent nurses from implementing the kind of care the victims of abuse need and deserve. This qualitative study echoes the results of my recent quantitative experimental design of the effectiveness of training on intimate-partner violence in emergency department settings (Campbell et al., in press). This kind of convergence of qualitative and quantitative findings on the same subject strengthens our science and makes it more persuasive.

Finally, in another extremely important article, Duncan and colleagues address the issue of nurses being victimized as part of their working environment. I have been waiting for a prevalence study of nurses' experiences of workplace sexual harassment for 20 years, and this article at least begins to break down that barrier. It also documents the extent of all of the different forms of violence and abuse that nurses encounter as part of their employment and uses sophisticated analytic techniques to identify risk factors, again demonstrating the importance of workplace structure and supports in making superior nursing performance possible. The article also addresses the issues of how to best define and how to best measure all of the different forms of violence and abuse. Although I believe we need to be careful about describing emotional abuse as a form of violence, many of the experts on violence against women have taken that approach, as have the Duncan research team. I am convinced that emotional abuse, if considered as a pattern of insults and degrading behaviour, can be extremely detrimental to women's health and well-being. I am also clear about the fact that physical and sexual violence are almost always accompanied by emotional abuse in chronically abusive relationships and that victims often describe the psychological abuse as the most hurtful. However, I am reluctant to include emotional abuse in what we call "violence," for fear that such nomenclature may inflate the prevalence of violence beyond what the public has experienced and thereby lessen the hard-won and growing public acceptance of violence against women as a significant problem (Klein, Campbell, Soler, & Ghez, 1997). I think that the overall prevalence of violence against nurses of 46% reported by Duncan may obscure the even more distressing (to me) 19% prevalence of threat of assault and 18% prevalence of physical assault that should be the occasion for a Canadian national outcry and government inquiry. I am afraid that policy-makers may discount the physical assault findings when they discover that the 46% prevalence can include nurses who were insulted by a co-worker. I also fear that the first national surveys done on psychological violence will demonstrate that males perceive

women as committing more emotional abuse than women perceive men as committing, further contributing to the backlash that often greets our policy endeavours in the field of violence against women. Nevertheless, I am impressed by the scholarship of the Duncan article and its contribution to our knowledge of workplace violence against nurses. These authors not only have investigated an extremely important facet of violence but have addressed measurement issues that we all need to thoughtfully investigate conceptually, empirically, and with policy outcomes in mind.

I therefore would like to thank my fellow nursing scholars in the field of violence who are represented in this volume as well as the staff of *CJNR*. It is an honour to be associated with a volume that truly presents outstanding research by any measure — methodological, innovative, substantive, and important to nursing practice and health-care policy. Readers whose primary interest is not violence will find a wealth of methodological information as well as scholarship that touches on issues of maternal child health, emergency nursing, mental health, workplace environments, children's growth and development, and immigration. The breadth of the violence field is indeed amazing, as illustrated here. Everyone involved in the volume has been a joy to work with, and I look forward to continuing achievement in nursing research in the field of violence.

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Jacquelyn C. Campbell, PhD, RN, FAAN, is Anna D. Wolf Endowed Professor and Associate Dean for PhD Programs and Research, School of Nursing, Johns Hopkins University, Baltimore, Maryland, USA.

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Discourse

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

Colleen Varcoe and Judith Wuest

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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Colleen Varcoe, RN, PhD, is Associate Professor, School of Nursing, University of Victoria, British Columbia, Canada. Judith Wuest, RN, PhD, is Professor, Faculty of Nursing, University of New Brunswick, Fredericton, Canada.

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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Portraits of Pain and Promise: A Photographic Study of Bosnian Youth

Helene Berman, Marilyn Ford-Gilboe, Beth Moutrey, and Saira Cekic

Au début des années 90, la guerre a éclaté en Bosnie-Herzégovine, forçant un grand nombre de personnes à fuir leur village et leur pays et à abandonner leur culture et tout ce qui leur était familier. Le conflit et le déracinement qui ont résulté de cette guerre ont mis fin de façon dramatique à la vie tranquille de ces enfants, que l'on qualifie souvent « d'innocentes victimes ». Bien que plusieurs ont pu s'échapper avec leur famille et s'installer dans des lieux plus paisibles, il existe de nombreuses preuves à l'effet que les jeunes réfugiés sont transformés à tout jamais à la suite d'une guerre et que la souffrance causée par les conflits ne prend pas fin lorsque la lutte armée est terminée. Cet article présente les résultats d'une étude menée auprès de sept enfants bosniens âgés de 11 à 14 ans, venus au Canada comme réfugiés au cours des années 90. Les défis qu'ont dû relever ce groupe et leurs luttes quotidiennes ont été explorés à l'aide d'une méthode de recherche novatrice, la nouvelle photographique. Le second objectif de l'étude consistait à évaluer les mérites et les limites de la nouvelle photographique comme méthode pouvant capter le point de vue et les sentiments des enfants. Des caméras jetables ont été remises aux participants, lesquels devaient prendre des photos de gens, de lieux et d'événements importants. L'interprétation des photographies a été faite par le biais d'un processus de dialogique appelé par les chercheurs *phototalk*. Les résultats ont révélé que ces enfants étaient dotés de nombreuses forces mais qu'ils continuaient aussi à lutter pour comprendre les événements qui ont transformé leur vie de façon si marquante. Les résultats et les implications en ce qui a trait aux infirmières font l'objet de discussions.

In the early 1990s, war erupted in Bosnia and Herzegovina, forcing large numbers of people to flee their homes and country, abandoning their culture and all that was familiar to them. For the children, often described as war's "innocent victims," the conflict and subsequent uprooting represented a dramatic end to their peaceful lives. Although many were fortunate enough to escape with their families and resettle amid more peaceful circumstances, there is considerable evidence that refugee youth are forever changed by their exposure to war and that the pain of war does not end when the fighting is over.

Helene Berman, RN, PhD, is Assistant Professor and NHRDP/MRC Career Scientist, School of Nursing, University of Western Ontario, London, Ontario, Canada. Marilyn Ford-Gilboe, RN, PhD, is Associate Professor and NHRDP/MRC Career Scientist, School of Nursing, University of Western Ontario. Beth Moutrey, BA, formerly an art therapist at the University of Western Ontario, currently practises in Toronto, Ontario. Saira Cekic, formerly Professor of Psychology and Pedagogy, Sanski Most, Bosnia and Herzegovina, is currently Facilitator, Success Resources London, London, Ontario.

This paper presents the results of a study with 7 Bosnian children, aged 11–14, who came to Canada as refugees during the 1990s. The everyday challenges and struggles faced by this group were explored using an innovative research method called photo novella. A secondary purpose of the research was to evaluate the merits and limitations of photo novella as a method for capturing children's perspectives and feelings. Participants were given disposable cameras and asked to take pictures of important people, places, and events. The meaning of the photographs was then explored through a dialogic process the researchers call phototalk. The findings revealed that while these children had many strengths, they continued to struggle to understand the events that so profoundly changed their lives. The results and the implications for nurses are discussed.

For Those Who Work To Heal

Not only the wounded
the traumatized,
but you
who work to heal them
relive the war
like miners
going deeper in
each day
crawling along
the tunnel floor
chipping
at the clay and rock
to find the speck of coal or gold
that might reflect
some Light

From *New Poems for Bosnia*
R. Menzies, 1998

During the early part of the 1990s, war erupted in Bosnia and Herzegovina, forcing large numbers of people to flee their homes and country, abandoning a culture they loved and all that was familiar to them. For the children, often described as war's "innocent victims," the conflict and subsequent uprooting represented a profound and dramatic end to their peaceful lives. The order and predictability that had characterized their everyday world were replaced by chaos, killings, fear, and uncertainty. Classmates and neighbours who had been considered friends were suddenly seen as enemies, resulting in feelings of betrayal and an enormous sense of confusion (Berman, 1999a, 1999b). Although many children were fortunate enough to escape with their families and resettle in more peaceful circumstances, geographically far removed from the terror of war, there is considerable evidence that

refugee youth are forever changed by their exposure to war and that the pain of war does not end when the fighting is over. As Menzies (1998) poignantly writes, "No war is ever over. The trauma, pain, loss and grief live on in the souls and bodies of all who survive the experience and must somehow be transformed if life is to continue with meaning and hope" (p. 6).

Research with Holocaust survivors lends support to the idea that the impact of human atrocity and suffering continues to be felt several generations after the event. According to Krell (1993), children who lived through the Holocaust were forced to learn how to stifle affect and embrace silence; to do otherwise would mean certain death. As adults, these survivors typically dampen their eagerness when enthusiastic and their grief when bereaved.

The effects of war on the lives of children are complex and not fully understood. Many of the problems that persist are subtle and often go unnoticed. As well, many child survivors demonstrate surprising resourcefulness and resilience, and go on to lead highly creative and productive lives (Krell, 1993; Werner, 1998). Although no longer living amid the terror of war, they may be haunted by their memories and experiences. The challenge for these young people is to find ways to make sense of events that in fact make little sense.

This paper will present the results of a recent study conducted with a sample of Bosnian children who came to Canada as refugees during the 1990s. The everyday challenges faced by this group were explored using an innovative research method called photo novella. A secondary purpose of this research was to evaluate the merits and limitations of photo novella in capturing children's perspectives of their lives.

Historical and Political Context: A Personal Reflection

In order to understand the experiences of refugee youth from Bosnia, one must consider the historical and political events that forced them to flee. The following description was provided by one of the authors of this paper, who escaped from Bosnia in 1993:

> *Before the war, Bosnia was a very happy place. We had security, family, neighbours, and friends who were constantly dropping in. Life changed quickly and irrevocably in the spring of 1992. Serbian artillery positions were set up on the hills around cities and shelling and shooting began. They took over many towns and started burning houses, killing, and raping. People watched their world fall apart. Understanding what was occurring was difficult, not only for children but for the adults as well. Children could no longer play outside or go to school. They could only*

comprehend that nothing was the same and nothing would ever be the same again.

In the process of genocide, carried out in the name of "ethnic cleansing," many Bosnian children, women, and the elderly became refugees. Muslims and Croats were driven from their homes by Serbian forces in a deliberate campaign of territorial conquest and ethnic purification. By 1995, the number of refugees reached 3.5 million (Fogelquist, 1996). Little international attention was paid to the tragedy that was unfolding until the world saw video footage of the appalling treatment of prisoners at Serbian-run camps.

Unfortunately, the arrival of Red Cross monitors and United Nations special missions did little to change the situation. While some prisoners were released from the most notorious camps, many others, including male children, were merely transferred to unknown locations or perhaps killed. The inability of the international peacekeeping agencies to protect us was most painfully apparent in the 1995 massacre of children in Tuzla. Despite its being declared a "Safe Area" by the UN, Karadzic's forces attacked the centre of the town where children had gathered. There they killed over 65 children, mostly between the ages of 18 and 25. In Srebrenica, also a "Safe Area," more than 6,000 people were killed. According to Selim Beslagic, mayor of Tuzla, the international community was not able or willing to protect Bosnian civilians (Beslagic, 1995).

Childhood was stolen from these children. They watched in disbelief as their lives were increasingly characterized by danger and fear. The confusion wrought by war is eloquently described by Sara, the heroine in Goran Stefanofski's (1996) play Sarajevo. *"I have never read so many papers in my life, or watched so much television or listened to the news so much, and I have never understood less."*

Review of the Literature

The study of refugee children and adolescents whose lives have been affected by war represents a relatively new, but growing, area of investigation. The findings of published studies are often inconclusive and contradictory. Several investigators have observed a wide range of physical and emotional problems among these children (Ajdukovic & Ajdukovic, 1993; Athey & Ahearn, 1991; Hjern, Angel, & Jeppson, 1998; Macksoud, Aber, & Cohn, 1996). Sack and colleagues (1995) studied the health of adolescent Cambodian refugees shortly after their arrival in the United States and again 3 and 10 years later. These researchers concluded that, although the Cambodian refugees were functioning relatively well in many areas of everyday life, depression and post-traumatic stress disorder (PTSD) persisted well beyond their departure from their war-torn homeland. In contrast, Rumbaut (1991, 2000) has

found little evidence of long-term harm and has observed that many refugee youth demonstrate remarkable resilience and motivation.

According to Beiser, Dion, Gotowiec, Hyman, and Vu (1995), it is likely that outcomes are mitigated by a variety of mediating variables and protective factors (i.e., individual, family, and environmental supports). In addition to these factors, Punamaki (1996) suggests that ideological commitment to the conflict may serve as a buffer against adverse outcomes. From this perspective, the capacity to rationalize and justify the war as a "necessary evil" helps to provide a purpose in life that may foster a positive sense of self. According to Kuterovac, Dyregrov, and Stuvland (1994), children and youth from the Gaza Strip and West Bank who actively participated in the Intifada (uprising) exhibited greater self-esteem than those who passively stood by.

Research with Bosnian youth is sparse. Further, most of the published studies were conducted with children and adolescents who remained in Bosnia throughout the war, or with those who resettled in refugee camps in Bosnia or Croatia, with or without other family members (Green & Kocijan-Hercigonja, 1998; Stein, Comer, Gardner, & Kelleher, 1999; Zivcic, 1993). Goldstein, Wampler, and Wise (1997) report that as many as 94% of their sample of 364 displaced Bosnian children aged 6 to 12 years met the diagnostic criteria for PTSD. Berk (1998) has published anecdotal data based on his work with a UNICEF program designed to increase resilience among Bosnian children. One result of this project was identification of several characteristics necessary for "healthy" outcomes. These included the presence of a social support network and a sense of connectedness to others, as well as the ability to psychologically distance oneself from the impact of suffering.

In one of the few studies of Bosnian adolescents living in North America, Weine and colleagues (1995) conducted psychiatric assessments and elicited trauma testimonies from 12 Bosnian youth who had recently resettled in the United States. Despite the fact that all had experienced trauma, displacement, and resettlement, and 25% were diagnosed with PTSD, participants were generally able to meet the usual challenges of adolescence. Weine et al. attribute the resilience of these young people to several factors: their lives before the outbreak of war were essentially "normal"; they were exposed to wartime trauma for relatively brief periods; they had not endured physical or sexual trauma; and most were living with their natural parents. Similar findings are reported by Berman (1999b), who notes that while participants experienced difficulty adjusting to life in Canada and most exhibited symptoms consistent with PTSD, the problems tended to subside over

time. Although negative attitudes were encountered, Bosnian children were not subjected to racism in the same manner or intensity as refugee youth who belonged to visible minority groups. While Bosnian children reported many painful memories associated with war, they also told of treasured moments before the war, as well as hopes and dreams for the future.

The Photograph as Research Instrument

Anthropologists have long recognized the scientific value of probing and understanding the visual world. According to Collier and Collier (1986), photographic ethnography can be used to document complex dimensions of social interaction and human behaviour, to reveal economic realities, to explore relationships between ecology and community, to examine the everyday patterns of people's lives and culture, and to elicit *emic*, or insider, perspectives. An early illustration of the potential merits of visual anthropology is Gregory Bateson and Margaret Mead's (1942) photographic study of Balinese culture. Thirty years later, Sorenson (1976) described the use of photographs to study child development in New Guinea. Similarly, Gesell (1945) used photographs in his groundbreaking research on child growth and development. The results of this work have profoundly influenced the field of child psychology.

In recent years, several nurse researchers have used photographs as a means of eliciting rich data about health that may not be accessible through more traditional approaches. Hagedorn (1994) used the method of hermeneutic photography in studying the family's lived experience of childhood chronic illness. According to Hagedorn, hermeneutic photography may be viewed as an aesthetic technique that allows the researcher access to unfamiliar or unknown aspects of human health experiences. Derived from hermeneutics and aesthetic philosophy, hermeneutic photography allows people to capture meaningful and symbolic life moments or events that can later be reflected upon, interpreted, and understood in new ways. In essence, the photograph constitutes an interpretive text that reveals the meaning of phenomena of interest. Just as the more familiar practice of audiotaping interviews provides verbal descriptions of experiences, photographs provide visual data. These data may be used in conjunction with other data or on their own as a means of recording visual content and experience.

Magilvy, Congdon, Nelson, and Craig (1992) describe the value of photographic approaches in exploring older adults' experiences with

home care. As part of a larger ethnographic study, these investigators took more than 400 pictures of various aspects of rural culture. Initially, members of the research team photographed the rural landscape as a means of familiarizing themselves with the environment. As relationships with the study participants evolved, cameras were brought into homes and community agencies, and pictures were taken of home-care nurses and their patients in the process of giving and receiving care. The researchers used the photographs as a means of engaging nurses, other agency staff, and seniors in dialogue in order to identify patterns of giving and receiving rural home care.

Photo novella. In contrast to the many studies in which investigators have used photographs to depict aspects of human experience from the vantage point of the photographer, a study that uses the technique of photo novella allows the participants to tell their stories from their own perspectives. Wendy Ewald (1985), a documentary photographer and educator, used this method in her work with children living in appalling conditions in the Appalachian mountains. Photo novella, which means "picture stories," lets participants make their own decisions about what to include or exclude in the photographic records of their lives, thus letting them control the images that are presented of their everyday world. The images enable participants to communicate personally meaningful thoughts or impressions in concrete terms. At the same time, the pictures provide a vehicle for researcher and participant to discuss meaningful aspects of the participant's life and to collaborate on the interpretation of experiences, feelings, and needs from the symbolic content of the photos and description of the image. This type of exchange may foster new insights into aspects of life that the participant is not able to express.

The empowerment potential of photo novella is described by Wang and Burris (1994), who used this method in a study of women's reproductive health in China. Photographs taken by the women were used to explore the ways in which their lives had changed over time, from their experiences as children to their current treatment as wives and mothers. The aims of this research included changing individual consciousness, influencing policy, and stimulating action at the individual and policy levels. Vukovic and Green (2000) used photo novella to describe the day-to-day lives of 83 persons with disabilities and to explore their needs for home- and community-based services. The investigators conclude that hermeneutic photography allowed participants to communicate issues of importance and concern to them that might not have surfaced through the more conventional method of researcher-guided interviews. Although these studies support the idea

that photographic methods hold much potential for health research, such methods remain a relatively underused approach.

Method

A convenience sample of seven refugee youths who had come to Canada from Bosnia during the 1990s were given an opportunity to tell their stories using the technique of photo novella. Identification of potential participants was carried out with the assistance of a leader within the Bosnian community who contacted families, briefly described the study, and invited participation. A meeting was subsequently held with all of the children, their families, and a translator, to describe the study in more depth, answer questions, and obtain written consent and assent. Although all of the participants were fluent in English, many of their parents were not; therefore all written information was translated into Bosnian.

The sample included four males and three females ranging in age from 11 to 14 years. All of the children were born in Bosnia and all were Muslim. The average age of the children at the time they left Bosnia was 5, and none were older than 10 at the time of departure. Entry to Canada was rather circuitous for most of the children. Only one of the six families came directly to Canada from Bosnia. Two families lived in Germany for up to 5 years prior to arriving in Canada, and the remaining four families lived in refugee camps in Croatia and Hungary before settling in Canada. The children had been living in Canada for 1 to 7 years and all resided with their biological parents and siblings. In one case, the child's paternal and maternal grandmothers lived with them as well.

Procedure

Over the course of the study the participants met with the researchers or the research assistant at least twice. During the first meeting, participants were given a disposable camera. They were shown how to use the camera and were offered an opportunity to practise using it and to ask questions. The participants were instructed to take pictures, over a 2-week period, of people, objects, or events important in their lives. Two sets of prints were made, one for the participant to keep and one for the researchers.

During the second meeting, the researcher and participant engaged in an in-depth dialogic interview about the meaning of the pictures.

Typically, we began the interview by asking the child to tell us about his or her pictures and to describe their significance. Probes were rarely needed, as the children readily discussed their photographs. In almost all cases the dialogue spontaneously turned to their lives in Bosnia, the transition to life in Canada, and their feelings about important people and events. The interviews were audiotaped and transcribed verbatim.

Data Analysis

Analysis took place in collaboration with the participants as the researchers met with them to discuss the content and meaning of their photographs. This dialogic process resulted in what we have called phototalk, or the narrative that evolved "in between" or "beyond" the photos. Phototalk is, in essence, a synthesis of the photographs and the dialogue. The data emerging from this "space" would not have been available without the presence of the image before the researchers and the participants. Similarly, these data could not have been attained through interviews alone. The photograph stimulated a dialogic process that went beyond the content of the picture but resulted in a rich exchange of ideas and experiences between the two parties. Stories, themes, and patterns emerged from what the photographer captured in the image and the phototalk around the image. A coding system was developed whereby the photographs were categorized according to descriptions provided by the participant, rather than according to the objective content of the photograph.

Results

Phototalk resulted in the identification of themes relating to aspects of the participants' lives prior to their coming to Canada, their everyday lives today, and their hopes and dreams for the future. Although gender was not a focus of this study, and the photographs taken by the male and female participants were comparable in content, the way in which the two groups talked about the pictures differed. Typically, the girls took pictures of people, places, and objects that reminded them of Bosnia. In contrast, the boys used their cameras to capture the "here and now" of their lives in Canada. Running throughout the children's stories is a sense of strength, courage, and resilience despite the seemingly overwhelming circumstances of their lives. All of the names are pseudonyms.

Understanding so much and so little at once

Each child recalled the same moment of the war, the bombing of the bridge at Mostar, as a particularly disturbing symbol of destruction and ruin. This event surfaced in both photo content and dialogue. Marina took two pictures of a bridge near her home in Canada (Photo 1) and described them as representing "the bridge in Mostar that got wrecked in the war." Mirza explained: "Nobody knows how it [the war] started. I know only they bombed the bridge so nobody could come over or go out." Clearly, the bridge signified a moment when the world that these children had known was forever changed.

Repeatedly, the children indicated that when they lived in Bosnia they were too young to understand the dangers and the impact that the war would have on their lives. They remembered being unable to go outside of their homes, and they remembered hearing bombs. Goran recalled the image of his father being taken away by soldiers. He spoke of the effect this had on his older brother, who understood that their father might not return. While his brother was clearly distressed, Goran stated that he did not comprehend why the rest of the family was not speaking:

> *Every time those big rockets came we were under the stairs. And my brother was scared and he was drinking the water with sugar in it. That's what my grandma gave to him so he wouldn't get scared and stuff because he knew all that stuff. And I didn't even know it was dangerous. I was, like, talking so much and they were all scared and sitting there...*

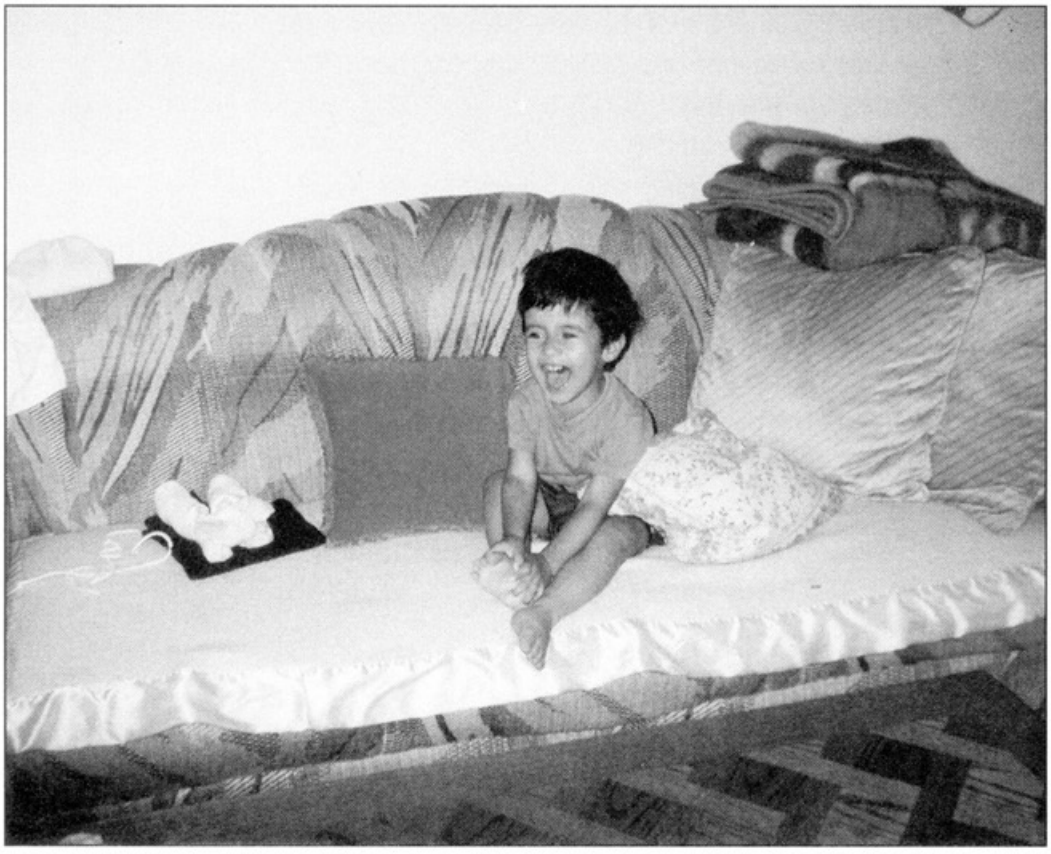
Adrijana described one of her photos as representing the Sana River. This revelation led to a conversation about the bridge blowing up and about how she would take her Barbie dolls into the bathroom, the safest place in her apartment. This was where she spent the day when her mother was at work and her father was away in the army. But she insisted that she was not frightened. She was too little. Adrijana and the other children made it clear that they were no longer too young to understand what they had lost because of the war.

We know nobody and start from the beginning

One of the strongest themes was the frequent necessity to relocate and leave family and loved ones behind. Katarina photographed a car that reminded her of one that her family had owned in Bosnia. She described the significance of this picture, but then moved beyond the image of the car as she recalled her life in Bosnia during the war and before she came to Canada: "Yeah. We got messed around. We all went everywhere... We moved around, like, six, five times... It's not that good. You make friends and then you got to go and you'll probably never see them again."

Most of the children had lived in another country prior to coming to Canada. For the majority of families, the time spent elsewhere was sufficient for them to develop a sense of community. Thus memories and feelings of being uprooted were often connected to not one place but many. Mirza, the oldest child in the study, described a photo of his family's living room as important because this was where family members spent most of their time. An excerpt from the dialogue that followed reflects the theme of moving and demonstrates the evolutionary process of phototalk:

> *We just came to Germany and then started to have life and then move again to new country and then again we know nobody and start from the beginning. ...five years, it's not like two months or something. Obvious, it's...a long time and then we start to know other people and then again know nobody.*



Because they are my family and I love them

Virtually every child spoke about the importance of family and friends. The children's devotion to their loved ones was articulated during the interviews and was evident in both the content of the photos and the discussion of them. In a photo of a beach scene, Ivan pointed out his mother and brother. When asked why it was important for him to take this photo, Ivan said, "I always want to be with my family. I don't want to lose them." Another of Ivan's photos showed a boy standing on the balcony of his apartment. Ivan said it was a significant photo "because he is one of my best friends and I don't want to forget him." Later in the interview Ivan spoke of his recurring nightmare about losing his loved ones. Adrijana, referring to a photo of her baby sister, said that her sister was "the best thing about coming to Canada." Goran spoke similarly of his youngest brother, explaining that he was loved and treasured by the family. Goran had taken numerous photos of this little boy (Photo 2). Petar described the image of his mother and father as one of his most important photos. Examples of the children's devotion to family and friends are endless. When asked, "Why was that an impor-

tant photo to take?" they responded with quizzical expressions, as though the question was foolish and need not be addressed. Said Goran about a picture of his little brother, "...because I love him...that's the only reason I took it." Family was clearly the most important thing in the lives of these children.

Bosnia the way it used to be

Feelings of confusion were apparent when the children spoke about Bosnia. Most stated that they would like to return — not to the Bosnia of the present, however, but, as Mirza put it, "Bosnia the way it used to be." When asked if he missed Bosnia, Mirza said: "I don't know. I miss it sometime to see how it was. The only memories I have are my room and my grandpa's house. I remember, 'oh, this was there, this was there.' I miss to see how it really was. But now most things are destroyed. I don't miss it like now." The children appeared to accept their current situation. Many recounted being told by parents that going home would not be in the best interests of the family. Some expressed frustration at their inability to remember Bosnia. All clearly possessed a strong sense of belonging to the Bosnian Muslim community. At the same time, however, the majority had memories of a homeland that they knew would never be as it was before the war. There was a sense among the children of "being Bosnian" and "belonging to Bosnia" but an awareness that they had little direct, personal knowledge of this place called home. In an exchange about a photo he had taken of the sky, Goran poignantly remarked, "...sometimes it feels good, sometimes it feels bad. Then when I ask people how it is, some people say it's bad, some say it's pretty, and I still don't know how it looks." Not knowing a culture yet belonging to it was an experience common to many in this group of refugees.

My parents don't want me to forget

Ambivalence about embracing a new culture while remaining loyal to the old was evident in the children's stories and anecdotes. Katarina spoke of the decisions she continually had to make regarding when and where to speak Bosnian and the implications of choosing one language over the other. Referring to a photo of a weeping willow tree (Photo 3), Katarina described her experience of belonging to two cultures. Her words reveal a sense of loyalty to her family and her heritage. They also demonstrate a perceived need to balance the tension between allegiance to family and the desire to feel connected to Canadian life:

That tree, it's called a weeping willow. We had that tree in Bosnia and my dad was talking about it and he asked me what it was called. I said "weeping willow," and he said it in our language... I usually speak English around the house with both of my parents... I speak our language too. I speak English and they don't tell me not to speak English, but I think they'd rather I spoke Bosnian in the house. Like, when we go to Adrijana's house I'm not allowed to speak English because her parents don't want her to forget... My parents don't want me to forget, but I don't think that one little word is going to make me forget. I do talk our language a lot. I talk English too.

At a very early age the children had been forced to form new understandings about the workings of the world. With profound and articulate sensibility, they explained how they had come to accept the realities wrought by war. Katarina said, "It's a chapter. I just think, move on, find somewhere else. You have to think that way." One of Adrijana's photos reminded her of her grandmother's home: "But what can you do? You can't just think I have to go home."

Mirza reflected upon the positive aspects of the traumatic changes he had endured, articulately expressing the impact of war and refuge-

seeking on his perception of the world: "...all the things stay there, but you see the world if you move around; you learn the language." The majority of Mirza's photos reflected a stark quality that was mirrored in his words: "When I was smaller, I never thought of the negative things. I always thought of the positive... I didn't see the negative things. But now I see them."

One big messed-up dream

The surreal nature of being uprooted and moving to a foreign country was expressed both verbally and visually. One of Mirza's photos depicted the entrance to the apartment building where he and his family lived, a passage through which he walked every day. The picture appeared to function as a reminder to Mirza that his home was now in Canada. He discussed his photos in relation to having left behind everything he knew. Mirza frequently emphasized the strain of having to leave not one home but two and his difficulty in grasping the fact that he was no longer in Germany:

> *You don't really understand it. We just came to Canada and we came to the airport and everything. I didn't really realize that I was in Canada because three hours ago I was in Germany. And it went so fast. In Germany, it was like long time, it was five years, but when you go it looked so fast.*

Similarly, Katarina shared the moment when it had dawned on her that life in Canada was not a dream and that she would not be returning to Bosnia:

> *I always used to think that this is just a big long dream and it's all going to be over. That's the way I used to think about it... I was in the elevator and I was pressing the button and I just started thinking this is all one big messed-up dream and it's going to be over, you'll see when you wake up. But it's never over, I guess...that was about two years ago. If someone had told me when I was little that I would be living in Canada and, you know, moving to a house that day, I would have just said, like, you're lying.*

Life after the war

Many of the families were struggling to survive financially and were experiencing an enormous depreciation in their standard of living. Not only had they lost loved ones, but their lifestyles had changed dramatically. Houses had been replaced by small apartments. A photo taken by Mirza showed the few things that his family had been able to take with them when it was time to leave Germany. He described the frus-

tration of having to start all over again, his family's lack of living space, and the pain and confusion of knowing that their home in Bosnia was most likely still there but with other people living in it. His brother, Goran, told of their family's efforts to create a new home despite the absence of personal items, and he recalled the emptiness of an apartment the family had moved into after leaving Bosnia.

Despite the challenges, many children expressed hopes and dreams for the future. A picture taken by Ivan showed him standing proudly with a plaque his basketball team had won in a tournament. Around his neck were medals he had been awarded as Most Valuable Player. Ivan described this image as "my basketball career." Katarina pointed to an ambulance she had photographed and told of her dream to become a "pediatrics doctor." "This is something perfect for me," she said, "because I love little kids and I would love to have a job where I help someone."

Discussion

All of the participants were touched by war in deeply personal ways. Given that the actual length of time they had spent living in a war zone was relatively brief, the profound impact of war may seem surprising. Further, many appeared to be unaware of the full extent of the danger they had faced. Consistent with the findings of studies with children living in Europe during World War II (Freud & Burlingham, 1943; Henshaw & Howarth, 1941) and with children living amid war in the contemporary world, the participants' fears regarding separation from family were more pronounced than those associated with bombings, military invasions, and "ethnic cleansing" (Berman, 1999b; Garbarino, Kostelny, & Dubrow, 1991). The children's strong attachment to family was evident time and again, through their words and their pictures. Family appeared to be the most stable factor in their lives. During and after the war, throughout their displacement within and outside of Bosnia, to other European countries, and ultimately to Canada, family remained the only constant.

Childhood is typically characterized by an increasing sense of security and growing awareness of one's purpose and place in the world. For these children, however, the early years could more aptly be characterized by being uprooted and the need to form new understandings about home, security, and self. Although the children showed a great deal of confusion regarding identity, they firmly maintained that they considered themselves Bosnian. This understanding of self was complex. They knew that there was a place called Bosnia, but it was a

place that was part illusion and part reality. They remembered aspects of Bosnia through their own cherished but dim memories and, perhaps more so, through the stories told by their relatives. From their parents they learned that Bosnia was a very beautiful place before being so rudely transformed by war. Now their lives were firmly grounded in the Bosnian-Canadian community. Although they considered themselves Bosnian, in many respects they knew much more about what it meant to be Canadian. Although all participants were able to speak Bosnian, and did so to varying degrees in their homes, several had never attended school in Bosnia. While there was an almost surreal quality to the place they called home, they were nevertheless Bosnian to the core and proudly asserted their Bosnian heritage.

For many of the children, the war was symbolized most graphically by the bombing of the bridge in Mostar. This bridge spanning the Neretva River, built under Turkish rule in the 16th century, was destroyed during the war in 1993. The Croatian journalist Slavenka Drakulic (1994) ponders the significance of this event: "Why do we feel more pain looking at the image of the destroyed bridge than the image of the massacred people? Perhaps because we see our own mortality in the collapse of the bridge. We expect people to die; we count on our own lives to end. The destruction of a monument to civilization is something else. The bridge, in all its beauty and grace, was built to outlive us. It was an attempt to grasp eternity. It transcended our individual destiny" (p. 1). Although many of the children in the study had never actually seen this bridge, and most were very young when they had fled Bosnia, its destruction had a profound impact on their lives and on their understanding of the war. Like many Bosnian adults, these children appeared to have adopted the bridge as a cultural symbol of their past. Sharing this interpretation with others in the Bosnian community may have been a means of staying connected with a culture about which they remembered little.

War has been described as "the epidemic of the twentieth century" (Misgeld, 1995). It is one of the most endemic forms of violence against children, affecting millions of young lives throughout the world. Increasingly we are recognizing that, despite children's capacity for strength and resilience, the health effects of human atrocity are enormous. Nurses are in key positions to provide support to refugee youth and to play a leading role in efforts to make the world a less violent place. Such efforts require intervention at the individual, family, and community levels. The strategy of providing spaces for children to "tell their stories," to express their pain and their hopes, is one way of supporting children's views of their past and present situation; their own

perceptions of their experiences, reflecting their principles and values; and their need to find meaning in chaos. Educational strategies must, at a minimum, convey the message that human rights violations, including racial persecution, terror, and other forms of oppression, cannot be tolerated.

Although the children in this study revealed many strengths, programs and policies are needed if such children are to achieve success in life. Canada opens its doors to approximately 230,000 newcomers each year. In a recent report (Kunz & Hanvey, 2000), many health and social service providers state that their ability to offer culturally appropriate services is being hampered, particularly as they have experienced a decline in financial and human resources in recent years. The barriers they identify are language, cultural differences, and lack of knowledge about existing services. Focus groups conducted with immigrant children reveal that they are generally well integrated into Canadian society and are succeeding in school, but that they continue to encounter social isolation, racism, and ostracism.

Partnerships among community health centres, boards of education, and various levels of government are an important step in the development of multicultural programs. However, if an initiative is to be successful, we must acknowledge the significant needs of refugee youth and direct appropriate levels of funding to programs for them. As nurses become increasingly active in the political domain, we can become a strong voice for refugee youth.

Relevance of Photo Novella as a Method

Through their pictures, the children in this study told stories of pain and promise. Their stories were about sadness and confusion, but their pictures also revealed much about strength and courage, about hopes and dreams for the future, and about the promise of a better world for generations to come. Based on discussions among members of the research team, feedback from the participants and their families, and the richness of the data, we believe that photo novella holds enormous potential and that the possibilities extend far beyond what we have captured in this small study. All of the children indicated that they enjoyed participating in the study, including playing the role of photographer, and welcomed the opportunity to share their stories. For children whose verbal skills in English may be greater than their written skills, photo novella allows access to sensitive issues and ideas that might be difficult to elicit using more traditional approaches. Further, the universal appeal of pictures to all cultural groups makes photo novella an

intrinsically attractive and viable method. Although it would be an overstatement to suggest that any child was emancipated by his or her participation in this research, the persuasive power of pictures has the potential to bring about change at the individual and policy levels.

As with any method, several questions need to be addressed in determining the usefulness of photo novella. Although gender differences were noted, it is difficult to know if these were design artifacts or if they would have emerged regardless of study method. Further research is needed to evaluate this issue, and also to determine whether photo novella is most appropriate for particular age groups. Ultimately, decisions about method must be made in the context of how the approach "fits" with the research question and the characteristics of the population of interest. We suggest, however, that photo novella is a creative and innovative means for understanding and describing human health experiences, and for examining these experiences in new ways.

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Battering and Breastfeeding in a WIC Population

Linda F.C. Bullock, M. Kay Libbus, and Marjorie R. Sable

L'étude sur laquelle porte cet article a été fondée sur l'hypothèse selon laquelle les femmes victimes de violence conjugale ont moins tendance à choisir l'allaitement naturel que les femmes qui ne sont pas violentées. Un consentement éclairé a été obtenu auprès de 212 femmes desservies par deux cliniques du programme de supplément nutritionnel pour femmes, nourrissons et enfants (Women, Infants and Children [WIC] Nutritional Supplemental Program), de la région centrale-ouest (Midwest) des États-Unis. L'évaluation concernant le vécu en rapport à la violence chez les participantes a été faite dans le cadre d'entrevues. Les femmes ont été interrogées sur la méthode d'allaitement qu'elles avaient l'intention d'adopter. Elles ont aussi été interrogées à savoir si elles avaient déjà pratiqué l'allaitement naturel. Les résultats ont indiqué qu'il n'existait aucun lien entre la violence qu'elle subissait actuellement ou qu'elles avaient subie dans le passé et le fait de choisir l'allaitement naturel. Néanmoins, ces résultats sont considérés comme importants, en raison des deux points suivants : (1) il s'agissait d'une première étude qui se penchait sur le lien entre un vécu de violence et une capacité de choisir la méthode d'allaitement pour un nourrisson; et (2) la proportion de femmes dans l'échantillonnage qui disaient être victimes de violence présentement ou récemment et qui étaient capables de pratiquer l'allaitement naturel était la même que chez les femmes qui n'ont pas signalé de traitements violents à leur égard, ce qui suggère que la préoccupation que porte une femme envers son enfant est plus forte que ses peurs d'être potentiellement contrôlée par l'abuseur.

The study reported in this paper was based on the hypothesis that women who are victims of domestic violence may be less likely to select breastfeeding than women who are not abused. Informed consent was obtained from 212 women at 2 Women, Infants and Children (WIC) Nutritional Supplemental Program clinics in the Midwestern United States. The Abuse Assessment Screen was administered by interview and women were also questioned about intended feeding choice and whether they had breastfed any previous children. No association was found between present or previous abuse and infant-feeding choice. Nevertheless, the findings of this study can be considered important, for two reasons: (1) this was an initial inquiry examining the relationship between having been abused and ability to choose the feeding method of a newborn; and (2) women in the sample who reported present or current abuse were able to breastfeed their infants in the same proportion as those who did not report abuse, which suggests that a woman's concern for her child overcomes her possible fears of control by the batterer.

Linda F.C. Bullock, PhD, RN, and M. Kay Libbus, DrPH, RN, teach at the Sinclair School of Nursing, University of Missouri, Columbia, USA. Marjorie R. Sable, DrPH, MSW, teaches at the School of Social Work, University of Missouri.

The positive effects of breastfeeding on infant health (Bass & Groer, 1997; Lawrence, 1997; Raisler, Alexander, & O'Campo, 1999) and cognitive development (Johnson, Swank, Howie, Baldwin, & Owen, 1996; Lucas, Morley, Cole, Lister, & Leeson-Payne, 1992) are well documented. Breastfeeding is beneficial to the mother both physically (Lawrence) and emotionally (Pesa & Shelton, 1999). Finally, breastfeeding serves to strengthen infant-mother attachment, communication, and interaction (Dignam, 1995; Klaus & Kennell, 1982; Rowley & Dixon, 1997). Clearly, the choice of whether to breastfeed or bottlefeed breastmilk substitutes may affect both infant and maternal health and the development of parenting skills in the mother (Locklin & Naber, 1993).

Many demographic factors, including maternal age, residence, education, and ethnicity, are associated with the decision to initiate and continue breastfeeding. The infant-feeding decision is based on a complex interaction of these demographic factors with a woman's perceptions, attitudes and knowledge, and work or school intentions, and the influence of her significant other (Dix, 1991; Mulford, 1995). Cultural values and social environment may also influence the ways in which these factors are understood and applied in choosing the feeding method (Littman, Medendorp, & Goldfarb, 1994; Marchand & Morrow, 1994; McNatt & Freston, 1992). For example, Marchand and Morrow found that women's perceptions of social and emotional support and prohibition of breastfeeding in public played a larger role in the decision to initiate breastfeeding than knowledge of the nutritional and health benefits. Further, a developing body of literature suggests that the mother's decision often revolves around the infant-feeding preference of the father (Gamble & Morse, 1993; Littman et al.; Sciacca, Dube, Phipps, & Ratliff, 1995).

The results of breastfeeding research over the past 2 decades show that infant-feeding choice in the United States is associated with socioeconomic status. Specifically, low-income women are less likely to select breastfeeding than their more affluent counterparts (Jacobson, Jacobson, & Frye, 1991; Ryan et al., 1991). Locklin and Naber (1993) note that the decline in breastfeeding from 57.9% to 52.2% between 1984 and 1989 was greatest in women from lower socioeconomic groups. More recently, the United States General Accounting Office (1993) reports that between 1989 and 1992 inhospital breastfeeding rates were 38.9% for low-income women, compared to 66.1% for women in middle- and upper-class groups. This last finding was in spite of a 12% increase in breastfeeding inception among low-income women during the same period.

The Effect of Domestic Violence on Infant-Feeding Choice

Studies during the last decade estimate that the prevalence of domestic violence among pregnant women in the United States ranges from 7% to 20%. As these numbers are based only on women presenting for prenatal care (Gazmararian et al., 1996; McFarlane, Parker, Soeken, & Bullock, 1992; Parker, McFarlane, & Soeken, 1994), it is not unreasonable to suspect that the actual proportion of women battered during pregnancy is higher than these estimates.

The need to control the actions of the intimate partner provides one well-accepted theory for partner violence (Campbell, Harris, & Lee, 1995; Helton, McFarlane, & Anderson, 1987). The effects of this need are manifested, and perhaps magnified, during pregnancy. For example, men may fear disclosure of the violence during women's face-to-face meetings with health-care providers; as a result, victims of violence are not likely to begin prenatal care early nor to keep all of their appointments (McFarlane et al., 1992).

Jealousy is thought to be another reason for initiation of or increase in battering during pregnancy (Bohn & Parker, 1993; Campbell, Oliver, & Bullock, 1998). The abuser may view the infant as competition; jealousy and the desire for control may escalate as the woman's attention is focused increasingly on the infant (Helton et al., 1987). Jealousy may be exacerbated if the male partner views breasts as sexual objects. Morse (1990) and Dignam (1995) both found that many mothers are inhibited from breastfeeding because of the sexual connotations of the breasts. Finally, investigators have reported that some fathers perceive a qualitative difference between their relationship with the infant and the mother-infant relationship that develops during breastfeeding (Dignam; Gamble & Morse, 1993). Dignam describes breastfeeding as an intimate exchange between mother and infant. They share the harmony, emotional closeness, touching of skin, and reciprocity that are characteristic of intimate exchanges. This relationship by definition excludes the father.

This brief review of the literature suggests that partner support for breastfeeding, an important factor in a woman's success with breastfeeding, is unlikely to occur in an abusive relationship. Further, the need for the abuser to control all aspects of the woman's life indicates that he may not approve of breastfeeding. The relationship between domestic violence and a woman's infant-feeding decision has not been previously investigated. The purpose of this preliminary study was to

assess for the presence of a relationship between history of domestic violence and breastfeeding in a sample of women attending a Women, Infants and Children (WIC) clinic.

Methodology

A case-control design was selected to explore the possible association between reported abuse and infant-feeding choice. The study took place at a WIC Nutritional Supplemental Program site in each of two cities in the Midwestern United States. Data collection was carried out over a 10-month period. Although battering occurs in all socioeconomic groups, there is some evidence that it may be more common and more severe in families of lower socioeconomic status (Institute of Medicine, 1998). WIC serves low-income families under 185% of poverty; it provided an ideal setting for this study because women could be objectively identified as breastfeeding or bottlefeeding based on the type of food vouchers they received. Breastfeeding women may obtain vouchers to purchase nutritious food to supplement their diet. Bottlefeeding women may obtain vouchers for breast-milk substitutes. The limitation of measuring breastfeeding in this manner is that women may be partially breastfeeding but elect to receive the vouchers to buy formula for supplemental feeding. Although examination of type of voucher received runs the risk of misclassification or underreporting of breastfeeding, however, we believe this method is preferable to self-report. Self-report carries the risk of overestimating the number of breastfeeding women, since women might answer affirmatively because of the perceived social desirability of that response.

Sample and Procedure

A convenience sample was used for this preliminary study. Women attending WIC clinics were invited to participate if they were at least 28 weeks pregnant and 18 years of age. The study was introduced during the nutritional educational session that all women are required to attend in order to receive their food vouchers. Before the session began, the study was described to the group as an examination of the reasons why women select a particular infant-feeding method. If the study was introduced in this manner, we believed, a woman who was accompanied by an abuser to the educational session would be able to participate safely. After the session was over, women indicating a willingness to participate were taken individually to a private room where the investigator fully explained that the study would examine the relation-

ship between abuse and infant-feeding choice. Of the women who received the full explanation, only a few declined to continue. Once they agreed to participate, the women signed a consent form. Following the brief interview, all women were given a $5 incentive as well as community resource information about local agencies that provide services to victims of domestic violence. Respondents were also given a packet of information on health behaviours during pregnancy and infant-feeding choice. This package was intended to serve as evidence for a woman that the interview concerned pregnancy and feeding choice, in case the abuser was waiting for his partner.

Figure 1 *Abuse Assessment Screen (AAS) Questions*

1. Have you ever been emotionally or physically abused by your partner or someone important to you?
2. Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone?
3. Since you have been pregnant, have you been hit, slapped, kicked, or otherwise physically hurt by someone?
4. Within the last year, has anyone forced you to have sexual activities?
5. Are you afraid of your partner or anyone you have listed?

Instrumentation

After formal consent was obtained, a short questionnaire containing items on demographics, prior pregnancy and breastfeeding histories, intended infant-feeding method, and the Abuse Assessment Screen (AAS) was administered. The AAS, consisting of five questions about abuse (Figure 1), was developed by the Nursing Research Consortium on Violence and Abuse (Parker, Ulrich, & Nursing Research Consortium on Violence and Abuse, 1990). Criterion validity has been established (McFarlane et al., 1992) with the Conflict Tactics Scale (Straus, 1979), the Index of Spouse Abuse (Hudson & McIntosh, 1981), and the Danger Assessment Scale (Campbell, 1986). Although the AAS was designed primarily as a clinical screening tool, a positive response to questions 2, 3, or 4 has been used as a dichotomous measure of abuse in several studies (Berenson, Wiemann, Wilkinson, Jones, & Anderson, 1994; Martin, English, Clark, Cilenti, & Kupper, 1996; Parker et al., 1994).

As noted above, classification as either breastfeeding or bottlefeeding was determined by the type of food voucher the woman received postpartum. Duration of breastfeeding was determined by the number of months that women initially classified as breastfeeding their infant received breastfeeding vouchers. In order to ensure confidentiality, individual interview forms were coded using the number of the woman's WIC record. The interview forms were not seen by the WIC staff and were stored in a locked receptacle accessible only to the investigators, geographically removed from the WIC office. When the investigators returned to ascertain the types of vouchers women were receiving postpartum, only the code numbers were brought to the WIC program for use in data retrieval.

Table 1 *Demographics of WIC Participants*

Variable	*N*	Mean	*SD*	Minimum	Maximum
Age (years)	212	24.6	5.1	18	40
Number of Pregnancies	212	2.3	1.4	1	10
Marital Status					
Single	91	42.9%			
Married	98	46.2%			
Common law	9	4.2%			
Separated	14	6.6%			
Race					
Anglo-American	163	76.9%			
Afro-American	34	16.0%			
Other	15	7.1%			

Table 2 *Infant-Feeding History and Feeding Intentions for This Infant*

Variable	Frequency (*n*)	(%)
Last Infant		
Breastfed	43	20.3
Bottlefed	59	27.4
First pregnancy/no feeding history	111	52.4
Intentions for This Infant		
Breastfeed	152	71.7
Bottlefeed	50	23.6
Unsure	10	4.7

Results

A total of 212 women were interviewed, 98 at one site and 114 at the other. The two groups of clients did not differ significantly on important demographic variables. Therefore, data from the two sets were pooled for portions of the analysis. A description of the entire sample is provided in Table 1. Respondents were primarily Anglo-American (n = 163), with 16% (n = 34) reporting African-American ethnicity. The *other* category included the few Hispanics and Asian women and women from other ethnic groups who were interviewed. Approximately half of the study population were married or living in a common-law relationship.

Prior to administration of the AAS, the women were asked about infant-feeding history and their feeding intentions for the newborn. The results of these two questions can be seen in Table 2. Less than half of those women who had had a prior delivery had breastfed, but over 70% of the sample responded that they intended to breastfeed the infant they were carrying. We emphasize, however, that 55% (n = 84) of those indicating they were going to breastfeed were first-time mothers who had no feeding experience.

To ascertain if there were differences between the two sites regarding the proportion of women admitting to abuse, the data from the two sites were analyzed separately. Primary data analysis classified a woman as being abused if she answered *yes* to questions 2, 3, and/or 4 on the AAS (see Figure 1). These three questions refer to incidents of abuse within a specified period. Lifetime history of abuse, which included all of the above women (those answering *yes* to questions 2, 3, and/or 4) as well as those women answering *yes* to question 1 only, was used to determine whether the broader definition of abuse affected feeding choice. Additional analyses examined the relationship of other variables, such as age, marital status, and prior breastfeeding history, and the relationship of these variables to the research question.

Table 3 *Percentages of Positive Responses on Abuse Assessment Screen (AAS)*

Question	Clinic 1	Clinic 2
Q1: Ever been abused	47.2	57.2
Q2: Hit in last year	12.4	13.3
Q3: Hit since pregnant	8.5	5.1
Q4: Forced to have sex	2.8	2.0
Q5: Afraid of someone	10.4	9.2

The two sites were similar in proportion of women reporting abuse (Table 3), with 12% to 13% of all women admitting to having been abused in the preceding year and between 5% and 8.5% admitting to being physically abused during pregnancy. Almost one out of every two women reported that they had suffered some form of abuse in their lifetime.

Table 4 *Chi-Square Test for Frequency of Breastfeeding in Abused and Non-Abused Women*

	Breastfed	Bottlefed	Total
Abused	11	10	21
Non-abused	68	61	12
Total	79	71	150

χ^2 (1, N = 150) = 0.001 p = 0.98

Breastfeeding Initiation

This analysis operationalized breastfeeding as a dichotomous variable, determined by the type of food voucher obtained the first month after delivery. Chi-square was used to explore any possible association between the relative frequency of breastfeeding and abuse and other categorical variables. No significant difference was found in the proportions of abused women who breastfed and non-abused women who breastfed (Chi-square test, $p = 0.98$). The proportions were in fact almost identical (11/21 = 52.4% for abused, 68/129 = 52.7% for non-abused). While the sample proportions are very close, we recognize that the small number in the abused groups limits the power. However, with these sample sizes there is 80% power for detecting a 28% difference in proportions of breastfeeding when doing a one-sided test.

Further analysis was carried out to determine whether women who chose breastfeeding differed on other variables. No significant differences were found in the proportion who breastfed by marital status, ethnicity, or lifetime history of abuse (question 1 of the AAS) or by age (age was categorized). The only significant finding — which was not surprising — was an association between a woman's feeding method for a previous infant and her infant-feeding choice for this infant ($p = < 0.001$).

Breastfeeding Duration

As noted above, the duration of breastfeeding was determined by the number of months the woman obtained food vouchers for breastfeeding. At the end of the data-collection period, the number of months of postpartum data collected for each participant varied among the sample. Additionally, the women differed on duration of breastfeeding. Therefore, survival analysis techniques were used to examine duration of breastfeeding. Women who were still breastfeeding at the last recorded month of data collection had times that were censored — that is, we know that the duration of breastfeeding was at least n months, but we do not know the exact number of months. Our goal was to compare duration of breastfeeding for different groups, specifically those classified as abused and non-abused. This comparison was made using SAS and PROC LIFETEST. Kaplan Meier survival curves were estimated and were compared for different levels of the group variables by the Log-Rank test. The results were consistent with those given earlier for breastfeeding initiation. No significant differences were found between the curves for abused and non-abused women ($p < 0.65$). P-values for comparisons with lifetime history of abuse, age, marital status, and ethnicity were 0.65, 0.68, 0.15, and 0.48, respectively. Again, significant differences in duration were found for the questions on feeding method used for the last infant ($p = < 0.0001$) and feeding intentions for this infant ($p = < 0.0001$).

Discussion

This study was a preliminary attempt to see if *major* differences could be detected in feeding choices between women who admitted to abuse and those who did not. The women who were classified as breastfeeding, based on the fact that they did not receive vouchers for formula, were probably breastfeeding exclusively. However, the finding that the same percentage of abused and non-abused women were obtaining breastfeeding vouchers, in the same proportion, indicates that battered women are nevertheless able to choose to breastfeed their infants. Our results suggest that, by choosing to breastfeed, these women illustrate that they have their children's best interests at heart. This finding is consistent with a sentiment often expressed by women in shelters: that they decided to leave the abusive relationship when their children became a target of battering (Humphreys, 1998).

Although we had anticipated somewhat different findings when we began this study, the results are nevertheless important. We originally speculated that women who reported battering would be less

likely to initiate or continue with breastfeeding than women who did not report abuse. We postulated that in the reported cases of abuse, the man's need to control the woman would make it very difficult for her to find the time or energy required to breastfeed. We also speculated that the view of breasts as sexual objects could increase the man's possessiveness and that therefore he would not allow infant breastfeeding. This does not seem to be the case.

There are limitations in interpreting the results. The number of women classified as breastfeeding and the number of women classified as abused may have been underestimated. As acknowledged, some of the women classified as bottlefeeding could also have been partially breastfeeding, thus the overall rate of breastfeeding found for both groups may be low. Obtaining more exact numbers of partially breastfeeding women would require more in-depth research. Women would need to be screened for abuse during the antenatal period and then followed into the postpartum period. They would then need to be interviewed on a regular basis about infant-feeding patterns so that breastfeeding rates could include women who only partially breastfed.

Based on the body of work related to pregnancy and battering, we also suspect that we had a greater number of false negatives than false positives in the results concerning abuse. This study found reported abuse to be 12% to 13% in the year preceding pregnancy and 5% to 8% during pregnancy. These proportions are lower than the rates found by McFarlane, Parker, and Soeken (1996). Using the AAS, these authors found that 24.3% of respondents reported physical and sexual abuse in the preceding year and that 16% admitted to abuse during the pregnancy. In the present study, the AAS was administered shortly after we had first met the woman. Given the limited time to build rapport, many women may not have felt comfortable enough to reveal abuse. False negatives in the group would thus have been identified as non-abused. If our original hypothesis were true, that abused women are more likely to bottlefeed, then the rates of bottlefeeding in the non-abused group would have been inflated.

Additionally, we did not record whether women currently being abused were still with the abusive partner. However, there is evidence that abused women may suffer post-traumatic stress syndrome for years after the abuse stops (Institute of Medicine, 1998). For this reason the physical act of breastfeeding could result in emotional discomfort, and this could affect a woman's infant-feeding decision.

Other obvious limitations of this study were the small sample size and the self-selection of respondents. For example, we suspect that

there were eligible women attending the nutritional educational classes who did not volunteer to hear the full description of the study. Due to confidentiality issues and program restrictions, the researchers could not discover the age of a woman attending the educational session nor how far along she was in her pregnancy. Therefore it was impossible to estimate the number of eligible women who chose not to speak to them. It is possible that, after the initial description of the study, the women who had decided to breastfeed were more likely to participate than those who planned to bottlefeed. If abused women are indeed more likely to bottlefeed, this self-selection bias could have had a major impact on the results.

Another possible limitation was the homogeneity of the sample, the bulk of which was made up of Anglo-American women. The literature suggests that minority women have lower rates of breastfeeding than Anglo-American women (Raisler, 1993). If the study had been done in those WIC clinics that are attended by a higher proportion of minority women, the results might well have been different.

Implications for Nursing Practice

In spite of the limitations of this study, our results do have implications for nursing practice. First, it appears that if faced with limited resources for breastfeeding education, the best use of the funds would be to target first-time mothers. Our findings support the body of literature (Barber, Abernathy, Steinmetz, & Charlebois, 1997; Hill, 1988) that suggests that women who have already breastfed one infant will most likely breastfeed their other infants. Conversely, a woman who did not breastfeed her previous infant is not likely to breastfeed subsequent ones. It is the mother with no prior experience who stands to benefit most from information and education on the value of breastfeeding, and in many cases her significant other as well. Even if the results of our investigation underestimated the number of women who were battered, prior history of breastfeeding appears to be the strongest indicator of whether a woman will choose this method of infant-feeding.

Notwithstanding the obvious benefits of breastfeeding for mother and infant, the literature suggests that successful breastfeeding may have an empowering effect on women, particularly low-income women (Locklin, 1995; Locklin & Naber, 1993). If breastfeeding does indeed empower women, it seems reasonable that the increased sense of personal power could encourage a woman to alter or leave a battering relationship, exponentially increasing the benefits of breastfeeding for mother and infant. Given this premise, the importance of further

studies to explore and clarify a potential relationship between abuse of pregnant women and feeding choice should not be underestimated.

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Authors' Note

Correspondence should be directed to Linda F.C. Bullock, S327 Sinclair School of Nursing, University of Missouri, Columbia, Missouri 65211 USA. Telephone: 573-882-0234. Fax: 573-884-4544. E-mail: <LBullock@missouri.edu>.

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Nurses' Experience of Violence in Alberta and British Columbia Hospitals

Susan M. Duncan, Kathryn Hyndman, Carole A. Estabrooks, Kathryn Hesketh, Charles K. Humphrey, Jennifer S. Wong, Sonia Acorn, and Phyllis Giovannetti

Cette recherche examine les résultats d'une étude ayant pour thème la violence en milieu de travail, laquelle a été effectuée auprès de 8780 infirmières autorisées œuvrant dans 210 hôpitaux situés dans les provinces de l'Alberta et de la Colombie-Britannique. Les résultats portent sur la fréquence d'incidents violents vécus par les infirmières, soit le nombre de fois qu'elles ont subi de la violence en milieu de travail. Près de la moitié (46 %) des participantes ont vécu une ou plusieurs formes de violence pendant leurs cinq derniers quarts de travail. La fréquence variait selon la forme : 38 % ont vécu de l'abus émotif, 19 % des menaces d'attaque physique, 18 % des attaques physiques, 7,6 % du harcèlement sexuel, 0,6 % une agression sexuelle. De plus, 70 % des participantes ayant vécu de la violence n'ont pas signalé l'incident. La violence sous toutes ses formes avaient principalement été perpétrée par des patients. La forme la plus prédominante, l'abus émotif, a fait l'objet d'une étude plus approfondie pour en identifier les déterminants. L'abus émotif était également la forme de violence dont la distribution était la plus constante quant aux sources (patients, familles, collègues, médecins). La modélisation à régressions multiples utilisant l'individu, soit l'infirmière, comme unité d'analyse a indiqué que les variables explicatives importantes dans le contexte de l'abus émotif étaient l'âge, le statut de travail

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Susan M. Duncan, RN, PhD(c), is Assistant Professor, School of Nursing, University College of the Cariboo, Kamloops, British Columbia, Canada, and a doctoral candidate in the Faculty of Nursing, University of Alberta. Kathryn Hyndman, RN, MN, is a doctoral student in the School of Nursing, University of British Columbia. Carole A. Estabrooks, RN, PhD, is Assistant Professor, Faculty of Nursing, University of Alberta, MRC/CIHR Health Scholar, AHFMR Population Health Investigator, and Co-investigator, Alberta Team. Kathryn Hesketh, MSc, is Project Coordinator, Hospital Outcomes Study, Alberta Team. Charles K. Humphrey, MA, is Director, Data Library, University of Alberta, and Technical Advisor and Programmer/Analyst, Alberta Team. Jennifer S. Wong, MA, works at the Centre for Health Service and Policy Research, University of British Columbia. Sonia Acorn, RN, PhD, is Professor, School of Nursing, University of British Columbia, and Co-investigator, BC Team. Phyllis Giovannetti, RN, ScD, is Associate Dean, Faculty of Nursing, University of Alberta, and Principal Investigator, Alberta Team.

occasionnel, la qualité de soins, l'ampleur de la restructuration hospitalière, le type d'unité, les relations au sein du personnel hospitalier, le ratio infirmières-patients et les mesures de prévention de la violence. Selon une approche dont l'unité d'analyse était l'hôpital, les variables explicatives étaient la qualité des soins, l'âge, les rapports avec le personnel hospitalier, la présence de mesures de prévention de la violence, et la province. Ces résultats mettent en lumière d'importantes différences selon le modèle utilisé, soit celui fondé sur l'individu comme unité d'analyse, soit celui axé sur l'institution. Les résultats de la recherche indiquent la nécessité de mettre en place des stratégies de prévention non seulement auprès des infirmières mais aussi et surtout à l'échelle des hôpitaux. En somme, les conclusions suggèrent que les institutions de santé ne constituent pas toujours des milieux de travail sains et peuvent s'avérer des environnements de plus en plus stressants et à risque.

This study examined responses to a survey on violence in the workplace from a sample of 8,780 registered nurses practising in 210 hospitals in the Canadian provinces of Alberta and British Columbia. Findings relate to the frequency of violence against nurses, reported as the number of times they experienced a violent incident in the workplace. Nearly half (46%) of those surveyed had experienced 1 or more types of violence in the last 5 shifts worked. Frequency varied by type: emotional abuse 38%, threat of assault 19%, physical assault 18%, verbal sexual harassment 7.6%, sexual assault 0.6%. Further, 70% of those who had experienced violence indicated they had not reported it. Patients constituted the main source of all types of violence. The most prevalent type, emotional abuse, was further explored for its possible determinants. This was also the type of violence most evenly distributed among sources (patients, families, co-workers, physicians). Multiple regression modelling using the individual nurse as the unit of analysis showed the significant predictors of emotional abuse to be age, casual job status, quality of care, degree of hospital restructuring, type of unit, relationships among hospital staff, nurse-to-patient ratios, and violence-prevention measures; using the hospital as the unit of analysis the predictors were found to be quality of care, age, relationships with hospital staff, presence of violence-prevention measures, and province. These findings illustrate important differences in models that use the individual and the institution as the unit of analysis. Implications include targeting prevention strategies not only at the nurse but, perhaps more importantly, at the hospital. Overall, the findings suggest that health-care institutions are not always healthy workplaces and may increasingly be stressful and hazardous ones.

A safe practice environment for nurses and other health-care providers is critical to the integrity of the health-care system and to the quality of patient care. However, the hospital environment is frequently characterized by tension and emotion, and at times violent episodes are directed at nurses as primary caregivers. Concern for the health and safety of nurses is more compelling when one considers two facts. First, nurses are the health-care professionals most often called upon to assist individuals, families, and entire communities suffering the effects of violence. It is worthwhile asking if they are able to respond to the suffering of others if they are themselves the victims of violence. Second, there is a substantial body of research identifying critical links between the quality of practice environments and patient health outcomes

(Aiken, Smith, & Lake, 1994; Gleason, Sochalski, & Aiken, 1999). A hospital environment in which nurses are the target of violence is likely to influence patient outcomes.

Research findings point to the restructured health-care environment as influencing nurses' satisfaction with their work, nurses' workplace experiences, and the quality of patient care (Aiken, Clarke, & Sloane, 2000). Discussion of the reasons for the restructured hospital environment's increased vulnerability to violence is just beginning (Morrison, 1999; Smith Pitman & McKoy, 1999). To date there has been little empirical identification of organizational factors that contribute to workplace violence against nurses.

The purpose of this paper is to report on the frequency with which nurses experienced and reported five types of workplace violence, as well as on the source of the violence. We examined the organizational and individual factors predicting the emotional abuse experienced by a sample of 8,780 nurses practising in 210 hospitals in the Canadian provinces of Alberta and British Columbia (BC). Our analyses of these data at the levels of the individual nurse and the hospital contribute to theory development in the area of workplace violence against health professionals by identifying characteristics of the hospital environment that predict emotional abuse of staff nurses.

Background

This study is part of a larger international research project, Hospital and Patient Outcomes: A Cross-National Study, involving Canada, the United States, England, Scotland, and Germany (Sochalski et al., 1998). This international multidisciplinary study was undertaken to investigate the relationships among hospital-sector restructuring, the organization of professional nursing practice, and patient-care outcomes. Primary data in the current study are derived from both the Alberta and BC Nurse Surveys, similar versions of which have now been completed in all five participating countries, including three Canadian provinces. Questions relating to violence in the workplace were explored uniquely by the Alberta and BC teams.

Literature Review

The published research on workplace violence relates to frequency of violence among different groups of health-care providers; sources, or perpetrators, of violence; effects of violence; and the reporting of violent

episodes. Definitions of violence vary to the extent that they sometimes encompass incidents that do not result in physical injury such as verbal or emotional abuse or harassment (Hewitt & Levin, 1997). However, there is an emerging consensus that violence encompasses multiple forms of aggression, rooted in the dynamics of power and control (Canadian Nurses Association, 1996; Wigmore, 1995). Also identified were gaps in the literature concerning methodological inconsistencies and, in some key areas, lack of focus.

The International Council of Nurses (1999) acknowledges the "extent and gravity of the increasing problem of violence in the workplace, particularly as it affects nursing and health care." In the United States, assault against health-care workers, including nurses, has been recognized as an occupational health hazard (Lipscomb & Love, 1992; Olson, 1994; Simonowitz, Rigdon, & Mannings, 1997; Sommargren, 1994). In Canada, the Canadian Nurses Association (1993) and most provincial nursing associations and unions have, over the past decade, addressed the issue of workplace violence by conducting surveys to assess the extent of workplace abuse and by issuing policy statements and resource guides that target prevention strategies.

Comparison across populations with respect to the incidence and prevalence of workplace violence is hindered by the lack of standardized definitions. While workplace violence has been traditionally defined as that resulting in physical injury, the literature shows a trend towards basing research on more inclusive definitions. Therefore some studies define and measure the frequency of violent incidents that encompass one or more forms of emotional, verbal, physical, or sexual abuse or assault. Despite the inconsistencies in definition, there are indications that nursing is at high risk for workplace violence relative to other occupations, including law enforcement (Hewitt & Levin, 1997). According to the United States Bureau of Labor, health-care providers are at 16 times greater risk for nonfatal workplace violence than other workers (Elliott, 1997). In the United States from 1992 to 1996, nurses were victims of nonfatal assaults at the rate of 24.8 per 1,000, compared to police officers at 30.6, junior high school teachers at 57.4, and mental health professionals at 79.5 (Warchol, 1996).

While nursing unions and associations report that workplace violence is increasing, these trends are hard to confirm due to varied epidemiological measures such as incidence and prevalence rates and the different time frames on which the calculations are based (Arnetz, Arnetz, & Petterson, 1996). In Canada up to 80% of nurses have

reported experiencing some form of violence during their careers (Fédération des Infirmières et Infirmiers du Québec, 1995). Swedish investigators have calculated standardized career prevalence rates of 29% for workplace violence and 35% for threats of violence (Arnetz et al.). Canadian research has found that 33% of nurses reported experiencing physical or verbal abuse in the last five shifts worked (Graydon, Kasta, & Khan, 1994). Other studies have found that up to a third of nurses experience workplace violence over a 1-year period (Carroll, 1999; Liss & McCaskell, 1994; Whittington, Shuttleworth, & Hill, 1996). Researchers recommend a more standardized approach to defining and measuring workplace violence against nurses and other health-care providers (Arnetz et al.; Hewitt & Levin, 1997).

Sources of Abuse

Nurses report workplace violence as originating with four groups: patients, physicians, patients' family/friends, and supervisors and co-workers. Patients are overwhelmingly reported as the main perpetrators of physical assault and threatening behaviours (Croker & Cummings, 1995; Keep & Glibert, 1992; Liss & McCaskell, 1994; Powell, 1996; Yassi, 1994). Physicians are reported as the main perpetrators of verbal assault by some studies (Cooper, Saxe-Braithwaite, & Anthony, 1996; Cox, 1991b; Hilton, Kottke, & Pfahler, 1995; Levin, Hewitt, & Misner, 1998; Manderino & Berkey, 1997), while patients are reported as the main perpetrators of verbal abuse by others (Braun, Christle, Walker, & Tiwanak, 1991; Graydon et al., 1994; Pekrul, 1993; Yassi, Tate, Cooper, Jenkins, & Trottier, 1998).

Risk of abuse varies with the time of day and day of the week, but the greatest risk occurs in the late evening and during the night shift (Arnetz et al., 1996; Mahoney, 1991; Yassi et al., 1998). One study found that 30% of abusive episodes were reported by health-care workers who had been caring for the patient for the first time or for less than 1 week (Yassi et al.).

Being male has been associated with higher rates of abuse-related injury (Arnetz et al., 1996; Liss & McCaskell, 1994; Mahoney, 1991; Yassi, 1994). Both age and years of experience have been found to be factors in workplace violence among nurses (Arnetz et al.; Diaz & McMillin, 1991). Nurses aged 35 or under with less than 10 years' experience have reported greater verbal abuse by physicians than nurses aged 36 or older. Older nurses with 10 or more years' experience have reported fewer incidents of sexual abuse (Diaz & McMillin). Registered

nurses have been found to experience a lower incidence of abuse than registered nursing assistants (Arnetz et al.; Britt, 1992; Graydon et al., 1994; Yassi).

Effects of Abuse

Workplace violence has been implicated as a possible etiological factor in post-traumatic stress disorder (Powell, 1996). Verbally abused nurses have reported emotional effects such as anger, anxiety, irritability, and loss of control/powerlessness (Cooper et al., 1996; Cox, 1991a; Mahoney, 1991), feelings of decreased self-worth and morale and decreased job satisfaction (Cox, 1991b; Cox & Kerfoot, 1990), embarrassment and humiliation resulting in negative relationships with physicians (Manderino & Berkey, 1997), and a desire to leave the current unit or to leave nursing (Braun et al., 1991; Graydon et al., 1994). Nurses who have been assaulted causing physical injury may also experience the full range of emotional effects, including fear; the consequences of injury or trauma can be either immediate or delayed (Hewitt & Levin, 1997).

Reporting of Violent Episodes

A striking finding of our literature review was an underreporting of violent episodes. In fact, less than half of nurses report the abuse to a nursing supervisor or to anyone other than an immediate colleague (Croker & Cummings, 1995; Graydon et al., 1994; Hewitt & Levin, 1997). Several authors concur that the study of workplace violence is usually limited to formal incident reports (Lippman, 1993; Lipscomb & Love, 1992; Pekrul, 1993). Even when compensation data are examined, no statistics are available for denied claims or claims that do not involve lost time, so that the data likely underestimate the nature and extent of the problem (Liss & McCaskell, 1994; Yassi, 1994).

Most often nurses report abuse to a colleague (British Columbia Nurses Union, 1991; Cruickshank, 1995a, 1995b; Yassi, 1994). Nurses and other health-care providers have the additional risk of working with people who may, due to extreme stress, disease, injury, or drug-induced changes, have reduced capacity to understand or control their behaviours (Duncan, Estabrooks, & Reimer, 2000; Gates & Horstman, 1995; Stultz, 1993). When vulnerable patients are involved, workers may be reluctant to report violent episodes or to press charges. Further, nurses may be reluctant to complete injury forms for fear of being blamed by management; hence the assaults against them are hidden (Roberts, 1991).

Summary

The findings of recent studies validate the growing concern that violence is a serious occupational hazard for nurses. Researchers have measured the extent of workplace violence through surveys and, to a lesser extent, through analyses of secondary data including incident reports, Workers Compensation Board claims, and qualitative methods. Between-study comparison is difficult to conduct because of the variety of definitions of violence. Some studies report only assault resulting in injury, while others cite epidemiological measures, such as prevalence and incidence, for which denominators are inconsistently derived or omitted from the report. Prevalence rates tend to be based on career prevalence, while frequency rates tend to be measured over the preceding 5 years, 1 year, or 1 month. There has been a call for research that is based on an inclusive definition of violence (Wigmore, 1995) and consistent measures for identifying and confirming trends in workplace violence against nurses (Arnetz et al., 1996; Hewitt & Levin, 1997).

Finally, research into violence against nurses has focused on personal (nurse and patient) factors, paying much less attention to organizational factors that might influence or predict the problem in nurses' practice environments (Arnetz et al., 1996; Hewitt & Levin, 1997). Although some organizations have responded by redesigning the workplace and administrative and work practices (Canadian Centre for Occupational Health and Safety, 1999), there has been little evaluation of these or other initiatives in preventing workplace violence in healthcare settings.

Methods

Procedures

This study combined survey data from two provinces, Alberta and BC. The Alberta Nurse Survey was mailed to the total population of 12,332 registered nurses in the province who had selected the category of "staff nurse" on their 1998 registration renewal. Nurses from 129 hospitals in 17 health regions were invited to participate in the study between September 28, 1998, and January 15, 1999. A total 6,526 useable surveys were returned, for a response rate of 52.8%. In BC, the names of registered nurses working in acute-care hospitals were collected from provincial licensure registration, and survey packages were mailed out in November 1998. In hospitals with 100 or fewer nurses, the total population of nurses was surveyed; in hospitals with more than 100 nurses, a random sample of 100 nurses were surveyed. Reminder telephone calls were made to non-respondents 4 weeks after the mailout. Of the

Table 1 *Comparison of Sample and Population Demographics for Each Province*

	Alberta*		British Columbia**			
	Sample	Population	Sample		Population	
Regular (full-time/ part-time)	78%	72%	82%		73%	
Casual	23%	28%	18%		27%	
Female	97.6%	97.5%	97%		96%	
Male	2.4%	2.5%	4%		4%	
Age (years)	41 (9.32)	41.8	<25	2%	< 25	2%
			25–34	18%	25–34	18%
			35–44	36%	35–44	31%
			45–54	34%	45–54	33%
			55–64	11%	55–64	15%
			65+	0.1%	65+	1%
Diploma (RN)	77%	79%	84%		89%	
Baccalaureate	22%	21%	15%		11%	
Med/Surg	36%	34%	25%		24%	
Critical Care	19%	19%	16%		8%	
Emergency	8%	7%	10%		5%	

* Source: Alberta Association of Registered Nurses (1988).
** Source: Registered Nurses Association of BC (1998).

Figure 1 *Definitions of Violence Categories Used in Survey*

Violence against nurses or nurse abuse is defined in this study as any incident where a nurse experiences any of the following:

- physical assault (e.g., being spit on, bitten, hit, pushed)
- threat of assault (verbal or written threats intending harm)
- emotional abuse such as hurtful attitudes or remarks (insults, gestures, humiliation before the work team, coercion)
- verbal sexual harassment (repeated, unwanted intimate questions or remarks of a sexual nature)
- sexual assault (any forced physical sexual contact including forcible touching and fondling, any forced sexual act including forcible intercourse)

5,479 nurses sampled, 2,661 useable surveys were returned, for a response rate of 48.6%. The study was based on the combined sample of 8,780 nurses.[1] The sample is representative of the population of nurses in both provinces (see Table 1).

An identical subset of questions on violence against nurses, developed by the Alberta team, was included in the larger survey in both provinces, prefaced by definitions of the five types of violence as indicated in Figure 1.

To assess the acuity of the problem, nurses were asked to indicate whether they had experienced any of the five types of violence over the last five shifts worked. The time frame of the last five shifts worked was based on the rationale that this would elicit the most accurate recall (Graydon et al., 1994). Subsequent questions asked nurses to indicate the source of the violence, whether they had reported the incident, and the extent to which they thought their employer had taken measures to prevent violence in the workplace. The survey included examples of preventive measures such as zero tolerance policy, education, and conflict management programs. We determined frequencies of the five types of violence, the source, and reporting of violence episodes for the two provinces.

Standard multiple regression was used to identify variables that predicted emotional abuse using both the individual nurse and the hospital as units of analysis. Emotional abuse was selected as the dependent variable for this analysis because of its high incidence among nurses and because this type of abuse is perpetrated not only by patients, but also by nursing co-workers, other colleagues, and families and visitors. It was thought to be significant for the organizational culture of Canadian acute-care institutions that employ nurses. Methodologically, the distribution and frequencies of emotional abuse facilitated the use of regression analysis.

The conceptual framework guiding the selection of predictor variables associated with nurses' experiences of violence included interpersonal, organizational, and societal factors. This selection was influenced by the literature on workplace violence and on the impact of hospital restructuring on practice environments and patient outcomes (Aiken et al., 2000; Hewitt & Levin, 1997; Levin et al., 1998). Conceptualization of the predictor variables was also influenced by the framework of the

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[1] 407 cases were lost in the Alberta data when non-acute hospitals were eliminated from the sample.

Nurse Survey, which included factors related to the quality of practice environments (Aiken & Patrician, 2000; Gleason et al., 1999). All analyses were conducted using SPSS Version 10.0 (Chicago).

Measures

A proxy measure of quality of care was created using five individual items from the Nurse Survey. Nurses were asked (in the context of their last shift): "Which of the following tasks were necessary but left undone because you lacked the time to complete them?" The response items addressed components of quality care of which the patients and families would be aware. They included: routine teaching, preparing patients for discharge, comforting and talking with patients, backrubs, and oral hygiene. This proxy measure is cumulative, ranging from zero to five tasks not completed. The rationale for including this measure was that tasks left undone (resulting in decreased quality of patient care) would lead to anger and frustration among patients and family members, resulting in increased emotional abuse towards nurses.

A second proxy measure was created to address the degree of restructuring that had taken place in the work environment. The central question asked whether or not "...the following changes occurred in your hospital in the past year." The changes were: substitution of part-time, per diem, or temporary RNs for full-time positions; reduction in the number of nurse managers; increase in cross-training of staff; loss of senior nurse administrator without replacement; and hiring of unlicensed personnel to provide patient care previously provided by RNs. This proxy measure is cumulative, ranging from zero to five, and provides an approximate indicator of the amount of restructuring in the nurses' work environment. The rationale for including this proxy measure was that the changes indicated in the question were associated with a restructured nursing practice environment (Aiken et al., 2000; Blythe, Baumann, & Giovannetti, in press).

The Nurse as Unit of Analysis

The responses of the combined sample of 8,780 RNs were analyzed. Frequencies of each of the five types of violence, the sources of the violence, and the reporting of abuse were calculated for each province separately. Where appropriate, frequencies were examined for nursing specialty. In the multiple regression models, the presence or absence of the experience of emotional abuse (as a binary outcome) was predicted by a selection of independent variables.

The Hospital as Unit of Analysis

The individual data from the nurse level of analysis were aggregated at the hospital level for 190 acute-care hospitals in both provinces. Analyses were conducted on the aggregated mean of each variable across all nurses reporting within a hospital. The regression model predicted the average incidence of emotional abuse within a given hospital setting. A criterion of $p < 0.05$ was used to retain variables in the model at the individual nurse unit of analysis and $p < 0.10$ at the aggregated hospital level. The different p values were chosen due to sample size differences between the two units of analysis, with the hospital level consisting of only 190 cases (versus 8,780). Furthermore, the exploratory nature of the modelling led to more lenient practices for retaining variables.

Results

Important findings of this study are the frequencies with which the nurses experienced the five categories of workplace violence in the last five shifts worked (Figure 1), the source of the abuse, and whether the abuse was reported. When calculated over all five types of violence, a cumulative 46% of the nurses in the sample experienced one or more types in the last five shifts. The percentage of nurses experiencing abuse varied by type of violence and by province (Table 2). BC nurses reported significantly more cases of physical assault and threats of abuse than Alberta nurses.

Table 2 *Incidence of Violence*

Type of Violence	Alberta (%)	British Columbia (%)
Physical assault*	16.9	21.0
Threat of assault*	17.6	22.3
Emotional abuse	38.0	36.6
Verbal sexual harassment	7.6	7.6
Sexual assault	0.5	0.8

*Significant difference ($p = .000$)

Patients were the main source of all types of abuse. However, the sources of emotional abuse, the most pervasive type, were more evenly distributed amongst perpetrators (Table 3). For instance, more than one quarter of the emotional abuse originated with physicians and other

nurses. Overall, 70% of nurses in the combined sample did not report the abuse. The frequency of reporting varied with the type of abuse experienced, the most underreported forms being verbal sexual harassment and sexual abuse (see Table 4).

Table 3 *Sources of Emotional Abuse*

Source	Alberta (%)	British Columbia (%)
Patient	35.4	34.3
Family/visitor	11.6	12.2
Physician	13.5	19.6
Nursing co-worker	13.0	13.3
Other	2.6	4.6
Multiple sources	24.0	16.1

Table 4 *Percentages of Nurses Reporting Violent Incidents in Last Five Shifts Worked*

Type of Abuse	Reported (%)
Physical assault	36.4
Threat of assault	38.2
Emotional abuse	28.4
Verbal sexual harassment	23.3
Sexual assault	25.6

Regression Analysis: the Nurse as Unit of Analysis

The regression model, as previously described, predicted 13.2%[2] of the variance in emotional abuse experienced by nurses, and is significant (F (10, 6208) = 94.6, $p < .000$) (see Table 5). The 10 predictor variables at the individual level included personal, interpersonal, and organizational factors. Of these, the most prominent personal factors were age and casual job status (versus full-time, part-time, or temporary, as indicated by the nurse). Experience of emotional abuse varied inversely with the age of the nurse. Casual status predicted significantly less abuse than other forms of employment.

[2] While this model has a relatively modest coefficient of determination, it has been pointed out that the ratio of standard error to the unstandardized regression coefficient for each variable is a better indicator of the goodness of fit of a regression model (King, 1986).

Table 5 *Predictors of Emotional Abuse at Nurse and Hospital Levels*

Predictor	B	*t*-value
Nurse Level		
Constant	*0.414*	*8.431***
Restructuring	0.170	3.124**
Age	-0.002	-3.667***
Casual job status	-0.03	-2.403**
Emergency	0.21	10.513***
Psychiatry	0.26	8.507***
Patients assigned per nurse	0.03	2.291**
Existence of violence-prevention measures	0.08	10.878***
Relationships with physicians	-0.07	-8.041***
Relationships with LPNs	-0.02	-3.185***
Quality of care	0.06	16.161***
Hospital Level (mean)		
Constant	*2.062*	*2.472***
Province	0.40	2.292**
Age of nurses	-0.04	-2.050**
Quality of care	0.11	4.659***
Relationships with physicians	-0.57	-2.229**
Relationships with LPNs	-0.04	-1.487
Existence of violence-prevention measures	0.09	1.870*
Province by prevention measures	-0.16	-2.340**
Age by relationships with physicians	0.01	1.892*

* $p < 0.1$ ** $p < 0.05$ *** $p < 0.01$

Note 1: Variables that were tested but did not contribute significantly to the Nurse Level model included: province, highest nursing credential, opportunity to be involved in hospital governance, job satisfaction, emotional exhaustion, and sense of depersonalization.

Note 2: Variables that were tested but did not contribute significantly to the Hospital Level model included: job status, job specialty, size of hospital, job satisfaction, and degree of restructuring.

Organizational factors included quality of care, restructuring, patient assignment, type of unit, and violence-prevention measures. Of these, quality of care was the most significant predictor. The probability of experiencing emotional abuse increased incrementally by 6.8% with each direct-care nursing task that a nurse was unable to complete. As expected, psychiatric and emergency settings predicted a greater incidence of abuse. Increasing quality of relationships between registered nurses and physicians and between nurses and licensed practical nurses (LPNs) predicted lower probabilities of emotional abuse. Other variables were included in the analysis but did not contribute significantly to the model (see Note 1 in Table 5).

Regression Analysis: the Hospital as Unit of Analysis

The regression model that predicted emotional abuse at the level of hospital (the aggregated abuse score based on all nurses reporting abuse in a given hospital) consisted of six variables and two interaction effects. The model predicted 25.0% of the total variability and is significant (F (8, 180) = 7.52, $p < .000$) (see Table 5). As in the individual model, quality of care was the most important predictor of emotional abuse. The mean age of nursing staff and the average score of the quality of relationships with physicians were also important predictors of emotional abuse at the organizational level. The existence of measures to prevent violence within the hospital was significant in interaction with province. Where violence-prevention measures in BC were shown to decrease predicted organizational levels of abuse, this relation was inverse in Alberta. These results indicate that in Alberta the more strongly the nurses in a hospital agreed that workplace violence prevention measures were in place, the more likely they were to experience emotional abuse.

The mean age of nurses in the hospital interacted with the quality of nurse-physician relationships in that hospital. As the average age of nurses in a hospital increased beyond 46 or 47 years, the relationship with physicians started to improve. This change in relationships between physicians and nurses is coincident with a decrease in the likelihood of nurses experiencing emotional abuse in that hospital. Finally, while the relationships of RNs with LPNs did not contribute significantly to the model on its own, it contributed to the predictability of the model as a whole. Unaccounted interaction among other variables might explain this variable's importance to the model. For other variables that were included in the analysis but did not contribute significantly to the model, see Note 2 in Table 5.

Discussion

Scope of the Problem

These findings show that the frequencies with which nurses in Alberta and BC experience violence are cause for concern. The impact of these frequencies is more compelling when one considers that 46% of nurses in our sample experienced one or more types of violence *in the last five shifts worked.* Although this study cannot easily be compared with other studies due to the methodological inconsistencies across studies, our findings indicate a higher rate of violence among nurses in the past five shifts worked than did an earlier study with Ontario nurses (Graydon et al., 1994).

Patients were the main source of all types of violent episodes in hospitals. This is an understandable finding in light of the stressfulness of illness and hospitalization. However, if we are to comprehend and ultimately prevent violence between patients and health-care providers, we must move, in our thinking and actions, from an exclusively interpersonal model to include institutional models. It is critical for us to understand that all interactions are influenced by complex systemic factors. Our results show that emotional abuse is prevalent across different types of interactions in hospitals — between and among care providers, families, co-workers, and physicians — and is predicted by both interpersonal and organizational factors. Although not part of this study, analyses of incidents in which violence originates with the nurse in interaction with patients and co-workers will lead to a deeper understanding of the problem of violence and help to identify meaningful solutions. We also acknowledge that we were unable to determine patterns of abuse or violence from the results of this survey, which was based on the recall of isolated incidents; we did not ask nurses to differentiate between isolated and repeated incidents.

Our data show that 70% of the nurses did not report their violent incident(s). There are likely several plausible explanations for this result. For example, the underreporting may be related to an acceptance of a *culture of violence* in hospitals, particularly by mid- and late-career nurses. Such a phenomenon would not be asynchronous with the societal trend towards tolerance for increasing levels of violence — for example, in high schools, on the highways, and in the air. Underreporting may also be related to nurses' reticence to disclose violence to hospital administrators. It is also likely that the magnitude of the problem of violence against nurses is greater than currently acknowl-

edged. An exploration of the reasons why nurses do not report violent episodes is urgently needed.

Predicting Emotional Abuse in Individual Nurses

Personal, interpersonal, and organizational factors were found to predict emotional abuse in nurses. With respect to personal characteristics, younger nurses experienced more emotional abuse than older nurses. One explanation for this finding may be that younger nurses are more vulnerable to violence because of their age and lack of experience in the work setting. A second explanation may be that younger nurses acknowledge their experiences of violence more readily than older nurses, who might accept a level of violence as part of the job.

Employment status and practice setting are also predictive. Casual status predicted less emotional abuse; the nature of casual work may protect nurses from developing emotionally abusive relationships in that it allows them to move away from problematic situations. Nurses in psychiatric and emergency settings were more likely to experience violence of all types, including emotional abuse. This finding is consistent with those of previous studies. Critical-care nurses experienced the lowest incidence of all types of violence. Based on our analysis of other components of the Nurse Survey, it is our understanding that critical-care nurses report greater job satisfaction, a higher nurse-to-patient ratio, and more collaborative working relationships with physicians (Giovannetti & Estabrooks, 2000). It may also be that critical-care units have been buffered from some of the effects of restructuring. These observations provide further insight into how the quality of relationships and organizational factors actually influences the experience of violence in different practice settings.

The nurse's ability to complete the five functions included in the proxy quality-of-care measure was the single greatest predictor of emotional abuse. Hospital restructuring, including mergers, downsizing, and resource constraints, has been previously linked to changes in nursing practice that have had a detrimental effect on quality of care (Aiken et al., 2000; Blythe et al., in press; Moore, Clarke, Regan, & Steele, 1999). The significance of organizational factors in this model points to strained relationships and lack of support for quality care in a stressful practice environment. The link to emotional abuse is therefore not surprising. Most important, the relationship among organizational restructuring, quality of care, and emotional abuse re-frames the problem and its prevention at the level of the organization.

Measures taken to prevent violence also predicted less emotional abuse among individual nurses. It is difficult to analyze the significance of these findings, as our survey indicates little about whether or how preventive measures might address this problem. Previous research has included little evaluation of preventive measures such as zero tolerance policies or staff education. Furthermore, the timing of the implementation of these measures is unknown, a factor that may or may not have influenced the nurses reporting emotional abuse in our study.

Predicting Emotional Abuse at the Organizational Level

The proxy quality-of-care measure overwhelmingly predicted emotional abuse among nurses at the hospital level. This is a measure of nurses' inability to complete the most basic direct nursing functions that they believe their patients require. Based on its significance to both the nurse and hospital levels of analysis, we must consider that the quality of care that nurses provide is a powerful organizational determinant of the emotional health of hospitals. This realization again re-frames the discussion of violence beyond the level of individual and interpersonal relations and leads us to consider the related issues of organizational change, organizational culture, and the valuing of nursing work and concomitant resource adequacy.

This is not to say that interpersonal issues are not significant. As in the previous model, the quality of nurse-physician relationships at the level of the hospital is a significant predictor. The quality of the nurse-physician relationship also interacts with the mean age of the nurses in a hospital to predict greater emotional abuse. This leads us to consider the impact of nurse-physician interactions during the formative years of a nurse's career. It may also be that younger nurses acknowledge emotional abuse from physicians instead of accepting it as a part of the job. Alternatively, it may be that younger nurses are more vulnerable to the existing power differentials among physicians, nurses, and hospital policy-makers (Clare, 1993; Dan, Pinsof, & Riggs, 1995; Libbus & Bowman, 1994; Lippman, 1993; Wigmore, 1995).

These organizational issues are also important in a broader social context, as our organizational model points to the province itself as a source of variability. The province factor is significant in its interaction with violence-prevention measures. In Alberta, preventive measures appear to be inversely related to emotional abuse, whereas in BC they are correlated in the expected direction. For reasons cited above, we were not able to interpret the meaning of the preventive measures and their relationship to emotional abuse. However, the interaction effect

does point to the significance of social context at the level of the province. For instance, we are aware of some differences between the two provinces in their implementation of hospital restructuring. In BC, for example, nurses' job security was protected somewhat during the most vigorous period of restructuring (Moore et al., 1999), whereas in Alberta large numbers of RNs were laid off. There are likely other contextual differences in the implementation of restructuring, including approaches to regionalization. Further analyses of contextual differences beyond the level of the organization will be important to our understanding of violence as a social phenomenon.

Implications

To our knowledge, this is the first instance in which violence against nurses has been examined at both the individual and hospital levels. Such an analysis underscores the importance of the organizational and cultural dimensions of violence and demonstrates the complementarity of the individual and hospital models. Together, these models add to our understanding of the dynamics of violence in the nursing environment. Moreover, this study provides a baseline measure for future comparisons.

The most compelling implications of this analysis are those concerning policy, both organizational and governmental. Policies to prevent emotional abuse, the most pervasive form of violence in institutions, must focus on the adequacy and appropriateness of human resources and the quality of patient care. Whereas past and current approaches to violence prevention have been educational and focused on the individual nurse and the interpersonal domain, we now need to target the practice environment and the social context in which it is created.

Our analysis was based on the selection of variables from the Nurse Survey, and there may be other variables that would increase the explained variance in future analyses. However, as King (1986) illustrates, explained variance is not necessarily the best indicator of goodness-of-fit. Future research on workplace violence against nurses should address questions in four unresolved areas. First, it is important that we understand the culture of violence in hospitals, including nurses' decisions about whether to report incidents of violence. Cultural perspectives will also help us to understand the organizational context of providing care and how it may contribute to an environment in which violence occurs. Second, we need more sophisticated analyses of the predictive capacity of organizational factors such as those identified

in this study. Structural equation modelling would assist in the development of theory related to the organizational and systemic determinants of workplace violence. Further, it is important that modelling be conducted using the other types of violence (physical assault, threat of assault, verbal sexual harassment, sexual assault) as the dependent variable, so that we can learn about predictors and preventive strategies uniquely associated with each. Third, more comprehensive measures of quality of care could possibly improve the predictive ability of the models. Finally, we need evaluations of policy interventions designed to prevent violence. We believe that research in which the organization serves as the unit of analysis will be the most useful in identifying and evaluating systemic solutions to workplace violence.

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Correspondence may be directed to S. Duncan, Assistant Professor, School of Nursing, University College of the Cariboo, Box 3010, Kamloops BC V2C 5N3 Canada.

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Beyond Survival: Reclaiming Self After Leaving an Abusive Male Partner

Judith Wuest and Marilyn Merritt-Gray

La recherche sur le processus de quitter un conjoint violent a porté jusqu'à maintenant sur la survie en situation de violence et sur la crise générée par le départ. Il existe peu de données sur le vécu des femmes qui ont quitté des conjoints violents et qui ne sont pas retournées. Dans les études théoriques axées sur une approche féministe qui portent sur les femmes ayant quitté leurs partenaires violents, les chercheurs ont découvert le processus sociopsychologique fondamental de *recouvrer son sens d'identité.* Au cours de cette démarche, les femmes passent par quatre étapes : résister à la violence, se libérer, ne pas retourner et poursuivre leur vie. Cet article porte sur la dernière étape, celle de *poursuivre une vie,* phase au cours de laquelle les femmes dépassent le stade de concevoir leur vie en tant que survivantes de violence conjugale et vivent le processus de *comprendre ce qui leur est arrivé, remettre cette expérience à la bonne place, amorcer de nouvelles relations* et *se doter d'une nouvelle image.* Les résultats approfondissent nos connaissances du processus de rupture en identifiant comment l'expérience de la violence et le processus de survie sont déplacés hors du centre de la vie intrapsychique, interpersonnelle et sociale d'une femme. Des questions sont soulevées à l'intention du personnel infirmier et d'autres professionnels de la santé à savoir comment ceux-ci peuvent éviter de revictimiser les femmes dont le cheminement les a amené à *dépasser* cette expérience.

Research on the process of leaving an abusive male partner has focused on surviving abuse and the crisis of leaving. Little is known about the experience of women who have left abusive male partners and not gone back. In this feminist grounded theory study of women leaving abusive partners, the researchers discovered the basic social-psychological process of *reclaiming self* in which women voyaged through 4 stages: counteracting abuse, breaking free, not going back, and moving on. The focus of this paper is the last stage, *moving on,* during which women move beyond framing their lives as survivors of an abusive relationship through the processes of *figuring it out, putting it in its rightful place, launching new relationships,* and *taking on a new image.* The findings extend our knowledge of the leaving process by delineating the ways in which the abuse experience and the survival process are displaced as the centre of the woman's intra-psychic, interpersonal, and social existence. Questions are raised about how nurses and other health professionals can avoid revictimizing women who have *moved on.*

Despite the prevalence of woman abuse by men, little is known about the ways in which surviving an abusive conjugal relationship affects women over time, or the implications of this legacy for nursing practice

Judith Wuest, RN, PhD, is Professor, and Marilyn Merritt-Gray, RN, MN, is Associate Professor, Faculty of Nursing, University of New Brunswick, Fredericton, Canada.

with women. In this feminist grounded theory study of the process of leaving an abusive male partner, *reclaiming self* emerged as the central social-psychological process. *Reclaiming self*, a process of reinstating self in the larger social context, has four stages: counteracting abuse, breaking free (Merritt-Gray & Wuest, 1995), not going back (Wuest & Merritt-Gray, 1999), and moving on. The focus of this discussion will be the last stage, *moving on*, and its implications for practice with women who have been abused by their male partner. Women who are *moving on* are past the immediate crisis of leaving, and over time have achieved some stability, establishing a new life separate from the abuser. In this stage, they are able to devote their energy to reflecting on the past and claiming a future in which they are no longer defined by either the abuse or the survival experience. For these women, *reclaiming self* is a process grounded not only in intra-psychic work but also in reconstructing day-to-day activities, interpersonal relationships, and social connections.

Background

One in four Canadian women experiences violence at the hands of a conjugal partner (Statistics Canada, 1993). Our work with women who have left abusive partners indicates that leaving is a process, not a singular act. Research on the process of surviving or leaving has focused principally on preparing to leave and the crisis of leaving (Fiene, 1995; Landenburger, 1989, 1993, 1998; Mills, 1985; Ulrich, 1991, 1993). Campbell, Rose, Kub, and Nedd (1998) recently delineated women's resourcefulness in achieving nonviolence in previously violent relationships. Studies that have included the post-leaving period have focused on the concepts of recovery (Kearney, 1999; Landenburger, 1989, 1998; Taylor, 1998) and healing (Farrell, 1996). Landenburger (1989, 1998) has developed a model of entrapment in and recovery from an abusive relationship, identifying three subprocesses of the recovery stage: struggling for survival, grieving, and searching for meaning. Farrell's phenomenological study of healing following an abusive relationship identified four themes: flexibility, awakening, relationship, and empowerment. Healing, according to Farrell, consists of reconnecting the fragments of the self by putting the abuse experience into perspective and developing a sense of wholeness. Kearney applied her substantive theory of recovery from trauma and illness to the literature on leaving an abusive relationship. Recovery is conceptualized as reconciling by "reassembling the shattered self" (p. 137). Healing and recovery are seen to start while the woman is still in the relationship and continue through the process of leaving into the post-leaving period.

In contrast, Taylor (1998), in an ethnographic study of resilience and recovery among African-American women survivors of domestic violence, focused on what the women did to thrive and move past mere survival. She identified strategies used by the women as a means of resistance during recovery: telling our business, reclaiming ourselves, renewing the spirit, building a new foundation, knowing my place, forgiving, being your own woman, beating back the barriers, and looking forward. These findings extend previous understandings of leaving but are specific to African-American survivors in that the women's actions relate not only to moving beyond the violence but also to addressing racial oppression. We need similar knowledge regarding other populations. Given the prevalence of woman abuse, it is imperative that we understand how women move beyond framing their lives as survivors of an abusive relationship, and having their lives framed that way by others, in order to increase our knowledge of the whole process of leaving and inform our practice with women who have experienced abuse in the past.

Research Design

We selected grounded theory from a feminist perspective (Wuest, 1995) as the method for exploring the process of leaving abusive relationships among women living in small towns and rural communities in eastern Canada. Grounded theory (Glaser, 1978; Glaser & Strauss, 1967), as a method for discovering social process within social structure, was well suited to exploration of the process of leaving. Feminist perspectives on violence have eroded the primacy of individual and interpersonal explanations of violence in relationships, looking instead to gender and power issues in the larger social context (Varcoe, 1996). A feminist perspective in this grounded theory study ensured that the women's subjective experiences would be examined in social context.

Data Collection and Analysis

In grounded theory, data collection and analysis proceed simultaneously and participants are selected not on the basis of their representativeness but because the investigator believes them to be a source of knowledge of the domain being explored or for a specific analytic goal (Glaser, 1978; Sandelowski, 1995).

Lay and professional helpers such as transition-house workers and community-health nurses gave explanatory letters with stamped response cards to potential participants — women who they knew had

left abusive relationships. Respondents were telephoned, their questions answered, and arrangements made for an interview at a mutually agreeable location. Data were collected through unstructured audiotaped interviews with 15 Caucasian women who originated and currently lived in small towns and geographically isolated areas in eastern Canada. The women ranged in age from their late teens to mid-50s; were either employed, students, or receiving social assistance; and had educational levels ranging from elementary school to university degree. About half of the women had accessed women's shelters at some point in the leaving process. None of the women had access to support groups and very few had sought professional counselling.

Each participant gave her informed consent and the investigators made it clear that she was free to stop the interview or refuse to answer any question. Initially, the women were asked to talk about how they had left the relationship. Invariably, they spoke not only about the abusive relationship and leaving, but also about what they and their lives had become since they had left. For the women in this study, the process of leaving and *reclaiming self* eventually included moving the experience of abuse and survival away from a position of primacy in their lives, not only intra-psychically but also interpersonally and socially.

Interviews were transcribed with all identifying data removed and the tapes were returned to the participants or erased. As concepts were identified in data analysis, information to illuminate the theoretical properties of emerging concepts was sought by theoretical sampling of data from repeat interviews and interviews with new participants, as well as focus-group data from a study to explore sociocultural perspectives on woman abuse (Wuest & Merritt-Gray, 1997). Theoretical coding was used to clarify relationships between concepts and to facilitate the development of a theoretical framework (Glaser, 1978). In repeat interviews, the emerging theory was shared with the participant for discussion and refinement.

Findings

Reclaiming self was the central social-psychological process that emerged in this study with women who had left abusive relationships. *Counteracting abuse,* the initial stage of this process, reflects survivor resiliency from the onset of abuse as women learn strategies for minimizing abuse and building their own strengths despite sustaining painful losses (Merritt-Gray & Wuest, 1995). *Breaking free,* the stage of disengagement, is tortuous and iterative as survivors tentatively draw

on their increased competence, test different exits, and discover the unpredictable and dangerous consequences of leaving the relationship. *Not going back* is the stage in which the women attempt to establish and protect physical and emotional territory separate from the abuser despite increased risk from escalating violence or abuse (Wuest & Merritt-Gray, 1999). In this stage, women garner control using the strategies of harnessing the system for assistance, setting limits on partners and helpers, formulating a plan for the future, and coming to terms with living in significant danger from partner harassment. At the same time, survivors face the challenges of getting established in a new location separate from the abuser by negotiating for and reclaiming belongings, taking ownership of finances, resuming normal day-to-day activities, and settling their children in new neighbourhoods. Throughout this period, women engage in relentless justifying, a process of feeling compelled to explain their situation not only to the outside world but also to themselves. The work of *not going back* is demanding, made more so by emotional pain and fatigue and the need to put children's needs first.

Moving on is the fourth stage in the process of *reclaiming self.* Survivors are now relocated and are no longer consumed by the practical issues of claiming their own territory. Although memories of the abuse, intense fear, pain, and anxiety occasionally resurface, the woman no longer feels at risk. This relative stability allows her time and energy for purposeful reflecting on the past, engaging in other aspects of her life, and investing in her future. *Moving on,* then, consists of shedding the identities of "victim" and "survivor" and of *figuring it out, putting it in its rightful place, launching new relationships,* and *taking on a new image.* These processes occur simultaneously, each providing a system of checks and balances for the others. The *moving on* stage takes place over several years.

Figuring It Out

Figuring it out is the process of searching for reasons why the abuse happened and why the woman remained in the relationship as long as she did. It is similar to what Landenburger (1989) calls "searching for meaning." During the *not going back* stage, survivors *reviewed and replayed* the abuse as they were called upon to justify and defend their decisions and to measure up to established criteria for accessing services for abused women (Wuest & Merritt-Gray, 1999). Reviewing and replaying their past heightened their pain, isolation, and sorrow for the loss of innocence, dreams, hopes, material possessions, and a sense of

self. *Figuring it out* is a more conscious and proactive process, often driven by a desire to prevent abuse from happening in their future relationships and, perhaps more importantly, to prevent it from happening in the relationships of their sons and daughters. The complexity of factors which might have contributed to their abuse is explored and expanded by women through the process of *figuring it out.*

Much of the focus in *figuring it out* is assignment of blame. Survivors felt that they were socially called upon to clarify the blame and to account for what they did wrong. Few of the women accessed professional help at this stage of *reclaiming self.* Rather, they reflected, talked, kept journals, drove around in their cars thinking, and, over time, observed the abuser interact in new relationships. The women reviewed turning points in the leaving process, re-examining which encouragements and instrumental supports had been helpful and which had not. Rarely in the process of *figuring it out* did they consider the impact of social conditions, societal and cultural norms, or family traditions.

Their questioning at first focused on self-blame, beginning with "Why me? What's wrong with me?" Many women compared themselves with women in good relationships: "It's not fair. Why do these things happen to me?" They questioned what made them vulnerable by examining personal shortcomings. Was it their tendency to be dependent on men, their attraction to "his type," their need to be attached, or their youthful naivety, which resulted in "false love"? Some women blamed themselves for "hanging around places I shouldn't." Some ruefully acknowledged their continuing love for the abuser, even after being out of the relationship for a long time. This reflective process caused some women to wonder if they were capable of having a "normal relationship" with a man.

In the *moving on* stage most of the women had stopped believing they could have altered the relationship by being a "better" wife. Socially, however, they continued to get subtle messages that had they been more "obedient" or "self-sacrificing" or "caring" they could have made the relationship work. They spoke of acquiring the skills needed to "tune out" these messages in order to get on with their lives. Friends of the women in the present study had sometimes been more sympathetic towards the abuser in his plight and only after many months or years began to acknowledge evidence of his unwillingness to take responsibility for his behaviour that put others at risk. When friends or family members validated her perspective of the abuser, the survivor was less inclined to blame herself:

> *I don't care what people think of me. I have been called everything, including a whore, because I broke up this happy home. But the thing is, it's going on 3 years and people are starting to wake up. And they're coming back and talking to me and realizing it was not as good as what they thought.*

The women asked themselves, "Why did I stay so long?" Some attributed the length of time they stayed to personal and social expectations — "You don't just walk out" — or to the absence of resources, such as money or a place to stay. Others linked staying in the relationship to their spiritual beliefs: "God will never give you more than you can handle." But most identified personal deficiencies such as an inability to face failure in the relationship, pity for the abusive partner, or insufficient strength to stay away, or they bought into his excuses: "I was brainwashed," "I loved him," "He was a bad habit." They noted their difficulty in naming what was happening to them as abuse, the paucity of information on norms for everyday relationships, and the difficulty of talking to anyone about what was happening. A final factor identified — perhaps the most significant one — was the enduring hope that the partner would change if she just kept trying to make him understand.

The women also tried to determine what was wrong with their partner, considering factors such as his unstable family background, substance abuse, or difficulty holding down jobs. Many noted their abuser's manipulative behaviour or his inability to deal with anger or frustration. Several said he was "strange" or "did weird stuff," alluding to his being twisted or evil in other ways, but remarked on the absence of early cues that might have warned them of the potential for abuse. Some were angry that people in the community who had knowledge of his previous abusive behaviour failed to give any warning. With frustration, survivors frequently observed that their abuser refused to accept responsibility for his actions and that society had no expectations of abusers to do so.

As the women considered the character of their relationship, they asked whether their own role, particularly early in the relationship, might have contributed to the abuse: "I let him walk over me," "I played mother." Some commented on the quality of the relationship: "There just wasn't enough caring." Some women were confident about their conduct in the relationship:

> *I know that it wasn't my fault because I never did anything. I never ran around. I didn't go out and drink and get stupid or any of those things. So there was no reason. It's different if you have a reason. Then maybe*

> *you can accept some of the guilt or you think maybe it is my fault, but I knew it wasn't my fault.*

Others viewed themselves as having some responsibility:

> *The majority of our friends were dead against me. I have told them, "I am not going to sit back and blame him for everything. It's just as much my fault, because maybe I could have done things differently too." But he still blames me solely.*

As they considered the relationship, attribution of blame to themselves lessened when they considered broader social factors. Participants noted the absence of social norms around what is normal in a relationship and the assumption that parents teach children about relationships: "We leave so much to assuming that parents did a good job." Women who had received premarital counselling were angry that spousal abuse had not been a topic for discussion, given its prevalence. This was particularly true of women whose family of origin included no exposure to abusive behaviour or discussion about how to handle violence in a relationship. In the present study, survivors eventually came to an understanding that there was no clear reason for the abuse, no one to blame, and finally recognized that they could live with not knowing why abuse happened.

Putting It in Its Rightful Place

"Putting it in its rightful place" is how one woman described the process of no longer allowing the abuse experience to define her existence. The women had various ways of framing this process. "I just want that person [the woman who was abused] to be dead," "I'm filing it for future reference," "I broke that habit, and the dreams that I had when I was younger have come back but they are modified."

The women spoke of being repeatedly told by family members, friends, and helpers to not dwell on the abusive experience and to "forgive and forget," advice that they found untenable. In contrast to the women in Taylor's (1998) study, the participants in this study did not consider forgiveness central to healing. Some were frustrated with a community that expected them to forgive but did not expect their abusers to show remorse. Moreover, many felt lied to by helpers such as members of the clergy who had made such comments as "You'll remember the good and not the bad." They were angered by the assumption that it was possible to forget such a significant experience. In fact, the participants, not unlike war veterans, said that it was vital the experience not be forgotten, so that it would not be repeated. They

said that despite *putting the abuse in its rightful place,* the painful memories resurfaced, even many years later. The women graphically and eerily described such feelings as "his eyes on me," "pressure on the wrists," and "his presence in a room."

Despite the fact that the abuse is not forgotten, it does become displaced as the centre of the woman's existence. It is put in the context of other life events and new challenges such as taking a new job, dealing with a teenager in trouble with the law, becoming a mother, or finding a lump in the breast. The women spoke of discovering that some events, such as the death of a baby or the loss of a loved one to cancer, are worse than abuse. One woman spoke of finding her new partner in bed with another woman. This was worse than the abuse she had endured because they had a loving relationship and she had finally allowed herself to trust a man again.

As the women stopped defining themselves in terms of the abusive experience, they incorporated the abuse as part of their past and began to recognize the positive consequences of the relationship. Some, especially those with children, developed a careful co-existence with the ex-partner, particularly when he and his extended family lived in close proximity. Although this co-existence may be co-operative in some ways, it is most often awkward and extremely difficult. The women confessed to taking pleasure in hearing about misery or misfortune befalling their ex-partner. Over time, the survivors sensed a softening of their anger towards family and friends who had failed them or put them at greater risk. However, they were less forgiving of institutions that had repeatedly hampered their leaving process with red tape, inaction, and misinformation. After all, they reasoned, helping was "their job." As the women put abuse *in its rightful place,* they were able to reinvest in their futures.

Launching New Relationships

Launching new relationships takes place within a social environment where there is a pervasive expectation that women be partnered. The participants indicated that they felt uncomfortable without a partner at social or sporting events, or even eating out. Yet they were ambivalent about launching new relationships. They wanted to believe they were capable of having a loving relationship but feared that history would repeat itself. Several women had become involved with men for support and refuge during the stages of *counteracting abuse* or *breaking free,* but becoming involved during *moving on* was a more considered process. The participants identified different levels of commitment in

relationships, ranging from "just sex" to real involvement. All found it important to give themselves time and to trust their gut feelings about readiness for exposure to environments with the potential for initiating new relationships. One woman recalled, "I went through a relationship but I ended it because I am not ready. I don't feel anything." The women distinguished between *being able to* and *wanting to* engage in a new relationship. A woman who had been out of her relationship for 16 years said, "I could do it now...but I don't want to." Another described relationships as "stepping stones...one building on the next."

The women spoke of their vigilance in new relationships as "being on guard," "reading all the signs," and "surveying the whole scene." None of the women wanted to find themselves in another abusive relationship but the constant surveillance was nerve-racking and exhausting. Vigilance included setting criteria for themselves, their partner, and the relationship. The women made protective rules such as "I won't marry again," "I'll keep control of my own money," and "I'll always have an exit."

> *I am absolutely sure that I would never...I could date a man as long as we could see each other once or twice on the weekend...for 20 years, fine. But he is staying in his place and I am staying in mine. I am never letting anybody take that away from me again!*

The women believed that they could not change men: "If your man is that way when you get him, he's that way when you leave him." This belief led them to check out potential mates using their newly established criteria. They watched for warning signs such as rage, name-calling, surveillance, antagonistic behaviour, and drinking or taking drugs. The women looked for men with whom they felt comfortable talking and problem-solving, who showed understanding with regard to their abusive experiences, and who offered affection and support in response to unreasonable behaviour on their own part. It was important that potential partners be able to withstand exhaustive testing:

> *I'd call him at three or four o'clock in the morning just to see what kind of reaction I'd get. When we started living together, I'd make noise just to see if he'd get up and start screaming and yelling at me or call me names or something like that. I just had to be sure that he wasn't really putting on an act for me.*

One woman said, "If he doesn't measure up, he's out."

Women defined what they would accept in a relationship, particularly with respect to trust, problem-solving, fighting, and amount of personal investment:

> *If he does something I don't like, I don't keep quiet about it just to keep peace in the house. I tell him that I don't like it, that I don't want it to happen again. You know, it's nothing major but your attitude is totally different.*

They described a reluctance to fully trust any partner again, while acknowledging that trust was essential in the kind of relationship they wanted. They looked for evidence that it would be at least a 50/50 partnership, with some women being adamant that they come first in any relationship. The women wanted to be able to discuss concerns about their new relationships with trusted friends and family members; helpful family members supported their judgement and their decision to partner. Participants did not expect their relationships to be without conflict, but they wanted to know that "fighting in the relationship will be fair." They wanted to be able to resolve problems in a civil manner and to believe that both partners could speak their minds and confront each other without feeling threatened. Over time, the women said they began to relax their criteria, acknowledging that "while this man may not be perfect, the relationship works and feels good."

Taking on a New Image

Taking on a new image is the process of leaving behind the image of abused woman or survivor and taking pride in the person one has become. When the women in the present study were being abused, they relinquished parts of themselves, assuming aspects of the abuser's image. Although in the process of *counteracting abuse* they fortified themselves in ways that eventually allowed them to *break free* and *not go back,* they lacked the freedom, energy, and time to forge a new image:

> *You left a man but you haven't left that life. You haven't left the thinking. It's not so much the life, it's what they create you to be.*

Moreover, in order to qualify for help needed to survive, women were forced to demonstrate over and over again how they met the criteria of the "abused woman" established by various agencies. This public framing of the woman as victim or survivor limited her options and put her in a box. In *moving on,* women begin to take stock of themselves, recognizing ways in which they are now different. They have let go of shattered dreams and are acutely aware that their views of the world have changed. Material possessions, the loss of which was central in the process of *not going back,* are less important; opportunities do not depend on their attaining and keeping them. With these discoveries, the woman begins to enjoy the person she has become.

The women in this study spoke of finally being able to enjoy spending time at home, of taking pleasure in the more mundane aspects of daily life in the home and in the community:

> *I'm really happy now. I'm so much more content.... I'm home all the time. You know, I was never home then. No matter what we did to the house, I was never there to enjoy it because I hated to be there.*

One woman said, "The woman who was abused is not who you are now."

They expressed curiosity about the potential of the person they had become. They spoke of a new awareness of others' emotional pain and their own enhanced potential for helping them:

> *I am more aware...I can see in other people when they are hurting...you can almost reach out and help somebody who was in the same situation that you were in, because you can sense it.*

The women were aware of their personal power and control. Having conquered abuse, most reported feeling stronger, braver, more capable of caring for themselves, and more secure in who they were. A woman who had experienced censure by friends and acquaintances said:

> *Now, I can walk down Front Street and anybody that knows, knows of me, they could turn around and say whatever they wanted to me now and it's, like, I don't care, say what you want, I know who I am.*

Dreams such as having a career, returning to school, or owning a home began to seem possible: "There's a future for me now. I see a future now."

Women with children spoke of becoming better parents. They wanted to be seen as "together," not as survivor or victim, and purposefully exhibited that side of themselves. These new self-perceptions were reinforced by employers, co-workers, friends, and family members: "I've seen such a difference in you," "You look great," "It was a good move."

Implications

These findings related to *moving on* complete the in-depth description of the theory of *reclaiming self* begun in descriptions of the stages of *counteracting abuse, breaking free* (Merritt-Gray & Wuest, 1995) and *not going back* (Wuest & Merritt-Gray, 1999). This theory provides an inclusive framework to assist nurses and others in their work with women who are in any one of the stages. It also may help women who are in the process of leaving to frame their progress and make sense of the

experience. Although the sample used was a homogeneous group of Caucasian women living in eastern Canadian small-town and rural settings, the theory may be applicable to women of various races, ethnic groups, social classes, or life circumstances. By testing its usefulness with diverse women, clinicians may be able to further develop or modify the theory. Researchers may be able to extend the theory by using constant comparative analysis with other populations. Campbell et al. (1998) found that some women were able to change their lives and create a safe social environment for themselves without leaving the abusive partner. One area for future research would be to determine whether such women also go through a process of *moving on.*

The findings of this study have changed our thinking with regard to the term *survivor.* The literature on domestic violence reveals a shift in descriptive terminology concerning women who have been abused, from *victim* to *survivor* (Campbell, 1986, 1992; Hoff, 1990). In our previous writings and presentations, we carefully used the term *survivor,* believing that it emphasized women's strengths and capacities. Our analysis of the process of *moving on* has shown us that this label still gives primacy to abuse in women's lives, even though women in this stage are clearly *taking on a new image* and no longer see abuse or the survival experience as the centre of their existence. Hence, although *survivor* may be an empowering term for women in the stages of *counteracting abuse, breaking free,* and *not going back,* we believe it has the potential to disempower women who are in the process of *moving on.* Any label applied by socially defined experts has the potential to take away from the woman's redefinition of herself, and we need to ask ourselves who the label serves. Clinicians can more usefully build on the woman's efforts to take on a new image by using language that resonates with her orientation towards the future.

These findings also raise important issues for other health professionals who work with women. Given that one in four women in Canada is abused by her conjugal partner, many women who seek health services are in some stage of the leaving process. Abuse screening by nurses and other health professionals can help to identify women in all stages of the process of *reclaiming self,* providing opportunities both to offer assistance and to revictimize by making assumptions and inappropriately labelling women as survivors or victims. Campbell (1998) calls for the health-care system to be an empowerment zone for battered women and their children. To achieve this goal, assessment would include determining a woman's stage in the leaving process and tailoring assistance to needs associated with that stage. Additional work

is required to design and test stage-specific clinical interventions based on this theoretical framework.

The findings concerning *moving on* offer direction for public and professional education concerning the leaving process. Women who enter the health-care system while in the *moving on* stage will most likely be seeking help for non-violence-related issues, yet their health-care providers need to be cognizant of their present issues in *moving on.* The fact that data that led to the conceptualization of moving on originated with women who were asked to talk about the process of leaving suggests that, for women, the process is not complete until they have been able to reposition abuse so that it no longer defines their life experience publicly. Therefore, societal understanding of the process of leaving needs to reflect this important stage.

A core issue for women in the process of *figuring it out* was assignment of blame. Most focused on their own shortcomings and those of their partner as reasons for the abuse, a practice encouraged socially and professionally and consistent with a North American value system of taking responsibility for events. Women should be encouraged to move beyond individual responsibility, to consider family and societal influences that support the development of abuse. This is more likely to happen in an environment in which the public understands abuse as socially constructed and does not exert pressure on women to accept an unreasonable amount of responsibility.

Women also may benefit from being encouraged to remember, reflect on, and learn from the experience, as opposed to being pressured to forget. Lay and professional helpers should heed women's construction of *putting it in its rightful place.* As women move on, they may accumulate losses that overshadow the abuse experience. Nurses and other health professionals must be careful not to give primacy to abuse when, in fact, other life experiences may have become more central to the woman's health. They must nevertheless acknowledge abuse as a significant part of her past, be prepared for its resurfacing, and offer validation and anticipatory guidance.

Finally, all women who have left abusive relationships require confirmation of their strengths and their growth in order to foster the development of their *new image.* Our findings reinforce the position that revictimization by individuals, families, professional helpers, and institutions happens over and over again to women in all stages of the process of leaving. Often, nurses and other health professionals who encounter women in the process of reclaiming self have little knowledge of domestic violence and little experience in offering constructive

assistance to women who have been abused by their partner. While such helpers may not know what intervention may be most helpful, at the very least they must take steps to do no harm and reinforce women's strengths and security.

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Correspondence concerning this article may be directed to either Judith Wuest or Marilyn Merritt-Gray, Faculty of Nursing, University of New Brunswick, PO Box 4400, Fredericton NB E3B 5A3 Canada. E-mail: <wuest@unb.ca> or <mmerritt@unb.ca>.

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Abuse Obscured: An Ethnographic Account of Emergency Nursing in Relation to Violence Against Women

Colleen Varcoe

La violence faite aux femmes est une question de grande importance en matière de santé au Canada et partout dans le monde, mais les services de santé mis en place s'avèrent inadéquats face à ce phénomène. Bien que plusieurs raisons ont été mises d'avant pour expliquer cette lacune, peu de recherches systématiques sur le sujet ont été entreprises. Cette étude ethnographique exécutée dans deux unités d'urgence hospitalières vise à décrire les pratiques infirmières en rapport à la violence faite aux femmes. Des entrevues menées auprès de cinq infirmières œuvrant dans d'autres unités d'urgence s'ajoutent aux observations des participantes et aux entrevues menées auprès de 25 pourvoyeurs de soins et de cinq patients de deux autres unités. Les résultats indiquent que la violence est passée sous silence et que la pratique véhicule les stéréotypes et une approche axée sur les problèmes physiques et la rapidité de traitement. Les perceptions de la gravité de la situation de la patiente influent sur les soins, qui peuvent varier d'une approche caractérisée par « l'absence d'intervention » à une approche active où les intervenants offrent aux patientes certaines options. Cette description permet de mettre en place une base qui améliorera la formation du personnel infirmier et favorisera une pratique plus efficace.

Violence against women is a significant health issue in Canada and around the globe, yet the health-care response has been inadequate. While various reasons for this inadequacy have been suggested, little systematic research has been undertaken. This ethnographic study of 2 hospital emergency units was conducted to describe nursing practice in relation to violence against women. Participant observation and interviews with 25 health-care providers and 5 patients in the 2 units were complemented by interviews with 5 nurses from other emergency units. The findings illustrate that abuse is obscured and practice shaped by stereotypical thinking and a focus on physical problems and rapid patient processing. Perceptions of patient deservedness influenced care that ranged from "doing nothing" to actively offering the patient choices. This description provides a basis for designing meaningful education for nurses and systemic changes that will foster more effective practice.

The health-care response to violence against women remains less than adequate despite widespread acknowledgement that it is a health problem of epidemic proportions. This study examined the relationship

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Colleen Varcoe, RN, PhD, is Associate Professor, School of Nursing, University of Victoria, Lower Mainland Campus, Vancouver, British Columbia, Canada.

between the social context of practice and the ways in which nurses recognize and respond to the plight of women who have been abused.

Literature Review

In Canada, the prevalence, frequency, and severity of violence against women are similar to those in other countries around the globe. The Violence Against Women Survey (VAWS) interviewed a randomly selected national sample of 12,300 women. Analyses of these data (Johnson, 1996; Kerr & McLean, 1996; Ratner, 1995; Rodgers, 1994) provide the most comprehensive picture of the problem in Canada to date. The VAWS estimated that one in every two Canadian women over the age of 18 had experienced at least one incident of sexual or physical assault, and that 10% of these women had been assaulted in the preceding year (Johnson; Rodgers). Congruent with global statistics (Heise, Pitanguy, & Germain, 1994), 29% of women in Canada who had ever been married or in a common-law relationship reported being physically or sexually assaulted by their partner at least once during the union (Johnson; Rodgers). Johnson estimates that over 2.6 million women in Canada have been assaulted and that 15% (1.02 million) of those currently in a marital relationship have been assaulted.

In addition to these alarming figures on prevalence, the VAWS estimated the frequency and severity of abuse. In 63% of all cases of wife assault, violence occurred more than once, and 32% of all cases involved more than 10 episodes of violence. In 34% of all cases, the woman feared for her life. In almost half of all relationships with violence, a weapon was used at some point and almost half of those assaults resulted in injury to the woman. In 43% of situations in which the woman was injured, she sought medical attention.

The response of the health-care system to violence against women has been characterized by failure to recognize abuse and by negative attitudes and responses. Most research on recognition of abuse by health-care professionals has been conducted in Emergency units, with 2% to 8% of female trauma patients being clinically recognized as abused. Yet research strategies and identification protocols identify approximately 30% of the same population as abused (e.g., Abbott, Johnson, Kozoil-McLain, & Lowenstein, 1995; McLeer & Anwar, 1989; Olson et al., 1996; Roberts, O'Toole, Raphael, Lawrence, & Ashby, 1996; Tilden & Shepherd, 1987). Similar lack of recognition has been identified in primary-care settings (e.g., Bullock, McFarlane, Bateman, & Miller, 1989; McCauley et al., 1995) and during pregnancy (e.g., Campbell, Oliver, & Bullock, 1993; Campbell, Poland, Waller, & Auger,

1992). The latter is of grave concern, as the VAWS found that 21% of abused women were abused during pregnancy (Johnson, 1996).

Responses by health-care providers to recognized abuse have been characterized as narrowly focused on the physical consequences of abuse and on victim-blaming (Dobash & Dobash, 1988; Kurz & Stark, 1988; Stark & Flitcraft, 1991; Warshaw, 1993). McMurray and Moore (1994) found that women admitted to hospital as a result of abuse experienced disengagement from hospital staff, loss of status, disempowerment and lack of control, stigma and social isolation, and a sense of being misunderstood. The women told of being humiliated, blamed, judged, and made to feel unworthy. Such experiences can have a negative impact on health. In analyzing the VAWS data, Ratner (1995) concludes that contact with health-care providers had a slightly negative effect on the health outcomes of the women. She suggests that these findings may be due to the professional's focus on physical injuries and disregard for the woman's experience.

Some investigators have examined the negative health-care responses, but their explanations are incomplete. After studying the medical records of 153 women who experienced abuse, Shields, Baer, Leininger, Marlow, and Dekeyser (1998) conclude that negative outcomes may be a result of negative attitudes and a lack of knowledge and collaboration among care providers. Gerbert et al. (1996), after investigating the health-care experiences of 31 women, report that the women perceived care providers to be uninterested and unsympathetic. This finding is supported by findings that consistently show negative attitudes on the part of health-care providers towards women who have been battered (e.g., Chung, Wong, & Yiu, 1996; Cochrane, 1987; Easteal & Easteal, 1992; Renck, 1993; Rose & Saunders, 1986). An additional finding of Gerbert et al. was that the women thought the health-care system did not allow providers to deal with anything beyond immediate physical injury.

These studies point to both the attitudes of health-care providers and the structures of the health-care system as influencing the quality of responses to violence against women. However, little systematic study of health-care responses has been undertaken. It should be noted that most research on these responses does not distinguish the practice of nurses from that of other health-care professionals. Despite increasing attention in nursing to violence against women, the practice of nurses in this regard has not yet been described. Further understanding of the health-care system and its response to violence against women might provide a basis for improving that response and, ulti-

mately, outcomes for women. The purpose of this study was to describe the relationship among the social context in which health care is provided, nurses, and care for women who have been abused.

Method

In order to study the context of nursing practice, I used an ethnographic approach. In ethnography, a method of studying social context (Atkinson & Hammersley, 1994; Hammersley & Atkinson, 1983), participant observation and interviews are used to create a comprehensive picture of a specific culture or context. I wanted to pay particular attention to power relations both between patients and health-care providers and among health-care providers, and I wanted to contribute to change through the research process. Hence I used a *critical* ethnographic approach. Critical ethnography is concerned with: (1) relationships and power inequities between individuals and the socio-political framework, (2) transformation of those relationships, and (3) attention to the research process as a form of action (Anderson, 1989; Quantz, 1992; Simon & Dippo, 1986). The study was also informed by a feminist understanding of violence and oppression (Varcoe, 1996), which guided my analysis and critical self-reflection.

Data were collected over 2 years in the Emergency units of two urban hospitals and the communities they served. The reason for my focus on Emergency was that a large number of women who come to hospital Emergency units do so because of injuries inflicted by their abusers or because of health-care problems that result from living under the chronic stress of violence. Thus Emergency is one of the most common points of contact between nurses and women who have been abused (Campbell, Pliska, Taylor, & Sheridan, 1994; Goldberg & Tomlanovich, 1984; McLeer & Anwar, 1989; Pakieser, Langhan, & Muellerman, 1998; Warshaw, 1993). The reason for using two hospitals instead of one was that co-workers in the study might be able to identify individuals by their job title (e.g., social worker, clinical nurse specialist); use of two separate hospitals would serve to protect identities.

Both hospitals were located in communities that formed part of a large city. The communities were diverse in terms of ethnic and cultural composition, income, religious preferences, and languages spoken. Both included a large First Nations community as well as people whose first language was Chinese, Korean, Punjabi, Hindi, Farsi, and Tagalog (Statistics Canada, 1996). As with most Canadian hospitals at the time (Hotch, Grunfeld, McKay, & Ritch, 1996), these units had no programs or policies regarding abuse.

Ethical review was conducted by the supervising university and the two study sites. After making presentations at staff meetings, I obtained written consent to observe practice from approximately 85% of all Emergency staff — nurses, physicians, and others. I treated non-return of consent forms (after leaving a second copy for each person) as refusal to participate, and made no observations of those staff members. I obtained verbal consent to observe each patient with whom I had contact and the many health-care providers who came to Emergency from other departments (e.g., lab technicians, porters, ambulance attendants). None refused. No one was approached for an interview. Rather, I informed everyone of my interest and my method, and participants volunteered. As I had a large number of volunteers from whom to choose, I was able to select a diverse sample of nurses and a variety of other health-care providers.

I completed over 200 hours of observation in the two Emergency units. Data collection began with observation, during which time I "buddied" with one of eight nurses who had volunteered. My priority of observation was well respected by most staff members. Within that priority, as an experienced critical-care nurse I was able to contribute to care, mainly by providing comfort and emotional support; I did not administer medications, perform procedures, or chart care.

Interviews were conducted with 30 health-care providers and five women who had been abused. The interview sample consisted of a core sample of 12 Emergency nurses who were observed extensively and interviewed twice. The purpose of the second interview was to obtain clarification and discuss the evolving analysis. I interviewed nine additional Emergency nurses, four from the study sites and five from various other hospitals throughout the province in which the two sites were located. I interviewed nine other health-care providers. These included admitting clerks, social workers, physicians, and hospital administrators. Five women who had personal experiences of abuse also volunteered to be interviewed; I met three as patients in Emergency and two in the community during field work. These women self-disclosed their experience and volunteered while I was obtaining informed consent to observe nursing care or community activities. The interviews lasted from 1.5 to 5 hours (average 2 hours) with nurses and from 1 to 3 hours with others.

All of the 21 nurses interviewed were female and Caucasian, reflecting the underlying populations in the study units. With the exception of one student in an Emergency Nursing program, all had a minimum of 4 years' Emergency nursing experience, with an average

of 9 years. Of the 21 nurses, two were Assistant Head Nurses, five were Nurse Managers, one was a student, and 13 were staff nurses working casual, part-time, or full-time. Eighteen of the nurses had a diploma as their initial nursing education, and three of these also had a bachelor's degree; the other three nurses had a bachelor's degree as their initial nursing education. Thirteen nurses had completed one or more certificates in Emergency, Critical Care, or Outpost Nursing. Of the 17 nurses who specified their personal experiences, 11 had experienced violence in their families. All but three nurses could recall at least one instance of caring for a woman who had experienced abuse. Demographic data for the other nine health-care providers and the five patients could potentially identify individuals; it is therefore being withheld.

Data collection and analysis took place over a 2-year period. All interviews were transcribed, and rough field notes were expanded as they were typed. I combined established approaches to ethnographic analysis, drawing on the work of Atkinson and Hammersley (1994), Clifford and Marcus (1986), Hammersley and Atkinson (1983), and Spradley (1979), with ideas from critical ethnography (Anderson, 1989; Quantz, 1992; Simon & Dippo, 1986). In seeking an analysis of power relations, critical ethnography requires attention to multiple perspectives. Thus I continually sought competing and contradictory perspectives, using tensions between perspectives as points for analysis rather than as problems to be solved or choices to be made. Instead of glossing over contradictions in the data, I sought to create conceptualizations to accommodate multiple and competing perspectives. Other important features of the analysis included involving participants in the analysis to the extent that they were interested (usually through a second interview) and attempting to account for my own biases, particularly with respect to racism. In this I was guided by feminists such as Alcoff (1991), Harding (1987, 1991), Lather (1986), and Opie (1992) and by my dissertation supervisors (Varcoe, 1997).

MacLeod (1997) claims that all research is intervention. I began this research with the explicit intention of having the participants become more aware of violence in their practice, an objective that was realized. Also, as the analysis unfolded, the impact of workplace economics and power became central in our discussions and may have contributed to political action taken in one unit. My greatest challenge was countering the racism that I discovered without alienating staff. I attempted to draw attention to assumptions without criticizing. In this, and throughout the analysis, I was greatly aided by my dissertation supervisors.

Findings

The data permitted, generally, a rich understanding of Emergency nursing and, specifically, a description of practice in relation to abuse. The nurses were dismayed at the extent to which, they believed, they had been either overlooking abuse or, when they recognized abuse, "doing nothing." However, my conclusion is that abuse was obscured by the practices required to keep Emergency running. Further, it was evident that the nurses often went beyond doing nothing.

Abuse Unrecognized

Abuse went largely unrecognized. At both study sites many nurses told me, "We don't see much of it here." Most nurses did not think they saw much abuse, could recall few instances of it, and, during the study period, rarely recognized it. During the 200 hours of observation, more than 20 patients told me about significant past or present abuse by a partner. However, only four of the disclosures occurred in the presence of a nurse (in response to my seeking informed consent), and only one disclosure occurred during the nurse's assessment (in response to trying out some assessment techniques we had been discussing). Two other instances of abuse were brought to my attention. One involved an elderly man with obvious physical injuries, the other a woman with mental health problems who staff suspected was abused because her husband was angry and verbally abusive with staff.

The nurses reported recognizing only "blatantly obvious" abuse. Nurses and other care providers could recall recognizing abuse only when there had been significant physical evidence of it. They believed that they had overlooked less obvious physical and emotional abuse. The following excerpt is typical of the instances of abuse recalled by nurses:

> *It was a Chinese lady that was beaten up by her husband. Actually she went unconscious for 30 minutes. In actual point he could have killed her. She had no thought left, she had strangulation marks, she had petechiae actually, probably struggling...bruise marks to her back and leg...*

Abuse Obscured Through Efficient Patient Processing

Abuse was recognized only when there was serious physical injury, primarily because this fit the pattern of Emergency practice. The prevailing feature of the Emergency unit was unpredictability, and the prevailing sense of the health-care system was one of scarce resources. The

unpredictability of patient flow and acuity in a system with static resources perceived as scarce called for rapid processing of patients. This in turn required nurses to focus their care, to quickly establish and constantly re-evaluate priorities, and to be "prepared for anything."

The predominant pattern of practice was thus one of "efficient patient processing." The patient was first stripped down to a "manageable problem." In the stripping-down process, the person became a patient, and a recorded version of the person was created on a chart and in places such as the unit triage log, white board, and computer system. A manageable problem was usually a physiological label such as "chest pain," "laceration," "fracture," or "overdose," with known solutions. The manageable problem was then processed and the stretchers emptied as promptly as possible. The process was efficient in that patients were moved quickly out of Emergency.

Violence was not foremost in the nurses' minds as they began the process of reducing the person to a manageable problem. They began triaging all patients from the complaint with which the person presented. If the presenting complaint was a direct result of violence, the cause was not necessarily obvious. Complaints ranged from injuries such as fractured jaw or black eye (obvious), to bruising on the arms or face (suggestive), to abdominal pain, pelvic inflammatory disease, or migraine (apparently unrelated to violence). If the presenting complaint was an indirect result of abuse, the cause was not likely obvious. Problems that could be caused by living under conditions of chronic stress and abuse (e.g., chronic bowel problems, arthritis, depression, alcohol abuse) were often difficult to associate with abuse, even for the woman herself. Finally, if the presenting problem was unrelated to violence, such as cardiac dysrhythmia or renal colic, there was often no basis for identifying abuse. For example, the staff were shocked when an elderly woman who had been repeatedly admitted with supraventricular tachycardia disclosed to me that her tachycardia was always associated with assault by her husband. One nurse summarized practice with these words:

> *I suppose part of it is that, one, it is not always blatantly obvious, and two, if you're an Emergency nurse you're probably busy...and if things are not blatantly obvious, that this woman has been abused, you may not just be mentally tuned into seeing what is going on. You're maybe taking the complaint at the time, "I've got a urinary tract infection" or whatever, and treating the woman for that.*

The nurses thought that the need to quickly and efficiently process patients was escalating under "health-care reform." They saw this esca-

lation not only as affecting their ability to recognize abuse, but also as limiting their ability to engage with all patients: "We totally ignore the psychosocial needs of the patient. We don't do anything." They expressed considerable distress at being unable to provide what they considered adequate care: "I get really angry when I don't have the time to spend with the patients, and yet...there are lots of times that I'm thinking, thank God they don't want it." Nurses saw time and resources as scarce commodities limiting their ability to attend to "psychosocial" needs in general and abuse in particular. Repeatedly they explained that they could not afford to deal with anything except physical priorities:

> *I think you feel guilty because you're trying to nurse the whole person but you can't. You've got to narrow it down to what is your biggest problem...if you're upset about it go see your doctor tomorrow. That's how we tend to operate, which is kind of callous but if we said to everybody, "And how do you feel about this, and is there anything else going on at home that maybe caused this that we can help you with?" you would be with the patients that want to talk for hours.*

Thus, despite the distress it caused them, the nurses saw themselves as unable to engage with patients and thus unlikely to recognize anything but the most blatant physical abuse.

> *If you've got abdominal pain because you're depressed because you're being abused at home, I'm unlikely to pick that up. I'm more likely to trot in there after the doctor has found nothing wrong and say, "You can go home now. How are you going to get home?" The reason for that...is because you might only have that one patient but you've got to get her out because in 10 minutes you might have eight of them.*

Abuse Obscured Through Stereotypical Thinking

> *...there's also a Native population that drink a lot and there's a lot of physical violence in the family units, and so you certainly get twigged when certain people come in to the Emergency Department.*

In addition to the need to focus on physiological problems, stereotypical ideas tended to obscure abuse. Nurses and other health-care providers associated abuse with direct physical trauma, poor people, or racialized people. Nurses usually said that they should be looking particularly for bruising, and tended to not name other forms of physical injury, other health problems, or non-physical problems as suggestive of abuse. Throughout the study, most health-care providers racialized violence and associated it with poverty. I was constantly directed to go to other hospitals where certain racialized groups and poor people were thought to be more concentrated. Most accounts I was given

about patients who had experienced abuse were marked by the ethnicity, religion, or language group of the patient, signifying "not white." The women were identified as Inuit, Indian, Native, Chinese, Iranian, East Indian, Farsi, Muslim, Asian, and so on. In fact there were few accounts of abuse in which the woman was *not* racialized.

Violence was anticipated predominantly among poor and racialized people, and conversely not anticipated among white and middle-class or wealthy groups. Nurses repeatedly told me that, concerning violence, they were "more comfortable" questioning and talking to some women than others.

> *I'll just say, "maybe this could be," rather than, really, "look, let's deal with this, I think there is some violence here," which I would do with the Indian women, which I probably wouldn't do with the [wealthy] ladies. That's where I'm at.*

This differential scrutiny and anticipation of violence suggests that abuse is less likely to be recognized among affluent white patients than among poor or racialized ones, and that women in the latter groups are more likely to be falsely suspected of having been abused. The following examples illustrate these dynamics:

> *I mean, the husband was there and* he was in a suit and he was on his way to work...*and the medicine cabinet she had opened while they were in the bathroom...and she lacerated the top of her eyebrow. That was the history that I got...and the nurse, who is an excellent nurse, jokingly said, "So he's been hitting you again, has he?" which at that particular time they both laughed and said, "Yeah, I bet everybody at work is going to be thinking that"...but it could have very easily been true. [emphasis added]*

One day several staff members greeted me by saying, "We've got one for you." A young woman had been admitted with paralysis and aphasia. She had been admitted before, and organic and psychiatric explanations for her symptoms had been ruled out. The staff suspected that her husband abused her because he was angry and hostile towards the staff. When I later spoke to the woman's brother, he was very frustrated with the staff for offering no explanations for his sister's condition and for assuming violence was an issue. There were no indications of abuse. The family spoke Arabic and little English.

For the most part, the health-care providers reported that they recognized abuse only when it was blatantly obvious — that is, in the face of significant physical evidence or a statement by someone (e.g., ambulance attendant, police officer, family member, friend) that abuse was

the problem. Instances of abuse that were recalled almost exclusively concerned obvious physical abuse, racialized women, or poor women.

When abuse was recognized, the response of health-care providers fell into three overlapping patterns: *doing nothing, influencing choices,* and *offering choices.* No participant used only one pattern of practice, although one or two patterns tended to predominate, and during the interviews the nurses struggled with the ideas represented by all three.

Doing Nothing: The Undeserving Victim

Nurses reported that their most common responses to abuse were to: recognize cues yet not pursue them; deal with obvious physical injuries but do nothing further; or shift responsibility to someone else such as a physician, social worker, or family member. Nurses characterized these responses as "doing nothing." The reasons they gave for doing nothing were the same as those they gave for failing to recognize abuse: focusing on physical problems, not knowing what to do, lacking adequate resources. However, embedded in each account were reasons why doing nothing served the interests of health-care providers:

> *I just remembered another case of a woman who was brought in by her son and I could swear on a stack of bibles that he had been abusing her. We really didn't do anything about the situation, we sent them right back out...the son with the mother, because, again, we were so busy treating the situation... The son was raising Cain and being difficult, saying his mother had a broken nose, and the plastic surgeon said no she doesn't, he said yes she does, and the idea was, just get this guy out of here, he is just being unreasonable that he thinks that his mother has a broken nose and we are telling him she doesn't. So the idea was to get him out of the place. But I'm sure he had been abusing her. The way he told the tale, he was waiting for someone to say, "What happened, are you having problems?" His mother was senile.*

Repeatedly doing nothing served the interests of maintaining efficiency and functioned effectively with the dominant pattern of practice.

Doing nothing was justified and supported by viewing the woman as an undeserving victim. The nurses and other health-care providers routinely made judgements about the extent to which patients deserved care, and women who had been abused were no exception. In fact several factors frequently interpreted as signifying undeserving status (perceived to be abusing alcohol, using Emergency frequently or inappropriately, failing to take steps to improve one's life) were also perceptions that the health-care providers commonly held about abused women. In the account above, senility may have been perceived as ren-

dering the elderly woman undeserving of intervention. In the account below, the physician appears to draw on his attitudes towards alcohol abuse, First Nations people, and women to judge the patient undeserving of care:

> *...a young Native Canadian woman was found with her pants down in the park and she was extremely drunk...there's a strong possibility that she had been assaulted. [The physician] walked into the room...and in front of the patient and two nurses he said, "This is a societal derelict and I am too embarrassed to even call [the sexual assault team] over an issue like this." He said, "Put her to bed and let her sober up and then she can go home."*

Doing nothing may allow health-care providers to avoid some of the emotional costs of dealing with abuse, but, to the extent that they see doing nothing as insufficient, it may create feelings of inadequacy. Doing nothing overlapped with other forms of intervention at the point at which health-care providers challenged the adequacy of ignoring cues, dealing only with the physical consequences of abuse, or shifting responsibility to others.

Influencing Choices: The Deserving Victim

The health-care providers recalled instances of having gone beyond doing nothing, to intervening. One of the ways in which nurses and others intervened was to guide the woman towards what they thought were the best choices.

Influencing women's choices was associated with women who were judged as deserving. In addition to social status, the severity of the physical injury seemed to influence the extent to which women were judged as deserving. Instances of having influenced choices were associated with women who had been seriously abused physically. For example, one nurse judged a woman who had been sexually assaulted as less deserving than another because she was drunk and because the other woman was "an actual date rape" and had "marks around her neck." Another nurse recalled with empathy actively helping "one lady who came in with very battered chest and breasts, lots of bruising." Because health-care providers tended to recognize only blatantly obvious abuse, and routinely judged acuity based on the extent of physical injury and risk, it is not surprising that their interventions were associated with serious physical injury. The severity of the physical abuse contributed to their perceiving the woman as deserving, and thus requiring them to "do something."

The influence exerted by the health-care providers ranged from offering suggestions, to "convincing," to making decisions for the woman. The choices towards which they guided the women were largely limited to disclosing the abuse, calling the police, and leaving the relationship:

> *The nurse asked the woman if the boyfriend had raped her. The woman repeatedly said, "I don't want to get anyone in trouble." The nurse said, "Eventually, after repeated questions, she admitted he had raped her." At this point the nurse and the physician decided to send the woman to [another hospital] for the sexual assault exam. (field notes)*

> *I said, "There's no need to stay in something like this. No matter what you might have said or done it doesn't warrant being beaten for it. That's not necessary." I had her to the point where she was convinced, and I got Social Services involved, and they came and talked to her and were all ready to set her up to go to the [transition house] and everything.*

Many nurses described instances of staff wanting to call the police even though the woman asked them not to, and most expressed frustration at their lack of success in persuading women to make the limited choices.

Influencing choices served the interests of the hospital and the health-care system to the extent that women were directed towards existing solutions and resources. It was also congruent with the pattern of practice in that women could be processed efficiently if they accepted the choices offered, and it served the interests of the health-care provider in that doing something generated less of a sense of inadequacy than doing nothing. However, a woman's unwillingness to be influenced was a source of frustration for health-care providers, often leading them to view her as less deserving and justifying their decision to do nothing further. A nurse describes the case of a "non-white" woman who presented repeatedly with migraine. She had been "offered help before and returned" to her abusive partner.

> *So not only was her physical problem not dealt with, but she wasn't given any empathy or respect, because people said, "Hey, she's had the choices, she's had the opportunity, there she is behind the curtain, Social Work is dealing with it," and nothing further was done or said.*

Influencing choices overlapped with a different pattern of intervention at the point at which health-care providers questioned the efficacy of influencing choices, shifted the focus of their frustration to the "system," and examined the limits to women's choices.

Offering Choices: The Woman with Agency

> *...I try, when we get to that point, I usually try and let her make that decision. I just say, "You've got alternatives, these are your alternatives, would you consider making any of these alternatives a choice for you today?"*

Strikingly different from the constructions of the woman as a deserving or undeserving victim were constructions of her as having personal agency. The approaches to care that accompanied these latter constructions were characterized by *offering choices* to the woman. Notably, in recalling these instances the health-care providers used terms similar to those used by the women I interviewed, and described care that the women requested. In contrast to *influencing* choices, *offering* choices was characterized by giving up control. It comprised strategies such as listening, respecting choices, and encouraging the woman to return to Emergency. Notably as well, nurses' experiences of "success" were characterized by offering choices. For example, when asked to elaborate on an experience that she described as successful, one nurse said:

> *...if anything, it was just absolutely listening to her and kind of opening doors and getting her to look at her options and where her supports lay and where her possible areas of danger lay, and having her tell this to me brought them all out on the table and kind of made a turning point for her. She could see them in front of her and...said them out loud and they became real, and you did that by just sitting and listening.*

Sometimes offering choices ran counter to the interests of health-care providers because it required emotional and time commitments, and sometimes it ran counter to the interests of the organization and the pattern of practice because it reduced efficiency. However, offering choices could also serve the interests of the health-care provider, depending on how he/she framed those interests. Offering choices sometimes caused frustration, but this was directed less at the woman than at the "system," as the health-care provider encountered limitations to women's choices. Similarly, offering choices could serve the interests of the organization if, for example, the interests were framed in terms of patient satisfaction.

Nurses struggled to reach a decision on the best approach. Repeatedly their sense of responsibility was at odds with their view that the women needed to decide for themselves:

> *Is it acceptable to...give them 10 or 15 minutes, and if that is enough and it has got them started..."this is important, people do listen, people do care," is it acceptable to let them go home then and follow up with their family doctor, if that is what they want to do? I have this gut feeling:*

> *"No. Get out of there. It's not going to get better." This is my feeling, but I don't know. They say that [abusers] will abuse again and again and it gets worse, so my gut is if I know about it, I have got to fix it, so I don't know if that's okay. What if she gets killed overnight?*

However, those nurses who had sufficient experience with recognizing abuse to reflect on their practice had moved towards greater respect for the woman's agency and autonomy. For some nurses, participating in the research helped them to clarify and develop their thinking along similar lines: "I think you are beating your head against a wall if you tell someone, 'You have to leave and you have to go here,' because that's not going to work." "It is us rearranging our thoughts and our attitudes to fit what is best for the client, rather than what we think is best." Whether through experience or critical reflection, they often came to think that listening and not being judgemental were the essential skills. One nurse said she would have to "learn to listen and not talk so much, and cue words to get them to talk." These ideas were accompanied by a greater sense of confidence in their own practice:

> *I think maybe I'm doing more than I think I'm doing sometimes, maybe I am empowering more...by just telling them that this doesn't have to be the way it is... What seemed to me to feel like the biggest change [was when] I said to somebody who had been abused, "Today may not be the day."*

Indeed, the women who had experienced abuse agreed. For example, one woman who disclosed abuse (and with whom we had spent no more time than with the other patients) remarked later in an interview, "I got more attention from you two than I got in 9 years from my husband." An elderly woman, who chose to remain with her abusive husband, cried as she said, "Thank you for letting me talk, thank you for listening." All the women interviewed spoke about the importance of listening and not telling them what to do. I asked the women what they thought nurses ought to do concerning women who have been abused. One replied, "I think the listening and not necessarily taking an authority position always over a woman." Another said, "Sometimes all it takes is to listen, because by the time you have finished a conversation you know exactly what to do."

Discussion and Implications

The most profound influence on nursing practice in relation to women who have been abused was the pattern of efficient patient processing, driven by the notions of scarcity that pervade the health-care system. This finding is consistent with that of Ellis (1999). In that study, nurses

identified lack of privacy and lack of time as the primary barriers to care. The drive to move patients through Emergency necessitated a focus on physiological concerns and thus obscured many non-physical issues and all but the most obvious abuse. These patterns of practice left nurses feeling chronically inadequate. In her study of Emergency units, Malone (1996) reports that staff often felt like "failures as they try to pick up the pieces for failing or absent families, communities and social programs" and that their frustration "can contribute to the stigmatization of HU [Heavy User] patients, missed clinical diagnoses, and reduced nurse morale" (p. 176). Staff nurses alone cannot rectify the failings of the social and health-care systems. Malone concludes that nurses need to acknowledge the limits of their control and responsibility, and must refuse to accept blame for restrictions imposed by health-care structures. It is critical that the development of programs to deal with violence against women take into account the context of practice, what is feasible within prevailing resources and patterns of practice, and the extent to which these need to change. The findings suggest that fundamental health-care improvements are required, concurrent with improvements to practice specific to abuse. Little evaluation research has been conducted (Chalk & King, 1998), and research is sorely needed to identify health-care outcomes associated with various nursing approaches to violence against women.

Health-care providers racialized violence throughout the period of the study. Racialized women are often required to expose their partners and communities to racism when seeking help related to abuse (Agnew, 1998; Crenshaw, 1994; Dobash & Dobash, 1992; Mosher, 1998). In Canada, widespread racism has been found within mainstream social and legal services for abused women (Agnew). Although Barnett (2000) questions whether racism deters help-seeking from the justice system, racialization of violence by the health-care system may compound other deterrents to disclosure. Paradoxically, such racialization may foster unfounded suspicions by health-care providers concerning abuse among racialized groups and expose those groups to racist stereotyping; conversely, it may lower the index of suspicion for abuse among other groups. Limandri and Sheridan (1995) identify racism and classism as problematic in the prediction of violence, as they have a way of "unmindfully influencing clinical judgment" (p. 15). Kelly and Radford (1998) argue that "we lack studies which elucidate the legacy of colonization and attempt to unpick the sexual organization of racism" (p. 63). Clearly, education, practice, and future research related to violence against women must incorporate antiracist strategies.

This study found that decisions concerning patient deservedness for various forms and levels of care included subjective judgements about patient acuity and social judgements about patients. Social judgementalism in nursing is not a new concern, but, as Johnson and Webb (1995) illustrate, the emotional costs of caring, and their role in social judgement, are insufficiently recognized. As with the Johnson and Webb investigation, nurses in the present study experienced significant moral distress over the judgementalism they observed in others and their own as well. Racism and classism may function in concert with the stigmatizing nature of abuse just as they do with HIV status, as described by Bunting (1996). Educational interventions and further research into ways of limiting social judgementalism are needed.

The nurses in this study rarely recognized abuse. When they did recognize it, they provided care that they considered inadequate. They generally blamed themselves, although they were aware of the significant limitations imposed by their practice setting. Improved practice in relation to violence against women requires more than concerned nurses. Care that is effective in terms of health-care outcomes, rather than merely efficient in terms of patient processing, requires political will and adequate resources.

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Correspondence may be directed to Colleen Varcoe, Associate Professor, University of Victoria School of Nursing, Lower Mainland Campus, c/o Langara College, 5th Floor, Library Building, 100 West 49th Avenue, Vancouver BC V5Y 2Z6 Canada. Telephone: 604-323-5925. Fax: 604-323-5929. E-mail: <cvarcoe@telus.net>.

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Designer's Corner

Research on Violence and Abuse in Canada: Challenges and Opportunities

Judee E. Onyskiw

Only fairly recently has there been public recognition of how frequently family members — most often women and children — are the targets of violence in their own homes. The risk of experiencing violence from a family member far outweighs the risk of experiencing violence from a stranger, and the consequences for people's health go far beyond the immediate injuries sustained. Health-care professionals have responded by identifying family violence as a serious public health problem and by giving primacy to this issue. Yet, despite the prevalence of violence in our society, the significance of this public health problem, and the strong potential for nurses to initiate prevention efforts and become actively involved in efforts to enhance the health and well-being of abused women and children, there is only a small cadre of nurse researchers in Canada conducting research in this area. To further complicate research efforts, nurses who are actively involved in violence research are scattered across this vast country, making dialogue and collaboration with others in the field a challenge. There is a definite need for more nurses to conduct research in this important area of inquiry, and for those already involved in violence research to seek means of facilitating collaboration with each other.

Canadian Nurses' Contribution to Research on Violence and Abuse

Although there is only a small number of Canadian nurses conducting violence research, their efforts have made a significant contribution to the body of knowledge on abused women and their children. Studies have provided nursing with an emic perspective of the nature of vio-

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Judee E. Onyskiw, RN, PhD, is a post-doctoral fellow in the Department of Mathematical Sciences, University of Alberta, Edmonton, Canada.

lence in intimate relationships; the experience of women coping with this adversity; the process of leaving an abusive relationship, healing, and recovery; and the availability of support, *or the lack of support,* for abused women (e.g., Henderson, 1990, 1993, 1995; Merritt-Gray & Wuest, 1995; Varcoe, 1997). Nurse researchers have documented the mental and physical health problems experienced by abused women (Kérouac, Taggart, Lescop, & Fortin, 1986; Ratner, 1993, 1995a) and have examined the effectiveness of societal responses, including the health-care community's response, to woman abuse (Ratner, 1995b).

Nurse researchers have sought to understand children's experience of witnessing violence, some from the unique perspective of the children themselves (Bennett, 1991; Berman, 1999a, 1999b; Ericksen & Henderson, 1992). This is particularly noteworthy because most researchers in other disciplines have obtained information about children from mothers. Thus, nursing research has made a unique contribution by providing children's own perspective of the profound effect that growing up amid violence has on their lives. The health, developmental, and behavioural outcomes of children exposed to violence in their families have also been studied (Kérouac et al., 1986; Onyskiw, 1999).

Challenges in Research on Violence and Abuse

While nursing research conducted over the last decade has made a significant contribution by generating knowledge for practice and providing direction for future research, it is clear that much work remains to be done. Several methodological challenges in this area of research need to be addressed, so that the body of nursing knowledge on violence and abuse can accumulate and can be used to inform policy, prevention, and treatment efforts.

The Need for Diversity in Approaches to Research

The vast majority of nursing research conducted to date in Canada has used qualitative approaches. These studies have enabled practitioners to understand the experience of violence from the perspective of those involved, which is vital for providing humanistic, holistic, and artful nursing care. Hearing women's and children's stories can help practitioners in a way that is never possible with numbers alone. By comparison, though, there are few studies that have employed quantitative methods. The lack of quantitative research in this area of inquiry is not specific to the Canadian scene; there is a need for more quantitative research internationally as well. We need to balance the insights

obtained using qualitative methods with more quantitative research, because knowledge is also needed that leads to explanation and that is generalizable to all abused women to inform nursing practice.

There is a critical need for treatment research on how to mitigate the effects of violence on its victims and for evaluation research on the effectiveness of interventions and treatment programs. Although the paucity of evaluation research is also not specific to the Canadian scene, or specific to interventions for abused women, without an understanding of the effectiveness of strategies and interventions, decisions to continue, extend, or terminate programs will not be based on sound evidence (Innes, Ratner, Finlayson, Bray, & Giovannetti, 1991). Moreover, as more health practitioners identify, treat, and refer abused women and their children to domestic violence programs for assistance and support, the need to advocate for additional funding for these services becomes essential. Both quantitative and qualitative data are needed to support the demand for these services. When decisions are being made to devote additional resources for programs and services, policymakers are often most influenced by a combination of *stories* and *numbers* (Berman, Ford-Gilboe, & Campbell, 1998).

The Need for Non-Sheltered and More Ethnically Diverse Samples of Women

There is a pressing need for data on women who do not access shelter services. With some exceptions, violence research has focused on women recruited from shelters or transition houses. Yet, the 1993 Violence Against Woman Survey conducted by Statistics Canada found that less than 20% of abused women sought refuge in shelters or transition houses when they left their partners (Trainor, 1999). Compared to women who did not access these services, women who did use shelters tended to be more isolated, have fewer resources, lower socioeconomic status, and less social support, and were more likely to have endured more violent forms of abuse (Johnson, 1996; Trainor). Thus, the majority of research has been conducted on a small subgroup of abused women, albeit those most severely abused. Studies of non-sheltered abused women may well provide nurses with a somewhat different perspective of women's experience, responses, and specific health-care needs.

To date, the samples employed in violence research have rarely reflected the ethnic diversity of our population, and the issue of culture has been largely neglected in Canadian research. Researchers need to recruit samples that are more ethnically diverse and that are sufficiently

large to allow examination of the role of ethnicity in women's responses to experiencing violence and in their help-seeking behaviour. It is important that the role of ethnicity and culture be understood, so that interventions specific to various ethnic and cultural groups of Canadian women can be developed.

Opportunities for Research on Violence and Abuse

Although violence is prevalent in our society and exists in all types of family relations, violence in families is still shrouded in secrecy and the family remains one of the most private of all institutions. Consequently, this area of research presents some unique challenges in terms of accessing subjects and collecting sensitive data.

One alternative frequently overlooked in our discipline, but widely used in other disciplines, is the secondary analysis of data (Nicoll & Beyea, 1999). This option is often not considered because there is a norm within our profession that assigns higher value to primary data collection (McArt & McDougal, 1985). Secondary data analysis is commonly viewed as less credible, less valid research. Scholars need to be open to the possibilities offered by the use of existing datasets. While there are certain conceptual and practical issues to consider when conducting a secondary analysis (Shepard et al., 1999), and issues to consider when choosing a large database (Moriaty et al., 1999), the problems are not insurmountable and the advantages of secondary data analysis often outweigh the disadvantages.

There are at least two large datasets with information on violence and abuse in Canada. The Violence Against Women Survey, a national survey of 12,300 women, was devoted entirely to the occurrence of violence, including intimate violence, in women's lives. Information was sought about threats, intimidation, and sexual harassment to help place women's experience of violence into a broader social context. The General Social Survey, another Statistics Canada survey, interviews approximately 10,000 people 15 years of age and older in the 10 provinces every 5 years. This survey first incorporated a cycle on crime victimization in 1988 and has since modified items to clarify questions about violence in intimate relationships. There is a third dataset of possible interest to violence researchers. The National Longitudinal Survey of Children and Youth assessed child development and well-being in 22,831 children who were newborn to 11 years of age during the first wave of data collection (1994/95). This cohort will be followed every second year for up to 20 years. Since the survey inquired about children witnessing violence at home, it is possible to study the developmental

outcomes of children exposed to family violence. Researchers affiliated with institutions that are part of Statistics Canada's Data Liberation Initiative have access to these and other national datasets that are available for public use.

Although these surveys are still imperfect tools, their immense potential to provide nurse researchers with opportunities to answer questions that address important health and social problems and health-policy issues should not be ignored. With careful planning and attention to conceptual and methodological issues, these datasets offer the possibility to empirically test existing theories, develop new theories, or examine a question from different theoretical perspectives and then compare the explanatory power of those perspectives. Because information has been collected on numerous variables and the samples are large, multivariate analyses using sophisticated approaches are possible.

The effects of specific forms of relationships among variables, such as mediating and moderating variables, can be tested. A mediator or moderator is a third variable that changes the association between an independent and an outcome variable (Baron & Kenny, 1986; Bennett, 2000; Lindley & Walker, 1993). Understanding the influence of these types of variables can help in eliciting information about how or why an association occurs, or the specific conditions under which it occurs. Understanding factors that mediate or moderate the relationship between abuse and its effects on health and well-being can help us develop more effective strategies to assist vulnerable women and children. For example, scholars have suggested that parenting mediates the effects of family violence on children (Wolfe & Jaffe, 1991). As violence escalates, women become increasingly overwhelmed and less involved with their children, exhibiting less responsive and less effective parenting (Ericksen & Henderson, 1998; Henderson, 1993). In other words, one explanation for the negative impact of family violence (independent variable) on children's adjustment (outcome variable) is the deterioration in the parent-child relationship (mediating variable). Onyskiw (1999), using data from the National Longitudinal Survey of Children and Youth, examined the role of parenting as a mediating variable and found support for this hypothesis. In families characterized by violence, mothers were less responsive to their children, which, in turn, contributed to children's adjustment difficulties. This information suggests that interventions designed to support mothers in their parenting holds some promise for mitigating the adverse effects of children's exposure to violence.

One of the advantages of using existing datasets is that the samples are large and randomly selected from the population. The sampling

methodologies employed in these surveys eliminate plausible rival hypotheses associated with selection biases that occur when a restricted range of women volunteer to participate in research (e.g., women in shelters or transition houses). Thus, findings can be generalized to the larger population of Canadian women.

There is usually (but not always) sufficient power to analyze subgroups of individuals. It may be possible, for example, to examine women in the Violence Against Women Survey who were resilient despite severe abuse, and discover certain personal characteristics, resources or strategies used by these women that distinguish them from other women in the sample. Information such as this can help us develop interventions to assist more vulnerable women.

A final advantage of using existing datasets, but by no means a trivial one, is that it is an efficient and cost-effective means of conducting research. There is the potential to answer nursing research questions with less time commitment and few fiscal resources.

Conclusion

In the last decade, nursing research on violence and abuse has primarily focused on understanding the experiences of abused women and the adverse effects of violence on their health and well-being, as well as on the children raised in families characterized by violence. These studies have made a significant contribution to the body of knowledge on violence and abuse. If nurses are to make further advances in this area of inquiry, there are many challenges to be addressed. In order to develop a generalizable knowledge base, researchers need to employ more quantitative methods and derive data from representative samples of women. They need to attend to the role of ethnicity and culture in women's responses to violence, so that culturally sensitive interventions can be developed. Also, it is critical that the effectiveness of various forms of interventions and treatment programs be tested, both to demonstrate the value of nursing's role in the anti-violence agenda and to obtain the evidence needed to advocate for additional funding for these essential services.

Research on violence and abuse is an immensely significant area of inquiry for nursing, given the prevalence and significance of this public health problem, but it is also a complex and difficult topic to study. While researchers undeniably face many challenges, they also have an opportunity to conduct research that has the potential to improve the health and well-being of so many women and children in our society.

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Comments or questions concerning this article may be directed to Judee E. Onyskiw, Perinatal Clinical Research Centre, University of Alberta, #4510 Children's Centre, Royal Alexandra Hospital, 10240 Kingsway Avenue, Edmonton AB T5H 3V9 Canada. Telephone: 780-491-5261 or 780-477-4863. Fax: 780-477-4832. E-mail: <jonyskiw@ualberta.ca>.

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Happenings

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

Marilyn Ford-Gilboe

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;

Marilyn Ford-Gilboe, RN, PhD, is Associate Professor and NHRDP/MRC Career Scientist, School of Nursing, University of Western Ontario, London, Ontario, Canada.

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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Further Information

For more information about the NNVAWI, contact: Kathi Mills, Administrative Assistant, NNVAWI, PMB 165, 1801 H Street, Suite B5, Modesto CA 95354-1215 USA. Telephone: 1-888-909-9993. E-mail: <katem1@mindspring.com> (or Dr. Barbara Parker, President: <bparker@virginia.edu>).

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Development and Psychometric Testing of the Wilmoth Sexual Behaviors Questionnaire–Female

Margaret Chamberlain Wilmoth and Lynne Robinson Tingle

L'objectif de cette étude était de développer et d'évaluer le questionnaire Wilmoth portant sur les comportements sexuels chez les femmes (WSBQ-F). Tel que conçu au départ, le WSBQ-F comportait 54 points organisés en huit sous-catégories. Les points étaient évalués selon une échelle du type Likert, le pointage élevé reflétant la présence plus soutenue d'un comportement sexuel. Un échantillon de commodité de 310 femmes atteintes de cancer du sein (n = 165) et de femmes bien portantes (n = 145) a été utilisé dans le cadre de cette étude. Un index de validité de contenu de 1,00 a été établi. La validité conceptuelle a été évaluée à l'aide de l'analyse factorielle et de la méthode des groupes connus. La fiabilité de la consistance interne était de 0,94 en ce qui a trait à l'échelle totale, avec des coefficients variant de 0,52 à 0,94 quant aux sous-catégories. La corrélation de test-retest était de 0,81 en ce qui a trait à l'échelle totale; les coefficients des sous-catégories se situaient entre 0,58 et 0,88. Les tests initiaux de la mesure suggéraient que le WSBQ-F est un outil de mesure de comportements sexuels féminins fiable et valable.

The purpose of this study was to develop and test the Wilmoth Sexual Behaviors Questionnaire–Female. As initially developed, the WSBQ–F consisted of 54 items arranged in 8 subscales. Items were rated on a Likert-type scale, with high scores reflecting more consistent use of a sexual behaviour. A convenience sample of 310 women with breast cancer (n = 165) and healthy women (n = 145) participated in the study. An Index of Content Validity of 1.00 was obtained. Construct validity was estimated using exploratory factor analysis and the known groups method. Internal consistency reliability was .94 for the total scale, with coefficients ranging between 0.52 and 0.94 for the subscales. The test-retest correlation coefficient was .81 for the total scale; coefficients were between .58 and .88 for the subscales. Initial testing of the measure suggests that the WSBQ–F is a reliable and valid measure of female sexual behaviours.

Sexuality is a quality-of-life issue that nurses can no longer ignore. Our patients expect and deserve high-quality, holistic health care. Nursing care that ignores this aspect of life is substandard. Furthermore, there are standards of practice related to sexuality (American Nurses Association & Oncology Nursing Society, 1996) that nurses are held to,

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Margaret Chamberlain Wilmoth, RN, PhD, is Associate Professor, Department of Adult Health Nursing, and Lynne Robinson Tingle, PhD, is Assistant Professor, Department of Health Promotion and Kinesiology, University of North Carolina, Charlotte, USA.

and these may be considered legal standards as well (Andrews, Goldberg, & Kaplan, 1996).

Nurses cannot meet these standards of practice without adequate information. The literature on the sexual effects of medical conditions or developmental changes is sparse. There are various reasons for this situation, including the limited number of reliable and valid measurement tools. Sexuality is a broad, complex construct and therefore is difficult to measure. A related problem is the lack of tools specific to female sexuality. Male and female sexuality differ (Masters & Johnson, 1966; Taylor, Rosen, & Leiblum, 1994), and it is important that measurement tools reflect the differences. The purpose of this study was to develop a measure specific to female sexuality based on a nursing model. What follows is a report on the development and initial testing of the measure.

Literature Review

Sexuality research generally focuses on a limited component of the construct, and this leads to a lack of comprehensive information on the sexual limitations of medical conditions and treatments. The literature was reviewed to determine whether a lack of measurement tools has contributed to this lack of knowledge. Female sexuality is broadly defined in the literature as physiologic, psychologic, and cognitive aspects of defining the self as female, including giving and receiving sensual pleasure, a desire for closeness and intimacy, and the release of sexual tensions. The criteria used in reviewing sexuality measurement tools included: (1) use of an identified theory, (2) comprehensive assessment of female sexuality, (3) clinical utility, (4) utility not limited to a specific medical condition, and (5) psychometric properties. None of the sexuality measures that were reviewed met all of these criteria.

Tools have generally lacked an identified theoretical framework or a theoretical definition of the construct being measured (Bentler, 1967; Hanson & Brouse, 1983; Hoon, Hoon, & Wincze, 1976; Taylor et al., 1994). The tool developed by Waterhouse and Metcalfe (1986) was loosely based on the Roy Adaptation Model (Metcalfe, 1990). Some authors report on psychometric testing of heterosexual samples but do not identify the presence or absence of medical conditions in the subjects, which inhibits use of the tools among samples with a diagnosed condition (Bentler; Derogatis & Melisaratos, 1979; Hoon et al.; Taylor et al.). Other tools have been designed for use among subjects with a specific medical condition (Bransfield, Horiot, & Nabid, 1984; Hanson & Brouse; Waterhouse & Metcalfe), which hinders comparison to healthy

samples and to those with other health problems. Some tools address a limited aspect of sexuality such as sexual intercourse (Bransfield et al.), arousal (Hoon et al.), or intimacy (Hetherington, 1988), or are specifically directed at heterosexual women (Bentler). Two measures are quite lengthy and thus of limited clinical utility (Derogatis & Melisaratos; Waterhouse & Metcalfe). Finally, while adequate reliability is reported for all measures, satisfactory validity is reported for only three (Hetherington; Hoon et al.; Taylor et al.).

In summary, there is a lack of psychometrically sound measures that are clinically useful and that address a broad range of female sexual behaviours in multiple populations using an identified theory base. This deficit prompted the development of a measure of female sexuality guided by a nursing conceptual framework.

Tool Development Process

Conceptual Framework

Johnson's Behavioral Systems Model (JBSM) (Johnson, 1980) guided development of the tool. The JBSM views the individual as an open behavioural system with integrated and interdependent parts. The parts, called subsystems, encompass physiologic as well as psychologic behavioural functioning.

The "sexual subsystem" encompasses a wide range of sexual behaviours related to biologic sex, with the dual functions of procreation and gratification (Johnson, 1980). Johnson does not identify the specific sexual behaviours in which an individual can engage, but does indicate that desire is the drive or motivation necessary for attainment of the goal of sexual gratification. She does not define gratification or indicate how to determine when it has been achieved, but she does imply that behaviours indicate the drive that has been stimulated or the goal that is being sought.

Johnson (1980) explains that the behaviours typically chosen by an individual make up that person's "set" of behaviours, and that behaviours may vary slightly according to the individual's current emotions, relationship status, and health status. The model indicates that sexual behaviour is a trait attribute that is relatively stable until a crisis occurs, such as diagnosis and treatment of a medical condition. Consistent with this, frequency of a given behaviour is one way to measure and identify an individual's set of behaviours. This is congruent with Cronbach's (Waltz, Strickland, & Lenz, 1991) and Johnson's assumptions that trait conceptualizations have behavioural regularity.

Tool Construction

The Wilmoth Sexual Behaviors Questionnaire–Female (WSBQ–F) was developed from a comprehensive review of the literature, a review of measures of sexuality, and focus-group input. Sexual behaviour is defined as the range of behaviours in which an individual can engage, alone or with another person, to reduce sexual tensions and achieve satisfaction (Wilmoth, 1993). Respondents are asked to refer to their current sexual behaviour when completing the questionnaire.

The JBSM guided identification of behavioural components from the literature. These were: communication, appearance, arousal, activity level, techniques, and orgasm. Communication was defined as verbal talk between partners. Appearance was conceptualized as physical appearance both when clothed and when unclothed. Desire was defined as interest in sexual activity both with and without a partner. Arousal was conceptualized as the physical manifestation of desire, such as vaginal lubrication. Activity level was defined as both initiation of and frequency of sexual activity. Techniques was defined as self-touch of various body parts as well as positions used when engaging in sexual activity. Orgasm was defined as the ability to achieve orgasm as well as the intensity of orgasm. Finally, satisfaction was conceptualized as being content after sexual activity and feeling close to one's partner after engaging in sexual behaviours.

An item pool of 86 behaviours was developed. Items represented identified components of sexual behaviour and the subsystem drive and goal (desire and gratification). Items were worded to elicit typical sexual behaviour, which is consistent with measurement of trait attributes (Waltz et al., 1991). Items were worded as statements rather than questions, to make them seem less intrusive and as neutral as possible regarding sexual orientation.

A focus group of 20 healthy women plus a group of breast cancer survivors from a university community and breast cancer support groups volunteered to review the items. Focus groups recommended that items on anal intercourse be eliminated to reduce embarrassment and to enhance the willingness of participants to complete the questionnaire.

A revised draft of the WSBQ–F was reviewed by the focus group a second time for content, wording, and format. The focus group recommended that of 54 of the original 86 items be tested. The instrument was pilot tested by six women with breast cancer and four healthy women. The women were asked to review the items on the WSBQ–F

and to make suggestions for additions, deletions, and rewording. Their suggestions resulted in increased clarity but no change in the number of items.

Description of the WSBQ–F

The WSBQ–F measures consistency in use of a sexual behaviour in terms of frequency. Higher scores reflect greater consistency in specific sexual behaviours. If the WSBQ–F is administered to the same individual at different times, score differentials would quantify changes in use of one or more sexual behaviours, indicating a change in the individual's set of behaviours and perhaps a need for further assessment and referral.

The version of the WSBQ–F that was submitted for psychometric testing consisted of 54 statements scored on a 7-point Likert scale of 0 to 6 (0 = not applicable, 1 = never, 6 = always). The *not applicable* choice was included to distinguish between items that were not part of a subject's set of sexual behaviours and items that were part of their set of behaviours but were not currently being used, which would receive a *never* response. For example, items on touching of surgical scars would be *not applicable* if the subject had not had surgery, whereas items on heterosexual intercourse would receive a *never* response if they were part of one's set of behaviours but were not being used currently.

The measure requires 20 minutes to complete. Items reflective of each component of sexual behaviour were grouped together for initial testing of the tool. The range of scores is 0–324; higher scores reflect greater regularity in use of sexual behaviours.

Method

Sample

Women from two distinct populations, healthy women and women with breast cancer, were selected to test the WSBQ–F for its ability to distinguish between groups. The study sample consisted of a convenience sample of healthy women ("healthy subjects") and women with breast cancer treated with either a modified radical mastectomy or breast conservation surgery (lumpectomy) ("breast cancer subjects"). A minimum of 270 subjects were needed to adequately perform factor analysis (54 items x 5 subjects per item) (Ferketich, 1991). Oversampling of both groups was planned, to account for potentially high non-response rates due to the sensitivity of the material.

A convenience sample of healthy subjects was drawn from among 400 nurses selected from the membership of a professional organization. Inclusion criteria were: over 25 but not more than 75 years old, no history of breast cancer, and ability to read and write English. A total of 145 nurses (36%) returned the completed questionnaire. The 50 subjects who returned it within 4 weeks were mailed the WSBQ–F a second time for test-retest purposes; 25 (50%) of this group returned the completed questionnaire.

A convenience sample of breast cancer subjects was drawn from among 330 women with a history of breast cancer from physician practices, national and regional breast cancer support groups, on-line support groups, and individual networking. Inclusion criteria were: over 25 but not more than 75 years old, at least 6 months post-diagnosis of cancer, and ability to read and write English. A total of 165 women with breast cancer (50%) returned the completed questionnaire.

The demographic characteristics of both groups of subjects are described in Table 1.

The majority of healthy subjects were Caucasian, married, between the ages of 25 and 45, with a university degree. The majority of these women had not yet experienced menopause (85%) and described themselves as "healthy," although 68% had had surgery at some point in their lives, the most common type being Caesarean section.

The majority of breast cancer subjects were Caucasian, married, between the ages of 36 and 55, with some university education. One half (51%) of these women were within 3 years of their cancer diagnosis. Most (n = 119, 72%) had had a modified radical mastectomy as their primary surgical treatment, 45 (27%) had had a lumpectomy, and one subject did not know what type of surgery she had had. Forty-eight subjects had chosen to have breast reconstruction. A majority of this group had received one or more forms of adjuvant therapy. It was not possible to compare subjects and non-respondents, since no data were available for the non-respondents.

Procedure

All potential subjects were mailed a study packet consisting of a letter describing the purpose of the study, a Demographic Data form, the WSBQ–F, and a self-addressed, stamped return envelope. A university human subjects committee approved the study. Consent to participate was indicated by return of the confidential survey.

Table 1 *Demographic Characteristics of Subjects*

	Healthy	Breast Cancer
Age		
25–35	56 (39%)	12 (7%)
36–45	55 (37%)	48 (29%)
46–55	26 (18%)	62 (38%)
56–65	7 (5%)	28 (17%)
66–75	1 (1%)	15 (9%)
Education		
< High school	0	3 (2%)
High school	1 (1%)	18 (11%)
Technical	3 (2%)	10 (6%)
Some university	16 (11%)	52 (31%)
University	82 (56%)	34 (21%)
Postgraduate	43 (30%)	48 (29%)
Race		
Caucasian	136 (94%)	158 (96%)
Black	4 (3%)	4 (2%)
Hispanic	3 (2%)	2 (1%)
Asian	2 (1%)	0
Marital Status		
Married	101 (70%)	137 (83%)
Divorced	18 (12%)	10 (6%)
Widowed	0	4 (2%)
Single	26 (18%)	9 (5%)
Living with partner	0	5 (3%)

N = 310 (healthy = 145; breast cancer = 165)

Several types of validity and reliability estimates were calculated on the WSBQ–F. These included an Index of Content Validity, two levels of exploratory factor analysis, and both rest-retest and internal consistency reliability. It was hypothesized that the healthy women would have higher scores on the WSBQ–F, indicating greater consistency than the women with breast cancer in the set of behaviours and a greater level of sexual gratification.

Table 2 *Factor Loadings of the WSBQ–F*

	Factors							
Item	1	2	3	4	5	6	7	8
Communication								
$\alpha = .94$, $r = .78$								
1. hugging	.84							
2. hold and touch	.84							
3. partner important	.83							
4. talk	.80							
5. talk about sex	.75							
6. appear nude	.70							
7. satisfied	.67							
8. kiss face	.66							
9. feel closer	.58							
10. partner touch	.58							
11. I initiate	.58							
12. I start talks	.57							
13. partner touch	.57							
14. lights on	.54							
15. undress	.52							
16. partner touch	.50							
17. shower together	.49							
18. satisfied	.48							
19. lingerie	.44							
Sexual Technique								
$\alpha = .87$, $r = .58$								
20. oral sex		.70						
21. side to side		.66						
22. oral sex		.66						
23. rear entry		.66						
24. woman on top		.65						
25. woman on bottom		.59						
26. manual stimulation		.52						
27. clitoral touch		.50						
Sexual Response								
$\alpha = .88$, $r = .74$								
28. turned on			.81					
29. interested			.81					
30. sexual touching			.72					
31. wet vagina			.64					
32. sexual interest			.60					
33. orgasm			.55					
34. orgasm important			.50					
35. orgasm intense			.50					

(continued on page 143)

Table 2 *(cont'd)*

	Factors							
Item	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
Body Scar[a]								
$\alpha = .73$, $r = .84$								
36. touch scar				.87				
37. partner look				.86				
38. look at scar				.86				
39. partner touch				.85				
Self-Touch								
$\alpha = .87$, $r = .73$								
40. touch stomach					.91			
41. touch breasts					.91			
42. touch clitoris					.77			
43. touch face					.67			
Relationship Quality[b]								
$\alpha = .57$, $r = .80$								
44. relationship good						.93		
45. brought closer						.91		
46. less feminine						.91		
Masturbation								
$\alpha = .52$, $r = .88$								
47. masturbation							.54	
48. sex toy							.53	
49. look naked							.42	
Removed Factor								
44. tense after sex								.58
22. frequency								.47
Total Scale								
$\alpha = .94$, $r = .81$								
E–Value	15.6	3.7	3.6	2.8	2.2	2.2	1.7	1.4
Proportion	30.5	7.3	7.2	5.5	4.4	4.3	3.3	2.8
Cumulative %	30.5	37.8	44.9	50.4	54.8	59.1	62.4	65.3

$N = 310$ ([a]$N = 226$; [b]$N = 135$)

Results

Validity

An Index of Content Analysis was determined for the WSBQ–F. Two experts from the field of sexuality and two experts from oncology nursing were asked to link each item with the appropriate sexual subsystem and to assess the relevancy of the item to the subsystem. Two experts in nursing theory critiqued the tool for congruency with the JBSM. All experts agreed that the items adequately reflected the domain of sexual behaviours and an Index of Content Validity (Lynn, 1986) of 1.00 was obtained.

Exploratory factor analysis was performed to determine the factor structure of the WSBQ–F. Initially all 54 items were entered into a principal components analysis with a varimax rotation. Varimax rotation is an orthogonal rotation in which variables tend to load high on one factor and low on others (Kaiser, 1960), facilitating interpretation of factors. Eight factors were forced in the initial factor analysis, since the WSBQ–F was designed on the basis of eight types of sexual behaviours (Tabachnick & Fidell, 1989). A liberal item loading criterion of .30 was used for the first factor analysis, resulting in the elimination of three items.

A second factor analysis was performed with a more conservative item loading criterion of .40 on 51 items. The number of factors retained was determined by using the Kaiser rule of eigenvalues greater than or equal to 1 (Kaiser, 1960). Two items that created a weak factor and that were not conceptually related to each other were eliminated. This resulted in a tool with seven factors and 49 items. The total variance accounted for by the factors was 65%.

Factor 1 consisted of 19 items on verbal and non-verbal communication techniques and was named the Communication Scale. Factor 2, the Techniques Scale, contained eight items referring to sexual techniques, including various positions used during heterosexual intercourse, manual stimulation by the partner, and touching of the clitoris by the partner. Factor 3, termed the Sexual Response Scale, included eight physiologic items. Factor 4, labelled Body Scar, included four items related to looking at and touching a scar. Factor 5, Self-Touch, included four items on non-sexual touching of various parts of one's own body. Factor 6, Relationship Quality, contained three items on the impact of a health problem on the respondent's sexual relationship and sense of femininity. Factor 7, the Masturbation Scale, included three items on masturbation. Factors, item loading, and samples of items are shown in Table 2.

A two-group Multivariate Analysis of Variance (MANOVA) was performed to test the hypothesis that healthy women would have higher scores than women with breast cancer on the WSBQ–F. MANOVA was the appropriate statistical test because the variables have a common conceptual meaning; use of fragmented Univariate tests would greatly inflate the type I error rate (Stevens, 1996). Two factors composed of items that did not apply to every participant were omitted from the analysis: since a participant with no body scars or with no health problems would not have a score for Body Scar or Relationship Quality, factors 4 and 6 were eliminated.

With an alpha level set at $p = .05$, the omnibus test revealed a statistically significant difference between the sexual behaviours of healthy subjects and those of breast cancer subjects ($F = 3.785$, $df = 4,261$). Univariate tests revealed significant differences between the healthy women and those with breast cancer on factors 2 (Techniques Scale) and 3 (Sexual Response Scale), with the healthy sample scoring higher on both factors (Table 3). These analyses were repeated controlling for differences between the two groups in age, education, and marital status; significant differences were found between the two groups on the Techniques and Sexual Response scales.

Table 3 *Two-Group MANOVA on Differences Between Healthy Women and Women with Breast Cancer, as Measured Using WSBQ–F Subscales*

Subscale	*df*	Mean Square Between	Mean Square Error	*F*
Communication	1	2227.8	620.2	3.6
Techniques	1	536.7	88.9	6.0*
Sexual Response	1	1171.4	90.7	12.9*
Self-Touch	1	35.2	26.9	1.3
Masturbation	1	.31	7.4	.04

$N = 262$ (healthy sample = 131; breast cancer sample = 131)
* $p \leq .01$

Reliability

Internal consistency of the WSBQ–F was determined using Cronbach's alpha (Waltz et al., 1991). The alpha coefficient for the total scale was .94 and subscale alphas ranged between .52 and .94. (Table 2).

The JBSM suggests that sexual behaviour is a relatively stable attribute in healthy individuals not experiencing severe life crises (Johnson, 1980). This assumption directed the decision to use a sample of healthy subjects for test-retest reliability. As can be seen in Table 2, the Pearson correlation coefficients ranged between $r^2 = .58$ and .88. The correlation for the total scale was $r^2 = .81$, which is an adequate value obtained from initial testing of a measure (Waltz et al., 1991).

Discussion

The WSBQ–F was designed to assess women's sexual behaviours from a broad perspective using the JBSM (Johnson, 1980) as a guide. Initial psychometric testing utilized healthy women as one sample to validate the model's assertion that sexual behaviours are a relatively stable trait in the absence of a crisis situation. Breast cancer patients were chosen to test the ability of the tool to differentiate between two diverse samples. Initial testing of the WSBQ–F provided support for the validity and reliability of the measure. The final version of the WSBQ–F consisted of 49 items scored on a 7-point Likert scale with the possible range of scores from 0 to 294.

The subscales identified through factor analysis were Communication, Techniques, Sexual Response, Body Scar, Self-Touch, Relationship Quality, and Masturbation. These factors differed slightly from those identified a priori, yet conceptually they supported the assertion by the JBSM (Johnson, 1980) that the sexual subsystem comprises a broad range of behaviours. These factors will be discussed in more detail below. Test-retest reliability in the group of healthy women supported the assertion that sexual behaviour is a trait attribute. The assumption that greater regularity of use of a set of behaviours reflects attainment of the subsystem goal of gratification remains to be tested.

Construct Validity

Analysis indicated that communication consists of a wide variety of verbal and non-verbal behaviours — for example, hugging, talking, and physical appearance. Items on satisfaction, which infer the subsystem goal of gratification, also loaded on this factor, suggesting that sexual gratification is at least partially dependent on communication. The Communication subscale produced the largest factor, accounting for 30.5% of the variance, which indicates the importance of multiple modes of communication of sexual behaviours by and towards women.

Factor analysis indicated that techniques used in achieving sexual gratification were viewed more narrowly than found in the literature. Items factoring onto the Techniques subscale were positions used during intercourse, not behaviours such as hugging and touching of partner. Two items reflecting masturbation also had initially been hypothesized to be forms of techniques. These items factored separately and may be reflective of either being used alone or resulting from the high number of non-responses to these two items. Further testing of these items is warranted.

Desire, the drive for the Sexual Subsystem, factored into the scale that included other components of the sexual response cycle (desire, arousal, and orgasm). This suggests that desire is intricately related to the other components of sexual response, that desire cannot be measured by itself, or that the items were not sensitive enough to distinguish desire from other components of the sexual response cycle.

The Body Scar subscale, which refers to looking at and touching a surgical scar, may not immediately appear to be related to sexual behaviours. However, the literature on body image and female sexuality suggests that scarring and a partner's reaction to it affect a woman's level of comfort with her sexuality and her sexual behaviour (Derogatis, 1980a; Schover, 1994). These items need revision and further testing to determine their relevance.

Construct validity using contrasted groups indicated that the WSBQ–F was sensitive to differences in sexual behaviours between healthy women and women with breast cancer. There is literature supporting the higher Technique scores on the WSBQ–F by healthy women. Andersen and Jochimsen (1985) found that healthy women reported higher levels of sexual behaviours and sexual arousal than either breast or gynecological cancer patients. They found that healthy subjects reported significantly higher levels of arousal than either group of cancer subjects, but no significant difference in the desire or orgasm phases of the sexual response cycle. This finding supports the model's assertion that individuals exhibit behavioural regularity and routinely practise a set of sexual behaviours.

The ability of the WSBQ–F to differentiate between healthy women and women with a serious medical condition provides validation for the assertion that sexual behaviours differ between these two groups. These data suggest that the WSBQ–F is sensitive to sexual differences between groups and has the potential to be able to identify behavioural instability in the Sexual Subsystem. For further discussion of differences in sexual behaviours between women who have had a lumpectomy and

those who have had a mastectomy, with or without reconstruction, the reader is referred to Wilmoth and Townsend (1995). Testing of the measure in women with other medical conditions or in women who have had surgery for non-malignant reasons is indicated. Testing of the measure in women from other cultures and gender orientations, as well as women with a variety of chronic illnesses, is clearly indicated. Testing of the WSBQ–F in a sample across time is also required, to validate the ability of the WSBQ–F to detect subtle changes in behaviours and provide data for its applicability in a clinical population.

Reliability

The WSBQ–F underwent two types of reliability testing. Internal consistency reliability resulted in an alpha for the total scale of 0.94, indicating that the tool is internally consistent. The WSBQ–F was found to be a stable measure of sexual behaviours in healthy women. This supports the assumption that sexual behaviour is a trait attribute with behavioural regularity. The values of alpha and r^2 reported for the total measure and subscales are consistent with values reported for the Derogatis Sexual Functioning Inventory (Derogatis, 1980b; Derogatis & Melisaratos, 1979).

A goal of the WSBQ–F was to be inclusive of women of different gender orientations. This goal was not completely achieved. Further work is required to make the WSBQ–F applicable to women from various cultures and of other sexual orientations. Limitations of the data include use of a convenience sample comprising primarily Caucasian women. All subjects self-selected themselves for the study; thus it might be assumed that participants were more liberal in their sexual views than non-participants. However, there are reports suggesting that sexuality research features less liberal bias than is frequently assumed and that subjects who self-select for this type of research may simply be more aware of and more open about their sexuality (Catania, McDermott, & Pollack, 1986). Additional sampling limitations include differences in age and education between the two samples. These factors limit the generalizability of the data. Use of a convenience sample may not be optimal but is common early in tool development (Derogatis & Melisaratos, 1979; Taylor et al., 1994; Waterhouse & Metcalfe, 1986).

An additional limitation of this study was inclusion of heterogeneous respondents in the factor analysis. All subjects were included in the analysis (n = 310). Use of this heterogeneous sample may have altered the results of the factor analysis. Subsequent testing of the

measure should use homogeneous samples of adequate size for this type of validity assessment.

The model imposed constraints on development of the tool by limiting inquiry to observable behaviours. Items referring to the subsystem drive and goal, which were not behavioural items, did not factor onto their own scales. Items on desire and gratification require further investigation. Additional research is needed to validate the model's assumption that behavioural regularity and frequency of use of a set of sexual behaviours are reflective of gratification.

A strength of this study lies in its sample size. A sample size in the range of 200–300 is recommended when conducting a reliability study (Streiner & Norman, 1995). The sample sizes in other psychometric studies on sexuality measures range between 30 (Bransfield et al., 1984) and 380 (Derogatis & Melisaratos, 1979). Another strength is the response rate of 36% and 50% for the two groups of subjects. Such a response rate is adequate for a mailed questionnaire (Waltz et al., 1991) on a sensitive topic (Waterhouse & Metcalfe, 1986).

Initial testing of the WSBQ–F indicates that the measure achieved the five evaluative criteria set forth for a tool measuring female sexuality. The WSBQ–F is a theory-based measure that assesses multiple facets of female sexuality and may prove to be clinically useful. The measure differentiates between healthy women and women with breast cancer. Future testing will include the addition of descriptors at each scale point. The WSBQ–F requires testing among women with conditions other than cancer and among women of different ethnic groups and sexual orientations. While further work is indicated, the WSBQ–F provides researchers with a conceptually grounded gender-focused measure of sexuality.

Sexuality is an important aspect of quality of life and one that nurses have a legal and moral responsibility to address. They cannot meet this standard of practice without adequate knowledge about the effects of normal developmental changes in sexuality and the effects of medical conditions on sexuality. The Wilmoth Sexual Behaviors Questionnaire–Female is a tool that can help nurses add to their knowledge base in this area.

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Correspondence may be addressed to: Dr. Margaret C. Wilmoth, Department of Adult Health Nursing, University of North Carolina, Charlotte NC 28223 USA.

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Book Reviews

To Have and To Hit: Cultural Perspectives on Wife Beating

Edited by D.A. Counts, J.K. Brown, and J.C. Campbell
Champaign: University of Illinois Press, 1999, 344 pp.
ISBN 0-25206-797-5

Reviewed by Helene Berman

Violence against women is a global problem. Although there are vastly different understandings of what constitutes acceptable treatment of women, understandings that are shaped by a complex interplay of social, historical, political, economic, and cultural realities, few if any parts of the world may be said to be violence free. Efforts to examine this disturbing reality — to consider the problem of wife beating and wife battering within the broad context in which it occurs — are complicated by the fact that violence is a multi-faceted and multi-layered phenomenon eluding simple explanations and dichotomous notions of cause and effect.

Despite the challenge, a new book, *To Have and To Hit*, edited by D.A. Counts, J.K. Brown, and J.C. Campbell, represents a laudable and noteworthy attempt at providing such clarification. As the authors consider the relevance of various theoretical frameworks such as cross-cultural research, evolutionary biology, feminist theory, social learning theory, subculture of violence theory, and general systems theory, they simultaneously explore strengths and limitations inherent in each. In an effort to examine difficult issues, the book forces us to confront widely accepted feminist understandings. Though not rejecting these outright, the authors encourage us to reflect critically upon our stock of taken-for-granted tenets of feminist thought.

To Have and To Hit is in part a compilation of ethnographic accounts from 15 distinct societies primarily in Melanesia. Also represented, though to a smaller extent, are groups in Central America, South America, Taiwan, the Middle East, and Africa. However, this book goes well beyond mere ethnographic description. While these accounts make for fascinating reading, the book's real strength lies in its attempt to critically examine the many manifestations of wife beating and battering; the pathways by which these behaviours are learned, transmitted, and enacted; and the strategies that women use to protect themselves

and/or escape from the violence in their lives. We also learn how those affected by violence, namely the victims, the perpetrators, and their families, feel about the violence that occurs within their communities. Most significantly, the authors provide insight into acceptable and unacceptable standards of behaviour, and then contemplate the behaviours and the responses to them within broad political and cultural contexts.

In addition to the accounts of human behaviour, three analytic chapters offer conceptual and theoretical insights. The introductory chapter (Brown) provides important definitions, premises, and assumptions that form the foundation for subsequent chapters. Among the insights is a distinction between wife beating and wife battering. This notion is raised briefly at various points throughout the book, then covered in greater depth towards the end in Campbell's compelling chapter on "sanctions and sanctuary." Upon first reading, this distinction is difficult to fully grasp, or, more aptly, accept. It is one that is not widely embraced in North America. In essence, wife beating is conceptualized as a range of aggressive acts against an intimate partner that fall within the scope of culturally acceptable behaviour. Viewed on a continuum of violent behaviours, wife beating lies at one end, construed as a form of physical aggression that is culturally sanctioned, inflicted occasionally, and typically resulting in few lasting or serious harmful effects. Wife battering lies at the other end of the continuum, construed as ongoing assault, carried out in the context of coercion, and not sanctioned or endorsed by others in the culture. The former is considered to be culturally universal.

While the authors explicitly state that they do not find any form of wife beating acceptable, they maintain that for the purpose of advancing theoretical understandings it is more fruitful to concentrate on wife battering. Herein lies an interesting dilemma. Throughout the book we are told of many instances of wife beating. In Lateef's chapter about an Indo-Fijian community, we learn about the widespread practice of wife beating stemming from a deeply entrenched ideology that insists on female submission to male dominance. Ironically, this ideology is sustained by the senior women in the household. The cultural imperative is for young wives to endure the beatings until they are old enough to gain respect as mothers of sons and can impose the same treatment on other young women.

We learn that among the Abelam, a horticultural people in Papua New Guinea, it is not unusual for men to physically beat their wives. This practice is tolerated if the violence is sufficiently moderate and

infrequent. The reasoning is that the socialization of women requires that they be subjected to such "punishments." Child beating, in contrast, is frowned upon by the Abelam, and the forms of physical discipline that might be deemed acceptable in Western society are prohibited.

Like any important work, *To Have and To Hit* raises more questions than it can fully answer. One of these concerns the issue of cultural relativism. In the name of cultural relativism, do we accept all forms of violence towards women? Or do we view cultures and their customs as constantly in flux and subject to change? Is it possible, then, to create a world where violence against women does not exist? Rather than attempt to provide simple solutions to such complex problems, or pass judgement on the relative rights or wrongs of each society, *To Have and To Hit* offers a framework for contemplating these difficult and thorny questions. The issues presented in this volume are of vital importance to nursing, and the book is a must for anyone concerned with an understanding of violence from a cross-cultural perspective.

Helene Berman, RN, PhD, is Assistant Professor and NHRDP/MRC Career Scientist, School of Nursing, University of Western Ontario, London, Ontario, Canada.

Changing Violent Men

R.E. Dobash, R.P. Dobash, K. Cavanagh, and R. Lewis
Thousand Oaks, CA: Sage, 2000, 210 pp.
ISBN 0-7619-0534-0; ISBN 0-7619-0353-9

Reviewed by Angela Henderson

This book makes an important contribution to our understanding of the task facing those who attempt to change the behaviour of men who use violence in intimate relationships. The authors first examine approaches taken by the criminal justice system to accomplish this task and then place their exploration within the context of society's response to the use of violence.

Changing Violent Men is an account of an evaluation designed to show the relative effectiveness of two court-imposed sanctions against men convicted of domestic violence. Two treatment programs — one court-mandated and one based in the voluntary community — are contrasted with other forms of sanction such as imposition of fines, probation, and imprisonment. The study focuses on the question *What, if anything, works, and why?* and then speaks to the larger question of whether men *can* change. The research design combines qualitative and quantitative approaches. The authors integrate the qualitative data effectively throughout the book by giving voice to the research participants, thus contextualizing the findings. One of the strengths of *Changing Violent Men* lies in its tone: at no time is one left with the impression that the authors condone the behaviour of violent men, yet they demonstrate enormous sensitivity and respect towards the men; Dobash et al. are clearly aware of the discomfort that participation in the program might have caused these men.

The first three chapters provide an overview of the issues involved in undertaking the research; some insights into the extent, characteristics, and impact of violence as described by the participants; and a summary of the usual criminal justice approaches to disciplining violent men and the specific content of the two programs. Chapter 4 describes the research design as well as solutions to some of the problems encountered in planning and conducting the study — for example, the intricacies of recruitment, timing, and data collection. Not least was the issue of how to help men who traditionally deny and minimize their violence to confront the reality and enormity of it. One of the creative solutions to this last problem involved the use of cue cards, a technique of holding up cards on which specific forms of violence are identified with a number; a man who cannot verbally acknowledge that he

kicked his partner, for example, can apparently say "yes" when the research assistant states the number associated with that item on a card.

Before describing the findings of the study, the authors, in chapter 5, outline the extent of the violence the men perpetrated before being sent to court. In the remainder of the book Dobash et al. describe the findings in terms of what works, whether violent men can change, whether any of the interventions had a positive effect on the participants' quality of life, and, last but not least, the nature of the challenge that remains to us. The book is clear and logical, and it provides excellent direction for those who work with violent men as well as those who might be considering similar research.

The findings confirm that all approaches do meet with some success in the short term. The study also found that the two treatment programs resulted in an apparent change of attitude on the part of the men, enabling them to put themselves in the other person's place and to take responsibility for changing their violent behaviour. An additional finding is that the men demonstrated a concurrent decrease in the use of other controlling tactics such as threats. This contradicts the widely held belief that non-physical means of control escalate when physical ones decrease. These findings poignantly illustrate that when interventions are effective, not only in curtailing men's violence but also in changing their views on the nature of their relationships, everyone benefits: men and women once again begin to enjoy each other's company and that of their children; children cease to be exposed to parental conflict; and the culture as a whole benefits from decreased financial drain and strong, healthy families as a foundation for the next generation.

This excellent book concludes with a call for action. The authors point out that a sustained change in male behaviour requires a comprehensive and coherent approach by the culture as a whole. Support services must be available to women seeking to escape violent partnerships; police and courts must take the problem seriously; and, while programs for abusers are important, we must all be committed to rejecting the status quo. As *Changing Violent Men* makes explicit, much remains to be done in the drive to end violence against women in their homes.

Angela Henderson, RN, PhD, is Associate Professor, School of Nursing, University of British Columbia, Vancouver, Canada.

Canadian Journal of Nursing Research, 2000, Vol. 32, No. 4, 159

Erratum

In the review of Bernice Buresh and Suzanne Gordon's *From Silence to Voice: What Nurses Know and Must Communicate to the Public*, reviewed by Gail J. Donner (Vol. 32, No. 3), Ms. Buresh is mistakenly referred to in the text as Bonnie Buresh. The editorial staff of *CJNR* apologize to the authors and to the reviewer for this grave error.

Canadian Journal of Nursing Research
Revue canadienne de recherche en sciences infirmières

Cumulative Index/*Index cumulatif* **Volume 32: 2000–2001**

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TITLES/TITRES

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Volume 32: 2000–2001

The Canadian Journal of Nursing Research *is indebted to the persons below who served as reviewers for Volume 32. They gave generously of their time and shared their knowledge, and in so doing have contributed greatly to the editorial process and to the development of nursing knowledge.*

La Revue canadienne de recherche en sciences infirmières *est reconnaissante envers les personnes ci-dessous nommées pour avoir révisé son volume 32. Ces personnes ont généreusement donné de leur temps et ont partagé leur savoir. Ce faisant, elles ont largement contribué au processus éditorial et au développement des connaissances en sciences infirmières.*

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Focus Topics, Deadlines, and Publication Dates

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Primary Health Care
Submission deadline: October 15, 1999
Publication date: June 2000

Philosophy / Theory
Submission deadline: January 15, 2000
Publication date: September 2000

Chronicity
Submission deadline: April 30, 2000
Publication date: December 2000

Abuse & Violence
Submission deadline: July 30, 2000
Publication date: March 2001

VOLUME 33

Economics of Nursing Care
Submission deadline: October 15, 2000
Publication date: June 2001

Home Care
Submission deadline: January 15, 2001
Publication date: September 2001

Women's Health
Submission deadline: April 15, 2001
Publication date: December 2001

Health Resource Planning
Submission deadline: July 15, 2001
Publication date: March 2002

VOLUME 34

Coping / Adaptation
Submission deadline: October 15, 2001
Publication date: June 2002

Ethics, Values, & Decision-Making
Submission deadline: January 15, 2002
Publication date: September 2002

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Nursing-Care Effectiveness
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Health Promotion
Submission deadline: April 15, 2003
Publication date: December 2003

Continuity & Transitional Care
Submission deadline: July 15, 2003
Publication date: March 2004

Women's Health

December 2001 (vol. 33, no. 3)

Given that women make up over half the population, the importance of optimizing women's health goes without saying. This issue of *CJNR* will focus on all aspects of women's health. Research-based manuscripts related to women's health issues across the lifespan are being sought. These issues include the role of gender in health, social and economic aspects of women's health, the interaction of environment and occupation with women's health, and the health of indigenous, immigrant, and visible minority women. Among the topics being sought are: mental health, violence, sexuality — including lesbian health issues, alternative therapies, multiple pregnancies, genetic interventions and other reproductive health issues, and infectious diseases and cancers more common in women.

Guest Editor: Dr. Anita J. Gagnon
Submission Deadline: April 15, 2001

Health Resource Planning

March 2002 (vol. 33, no. 4)

Nursing shortages are once again making headlines in the mass media worldwide. Health resource planning attempts to determine the appropriate quantity, mix, and distribution of health personnel in order to meet the needs of the population. Historically, health resource planning approaches have been primarily single-discipline, intermittent, varying in quality, and supply-based in nature. They do not build upon the conceptual and analytic advances that have been made, and they rarely focus on outcomes. For this issue of *CJNR*, theoretical and research-based manuscripts on health resource planning that demonstrate innovative conceptual or analytic approaches with a focus on outcomes are requested.

Guest Editor: Dr. Linda O'Brien-Pallas
Submission Deadline: July 15, 2001

Please send manuscripts to:
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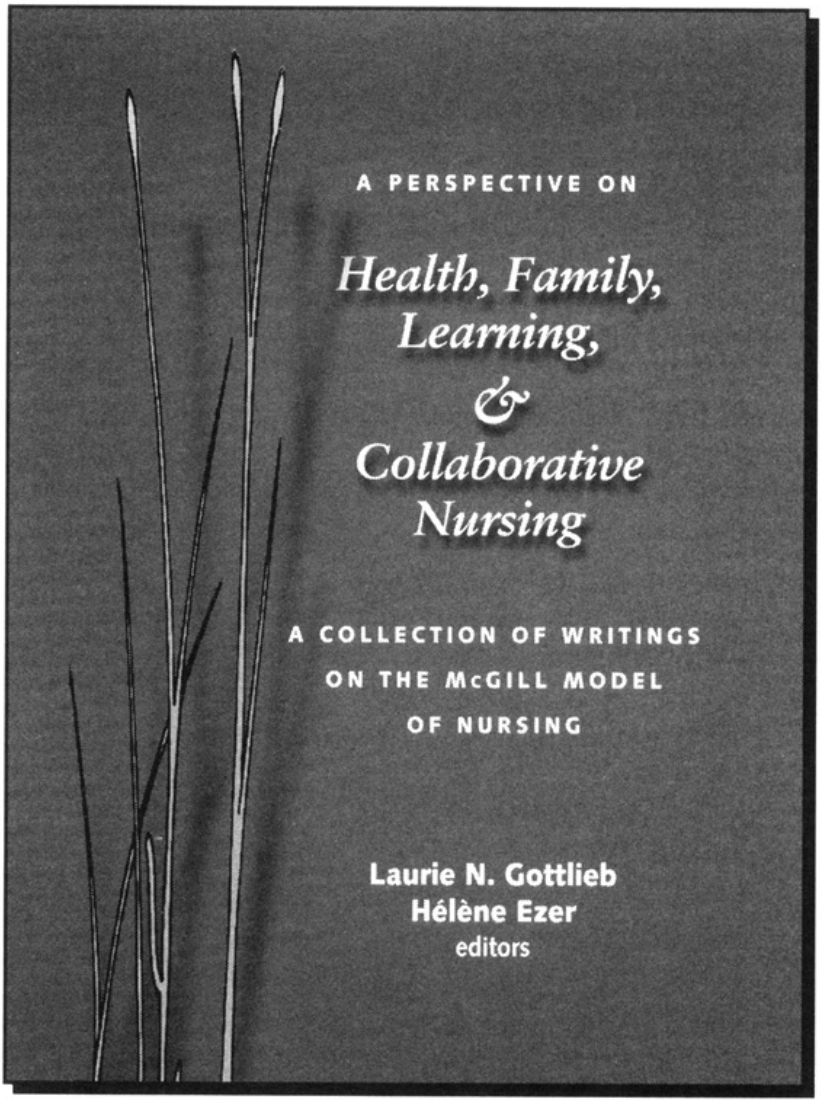

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Procedure: Three double-spaced typewritten copies of the manuscript on 8 ½" x 11" paper are required. Authors are requested not to put their name in the body of the text, which will be submitted for blind review. Only unpublished manuscripts are accepted. A written statement assigning copyright of the manuscript to the *Canadian Journal of Nursing Research* must accompany all submissions to the Journal. Manuscripts are sent to: The Editor, *Canadian Journal of Nursing Research*, School of Nursing, McGill University, 3506 University Street, Montreal, QC H3A 2A7. E-mail: jtoti@po-box.mcgill.ca

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All manuscripts must follow the fourth edition of the *Publication Manual of the American Psychological Association*. Research articles must follow the APA format for presentation of the literature review, research questions and hypotheses, method, and discussion. All articles must adhere to APA guidelines for references, tables, and figures. Footnotes should not be used.

Title page: This should include author name(s), degrees, positions and affiliations, information on financial assistance, acknowledgements, and contact information.

Abstract: Research articles must include a summary of 100–150 words on the purpose, design, sample, findings, and implications of the research. Theory and review papers must include a statement of the principal issue(s), the framework for analysis, and a summary of the argument.

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Tables and figures: Tables and figures should appear only when absolutely necessary. They must be self-explanatory and summarize relevant information without duplicating the content of the text. Each table must include a short title, omit abbreviations, and be typed on a separate page. Figures must be in camera-ready form.

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Canadian Journal of Nursing Research
Revue canadienne de recherche en sciences infirmières

Volume 32, No. 4 March / mars 2001

Focus: Abuse & Violence / L'abus et la violence