

Guest Editorial and Discourse

A Further Celebration of Nursing Research in Violence

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We have been delighted to work together and with the outstanding editor and staff of *CJNR* as well as all of the wonderful scholars who responded to our request for manuscripts and reviews. It has been a wonderful and relatively easy process, and, more importantly, we have all produced a volume that will be an important 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, several more on the topic of violence from the original solicitation will be published in *CJNR* over the next year. We hope that this issue and the articles that follow will spark even more interest in nursing scholarship on the topic.

When the first special issue of *CJNR* on violence was published in 2001, it was wonderful to be able to remark on the incredible growth of published nursing research on violence, especially violence against women, over the preceding 25 years. Now another 5 years have gone by with another burst of publications, not only from the United States and Canada but also from Australia, New Zealand, and the United Kingdom, in addition to a few nursing publications from Africa, Hong Kong, and other parts of the world. Sometimes we do not pay enough attention to the nursing research from other countries, chiefly because nursing journals are not always well indexed in the main search strategies but also because we sometimes fail to include international journals in our searches. We were glad to see that the authors whose articles appear in this volume have been conscientious about citing relevant nursing literature, something that we think nursing as a discipline needs to do. The field of interpersonal violence is laudably interdisciplinary in nature, with relevant research from many different fields to build on, but we still need to read and use the research of our nursing colleagues as much as possible. In this way, researchers in other discipline will see the references to the important nursing science, and our colleagues will get those citations that we all find so important to our academic careers.

The contribution of nursing research to the literature on intimate partner violence (especially abuse during pregnancy and intimate partner forced sex) and the health effects of violence is substantive. In fact, IPV is one of the few areas of nursing research whose knowledge base has been recognized by several important publications as meriting a separate chapter (e.g., Hinshaw, Feetham, & Shaver, 1999, *Handbook of Clinical Nursing Research*; Fitzpatrick, Taunton, & Jacox, Eds., 1992 and 2001 [two volumes], *Annual Review of Nursing Research*). Nursing researchers are being asked to contribute chapters to important interdisciplinary textbooks in the field (e.g., Mitchell, in press, *Medical Response to Intimate Partner Violence*; Feerick & Silverman, 2006, *Children Exposed to Violence*; Roberts, Hegarty, & Feder, 2005, *Intimate Partner Abuse and Health Professionals: Old Problems, New Approaches*). This is a testament to the recognition of nursing expertise by other disciplines in this area. Nursing research on violence has often been characterized by collaboration with community agencies and health-care systems, by interdisciplinarity, and by combinations of qualitative and quantitative data, as well as work from each data-analytic tradition alone (see, for instance, the contributions in this volume by Berman and colleagues and by Lutz, both from a qualitative perspective, and the contribution by Lipscomb and colleagues using a combination of data). This issue of the Journal is noteworthy in that it represents a variety of exciting cutting-edge research methods, as has been true of most of the previous nursing research in the field.

Contributions of Papers in This Volume

The papers in this issue of *CJNR* address a wide range of violence-related topics and thus illustrate the complex and interrelated nature of the phenomenon. Readers whose primary interest is not violence will also find a wealth of methodological information of interest as well as scholarship that touches on issues of the health of immigrant women, maternal child health, emergency department nursing, mental health nursing, workplace environments, system change evaluations, and policy implications. For example, Berman and colleagues clearly illustrate the profound effect of both direct and indirect violence on women whose experiences began in the context of war. This narrative study poignantly shows that for survivors of violence — even when the violence was directed not at them but at someone close to them — the world is forever changed. Even as the women attempted to establish themselves in a new country, they experienced the aftermath of the violence in the form of depression and feelings of helplessness. Partly in recognition of those feelings, the authors organized an invitational forum upon completion of the study. Most of the participants were able to attend, and the

authors and the women made a joint public statement at its conclusion. This approach illustrates an action-oriented empowerment focus that is a commendable feature of much of the nursing research in this arena.

Although the participants in the Berman et al. study did not speak specifically of nurses in the context of their stories, we are enormously concerned with the influence of contact with nurses on the quality of abused women's experiences. As the literature has demonstrated over the years, individual nurses are more likely than other health professionals to encounter abused women in their practice. In fact, a great deal of the literature in the past few years has related to the nature of the interaction between abused women and nurses. Two of the articles in this issue are specifically concerned with the nurse part of that equation. The article by Hollingsworth and Ford-Gilboe describes nurses' self-efficacy as it relates to individual perceptions of ability to assess and respond to woman abuse. The authors used a descriptive correlational design to conduct a secondary analysis of data from 158 registered nurses who took part in a large survey. The results of the study demonstrate clearly that the ability of nurses to provide appropriate assessment and intervention requires the active support of administration as well as unambiguous policy guidelines.

Nurse readiness to act is another aspect of the interactions between nurses and abused women addressed in these pages. As Webster and colleagues point out, most of the literature on nursing and abused women focuses on the changes over time in women who are abused. These researchers, in contrast, conducted semi-structured interviews with 11 public health nurses, with a view to describing the process as experienced by the nurse. This article, along with that of Hollingsworth and Ford-Gilboe, illustrates the complex nature of interactions between women and nurses. Many factors — including nurses' comfort level with the topic and the definition of success — apparently contribute to nurses' readiness to intervene with abused women. Again, in both articles, as well as in prior nursing research (e.g., Campbell, Coben, et al., 1998), the importance of administrative support is identified as a crucial factor in the individual nurse's ability to interact comfortably and to actually improve the health-care response to abused women.

Another form of administrative support — concrete, unambiguous, and rigorously administered policies — concerns efforts to keep nurses and other health-care providers safe in the workplace. Only workers who feel safe at work can be effective in their jobs. Lipscomb and colleagues describe the process of implementing the US Department of Labor and Occupational Health and Safety Administration (2004) *Guidelines for Violence Prevention for Health Care and Social Service Workers* in three in-patient mental health settings in New York State. This study demonstrates

the feasibility of successful implementation of such programs. Most interestingly, it illustrates the positive impact of management support on staff perception. Again and again, the articles in this issue underline the importance of providing supportive, safe environments for health-care providers who undertake this work.

In addition to discussing the characteristics of the nurse and the nurse's environment when attempting to ensure successful intervention with abused women, this issue of *CJNR* includes two articles that address the experiences of specific groups of abused women, Latina and pregnant women, with regard to the nature of the relationship with care providers. These articles articulate women's perceptions of their relationship with their care providers (including nurses) and show how these perceptions influence the interactions between them. Ursula Kelly's powerful phenomenological study of battered Latina women reveals some of the complexity inherent in the way in which women arrive at the decision whether to disclose abuse. Kelly interviewed a purposive sample of women using services for battered women — including both women who had left the abusive relationship and those who were still with the abuser — in order to explore their experiences with accessing services and their expectations of health-care providers. The disturbing parallels between the women's emotional responses to interactions with their abusers and to interactions with their health-care providers illustrate the pitfalls created by inadequate health-care responses.

Several sources of data were used in the study *Double Binding, Abusive Intimate Partner Relationships, and Pregnancy* by Lutz and colleagues. These researchers used an inductive-deductive process to analyze a combination of clinical experience, a literature review, and qualitative data from two studies of abuse during pregnancy to identify the notion of double binding as a response of women to abuse during pregnancy. This construct was developed during consultations among the authors as they sought to understand the problems inherent in simultaneously integrating the processes of becoming a mother and being abused. The complexity of the women's experiences is persuasively illustrated, as is the importance of understanding each woman's circumstances, particularly the degree of threat she experiences.

In sum, the articles in this issue of the *Journal* argue for the importance of competent health-care involvement; the need to understand the multifaceted nature of women's lives and the many factors that impede or enhance their ability to act; the complexity of the relationship between abused women and their health-care providers; and, last but not least, the importance of meaningful administrative support for those frontline professionals who choose to intervene on behalf of abused women and their children. We are becoming more aware of the complex

interconnectedness of the effects of violence — for example, the influence of personal experiences of violence on a nurse's perception of abused women encountered in practice and the influence of biological factors in relation to the nature/nurture debate as discussed by Jean Hughes in the Commentary in this issue.

Other Violence-Related Areas Needing Nursing Research

Another exciting aspect of this issue of *CJNR* is the attention given to issues of immigration and culture, especially in the Berman et al. and Kelly articles. A related concept is that of health disparities or health differentials. Usually thought of in terms of differences in traditionally measured health status (outcomes) and health care between majority and minority populations, the influence of violence on health disparities is only beginning to be considered and is seldom addressed by nursing research. Yet in both Canada and the United States there remains a gap in health-care access and outcomes between First Nations and other minority peoples and non-minority populations. Women of colour and their children are at greater risk for health disparities, in terms of both prevalence of health problems and quality of health care, encompassing access to care, processes of care, and health outcomes. The context of the lives of minority families, which often includes multiple forms of oppression, low levels of education, high rates of poverty, and particular vulnerability to IPV and its effects, contributes significantly to these health disparities. The confluence of these issues and decreased access to quality health care are manifested in shorter life expectancy, higher rates of infant mortality, greater prevalence of chronic diseases such as cardiovascular disease and lupus, certain cancers and infections (HIV/AIDS, tuberculosis, hepatitis), and traumatic injury. As well as disparities related to ethnicity, women continue to experience more health disparities than men (Department of Health and Human Services [DHHS], 2001; Institute of Medicine, National Research Council [IOM, NRC], 2001). Consideration of social context is particularly important for examining the health status of poor women and women of colour (Mirsa, 2001), who suffer disproportionately from disease, disability, and premature death (DHHS, 2001).

Violence against women and health-care disparities are two topics that have received increased attention over the past decade from health-care researchers, practitioners, and policy-makers (Humphreys, Campbell, & Parker, 2001; IOM NRC, 2001). Yet their connections remain unexplored in research. Among young African-American women between the ages of 15 and 24, IPV is the leading cause of non-lethal injury and premature death from homicide (Rennison & Welchans, 2000). Recent

data have indicated that the rates of non-lethal IPV are highest among women in low-income households (Greenfeld et al., 1998). Several population-based surveys have found that IPV is significantly more common among women of colour, particularly African-American and Native American women, although when differences in income, education, and/or employment are considered, the differences attributable to race decrease dramatically or disappear (Jones et al., 1999; Rennison & Planty, 2003; Tjaden & Thoennes, 2000). The differences that do exist seem to be more dramatic in terms of past-year IPV than in terms of lifetime IPV. In other words, majority-ethnicity women are equally likely to experience IPV but may have more resources with which to escape or deal with the situation and therefore are less likely to be recently abused. In the United States, African-American women are disproportionately killed by abusive partners compared to white women, while unemployment is significantly higher among those killed and their perpetrators (Campbell et al., 2003). In the New York City femicide database, the only database with sufficiently large numbers of both immigrants and homicides to allow for accurate calculation and comparison of these proportions, immigrant women are at greater risk of being killed by intimate partners than native-born Americans (Frye, Hosein, Walturmauer, Blaney, & Wilt, 2005).

Since low income and underemployment are most common among women of colour, the increased rates of IPV and IPV injury among these women must be considered a potential cause of disparities in health conditions associated with IPV (Walton-Moss, Manganello, Frye, & Campbell, 2005). Women of colour are overrepresented in emergency departments and in injury databases. In addition to immediate injury, IPV has significant consequences for physical and mental health. Empirical findings from research in nursing and other disciplines (e.g., Campbell, Snow-Jones, et al., 2002; Coker et al., 2002; Plichta, 1996) and comprehensive reviews of the health consequences of IPV (Campbell, 2002; Humphreys, Lee, Neylan, & Marmar, 2001; Nauman, Langford, Torres, Campbell, & Glass 1999; Sharps & Campbell, 1999) describe a variety of negative health outcomes. Compared to other women, battered women use more primary care and mental health services, spend more days in bed due to illness, and are more likely to describe their health as fair or poor. Immediate trauma includes broken bones, lacerations, facial trauma, and tendon and ligament injuries. Chronic physical conditions for which IPV is a significant risk factor include gastrointestinal disorders (loss of appetite, eating disorders), neurological problems (fainting, severe headaches, vision and hearing problems), urinary tract and other infections, and shortness of breath (Campbell; Nauman et al.; Sharps & Campbell).

Among female IPV survivors, 40% to 45% are forced into sex by male intimate partners (Campbell & Soeken, 1999a). Forced sex is associated with acute and chronic reproductive health problems, including increased pelvic inflammatory disease, increased risk of sexually transmitted diseases including HIV/AIDS, vaginal and anal tearing, dysmenorrhea, sexual dysfunction, and pelvic pain (Campbell, 2002; Nauman et al., 1999). Several of these conditions are also those for which health disparities are greatest among minority women. From 3% to 19% of pregnant women are battered, with associated adverse outcomes for both mother and infant (Campbell, Garcia-Moreno, & Sharps, 2004). Maternal consequences include injury, increased miscarriage, increased unintended or mistimed pregnancy, failure to gain sufficient weight, increased risk for sexually transmitted and urinary tract infections, increased substance use including cigarette smoking, and late entry into prenatal care. Neonatal and infant consequences include fetal injury, low birth weight, preterm delivery, and substance exposure (Nauman et al.; Sharps & Campbell, 1999). Poor maternal-child outcomes of pregnancy are also more common among women of colour, yet IPV as a contributing factor in these health disparities is seldom considered.

Female IPV survivors suffer increased mental health problems, accounting for much of the increased health-care costs of IPV (Wisner, Gilmer, Saltzman, & Zink, 1999). Depression is the primary response of battered women to IPV (Campbell, Kub, Belknap, & Templin, 1996). Other mental health problems prevalent among women survivors of IPV are posttraumatic stress disorder and increased use of substances including alcohol, illegal drugs, and cigarettes (Campbell & Soeken, 1999b; Sharps & Campbell, 1999; Sharps, Campbell, Campbell, Gary, & Webster, 2001). Again, women of colour are more likely than Anglo women to smoke, to use illegal drugs, and to have untreated mental health problems, but the relative contribution of IPV to these health disparities is usually not specifically identified.

These issues are beginning to be addressed (e.g., Jones et al., 1999; Price, 1996; Schollenberger et al., 2003; Sharps, Campbell, et al., 2001; Torres et al., 2000). Health effects of IPV specific to African-American women include higher rates of hypertension and higher rates of emergency department use for IPV injuries in abused African-American compared to Euro-American women and more low-birth-weight infants among abused African-American than white and Latina women (Price; Schollenberger et al., 2003). An examination of depression and IPV in a diverse sample found that for African-American women IPV was a significant predictor of depression, and the depressive effects of IPV lasted long after the IPV ended (Campbell & Soeken, 1999b). More research is

needed to identify the health needs of African-American and other minority female survivors of IPV.

Intersection of Violence against Women and HIV/AIDS

One of the most important areas of health disparity for women all over the world is HIV/AIDS. The increasing numbers of women dying from HIV/AIDS and the large racial disparities in morbidity as well as mortality from this disease point to the multiple complex interfaces between HIV/AIDS and IPV. The harsh reality of the new face of the HIV/AIDS epidemic is that women all around the world are being infected in the largest proportions and in Africa they are the majority of those infected and the majority of those dying. It is well documented that in the United States women of colour are the most affected by this particular health disparity. The intersections of HIV/AIDS and IPV are increasingly being recognized and definitively documented by means of persuasive and rigorous research (e.g., Dunkle et al., 2004; El-Bassel et al., 1998; Gielen, O'Campo, Faden, & Eke, 1997; Greenwood et al., 2002; Maman, Campbell, Sweat, & Gielen, 2000; Maman et al., 2002; Relf, 2001; Outwater, Abrahams, & Campbell, 2005; Relf, 2001; Whetten et al., 2006; Wingood, 2001; Wingood & DiClemente, 1997; Wyatt et al., 2002). Since women of colour are the most frequent victims of sexual violence by intimate partners and others, they are the most affected by this intersection; it is for these women that the issues are most critical.

The important interfaces of HIV and violence can be summarized as follows: (1) epidemiological studies showing significant overlap in prevalence (Greenwood et al., 2002); (2) studies showing IPV as a risk factor for HIV among women and men (e.g., Dunkle et al., 2004; Greenwood et al., 2002); (3) studies showing violent victimization such as childhood sexual abuse increasing HIV risk behaviours, including IV drug use (e.g., Abdool, 2001; Choi, Binson, Adelson, & Catania, 1998; Gilbert et al., 2002; Wyatt et al., 2002; Zierler, Witbeck, & Mayer, 1996); (4) emerging research showing immune-system alteration due to violence against women (Woods et al., 2005); (5) studies showing violence or fear of violence impeding or resulting from HIV testing (Gielen, McDonnell, Burke, & O'Campo, 2000; Maman, Mbawambo, Hogan, & Kilonzo, 2001; Maman et al., 2002); (6) studies showing partner violence as a risk factor for sexually transmitted diseases, which increases the rate of transmission of HIV (Thompson, Potter, Sanderson, & Maibach, 2002); (7) data indicating that abusive men are more likely to have sexual partners unknown to their wives (Garcia-Moreno & Watts, 2000); and (8) studies showing the difficulties of negotiating safe sex behaviour for abused partners (Davila & Brackley, 1999; Wingood & DiClemente, 1997). In addition,

there are hypothesized but as yet untested relationships between increased HIV transmission and IPV through forced sex, known as a frequent form of IPV (Campbell & Soeken, 1999a; Maman et al., 2000). Forced vaginal sex can cause trauma that increases the chance of transmission. In addition, abused women report forced anal sex as a frequent form of forced sex in violent intimate relationships, and anal sex is known to increase HIV transmission.

The current emphasis on increasing the availability of antiretroviral medications and vaccine development to combat HIV/AIDS must continue and be supported. Violence can also be related to differential access to care for women by contributing to a delay in obtaining treatment if there is a fear of violence in the relationship. Prevention efforts must also continue, and issues of interpersonal violence need to be addressed throughout the spectrum of initiatives that will be needed for many years to come (regardless of vaccine development): primary prevention, testing, medication adherence, and transmission reduction. Prevention and intervention programs are beginning to include content on violence (e.g., Wingood et al., 2006); however, evidence supporting these interventions is limited and few interventions systematically address the issue. The forced sex that is the sexual initiation for so many girls around the world, especially in Africa (20–30% of all women) but also in the United States, where 25% of sexually active young adolescents (< 14 years) state that their first sexual encounter was forced, must be acknowledged and addressed (Heise, Ellsberg, & Gottemoeller, 1999; Jewkes, Levin, Mbananga, & Bradshaw, 2002). This illustrates the futility of an abstinence-only approach. In the policy arena, the PATHWAY bill introduced in the US Congress needs our support so that the abstinence-only restrictions in current US funding to address the HIV/AIDS epidemic in developing countries are eliminated and so that more attention can be given to women's particular vulnerabilities, which range from violence to HIV/AIDS.

Thus, in Canada and the United States and all around the world there are glaring disparities in the health of women of colour compared to white women. This reality is well known, as is the reality of IPV for a large proportion of women. Yet these two intersecting issues are seldom considered together, in spite of the documentation of violent victimization among women of colour and IPV as a risk factor for many conditions. More research is needed to further explore these connections — for instance, to determine whether the health disparities are related to differential causation specific to IPV, lack of access to care for poor and minority ethnic women and/or differential lack of health-system recognition of and appropriate intervention for violence, or differential rates in obtaining treatment because of the controlling behaviour of abusive

partners. Until these questions are answered, the culturally appropriate strategies and types of setting for health-system interventions for abused women will remain undetermined. As health-care interventions for domestic violence are developed and tested (e.g., Parker, McFarlane, et al., 1999), it is imperative that they be tested specifically among different racial, ethnic, and cultural groups, or we may end up increasing rather than decreasing the health disparities for abused women of colour. Nursing is in a terrific position, in terms of its prioritizing of social as well as health inequities, to conduct the kind of research that is needed, across the full range of violence and health-disparities research.

Final Thoughts

Another area of inquiry that is a natural for nursing but still has not been taken on is the health effects of lifetime trauma, including child abuse. Research in other disciplines has demonstrated that childhood physical and sexual abuse has detrimental effects on women's health over and above that resulting from domestic violence (e.g., McCauley et al., 1997), and the recent exciting Adverse Childhood Events study demonstrated that adverse childhood experiences, including physical and sexual abuse and the witnessing of domestic violence between parents, have long-lasting effects on morbidity and even mortality from seemingly unrelated causes such as cardiovascular disease (Felitti et al., 1998). Yet nursing investigations of child abuse and its resultant health effects have been sparse. Nursing research on elder abuse is also limited. Although forensic nursing has begun to include elder abuse, the focus has been clinical and in terms of injury documentation rather than research. Yet evidence-based practice calls for more researchers to follow in the footsteps of such leaders as Terry Fulmer (e.g., Fulmer, McMahon, Baer-Hines, & Forget, 1992). Rape is one pervasive form of violence against women that, since Burgess and Holmstrom's (1974) groundbreaking nursing research in the field, has been relatively neglected by nursing scholars, even though forensic nursing and Sexual Assault Nurse Examiners have been increasingly recognized as important to the field. The research of Marilyn Sommers (Sommers et al., 2006), as well as that of Natalie McClain and Sarah Anderson (Anderson, McClain, & Riviello, 2006), is beginning to fill the gaps, but more work is needed. And although child abuse and its long-term detrimental effects continue to exist to a discouraging extent, with a nursing intervention shown to be the most effective in preventing its occurrence (Kitzman et al., 2000), nursing research has never been particularly notable in that area.

In conclusion, we would like to thank our fellow nursing scholars in the field of violence who are represented in this volume, as well as the

CJNR staff. We were honoured and excited to be asked by the CJNR editors to put together another special issue on violence, and to see that they recognize the importance of the field to the continuing development of nursing research. It is an honour to be associated with a volume that truly presents outstanding research by any measure — methodological, innovation, substance, and importance to nursing practice and health-care policy. The breadth of the violence field is indeed amazing, as illustrated in the pages that follow. Everyone involved in the volume has been a joy to work with, and we look forward to further achievements in nursing research in the field of violence.

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