

**Panser la blessure sociale :  
l'expérience des infirmières de la  
santé publique en matière de dépistage  
des cas de violence conjugale**

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Le projet avait pour but de décrire l'expérience des infirmières de la santé publique (ISP) chargées de dépister les cas de violence conjugale dans le cadre de leurs fonctions. Les chercheuses ont mené des entrevues en profondeur et semi-structurées auprès de onze ISP dont le degré d'expérience en intervention auprès des femmes victimes de violence variait largement. Elles constatent que la préparation constitue un facteur important en matière de dépistage. Elles décrivent les étapes que semblent traverser les infirmières avant de se sentir à l'aise dans leur rôle : se faire à l'idée que la violence existe; soulever la question; rendre témoignage; « accompagner » la cliente. Au fur et à mesure qu'elles apprivoisent leur rôle, les ISP en viennent à redéfinir en quoi consiste le succès. Pour elles, une interaction réussie se mesure désormais à la croissance personnelle des clientes sur une certaine période, plutôt qu'au seul fait de quitter le conjoint violent. Les auteures présentent les conséquences de ces observations pour l'exercice des soins infirmiers.

Mots clés : violence conjugale, dépistage, soins infirmiers

# **Nursing the Social Wound: Public Health Nurses' Experiences of Screening for Woman Abuse**

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The purpose of this study was to describe the experiences of public health nurses (PHNs) who screen for woman abuse within their clinical practice. Semi-structured, in-depth interviews were conducted with 11 PHNs. There was a great deal of variability in participants' level of experience in working with abused women. The results reveal that nurse readiness is an important factor in screening for woman abuse. The authors describe a number of steps participants appeared to grapple with in order to become comfortable working with abused women, including coming to terms with abuse, asking the question, bearing witness, and "walking with" the client. As the PHN became increasingly comfortable working with abused women, she came to redefine success. Her client's personal growth over time, rather than the single act of leaving an abusive relationship, now defined a successful client interaction. The authors also discuss implications for practice that arise from these accounts.

**Keywords:** Spouse abuse, mass screening, nursing, nursing research

In 1993, the United Nations defined woman abuse as any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivation of liberty whether occurring in public or private life (United Nations General Assembly, 1993). Prevalence rates of woman abuse vary according to the method and data source used (Johnson, 2005; Wathen & MacMillan, 2003). According to the 2004 General Social Survey, 7% of Canadian women experience some type of violence in their intimate relationships, ranging from threats to sexual assault (Canadian Centre for Justice Statistics, 2005). Other sources, using a broader definition, have estimated that as many as one in four Canadian women have experienced violence in their intimate relationships (Campbell, 1999; Wuest & Merritt-Gray, 2001). Woman abuse has far-reaching health and social implications for women's lives and well-being, and during pregnancy it is associated with compromised health outcomes for the child (Murphy, Schei, Myhr, & DuMont, 2001). Once considered a private matter within the family, woman abuse is now recognized by most theorists as being a social rather than an individual problem and is

viewed internationally as a pressing health concern (Bryant & Spencer, 2002; Haggblom, Hallberg, & Anders, 2005; Protheroe, Green, & Spiby, 2004; Stayton & Duncan, 2005; Walton-Moss & Campbell, 2002; Wathen & MacMillan). Violence against women, then, does indeed constitute a social wound.

The purpose of this study was to explore public health nurses' (PHNs') experiences of screening for and dealing with woman abuse in a public health setting in the care of women during the pre- and postpartum period. Nurses are in a unique position in relation to screening for woman abuse. For example, women experiencing partner violence are significantly more likely than non-abused women to seek health care, including emergency care, and yet are rarely identified by health professionals (Dickson & Tutty, 1996; Feder, Hutson, Ramsay, & Taket, 2006). It is likely that the first provider an abused woman encounters will be a nurse (Ford-Gilboe, 2001). One study found evidence to suggest that the reported prevalence of woman abuse increases when nurses interview women about abuse, compared to women independently reporting abuse to nurses (McFarlane, Christoffel, Bateman, Miller, & Bullock, 1991). Furthermore, women in their childbearing years report the highest rates of abuse and many abused women report that the abuse begins or escalates during pregnancy (Hart & Jamieson, 2001). Therefore, educating and supporting PHNs in screening for abuse, especially in the prenatal and postnatal population, could have a significant positive impact on providing assistance to abused women.

Nurses in general, and PHNs specifically, have long been dealing with and screening for woman abuse. Since 1998, PHNs working within the Healthy Babies, Healthy Children (HBHC) Program in Ontario public health units have been caring for high-risk postpartum families and regularly asking questions about violence. HBHC is a prevention and early intervention program developed to provide support and services to families with children from before birth to 6 years of age. Through the program, a hospital nurse completes the Parkyn Screen on every postpartum woman going home with an infant prior to discharge from hospital. The Parkyn Screen identifies risk for difficulties affecting the child's growth and development, including family violence. Shortly after the new mother arrives home from the hospital, a PHN calls all consenting postpartum women and offers a home visit. Following the initial home visit, clients deemed high-risk may go on to receive regular contact with a PHN.

There is a paucity of evidence regarding nurses' experience of working with abused women in their practice. The majority of literature focuses on abused women's experiences of screening (Feder et al., 2006; Lutz, 2005), the prevalence of screening (Stayton & Duncan, 2005;

Waltermaurer, 2005), and providers' attitudes towards screening and/or abused women (Bryant & Spencer, 2002; Dickson & Tutty, 1996; Haggblom et al., 2005). There are few studies focusing on nurses' experiences of screening. The Canadian nursing researchers Varcoe and Wuest (2001) comment that the "limited attention to violence in Canadian nursing research" is a serious gap (p. 15). They note that while abuse in pregnancy has been well documented in Canada, this documentation has not necessarily translated widely into policy and educational initiatives related to nursing practice. They invite researchers to "take up the challenge" of ensuring that nurses' voices are heard as communities strive to address violence and abuse (p. 17).

In response to this challenge, the present study explores nurses' experiences of working with woman abuse using a grounded theory approach in which theory develops from the data as opposed to theory directing the research questions. The approach has also been a feminist one insofar as it is informed by women's experiences.

## **Method**

Eleven in-depth, semi-structured individual interviews were conducted with PHNs in the HBHC Program in an Ontario health unit. The study period coincided with the introduction of a new abuse screening protocol. The protocol, called Routine Universal Comprehensive Screening (RUCS), recommends universal screening for all females over the age of 12 years (Middlesex-London Health Unit, 2000).

The interviews focused on participants' experiences of screening for and dealing with woman abuse in the care of women pre- and post-partum. A qualitative method was indicated because of the exploratory nature of the study and as a means of attending to the sensitive nature of the topic. The protocol anticipated that participants could disclose their own personal experiences of abuse or become distraught in sharing their experiences from the field. A package of local community resources was made available to each participant. The host health unit also had an Employee Assistance Program (EAP) from which immediate assistance could be accessed if necessary. Ethical approval was obtained through the University of Western Ontario.

PHNs in the HBHC Program were informed of the study by the study interviewer during a team meeting and were encouraged to contact the interviewer directly if they were interested in participating. Team managers were not present at the meeting and were not informed of who participated in the study. Participants were permitted to take part in the interview during their regular work hours and were assured that their participation was anonymous. Following the initial presentations, a

number of participants came forward to be interviewed. Reminder e-mails were sent to all PHNs in the HBHC Program. Recruitment continued using the snowball sampling technique, whereby each participant is asked for the names of other potential participants with different perspectives. This method was used in order to access a maximum variation sample. Maximum variation sampling is a purposeful sampling strategy used to capture central themes across participant variation. It limits the tendency to reduce complex concepts to simplistic descriptions (Patton, 1990).

### ***Data Collection***

All interviews were conducted by a research associate with considerable experience in qualitative research (MSB). The interviews were conducted during regular working hours in a private meeting room located in the health unit. Using a semi-structured interview guide with mainly open-ended questions (see Figure 1), the interviewer was free to word and sequence the questions as appropriate, ensuring that all key areas of the interview were addressed. Each interview lasted approximately 90 minutes. Interviews were recorded and transcribed verbatim by a professional transcriber. Tapes and transcripts were kept in a locked filing cabinet at all times and will be destroyed following organizational protocol. Because the interviewer worked in the same organization, she was known by name to many of the members of the HBHC Program. However, she was not involved in the clinical work of the PHNs. Considerable emphasis was placed on the importance of hearing all perspectives.

### ***Data Analysis and Interpretation***

Data collection and preliminary analysis took place simultaneously using a combination of the editing and template organizing styles as outlined by Miller and Crabtree (1999). Central elements of grounded theory were key aspects of this qualitative inquiry; they included coding, hypothesizing and categorizing, comparing, connecting and integrating concepts, and asking participants to respond to the findings (Stern, 1985).

Immediately following each interview, the interviewer wrote a brief summary of the interview, including reflective thoughts and emerging themes. This summary was shared and discussed with the principal investigator (FW). By the ninth interview, these researchers (FW and MSB) felt that saturation was reached. Two more interviews were completed to see if any new themes or concepts emerged.

At the end of the data-collection period, two researchers (FW and MSB) independently read transcripts from four diverse interviews. These independent analyses were compared and an analysis template or

**Figure 1 Interview Guide**

**Basic demographic information/warm-up**

1. How long have you worked at this health unit?
2. How long have you worked in the Healthy Babies, Healthy Children Program?
3. Can you tell me a little bit about your role as a public health nurse in the HBHC Program?
4. What's your favourite part of your job?

**Woman abuse – general**

5. If you were asked to describe your current understanding of woman abuse, what would you say?

**Screening**

6. In dealing with your clients, how would you describe what you do in trying to find out if a woman has been abused?
  - *when do you do this?*
  - *has this changed over time?*
7. How often is woman abuse identified with your clients?
  - *has this changed over time?*
8. As we have indicated, this project is seeking to learn more about the issues around identifying woman abuse through public health nurses' experiences. Can you describe for me an experience you had in [insert participant's description for "screening"] for abuse?
  - *what was this situation like for you?*
  - *how did this situation impact your work? your life outside of work?*
  - *overall, what was this experience like for you? Was it positive or negative?*
9. Can you describe for me another experience you had in [insert participant's description for "screening"] for abuse? Perhaps one that was slightly different? (Probes – as above)
10. Have you ever interviewed a client you thought was abused but did not disclose the abuse when you asked?
  - *what were your reasons for thinking she was abused?*
  - *what did you do in this situation?*
  - *additional probes as above*

**Possible questions for participants with little experience in dealing with abused women**

11. What is it like for you to ask women if they have been abused?
12. What is it like for you when you hear about other nurses' experiences of working with abused women?

**Roles and training**

13. What do you feel your role is in screening for woman abuse?
14. Do you see yourself as having a role beyond screening?
15. Describe how you see your role in screening and caring for abused women in relation to other health providers.
16. What do you need to feel more comfortable in your role?

**Cool-down/wrap-up questions**

17. Is there anything else I haven't asked you about that you'd like to add?

codebook developed. The remaining transcripts were then read, coded, and entered into the NVivo computer program. Following the coding of all transcripts, data were examined for similarities and differences across the interviews and emerging themes were identified. A summary of the analysis was prepared and discussed by the authors. All of the authors engaged in the process of interpreting the data.

### ***Trustworthiness of Findings***

Although there is a risk of introducing bias into a study when only one method of data collection (in-depth interviews) is used, a number of strategies were employed to enhance the trustworthiness of the findings (Guba, 1981; Guba & Lincoln, 1989). Member-checking, the process of verifying the findings, was carried out during the interviews through direct questioning and after the interviews by means of sending the participant a summary of the findings and a request for feedback. Participants were also invited to attend a presentation of the findings followed by an open dialogue with the researchers and PHNs working in the HBHC Program. In addition, a team-analysis approach was used to ensure that the findings were grounded in the participants' words and that the researchers attended to their biases through reflection, discussion, and documentation.

## **Findings**

Eleven female PHNs were interviewed for the study. Nine worked full-time, one worked part-time, and one was a casual PHN. The majority of participants (seven) had been involved in the HBHC Program since its inception in 1998. Three participants had been employed at the health unit for more than 20 years, two for more than 10 years, and six for less than 5 years. There was considerable variability in participants' level of experience working with abused women. Some participants had extensive experience spanning more than 30 years, whereas others were just beginning to implement a routine screening protocol.

We have organized the themes that emerged from the data according to the actual experiences of working with a client. The themes include *coming to terms with abuse*, *asking the question*, *bearing witness to the stories of abuse*, and, finally, *"walking with" the woman who has been abused*.

### ***Coming to Terms with Abuse***

For some nurses, coming to terms with the concept of abuse itself was challenging. They described having little or no awareness of or personal experience with woman abuse prior to their work in the HBHC Program. For these participants, the experience of encountering abuse in

the intimate relationships of their clients was difficult as it challenged their personal beliefs about intimate relationships and evoked intense feelings. This influenced their readiness to deal with woman abuse:

*I feel like I have been really protected, my life has been really protected. It's sort of opening a door to a side of our society that I never knew before and it's uncommon to me and upsetting. So when I hear about it happening... I have a lot of feelings of anger and feelings of fear for the woman.*

### **Asking the Question**

The participants were at various levels in their readiness to work with abused women. Some felt very comfortable asking their clients if they were abused, while others were still developing that level of comfort. Most participants felt it was reasonable to address the concerns of a new mother during a home visit and bring the conversation around to the point of asking her about issues of power and control in her intimate relationship. Participants' comfort in asking clients if they had been abused increased with experience and the development of a personal approach. Many found it helpful to embed the question in a statement about the prevalence of abuse in order to assure the client that she was not being singled out based on the nurse's a priori knowledge of her situation:

*I just always thought it was a touchy subject. It was something that women would be insulted by... So I started having to develop my own narrative, basically, so I would feel comfortable with asking a question... You need to feel comfortable that it is okay to ask.*

While most participants agreed that the question needed to be asked, a few had concerns about prioritizing screening for woman abuse above other health concerns that might arise during the home visit. These participants worried that clients might have distressing immediate issues, such as difficulties with breastfeeding, that would prevent them from wanting to talk about interpersonal abuse. As one participant commented, "If breastfeeding is the focus or something else is the focus, then sometimes there is not that opportunity because I don't want it to be a checklist of my agenda versus hers."

A few participants felt insufficiently prepared to ask clients about abuse. For some this feeling reflected their own comfort level with the topic, while for others it reflected their perceived lack of sufficient knowledge or skill to manage a disclosure of abuse:

*I'm not sure why, but I am a bit fearful. It goes back to...my feeling of maybe not being able to be helpful. I think that's sort of my greatest fear — that you ask the question but then what do you do with that?*



### ***Bearing Witness to the Stories of Abuse***

An emotionally challenging part of working with abused women was witnessing disclosures of abuse. As previously noted, for the nurse this can be a distressing experience evoking intense feelings, ranging from fear for the safety of her client and herself, to anger, frustration, worry, helplessness, and doubt about her professional ability. The following comment captures the degree of suffering that bearing witness can entail: "There was one weekend after I heard the majority of her story, I just didn't function. I didn't. Every time I thought about her I just cried."

For some PHNs who had already experienced woman abuse personally, a client's disclosure triggered stressful memories. One nurse described having difficulty separating her biography from her client's life: "I had to consciously tell myself, 'This is her story, it's not mine'."

However, a number of participants who were experienced in working with abused women discussed the rewards of their work. They were honoured that the women were prepared to share their stories with them and did not feel traumatized by their clients' situations: "I just admire these women and respect them so much... I feel very privileged and I often tell them that they are my heroes. They are."

Many participants described various self-care strategies they used to help manage the stress involved in their work with abused women. These strategies ranged from debriefing with a close colleague, manager, or partner to physical activities such as running and participating in activities outside of work such as gardening or enjoying time with their children. The strategies described were self-initiated by the participants.

### ***"Walking with" the Woman Who Has Been Abused***

One participant described her role in working with abused women as "walking with" her clients: "I have to sort of walk with her instead of drag her where she doesn't want to go." This eloquently captures the process that most of the participants experienced in their work: a moving forward, slipping backward progression that mirrored the process that the abused women experienced in coming to terms with their situation. This could be frustrating for a nurse whose instinct was to save her client and who defined success as the moment when her client left the abusive relationship. However, experienced participants felt their clients must make decisions for themselves; these nurses viewed their clients' steps towards personal growth as a mark of success.

More experienced nurses also defined an important part of their role as providing a bridge to other services. As one participant noted, this process can take place over time and the actual use of those services may never become known to the nurse during the period of her involvement with the abused woman:

*When you think about woman abuse, they can be involved in that for years, but there will be a point — and it may not be with you and it may be 5 years later or it may be a month later — that they are really able to make some movement for themselves.*

### **Professional Development Suggestions**

Participants identified professional development opportunities that could serve to increase their comfort level in working with abused women. A number of participants wanted to learn more effective ways of asking the question and handling disclosures from other professionals. Some wanted more opportunities for mentoring and debriefing support from their colleagues and managers. Finally, others indicated they wished to learn more about community resources such as shelters and counselling services so they could tell their clients exactly what to expect:

*Just more understanding of what the different resources in the community do. You know they are available and you know the agencies can be contacted, but...what concrete things do they do to help these women?*

We have described a number of steps the participants appeared to take in becoming comfortable working with abused women; these included coming to terms with abuse, asking the question, bearing witness, and walking with the client. Participants appeared to be at various stages in working through these steps and, as a result, at various levels of readiness to work with abused women. Experience appeared to be the greatest influence in helping nurses to become comfortable in their role.

### **Discussion**

Public health nurses were influenced and shaped by their work with abused women. The PHN and the client each drew on their own life experiences and each was affected by their relationship with the other. The process PHNs described in becoming comfortable working with abused women appeared to parallel their clients' process of working through the abusive relationship. While the client was struggling to understand her situation, the PHN beginning to work with abused women was often struggling with a number of issues, including coming to terms with abuse, learning how to ask the question, how to bear witness, and how to support the abused client. The literature focuses on the process that abused women traverse and tends to assume that the role of the health-care provider is static. Our findings clearly refute this idea and offer important implications for the training and support of PHNs, and potentially other health-care providers as well.

We observed a continuum of experience in the PHNs interviewed. For PHNs working with women in abusive relationships, experience and skill development took time. Their skills were enhanced not by their years of general nursing experience but, rather, their experience working directly with abused women. It should be noted that our notion of a continuum of experience does not imply a simple hierarchy. Continuum is a two-dimensional concept, and while it can be usefully applied to describe the continuum of expertise itself, it does not adequately capture the process of becoming an expert. We found that the PHNs' journey of gaining experience was not linear and required fluidity of response. For example, more experienced PHNs did not stop learning and growing, although their lessons differed from those of the inexperienced PHN.

In her book *From Novice to Expert*, Patricia Benner identifies different levels of nursing competence based on the Dreyfus model (Benner, 1984). The five levels of competence — novice, advanced beginner, competent, proficient, and expert — reflect three general changes in performance over time. The first is a movement from reliance on abstract principles to the use of past concrete experiences. The second change involves the learner's perception of the situation; the situation is seen less and less as a compilation of equally relevant bits and more and more as a whole in which certain parts are more relevant. The third is a passage from detached observer to involved performer, whereby the nurse no longer stands outside but is fully engaged in the situation.

While we did not attempt to locate our participants on this continuum, the Dreyfus model (Benner, 1984) broadly captured the differences among the participants in terms of their readiness to screen for and deal with woman abuse in their practice. Novice nurses working with abused women might focus on asking the questions and on the logistics of what, where, when, and how asking the question may affect their relationship with the client. Their interventions might tend towards attempting to rescue the woman by leading or urging her to get out of the situation before she is ready to do so. A competent nurse would engage in considerable conscious, abstract analysis of the problem in order to help the woman cope and manage the situation effectively. The expert nurse, in contrast, has an intuitive grasp of the situation and proceeds calmly and confidently. Expert nurses would also have well-developed self-care strategies that allow them to function well in the work that they have chosen.

The potential impact of different levels of competence on nursing practice was demonstrated in the participants' descriptions of bearing witness to their clients' stories of abuse. Witnessing the disclosure of abuse

evoked a range of feelings, from fear for the client's safety, doubt in their own professional ability, and triggering of stressful memories, to honour and respect for the abused woman. Dickson and Tutty (1996), in their study with PHNs, found similar descriptions of intensively negative emotions. They used a standardized measure to rate nurses' responses to a hypothetical home visit to an abused woman with a newborn baby. However, they did not report the positive responses that were described by some of our participants. In our study, novice and expert PHNs appeared to differ both in the degree and in the type of emotion they experienced and how they were able to manage it. Expert PHNs had well-developed self-care strategies, whereas novice PHNs appeared to be more at risk of suffering the effects of *vicarious trauma*, whereby the nurse empathetically engages with the client's story and becomes both a witness to and a participant in it (Pearlman & Maclan, 1995).

Differences were also observed between novice and expert PHNs in their ability to "walk with" a client. Learning to walk with the client appeared to involve a redefinition of success. The more inexperienced PHN often wanted to take control of the client's situation and defined success primarily as helping a woman to leave the abusive relationship. In contrast, the experienced PHN defined success in terms of her client's personal growth over time. Similarly, one paper describes emergency practitioners, both physicians and nurses, as being inclined towards action approaches that assume "leaving a relationship is the only solution to a clear-cut problem" (Kramer, 2002, p. 197). The author goes on to state that "health care providers need to relinquish their need to 'fix it' and shift the goal of intervention toward understanding where the woman is at presently, not where they want her to be" (p. 197).

More experienced PHNs seem to have already redefined success; they focus on gaining the trust of their clients and being a supportive presence in their lives. They tend to express the view that their objective is not necessarily to remove a woman from an abusive relationship but to guide her in identifying a healthy relationship, in recognizing patterns of power and control, and in making her own decisions. This finding mirrors Lutz's (2005) conclusion that abused women do not "expect or want health care providers to fix their situation" (p. 151).

The findings of our study support three main areas of focus that are relevant to clinical practice: (1) professional development opportunities, (2) supportive mentorship/debriefing, and (3) undergraduate nursing education. In each of these areas, information addressing the key themes of this study should be addressed: coming to terms with abuse, asking the question, bearing witness to stories of abuse, and "walking with" the client as she copes with the abusive situation.

Professional development opportunities need to be developed to support PHNs in becoming comfortable working with abused women. Furthermore, these training opportunities need to acknowledge that skill development in screening for abuse is a non-linear process that changes over time and increases with experience. The participants indicated that professional development opportunities could increase their confidence when working with abused women. Other researchers have found that providers' confidence in their abilities to assess and assist abused women significantly influenced their screening behaviour (reported in Stayton & Duncan, 2005). In addition to formal educational opportunities, PHNs could be supported through dialogue with other professionals to learn more effective ways of asking the question and handling disclosure. Some participants in our study indicated that they also wanted to learn more about community resources such as shelters and counselling services. We propose that agencies collaborate on educational opportunities. In this way, staff of community organizations and PHNs would have the opportunity to share their experiences, exchange their viewpoints, and make formal linkages to support each other's role.

A second area of focus would be to increase opportunities for PHNs to receive mentoring and debriefing support from their colleagues and managers. Considering the variability in PHNs' comfort and experience in working with abused women, the role of the manager is critical to support the work of all PHNs in this field. In addition, skilled peers could be assigned to lead support circles for those PHNs who are new to the field. PHNs need to know that they will be supported in learning new skills. They also need to know that they have permission to grapple with the challenging and emotionally fraught area of woman abuse. In some instances, PHNs may never become comfortable with screening for woman abuse, due to such issues as vicarious trauma. Organizations must be able to identify and support these PHNs without imposing negative professional consequences.

Inclusion of screening for woman abuse in undergraduate nursing curricula is strongly recommended. This would be an opportunity to raise awareness of the magnitude and potential health outcomes of this issue. Some clinical faculty may not be comfortable or experienced with woman abuse screening and response. Therefore, strong leadership within nursing education is needed to develop learning opportunities for both students and faculty to ensure that the topic is addressed and basic interviewing and skill development started. As well, leaders will need to provide discussion forums about how and when to introduce this topic within the curriculum, in collaboration with clinical placement partners who have moved forward with policies on screening for woman abuse. Collaboration with health units, outpatient clinics, and shelter system

agencies may provide the necessary support for both faculty and students as they study the current research about woman abuse. Mentoring and support for students is essential to their future confidence and skill development as they begin to effectively inquire about women's lived experiences of abuse.

Finally, PHNs need to know that their actions may not bring immediately tangible results. Other studies with abused women have found that even though a turning point might have been her point of contact with a care provider, that provider may not have been aware of the critical role he or she played. The process of change is complex and time-consuming, while the provider's involvement may be time-limited (Rhodes & Levinson, 2003). Mentoring and skill development for PHNs must acknowledge this "invisible" aspect of their work and provide recognition for raising awareness of power and control issues, labelling abuse, and providing a link to community resources for their clients.

### ***Limitations and Future Study***

The data collected may have been affected by the timing of collection. Interviews were conducted shortly after the introduction of a new abuse screening protocol. Because the interviewer was also an employee of the organization, some people may have been reluctant to come forward. However, there were no obvious signs that this was an issue, and the participants provided a wide range of responses.

One observation from our research that requires further study is the impact that bearing witness to abuse may have on PHNs who themselves have experienced or witnessed abuse. In the field of rape and sexual assault, many studies have focused on the experiences of professionals who work with women recovering from sexual violence (Campbell & Wasco, 2005; Schauben & Frazier, 1995; Wasco & Campbell, 2002). However, few studies have been done with nurses screening for interpersonal violence. One study calls for more research in this area and does suggest that "nurses with a personal history of abuse and those working with abused women need a source of psychological support" (Moore, Zaccaro, & Parsons, 1998, p. 181). One review article cites six studies that identify this aspect of nursing (Early & Williams, 2002). In general, however, these studies focus on whether or not the nurse's history of abuse affected the care provided to the abused client rather than on nurse well-being.

Finally, as this study was exploratory in nature, more research is needed in this area. Furthermore, it would be important to determine whether PHN experiences are similar to the experiences of other types of nurses and health professionals.

## Conclusion

In summary, our study reveals that nurse readiness is as important a factor in screening for woman abuse as client readiness. Indeed, both the PHN and the client seemed to traverse a parallel process of coming to readiness. We found that the role of the PHN was not static and PHNs were affected by their relationship with their clients. Most of the literature focuses on the evolution of the client. Our study adds an understanding of the journey undertaken by a PHN in becoming comfortable with screening for abuse. We have described the journey as coming to terms with abuse, asking the question, bearing witness, and, finally, “walking with” the client. In addition, as the PHN grew increasingly comfortable working with abused women, she came to redefine success as more than leaving the abusive relationship.

Woman abuse is a serious social and health concern in Canada. PHNs and other health-care providers are increasingly called upon to screen for and provide care to women experiencing interpersonal violence. The work of nursing this social wound is complex and uncertain. Public health units must attend to these unique needs and recognize that PHNs’ knowledge about and level of comfort in working with abused women changes with experience. Managers and educators need to provide learning opportunities through professional development, mentoring and debriefing opportunities, and undergraduate nursing curricula in order to support PHNs who work with abused women.

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