

EDITORIAL

Reviewing Peer Review: The Three Reviewers You Meet at Submission Time

Tongue firmly in cheek, we can talk about three roles that reviewers tend to assume — diviner, goalie, and coach. All reviews are useful to us as editors in some respect, but their contributions are distinct.

The first reviewer category is the diviner. He or she has expertise that the editors usually do not, either in the subject matter or in the methods described in a paper. The diviner arrives at a judgement — “thumbs up” or “thumbs down” (worthy of publication or not) and may be more or less cryptic about the basis for that assessment. The diviner asks three questions: Is this good work? Will it be good for the journal? Will it be good for the discipline? The diviner serves primarily as a counsellor to the editors. At their best, diviners use unique “insider” knowledge of a field. Sometimes this entails making a subjective call about whether a paper’s approach, perspective, or conclusions have merit or are interesting without delving too much into the details of the actual methods or data. (Non-researchers usually contribute to reviews in this way.) Diviners may, with their extensive knowledge of a specialized area of the literature, offer the best hope for journal editors to avoid becoming party to duplicate publication or scientific fraud. However, a careless diviner gives material only the most casual reading before reaching a conclusion and can be dead wrong about the contributions of a paper that takes a fresh look at a phenomenon.

The second role played by many (perhaps most) reviewers is that of goalie, trying to keep poor scholarly work out of the literature and holding high the bar for scientific publication. While diviners tend to get a global “feel” for a paper and make their assessments of suitability from there, goalies tend to be more rule-based in their attempts to keep scholars honest. They scrutinize the text for sound use of research methods, help to ensure that authors follow the conventions of reporting — including the all-important principles of making methods, results, and discussion distinct and providing enough methodological detail to enable readers to determine whether the findings actually speak to the working hypotheses. They’ll also cry foul (and appropriately so) when the discussion does not clearly distinguish conjecture from fact, overstates findings,

or fails to cite relevant work by other scholars. However, critique can be overdone and can even turn nasty.

The third role that reviewers assume is that of coach, helping both the author and the editor to ensure that only the best possible version of a manuscript (including the best science possible) appears in print. The coach offers specific, detailed feedback. Sometimes the coach makes a call that a particular manuscript is playing “out of its league” (the author is either rushing publication or has chosen an unsuitable journal in which to publish his or her work). Short of rewriting the paper, the coach asks pointed questions of the author, which leads to a rephrasing and reframing of the paper’s message. Clearly, coaching demands a great deal of sophistication and skill that may take years to master. One long-time reviewer has described the developmental process of becoming a coach as one of initially writing reviews to impress editors, to relaying the details of papers they would have written had they been in the authors’ shoes, to, ultimately, drafting collegial and focused reviews (Romanelli, 1996). Another scholar has written that reviewers tend to evolve over time, from seeing themselves as gatekeepers, to being participants in a dialogue with authors and editors, to, ultimately, being activists or coaches (Meyer, 1996). Scholars may reserve their critical eye and their time for reviewing the work of students and colleagues they know firsthand (a service to the literature and the profession in and of itself, to be sure). But some scholars take on this role for authors they do not know personally, by serving as blind reviewers.

Making the Most of Peer Review and the Contributions of the Three Extreme Types

A journal’s reputation ultimately hinges on the quality of the work that appears in its pages. Getting a critical mass of “good” submissions to begin with and then having an effective peer-review process that helps sort manuscripts and makes good papers even better are critical to the usefulness of the literature to the discipline and to the profession.

The best reviews succinctly summarize the contribution of a manuscript and immediately help the editor to determine whether it is within one revision/rewrite of being publishable by identifying what exactly needs to be done to make it acceptable. It bears repeating that reviewers are not the final authority on the fate of a paper. For reviewers, this can be either comforting (by easing the pressure) or distressing (by prompting some deeper questions about what the reviewer’s role really is and how much power the reviewer really wields).

A great review makes clear distinctions among issues that are “huge” (intractable and fatal conceptual and methodological flaws that can be

resolved only by redoing the study), “major” (requiring serious revisions, perhaps also involving data re-analysis), “medium-sized” (requiring a rewriting of sections), and “small” (requiring editing, minor additions or deletions). Of some use to editors, nonetheless, are reviews that are brief and short on detail but essentially correct in their judgement.

Along with all of the detailed comments one can make about the components of a research report, an evaluation with supporting data is critical. There are a couple of personal evaluative questions that reviewers should ask themselves: Is this an article I would cite in my own work? Is this an article I would recommend to my colleagues or students, because of either the importance of its findings or the quality of its reporting? A good reviewer will include justifications for his or her answers to such questions. Copious suggestions for line editing are rarely helpful and, if they replace deeper analysis, can be most frustrating for editors and authors alike. In the end, if we are not prepared to be coaches, or have little time to write coaching reviews, some blend of the diviner and goalie roles usually produces reviews that are the most useful for editors.

Evidence-Based Peer Review?

Classic and current research in both the social and the biomedical sciences (Fiske & Fogg, 1990; Godlee & Jefferson, 2003) shows that different reviews of the same paper tend to vary a great deal in terms of their substance and conclusions. An obvious implication is that editors need to synthesize reviewers’ observations and comments along with their own in order to reach decisions about the disposition of papers. Here at *CJNR*, we read reviews very carefully. Certainly we are swayed by uniformly negative or positive reviews from all the reviewers of a specific paper. However, our editorial decisions are based at least partially on our own reading of a manuscript. Sometimes we find ourselves reaching conclusions that differ from those of one or more of the reviewers in terms of a manuscript’s contribution to our editorial mission or the extent to which it can or cannot be salvaged.

Again, detail — as opposed to length — helps both the editors and prospective authors immensely. For authors, broad comments about “unscholarly” or “poorly informed” work are not useful, but comments that, for instance, point to a disconnect between the conceptual frame of a study and the variables actually measured can lead to meaningful revision. Very harsh reviews that mention no positive aspects of a piece of work or that attack the author’s competence or integrity are emotionally hard on authors — and usually require revising at our offices before being sent out. Reviewers and authors alike should be aware that not every comment or suggestion made by a reviewer must be acted upon

but that all feedback provided must be responded to. We are not suggesting aggressive “pushback” on reviewer critiques, but authors should know that if a reasonable argument can be advanced for leaving a particular aspect of a paper alone they are free to say so. As editors, we seek “good faith” efforts to appropriately revise manuscripts in line with reviewer and editor feedback. Collegial suggestions by reviewers increase the odds of collegial responses from authors — and the odds of better papers appearing in print.

Who writes good reviews? In selecting reviewers, the best choices are, at least in theory, authors of published work in the same field or of research that has used similar methodology. The next choices (and we must often turn to them) are well-informed individuals with less personal experience and/or publishing track records (such as graduate trainees, postdoctoral fellows, and junior faculty). Despite the huge stock we place in peer review, we actually know very little, empirically speaking, about the peer-review process, including reviewer selection (Godlee & Jefferson, 2003). Reviewer experience, methodological training, and past performance are all remarkably weak predictors of the quality of any particular review.

Although we do not know whether formal training and orientation to the reviewer role actually improve review quality, it seems unethical not to at least offer information and tools to orient and focus reviewers. For their part, new reviewers should carefully read the materials they are given about the role and should seek out opportunities to become as well informed as possible about the peer-review process. Experienced reviewers should not feel constrained by the lists of questions about particular formats that we suggest to new reviewers. They can and should feel free to make precise but short evaluations of the highest-order problems they see in a manuscript. Just as seasoned authors should never assume that their work cannot be improved upon, seasoned peer reviewers should never assume that the quality of their reviews cannot benefit from feedback and reflection on the purpose of the review process.

Some Final Thoughts

We receive submissions from scholars at a wide range of stages in their careers. It is a particular source of pride at *CJNR* that we offer a welcoming but challenging platform for nurse scholars making a first submission to the peer-reviewed scientific literature. We also arrange for experienced authors to get interesting and thought-provoking feedback on their work that strengthens their contribution to the literature.

Journals ask a great deal of reviewers in terms of time and intellectual energy. What we offer in return is a mechanism for reviewers to help

control the quality of the process of sharing knowledge and the shaping of the discourse in the field, because journal reviewers have a subtle but unmistakable impact on the discipline.

We tend to let many aspects of peer review drift into the background, because we see reviewing and receiving reviews as an imperfect but inescapable part of life as a scientist. But all of us involved in the process really need to read about, reflect on, talk about, and write about peer review and its successes and shortcomings. This will not only improve the process at individual journals and in nursing as a whole, but also, in the long run, help to create a system that gives us the kinds of reviews we ourselves would want to receive.

Sean P. Clarke
Associate Editor

References

- Fiske, D. W., & Fogg, L. (1990). But the reviewers are making different criticisms of my paper! Diversity and uniqueness in reviewer comments. *American Psychologist*, *45*(5), 591–598.
- Godlee, F., & Jefferson, T. (Eds.). (2003). *Peer review in health sciences* (2nd ed.). London: BMJ Books.
- Meyer, A. D. (1996). Balls, strikes and collisions on the base path: Ruminations of a veteran reviewer. In P. J. Frost & M. S. Taylor (Eds.), *Rhythms of academic life: Personal accounts of careers in academia* (pp. 275–282). Thousand Oaks, CA: Sage.
- Romanelli, E. (1996). Becoming a reviewer: Lessons somewhat painfully learned. In P. J. Frost & M. S. Taylor (Eds.), *Rhythms of academic life: Personal accounts of careers in academia* (pp. 263–267). Thousand Oaks, CA: Sage.

Guest Editorial and Discourse

A Further Celebration of Nursing Research in Violence

Jacquelyn C. Campbell and Angela Henderson

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, Walturmaurer, 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.

References

- Abdool Q, Karim. (2001). Barriers to preventing human immunodeficiency virus in women: Experiences from KwaZulu-Natal, South Africa. *Journal of the American Medical Women's Association*, 56(4), 193–196.
- Anderson, S., McClain, N., & Riviello, R. (2006). Genital findings of women after consensual and nonconsensual intercourse. *Journal of Forensic Nursing*, 2(2), 59–65.
- Burgess, A. W., & Holmstrom, L. L. (1974). Rape trauma syndrome. *American Journal of Psychiatry*, 131(9), 981–986.
- Campbell, J. C. (2002). Violence against women and health consequences. *Lancet*, 359(9314), 1331–1336.
- Campbell, J. C., Coben, J. H., McLoughlin, E., Dearwater, S., Nah, G., Glass, N. E., et al. (2001). An evaluation of a system-change training model to improve emergency department response to battered women. *Academic Emergency/Medicine*, 8, 131–138.
- Campbell, J. C., Garcia-Moreno, C., & Sharps, P. (2004). Abuse during pregnancy in industrialized and developing countries. *Violence against Women*, 10(7), 770–789.
- Campbell, J. C., Kub, J., Belknap, R. A., & Templin, T. (1996). Predictors of depression in battered women. *Violence against Women*, 9, 99–111.
- Campbell, J. C., & Parker, B. (1999). Clinical nursing research on battered women and their children: A review. In A. S. Hinshaw, S. L. Feetham, & J. L. F. Shaver (Eds.), *Handbook of clinical nursing research* (pp. 535–559). London: Sage.
- Campbell, D., Sharps, P. W., Gary, F., Campbell, J., & Lopez, L. (2002). African American women and domestic violence. *Online Journal of Nursing Issues*, 7(1), Manuscript #4.
- Campbell, J. C., Snow-Jones, A., Dienemann, J., Kub, J., Schollenberger, J., O'Campo, P., et al. (2002). Intimate partner violence and physical health consequences. *Archives of Internal Medicine*, 162, 1157–1163.
- Campbell, J. C., & Soeken, K. S. (1999a). Forced sex and intimate partner violence: Effects on women's health. *Violence against Women*, 5(9), 1017–1035.
- Campbell, J. C., & Soeken, K. (1999b). Women's responses to battering over time. *Journal of Interpersonal Violence*, 14(1), 21–40.

- Campbell, J. C., Webster, D., Koziol-McLain, J., Block, C. R., Campbell, D., Curry, M. A., et al. (2003). Risk factors for femicide in abusive relationships: Results from a multi-site case control study. *American Journal of Public Health, 93*, 1089–1097.
- Campbell, J. C., Woods, A. B., & Laughon, K. (2005). Impact of intimate partner abuse on physical and mental health: How does it present in clinical practice? In G. Roberts, K. Hegarty, & G. Feder (Eds.), *Intimate partner abuse and health professionals: Old problems, new approaches*. Oxford: Elsevier.
- Choi, K. H., Binson, D., Adelson, M., & Catania, J. (1998). Sexual harassment, sexual coercion and HIV risk among US adults 18–49 years. *AIDS and Behavior, 2*, 33–40.
- Coker, A. L., Davis, K., Arias, I., Desai, S., Sanderson, M., & Brandt, H. (2002). Physical and mental health effects of intimate partner violence for men and women. *American Journal of Preventive Medicine, 23*(4), 260–268.
- Davila, Y. R., & Brackley, M. H. (1999). Mexican and Mexican American women in a battered women's shelter: Barriers to condom negotiation for HIV/AIDS prevention. *Issues in Mental Health Nursing, 20*(4), 333–355.
- Department of Health and Human Services. (2000). *Healthy people 2010* (2nd ed.). *With understanding and improving health and objectives for improving health* (2 vols.). Washington: Author.
- Department of Health and Human Services. (2001). *Women's health issues: An overview*. Washington: Office on Women's Health.
- Dunkle, K., Jewkes, R., Brown, R., Gray, G., McIntyre, J., & Harlow, S. (2004). Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. *Lancet, 363*, 1415–1421.
- El-Bassel, N., Gilbert, L., Krishnan, S., Schilling, R., Gaeta, T., Purpura, S., et al. (1998). Partner violence and sexual HIV-risk behaviors among women in an inner-city emergency department. *Violence and Victims, 13*(4), 377–393.
- Feerick, M., & Silverman, G. (Eds.). (2006). *Children exposed to violence*. New York: Paul H. Brookes.
- Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study [see comments]. *American Journal of Preventive Medicine, 14*(4), 245–258.
- Frye, V., Hosein, V., Walturmauer, E., Blaney, S., & Wilt, S. (2005). Femicide in New York City: 1990–1999. *Homicide Studies, 10*.
- Fulmer, T. L., McMahon, D., Baer-Hines, M., & Forget, B. (1992). Abuse, neglect, abandonment, violence and exploitation: An analysis of all elderly patients seen in one emergency department during a six-month period. *Journal of Emergency Nursing, 18*(6), 505–510.
- Garcia-Moreno, C., & Watts, C. (2000). Violence against women: Its importance for HIV/AIDS prevention. *AIDS, 24*(3), S253–S265.
- Gielen, A. C., McDonnell, K. A., Burke, J. G., & O'Campo, P. (2000). Women's lives after an HIV-positive diagnosis: Disclosure and violence. *Maternal and Child Health Journal, 24*(2), 111–120.

- Gielen, A. C., O'Campo, P., Faden, R. R., & Eke, A. (1997). Women's disclosure of HIV status: Experiences of mistreatment and violence in an urban setting. *Women and Health*, 25(3), 19–31.
- Gilbert, L., El-Bassel, N., Rajah, V., Foleno, J., Fontdevila, V., Frye, et al. (2002). The converging epidemics of mood-altering drug use, HIV, HCV, and partner violence: A conundrum for methadone maintenance treatment. *Mount Sinai Journal of Medicine*, 67(5/6), 452–463.
- Greenfeld, L. A., Rand, M. R., Craven, P. A., Klaus, C. A., Perkins, C. A., & Ringel, C. (1998). *Violence by intimates: Analysis of data on crimes by current or former spouses, boyfriends and girlfriends*. Bureau of Justice Statistics Factbook. Washington: Department of Justice, Bureau of Justice Statistics, March, NCJ 167237.
- Greenwood, G. L., Relf, M. V., Huang, B., Pollack, L. M., Canchola, J. A., & Catania, J. A. (2002). Battering victimization among a probability-based sample of men who have sex with men (MSM). *American Journal of Public Health*, 92(12), 1964–1969.
- Heise, L. L., Ellsberg, M. C., & Gottemoeller, M. (1999). Ending violence against women. *Population Reports*, 27, 1–43.
- Hinshaw, A. S., Feetham, S. L., & Shaver, J. L. F. (Eds.). (1999). *Handbook of clinical nursing research*. London: Sage.
- Humphreys, J. C., Campbell, J. C., & Parker, B. P. (2001). Intimate partner violence against women. In D. Taylor & N. Fugate-Woods (eds.), *Annual review of nursing research* (pp. 275–306). New York: Springer.
- Humphreys, J., Lee, K., Neylan, T., & Marmar, C. (2001). Psychological and physical distress of sheltered battered women. *Health Care for Women International*, 22, 401–414.
- Institute of Medicine, National Research Council. (2001). *Confronting chronic neglect: The education and training of health professionals on family violence*. Washington: National Academy Press.
- Jewkes, R., Levin, J., Mbananga, N., & Bradshaw, D. (2002). Rape of girls in South Africa. *Lancet*, 26(359)(9303), 319–320.
- Jones, A. S., Campbell, J. C., Schollenberger, J., O'Campo, P. J., Dienemann, J. A., Gielen, A. C., et al. (1999). Annual and lifetime prevalence of partner abuse in a sample of female HMO enrollees. *Women's Health Issues*, 9(6), 295–305.
- Kitzman, H., Olds, D. L., Sidora, K. J., Henderson, C. R., Hanks, C., Cole, R., et al. (2000). Enduring effects of nurse home visitation on maternal life course: A 3-year follow-up of a randomized trial. *Journal of the American Medical Association*, 283(15), 1983–1989.
- Maman, S., Campbell, J., Sweat, M., & Gielen, A. (2000). The intersections of HIV and violence: Directions for future research and interventions. *Social Science and Medicine*, 50(4), 459–478.
- Maman, S., Mbwambo, J., Campbell, J. C., Hogan, M., Kilonzo, G. P., Weiss, E., et al. (2002). HIV-1 positive women report more lifetime experiences with violence: Findings from a voluntary HIV-1 counseling and testing clinic in Dar es Salaam, Tanzania. *American Journal of Public Health*, 92(8), 1331–1337.

- Maman, S., Mbwapbo, J., Hogan, N. M., Kilonzo, G. P., & Sweat, M. D. (2001). Women's barriers to HIV-1 testing and disclosure: Challenges for HIV-1 voluntary counseling and testing. *AIDS Care, 13*, 595–603.
- McCauley, J., Kern, D. E., Kolodner, K., Dill, L., Schroeder, A. F., DeChant, H., et al. (1997). Clinical characteristics of women with a history of childhood abuse: Unhealed wounds. *Journal of the American Medical Association, 277*, 1362–1368.
- Mirsa, D. (Ed.). (2001). *The women's health data book: A profile of women's health in the United States*. (3rd ed.). Washington: Jacobs Institute of Women's Health and the Henry J. Kaiser Family Foundation.
- Mitchell, C. (Ed.). (In press). *Medical response to intimate partner violence*. London: Oxford University Press.
- Nauman, P., Langford, D., Torres, S., Campbell, J., & Glass, N. (1999). Women battering in primary practice. *Family Practice, 16*, 343–352.
- Outwater, A., Abrahams, N., & Campbell, J. C. (2005). Women in South Africa: Violence and HIV/AIDS, intersections and prevention. *Journal of Black Studies, 35*, 135–154.
- Parker, B., McFarlane, J., Soeken, K., Silva, C., & Reel, S. (1999). Testing an intervention to prevent further abuse to pregnant women. *Research in Nursing and Health, 22*, 59–66.
- Plichta, S. B. (1996). Violence and abuse: Implications for women's health. In M. K. Falik & K. S. Collins (Eds.), *Women's health: The Commonwealth Fund Survey* (pp. 237–270). Baltimore: Johns Hopkins University Press.
- Price, P. J. (1996). *The effect of intimate partner abuse, daily stress and social support on infant birth weight in African American mothers*. Unpublished doctoral dissertation, Wayne State University.
- Relf, M. V. (2001). Battering and HIV in men who have sex with men: A critique and synthesis of the literature. *Journal of the Association of Nurses in AIDS Care, 12*(3), 41–48.
- Rennison, C., & Planty, M. (2003). Nonlethal intimate partner violence: Examining race, gender, and income patterns. *Violence and Victims, 18*(4), 433–443.
- Rennison, C., & Welchans, S. (2000). *Intimate partner violence*. Bureau of Justice Statistics Special Report. May, NCJ 178247. Washington: Department of Justice, Bureau of Justice Statistics.
- Schollenberger, J., Campbell, J., Sharps, P. W., O'Campo, P., Carlson, A., Dienemann, J., et al. (2003). African American HMO enrollees: Their experience with partner abuse and its affect on their health and utilization of medical services. *Violence against Women, 9*(5) 599–618.
- Sharps, P. W., & Campbell, J. C. (1999). Health consequences for victims of violence in intimate relationships. In X. Arriaga & S. Oskamp (Eds.), *Violence in intimate relationships* (pp. 173–180). Thousand Oaks, CA: Sage.
- Sharps, P. W., Campbell, J. C., Campbell, D. W., Gary, F., & Webster, D. (2001). The role of alcohol of alcohol use in intimate partner femicide. *American Journal of Addictions, 10*(2), 1–14.

- Sommers, M. S., Zink, T., Baker, R. B., Fargo, J. D., Weybright, D. J., Porter, J., et al. (2006). Effects of age and ethnicity on physical injury from rape. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, *35*, 199–207.
- Thompson, N. J., Potter, J. S., Sanderson, C. A., & Maibach, E. W. (2002). The relationship of sexual abuse and HIV risk behaviours among heterosexual adult female STD patients. *Child Abuse and Neglect*, *21*, 149–156.
- Tjaden, P., & Thoennes, N. (2000). *Extent, nature and consequences of intimate partner violence: Findings from the National Violence against Women Survey*. NCJ 181867. Washington: US Department of Justice.
- Torres, S., Campbell, J. C., Campbell, D. W., Ryan, J., King, C., Price, P., et al. (2000). Abuse during and before pregnancy: Prevalence and cultural correlates. *Violence and Victims*, *15*(3), 3033–322.
- US Department of Labor, Occupational Safety and Health Administration. (2004). *Guidelines for preventing workplace violence for healthcare and social service workers*. OSHA #3148. Washington: Author.
- Walton-Moss, B. J., Manganello, J., Frye, V., & Campbell, J. C. (2005). Risk factors for intimate partner violence and associated injury among urban women. *Journal of Community Health*, *30*, 377–389.
- Whetten, K., Leserman, J., Lowe, K., Stangel, D., Theilman, N., Swartz, M., et al. (2006). Prevalence of childhood sexual abuse and physical trauma in an HIV positive sample from the Deep South. *American Journal of Public Health*, *96*, 1028–1030.
- Wingood, G. M. (2001). Adverse consequences of intimate partner abuse among women in non-urban domestic violence shelters. *American Journal of Preventive Medicine*, *19*(4), 270–275.
- Wingood, G. M., & DiClemente, R. J. (1997). The effects of an abusive primary partner on the condom use and sexual negotiation practices of African-American women. *American Journal of Public Health*, *87*, 1016–1018.
- Wingood, G. M., DiClemente, R. J., Harrington, K., Lang, D., Davies, S., Hook, E. W., et al. (2006). Efficacy of an HIV prevention program among female adolescents experiencing gender-based violence. *American Journal of Public Health*, *96*, 1085–1090.
- Wisner, C. L., Gilmer, T. P., Saltzman, L. E., & Zink, T. M. (1999). Intimate partner violence against women: Do victims cost health plans more? *Journal of Family Practice*, *48*(6), 439–443.
- Woods, A. B., Page, G., O'Campo, P., Pugh, L., Ford, D., & Campbell, J. C. (2005). The mediation effect of post-traumatic stress disorder symptoms on the relationship of intimate partner violence and IFN- γ levels. *American Journal of Community Psychology*, *36*, 159–175.
- Wyatt, G. E., Myers, H. F., Williams, J. K., Ramirez-Kitchen, C., Loeb, T., Vargas-Carmona, J., et al. (2002). Does a history of trauma contribute to HIV risk for women of color? Implications for prevention and policy. *American Journal of Public Health*, *92*(4), 660–665.
- Zierler, S., Witbeck, B., & Mayer, K. (1996). Sexual violence against women living with or at risk for HIV infection. *American Journal of Preventive Medicine*, *12*, 304–309.

Jacquelyn C. Campbell, PhD, RN, FAAN, is Anna D. Wolf Chair and Professor, School of Nursing, Johns Hopkins University, Baltimore, Maryland, United States. Angela Henderson, PhD, RN, is Associate Professor and Associate Director, School of Nursing, University of British Columbia, Vancouver, Canada.

Commentary

Violence and Health: The Challenges of How We Talk About, Conceptualize, and Address Violence

Jean Hughes

This issue of *CJNR* recognizes violence as a multifaceted, complex threat to health, in which environmental factors, biology, social response, and social situation all play a role. This is particularly true of family-related violence. Given such complexity, it is not surprising that research in the field has moved slowly. A number of obstacles stand in the way of its progress in terms of how we talk about, conceptualize, and address violence.

Perhaps the most fundamental difficulty for violence research is the lack of a common language within the field (National Institutes of Health, 2004). Without a common language it is not clear whether terms such as abuse, maltreatment, aggression, and hostility are synonyms or are elements of a typology of violence. Further, without a clear definition, individual words can carry several meanings, as in the case of “bullying,” which, as Tremblay (2006) points out, can be thought of as both an *indicator of violence* and a *precursor to violence*.

The absence of a common language leads to a second challenge — that of fully conceptualizing violence in terms of its predictors, trajectories, influencing factors, and outcomes. In the absence of a comprehensive model, violence is often thought of in narrow terms — for example, by type, without consideration of other issues, such as degree or extent of maltreatment (Paz, Jones, & Byrne, 2005). These myopic views have, until recently, hampered the movement of violence research into areas such as genetics (Dionne, Tremblay, Boivin, Laplante, & Perusse, 2003) and the brain (Weaver et al., 2004). Likewise, narrow thinking has, until lately, prevented researchers from examining how these factors might work in combination — for example, by investigating the interaction of genetics and the environment (Caspi et al., 2002).

The challenge of conceptualizing violence leads to a third problem, and perhaps the most complex — how best to address violence? Such a challenge contains two areas of concern: finding the right treatment, and finding the right way to deliver it. On the first point, while there is evidence that specific targeted interventions (e.g., parenting programs) address target behaviours (e.g., nurturing behaviours), it is unclear that proven interventions provide positive outcomes in the local community similar to those achieved under research conditions where they were developed (Chinman et al., 2005). Further, it is becoming increasingly obvious that such interventions alone are insufficient to alleviate the multifaceted problems of violence (e.g., Hughes & Gottlieb, 2004). A much broader range of supports (e.g., social, educational, and health care services) may be necessary.

Recent reviews (e.g., Statham, 2004) have argued that children living with/or experiencing abuse need a holistic, multi-agency approach and intensive, targeted support within a framework of universal programs. While many clinicians in the field would concur with the spirit of this position, few researchers have tested the effects of combined interventions. This may be because such approaches are fraught with complications, involving conceptualization, operationalization, instrumentation, consistency, measurement, and data-collection strategies that can affect the nature, quality, and accuracy of data (Edens & Douglas, 2006; Jones, Cross, Walsh, & Simone, 2005). Further, not much is known about how best to *combine* strategies (Chinman et al., 2005). Specifically, we understand very little about the optimal ways of *prioritizing* or *sequencing* the different targeted supports. We have done little to identify the types of *universal* programs that would be useful, when they should be offered to maltreated families in need of multiple supports (e.g., parenting, housing, and mental health services), or whether their effects continue over time.

There is growing evidence to support the use of parent training for families who have abused their children (Tomlinson, 2003). However, these short-term targeted interventions are thought to need further long-term, wrap-around supports to address relationship problems, depression, low self-esteem, harmful substance use, and financial problems. Yet there is little evidence available to answer the questions: What services provide the best *wrap-around support* for a wide range of needs? Should they be generic or specialized? How and when should they be offered? Can needy families effectively accommodate interventions designed to address substance use and financial matters at the same time?

Such questions raise the second research problem regarding how to address violence: How best to deliver the treatment? What are the best ways to bring together different services, from different sectors, with different agendas (e.g., adult mental health services and child protection)

in order to work towards common goals (Bell, 2001; Jones et al., 2005; Kerwin, 2004; Sloper, 2004)? Partnerships present numerous challenges (political, financial, logistical, etc.) that have received little attention from researchers (Hughes, Sommerfeld, & Kay-Raining Bird, 2005). In addition, research has generally failed to explore critical issues such as a community's capacity to deliver multiple services to families living with violence, or the effects of different situational factors within a community on the effectiveness of interventions. We have also generally ignored the varying impact of multiple services on a family when delivered in different ways — for example, either as disconnected services or as coordinated or integrated services through team efforts (Chinman et al, 2005; Sloper).

Clearly, while much progress has been made in the field of violence research, how we talk about, conceptualize, and address violence presents problems for continued advancement. Like violence itself, these are complex research challenges whose resolution calls for the collaboration of a broad range of stakeholders (policy-makers, clinicians, agencies, etc.) rather than researchers working alone (Chinman et al., 2005; Spoth & Greenberg, 2005). Violence research can no longer be carried out in isolation. The time has come to build strategic partnerships and map out much more relevant, partnership-based research agendas.

References

- Bell, L. (2001). Patterns of interactions in multidisciplinary child protection teams in New Jersey. *Child Abuse and Neglect*, 25, 65–80.
- Caspi, A., McClay, J., Moffitt, T., Mill, J., Martin, J., Craig, I., et al. (2002). Role of genotype in the cycle of violence in maltreated children. *Science*, 297, 851–854.
- Chinman, M., Hannah, G., Wandersman, A., Ebener P., Hunter, S. B., Imm, P., et al. (2005). Developing a community science research agenda for building community capacity for effective preventive interventions. *American Journal of Community Psychology*, 35(3/4), 143–157.
- Dionne, G., Tremblay, R., Boivin, M., Laplante, D., & Pérusse, D. (2003). Physical aggression and expressive vocabulary in 19-month-old twins. *Developmental Psychology*, 39(2), 261–273.
- Edens, J. F. & Douglas, K. S. (2006) Assessment of interpersonal aggression and violence: Introduction to the special issue. *Assessment*, 13(3), 221–226.
- Hughes, J., & Gottlieb, L. (2004). The effects of the Webster-Stratton Parenting Program on maltreating families: Fostering strengths. *Child Abuse and Neglect*, 28(10), 1081–1097.
- Hughes, J., Sommerfeld, D., & Kay-Raining Bird, E. (2005). Collaboration: You can talk the talk, but can you walk the walk? *IMPRint* (Newsletter of Infant Mental Health Promotion, Department of Psychiatry and Community

- Health Systems Resource Group, Hospital for Sick Children, Toronto), 43 (Fall), 9–11.
- Jones, L., Cross, T., Walsh, W., & Simone, M. (2005). Criminal investigations of child abuse: The research behind “best practices.” *Trauma, Violence, and Abuse*, 6(3), 254–268.
- Kerwin, M. L. (2005). Collaboration between child welfare and substance-abuse fields: Combined treatment programs for mothers. *Journal of Pediatric Psychology*, 30(7), 581–597.
- National Institutes of Health. (2004). *Preventing violence and related health-risking social behaviors in adolescents: An NIH state-of-the-science conference*. Available online: <http://consensus.nih.gov/2004/2004YouthViolence-PreventionSOS023html.htm>
- Paz, I., Jones, D., & Byrne, G. (2005). Child maltreatment, child protection and mental health. *Current Opinion in Psychiatry*, 18(4), 411–421.
- Sloper, P. (2004). Facilitators and barriers for co-ordinated multi-agency services. *Child: Care, Health and Development*, 30(6), 571–580.
- Spoth, R. L., & Greenberg, M. T. (2005). Toward a comprehensive strategy for effective practitioner-scientist partnerships and larger-scale community health and well-being. *American Journal of Community Psychology*, 35(3/4), 107–126.
- Statham, J. (2004). Effective services to support children in special circumstances. *Child: Care, Health and Development*, 30(6), 589–598.
- Tomlinson, B. (2003). Characteristics and evidence-based child maltreatment intervention. *Child Welfare*, 82(5), 541–569.
- Tremblay, R. (2006). Prevention of youth violence: Why not start at the beginning? *Journal of Abnormal Child Psychology*, 34(4), 480–486.
- Weaver, I. C. G., Cervoni, N., Champagne, F. A., D’Alessio, A. C., Sharma, S., Seckl, J. R., et al. (2004). Epigenetic programming by maternal behavior. *Nature Neuroscience*, 7(8), 847–854.

Jean Hughes, RN, PhD, is Associate Professor, School of Nursing, Dalhousie University, and Department of Psychiatry, IWK Health Centre for Women, Children and Families, Halifax, Nova Scotia, Canada.

Analyse descriptive des expériences vécues par les réfugiées victimes de violence en temps de guerre

**Helene Berman, Estella Rosa Irías Girón
et Antonia Ponce Marroquín**

Même si les femmes se retrouvent rarement sur la ligne de front en temps de guerre, elles en subissent néanmoins les conséquences de façon disproportionnée, comme c'est le cas dans plusieurs autres sphères de la vie contemporaine. Celles qui ont connu la guerre sont nombreuses à avoir subi la torture ou été témoins d'actes de torture ou de meurtre infligés à des proches et à des amis. Le recours au viol ainsi qu'à d'autres formes de torture sexuelle est un fait attesté par de nombreux témoignages. Les femmes forcées de fuir leur foyer et leur pays se voient souvent obligées de se séparer de leur conjoint, de leurs enfants et des autres membres de leur famille. Le nombre de réfugiés et de déplacés ne cesse de croître en raison de l'ampleur même des conflits dans le monde : on estime que les femmes en représentent plus de la moitié. La présente étude avait pour but de décrire l'expérience de réfugiées qui ont été victimes de violence dans le cadre d'une guerre. Huit thèmes se dégagent des données recueillies : la transformation d'une vie à jamais; de nouvelles conceptions de la normalité; un sentiment de peur permanent; la perte d'identité; l'impression de vivre à cheval entre les cultures; la place de la femme au Canada; le sentiment de porter un lourd fardeau - le rôle central des enfants; l'indifférence des intervenants de la santé. Les auteures examinent les implications de l'étude pour la recherche et la pratique, soulignant les limites des approches individualisées suivies en Occident.

Mots clés : réfugiées, femmes, guerre, violence, santé

A Narrative Study of Refugee Women Who Have Experienced Violence in the Context of War

Helene Berman, Estella Rosa Irías Girón,
and Antonia Ponce Marroquín

Although women are rarely on the frontlines of battle, as in many other realms of contemporary life they bear a disproportionate burden of the consequences of war. Many have experienced torture firsthand or been witnesses to the torture or killing of family, friends, and loved ones. The use of rape and other forms of sexual torture has been well documented. For those who are forced to flee their homes and countries, separation from spouses, children, and other family members is common. Because of the sheer magnitude of global conflict, the number of refugees and displaced persons throughout the world has risen exponentially. It has been estimated that women constitute more than half of the world's refugee population. The purpose of this narrative study was to examine the experiences of refugee women who experienced violence in the context of war. Data analysis revealed 8 themes: lives forever changed, new notions of normality, a pervasive sense of fear, selves obscured, living among and between cultures, a woman's place in Canada, bearing heavy burdens – the centrality of children, and an uncaring system of care. Implications for research and practice, including limitations associated with individualized Western approaches, are discussed.

Keywords: Refugees, women, war, violence, trauma, narrative, health

Introduction

Although women are rarely on the front lines of battle, as in many other realms of contemporary life they bear a disproportionate burden of the consequences of war. Many have experienced torture firsthand or been witnesses to the torture or killing of family, friends, and loved ones. The use of rape and other forms of sexual torture has been well documented (Bourke, 2006; Drumbl, 2000; Hynes, 2004; Liebling, 2003; Moussa, 1998; Nikolic-Ristanovic, 2000; Young, 1997). For those who are forced to flee their homes and countries, separation from spouses, children, and other family members is common. Because of the sheer magnitude of global conflict, the number of refugees and displaced persons throughout the world has risen exponentially. It has been estimated that women constitute more than half of the world's refugee population, a scenario that has led Apfelbaum (2000) to suggest that we live in an *era of uprooting*.

For refugee women, the usual responsibility to care for, protect, and nurture their families never stops. Despite the premigration atrocities they may have endured, they are still expected to carry out their “mothering.” The disproportionate burden carried by refugee women, and the unique challenges they face, have received growing attention in recent years. However, theoretical understanding remains sparse and few programs have been developed that are responsive to the needs of these women. The purpose of this narrative study was to investigate the experiences of refugee women who have lived through violence in the context of war before migrating to Canada. Three research questions were addressed: *What experiences of premigration trauma have immigrant and refugee women had before arriving in Canada? How do premigration experiences influence current everyday life among refugee and immigrant women? What do refugee and immigrant women perceive as helpful or unhelpful in their interactions with health and social service providers?* It was expected that the knowledge gained from this study could be used to offer recommendations for the provision of nursing care to refugee women that takes into account the intersecting realities of their lives.

The Policy Context for Refugee Women in Canada

In order to understand the sociopolitical status of refugee women in Canada, it is worth considering key documents that have informed policy and legislation over the past decade. Two papers, *Not Just Numbers* (1997) and *Building on a Strong Foundation for the Twenty-First Century: New Directions for Immigration and Refugee Policy and Legislation* (Citizenship and Immigration Canada, 1998), provided the framework for the passage of the *Immigration and Refugee Protection Act* (IRPA) (2001). With an emphasis on “human capital,” the expectations and requirements for entry into Canada stipulated within these reports and by the IRPA are extremely restrictive. Entry would be granted only to those individuals who have high levels of formal education, are capable of supporting themselves or resettling in 12 months (in the case of refugees), speak at least one official language or have the ability to learn it quickly, are relatively young, are in excellent health, and exhibit the ability to adapt quickly and successfully to Canadian culture. Notably absent is attention to emotional trauma, imposed isolation, lack of a supportive social network, sexism, racism, and ethnocentrism. In a critique of *Not Just Numbers*, Arat-Koc (2000) observes that the paper is “a product of anti-immigrant, anti-refugee, and racist sentiments” (p. 18), especially with respect to newcomers from non-traditional source countries. Arat-Koc asserts that the report’s recommendations overlook the most disadvantaged group of immigrants and refugees, namely poor women and women of colour, and, moreover, that the document lacks a gender-based

analysis in its recommendations and “fails to acknowledge and address existing bias and discrimination against women in the immigration and refugee system” (p. 18).

Women and children are among those most adversely affected by these guidelines. Many refugee women have limited access to formal education, language courses, jobs that might provide them with needed skills, and financial resources. The fact that women are often victims of rape and other forms of intimate partner violence, while a large number of children suffer malnutrition and other health problems in the refugee camps, though well established, is essentially ignored in these documents. Finally, the *New Directions* recommendation to dissolve the Live-In Caregiver Designated Class, “the one predominantly female immigration stream,” and incorporate it into the Temporarily Highly Skilled Foreign Workers Class seems to be an attempt to leave more space for a male-centred flow of human capital (Hyndman, 2000, p. 9). These facts make the report’s stipulations not only controversial but unrealistic. Despite significant concerns with current policies, several positive initiatives have been undertaken in an effort to include women’s needs and voices in the international agenda. For example, the Canadian Immigration and Refugee Board’s decision to adopt the *Guidelines on Women Refugee Claimants Fearing Gender-Related Persecution* in 1993 represents an important effort to acknowledge the lived realities of refugee women. As well, the proposed policy direction that the Family Class criteria be broadened to include persons in common-law and same-sex relationships is commendable. However, we need more inclusive criteria that “explicitly recognize women’s rights as human rights and incorporate human rights abuses directed at women and children including sexual violence, domestic violence, and sex slavery” (Arat-Koc, 2000, p. 22). In the absence of explicit recognition of the distinct forms of abuse experienced by women and children, the net effect is policy that privileges men over women and that relegates the needs and welfare of women and children to the fringes of immigration and citizenship legislation.

Literature Review

This literature review examines research that is relevant to an understanding of the experiences of refugee women. It includes studies related to premigration experiences, including rape and other forms of sexual torture carried out in the context of war, and postmigration experiences and resettlement. The review is a result of database searches in the fields of nursing, sociology, anthropology, and psychology. Because much of the current knowledge regarding the responses of refugee women to wartime

trauma is derived from research using the concept of posttraumatic stress disorder (PTSD), several critical issues are identified.

Premigration Experiences

Before coming to Canada, refugee women are typically exposed, directly or indirectly, to a range of premigration atrocities. During the war in Bosnia, many women knew that their husbands were being beaten and tortured while held in concentration camps; although they did not witness the beatings, they saw the aftermath — the physical and emotional scars — and were deeply traumatized, and forever changed, by the events (Weine et al., 2004; White-Earnshaw & Misgeld, 1996). Similar experiences have been described in research with women from Mozambique (Sideris, 2003), Iraq (Laban, Gernaat, Komproe, Van der Tweel, & De Jong, 2005), Ethiopia (Fenta, Hyman, & Noh, 2004), and El Salvador (Zentgraf, 2002).

Many refugee women spend months or even years in refugee camps in their own or neighbouring countries. Although women in these camps are safe from the bombing and gunfire, they often experience sexual or physical abuse, lack of food, inadequate health care, isolation, and severe emotional trauma (Cardozo, Talley, & Crawford, 2006). Commenting on refugee camps, Crisp (2001) notes the lack of funding from the United Nations High Commission for Refugees and the failure to promote sustainability and development in these communities, thus promoting a cycle of dependency for the aid recipients. Shanks and Schull (2000) write about the occurrence of gender-based violence in refugee camps, asserting that the perpetrators of violence are often the peacekeepers, who have coerced women to engage in sexual activity in return for food (Black, 1998; Hynes, 2004).

Much of the research related to the experiences of women exposed to war has focused on the incidence of PTSD. In their study of the patterns of psychological distress among Salvadoran women refugees, Bowen and colleagues (1992) found that more than 50% of the participants exhibited PTSD symptoms, including recurrent and intrusive recollections, dreams, flashbacks, and intense feelings associated with the event; 41% met the diagnostic criteria for PTSD. The authors conclude that “there may be a high incidence of PTSD among the general population in El Salvador, with particularly traumatic effects on women” (p. 271). Similarly, Eytan and colleagues (2004) report that, among a sample of Kosovar refugees, 23.5% suffered from PTSD, with higher rates among females.

With respect to women refugees in the host countries, PTSD may be exacerbated by “long-standing conditions of social illegitimacy, powerlessness and violence” (Farias, 1991, p. 179). When the stress of alienation is coupled with family disruption, unemployment, inability to speak

either official language of the host country, and lack of social support, women may experience “a sense of personal disarray” (p. 186). These findings are supported by those of Gafner and Benson (2001), who report that PTSD hampers the ability of Central American refugees to integrate into the host society.

Sexual torture, assault, and rape in warfare. Rape and other forms of sexual violence against women occur in times of war and peace. In warfare, however, the brutality and acceptability of rape are escalated by the fact that “in the eyes of the rapist, the woman is the enemy” (Nikolic-Ristanovic, 2000, p. 48). In a study conducted in Sierra Leone, women in 94% of the households surveyed had experienced wartime “rape, torture, and/or sexual slavery” (Hynes, 2004). The use of rape as a weapon of war has also been clearly documented in studies with refugees from the Balkans (Nikolic-Ristanovic) and Mozambique (Sideris, 2003).

The way in which women experience wartime rape is exacerbated by the patriarchal values ingrained in society and amplified by what Hynes calls the “culture of war.” Sideris (2003) observes that gender discourses tend to lay the main responsibility for sexual integrity on women as the bearers of culture. For example, after the mass rape of women in Rwanda, the combined pressure of Roman Catholic values and social norms dictating that children of militiamen be rejected and considered “lixo” (rubbish) resulted in women giving birth in secret and abandoning their babies (Sideris).

According to Nikolic-Ristanovic (2000), during wartime “women’s bodies become a battlefield where men communicate their rage to other men, because women’s bodies have been the implicit political battlefields all along” (p. 63). Aron, Corne, Fursland, and Zelwer (1991) discuss the sociopolitical context of sexual abuse with respect to Guatemalan and Salvadoran refugee women. They delineate the differences between institutionalized (wartime) and non-institutionalized (peacetime) sexual assault. In state terrorism, sexual violence and rape are gender-specific and are seen as a means of annihilating the political opposition. Rape becomes a normal act, carried out to gain social control on behalf of the collectivity. The assailants are not punished because their acts are considered to be politically motivated. The authors note, not surprisingly, that refugee women often avoid speaking about sexual torture and rape for fear of losing whatever support they might have, not being believed, or, ironically, being blamed.

The shortcomings of the international human rights laws and their failure to adequately protect women’s rights have been addressed by numerous human rights advocates (Copelon, 1999; Malone, 1996; Pratt & Fletcher, 1994; Walton-Roberts, 2004). In recent years, efforts have been made to have rape included as a form of torture in the Tribunal

Statute under the Geneva Conventions and in the United Nations Torture Convention more explicitly. To date, rape has been mostly implied or very broadly presented in the legislation, and the only article in the Statute that explicitly identifies rape as a crime is Crimes against Humanity, Article 5 (Copelon, 1999). While Canada has shown some leadership by recognizing gender-based persecution and using gender guidelines since 1993, the devastating physical and psychological consequences of rape need to be included in the legislation.

Postmigration Resettlement

Many researchers have described the multiple losses that refugees face following migration to a new country. Prominent among these are the loss of homeland, loss of family members, loss of language, and loss of culture and its values (Forbes Martin, 2004; Jiwani, 2001; Momartin, Silove, Manicavasagar, & Steel, 2004; Warriner, 2004). Zabaleta (2003) writes of the suffering among refugee women who have lost their professional and personal identity, exacerbated by government policies that effectively restrict them to housekeeping and childrearing activities.

Resettlement is considered particularly stressful for women who have been separated from their families (Franz, 2003). Simich (2003) explores the supportive roles that the extended family can play in refugees' resettlement and notes that the ability to re-establish social networks and shared cultural experiences is critical. According to Beiser (1999), changing gender roles within the family heightens the sense of marginalization and depression among refugee women.

Seu (2003) conceptualizes the barriers to successful adjustment as either societal or individual. The societal barriers include racial, sexual, and cultural discrimination. Seu observes that xenophobia, cynicism, and the stereotyping of refugees are often internalized among citizens of host countries. From Seu's perspective, derogatory labelling and treatment of refugees is a defensive mechanism by which citizens avoid social responsibility for human rights abuses and express feelings of righteous indignation.

Culture shock and the relegation to minority-group status contribute to women's isolation and sense of displacement. The language barrier constitutes another significant impediment for refugee women and is one of the main obstacles to finding employment (Warriner, 2004). Language programs for newcomers in Canada are largely underfunded, and where courses are available refugee women who have suffered trauma may experience memory and concentration problems, making the task of learning a new language exceedingly difficult (Warriner).

Underemployment is another significant stressor in the lives of refugee women (Beiser, 1999). In her research with Bosnian refugee

women, Franz (2003) found that many accepted low-paying, low-skill jobs so as not to “upstage” their husbands; in this way, traditional gender roles were reinforced and sustained. In research with women from El Salvador, Zentgraf (2002) observed that work outside the home is not new to many refugee women and often gives them confidence and a sense of autonomy.

In sum, refugee women who have experienced violence in the context of war face a multitude of premigration and postmigration challenges. While much of the research related to this population has focused on the incidence of PTSD, several researchers have questioned the validity and relevance of the PTSD construct with respect to refugees from non-Western countries (Bracken, 1998; Friedman & Jaranson, 1994; Muecke, 1992). According to these researchers, PTSD is a diagnostic label established among individuals from Western societies who had experienced trauma and subsequently applied to refugees from non-Western countries. While they admit that all individuals display some similar symptoms, Friedman and Jaranson point out that “ethno cultural differences in the expression of traumatic stress may not conform to the diagnostic criteria for PTSD” (p. 215). Thus, the ethnocentricity and narrowness inherent in the PTSD model might affect our ability to fully comprehend the meaning of trauma in the lives of refugee women. Further, Salis Gross (2004) argues that the concept of trauma is often threatening to refugees, as the acceptance of the trauma discourse may undermine their experiences as victims of human rights violations, forcing them to accept a label in order to achieve legal status in the host country.

Research Methods

A narrative research design was used to address the research questions. Although narrative research embraces many theoretical approaches, several assumptions are shared. One of these is consensus on the pervasive nature of stories and storytelling. Under this assumption, human beings are storytelling organisms who, individually and socially, lead storied lives. Although storytelling has historically been accorded a marginal position in research, it has emerged as an approach with considerable potential (Berman, 2000; Dossa, 2004).

All of the women took part in an individual interview, conducted in an informal manner that encouraged dialogue and reflection. Thus, the semi-structured interview guide developed for this research was used flexibly and consisted of open-ended questions on aspects of the women’s lives before, during, and after migration to Canada. The interviews were conducted by two of the authors in either English or

Spanish. The Spanish interviews were translated using the “back translation” method. All interviews were audiotaped and transcribed verbatim. The interviews lasted approximately 2 hours and were conducted at a location chosen by the participants, usually in a quiet room in their place of residence. Ethics approval was obtained from the Health Sciences Human Subjects Review Board of the University of Western Ontario prior to data collection.

Data were analyzed using methods suggested by Mishler (1986) and Riessman (1993). These entailed re-transcribing sections of text that appeared to take a narrative form, thus establishing the boundaries of the narratives; reduction to the core narrative; and analysis of the core narrative. A qualitative computer program was used in the coding and sorting of data. By attending to the context and content of the narratives, we attempted to create a “conversational space” through reflexive listening and reading. Our challenge was to listen to the voices of the women in ways that allowed us to capture their “lived realities” while simultaneously understanding how these realities are shaped by dominant social and political systems.

Upon completion of the interviews, all participants were invited to attend a focus group during which emerging themes were shared, discussed, and revised. Six of the women took part in this process. In addition, an invitational community forum was held with health and social service providers, community stakeholders, policy-makers, and most of the study participants.

Sample

Sample size was determined according to the criterion of saturation, meaning that that sampling was discontinued when no new themes emerged from the interviews. The final sample consisted of nine women: three from Bosnia, three from Guatemala, two from El Salvador, and one from Chile. The women from Central and South America had arrived in Canada during the 1980s, those from Bosnia in the 1990s. One participant had not completed high school, six had undergraduate degrees, and one had postgraduate university education. All of the women had respected professions before arriving in Canada. Included were two teachers, one doctor, one psychologist, one clerk, one nurse, and one artist. None of the women were able to practise their profession in Canada as their academic credentials and professional experiences were not recognized or validated. Four women returned to school and earned new degrees. The others, after years of being underemployed and holding low-paying jobs, managed to achieve what they considered a respectable lifestyle. Some were still trying to gain social acceptance and a sense of belonging within Canadian society.

Findings

The women described traumatic experiences that included both direct and indirect exposure to violence. It was evident that their experiences of pain and suffering were shared equally, regardless of whom the trauma was directed at. For these women, life would never be the same. In this presentation of the findings, all names are pseudonyms.

Violence of War in the Lives of Women

Before coming to Canada, all of the Central and South American participants had been involved in various forms of social action. Their efforts included the seemingly innocuous activity of participating in labour unions, literacy programs, teachers' associations, and health reforms. However, in the social and political context of their countries, such activities targeted them as subversives. Paula, a participant from El Salvador, recalled an incident involving her husband, a teacher. He had attended a teachers' union meeting to plan activities for the school year when helicopters began to encircle the region. The army captured 40 teachers, including Paula's husband, and took them to a clandestine jail where they were imprisoned and tortured for 15 days. Later, the army destroyed their home and burned most of their belongings. According to Paula, people in the city who were in any way associated with human rights organizations were viewed as a threat and forced underground. The outcome of being found was typically persecution and/or death.

Virtually all of the women acknowledged that, in addition to the violence of war per se, other forms of violence — physical, sexual, and/or emotional — became an integral part of their lives. Many stated that they knew women who had been raped or that they had been sexually abused themselves. Although the incidents occurred long before, in some cases as much as 20 years, their accounts were clear and detailed. One woman described an incident in Guatemala when she was 15 years old:

[The soldiers] yelled at me and forced me out of the shower. They did not allow me to get dressed and with the butt of their bayonets were pushing me. They made me give them a tour of the house as they ransacked it and then took me naked out of the house... I yelled at the maid to ask for help, but she fled. The neighbours closed their doors and I felt so scared and infinitesimal. I was almost 16 years old.

Miriam recalled an incident in Chile when soldiers prodded her and a group of women anally using electrical wires while swearing and threatening to "screw" them. Some of the women were physically assaulted and others verbally harassed about the "firmness and appearance" of their "butts."

Frequently, the women's homes were invaded by strangers who would interrogate them and raid their homes before leaving. Raquel recognized this tactic as a form of torture. She described an incident during which soldiers invaded and ransacked her house while interrogating her about her husband. After they left, Raquel began to comprehend the enormity of the danger she and her husband were in, firmly believing that they would face torture, and possibly death, if they did not escape.

Lives forever changed. In many instances the wars were perceived to have begun very rapidly and the women's lives were changed suddenly and dramatically. Ariana, from Bosnia, recalled that, without apparent warning, she "woke up in a war, where everybody was trapped in their houses and the entire town was surrounded." Mira, also from Bosnia, had not believed that war in Sarajevo was imminent when she was forced to flee with her two children to Vienna, where they sought refugee status. Her husband stayed behind and fought with the Muslims, although he was not Muslim. Mira did not hear from him for three years. After the war, her family managed to come to Canada, where their lives were once again "turned upside down."

The women described how they were changed emotionally as a result of physical trauma, and noted that these changes, in turn, affected their physical health and well-being. One of the Bosnian women said that her menstrual periods stopped, which she attributed to shock, fear, and stress. After the war, she was unable to conceive a child. Excessive weight loss, malnutrition, and loss of hair and teeth were also described by the women.

All participants shared a deep sense of helplessness knowing that their loved ones were being tortured or were suffering in concentration camps or jail. They described the profound impact that this had on them, stating that witnessing violence was as devastating as having violence inflicted upon themselves:

I saw my cousin be shot at his face. His eyes were open. They shot him on his face! I had a disbelief and questioned why at his face? People that were killed were all neighbours and friends.

A woman who had described her husband's experience of torture and violence while in prison explained that soldiers would take some prisoners outside and stage "mock executions" to instil fear among the others.

The women often had difficulty, not surprisingly, remembering and recounting their stories, either laughing nervously or crying as they reflected on their past. The profound way in which war had altered their lives was particularly evident in the words of one woman: "War changed people, changed minds, changed everything."

New notions of normality. Although most of the women were able to recall life in “better times,” they stated that once war began it became a defining feature of everyday life. Witnessing and experiencing violence became commonplace and “normal.” It became routine to be followed by the “authorities,” to encounter armed soldiers and war machinery in the streets, and to hear the sound of gunfire sporadically both near and distant. The black market flourished, inflation was rampant, and long queues for water, milk, bread, or meat became the norm. According to the participants, the most disturbing aspect of this situation, and a somewhat eerie one, was that it came to represent the usual state of affairs. One woman told of a time when she would hear grenades going off, one at a time, and because the sound was so familiar to her, she knew they came in threes. After the three grenades went off, she would get out her broom and sweep the sidewalk — just as one might clean up any other debris from the streets.

Over time, the toll on the women’s health and well-being became evident. Deprived of electricity, water, and basic medication in the refugee and concentration camps, they developed a variety of infectious diseases. Despite the hardships, the women expressed gratitude that they and their families were alive, even if separated.

Arrival in a New Country: The Influence of War on Everyday Life

The women were asked how their premigration experiences influenced their everyday lives in Canada, upon their arrival and at present. Although they came from different countries, and in different decades, their stories contained many similarities. For all, the sudden nature of their flight and their uprooting and displacement, both geographically and emotionally, were central to the shaping of their lives.

Pervasive sense of fear. Despite the fact that they were now geographically far removed from war, many of the women continued to fear for their own safety and that of their loved ones, some of whom remained in their homelands. The fear was intensified by the Canadian social and political landscape. As refugees, all of the women were required to provide proof of persecution, something that was not always possible. Thus, many lived for years in fear of deportation. As well, they feared being unable to provide for their children, as they seldom had money, jobs, or support networks.

The women expressed fear of being misunderstood, combined with a distrust of people: “I am afraid of talking or disclosing to medical doctors for fear of having a medical record that later could be used against me.” The women from Bosnia spoke of being betrayed by friends and neighbours during the war, explaining that they now found it

difficult to establish trusting relationships, which contributed to their marked sense of isolation.

Selves obscured. Frequently the women reported a loss of the sense of self and identity. The physical and emotional pain they had endured, combined with being in a new country with an unfamiliar language and culture, changed these women. In some cases, they commented that they no longer recognized themselves.

The loss of the lives they had known before coming to Canada had different meanings for the women. Sonia had been a physician in Guatemala but was unable to practise medicine in Canada:

It affects my life, as I do not practise medicine, that for so many years I stayed home and I did not have a status in Canada, certainly all those losses, especially the family and friends that I lost, had an impact on my life and has an impact on my children as well.

Paula added that the loss of her former life greatly affected her everyday life:

I've spent a lot of time living in denial. I was here in Canada, but my mind was somewhere else, and I didn't want to be here.

Raquel continued to question her decision to come to Canada, a country that from her perspective was not particularly welcoming. Paula found herself “constantly thinking about El Salvador, wanting to be there” and stated that she has suffered from depression in recent years. Julia came from El Salvador. She explained that her husband became an alcoholic to “lessen the pain and enable him to talk about everything that happened.” After he stopped drinking he was no longer able to talk openly about his trauma and, after several years in Canada, they divorced.

Among and between cultures. Relocation was a difficult process for all the women. After arriving in Canada they encountered numerous barriers. Some commented that they would never fully identify with Canadian life. Most said that their home represented the quintessence of their culture. It was there that they preserved their customs, habits, values, and traditional way of life. As Paula said, “We live in our own world in our house.”

Many women expressed discontent with the roles they had to accept, especially during their first years of resettlement. Domesticity characterized their daily lives, a stark contrast to the professional lives they had had in their countries of origin. Paula recalled being isolated in the home for 12 years due to family responsibilities and her husband's uncertain legal status. Similarly, one of the Bosnian women, who had been a prominent fashion designer in her country, was dependent on social assistance despite her concerted efforts to find employment. Every woman told a

story of marginalization and seclusion, which deeply affected their lives. Although they were dedicated to their families, the fact that their roles had been restricted to those of mother and wife left them discouraged, pessimistic, and in some cases depressed.

At the time of the interviews, some of the women had been in Canada for almost 20 years. While they recognized Canada as their home, this reality was always associated with a degree of tension and ambivalence. They praised what they viewed as a Canadian valuing of freedom and security but stressed that they would never consider themselves entirely Canadian. Moreover, they criticized what they viewed as racist and xenophobic attitudes and Canada's failure to give racialized communities the recognition and respect they deserve.

***New Roots and Old Connections:
Facilitating the Transition to Life in a New Country***

The women were asked to discuss what had and had not been helpful to them after their arrival in Canada. In their responses, the positive and negative frequently overlapped. The women reported that programs or services that were intended to be helpful were often delivered in such a way that they were in fact unhelpful. All of the women spoke about the importance of having their basic needs met and reconnecting with family members who had arrived before them. Dolores considered herself fortunate because she had relatives already here. Sonia noted that the most difficult aspect of resettlement was having no one with whom to talk about her experiences. Although she found a physician whom she viewed as trustworthy, she was never asked by him, or anyone else, why she was in Canada. These intangible aspects of life seemed to be much more important to the women than material comforts.

A woman's place in Canada. Several women spoke about the availability of services for women, particularly for women who are experiencing abuse. When asked what was helpful to her, Julia spoke about the greater value placed on women here, as compared to Latin America. "Your life as a woman has worth. We do have support." While some women spoke about services for refugee and immigrant women, others had little knowledge of such services. Fatima, a Bosnian woman, spoke about the lack of violence-related services for women in Bosnia:

We don't have so many services [in Bosnia]...a man could beat up his wife and kids and there is no place where they would be really protected, or if he got drunk or something.... Nobody would really bother to help out, only that embarrassment from some neighbours or workplace, but there were no services like this that you could call the police or if you feel threatened in every way. That is something that they [Canadians] have and we [Bosnians] didn't have.

Several women expressed frustration with their financial dependence on their husbands. Their lack of confidence was reinforced by the discrimination they endured and the low status accorded to them as refugee women. Although they were aware that they possessed many skills, the fact that their skills were not recognized made them withdrawn, bitter, and voiceless.

Bearing heavy burdens: The centrality of the children. The participants viewed the academic success of their children as validation for their sacrifices, making them feel that they had not suffered in vain. Although the children did not participate in the study, it appeared that their mothers' expectations of them imposed tremendous responsibility on them. As well, several participants shared their concerns about their children not being accepted socially. One woman from El Salvador spoke about the prejudice her children faced at school, with classmates calling them "native Indians." Mira had lived with her children in three countries over a relatively short period. She said her children were having a difficult time adjusting to the Canadian education system:

When we came here, it was a new language. He [her son] didn't know a word, but having experience from being a stranger in another country, he really gave his best to learn English. But then he lost his working habits here, moving to different schools. I think kids go through changes we are not aware of, not at all. I never, ever thought about my son, how he is coping in his classroom, before I went to teachers' college, when I realized I am the only one among all these people who think I am stupid and ignorant because my English was not as good as theirs.

An uncaring system of "care." Encounters with health-care providers were varied. While a few women told of helpful and compassionate responses, many described attitudes they perceived as condescending, patronizing, and demeaning. These concerns were raised by the women from Central America who arrived in the 1980s as well as by the Eastern European women who had migrated more recently. Several of the Central American women commented that, in their view, resettlement assistance has not changed significantly over the years and health and social service professionals continue to lack understanding of the complex circumstances of refugee women. Some described explicit instances of hostility, racism, or other forms of violence. All indicated that, generally, health professionals showed little interest in learning about what had happened to them, and two participants noted that, in response to their efforts to speak openly with their physicians, they were given antidepressant medication.

Two women told of sexual assaults by physicians during prenatal visits. Paula recounted an incident several years after her arrival. A

physician at a walk-in clinic touched her inappropriately during her first prenatal visit. Too stunned and distressed to do anything at the time, Paula later told her husband what had occurred and subsequently returned to the clinic to inform the chief medical officer. Paula did not know if any action was ever taken against the doctor, but continued to feel a profound sense of violation. Another participant told of a similar experience with a gynecologist. Although she called for her husband, who had been forced to leave the room but was able to stop the abuse as it was occurring, no formal action was ever taken against the physician. In both cases, the women lacked the language skills necessary to articulate what had occurred, as well as information regarding their legal rights; formal action was simply not an option. The women were left with feelings of profound shame and anger that remained with them.

Discussion

The women who participated in this research thoughtfully and sensitively shared stories about their lives, how they were shaped by violence in the context of war, and about their efforts to establish themselves and their families in a new and unfamiliar country. Although the interviews often evoked deeply painful memories, the women repeatedly commented that they welcomed the opportunity to talk. Their need to tell, to bear witness to the horrors of war, is not surprising. Aron (1992) discusses the beneficial effects of *testimonio* for people who have suffered trauma under state-sponsored terrorism. According to Aron, *testimonio* “validates personal experience as a basis for truth and knowledge, and personal morality as a standard for public virtue” (p. 176).

In this study, the narrative interviews provided a vehicle for denouncing the sexual violence perpetrated against the women. Upon completion of the study, a follow-up invitational forum was held. It was attended by most of the women who participated in the research as well as community leaders, public health nurses, social service providers, and policy-makers. The forum served as a “safe space” for the women. They made a public plea for punishment of the perpetrators and called for the establishment of sustainable programs that are responsive to their distinct needs. In *The Blue Room*, Agger (1994) writes about the healing effects of testimony: “private shame can be transformed to political dignity, providing a source of knowledge about the methods of the dictatorship, while healing the wounds inflicted through these methods” (p. 10).

Several of the women in this study spoke about depression. The tendency to medicalize and individualize the “narratives of suffering” is discussed from a critical medical anthropological perspective by Eastmond (2000). According to Eastmond, refugees’ responses are best

analyzed in their own terms and interpretation, situated in the local cultural context of their experience. Like Aron (1992), Eastmond believes that refugee women need to go through the cathartic experience of telling their stories (testimonio) as part of the “meaning-making” process. Further, she asserts that the tendency to label refugee women as “traumatized,” and thus to stigmatize them, diverts their attention from the “more multifaceted definitions of their problems” (p. 81), ultimately hindering the process of healing. She implores health providers to approach human suffering from both clinical and anthropological perspectives in order to broaden their understanding of the refugees’ experiences. This approach contrasts with deeply entrenched Western-based scientific models, which often are unable to yield comprehensive understanding of the needs and concerns of refugee women.

Many of the participants in the study displayed a sense of resignation, saying that they were “just surviving.” The refugee women who arrived several decades ago and those with non-transferable occupational skills were more likely to be isolated in their homes, “stuck” on social assistance, or relegated to unskilled jobs. Although the women had come to Canada with valuable skills, their credentials were not recognized and they found themselves de-skilled and with few prospects. A Guatemalan woman who had been a teacher in her home country reported that, in a private conversation, her ESL teacher had implied that newcomers — refugees in particular — were expected to become manual labourers. As lack of language proficiency was identified as a major barrier to employment, the women realized that they had to make Herculean efforts to overcome the obstacles they encountered every day. Other barriers identified by the women were poor housing, poor health status, lack of proper access to health care and counselling, isolation, rejection, racism and other forms of violence, culture shock, and powerlessness.

The women in the study were cut off from their traditional support systems, from family, friends, and a sense of community, and they had all experienced trauma, directly or indirectly. They felt uprooted, confused, and disconnected. While a few of the women seemed satisfied with the quality of services they received upon arriving, most expressed dissatisfaction with the services provided to them. The general feeling was that, instead of mutually agreeing upon a plan of action, health and service providers assumed the role of “expert” and decided what was in the best interests of the women. The women were disheartened by what they perceived as the patronizing attitudes of service providers, and most expressed the need for greater understanding.

The findings from this research have implications for all health providers. Undoubtedly, the premigration and postmigration experiences of women refugees deeply affect their physical and emotional health and

can have a significant impact on the resettlement process. Many challenges in developing programs for refugee women have been identified. Much of the literature on existing programs is based on American programs that place the emphasis on health and well-being from a biomedical perspective. Many of these programs lack a holistic thrust and instead focus on the physical health of refugees, prioritizing vaccinations and parasite screening (Ford, 1995; Kennedy, Seymour, & Hummel, 1999).

One challenge addressed by both Goodburn (1994) and DeSantis (1997) is the fear and mistrust of refugees who have experienced persecution at the hands of untrustworthy officials. Health providers who rely on a foundation of trust in the relationship face challenges in establishing programs for this group. Most notably, refugees may be reluctant to approach the health-care worker with their specific needs. Therefore, developing trust must be a priority in caring for refugees, whether at the individual or the community level.

We need comprehensive approaches that include examination of societal, institutional, and individual factors that impact on health. The trauma of migration, racism, marginalization, and exclusion, and the dynamics of violence should be considered in tandem with assessment of the health needs of refugee women. Efforts to reduce the women's sense of isolation should be promoted through active outreach strategies and the deployment of public health or community nurses. Fluency in the person's language is a necessity, as is knowledge about the community's social and historical experiences. The unique and very challenging circumstances of refugee women have prompted a movement towards contextualized care. Such care takes into account the intersectionalities of oppression and includes a comprehensive analysis of gender, class, culture, and the political environment (Adams & Assefi, 2002; Atlani & Rousseau, 2000; Gasser, Dresden, Keeny, & Warren, 2000; Guruge & Khanlou, 2004; Jiwani, 2001; Sidieris, 2003; Whittaker, Hardy, Lewis, & Buchan, 2005).

One limitation of this research concerns the nature of the sample. As a group of well-educated women, the participants possessed resources and opportunities that would not be shared by refugee women with less education. Thus, research with refugee women from more varied socio-economic backgrounds would yield more comprehensive understandings. Another limitation is the inclusion of women who had arrived in Canada during two distinct periods. Finally, it might be argued that the inclusion of women from different ethnocultural backgrounds was a limitation. However, we are reluctant to advocate ethnospecific research because of the tendencies in both scholarly and popular media to reinforce unwarranted stereotypes (Dossa, 2004; Jiwani, 2001).

The stories told by the women who participated in this research are just a beginning. From their position in the margins of society, these courageous women do not need nurses or other health professionals to tell them how they should live, or to individualize their problems and deflect attention from the larger social, cultural, and structural barriers they face. Nor do they need medication to lessen the pain. Rather, they need social spaces and networks that can sustain the element of struggle and a belief in the possibilities for change; they need jobs and people to whom they can talk openly and honestly, without fear of retribution or judgement.

References

- Adams, K., & Assefi, N. (2002). Primary care refugee medicine: General principles in the postimmigration care of Somali women. *Primary Care Update for Ob/Gyns*, 9(6), 210–217.
- Agger, I. (1994). *The blue room: Trauma and testimony among refugee women. A psycho-social exploration*. London: Zed Books.
- Apfelbaum, E. R. (2000). And now what, after such tribulations? Memory and dislocation in the era of uprooting. *American Psychologist*, 55, 1008–1013.
- Arat-Koc, S. (2000). NAC's response to the Immigration Legislative Review Report "Not Just Numbers: A Canadian Framework for Future Immigration." *Canadian Woman Studies/Cahiers des Femmes*, 19(3), 18–23.
- Aron, A. (1992). Testimonio: A bridge between psychotherapy and sociotherapy. In E. Cole, O. Espin, & E. Binghamton Rothblum (Eds.), *Refugee women and their mental health: Shattered societies, shattered lives* (pp. 173–189). New York: Harrington Park Press.
- Aron, A., Corne, S., Fursland, A., & Zelwer, B. (1991). The gender-specific terror of El Salvador and Guatemala: Post-traumatic stress disorder in Central American refugee women. *Women's Studies International Forum*, 14(1/2), 37–47.
- Atlani, M., & Rousseau, C. (2000). The politics of culture in humanitarian aid to women refugees who have experienced sexual violence. *Transcultural Psychiatry*, 37(3), 435–449.
- Beiser, M. (1999). *Strangers at the gate: The Boat People's first ten years in Canada*. Toronto: University of Toronto Press.
- Berman, H. (2000). The relevance of narrative research with children who witness war and children who witness woman abuse. *Journal of Aggression, Maltreatment and Trauma*, 3(1), 107–125.
- Black, M. (1998). Girls and war: An extra vulnerability. *People and the Planet*, 7(3), 24–25.
- Bourke, J. (2006). War and violence. *Thesis Eleven*, 86(1), 23–38.
- Bowen, D. J., Carscadden, L., Beighle, K., & Fleming, I. (1992). Post-traumatic stress disorder among Salvadoran women: Empirical evidence and description of treatment. *Women and Society. Special Issue: Refugee Women and Their Mental Health: Shattered Society, Shattered Lives II*, 13(3), 267–280.

- Bracken, P. J. (1998). Hidden agendas: Deconstructing post-traumatic stress disorder. In D. Summerfield et al. (Eds.), *Rethinking the trauma of war*. London: SCE.
- Cardozo, B. L., Talley, L., & Crawford, C. (2004). Karenni refugees living in Thai-Burmese border camps: Traumatic experiences, mental health outcomes, and social functioning. *Social Science and Medicine*, *58*(12), 2637–2644.
- Citizenship and Immigration Canada. (1998). *Building on a strong foundation for the twentieth century: New directions for immigration and refugee policy and legislation*. Ottawa: Minister for Public Works and Services Canada.
- Copelon, R. (1995). Gendered war crimes: Reconceptualizing rape in time of war. In J. Peters & A. Wolper (Eds.), *Women's rights, human rights: International feminist perspectives*. New York and London: Routledge.
- Copelon, R. (1999). Surfacing gender: Reengraving the crimes against women in humanitarian law. In N. Dombrowski (Ed.), *Women and war in the twentieth century: Enlisted with or without consent*. New York and London: Garland.
- Crisp, J. (2001). Mind the gap! UNHCR, humanitarian assistance and the development process. *International Migration Review*, *35*(1), 168–191.
- DeSantis, L. (1997). Building healthy communities for immigrants and refugees. *Journal of Transcultural Nursing*, *9*(1), 20–31.
- Dossa, P. (2004). *Politics and poetics of migration: Narratives of Iranian women from the diaspora*. Toronto: Canadian Scholars' Press.
- Drumbl, M. (2000). Punishment goes global: International criminal law, conflict zones, and gender inequality. *Canadian Woman Studies*, *19*(4), 22.
- Eastmond, M. (2000). Refugees and health: Ethnographic approaches. In F. L. Ahearn Jr. (Ed.), *Psychosocial wellness of refugees: Issues in qualitative and quantitative research*. New York and Oxford: Berghahn Books.
- Eytan, A., Gex-Fabry, M., Toscani, L., Derro, L., Loutan, L., & Bovier, P. (2004). Determinants of post-conflict symptoms in Albanian Kosovars. *Journal of Nervous and Mental Disease*, *192*(10), 664–671.
- Farias, P. J. (1991). Emotional distress and its sociopolitical correlates in Salvadoran refugees: Analysis of a clinical sample. *Culture, Medicine and Psychiatry*, *15*(2), 167–192.
- Fenta, H., Hyman, I., & Noh, S. (2004). Determinants of depression among Ethiopian immigrants and refugees in Toronto. *Journal of Nervous and Mental Disease*, *192*(5), 363–372.
- Forbes Martin, S. (2004). *Refugee women*, 2nd ed. Lanham, MD: Lexington.
- Ford, M. (1995). Innovations in refugee health care. *Caring: The National Association for Home Care Magazine*, *14*(12), 32–35.
- Franz, B. (2003). Bosnian refugee women in (re)settlement: Gender relations and social mobility. *Feminist Review*, *73*, 86.
- Friedman, M., & Jaranson, J. (1994). The applicability of the posttraumatic stress disorder concept to refugees. In A. J. Marsella, T. Bornemann, S. Ekblad, & J. Orley (Eds.), *Amidst peril and pain: The mental health and well-being of the world's refugees*. Washington: American Psychological Association.
- Gafner, G., & Benson, S. (2001). Indirect ego-strengthening in treating PTSD in immigrants from Central America. *Contemporary Hypnosis*, *18*(3), 135–144.

- Gasser, N., Dresden, E., Keeny, G., & Warren, N. (2000). Status of women and infants in complex humanitarian emergencies. *Journal of Midwifery and Women's Health*, 49, 7–13.
- Goodburn, A. (1994). A place of greater safety. *Nursing Times*, 90(24), 46–48.
- Guruge, S., & Khanlou, N. (2004). Intersectionalities of influence: Researching the health of immigrant and refugee women. *CJNR*, 36(3), 2–47.
- Hyndman, J. (2000). Gender and Canadian immigration policy: A current snapshot. *Canadian Woman Studies*, 19(3), 7–10.
- Hynes, H. P. (2004). On the battlefield of women's bodies: An overview of the harm of war to women. *Women's Studies International Forum*, 27(5/6), 431–445.
- Jiwani, Y. (2001). *Intersecting inequalities: Immigrant women of colour, violence, and health care*. Vancouver: FREDa Centre. Available online: <http://www.harbour.sfu.ca/freda/pdf/inequal.pdf>
- Kennedy, J., Seymour, D. J., & Hummel, B. J. (1999). A comprehensive refugee health screening program. *Public Health Reports*, 114(September/October), 469–477.
- Laban, C., Gernaat, H., Komproe, I., van der Tweel, I., & de Jong, J. (2005). Postmigration living problems and common psychiatric disorders in Iraqi asylum seekers in the Netherlands. *Journal of Nervous and Mental Disease*, 193(12), 825–832.
- Liebling, H. (2003). Women's war experiences: Sexual violence and torture during civil war years in Luwero. *Impact*, 4, 22.
- Malone, L. A. (1996). Beyond Bosnia and *In re Kasinga*: A feminist perspective on recent developments in protecting women from sexual violence. *Boston University Law Journal*, 14, 319–341.
- Mishler, E. (1986). The analysis of interview-narratives. In T. R. Sarbin (Ed.), *Narrative psychology: The storied nature of human conduct* (pp. 233–255). New York: Praeger.
- Momartin, S., Silove, D., Manicavasagar, V., & Steel, Z. (2004). Complicated grief in Bosnian refugees: Associations with posttraumatic stress disorder and depression. *Comprehensive Psychiatry*, 45, 475–482.
- Moussa, H. (1998). Violence against refugee women: Gender oppression, Canadian policy and the international struggle for human rights. *Resources for Feminist Research*, 26(3/4), 79.
- Muecke, M. (1992). New paradigms for refugee health problems. *Social Science and Medicine*, 35(4), 515–523.
- Nikolic-Ristanovic, V. (Ed.). (2000). *Women, violence, and war: Wartime victimization of refugees in the Balkans*. Budapest and New York: Central European University Press.
- Not just numbers: A Canadian framework for future immigration*. (1998). Ottawa: Government of Canada.
- Pratt, K. M., & Fletcher, L. E. (1994). The case for international prosecutions of rape and gender-based violence in the former Yugoslavia. *Berkeley's Women Law Journal*, 9, 77–103.

- Riessman, C. K. (1993). *Narrative analysis*. Newbury Park, CA: Sage.
- Salis Gross, C. (2004). Struggling with imaginaries of trauma and trust: The refugee experience in Switzerland. *Culture, Medicine and Psychiatry*, *28*(2), 151–167.
- Seu, B. I. (2003). The woman with the baby: Exploring narratives of female refugees. *Feminist Review*, *73*, 158–165.
- Shanks, L., & Schull, M. J. (2000). Rape in war: The humanitarian response. *Canadian Medical Association Journal*, *163*(9), 1152–1156.
- Sideris, T. (2003). War, gender and culture: Mozambican women refugees. *Social Science and Medicine*, *56*(4), 713–724.
- Simich, (2003). Negotiating boundaries of refugee resettlement: A study of settlement patterns and social support. *Negotiating Boundaries in a Globalizing World*, *40*(5), 575–591.
- Walton-Roberts, M. (2004). Rescaling citizenship: Gendering Canadian immigration policy. *Political Geography*, *23*(3), 265.
- Warriner, D. S. (2004). Multiple literacies and identities: The experience of two women refugees. *Women's Studies Quarterly*, *32*(1/2), 179–195.
- Weine, S., Muzurovic, N., Kulauzovic, Y., Besic, S., Lezic, A., & Mujagic, A. (2004). Family consequences of refugee trauma. *Family Process*, *43*(2), 147–160.
- Whittaker, S., Hardy, G., Lewis, K., & Buchan, L. (2005). An exploration of psychological well-being with young Somali refugee and asylum-seeker women. *Clinical Child Psychology and Psychiatry*, *10*(2), 177–196.
- Young, M. Y. (1997). Bearing witness to the unspeakable. *Women and Therapy*, *20*(1), 23–25.
- Zabaleta, M. R. (2003). Exile. *Feminist Review*, *73*, 19–38.
- Zentgraf, K. M. (2002). Immigration and women's empowerment: Salvadorans in Los Angeles. *Gender and Society*, *16*(5), 625–646.

Authors' Note

This research was supported in part by a grant from the Centre for Research on Violence against Women and Children.

The authors would like to thank the women who shared their stories, research assistants Liana Voia, Sarah Derby, and Susana Caxaj, and the anonymous reviewers for their helpful insights.

Helene Berman, RN, PhD, is Associate Professor, School of Nursing, and Scotiabank Chair, Centre for Research and Education on Violence against Women and Children, University of Western Ontario, London, Ontario, Canada. Estella Rosa Irías Girón, MD, MSW, is Volunteer and Crisis Line Coordinator, Sexual Assault Centre London, and Woman's Support Worker, Native Family Healing Services, At^losha, London. Antonia Ponce Marroquín is Woman Abuse Counsellor, Changing Ways, London.

Autoefficacité des infirmières autorisées travaillant en salle d'urgence en matière d'évaluation et de prise en charge des femmes victimes de violence

Erin Hollingsworth et Marilyn Ford-Gilboe

L'avancement des connaissances au sujet des facteurs qui influent sur l'autoefficacité des infirmières autorisées intervenant en salle d'urgence auprès des femmes victimes de violence ne peut que contribuer à l'amélioration des soins. La présente étude avait pour but d'analyser cette question en rapport avec l'évaluation et la prise en charge. Les questions et les hypothèses de recherche retenues découlent de la théorie de Bandura sur l'autoefficacité. On a d'abord effectué une analyse secondaire ($N = 158$) des données d'une étude intitulée *Violence against Women: Health Care Provider Study*. Même si les questions de l'enquête n'avaient pas été formulées à l'origine dans le but d'opérationnaliser les concepts décrits par Bandura, elles se sont avérées de bons indicateurs. On a ensuite établi quatre échelles à partir du bassin d'éléments recueillis, pour ensuite les valider par une analyse factorielle et les utiliser pour opérationnaliser les variables de l'étude. On a constaté une corrélation positive entre l'information sur l'autoefficacité dont disposaient les infirmières autorisées des services d'urgence et leur autoefficacité réelle en matière d'évaluation et de prise en charge des femmes victimes de violence ($r = .73, p < .001$), leurs attentes et leurs interventions effectives ($r = .55, p < .001$), ainsi que les résultats attendus ($r = .56, p < .001$). Enfin, on a effectué une analyse par régression multiple hiérarchique pour évaluer la mesure dans laquelle l'information et les attentes en matière d'autoefficacité, de même que les résultats attendus, pouvaient permettre de prédire les interventions pratiquées par les intéressées. Le modèle aura permis d'expliquer la variance dans une proportion de 40 %. Les résultats confirment l'utilité de la théorie de Bandura et révèlent une complexité des réactions qui doit être comprise à la lumière de l'autoefficacité et des facteurs qui en favorisent le développement.

Mots clés : femmes victimes d'agression, autoefficacité, services d'urgence

Registered Nurses' Self-Efficacy for Assessing and Responding to Woman Abuse in Emergency Department Settings

Erin Hollingsworth and Marilyn Ford-Gilboe

Enhanced knowledge regarding the factors that influence and support the self-efficacy of emergency department (ED) registered nurses and their provision of care to women who have experienced abuse is necessary for the promotion of optimal health care. The purpose of this study was to examine the self-efficacy of registered nurses with respect to assessing and responding to woman abuse in the ED. Study hypotheses and research questions were derived from Bandura's theory of self-efficacy. A secondary analysis ($N = 158$) of data from the Violence against Women: Health Care Provider Survey was completed. Originally, survey questions were not developed to operationalize the concepts outlined by Bandura. However, they were found to be good indicators. Four scales were developed from the item pool, validated through factor analysis and used to operationalize study variables. Positive relationships were found between self-efficacy information available to ED registered nurses and their self-efficacy for assessing and responding to woman abuse ($r = .73, p < .001$), self-efficacy expectations, and actual clinical responses related to woman abuse ($r = .55, p < .001$) and outcome expectancies related to assessing and responding to woman abuse ($r = .56, p < .001$). Hierarchical multiple regression examined the extent to which self-efficacy information, self-efficacy expectations and outcome expectancies predicted ED registered nurses' clinical responses to woman abuse. Overall, the model explained 40% of the variance in ED registered nurses' clinical responses to woman abuse. Results provide additional support for Bandura's theory and demonstrate that the clinical responses of ED registered nurses are complex and must be understood in terms of self-efficacy and the factors that support its development.

Keywords: woman abuse, self-efficacy, emergency nursing, clinical practice

Introduction

Historically, woman abuse has received little attention, due in part to the widely held public belief that it is a "private" problem. This belief has resulted in widespread societal failure to recognize woman abuse as a legitimate social problem, in addition to a criminal act comparable to any other form of violence (Begin, 1992). Woman abuse is often defined as

— but is not limited to — physical, sexual, psychological, verbal, social, spiritual, and financial abuse occurring in intimate, kin, and dependent relationships (National Clearinghouse on Family Violence, 2006). It is estimated that as many as 23% of Canadian women experience abuse by an intimate partner in any given year (Clark & DuMont, 2003) and that 25% to 30% of Canadian and American women experience physical abuse by an intimate partner at some point in their lives (DeKeseredy & MacLeod, 1997; Johnson & Sacco, 1995). Given that the mental and physical health effects of woman abuse have been well documented (Campbell, 2002; Golding, 1999), interest is increasingly focused on developing appropriate services, including health services, to support women who have been abused. Yet Perley (1992) characterizes health-care agencies, and the professionals who work for them, as “insensitive” to the needs of women who have experienced abuse. Not surprisingly, battered women have identified health professionals as the least effective source of help among formal support systems (Bendtro & Bowker, 1989).

Many national and professional organizations, such as the Family Violence Prevention Fund (2004) and the Registered Nurses’ Association of Ontario ([RNAO], 2005), have advocated for universal screening for woman abuse in health-care settings, despite a lack of definitive evidence of its effectiveness in identifying women who have been abused and responding to their needs (Datner et al., 2004; Wathen & MacMillan, 2003). Universal screening entails the posing, by health professionals, of specific questions regarding abuse to *all* women in order to identify those who have experienced abuse so that support and referral can be initiated (Datner et al.). Beyond the issue of universal screening, Humphreys and Campbell (2004) propose that appropriate clinical responses to woman abuse include assessing the woman’s level of risk and developing a safety plan, conducting a thorough health assessment, identifying personal strengths and support systems, and identifying appropriate goals with the woman in collaboration with other health professionals, in order to provide support. In the absence of widespread organizational support for universal screening, the responsibility for identifying and responding to woman abuse frequently lies with practitioners, including registered nurses.

In Canada, the emergency department (ED) provides the majority of urgent/emergent care, representing an estimated 5.1 million visits in 1999 (Canadian Association of Emergency Physicians, 2004). A meta-analysis conducted by Wilt and Olson (1996) found that the incidence of abuse among American women presenting to the ED is between 4% and 30% for current abuse and 11% to 54% for lifetime abuse. Consistent with US rates, 13.9% of 768 adult women who presented to two Canadian EDs were found to have experienced abuse in the previous

year (Wathen et al., 2006). Thus, the ED is a key setting for identifying and supporting women who have experienced abuse (Davis & Harsh, 2001; Ellis, 1999; Haywood & Haile-Mariam, 1999; Zun, Downey, & Rosen, 2003).

For the ED, providing appropriate care to women who have experienced abuse is often a challenge. This is a fast-paced environment serving patients who vary in gender, age, race, religion, ethnic background, and socio-economic status and who present with a wide range of health problems (Ellis, 1999). Consequently, health professionals who work in the ED must possess broad clinical knowledge and skills and be able to efficiently manage large patient volumes and varying levels of patient acuity. Because women who have experienced abuse may present in a variety of ways, ED staff must be knowledgeable and adaptable in order to identify abuse and respond appropriately. Particular features of the ED, such as limited privacy, long waiting times for non-urgent matters, and lack of continuity of health-care providers, make the ED a less than ideal setting for providing care to women who have been abused. In spite of this, women who have experienced abuse do access the ED for injuries and health problems related to abuse, and, for some, the ED may be their only contact with the health-care system (Dearwater et al., 1998).

In the ED, RNs represent the first contact at triage and often provide the majority of ongoing care (Ellis, 1999), resulting in a unique opportunity for nurses to assist women who have experienced abuse. Research (Davis, & Harsh, 2001; Dearwater et al., 1998; Ellis; Erickson, Hill, & Siegel, 2001; Varvaro & Gesmond, 1997) has documented many barriers to providing appropriate care in the ED to women who have experienced abuse. Little attention has been given to factors that encourage health professionals to integrate appropriate clinical responses into their practice. Self-efficacy, an individual's confidence in his or her ability to enact a specific behaviour, has been consistently identified as a predictor of enacting that behaviour (Gage, Noh, Polatajko, & Kaspar, 1994; Holloway & Watson, 2002; Kuijer & de Ridder, 2003; Parjares, 2002), yet this concept has not been used to understand RNs' self-efficacy for assessing and responding to woman abuse in the ED setting. This study was undertaken to develop such an understanding.

Theoretical Framework and Literature Review

Bandura's (1977, 1997) theory of self-efficacy provides one explanation for individual behaviour. According to Bandura (1977), environmental, behavioural, and cognitive factors work together in a "triadic reciprocal" fashion to influence behaviour, each exerting various levels of influence on behavioural outcomes in specific situations.

Two types of expectations form the foundation of self-efficacy theory: efficacy expectations and outcome expectancies (Bandura, 1977, 1997). An efficacy expectation is an individual's belief in their personal ability to enact a specific behaviour in order to produce a desired outcome, whereas an outcome expectancy is a belief that performing a specific behaviour will result in a specified outcome (Bandura, 1977). Both efficacy expectations and outcome expectancies are important influences on behaviour (Bandura, 1977, 1997). Although an individual may believe that certain actions will lead to a desired outcome, if they perceive little ability to enact the behaviour, they may choose not to attempt the behaviour. Similarly, individuals may choose not to enact behaviour or make little effort if their self-efficacy is high but they believe that enacting the behaviour will result in negative outcomes.

Self-efficacy expectations are thought to vary on three dimensions: (a) level, the perceived difficulty of enacting the behaviour of interest; (b) generality, the range of activities or domains that self-efficacy expectations address; and (c) strength, the effort or perseverance required to accomplish a task (Bandura, 1977). Furthermore, self-efficacy expectations develop from four sources of information (Bandura, 1977, 1997). *Enactive mastery experience*, actual enactment of the behaviour of interest, is thought to be the most powerful way to achieve self-efficacy. The successful enactment of a behaviour provides the impetus to attempt more complex behaviours. *Vicarious experience* involves observing others successfully enact behaviour and then appraising one's ability in relation to the attainments of others. The more similar the model and the individual, the greater the support for self-efficacy. *Verbal persuasion*, praise or encouragement for one's abilities by others, serves to reduce self-doubt and the tendency to dwell on personal deficiencies, making behavioural attempts more likely. *Psychological and affective states* are emotions and reactions such as fear, anxiety, passion, or excitement that have the potential to either amplify or diminish self-efficacy, depending on the nature of the emotion and the extent to which it affects an individual's cognitive appraisal of self (Bandura, 1997).

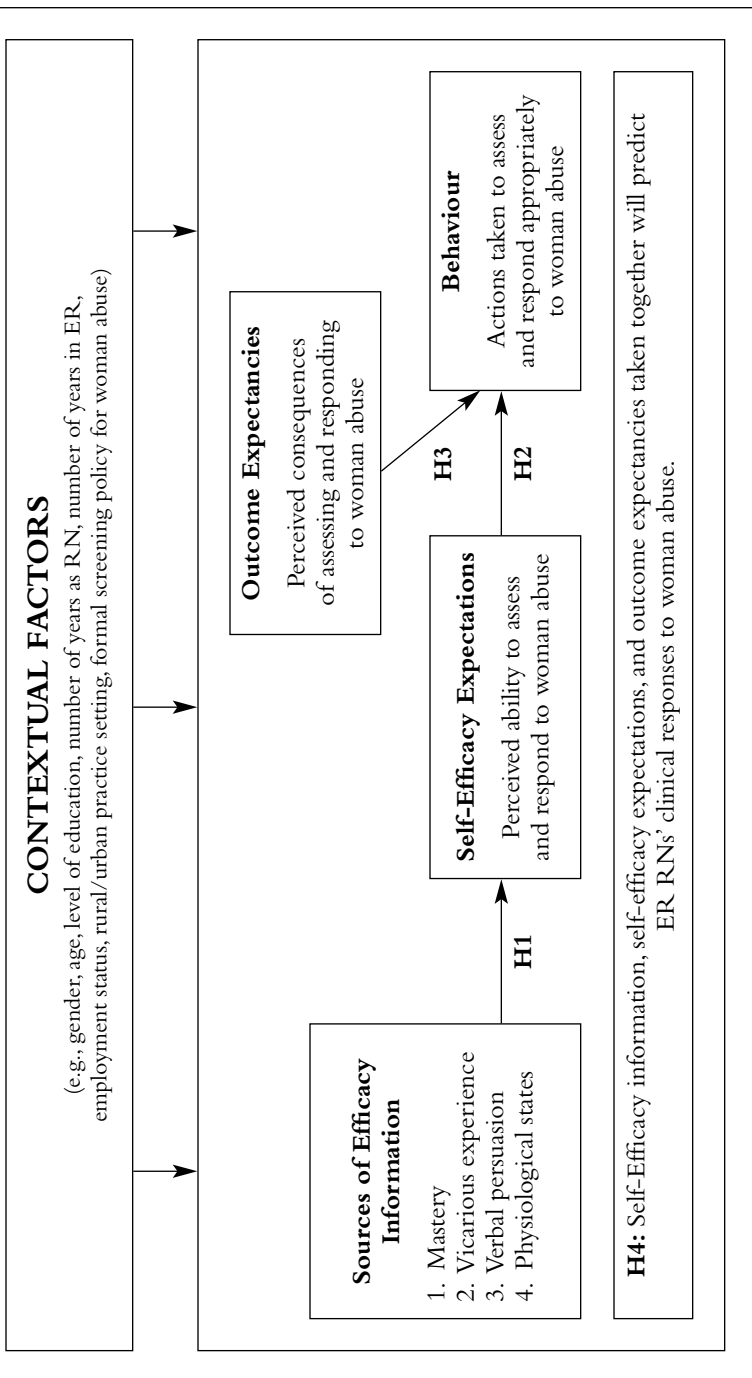
In previous health research, the concept of self-efficacy has been examined primarily in patient populations (Cook, 2004; Kuijer & de Ridder, 2003; Luszczynska & Schwarzer, 2003; Rahman, Amber, Underwood, & Shipley, 2004; Reicks, Mills, & Henry, 2004), with a focus on outcome behaviours. Few studies (e.g., Ozer et al., 2004) have examined the relationship between the health professional's self-efficacy and health-care delivery. The effectiveness of interventions designed to increase the self-efficacy of health-care providers has been examined in several studies (Cook; Farrell, Wicks, & Martin, 2004; Holloway &

Watson, 2002), including one study (Hamberger et al., 2004) that examined the effects of a comprehensive educational intervention on the self-efficacy of health professionals ($N = 752$) for screening and supporting female victims of partner violence. Using a pre-post test design, the investigators observed significant improvements in self-efficacy immediately post-intervention and at 6 months post-intervention, suggesting that tailored education programs are an effective means of increasing provider self-efficacy in the short term. Similar effects on self-efficacy have been documented in educational interventions in patient populations (Farrell et al.; Gaughan, 2003; Kara, 2004) and lay volunteers (Sullivan, Sharma, & Stacy, 2002), although none of these studies focused on the context of woman abuse.

The barriers associated with providing ED care to women who have experienced abuse have been well documented. Ramsden and Bonner (2002) identify several areas of concern: inadequate training and education, professional problem ownership, physical ED surroundings, the presence of male caregivers, and lack of incentives to screen. Ellis (1999) found lack of privacy for screening, lack of time, and not knowing how to ask about woman abuse to be the main barriers to screening for woman abuse among RNs working in the ED. Similar barriers have been identified among physicians (Gerbert, Caspers, Bronstone, Moe, & Abercrombie, 1999; Lachs, 2004; Renck, 1993; Sugg, Thompson, Thompson, Maiuro, & Rivara, 1999), nurse practitioners (Hinderliter, Doughty, Delaney, Rodgers-Pitula, & Campbell, 2003), and social workers (Tower, 2003) working in the ED. Each of these barriers can be thought of as a source of efficacy information (Bandura, 1977, 1997). Although many of the abovementioned studies were conducted in health-care settings with departmental policies addressing woman abuse, the lack of a formal screening process is the reality for many Ontario EDs. The impact of screening policies on the practice behaviour of ED RNs related to woman abuse is poorly understood.

In summary, despite the plethora of research related to self-efficacy and health behaviours, relatively little research has addressed the self-efficacy of RNs. Furthermore, the relationship between RNs' self-efficacy for assessing and responding to woman abuse and their actual clinical practice in any setting, including the ED, has yet to be studied. Given that the ED is a key health-care setting for women who have experienced abuse, an understanding of factors that predict RNs' clinical responses to woman abuse could inform the development of education programs and organizational structures and policies to support appropriate care for women who have experienced abuse.

Figure 1 Hypotheses Derived from Bandura's Theory of Self-Efficacy



Purpose and Hypotheses

The purpose of this study was to examine the self-efficacy of RNs with respect to assessing and responding to woman abuse in the ED, by testing hypotheses derived from Bandura's (1977, 1997) theory of self-efficacy (Figure 1). Hypothesis 1: *There is a positive relationship between efficacy information available to ED RNs and their self-efficacy for assessing and responding to woman abuse.* Hypothesis 2: *There is a positive relationship between the self-efficacy expectations of ED RNs for assessing and responding to woman abuse and their clinical responses to woman abuse in the ED setting.* Hypothesis 3: *There is a positive relationship between ED RNs' outcome expectancies related to assessing and responding to woman abuse and their clinical responses to woman abuse.* Hypothesis 4: *Self-efficacy information, self-efficacy expectations, and outcome expectancies taken together will predict ED RNs' clinical responses to woman abuse.*

Method

Design

A secondary data analysis was conducted using data from 158 RNs working in ED settings who participated in the Violence against Women: Health Care Provider Survey (Wright, Gutmanis, & Beynon, 2005), a large survey ($N = 2,000$) of health professionals practising in the Canadian province of Ontario in 2005. A descriptive correlational design was used to test hypotheses about the relationships between ED RNs' efficacy information, self-efficacy expectations, outcome expectancies and clinical responses to woman abuse, as these relationships have not been previously examined in the population of interest.

Setting and Sample

In the parent study, a random sample of 2,000 health professionals (1,000 RNs and 1,000 physicians) was drawn from the College of Nurses' of Ontario and Scott's directories. RNs who identified the ED, maternal/newborn, family practice, or community/public health, and physicians who identified family medicine, general practice, emergency medicine, or obstetrics/gynecology, as their primary practice domain were targeted for participation. The response rate was 72.2% ($n = 722$) for RNs and 32.8% ($n = 328$) for physicians. The response rate for the ED RN group is unknown. Of the 722 RNs who responded, 162 (22%) identified the ED as their primary location of practice. Four cases were unusable due to incomplete/missing data, resulting in a total of 158 participants. Based on a power analysis, this sample was found to exceed the minimum requirement for testing the study hypotheses. Using

Cohen's convention for a moderate effect size for multiple regression with three independent variables, alpha of .05, and a power of .80, a sample of 75 participants was required.

The vast majority of the RNs in the sample ($n = 151$, 96%) were female. The largest groups had been working in the ED environment for more than 20 years ($n = 42$, 27%) and for 1 to 4 years ($n = 34$, 22%), while the average length of time in nursing practice was 20.7 years (range = 2–43 years, $SD = 9.95$) (Table 1). Participants also varied widely in age. Slightly more than half ($n = 92$, 58%) were employed full time, the remainder part time ($n = 64$, 41%) or casual ($n = 1$, 0.6%), with 63% employed in non-teaching hospitals located across urban, rural, and mixed settings (Table 1). The majority ($n = 122$, 77%) of RNs had a college diploma, although some had a baccalaureate ($n = 31$, 19%) or a postgraduate degree ($n = 6$, 4%). While 71% ($n = 113$) reported that their employer expected them to screen for woman abuse, and only 28% had

Table 1 Selected Demographic Characteristics of Sample (N = 158)

Demographic	N	% of Total Sample
Practice setting		
Rural	35	22
Urban	73	46
Rural/urban	47	30
Missing	3	2
Type of organization		
Teaching	51	32
Non-teaching	100	63
Community	3	2
Other	2	1
Missing	2	1
Length of time in current area of practice		
Less than 1 year	1	.6
1 to 4 years	34	22
5 to 9 years	27	17
10 to 14 years	25	16
15 to 19 years	29	18
20+ years	42	27
Number of disclosures		
None	44	28
1 to 19	113	72
50 to 99	1	.6

never received a disclosure of abuse in their practice, relatively few ($n = 62$, 39%) had received any formal training in woman abuse. Forty-five percent ($n = 70$) of participants indicated that experiences of abuse in their personal lives led them to try and identify victims of abuse in their professional practice.

Data Collection

Data for the larger study were collected using a modified tailored design (Dillman, 2000). Potential participants were mailed a letter inviting them to take part in the study. One week later they were mailed a package containing a letter, a questionnaire, a stamped return envelope, and a small token of appreciation (a \$2 restaurant voucher). Three weeks after the package mail-out, reminder letters and replacement questionnaires were sent to those who had not returned a completed questionnaire. Ethical approval for the parent study was obtained from the University Research Ethics board at the study site. Participants were assured of the anonymity of their responses and were informed that participation was voluntary and that they could refuse to answer any questions or withdraw from the study at any time. Return of a completed questionnaire constituted consent.

Measurement

The survey used in the parent study contained 43 items reflecting barriers and facilitators to screening for woman abuse. Regarding either their current practice or a hypothetical scenario, participants were asked to rate their agreement with each item on a four-point scale (1 = *strongly agree*, 4 = *strongly disagree*). Demographic data and information on personal and professional experiences dealing with woman abuse were also collected. Although the survey questions were not developed to operationalize concepts in Bandura's (1977, 1997) theory, many items were reasonable indicators of the four constructs of interest in this study (i.e., efficacy information, self-efficacy expectations, outcome expectancies, and behaviour). Therefore, measures of the four concepts of interest were developed from the pool of existing items in two phases.

Phase 1: Item classification and content validation. Two members of the research team classified items for their fit with theoretical definitions of Bandura's concepts of efficacy information, self-efficacy expectations, outcome expectancies, and behaviour. Seven of the 43 items were discarded as they were unclear, ambiguous, or a poor theoretical fit, leaving 36 items, of which 10 were congruent with Bandura's (1977, 1997) concept of efficacy information, 12 with self-efficacy expectations for assessing and responding to woman abuse, 10 with outcome expectancies, and 4 with behaviour (i.e., clinical responses to woman

abuse). Content validity indices (CVIs) were created for each scale based on the proportion of items deemed to be a good or very good fit with the underlying theoretical concepts (Waltz, Strickland, & Lenz, 1991). Four expert reviewers completed the CVIs, giving the following results: 0.50 for self-efficacy information, 1.00 for self-efficacy expectations, 0.80 for outcome expectancies, and 1.00 for clinical responses to woman abuse. Seven items were rated as somewhat of a good fit by one or more reviewers; six of these items related to self-efficacy information. Reviewer comments indicated that these ratings reflected difficulty assigning the items to only one source of efficacy information, and not the possibility that the item represented efficacy information more generally. Therefore, all 10 items were retained for the next phase of analysis.

Phase 2: Reliability, validity, and scale modification. For each of the four scales, an item analysis was computed to determine initial internal consistency, followed by exploratory factor analysis using principal components analysis (PCA) in order to assess the underlying structure of each scale (Table 2). Although there are no definitive rules regarding appropriate sample sizes for factor analysis, larger samples produce more stable estimates, with a sample of 300 participants sufficient for most analyses (Tabachnick & Fidell, 2001). Due to the relatively small size of the ED RN sample ($N = 158$), data provided by RNs working in obstetrical settings in the parent study were combined with those of the ED sample for this analysis, resulting in a larger sample ($N = 338$).

Table 2 *Principal Components Analysis of Study Scales and Subscales*

Scale	Number of Items on Scale	Number of Factors	% Variance Explained	Factor Loadings	Alpha in Testing Sample	Alpha in ED Sample
Self-efficacy information	5	1	52.1	.63-.76	.74	.77
Self-efficacy expectations for assessing and responding to woman abuse	12	1	40.7	.10-.76	.85	.87
Outcome expectancies	10	1	35.8	.11-.77	.80	.75
Clinical responses to woman abuse	4	1	44.6	.56-.72	.56	.63

This decision was justified by the fact that RNs working in obstetrical settings and those working in the ED share similar professional and occupational characteristics, such as high patient turnover rates, care of families as well as individual patients, and a lack of continuity of care.

Prior to item analysis, selected items were recoded to ensure that all items reflected higher levels of the constructs they represented. Guidelines for retaining items based on item analysis include a minimum standard deviation of .40, item-total correlation between .30 and .70, a substantial decrease in the alpha if the item was deleted, and theoretical importance of the item to the construct. The results are shown in Table 3. With the exception of the self-efficacy information scale, items on each of the scales satisfied these conditions. On the self-efficacy information scale, five items were poorly correlated with the total score ($r = -.12$ to $.12$). Four of these tapped negative emotions, suggesting that they might represent a separate dimension of self-efficacy information.

Next, PCA with varimax rotation was completed for each scale using applicable items. Decisions regarding the number of factors to specify for further analysis were based upon the number of factors with Eigenvalues >1.0 , inspection of the scree plot, and the pattern of initial factor loadings. Results of PCA suggested that items on three scales (self-efficacy expectations, outcome expectancies, and behaviour) each represented a strong single factor, with all items loading cleanly. In each of these analyses, the Eigenvalue and percentage of item variance accounted for by the first factor was considerably larger than for all other factors. Although 1, 2, and 3 factor solutions were computed for each of these scales, items in the 2 and 3 factor solutions did not load cleanly on one factor and the pattern of item loading was not interpretable, reinforcing the original interpretation that each of these item pools represented a single factor.

Initial PCA of the 10 self-efficacy information items suggested that either a 1 or 2 factor solution would fit the data. However, the most reliable and interpretable solution was found to contain a single factor composed of five items, representing training (mastery) and peer support (Table 3). Although a 2-factor solution was computed, after rotation four items representing training or support from peers loaded cleanly on the first factor, four items representing arousal loaded on the second factor, and two items did not load cleanly on either factor. Additionally, the reliability of each of the four item scales was lower than desired. Although the five-item solution resulted in the loss of five items from the item pool, the items that loaded on this factor fit together well from a theoretical perspective. The five items that were deleted all had low ($< .30$) item-total correlations based on the item analysis (Table 2), reinforcing

Table 3 *Item Analysis for Study Scales*

Item	Item Mean	SD	Total Correlation	Alpha If Deleted
Self-efficacy information scale (N = 331)				
I have little experience dealing with woman abuse	2.87	.67	.30	.40
Hesitant to ask about woman abuse due to lack of training	2.52	.72	.34	.38
Comfortable discussing practice situations with colleagues to help me deal with woman abuse	3.08	.51	.11	.46
Participate with colleagues to plan abuse programs	2.23	.72	.47	.33
I have support from colleagues to help me feel comfortable dealing with woman abuse	2.76	.69	.35	.38
I have opportunities for consultation re: how to deal with woman abuse	2.45	.76	.46	.32
I worry about my safety when asking about abuse	1.96	.64	-.06	.51
Think about legal outcomes when asking about abuse	2.16	.65	.12	.46
Frustrated re: lack of time to talk about woman abuse	2.38	.71	-.12	.54
Hesitant to ask, as I treat other family members	1.98	.59	-.07	.51
Alpha = 0.46				
Self-efficacy for assessing and responding to woman abuse (N = 322)				
Confident with my ability to address woman abuse	2.62	.71	.65	.84
Unable to help women experiencing woman abuse	3.11	.66	.35	.87
Able to support women experiencing abuse	2.76	.60	.51	.85
Prepared to ask if woman is at risk of abuse	2.78	.69	.69	.84
Prepared to ask if woman is not at risk of abuse	2.37	.66	.51	.85
Ready to respond if no disclosure of woman abuse	2.63	.58	.55	.85

Ready to respond if woman discloses abuse	2.86	.62	.71	.84
Prepared to share info with women who report no abuse	2.57	.60	.50	.86
Able to listen to disclosure stories	3.27	.51	.49	.87
Able to continue discussion of abuse after disclosure	3.01	.59	.54	.85
Comfortable supporting woman who isn't ready to deal with abuse	3.02	.53	.53	.85
Able to help woman access resources re: abuse	2.91	.68	.52	.85
Alpha = 0.86				
Outcome expectancies scale (N = 317)				
Since this is a private family matter, I shouldn't interfere	3.38	.59	.51	.78
There isn't anything I can do unless she asks for help	3.17	.59	.54	.77
I don't ask about abuse because she isn't ready to tell	3.09	.54	.45	.78
Reluctant to intervene in case I make matters worse	3.01	.61	.61	.76
I don't initiate the topic of abuse	2.82	.58	.47	.78
Afraid to ask in case she stops seeing me	2.98	.45	.38	.79
Hesitant to ask as it may be culturally acceptable	2.79	.66	.42	.79
Reluctant to ask as there are no community resources	3.03	.60	.38	.79
Hesitant to ask re: CAS and police involvement	3.12	.58	.48	.78
Offer no assistance since there is no effective treatment for abuse	3.48	.53	.46	.78
Alpha = 0.80				
Clinical responses to woman abuse (N = 331)				
I routinely initiate the topic of woman abuse	2.16	.68	.39	.50
I ask directly about woman abuse	2.69	.72	.38	.50
I may forget to ask about woman abuse	2.92	.66	.41	.48
I introduce the topic by discussing frequency rates	3.01	.53	.29	.57
Alpha = 0.59				

the interpretation that they did not measure the same constructs as the five items that were retained.

For each of the four scales, scores were computed by summing and averaging applicable items, such that the possible range was one to four. Three of the four scales satisfied the criterion for acceptable internal consistency of a new scale ($\alpha > .70$) suggested by Nunnally (1978), with only the four-item behaviour scale falling short of this criterion ($\alpha = .59$).

Data Analysis

Data were analyzed using the Statistical Package for Social Sciences (SPSS). Appropriate descriptive statistics were calculated for all study variables. Hypotheses 1, 2, and 3 were tested using Pearson *r* correlations. Hierarchical multiple regression was used to examine the extent to which efficacy information, self-efficacy expectations, and outcome expectancies predicted the clinical responses of ED RNs to woman abuse (hypothesis 4). Relationships between the study variables and demographic characteristics were investigated using appropriate measures of association. The level of significance for all analyses was $p < .05$.

Results

Descriptive statistics for the study variables are presented in Table 4. Mean scores for self-efficacy information, self-efficacy expectations for assessing and responding to woman abuse, and clinical responses to woman abuse were moderate. Interestingly, mean scores for outcome expectancies were slightly higher, indicating relatively strong perceptions of positive outcomes associated with responding to woman abuse. Few demographic variables were related to the study variables. Length of time in practice was weakly but positively related to self-efficacy information ($r = .20, p < .01$) as well as to ED RNs' clinical responses to woman abuse ($r = .20, p < .01$). Participants' perception regarding the extent to which

Table 4 Observed Means and Standard Deviations of Major Study Variables (N = 158)

Variable	Mean	SD	Possible Range	Actual Range
Self-efficacy information	2.63	.52	1-4	1.20-4
Self-efficacy expectations	2.88	.39	1-4	2.08-4
Outcome expectancies	3.16	.32	1-4	2.50-4
Clinical responses to woman abuse	2.71	.46	1-4	1.50-4

their employers expected them to screen for woman abuse was related to all four study variables: self-efficacy information ($r = .33, p < .001$), self-efficacy expectations ($r = .28, p < .001$), outcome expectancies ($r = .29, p < .001$), and clinical responses to woman abuse ($r = .35, p < .001$).

A strong positive relationship was found between self-efficacy information available to ED RNs and their self-efficacy for assessing and responding to woman abuse ($r = .73, p = < .001$), providing support for hypothesis 1. Hypothesis 2 was supported by a moderate positive relationship observed between ED RNs' self-efficacy expectations for assessing and responding to woman abuse and their actual clinical responses related to woman abuse in the ER setting ($r = .55, p = < .001$). Consistent with theoretical expectations, ED RNs' outcome expectancies related to assessing and responding to woman abuse were positively related to their clinical responses to woman abuse ($r = .56, p = < .001$), providing support for hypothesis 3.

Hierarchical multiple regression was used to examine the extent to which self-efficacy information, self-efficacy expectations, and outcome expectancies predicted ED RNs' clinical responses to woman abuse (hypothesis 4). Since a departmental expectation to screen was positively related to the dependent variable, it was entered as a control variable at step 1. Consistent with Bandura's theory, self-efficacy information was entered at step 2, self-efficacy expectations at step 3, and outcome expectancies at step 4. All 158 cases were included in the analysis

Step	Multiple R	R ²	Adjusted R ²	Change R ²	F
1. Expectation to screen	.35	.12	.12	.12	21.39*
2. Self-efficacy information	.51	.26	.25	.13	26.53*
3. Self-efficacy expectations	.59	.35	.33	.09	27.28*
4. Outcome expectancies	.63	.40	.38	.05	25.50*
Variables in Equation	B		Beta		T
Expectation to screen	.11		.17		2.57**
Self-efficacy information	.20		.02		.23
Self-efficacy expectations	.34		.29		2.82**
Outcome expectancies	.44		.31		3.68*
* $p < .001$; ** $p < .05$.					

(Table 5). At step 1, the departmental expectation accounted for 12.1% of the variance in ED RNs' clinical responses to woman abuse, $F(1,156) = 21.39, p < .001$. At step 2, sources of self-efficacy information contributed an additional 13.5% to explained variance, $F(1,155) = 26.53, p < .001$, while the addition of self-efficacy expectations at step 3 resulted in a further 9.2% increase in explained variance $F(1,154) = 27.28, p < .001$. At step 4, outcome expectancies accounted for an additional 5.3% of the explained variance $F(1,153) = 25.50, p < .001$. The total variance explained by the model was 40.0%. With the effects of institutional expectations to screen for woman abuse held constant, self-efficacy information, self-efficacy expectations, and outcome expectancies explained 27.9% of the variance in the dependent variable, providing support for hypothesis 4. Each of the independent variables, with the exception of self-efficacy information, contributed uniquely to the prediction of RNs clinical responses to woman abuse, with outcome expectancies and self-efficacy expectations exerting the strongest effects.

Discussion

The results of this study support the utility of Bandura's (1977, 1997) theory of self-efficacy for understanding the clinical responses of ED RNs to woman abuse. Individually and collectively, each of the concepts in Bandura's theory was found to positively affect the ability of RNs working in the emergency department to appropriately assess and respond to women who have experienced abuse, thus extending validation of the theory to the ED clinical environment and context.

The moderate association found between efficacy information available to ED RNs and their self-efficacy for assessing and responding to woman abuse can be explained in several ways. RNs who work in the ED may have access to various types of efficacy information that, according to Bandura (1997), are the basis for developing self-efficacy. For example, the large number of abused women who present to the ED for care may result in increased opportunities for RNs to gain first-hand experience (i.e., mastery) or to observe the practices of other health professionals in caring for women who have experienced violence (i.e., vicarious experience). The majority of RNs in the sample had received at least one disclosure of abuse in their practice, providing a basis for reinforcing their own competence and encouraging other providers to develop appropriate care practices, through modelling or verbal persuasion, for women who have experienced abuse. Furthermore, the finding that RNs' length of nursing practice was positively related to self-efficacy information is consistent with the premise that greater experience may be a proxy for increased access to experiences that build self-efficacy. It is

not known whether RNs working in other clinical settings have similar levels of access to efficacy information to ED RNs or the effect of this on self-efficacy.

The self-efficacy of ED RNs for assessing and responding to woman abuse was positively associated with their clinical responses to woman abuse, which suggests that those with higher levels of self-efficacy are more likely to screen for woman abuse, follow up on overt cues provided by the women, and respond to such cues using appropriate support and referral. People tend to engage in activities in which they feel competent and confident (i.e., higher levels of self-efficacy) and, conversely, avoid activities that reflect low levels of confidence or self-efficacy (Bandura, 1977). Additionally, self-efficacy expectations influence the amount of effort individuals expend on certain activities and the degree to which they persevere in the face of adversity (Pajares, 2002). Given that many of the features of the ED make it a poor environment for addressing woman abuse, RN self-efficacy, when well developed, may be an important resource that can offset the environmental limitations of the ED, such as lack of privacy and time.

The strong positive relationship observed between outcome expectancies and clinical responses to woman abuse is consistent with the premise that beliefs and attitudes are powerful influences on behaviour (Gadomski, Wolff, Tripp, Lewis, & Short, 2001). Thus, the ED RNs who believed that assessing and responding to women who have experienced abuse is a futile endeavour were less likely to engage in appropriate clinical practices related to woman abuse. This finding is consistent with much of the literature documenting the barriers to screening for woman abuse, including negative attitudes and beliefs (Davis & Harsh, 2001). Conversely, ED RNs who held more positive beliefs about the benefits of assessing and responding to woman abuse were more likely to engage in appropriate clinical practices. The relatively high levels of positive outcome expectancy observed in this study contrast with the literature depicting health professionals as unsympathetic and uninterested in providing care to women who have experienced abuse (Bendtro & Bowker, 1989; Hamberger et al., 2004; Perley, 1992). It is possible that the conceptualization of woman abuse as a health issue has resulted in greater awareness and understanding of the nature of woman abuse, among health professionals, as well as increased commitment to providing care for women who have experienced violence as a legitimate part of professional practice, and not something to be relegated to other professions. External forces, both at the policy level and at the local level, may shape practice patterns. This premise is supported by the finding that participants' perceptions of organizational expectations to screen for woman abuse were related to RNs' clinical responses to woman abuse.

The finding that a combination of self-efficacy information, self-efficacy expectations, and outcome expectancies predicted ED RNs' clinical responses to woman abuse, and that each of these variables contributed uniquely to this prediction, is not surprising. Bandura (1977, 1997) proposes that motivation for behaviour is complex and is affected by environmental, cognitive, and behavioural factors. The combination of all three factors is thought to be more predictive of behaviour than any single concept on its own (Bandura, 1997). Professional nursing practice is a complex process that is shaped by many factors. The formation and maintenance of professional practice is not only an individual responsibility but also the product of one's work environment and the profession itself. The present findings suggest that the development of competent practice with women who have experienced abuse may require multiple factors. RNs who work in the ED must: (a) have confidence in their ability to address the needs of women who have experienced violence; (b) have access to means of building self-efficacy such as mentoring and support, expertise, and opportunities for ongoing education; (c) see the benefits of supporting women in order to address the effects of violence, and consider this as part of nursing practice; and (d) work in settings where there is organizational support for addressing woman abuse, including policies and systems to ensure that RNs have access to whatever time, space, and resources they need. Evidence showing that behaviour is reinforced by beliefs and personal actions is reported for other patient and professional populations as well (Gage et al., 1994; Holloway & Watson, 2002), which suggests that actions, whether direct or indirect, do not result from previous experience alone. Effective clinical practice is supported by a variety of factors, all of which must be in place in order to promote professionalism and appropriate care. Interestingly, educational interventions, which are common in self-efficacy research (Cook, 2004; Kara, 2004), are often aimed at modifying both internal and external factors in order to produce behavioural changes. In the ED setting, RNs could benefit from a similar approach in order to enhance their clinical responses to woman abuse.

Although assessing and responding appropriately to woman abuse may not be a standard expectation for RNs working in the ED setting, when such an expectation is in place it can have a positive influence on clinical responses. Such an expectation raises awareness and provides formal external validation of abuse as a health issue, supporting the need for RNs to develop the knowledge and skills necessary to respond appropriately as part of "good practice." Although there is no standard approach to the identification of woman abuse in the ED setting, individual ED departments may use a variety of identification practices, including both universal and indicator-based screening (RNAO, 2005).

This may encourage RNs to develop and use whatever knowledge and skills they need to support women who have experienced violence.

Strengths and Limitations

Although the findings of this study contribute to the knowledge base on RNs' clinical responses to woman abuse in the ED setting, several limitations must be pointed out. The use of a cross-sectional design limits our ability to draw causal inferences about the relationships between the study variables. Thus, the findings should be interpreted in terms of statistical prediction only. Additionally, the use of a self-report questionnaire, although more cost-efficient and timely than some other methods, presents the possibility of response bias (Polit & Tatano Beck, 2004).

The use of secondary data placed practical limits on the development of scales to measure concepts in Bandura's theory. It was not possible to modify scale items based on expert feedback, and there were few items that fit with theoretical definitions of some of Bandura's concepts, resulting in few items on some scales. Although the study scales demonstrated reasonable reliability and construct validity, further testing is warranted with larger, more diverse samples before they are used in other studies.

The use of a random sample drawn from the College of Nurses of Ontario directory is a strength of this study. However, it should be noted that this database relies on registrants' providing adequate and accurate information about their area of practice and experience as well as consent to release this information for research purposes. Although a random sample was drawn, there may have been systematic biases in the pool of professionals who agreed to participate. Despite these limitations, the sample was representative of Ontario ED RNs with respect to demographic variables, including age, gender, employment status, and educational background (Canadian Institute for Health Information, 2005). Replicating this study with a wider range of ED health professionals may provide further insight into similarities and differences across disciplines with respect to both self-efficacy and clinical responses to woman abuse, while providing a more profound understanding of the ways in which the work environment shapes both self-efficacy and the clinical responses of health professionals to women who have experienced abuse.

Conclusion

Health professionals, and the organizations within which they work, face the ongoing challenge of providing timely, sensitive, and competent care to women who have experienced abuse. Given that women often seek help in the ED for injuries and other health problems that result from

abuse, it is critical that effective practices be developed in this setting. The results of this study add to the support for Bandura's (1977, 1997) theory and demonstrate that the clinical responses of ED RNs to woman abuse are complex and should be understood in terms of self-efficacy and the factors that support the development of self-efficacy, their beliefs regarding the consequences of their actions, and the organizational structures within which they practise. The only way to ensure that women who have experienced abuse receive adequate, responsive care is to ensure that those providing the care are knowledgeable and are able to respond appropriately and professionally. Organizational structures, along with departmental policy and procedures, must be responsive to the needs of women who have experienced abuse and supportive of the professionals who implement the policies. Partnerships between the organization and the health professional are essential to ensuring that women who have experienced abuse receive high-quality care when they seek help in the ED setting.

References

- Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioural change. *Psychological Review*, 84, 191–215.
- Bandura, A. (1997). *Self-efficacy: The exercise of control*. New York: W. H. Freeman.
- Begin, P. (1992). *Violence against women: Current responses*. Political and Social Affairs Division: Publication #BP-267E. Background paper. Ottawa: Library of Parliament.
- Bendro, M., & Bowker, L. (1989). Battered women: How can nurses help? *Issues in Mental Health Nursing*, 10, 169–180.
- Campbell, J. C. (2002). Health consequences of intimate partner violence. *Lancet*, 359(9314), 1331–1336.
- Campbell, J. C. (2004). Helping women understand their risk in situations of intimate partner violence. *Journal of Interpersonal Violence*, 19(12), 1464–1477.
- Canadian Association of Emergency Physicians. (2004). *CAEP background: Emergency department overcrowding in Canada — myth and reality*. Retrieved January 7, 2005, from <http://www.caep.ca/002.policies/002-05.communications/2004/040614.bgnd-overcrowding.pdf>
- Canadian Institute for Health Information. (2005). *Workforce trends of registered nurses in Canada, 2004*. Ottawa: Author.
- Clark, J., & DuMont, J. (2003). Intimate partner violence and health: A critique of Canadian prevalence studies. *Canadian Journal of Public Health*, 94(1), 52–58.
- Cook, A. (2004). Health education programming for older adults based on social cognitive theory. *Gerontology Special Interest Section Quarterly*, 27(1), 1–3.
- Datner, E. M., O'Malley, M., Schears, R. M., Shofer, F. S., Baren, J., & Hollander, J. E. (2004). Universal screening for interpersonal violence: Inability to prove

- universal screening improves provision of services. *European Journal of Emergency Medicine*, 11(1), 35–38.
- Davis, R., & Harsh, K. (2001). Confronting barriers to universal screening for domestic violence. *Journal of Professional Nursing*, 17(6), 313–320.
- Dearwater, S. R., Coben, J. H., Campbell, J. C., Nah, G., Glass, N., McLoughlin, E., et al. (1998). Prevalence of intimate partner abuse in women treated at community hospital emergency departments. *Journal of the American Medical Association*, 280(5), 433–438.
- DeKeseredy, W. S., & MacLeod, L. (1997). *Woman abuse: A sociological story*. Toronto: Harcourt Brace.
- Dillman, D. A. (2000). *Mail and Internet surveys – The tailored design method*. New York: John Wiley.
- Ellis, J. M. (1999). Barriers to effective screening for domestic violence by registered nurses in the emergency department. *Critical Care Nursing Quarterly*, 22(1), 27–41.
- Erickson, M. J., Hill, T. D., & Siegel, R. M. (2001). Barriers to domestic violence screening in the pediatric setting. *Pediatrics*, 108(1), 98–102.
- Family Violence Prevention Fund. (2004). *Domestic Violence Screening, Treatment and Prevention Act*. Available online: <http://endabuse.org/programs/display.php3?DocID=315>
- Farrell, K., Wicks, M. N., & Martin, J. C. (2004). Chronic disease self-management improved with enhanced self-efficacy. *Clinical Nursing Research*, 13(4), 289–308.
- Gadomski, A. M., Wolff, D., Tripp, M., Lewis, C., & Short, L. M. (2001). Changes in health care providers' knowledge, attitudes, beliefs, and behaviours regarding domestic violence following a multifaceted intervention. *Academic Medicine*, 76(10), 1045–1052.
- Gage, M., Noh, S., Polatajko, H. J., & Kaspar, V. (1994). Measuring perceived self-efficacy in occupational therapy. *American Journal of Occupational Therapy*, 48(9), 783–790.
- Gaughan, M. E. (2003). Self-efficacy: An effective tool for managing eating behaviour change interventions for hypercholesterolemia. *Topics in Clinical Nutrition*, 18(4), 229–244.
- Gerbert, B., Caspers, N., Bronstone, A., Moe, J., & Abercrombie, P. (1999). A qualitative analysis of how physicians with expertise in domestic violence approach the identification of victims. *Annals of Internal Medicine*, 131(8), 578–584.
- Golding, J. (1999). Intimate partner violence as a risk factor for mental disorders: A meta analysis. *Journal of Family Violence*, 14(2), 99–112.
- Hamberger, L. K., Guse, C., Boerger, J., Minsky, Pape, D., & Folsom, C. (2004). Evaluation of a health care provider training program to identify and help partner violence victims. *Journal of Family Violence*, 19(1), 1–11.
- Haywood, Y., & Haile-Mariam, T. (1999). Violence against women. *Emergency Medicine Clinics of North America*, 17, 603–615.
- Hinderliter, D., Doughty, A. S., Delaney, K., Rodgers-Pitula, C., & Campbell, J. (2003). The effect of intimate partner violence education on nurse practi-

- tioners' feelings of competence and ability to screen patients. *Journal of Nursing Education*, 42(10), 449–454.
- Holloway, A., & Watson, H. E. (2002). Role of self-efficacy and behaviour change. *International Journal of Nursing Practice*, 8, 106–115.
- Humphreys, J., & Campbell, J. C. (2004). *Family violence and nursing practice*. New York: Lippincott, Williams & Wilkins.
- Johnson, H., & Sacco, V. F. (1995). Researching violence against women: Statistics Canada's national survey. *Canadian Journal of Criminology*, 37(1), 16–24.
- Kara, M. (2004). Effect of education on self-efficacy of Turkish patients with chronic obstructive pulmonary disease. *Patient Education and Counselling*, 55(1), 114–120.
- Kuijter, R., & de Ridder, D. (2003). Discrepancy in illness-related goals and quality of life in chronically ill patients: The role of self-efficacy. *Psychology and Health*, 18(3), 313–330.
- Lachs, M. S. (2004). Screening for family violence: What's an evidenced-based doctor to do? *Annals of Internal Medicine*, 140(5), 339–400.
- Luszczynska, A., & Schwarzer, R. (2003). Planning and self-efficacy in the adoption and maintenance of breast self-examination: A longitudinal study of self-regulatory cognitions. *Psychology and Health*, 18(1), 93–108.
- National Clearinghouse on Family Violence. (2006). *Annotated inventory of research reports: Completed through the five research centres on family violence and violence against women and children*. Retrieved January 13, 2005, from http://www.phac-aspc.gc.ca/ncfv-cnivf/familyviolence/html/femlukaw-iecky_e.html
- Nunnally, J. C. (1978). *Psychometric theory* (2nd ed.). New York: McGraw-Hill.
- Ozer, E. M., Adams, S. H., Gardner, L. R., Mailloux, D. E., Wibbelsman, C. J., & Irwin, C. E. (2004). Provider self-efficacy and the screening of adolescents for risky health behaviours. *Journal of Adolescent Health*, 35(2), 101–107.
- Parjares, F. (2002). *Overview of social cognitive theory and self efficacy*. Retrieved January 13, 2005, from <http://www.emory.edu/EDUCATION/mfp/eff.html>.
- Perley, M. J. (1992). Health care agency support for nursing intervention in violence against women. In C. M. Sampsel (Ed.), *Violence against women: Nursing research, education and practice issues*. New York: Hemisphere.
- Polit, D. F., & Tatano Beck, C. (2004). *Nursing research: Principles and methods*. Philadelphia: Lippincott, Williams & Wilkins.
- Rahman, A., Amber, G., Underwood, M., & Shipley, M. (2004). Important determinants of self-efficacy in patients with chronic musculoskeletal pain. *Journal of Rheumatology*, 31(6), 1187–1192.
- Ramsden, C., & Bonner, M. (2002). A realistic view of domestic violence screening in an emergency department. *Accident and Emergency Nursing*, 10, 31–39.
- Registered Nurses' Association of Ontario. (2005). *Best practice guidelines: Shaping the future of nursing. Woman abuse: Screening, identification and initial response*. Retrieved January 6, 2006, from: http://www.rnao.org/bestpractices/completed_guidelines/BPG_Guide_C5_Woman_Abuse.asp

- Reicks, M., Mills, J., & Henry, H. (2004). Qualitative study of spirituality in a weight loss program: Contribution to self-efficacy and locus of control. *Journal of Nutrition Education and Behaviour*, 36(1).
- Renck, B. (1993). Attitude of medical staff towards victims of violence and assaults: A tentative explanation. *Scandinavian Journal of Caring Science*, 7, 229–236.
- Sugg, N. K., Thompson, R. S., Thompson, D. C., Maiuro, R., & Rivara, F. P. (1999). Domestic violence and primary care: Attitudes, practices and beliefs. *Archives of Family Medicine*, 8, 301–306.
- Sullivan, T. A., Sharma, M., & Stacy, R. (2002). Effects of a brief training program for lay health volunteers to facilitate smoking cessation among African Americans. *Journal of Alcohol and Drug Education*, 47(2), 4–17.
- Tabachnick, B. G. & Fidell, L. S. (2001). *Using multivariate statistics* (4th ed.). Needham Heights, MA: Allyn & Bacon.
- Tower, L. E. (2003). Domestic violence screening: Education and institutional support correlates. *Journal of Social Work Education*, 39(3), 479–494.
- Varvaro, F. F., & Gesmond, S. (1997). ED physician house staff response to training on domestic violence. *Journal of Emergency Nursing*, 23(1), 17–22.
- Waltz, C., Strickland, O., & Lenz, E. (1991). *Measurement in nursing research* (2nd ed.). Philadelphia: F. A. Davis.
- Wathen, C. N., Jamieson, E., Wilson, M., Daly, M., Worst, A., & MacMillan, H. L. (2006). *Risk indicators to identify intimate partner violence in the emergency department*. Unpublished manuscript.
- Wathen, C. N., & MacMillan, H. L. (2003). Interventions for violence against women: Scientific review. *Journal of the American Medical Association*, 289(5), 589–599.
- Wilt, S., & Olson, S. (1996). Prevalence of domestic violence in the United States. *Journal of the American Medical Women's Association*, 51(3), 77–82.
- Wright, B., Gutmanis, I., & Beynon, C. (2005). [Violence against women: Health care provider survey.] Unpublished raw data.
- Zun, L. S., Downey, L., & Rosen, J. (2003). Violence prevention in the ED: Linkage of the ED to a social service agency. *American Journal of Emergency Medicine*, 21(6), 454–457.

Authors' Note

Comments or queries may be directed to Marilyn Ford-Gilboe, H37 Health Sciences Addition, University of Western Ontario, London, Ontario N6A 3C1 Canada.

Erin Hollingsworth, RN, MScN, is Primary Health Care Nurse Practitioner Student, Faculty of Nursing, University of Ottawa, Ontario, Canada. Marilyn Ford-Gilboe, RN, PhD, is Associate Professor and T. R. Meighen Family Foundation Community Nursing Professor, School of Nursing, University of Western Ontario, London, Ontario.

**« Que va-t-il m'arriver si je parle? »
L'expérience des Latino-Américaines victimes
de violence face à la prestation des soins**

Ursula Kelly

L'identification des cas de violence conjugale et la prestation de services adéquats aux victimes font couramment partie du travail en soins infirmiers. La présente étude phénoménologique vise à améliorer, grâce à une approche interprétative, notre compréhension de l'expérience des Latino-Américaines victimes de violence face à la prestation des soins. Dix-sept femmes ont été interrogées en espagnol ou en anglais; les données ont été analysées suivant la méthode de van Manen. La peur que ressentent les victimes à l'idée que leur situation puisse être détectée et divulguée par les prestataires de soins est analogue à celle qu'elles éprouvent devant leur agresseur et leurs actes. Ces craintes sont suscitées par les conséquences éventuelles du dévoilement. En dépit de celles-ci, les répondantes se sont montrées disposées à être interrogées et à recevoir de l'aide. L'auteure dégage plusieurs parallèles entre la relation des victimes avec leur agresseur et celle qui s'établit avec les intervenants de la santé. Elle dresse à l'intention des prestataires de soins une liste de critères à respecter en matière de divulgation des cas de violence conjugale.

Mots clés : violence conjugale, soins de santé, soins infirmiers, Latino-Américaines.

“What Will Happen If I Tell You?” Battered Latina Women’s Experiences of Health Care

Ursula Kelly

Identifying and appropriately responding to victims of intimate partner abuse is a standard of health care. The purpose of this interpretive phenomenological study was to improve health-care providers’ understanding of the health-care experiences of battered Latina women. Seventeen women were interviewed in either Spanish or English. Data were analyzed using van Manen’s approach. The themes of fear, worry, and uncertainty were found to permeate the women’s lives. The women’s fear of their abusers and the abuse was matched by their fear of detection and disclosure of the abuse to health-care providers. Their fears were based on the consequences of the abuse becoming known. Despite their fears, the women wanted to be asked about intimate partner abuse and to receive help. Several parallels in the women’s relationships with the abusers and with their health-care providers were identified. Requisites for safe disclosure of intimate partner abuse to health-care providers are discussed.

Keywords: Intimate partner abuse, qualitative research, health care, nursing, Latina, immigrant, cultural competence

Introduction

Domestic abuse is recognized as a growing public health problem in the United States. Reduction in the incidence of domestic abuse is one of the 28 focus areas of Healthy People 2010 (US Department of Health and Human Services, 2000). Health-care providers are faced with the challenge of appropriately identifying and responding to victims of domestic abuse in every health-care setting. In fact, professional standards of practice have been in place for over a decade, dictating that providers screen for and intervene in cases of domestic violence.

The challenge of responding to intimate partner abuse (IPA) is compounded by the social complexity of this problem and the increasing diversity of the general population. Extant literature in the area of IPA and health care has focused on the perspectives and practices of providers. Studies with patients experiencing domestic abuse have been carried out with largely Caucasian populations. This study was designed to address this health-care challenge and the lack of perspective in the literature of victims of IPA from ethnic minority populations.

Background

In the United States, between 20% and 30% of women will be physically abused, and up to 50% psychologically abused, by an intimate partner at least once in their lifetime (Rennison, 2002; Tjaden & Thoennes, 2000). A recent study by the World Health Organization (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005) involving 15 countries found a range of lifetime abuse of 13% to 61%, with a median range between 23% and 49%. The same study reported a lifetime occurrence of sexual violence by an intimate partner in a range between 6% and 59%, with most sites falling between 10% and 50%. Campbell and associates (Campbell, 2002; Humphreys, Sharps, & Campbell, 2005) and McFarlane, Groff, O'Brien, and Watson (2005) identify IPA as a significant global health problem across ethnic groups and a leading cause of morbidity and mortality in women, for which effective interventions are lacking.

The population of the United States is becoming increasingly ethnically diverse. Ethnic minorities are projected to represent 45% of the US population by the year 2050, with Hispanics projected to form more than 24% of the general population (US Census, 2004). Racial and ethnic disparities in health status and health care are significant problems in the United States (Smedley, Stith, & Nelson, 2003). Humphreys et al. (2005) suggest that intra-ethnic and cultural group variations and macro-level systematic discrimination in the health-care system require further investigation.

Screening for IPA is the current standard of care for health-care providers across disciplines (American Academy of Family Physicians, 1994; American Academy of Pediatrics, 1998; American College of Obstetricians and Gynecologists, 1999; American Medical Association, 1992; American Nurses Association, 1991; JCAHO, 1995).

Despite the proliferation of screening protocols and training for clinicians, IPA is often overlooked or simply missed (McFarlane, Soeken, & Wiist, 2000). Several barriers to patients' disclosing domestic abuse to health-care providers are described in the literature: embarrassment and shame; denial; confidentiality concerns; distrust of the health-care provider; fear of retribution by the abuser; fear of reaction of friends, family, or health-care providers; lack of financial resources for medical care and housing without the abuser's support; and fear of police and court involvement (McCauley, Yurk, Jenckes, & Ford, 1998; Plichta, Duncan, & Plichta, 1996; Sleutel, 1998). Health-care providers have been described as uncaring, unhelpful, judgemental, unsupportive, and ineffective (Bacchus, Mezey, & Bewley, 2003; Gerbert et al., 1996), as well as humiliating, blaming, and dismissive (Campbell, Pliska, Taylor, &

Sheridan, 1994). Gerbert, Abercrombie, Caspers, Love, and Bronstone (1999) describe a subtle “dance of disclosure” between health-care providers and patients, in which miscommunication could occur.

In only a few studies have the investigators specifically explored the health-care experiences of battered Hispanic women (Bauer & Rodríguez, 1995; Belknap & Sayeed, 2003; Rodríguez, Bauer, Fores-Ortiz, & Szkupinski-Quiroga, 1998). Barriers to medical help seeking by these battered women include a code of silence, maintained by both the women and their providers, and misdiagnosis and mistreatment of their abuse and attendant problems. In a study of health care received by women with a history of IPA, Rodríguez, Sheldon, Bauer, and Perez-Stable (2001) report that among the Latina women (29% of the sample), 34% identified language barriers and 21% had concerns about immigration authorities. In another study, Latina women described *confianza* (trust, confidentiality, support, comfort, and safety) as critical to any discussion of IPA within a patient-provider relationship (Rodríguez et al., 1998).

The purpose of this interpretive phenomenological study was to increase health-care providers' knowledge about the health-care experiences of battered Latina women. The specific aims of the study were to (1) describe the meanings that battered Latina women give to their health-care experiences, and (2) identify battered Latina women's expectations of health-care providers and health-care systems.

Method

Study Design

The research question and the design and implementation of the study were guided by a feminist framework and the concept of marginalization (Hall, Stevens, & Meleis, 1994). The study used Van Manen's (1990) phenomenological method, which is meant to elicit and articulate the informants' versions of reality and the meanings they give to their experiences — in this case what the women's health-care experiences were like, given the social, cultural, and political influences on such experiences. This method was well suited to the present study, as the health-care experiences of Latina women often span linguistic and cultural divides. Further, this method inherently involves the investigator in the research process, including one's assumptions, biases, and situatedness — critical features given the ethnic, cultural, and linguistic disparity between the researcher and the informants.

Sample

A purposive sample was recruited from a population of women using a service agency for battered women and a legal services program in an

urban area situated in the northeastern United States. The informants self-identified as Hispanic or Latina and were Spanish-speaking, English-speaking, or bilingual. The study included women who self-identified as previously abused by an intimate partner, no longer in an abusive relationship, and received health care during the abuse. Adequacy of sample size ($n = 17$) was determined by redundancy in the statements made by the women about their health-care experiences and the emergence of a profound understanding of their experiences.

Data Collection

Dialogic interviews were conducted in the language of the informant's choice (Spanish or English). They lasted from 60 to 120 minutes and were audiotaped. Whenever possible, two or three interviews were conducted per informant. The interviews conducted in Spanish were transcribed in Spanish and English. Stipends of \$25 per interview and child care were provided. Field notes and memos were considered data as well.

Demographic information, basic information about the abuse itself, and the women's health-care history were collected, followed by the dialogic interviews, which became conversations with evolving topics of interest. The women inevitably spoke about the abuse experience itself before raising any other topic. Important topics that emerged and were critical to understanding the meanings of the women's health-care experiences were their motherhood role, previous life experiences, and immigration experiences.

Data Analysis

Data analysis took place concurrent with data collection. For interviews conducted in Spanish, data analysis was carried out using both Spanish and English transcripts, to ensure that the essence of the text was captured. The interview data were analyzed thematically using Van Manen's (1990) method, which calls for reflection and entails three approaches to the data. In the holistic or sententious approach, each text is considered as a whole: the researcher seeks a phrase that captures the fundamental meaning of the text as a whole. In the selective approach, the tapes and texts are reviewed several times as the investigator searches for essential phrases describing the informants' experiences; narrative statements are written, capturing each informant's experiences and providing detail and explication. Finally, in the line-by-line coding approach, the researcher considers what each line or sentence says about the experience being described; when coding is complete, relationships between the codes and the narrative statements are considered and organized into themes.

Themes were discussed with the informants in the second or third interview, thereby allowing for clarification and co-creation of an interpretive analysis of their experiences. Validity of data analysis was ensured by means of checking with the informants via a focus group session and consulting with bicultural advocates. These discussions involved a presentation of the major themes, challenging and discussing the researcher's thoughts and presuppositions.

Rigour and Protection of Human Subjects

Within the interpretive paradigm, rigour in qualitative research ensures trustworthiness. Trustworthiness in this study was ensured through application of the criteria for rigour in feminist research established by Hall and Stevens (1991), with slight revisions reflecting the interpretive paradigm. Institutional Review Board approval was obtained from the relevant institutions. Informants provided written informed consent in the language of their choice. Pseudonyms were assigned to all informants. Any safety concerns that emerged in the interviews were discussed immediately with the informant's case workers or attorney.

Findings

This discussion begins with a description of the sample, followed by findings regarding the women themselves, the defining roles and concerns of their daily lives, and their experiences of living and leaving the abuse, all of which contextualize their health-care experiences. Next, the women's experiences of health care are described, followed by the requisites for ensuring safe disclosure and discussion of the abuse.

Description of Sample

The 17 participants ranged in age from 19 to 53 years. Spanish was the primary language for thirteen of the women: ten spoke Spanish only, six spoke English and Spanish, and one spoke English only. The women came from five Latin-American countries and Puerto Rico. They had been living in the United States for a range of 2 to 23 years. Eight of the women were undocumented, five were US citizens from Puerto Rico, and four were permanent residents. They had been in their most recent abusive relationship for a range of 6 months to 23 years and out of the abusive relationship for a range of 3 months to 4 years. Their years of education ranged from 4 to 14. All of the women had at least one child, with a range of one to four children.

Pervasive Fear and Despair

Challenges to one's sense of self and safety: "My children above all else, come rain, thunder, or lightning." Mothering was the most important

aspect of these women's lives. For the women, living as they did in dangerous homes in an alien world, mothering their children was a responsibility against which all of their decisions and actions were weighed. Worry about their own and their children's well-being was unremitting. They put their children's needs before their own, often making difficult decisions and personal sacrifices for the sake of their children. Several of the women stayed with their abuser despite the suffering, in the belief that their children needed a father. They hid the abuse from others in order to preserve the family unit. Iliana was pregnant with her fourth child, the result of rape by her ex-boyfriend:

Temor de que si yo digo, que él es violento conmigo, ¿yo voy a ir a dónde? Yo voy a perder mi trabajo, yo tengo tres hijos en Colombia, por quien yo debo trabajar llueva, truene, o relampaguee, haga lo que haga yo tengo que trabajar para sostener a mis hijos en Colombia. Yo prácticamente el temor era de que, si yo no tenía una vivienda, de que si yo perdía mi trabajo, ¿qué iba a ser de mis hijos?

[Fear that if I said he was violent towards me, where would I go? I'd lose my job. I have three children in Colombia whom I need to work for, come rain, thunder, or lightning. Whatever happens, I have to support my children in Colombia. If I had nowhere to live, if I lost my job, what would become of my children?]

Living beneath the radar: Undocumented and undetected. The women lived their lives beneath the radar, avoiding anyone who might cause harm to themselves or their children: the abusers, their health-care providers, child protection services, the police, and, for some, US Citizenship and Immigration Services. The need to be invisible permeated their lives, causing them to approach interactions with outsiders, including health-care providers, with caution and personal withholding. Language barriers and their avoidance of official agencies left many of the women ignorant of their rights and of the laws that might protect them.

Even the English-speaking women, who had no particular fear of the justice system, worried that any information about domestic abuse would result in the loss of their children to child protection services. Sheila, who had lost custody of her older daughter to her emotionally and psychologically abusive husband, felt penalized for being abused:

They [health-care providers] get you in trouble... As soon as a woman is in domestic violence they all assume the kid is in danger...so you get scared sometimes and you don't talk.

Being battered: Alone, abused, afraid, and having nowhere to turn. Fear, despair, worry, and uncertainty permeated the women's lives.

Abused and isolated, they felt they had nowhere to turn for help. Their lives were complex and rife with conflict and danger. They feared their abusers and the abuse to come. They were trapped in a catch-22 situation whereby they risked harm and even death by either staying with or trying to leave the abuser. They worried about threats made by their abusers that if they disclosed the abuse to anyone, including family and friends, but particularly to anyone in authority — a police officer or health-care provider — they or their children would suffer worse abuse or even be killed. The women faced the prospect of being deported or their abuser being deported, the loss of their children to the abuser or his family or to the authorities, harm coming to their families, and lacking the economic and personal resources to survive. Lacking information about their social and legal rights and about the availability of resources and support, the women took these threats seriously. The threats had a particular hold over those women who were undocumented or spoke no English and who were therefore more likely to be completely isolated — in some cases not knowing a single person in the United States other than the abuser and his family. Iliana had a chilling story:

Casi siempre, lo que él me decía que si yo le decía a alguien lo que nos estaba pasando, que a él lo iban a arrestar, que lo iban a deportar, que cuando lo deportaran a él, él se iba a mi país, y que iba a matar a mi familia.

[What he almost always said to me was that if I told anyone what was happening he would be arrested and deported, and when he was deported he would go to my country and kill my family.]

“Staying, then leaving, for the sake of my children.” For most of the women, fully realizing the harm that the abuse was causing to their children was the impetus for leaving the abuser. For many, the last straw was seeing their children behave like the abuser — “[my son] started yelling at me just like my husband did” — or reacting to the abuser as they did themselves:

They were...really afraid too. I'm afraid and they are afraid, and I saw my daughter crying. That was the day I felt bad, because she was crying, the same way I was crying for the same brush... My daughter was crying up and down because she couldn't find his brush. I saw myself in her, and I said, “She's going to grow up thinking that's right, and when she gets married, she's going to be doing the same thing...” So that's what I wanted to change, give the children what they deserve. (Cecilia)

For others, the motivation to act was the escalating violence and imminent danger of their children being left motherless. Long after sepa-

rating from the abuser, they still struggled to gain the strength needed to move forward in life. The women's fragile sense of self and sense of security greatly influenced both their experiences of the abuse and their encounters with health-care providers.

Interactions with Health-Care Providers

Fear was the women's constant companion. Isolated from loved ones, not knowing whom to trust, their only certainty was fear. Fear always took a toll. Some women paid with hearts that raced, stomachs that bled, hands that trembled, weight that could not be controlled. Some women withdrew into themselves.

“What will happen if I tell you?”: Fear of detection and disclosure of IPA. Fear of talking about the abuse and being “found out” pervaded the women's health-care experiences. Misperceptions about the consequences of the IPA becoming known increased their fear and worry. The stakes were high: the women could not have been in a more vulnerable position, the word vulnerable being defined as “can be wounded, open to attack” (*Webster's New World Dictionary and Thesaurus*, 2002, p. 711). The women were already so deeply wounded that to discuss the abuse with a health-care provider would be to lay themselves open to being wounded again, even with the hope of help. Many of the women feared child protection services and US Customs and Immigration Services more than they feared the abuser. This fear was fuelled by the abuser and it paralleled and overlapped their fear of the abuser. Many of the women believed that disclosure of the abuse to a health-care provider would set in motion a series of steps beyond their control, with grave consequences for themselves and their children: loss of their children to child protection services and deportation of the abuser or themselves, resulting in economic hardship or their children becoming motherless. They could not discuss the abuse with their health-care provider because of one burning question: “What will happen if I tell you?”

The women's fear of their abusers and of the authorities prevented them from disclosing the abuse. Cecilia saw her health-care provider two or three times a month for management of depression and a variety of physical complaints. Her provider never asked her why she felt depressed or screened her for IPA, even though a flyer about domestic abuse was posted on his office wall. The flyer made Cecilia realize she needed help, but she did not tell her provider about the abuse:

It was always in his room...and it was in Spanish. I wanted to say something but I didn't because I didn't know what would happen or what he would say, because I couldn't take it any more. I was pregnant again... I didn't know what would happen to me because they say they have

shelters or something and I said, "Maybe they're going to take me out of the house and they're going to take my kids..." Oh!

Sylvia thought that child protection services would take her children away with very little cause. When her health-care provider suspected abuse after she arrived for an appointment with facial bruises, she was worried and frightened:

Me puse muy nerviosa cuando él me preguntó que me había pasado. Él me decía, "No tengas miedo, cuéntame qué pasa? Tu esposo te pegó?" Yo le dije, "No, no, no, él no me pegó, él no me pega." Y él lo que hacía, era que hacía así, aaahhhh [frustrada] . . . Entonces me dijo que esperara un momentito y salió y llamó a la trabajadora social y entonces yo digo "Ay, Dios mío," Yo me metí en un problema yo pensaba, yo tenía miedo yo dije, "Oh my God, yo me metí en un problema."

[I became very nervous when he asked me what had happened. He said, "Don't be afraid. Tell me what's going on. Did your husband hit you?" And I said, "No, no, he didn't hit me, he doesn't hit me." And he was, like, you know...aaahhh [frustrated] ... And he said for me to wait a moment and he left and called the social worker, and then and I said, "Oh, my God." I thought, "I've gotten myself into trouble." That was what I thought. I was afraid. I said, "Oh, my God, I'm in trouble."]

"If you ask me, I will tell you": Wanting to Be Asked Despite the Fear

Relinquishing control. Despite the pervasive sense of fear and the risks involved, the women wanted to be asked about abuse and to receive help. They longed for someone to take control of the situation. They harboured a wish that someone, such as their health-care provider, would ask them about abuse or, better yet, figure it out for themselves. However, they would not disclose the abuse unless asked. A code of silence prevailed, maintained by both the woman and her health-care provider, with many of the women left with a continuing sense of isolation and resignation. They relinquished control to their provider by maintaining a posture of "If you ask me, I will tell you." Magdalena saw many health-care providers for herself and her disabled son, and was often tearful during the visits:

They didn't ask so I didn't tell... They never asked me why I was crying every day, they just wrote down... Sometimes you're afraid to tell. But when someone asks you, and you feel that you can trust them, you could be able to talk.

Giving clues: "But no one understood what I was trying to say."

In the absence of direct questioning by health-care providers, dropping

hints and giving clues was one way the women tried to prompt questioning that would enable them to disclose the abuse. This strategy failed to garner the support or help they needed. Several of the women described their partners to their health-care provider as having “*un caracter fuerte*,” which means a bad temper although it translates literally as strong character. To Iliana, this was an obvious clue that “something bad was happening to me, but no one understood what I was trying to say!” Others used more subtle clues. One woman commented that her partner “tell me I’m fat” — only to have her health-care provider suggest diet and exercise in order for her to lose weight. Many women used the words “stressed,” “tension,” and “depressed” as clues, but without success.

“How can they be so cold?”: Seeking a connection but not finding one.

Most of the women sought a sense of connection with their health-care provider, ranging from showing basic human decency to friendship of sorts. For many, this became clear only by its absence. They were surprised and dismayed to receive cold and distant treatment from their providers: “For many, many years, it felt like I was just a number, not even a patient.” Where they sought help, they found none. They looked for a person to whom they could confide their deepest, darkest secret, but instead found an untrustworthy person who treated them disrespectfully and uncaringly. Many of the women viewed their health-care providers as mechanistic in their approach to their jobs, treating their patients like parts on an assembly line. Central themes were “they’re just there to do their job,” “they do what they have to do and that’s it,” and “your five minutes are up.” Julia mimicked the typical behaviour of health-care providers: rushing in to the room, speaking rapidly without making eye contact — “Sit down. How are you? What do you need? Here you go. Goodbye.”

Creating Safety for Disclosure: What Women Need

None of the women had ever had a direct and fully honest conversation with a health-care provider about the IPA they were enduring. There was a nearly universal feeling that it was unsafe to reveal the IPA to a health-care provider. The risks involved in securing help to leave the abuser outweighed the risks of staying with the abuser. One set of fears overrode another. However, the women identified several requisites for safe disclosure, derived from their experiences with health-care providers.

“Where’s the love?”: Needing to know that health-care providers care.

The women needed to be recognized as human beings and to interact with their health-care provider on a human level. They were vulnerable and were reluctant to expose themselves for no reason: “Why should I be telling you my whole life if you’re not going to do anything for me?” Some women knew within a few minutes of meeting a new health-care

provider if he or she was a caring person. They observed body language, mannerisms, and eye contact, as well as verbal communication. Magdalena described the process:

Right now I'm talking with you, and I'm looking at you, and I trust you, and I don't even know you, but I'm looking at your face, I'm looking at your eyes...and I could see through your eyes, and I could see if you could help me, or if you cannot. So sometimes, in the way people talk to you, you can say, this is a good person, or this is not a so good person. That's exactly what I feel when I'm with my primary doctors.

“Can I trust you with my life?”: Needing to trust health-care providers.

The need for trust emerged as a major theme in the women's experiences of health care, and as an absolute prerequisite for honest communication about the IPA. The women needed to trust their health-care provider in a variety of ways: interpersonally, professionally, and practically. Interpersonal trust emerged in relationships in which the health-care provider demonstrated sincere caring behaviour over time. Professional trustworthiness was important only in its absence. Practical trust related to trusting health-care providers with information about the IPA and believing that no harm would come to the women or their children as a result.

“They didn't ask so I didn't tell”: Needing to be asked about IPA.

The women did not volunteer information about the IPA they were enduring, even when they were being seen for injuries or health problems directly related to the abuse. Their passivity and the failure of their health-care providers to ask about IPA, directly or indirectly, combined to create a code of silence about the abuse. Many of the women described the act of asking questions about their lives, and about IPA specifically, as an indication of caring and a critical step in building the requisite trust for disclosure:

If he asked me, I will explain, and I know I'm going to start crying, but I will tell him. But when they don't ask you, you don't want to talk, like, you feel, no. But if they ask you, “What's really going on?” and I could see you, and I could feel if I could trust in you. (Magdalena)

Just as important as the need for health-care providers to ask questions was the need for them to listen to the answers. The women described the importance of truly listening — to silences as well as to responses, to both verbal and non-verbal reactions. Many felt that attentive health-care providers could detect as much from a woman's silence as from her words. A few of the women described listening as a response in itself: “All they have to do is listen!”

“What’s Going to Happen Next?”: The Need to Know the Consequences of Disclosure in Advance

Knowing the specific consequences of disclosure (or detection) of the IPA in advance was critical to the establishment of a safe environment for disclosure. Cecilia trusted her health-care providers, a physician and a nurse practitioner. She saw them several times a year and felt cared for by them. There were flyers posted in the offices about domestic abuse that read, “Talk to your doctor, we can help.” However, she did not disclose the IPA to them for fear of what would happen. She was afraid she would be forced to go to a shelter or would lose her children. Sylvia did her best to hide the abuse from her providers and from her pediatrician, whom she adored. In one encounter, the pediatrician suspected abuse and called a social worker in to speak with Sylvia:

Yo solamente pasaba por mi mente lo que iba a pasar si yo hablaba... Yo pienso que fue eso lo que, que, esa persona no me hizo sentir, como la suficiente seguridad para, para yo hablar, o sea, de pronto fue muy cortante, muy, si, cortante,... Y yo no fijate que yo no voy a decir nada.

[All that was going through my mind was what would happen if I talked... I think what happened was that this person really didn’t make me feel, like, safe enough to talk. And she was very curt — very, yes, curt... And I said, “No, I’m not going to say anything.”]

The women had advice for health-care providers based on several requisites for safety: show that you care, ask questions and listen to the answers, provide information and support before and after screening for IPA, open the door and be there when women are ready, and abandon the need to “fix it.”

Parallels in Relationships: Abusers and Health-Care Providers

Several parallels emerged between the women’s relationships with their abusers and their relationships with their health-care providers. These related to the women’s emotional responses and their behaviours within the relationships, as well as the behaviours of the abuser and the health-care provider. The women’s parallel emotional responses included fear, lack of control and power, feeling controlled, feeling invisible, relinquishing control, and protecting the other.

Discussion

“It is not the culture that shapes the health care experiences of clients. It is the extent to which they are stereotyped, rendered voiceless, silenced, not taken seriously, peripheralized, homogenized, ignored, dehumanized, and ordered around.” (Meleis & Im, 1999, p. 96)

In summary, phenomenologically, being in the world was excruciating for these battered Latina women. They were abused, alone, and afraid, and they did not know whom to trust and where to turn for help. They worried about their children, their well-being, and their future. They struggled to manage everyone and everything around them, living beneath the radar, avoiding detection and notice. They had been made invisible by their life circumstances and by their abusers, and they chose to remain invisible — even to themselves — in order to protect themselves. They found interactions with health-care providers to be threatening, as providers represented authority, with the power to involve “officials” who could do them harm. The women’s fear, worry, and despair did not obviate their desire and need for help. They craved support and guidance, both emotional and logistical, from their health-care providers, but did not receive it.

Current State of Knowledge

The findings closely parallel extant knowledge about women’s experiences of IPA and the health-care experiences of abused women. The participants described similar experiences of abuse, health-care interactions, and barriers to disclosure as those reported in the literature (Bauer & Rodríguez, 1995; Belknap & Sayeed, 2003; Rodríguez et al., 1998). One of the most significant findings of this study was the women’s concern about the lack of support from their health-care providers, whom they described as uncaring, not listening, rushed, untrustworthy, and not asking about abuse. Rodríguez et al. (1998) similarly found that *confianza* was critical to communication between health-care providers and patients and that the participants were concerned about the loss of decision-making control and the outcome of disclosure, including intervention by police, child protection services, and US Customs and Immigration Services. In the present study, language barriers were less of a concern than in the study by Rodríguez et al. (2001), with the women being more concerned about interpersonal dynamics.

Contributions to the Current State of Knowledge

Nursing practice. These findings further our understanding of the health-care experiences of battered Latina women in two areas. An unexpected finding was the multiple parallels in the women’s relationships with their abusers and their health-care providers. We health-care providers think of ourselves as the antithesis of abusers. We are there to help, not to harm. But from the women’s viewpoints, the health-care system and health-care providers were an ominous threat. On an interpersonal level, the context, content, and character of the patient-provider relationship had the potential to mirror the abusive relationship. Perhaps the revelation of

these parallels should not be surprising. However, nursing has yet to recognize them and the reactions they can trigger. Such recognition is critical to the provision of effective health care to the Latina population, including effective identification of and intervention for IPA. The findings strongly suggest that health-care providers could significantly reduce barriers to disclosure of IPA by carefully attending to the interpersonal dynamics of their relationships with and communication with patients, striving to create a safe and supportive environment for those most in need.

The added dimensions of immigration status and Latin culture made the experiences of these battered women unique and intensified the fear of detection and disclosure of the IPA. For the Latina women in this study, concerns about the behaviours of health-care providers and the involvement of various authorities were much greater barriers to disclosure than the internal barriers experienced by Anglos: shame and embarrassment, denial, and fear of the reactions of friends and family. Their paramount question and concern was, "What will happen if I tell you?"

Health-care providers need to address this unspoken concern by providing anticipatory information about screening questions and the consequences of disclosure, proactively addressing confidentiality concerns very specifically. Screening strategies could be revised to include anticipatory guidance, while pamphlets and public education campaigns on domestic violence could be revised to include information about the consequences of disclosure. Health-care providers should screen patients in a meaningful way, fully cognizant of the possible significance of the question in a woman's life. Screening should be consistent over time, with the patient being asked about IPA at each visit, since a Latina battered woman may have to be asked several times before she feels secure enough to respond honestly.

Nursing research and health policy. The findings of this study illustrate the need for improved access to and quality of health care for battered Latina women and other immigrant women. The barriers to the disclosure and discussion of IPA contribute to poor health care and thus to health-care disparities for this population. The results of this qualitative study provide a foundation on which to develop more generalizable studies to address these barriers and disparities. Interdisciplinary collaboration within health-care systems and coalition-building within communities are critical to this process. For battered Latina women, the complexity of their situation requires a combination of approaches.

The primary strength of this study is the inclusion of Spanish-speaking battered women, whose voices, experiences, and health-care needs are underrepresented in the literature. The study was limited by the exclusion of the perspectives of women currently in abusive relationships,

particularly those who do not seek or receive health, legal, or battered women's services. The findings are generalizable in the universality of human emotions — for example, the desire and need for interpersonal connection and caring and the fear that accompanies violence. They are not generalizable across all cultural and linguistic groups, or to women who cannot or are reluctant to access health and social services for abuse.

Conclusions

Health-care providers have a responsibility to identify and respond to victims of domestic abuse in every health-care setting, according to professional standards that include culturally competent care. This responsibility is made all the more challenging by the social complexity of the problem of domestic abuse and the increasing diversity of the general population. Extant literature fails to provide an understanding of the health-care perspectives of battered women from immigrant and ethnic minorities, and of effective strategies for identifying IPA and intervening effectively.

The findings of this study provide some understanding of battered Latina women's perspectives on health-care interactions and the meaning they give to them. The result is patient-centred information that guides the development of improved health-care interventions for this population, increased patient satisfaction with health care, and enhanced patient-provider relationships.

References

- American Academy of Family Physicians. (1994). Family violence: An AAFP white paper. *American Family Physician*, 50, 1636–1646.
- American Academy of Pediatrics. (1998). The role of the pediatrician in recognizing and intervening on behalf of abused women. *Pediatrics*, 101, 1091–1092.
- American College of Obstetricians and Gynecologists. (1999). *Domestic violence*. ACOG Educational Bulletin No. 257. Chicago: Author.
- American Medical Association. (1992). Violence against women: Relevance for medical practitioners. *Journal of the American Medical Association*, 267, 3190–3190.
- American Nurses Association. (1991). *Position statement on physical violence against women*. Washington: Author.
- Bacchus, L., Mezey, G., & Bewley, S. (2003). Experiences of seeking help from health professionals in a sample of women who experienced domestic violence. *Health and Social Care in the Community*, 11(1), 10–18.
- Bauer, H., & Rodríguez, M. (1995). Letting compassion open the door: Battered women's disclosure to medical providers. *Cambridge Quarterly of Health Care Ethics*, 4, 459–465.

- Belknap, R. A., & Sayeed, P. (2003). Te contaría mi vida: I would tell you my life, if only you would ask. *Health Care for Women International*, 24, 723–737.
- Campbell, J. C. (2002). Health consequences of intimate partner violence. *Lancet*, 359, 1331–1336.
- Campbell, J., Pliska, M. J., Taylor, W., & Sheridan, D. (1994). Battered women's experiences in the emergency department. *Journal of Emergency Nursing*, 20(4), 280–288.
- García-Moreno, C., Jansen, H., Ellsberg, M., Heise, L., & Watts, C. (2005). *WHO Multi-country Study on Women's Health and Domestic Violence against Women*. Geneva: WHO Press.
- Gerbert, B., Abercrombie, P., Caspers, N., Love, C., & Bronstone, A. (1999). How health care providers help battered women: The survivor's perspective. *Women and Health*, 29(3), 115–135.
- Gerbert, B., Johnston, K., Caspers, N., Bleecker, T., Woods, A., & Rosenbaum, A. (1996). Experiences of battered women in health care settings: A qualitative study. *Women and Health*, 24(3), 1–17.
- Hall, J. M., & Stevens, P. E. (1991). Rigor in feminist research. *Advances in Nursing Science*, 13(3), 16–29.
- Hall, J. M., Stevens, P. E., & Meleis, A. I. (1994). Marginalization: A guiding concept for valuing diversity in nursing knowledge development. *Advances in Nursing Science*, 16(4), 23–41.
- Humphreys, J., Sharps, P.W., & Campbell, J. C. (2005). What we know and what we still need to learn. *Journal of Interpersonal Violence*, 20(2), 182–187.
- JCAHO. (1995). *Accreditation manual for hospitals*. Oakbridge Terrace, IL: Author.
- McCauley, J., Yurk, R., Jenckes, M., & Ford, D. (1998). Inside “Pandora's box”: Abused women's experiences with clinicians and health services. *Journal of General Internal Medicine*, 13, 549–555.
- McFarlane, J., Groff, J., O'Brien, J., & Watson, K. (2005). Prevalence of partner violence against 7,443 African American, white, and Hispanic women receiving care at urban public primary care clinics. *Public Health Nursing*, 22, 98–107.
- McFarlane, J. M., Groff, J. Y., O'Brien, J. A., & Watson, K. (2006). Secondary prevention of intimate partner violence: A randomized controlled trial. *Nursing Research*, 55(1), 52–61.
- McFarlane, J., Soeken, K., & Wiist, J. (2000). An evaluation of interventions to decrease intimate partner violence to pregnant women. *Public Health Nursing*, 17(6), 443–451.
- Meleis, A. I., & Im, E. O. (1999). Transcending marginalization in knowledge development. *Nursing Inquiry*, 6, 94–102.
- Plichta, S. B., Duncan, M. M., & Plitcha, L. (1996). Spouse abuse, patient-physician communication, and patient satisfaction. *American Journal of Preventive Medicine*, 12, 297–303.
- Rennison, C. M. (2002). *Intimate partner violence, 1993–2001*. Publication No. NCJ-197838. Washington: US Department of Justice, Bureau of Justice Statistics.

- Rodríguez, M., Bauer, H., Flores-Ortiz, Y., & Szkupinski-Quiroga, S. (1998). Factors affecting patient-physician communication for abused Latina and Asian immigrant women. *Journal of Family Practice, 47*, 309–311.
- Rodríguez, M. A., Sheldon, W. R., Bauer, H., & Perez-Stable, E. J. (2001). The factors associated with disclosure of intimate partner abuse to clinicians. *Journal of Family Practice, 50*(4), 338–344.
- Sleutel, M. (1998). Women's experiences of abuse: A review of qualitative research. *Issues in Mental Health Nursing, 19*, 525–539.
- Smedley, B. D., Stith, A. Y., & Nelson, A. R. (Eds.). (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington: National Academies Press.
- Tjaden, P., & Thoennes, N. (2000). *Full report of the prevalence, incidence, and consequences of violence against women*. Washington: US Department of Justice, National Institute of Justice.
- US Census. (2004, March). *Projected population of the United States, by race and Hispanic origin: 2000 to 2050*. Retrieved April 30, 2006, from <http://www.census.gov/ipc/www/usinterimproj/natprojtab01a.pdf>
- US Department of Health and Human Services. (2000). *Healthy people 2010* (2nd ed.). Washington: US Government Printing Office.
- Van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy*. Ontario, NY: State University of New York.
- Webster's new world dictionary and thesaurus*. (2nd ed.). (2002). New York: Hungry Minds.

Author's Note

This study was funded by NIH, NINR, NRSA, #1 F31 NR07686-01, a Boston College Predoctoral Fellowship, and an MGH IHP Faculty Seed Grant.

The author gratefully acknowledges the assistance of Dr. Joellen Hawkins (Dissertation Chair), Dr. Margaret Kearney, and Dr. Nancy Veeder.

Comments or queries may be sent to Ursula Kelly, 130 Colberg Avenue, Roslindale, Massachusetts 02131 USA.

Ursula Kelly, PhD, APRN, BC, is Assistant Professor and Coordinator, Adult Nurse Practitioner Specialty Track, MGH Institute of Health Professions, Boston, Massachusetts, United States.

Prévention de la violence en soins de santé mentale : le cas de l'État de New York

**Jane Lipscomb, Kathleen McPhaul, Jonathan Rosen,
Jeanne Geiger Brown, Mona Choi, Karen Soeken,
Victor Vignola, Deborah Wagoner, Janet Foley et Peggy Porter**

En 1996, le New York State Office of Mental Health adoptait une politique obligeant tous les établissements psychiatriques administrés par l'État à se doter d'un programme proactif de prévention de la violence fondé sur les lignes directrices imposées par la *U.S. Occupation Safety and Health Administration*. Cette décision a fourni une occasion d'évaluer l'effet de ce type de lignes directrices sur la santé et la sécurité au travail. Les auteurs rapportent ici les résultats d'une étude à plusieurs volets dont le but était d'évaluer la faisabilité et les répercussions d'une intervention participative destinée à prévenir la violence au travail. Ils décrivent la mise en œuvre d'un programme de prévention dans trois établissements hospitaliers, en se fondant sur : une analyse approfondie du milieu de travail; des groupes de discussion réunissant des employés; des sondages menés avant et après l'instauration du programme dans le but d'évaluer les changements de perception à l'égard des agressions physiques et de la qualité des différents volets du projet. Les résultats attestent de la faisabilité de ce type de programme et de ses répercussions favorables au sein des établissements de santé mentale. On a constaté chez les employés de tous les milieux de travail concernés une amélioration notable des perceptions concernant l'engagement de la direction et la participation du personnel en matière de prévention de la violence.

Mots clés : prévention de la violence, violence au travail, établissements psychiatriques.

Violence Prevention in the Mental Health Setting: The New York State Experience

**Jane Lipscomb, Kathleen McPhaul, Jonathan Rosen,
Jeanne Geiger Brown, Mona Choi, Karen Soeken,
Victor Vignola, Deborah Wagoner, Janet Foley, and Peggy Porter**

In 1996 the New York State Office of Mental Health issued a policy requiring all State-operated psychiatric facilities to develop and implement a proactive violence-prevention program based on guidelines issued by the US Occupational Safety and Health Administration. This presented an opportunity to evaluate the impact of the guidelines on worker health and safety. The authors report the findings of a mixed-method study to evaluate the feasibility and impact of a participatory intervention to prevent workplace violence. They describe the implementation of the intervention in 3 in-patient facilities, including an extensive worksite analysis, staff focus groups, and a baseline and post-intervention survey of changes in staff perception of the quality of the program's elements and physical assault following implementation of the program. The authors provide evidence for the feasibility and positive impact of a comprehensive violence-prevention program in the in-patient mental health workplace. Staff perception of the quality of management commitment and employee involvement in violence-prevention was significantly improved in all worksites post-implementation.

Keywords: Violence prevention, occupational health, worksite analysis, staff assaults, workplace violence, psychiatric hospitals

Introduction

In 1996 the US Occupational Safety and Health Administration published *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers* (US Department of Labor & OSHA, 1996). These federal guidelines include the basic elements of any proactive health and safety program: Management Commitment and Employee Involvement; Worksite Analysis; Hazard Prevention and Control; and Training and Education. The OSHA guidelines provide an outline for developing a violence-prevention program, but they are “performance-based,” so the challenge of developing a specific, effective process for implementation is left to each individual workplace. It should be noted that a number of international professional and governmental agencies have issued policies

and guidance on violence prevention in the health-care setting (American Association of Colleges of Nursing, 2004; American Nurses Association, 1994; Canadian Federation of Nurses Unions, 1994; Canadian Nurses Association, 2002; International Council of Nurses, 2000; International Labour Organization, 1998; World Health Organization, 2005). For example, the Canadian Federation of Nurses Unions and the Canadian Nurses Association have issued strongly worded position statements recognizing the prevalence of workplace violence in health care and advocating for its prevention. The authors of these statements believe that recognition of workplace violence in the form of prevention policy must be part of a comprehensive program such as the one described in this paper.

This paper describes a participatory intervention to prevent workplace violence, based on the OSHA guidelines, that was implemented in three New York State in-patient mental health facilities between 2000 and 2004. The purpose of the study was to evaluate the feasibility of the participatory intervention process as well as to evaluate the impact of the program on threats of assault and staff perception of the quality of their facility's violence-prevention program. Finally, the paper describes best practices as identified by joint labour-management advisory groups that were responsible for developing and implementing the violence-prevention programs at the study facilities.

Literature Review

Workplace violence is recognized as a significant occupational hazard in the health and social service sectors, particularly in mental health facilities (Bensley, Nelson, Kaufman, Silverstein, & Kalat, 1993; Bensley et al., 1997; CDC/NIOSH, 2001; Duhart, 2001; Duncan et al., 2001; Flannery, Hanson, & Penk, 1994; Gerberich et al., 2004; Hesketh et al., 2003; Lipscomb & Love, 1992; Love & Hunter, 1996; McPhaul & Lipscomb, 2004; Rippon, 2000; Toscano & Weber, 1995; UIIPRC, 2001). According to the Department of Justice National Crime Victim Survey (Duhart), an average of 1.7 million assaults occur at work annually in the United States. The assault rate for mental health professionals and custodial workers is 68.2 per 1,000, compared to 12.6 per 1,000 workers across all occupations. The rate for nurses across all settings is 21.9% (Duhart). Six percent of the workplace crimes result in injury requiring medical treatment, yet only about half (46%) of all incidents are reported to the police. The health sector leads all industries in non-fatal assaults, with 45% of all non-fatal assaults against workers in the United States resulting in lost workdays (Bureau of Labor Statistics, 2006). The rate of nonfatal assaults to workers in "nursing and personal care facilities" is 31.1 per 10,000, versus only 2.8 per 10,000 in the private sector as a whole

(Bureau of Labor Statistics). In a Washington State psychiatric facility, 73% of staff surveyed reported at least a minor injury related to an assault by a patient during the previous year; only 43% of those reporting moderate, severe, or disabling injuries related to such assaults had filed for workers' compensation. The survey found an assault incidence rate of 437 per 100 employees per year, compared to hospital incidence rates of only 35 per 100 (Bensley et al., 1997).

Very few published studies include an evaluation of violence-prevention efforts. Runyan, Zakocs, and Zwerling (2000), in a comprehensive review of the literature on violence-prevention interventions, found five studies evaluating training interventions (Carmel & Hunter, 1990; Goodridge, Johnston, & Thomson, 1997; Infantino & Musingo, 1985; Lehmann, Padilla, Clark, & Loucks, 1983; Parkes, 1996), two examining post-incident psychological debriefing programs (Flannery, Rosen, & Turner, 1998; Matthews, 1998), and three evaluating administrative controls to prevent violence (Drummond, Sparr, & Gordon, 1989; Hunter & Love, 1996). All studies focused on the health-care sector and all involved registered nurses as well as other direct-care staff. Findings from these nine studies were equivocal, with six reporting a positive impact and three reporting no impact or a negative impact. All were quasi-experimental and did not use a formal control group. Runyan et al. criticize the design of violence-prevention interventions published to date because of the lack of systematic rigour in the evaluation.

Since publication of the Runyan et al. (2000) review, Arnetz and Arnetz (2000) have reported on a randomized controlled trial of 47 health-care workplaces that examined an intervention of "continuous registration" of violent events for 1 year with "structured feedback" from supervisors. Hospitals that received the intervention reported significantly more incidents of violence than the control hospitals. The authors attribute this finding to increased awareness and reporting of the violence following the intervention, as well as improved supervisory support at these facilities. None of the aforementioned intervention studies documented the organizational process for implementing a violence-prevention program or for evaluating the impact of a program.

Methods

Setting

The New York State Office of Mental Health (OMH) was selected as the setting for this study, as a result of pilot work that demonstrated both feasibility and strong labour-management cooperation (Rosen, 1997) and monitoring by an active labour-management health and safety committee, the OMH Multi-Union Health and Safety Committee. In

1998, the OMH, working through this committee, instituted a Safe and Therapeutic Environment Program (STEP) policy requiring all 26 in-patient OMH facilities to develop and implement a proactive violence-prevention program based on the OSHA guidelines and pilot projects. The 1998 STEP policy integrated existing agency policies and requirements of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The system-wide implementation of STEP, along with the strong support of the Health and Safety Committee and the collaboration of academic researchers, presented a “natural experiment” whereby the feasibility and impact of a participatory workplace violence-prevention intervention could be evaluated.

Sample

Early in this 4-year project, a Request for Applications was sent to all in-patient mental health facilities in New York State inviting them to serve as intervention sites ($n = 26$). Criteria for selection as a study site included management commitment, as measured by willingness to commit the resources necessary to develop and implement a program and labour/management cooperation demonstrated by the presence of an active health and safety committee. Seven applications were received and three psychiatric facilities (two for adults and one for children) were selected to receive the interventions. Later, three facilities similar to the intervention sites in terms of the type of facility (i.e., for adults or for children) and location (i.e., upstate, downstate), as well as having established labour and management cooperation, were selected for comparison. The selected psychiatric facilities ranged in size from 54 beds (children) to 369 beds (adults). The children’s facilities serve a larger geographic area than the adult facilities. All intervention and comparison facilities serve a civil population. A large percentage of patients in all OMH facilities have dual diagnoses of mental illness and chemical addiction and, often, a history of criminal activity. Despite these similarities, there are substantial differences between individual facilities, due in part to a high degree of operational autonomy and a high degree of variability in the implementation of the STEP policy amongst the 26 OMH facilities.

Participation by comparison facilities was voluntary and, at baseline, these facilities had lower rates of assaults on staff. Furthermore, staff in comparison facilities perceived the quality of their facilities’ violence-prevention program as higher than did staff in intervention facilities. Management and union leaders have ascribed this finding to the high level of cooperation between labour and management at the comparison facilities. In this paper, we refer to the non-intervention sites as “comparison” sites; however, they might more accurately be described as “usual

practice” sites, as they were responsible for implementing the OMH STEP policy but did not benefit from the support of the team resources of the worksite-violence study (i.e., consultation with the team and with the project’s New York State-based violence-prevention coordinator). Within each intervention and comparison facility, three wards were selected as the focus of the intervention and evaluation so that the study team could concentrate our efforts and resources on a feasible number of study units.

Description of the Intervention

The OSHA *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers* (www.osha.gov) served as a framework for the study. The study used a participatory action research approach, with management, labour, and direct-care staff representatives working closely with researchers in the design and implementation of the project (Israel, Eng, Schulz, Parker, & Satcher, 2005; Robson, Shannon, Goldenhar, & Hale, 2001). A Project Advisory Group (PAG) made up of labour, OMH, and academic partners provided guidance and oversight for the overall project. The intervention had three main components: (1) developing and supporting a facility-level PAG to design and implement a facility-specific program, (2) conducting a comprehensive risk assessment, and (3) designing and implementing feasible recommendations evolving from the risk assessment.

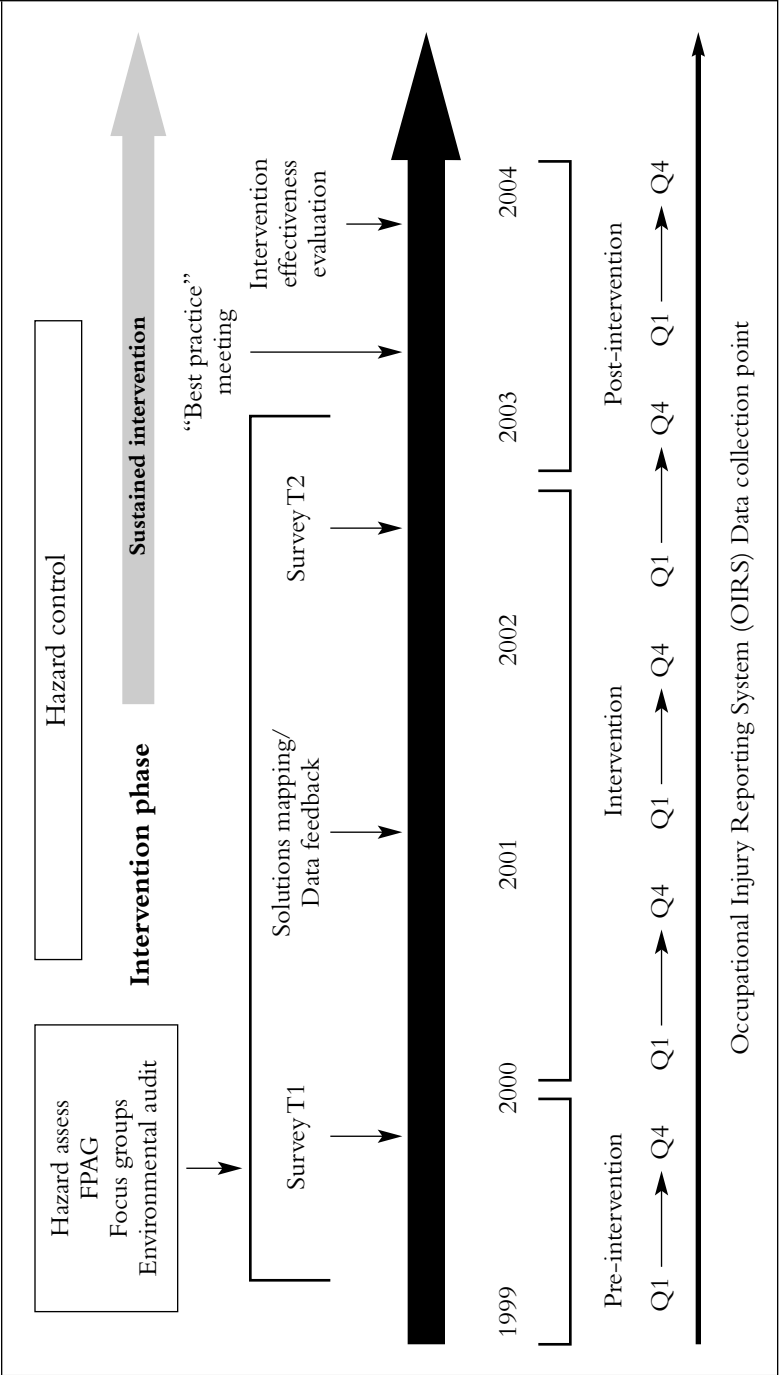
The 4-year project included a number of specific activities as depicted in the study timeline (Figure 1). The timeline was driven in part by the availability of federal funds; however, efforts to sustain the project continue with labour/management cooperation in several OMH facilities.

The OSHA elements of management commitment and employee involvement, worksite analysis, hazard control and prevention, and training were operationalized within the project as described below.

Management Commitment and Employee Involvement: Joint Labour-Management PAGs

The greatest challenge in designing and implementing a comprehensive violence-prevention program is securing strong management and labour (and/or worker) support. The central mechanism for assuring this first and most critical element of the OSHA guidelines was joint hospital-level labour-management PAGs. These local groups of 10 to 15 individuals were responsible for shaping and implementing the violence-prevention program in each intervention workplace. They reviewed draft focus group and survey questions and participated in walk-through environmental surveys. They developed action plans for responding to each specific recommendation in the worksite analysis. This included evaluating recom-

Figure 1 *Workplace Violence Prevention Intervention Study Timeline*



mended changes to clinical and work practices and, where necessary, updating policies and implementing suggested environmental controls. The groups also guided the development of site-specific training and ongoing evaluation of the project.

Worksite Analysis

A primary function of the study team was to conduct a comprehensive worksite analysis based on strong input from the PAG and direct-care providers. The analysis had four components: (1) review of facility injury data, (2) environmental survey of the study wards in each intervention facility, (3) staff focus groups, and (4) staff survey. The first two of these components are described below.

Review of injury data. The collection and evaluation of injury data is critical to the success of any violence-prevention program. The OMH maintains an electronic injury and illness database, the Occupational Injury Reporting System (OIRS), which tracks staff injuries from all causes. Quarterly reports are provided to all the facilities. This system allowed for the analysis of injury trends by job title, time of day, severity, and other factors. The OIRS injury data were tracked over the course of the study (including a retrospective review of data from the preceding 2 years) to evaluate the impact of the intervention on patient-related assaults.

Environmental survey. An architect specializing in the design and renovation of secure state buildings conducted extensive walk-through evaluations of each intervention ward across all work shifts. The survey had six components: (1) review of background data such as floor plans, typical patient characteristics, incident reports, and staffing levels; (2) an initial tour to examine the worksite layout; (3) a discussion with direct-care staff to learn about how the ward operated, typical schedules, and problems or concerns; (4) observation of staff and patient interaction and discussion with staff during both day and evening shifts; (5) follow-up discussion with the PAG to review observations and initial impressions; and (6) preparation of a written report documenting observations, including photographs of the wards, making comparisons with similar environments, and providing short- and long-term recommendations for environmental modification.

Hazard Prevention and Control

The intervention consisted of a number of distinct, ongoing hazard-control activities. Early in the project, the PAGs developed hazard-control action plans to address risks identified in the injury data review, environmental survey, focus groups, and staff survey. The Statewide Project

Advisory Group tracked each facility's progress in implementing these plans.

Environmental controls. Short-term and long-term environmental recommendations were addressed as part of the hazard-control portion of the project. Each intervention facility attempted to implement the feasible short-term recommendations within 6 months of receiving its individual environmental survey report. Long-term recommendations were considered for future capital-improvement projects. In a number of cases, the environmental audit was used to support requests for funding. Examples of specific recommended controls are shown in Figure 2.

Administrative and work-practice controls. A major focus of the intervention was improved communication and teamwork — for example, including direct-care staff in developing and implementing treatment plans and sharing information between shifts regarding individual patient aggressiveness. In one facility a peer “coach” was assigned to help direct-care staff to improve their skills in preventing and managing crisis situations.

Figure 2 Recommendations from Environmental Survey	
Design	Replace solid panel doors with lexan (transparent) panels to allow for line of sight in and out of staff offices (ST). Reorganize patient sleeping areas to reduce staff need to monitor at any given time (LT).
Structure	Secure bedroom wardrobes to floor/wall to avoid use as weapon or as door blockade (ST). Replace solid wall in day room with a lexan (transparent) window to allow for line of sight and more light into this highly used space (LT).
Hardware/Mechanical	Replace open hinges with continuous hinges on doors leading in and out of patient-care areas to reduce pinching hazards (ST). Instal a personal alarm system (LT).
Acoustics	Provide carpet and absorptive wall panels in day room to address poor acoustics and to reduce stress and anxiety (ST).
Functional	Modify medication administration policy to avoid long patient lines and the potential for client-on-client altercations (ST). Implement a smoke-free workplace to reduce workplace violence associated with smoking (LT).
<i>Note: ST = short-term recommendation; LT = long-term recommendation.</i>	

Staff Training and Education

Training and education is a distinct element of the OSHA guidelines. The OMH's Preventing and Managing Crisis Situations (PMCS) is a comprehensive, mandatory two-and-a-half-day course given annually at all OMH facilities by staff certified as PMCS trainers. The curriculum covers assessment of potential violence, non-verbal and verbal de-escalation techniques, approved physical defensive intervention techniques, and application of seclusion/restraint procedures.

Rather than provide redundant training, the project's training element was designed to increase management commitment and employee involvement in the violence-prevention process and to identify additional interventions. Staff learned how to use risk-assessment data (e.g., focus group and staff survey results) to develop a specific hazard-control plan, identify barriers, reach consensus, and keep the process moving. This was accomplished in a participatory, multidisciplinary day-long workshop. It also served as a forum for the PAG and researchers to communicate directly with direct-care staff and managers on the progress of the project. Project-related training began with a presentation and discussion of focus group results, environmental surveys, and the staff survey findings. Next, joint management and labour teams facilitated small group discussions of specific problems identified during the risk-assessment process and spent several hours generating concrete, feasible solutions acceptable to staff and management alike. Over the subsequent 6 months, the PAG developed action plans for each proposed solution and communicated its progress to staff during follow-up meetings.

Evaluation of Intervention Effectiveness

Focus Group Methods

Purposive sampling of direct-care workers at each of the three intervention facilities was conducted in such a way that non-supervisory direct-care workers were recruited to participate in focus groups on work time prior to the commencement of the intervention. Two focus groups at each intervention facility were conducted, allowing for participation across shifts and non-supervisory job titles. The pre-intervention focus groups launched the intervention in the sense that, by discussing the issue, the workers became sensitized and engaged in violence-prevention efforts. The post-intervention focus group was conducted with members of the Facility Project Advisory Groups (FPAGs) from each of the three intervention facilities and observed by the PAG members. Instead of being a confidential forum for staff to discuss violence, the post-intervention group represented an opportunity to share best practices and what worked for each facility.

Focus groups were conducted with direct-care staff to inform survey development and to provide qualitative data on staff perceptions of risk factors for violence on their wards and proposed solutions. Sixty staff members participated in one of six focus groups (two per intervention facility) conducted across all shifts at the three sites. Each 90-minute discussion was led by a trained facilitator, external to the OMH, and was centred on four questions: (1) In your opinion, what are the three leading causes of violence on your unit and/or in your facility? (2) If you were the director in charge of a safe and therapeutic environment, what practical steps would you take to reduce violence, provide safety to the direct care staff, and improve therapeutic treatment of patients? (3) In your opinion, what are the greatest barriers to implementing these practical steps? (4) Are you satisfied with the current violence-prevention core curriculum/training in your facility?

Focus Group Findings

Findings related to common themes emerging from the focus group discussions were presented to the FPAGs for discussion and action. They were also presented to direct-care staff during the project-related training sessions that generated additional ideas for intervention. These themes included the changing patient populations, inadequate staffing and deployment of staff, hierarchical management style, and low management commitment to staff safety. Additional, specific risk factors that emerged from the focus group discussions included ineffective patient programming and problems such as long wait times in food lines.

In the final year of the project, representatives of the three intervention PAGs met with the research staff to discuss lessons learned and the project's successes. This discussion was conducted as a focus group, with one member of the project staff serving as facilitator. Individuals representing the three facilities were asked to discuss what worked and did not work throughout the project. The discussion was recorded on flip charts, summarized in a report, and shared with participants for review, validation, and revision. This report was ultimately shared with the directors of all 26 facilities.

Project successes included a violence-prevention training coach at one study site and the adoption of one facility's written violence-prevention program in the facility's overall strategic plan. A summary of the meeting resulted in the following list of violence-prevention best practices addressing each of the five elements of the OSHA guidelines:

Management commitment to the violence-prevention program

- management communication of its intentions to reduce violence on the wards

- regular participation of senior leadership in violence-prevention meetings
- senior staff presence at all PMCS training sessions and a requirement for management to comply with annual PMCS training
- participation of upper-level administrators in ward rounds and morning report
- ongoing data collection, data sharing, and discussion of injury data with staff
- use of the courts for medication over-resistance and pressing assault charges
- management responsiveness to staff solutions for reducing violence
- allocation of resources for staff training and overtime related to violence prevention
- strong program for post-assault response staff

Employee involvement in the violence-prevention program

- regular communication via the committee process: rounds, shift-to-shift communication
- multidisciplinary STEP committee membership
- team approach to identifying needs and solutions and consensus decision-making on implementation of project recommendations

Hazard-assessment activities

- use of staff focus groups and staff surveys
- periodic environmental audit/assessment and mapping of high-risk areas with staff input
- encouragement of accurate and timely reporting of injuries
- data collection and analysis and review of reporting practices

Hazard-control activities

Infrastructural/organizational

- creation of violence-prevention infrastructure (STEP/PAG committee)
- documentation of the hazard controls implemented or a timetable for implementation
- assessment of hazard-control effectiveness via the committee infrastructure using ongoing data collection and review

Environmental

- assessment of ward movement to avoid prolonged standing in line
- installation of locks wherever necessary
- installation of staff personal alarm system and alarms in all nursing stations and medicine and treatment rooms
- removal of wire glass

Administrative

- ongoing assessment of data collection and data use
- ongoing assessment of PMCS training and management of psychiatric emergencies

Behavioural

- improvement of the shift-to-shift reporting process
- senior staff rounds of treatment units
- clinical/treatment rounds across disciplines, including treatment aides

Staff Survey Methods

A representative staff survey was conducted prior to full implementation of the participatory intervention and 1 year post-intervention. In each of the six facilities (three intervention and three comparison), all staff, including supervisors and administrators, were invited to participate in the survey. Staff were provided release time to complete the survey during work hours. The study coordinator visited the facilities and administered the survey on all three shifts.

Identical direct-care staff surveys were conducted in 2001 and 2003. The survey was adapted from a Washington State survey developed for assessing assaults in state mental hospitals (Bensley et al., 1997). It included sections on risk factors for violence, violence-prevention measures, threats and assaults, and staff perceptions of the quality of the OSHA elements on their ward. The self-administered survey took approximately 20 minutes to complete and was completed on work time.

The survey analysis consisted of the change in staff perceptions of the quality of the OSHA elements on their ward, as well as their change in frequency of assault experience over the preceding 12 months. Staff were asked to evaluate the quality of (1) management commitment to violence prevention, (2) employee involvement in violence-prevention efforts, (3) environmental design of ward (environmental controls), and (4) staff teamwork and cooperation (administrative and work practice controls) on their ward over the preceding 12 months (1 = *poor*, 2 = *fair*, 3 = *good*, 4 = *excellent*). Staff were also asked if they had participated in PMCS training during the previous year (yes/no).

The aforementioned staff assaults were assessed by asking the number of times in the preceding 12 months the worker experienced patient aggression while assigned to duties on their current ward. There were six levels of violence: (1) threat but no physical contact, (2) physical assault but no physical injury, (3) physical assault resulting in mild injury, (4) physical assault resulting in moderate injury, (5) physical assaults resulting in major injuries, and (6) physical assault resulting in permanent/partial physical disability.

Frequencies were examined by facility and also by intervention and comparison group. Analysis of variance was used to test the change in scores, using an alpha of .05 to evaluate level of significance. All analyses were conducted using SPSS Version 11.0.

Staff Survey Findings

Between May 2001 and January 2002 the pre-intervention survey was completed by 406 direct-care staff (90% response rate) from three intervention and three comparison facilities. The post-intervention survey was conducted in the spring of 2003 and was completed by 319 direct-care staff (70% response rate). The number of respondents from individual facilities ranged from 43 to 117 for the pre-intervention survey and 36 to 69 for the post-intervention survey. Because surveys were anonymous and no identifiers were used, it was not possible to match data from pre- and post-surveys. Among respondents, approximately 65% were female; > 70% were 40 years of age or older; 60% were non-white; 50% were mental health therapy aides, 24% were registered nurses, and 26% had various clinical job titles.

Table 1 compares staff ratings, for intervention and comparison facilities (mean value on a scale of 1–4), of the quality of the OSHA elements. The item “percentage trained in the past year” was reported as yes/no. Staff in both intervention and comparison facilities reported statistically significant (or borderline) improvements in the first four elements, while the intervention facilities also reported significant improvement in the fifth element.

Table 2 compares the frequency of reported threats and physical assaults among intervention and comparison facility staff pre- and post-intervention. Overall, nearly 90% of staff reported threats of assault in the preceding 12 months (data not shown), with the mean number ranging from 35 to 70 threats for the two time periods and two groups. By comparison, less than 40% of staff reported a physical assault with moderate injury, with the mean number ranging from 0.8 to 1.76 per staff member. When the difference (or change) in reported threats and physical assaults during the preceding 12 months was calculated for the pre- and post-intervention periods, a slight reduction in the mean change in physical assaults with any level of injury among intervention facility staff and among severe and permanent injury among comparison facility staff was noted. An increase was observed in threats of assault among the staff of both intervention and comparison facilities. Possible interpretations for this finding include: a greater tendency to report these less severe events; a shift of some physical assaults to threats of assault (an averted physical assault); or a real increase in threats of assault.

Table 1 Change in OSHA Element Mean Item Scores for Staff Working in Six New York State Inpatient Psychiatric Facilities (Pre-survey in 2001, Post-survey in 2003)

OSHA Elements	Intervention (N=468)			Comparison (N=257)				
	Mean (SD)	F	P Value	Mean (SD)	F	P Value		
Management commitment ^a	Pre	2.16 (0.88)	19.56	< .001	Pre	2.38 (1.00)	5.52	0.020
	Post	2.53 (0.84)			Post	2.65 (0.82)		
Employee involvement ^a	Pre	2.41 (0.85)	13.39	< .001	Pre	2.43 (0.90)	15.41	< .001
	Post	2.71 (0.81)			Post	2.84 (0.74)		
Environmental design of ward ^a	Pre	2.01 (0.83)	6.01	.015	Pre	2.18 (0.89)	4.56	0.034
	Post	2.21 (0.81)			Post	2.41 (0.82)		
Staff teamwork and cooperation ^a	Pre	2.79 (0.83)	4.74	.030	Pre	2.69 (0.90)	2.96	0.087
	Post	2.97 (0.87)			Post	2.89 (0.83)		
% Training in past year ^b	Pre	62.4 (48.5)	30.29	< .001	Pre	60.7 (49.0)	0.95	0.201
	Post	85.6 (35.2)			Post	66.7 (47.4)		

^a Response options: 1 = *poor*, 4 = *excellent*.

^b Percentage of staff receiving PMCS training in the preceding year.

Table 2 *Change in Frequencies of Threats and Assaults for Psychiatric Hospital Staff Working in Six NYS Inpatient Facilities (Pre-survey in 2001, Post-survey in 2003)*

Threats/Assaults	Intervention (N=468)			Comparison (N=257)		
	Mean Number of Assaults (SD)	Mean Change %	P Value	Mean Number of Assaults (SD)	Mean Change %	P Value
Threat of assault by a patient but no physical injury	Pre	35.30 (70.31)	< .001	Pre	36.24 (72.03)	0.08
	Post	70.00 (90.32)		Post	53.21 (76.02)	
Physical assault by a patient but no injury	Pre	10.26 (38.85)	0.59	Pre	7.21 (31.78)	0.75
	Post	12.43 (43.45)		Post	8.57 (34.07)	
Physical assault by a patient – mild injury	Pre	6.53 (29.50)	0.95	Pre	3.28 (18.02)	0.54
	Post	6.34 (27.07)		Post	4.98 (24.67)	
Physical assault by a patient – moderate injury	Pre	1.76 (7.29)	0.65	Pre	0.85 (1.93)	0.47
	Post	1.45 (6.49)		Post	1.30 (6.81)	
Physical assault by a patient – severe injury	Pre	0.23 (0.95)	0.23	Pre	0.17 (0.60)	0.77
	Post	0.13 (0.54)		Post	0.14 (0.75)	
Physical assault by a patient – permanent injury	Pre	0.09 (0.42)	0.69	Pre	0.06 (0.27)	0.60
	Post	0.08 (0.30)		Post	0.05 (0.28)	

^aNumber of threats/assaults during the preceding 12 months. Unit = Number of times/preceding 12 months.

Trends in facility-level occupational injury data (OIRS) prior to and during the course of this study yielded equivocal results (not shown) and suggest either that facility-level data are not sensitive to the impact of the intervention at the ward level or that the intervention had no detectable impact on incident reports over the study period.

Discussion

This paper has described a process for implementing the OSHA guidelines in the in-patient mental health setting. The process, although examined within the in-patient mental health setting, can serve as a model for all health and social service workplaces regardless of the risk of workplace violence in the setting. The process of worksite analysis, hazard control, education, and evaluation is a traditional approach to workplace safety and, as such, should be incorporated into risk-management activities. In settings with a patient population at lower risk of violence than the mental health setting, such as acute care and outpatient settings, a more limited environmental audit than the one conducted here may be sufficient — for example, a walk-through survey conducted by direct-care and building maintenance staff. It should be pointed out that most health-care workplaces are at risk of workplace violence. The benefit of averting an incident of serious workplace violence far outweighs the cost of a proactive program.

The OSHA guidelines serve as an effective performance-based model for a comprehensive program. Their emphasis on management commitment and employee involvement was critical to the successful implementation of the program at each of the three facilities. The model of ongoing hazard analysis, control, and evaluation has facilitated the continuing growth of each program. The discussion among PAGs from the three intervention facilities in the final year of the project was highly effective for synthesizing and sharing project success stories and will facilitate the dissemination of the project beyond the three study sites. Moreover, future communication will help to sustain and improve programs across all facilities.

Program impact was evaluated through a combination of quantitative and qualitative assessments. Specifically, qualitative (i.e., focus group) data informed quantitative (staff survey) tool development. Both types of data were used by PAGs to define the nature and magnitude of the hazard and to craft control strategies. A comparison of pre- and post-intervention survey data indicates an improvement in staff perception of the quality of the facility's violence-prevention program (i.e., OSHA elements) in both intervention and comparison facilities. Objective data that might validate

staff perception data were not sought since, in general, we were most interested in staff perceptions relative to violence-prevention efforts. Staff in both intervention and comparison facilities reported improvements in management commitment, employee involvement, environmental design of ward, and staff teamwork and cooperation. The intervention facilities also reported improvements in the percentage of staff receiving PMCS training in the preceding year, which may reflect heightened awareness of the importance of training in the context of a comprehensive program.

It should be noted that because this intervention project was conducted within a highly dynamic mental health-care system, the OMH continued to implement a number of statewide initiatives to address workplace violence prior to and during the study. These initiatives included: the Safe and Therapeutic Environment Program (STEP) policy, a statewide Trauma Response policy, a comprehensive employee training initiative, and a related clinical program for trauma and mentally ill substance abusers. It was in this dynamic environment that we measured improvements at both intervention and comparison facilities. Comparison of the change in staff-reported physical assaults did not indicate a statistically significant reduction in staff assaults at the facility level in either intervention or control facilities.

The project has a number of limitations. Many factors, individually and in combination, contribute to physical assaults in the in-patient mental health setting. We did not measure and therefore were unable to control for any of the individual patient or staff characteristics that undoubtedly contribute to the occurrence of assaults. For example, it is recognized that a small percentage of the patient population, less than 10%, is responsible for up to 50% of violence towards staff (Lion, Snyder, & Merrill, 1981). This project did not attempt to develop a specific strategy for preventing the violence perpetrated by this patient subset. We did not control for the movement of these patients throughout the system, which may have contributed to our difficulty in demonstrating a reduction in physical assault over time. The need to address the problem of patients who are frequent assaulters was identified in this project.

The OSHA guidelines focus on controlling workplace violence via environmental modification, review of policy and procedure, and training. Likewise, this project focused on these types of prevention activities. In addition, an intervention designed to promote change at the organizational level is likely to require a longer follow-up period than 1 year between the project-related training and the post-intervention survey. In addition, because of the relative intensity of the intervention, the number of participating facilities was limited (i.e., study units and

staff). Lastly, we were unable to randomly assign facilities to either the intervention or the comparison group, and therefore were unable to control for many unmeasured differences between and among intervention and comparison facilities.

Among the project's many strengths was the participatory research framework, which maximized the expertise and collaborative work of academic researchers, management, labour unions, and direct-care staff. A second important strength was the commitment of the OMH Multi-Union Health and Safety Committee to the transparent and ongoing evaluation of its violence-prevention activities, allowing for the description and evaluation of this unique endeavour. In an effort to communicate the results to other OMH facilities and beyond, the project findings were presented at a meeting of the 26 facility directors upon completion of the funded research project.

In conclusion, this paper provides evidence of the feasibility and positive impact of a comprehensive violence-prevention program, based on the OSHA guidelines, within the in-patient mental health workplace. In addition, the paper has described the challenges entailed in evaluating a program's impact in mental health settings as well as the importance of using both quantitative and qualitative measures to assess impact. Evaluation of the project's sustainability will include conducting future focus groups in the intervention facilities and continuous evaluation of the OIRS data on injuries related to patient behaviour.

References

- American Association of Colleges of Nursing. (2004). *AACN position statement for workplace violence*. Retrieved June 9, 2006, from www.aacn.org/AACN/pubpolcy.nsf
- American Nurses Association. (1994). *Workplace violence: Can you close the door on it?* Retrieved June 9, 2006, from www.nursingworld.org/dlwa/osh/wp6.htm
- Arnetz, J. E., & Arnetz, B. B. (2000). Implementation and evaluation of a practical intervention programme for dealing with violence towards health care workers. *Journal of Advanced Nursing*, 31(3), 668–680.
- Bensley, L., Nelson, N., Kaufman, J., Silverstein, B., & Kalat, J. (1993). *Study of assaults on staff in Washington State hospitals: Final report*. Seattle: Department of Labor and Industries, State of Washington.
- Bensley, L., Nelson, N., Kaufman, J., Silverstein, B., Kalat, J., & Walter Shields, J. (1997). Injuries due to assaults on psychiatric hospital employees in Washington State. *American Journal of Industrial Medicine*, 31, 92–99.
- Canadian Federation of Nurses Unions. (1994). *Violence in the workplace*. Policy statement. Ottawa: Author. Retrieved June 9, 2006, from www.cna-nurses.ca/CNA/documents/pdf/publications/FS22_Violence_Workplace_e.pdf

- Canadian Nurses Association. (2002). *Violence*. Position statement. Ottawa: Author. Retrieved June 9, 2006, from www.cna-aiic.ca/CNA/documents/pdf/publications/PS57_Violence_March_2002_e.pdf
- Carmel, H., & Hunter, M. (1990). Compliance with training in managing assaultive behavior and injuries from inpatient violence. *Hospital and Community Psychiatry, 41*(5), 558–560.
- CDC/NIOSH. (2001). *The national occupational research agenda*. Cincinnati: National Institute for Occupational Safety and Health.
- Drummond, D., Sparr, L. F., & Gordon, G. H. (1989). Hospital violence reduction among high-risk patients. *Journal of the American Medical Association, 261*(17), 2531–2534.
- Duhart, D. T. (2001). *Violence in the workplace, 1993–99*. (December 2001, NCJ 190076.) Washington: US Department of Justice, Office of Justice Programs.
- Duncan, S. M., Hyndman, K., Estabrooks, C. A., Hesketh, K., Humphrey, C. K., Wong, J. S., et al. (2001). Nurses' experience of violence in Alberta and British Columbia hospitals. *Canadian Journal of Nursing Research, 34*(4), 57–78.
- Flannery, R. B., Hanson, M. A., & Penk, W. E. (1994). Risk factors for psychiatric inpatient assaults on staff. *Journal of Mental Health Administration, 21*(1), 24–31.
- Flannery, M., Rosen, H., & Turner, K. (1998). Victims no more: Preventing home care aide abuse. *Caring, 17*(8), 48–50, 52–43.
- Gerberich, S. G., Church, T. R., McGovern, P. M., Hansen, H. E., Nachreiner, N. M., Geisser, M. S., et al. (2004). An epidemiological study of the magnitude and consequences of work related violence: The Minnesota Nurses' Study. *Occupational and Environmental Medicine, 61*(6), 495–503.
- Goodridge, D., Johnston, P., & Thomson, M. (1997). Impact of a nursing assistant training program on job performance, attitudes, and relationships with residents. *Educational Gerontology, 23*, 37.
- Hesketh, K. L., Duncan, S. M., Estabrooks, C. A., Reimer, M. A., Giovannetti, P., Hyndman, K., et al. (2003). Workplace violence in Alberta and British Columbia hospitals. *Health Policy, 63*, 311–321.
- Hunter, M. E., & Love, C. C. (1996). Total quality management and the reduction of inpatient violence and costs in a forensic psychiatric hospital. *Psychiatric Services, 47*(7), 751–754.
- Infantino, J. A., Jr., & Musingo, S. Y. (1985). Assaults and injuries among staff with and without training in aggression control techniques. *Hospital and Community Psychiatry, 36*(12), 1312–1314.
- International Council of Nurses. (2000). *Abuse and violence against nursing personnel*. Position statement. Geneva: Author.
- International Labor Organization. (1998). *When working becomes hazardous: World of work*. Retrieved June 9, 2006, from www.ilo.org/public/english/bureau/inf/magazine/26/violence.htm
- Israel, B. A., Eng, E., Schulz, A. J., Parker, E. A., & Satcher, D. (2005). *Methods in community-based participatory research for health*. San Francisco: John Wiley.

- Lehmann, L., Padilla, M., Clark, S., & Loucks, S. (1983). Training personnel in the prevention and management of violent behavior. *Hospital and Community Psychiatry, 34*(1), 40–43.
- Lion, J., Snyder, W., & Merrill, G. (1981). Underreporting of assaults on staff in a state hospital. *Hospital and Community Psychiatry, 32*(7), 497–498.
- Lipscomb, J., & Love, C. (1992). Violence toward health care workers: An emerging occupational hazard. *American Association of Occupational Health Nurses, 40*(5), 219–228.
- Love, C. C., & Hunter, M. E. (1996). Violence in public sector psychiatric hospitals. Benchmarking nursing staff injury rates. *Journal of Psychosocial Nursing and Mental Health Services, 34*(5), 30–34.
- Matthews, L. R. (1998). Effects of staff debriefing on post-traumatic stress symptoms after assaults by community housing residents. *Psychiatric Services, 49*(2), 207–212.
- McPhaul, K. M., & Lipscomb, J. A. (2004). Workplace violence in health care: Recognized but not regulated. *Online Journal of Issues in Nursing, 30*(3), 7.
- Parkes, J. (1996). Control and restraint training: A study of its effectiveness in a medium secure psychiatric unit. *Journal of Forensic Psychiatry, 7*(3), 525–534.
- Rippon, T. J. (2000). Aggression and violence in health care professions. *Journal of Advanced Nursing, 31*(2), 452–460.
- Robson, L. S., Shannon, H. S., Goldenhar, L. M., & Hale, A. R. (2001). *Guide to evaluating the effectiveness of strategies for preventing work injuries: How to show whether a safety intervention really works*. DHHS (NIOSH) #2001-119. Cincinnati: Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health.
- Runyan, C. W., Zakocs, R. C., & Zwerling, C. (2000). Administrative and behavioral interventions for workplace violence prevention. *American Journal of Preventive Medicine, 18*(4 Suppl), 116–127.
- Toscano, G., & Weber, W. (1995). *Violence in the workplace*. Washington: US Department of Labor, Bureau of Labor Statistics.
- UIIPRC. (2001). *Workplace violence: A report to the nation*. Iowa City: University of Iowa.
- US Department of Labor & OSHA. (1996). *Guidelines for preventing workplace violence for healthcare and social service workers*. OSHA #3148. Washington: US Department of Labor, Occupational Safety and Health Administration.
- World Health Organization. (2005). *Framework guidelines for addressing workplace violence in the health sector*. Retrieved June 9, 2006, from www.who.int/violence_injury_prevention/violence/activities/workplace/en

Authors' Note

This study was funded by NIOSH RO1 OH04051. We would like to thank Dr. Blair Maddy and Matt London for their thorough and constructive review of various drafts of this paper. We would also like to acknowledge the leadership of our environmental consultant, Kevin Murrett, in conducting the environmental assessments for this project.

Jane Lipscomb, RN, PhD, is Professor, School of Nursing, University of Maryland, Baltimore, United States. Kathleen McPhaul, RN, PhD, is Assistant Professor, School of Nursing, University of Maryland. Jonathan Rosen, MS, CIH, is Director, Occupational Safety and Health Department, New York State Public Employees Federation. Jeanne Geiger Brown, RN, PhD, is Assistant Professor, School of Nursing, University of Maryland. Mona Choi, RN, PhD, is Research Assistant, School of Nursing, University of Maryland. Karen Soeken, PhD, is Professor, School of Nursing, University of Maryland. Victor Vignola, BS, is Agency Labor Relations Specialist, New York State Office of Mental Health. Deborah Wagoner is Director, Center for Human Resources Management, New York State Office of Mental Health. Janet Foley, BS, is Director, Civil Service Employees Association. Peggy Porter, RN, BS, COHN-S, is Health and Safety Coordinator, New York State Correctional Officers and Police Benevolent Association.

Double attachement, violence conjugale et grossesse

**Kristin F. Lutz, Mary Ann Curry, Linda C. Robrecht,
M. Kay Libbus et Linda Bullock**

Cette étude visait à intégrer les théories du processus de la motivation afin de définir un cadre d'analyse pertinent qui pourrait servir à expliquer les réactions comportementales des femmes face à la violence conjugale pendant la grossesse. Pour analyser le phénomène, les auteures proposent le concept de double attachement. Cette notion désigne les mécanismes psychologiques et sociaux simultanés et bien souvent conflictuels qui amènent la future mère vivant aux côtés d'un conjoint violent à s'attacher, au fil des tâches développementales associées à son nouveau rôle, à l'enfant encore à naître et à son partenaire intime. Le concept de double attachement est l'aboutissement d'un processus inductif-déductif fondé sur l'expérience en milieu clinique, une recension de la documentation et des données qualitatives provenant de deux études sur la violence pendant la grossesse. Les auteures arrivent à la conclusion qu'il offre un cadre utile pour interpréter les réactions comportementales des femmes enceintes face à la violence. Elles suggèrent des avenues de recherche et d'intervention qui permettront de mettre au point des méthodes qui s'en inspirent.

Mots clés : grossesse, violence pendant la grossesse, violence conjugale

Double Binding, Abusive Intimate Partner Relationships, and Pregnancy

**Kristin F. Lutz, Mary Ann Curry, Linda C. Robrecht,
M. Kay Libbus, and Linda Bullock**

The purpose of this study was to extend and integrate the process theories of abuse and becoming a mother in order to provide a contextually appropriate perspective for understanding women's behavioural responses to intimate partner abuse during pregnancy. Double binding is proposed as a construct for understanding intimate partner abuse during pregnancy. Double binding refers to the simultaneous and often conflicting psychological and social processes of binding-in to the unborn child and to the abusive intimate partner that women engage in as they perform the developmental tasks associated with becoming a mother while living with an abusive partner. This construct was developed through an inductive-deductive process using clinical experience, a literature review, and qualitative data from 2 studies of abuse during pregnancy. The authors conclude that double binding is a suitable lens through which to interpret pregnant women's behavioural responses to abuse. They offer suggestions regarding clinical practice and research to further develop appropriate interventions incorporating this construct.

Keywords: Pregnancy, motherhood, abuse during pregnancy, domestic violence

The purpose of this paper is to present a construct, double binding, that integrates the developmental process of becoming a mother with the process of being in an abusive relationship. The integration of these two theoretical perspectives is an important step in broadening our understanding of the behavioural dynamics exhibited by pregnant women in abusive relationships. Becoming a mother assumes a positive, supportive intimate partner relationship, yet pregnancy and being in an abusive relationship often coexist and present competing behavioural demands and social expectations for women. Consistent with the uniform definitions of intimate partner violence put forth by the Centers for Disease Control and Prevention (Saltzman, Fanslow, McMahon, & Shelley, 1999, pp. 11–13), for this study intimate partners included spouses, former spouses, and non-married partners, and abusive acts included physical violence, sexual violence, threat of physical or sexual violence, and psychological or emotional abuse (including coercive tactics) with prior physical or sexual violence or threat of physical or sexual violence.

Background

Between 3.0% and 18.4% of pregnant women report experiencing abuse by an intimate partner (Bacchus, Mezey, & Bewley, 2003; Neggers, Goldenberg, Cliver, & Hauth, 2004; Reichenheim & Moraes, 2004), although the actual incidence is unknown as significant barriers to disclosing abuse during pregnancy, such as fear of partner retaliation, fear of being reported to child protection services, and a desire to maintain a positive public perception of a normal family are common (Bacchus et al.; Lutz, 2005a, 2005b). Intimate partner violence during pregnancy has been associated with an increased risk of the woman being murdered (Campbell, 1999) or delivering a low-birth-weight infant (Curry, Perrin, & Wall, 1998; Lipsky, Holt, Easterling, & Critchlow, 2003; Murphy, Schei, Myhr, & DuMont, 2001). Also, intimate partner abuse may be responsible for many cases of pregnancy-associated mortality (Horon & Cheng, 2001; Krulewitch, Pierre-Louis, Leon-Gomez, Guy, & Green, 2001).

As a consequence, public health and professional efforts have been directed at implementing routine screening for abuse during pregnancy. Protocols endorsed by the March of Dimes and the Family Violence Prevention Fund are founded on the research-based empowerment model developed by McFarlane and Parker (1994) for all women experiencing violence. This model includes a private face-to-face assessment, review of the cycle of violence, assessment of the woman's increased risk for danger, and discussion of the woman's options whether she decides to stay or leave. Actions if she stays include calling the police or obtaining an order of protection; actions if she leaves include assembling essential items to take such as important documents, car keys, and clothing. However, neither this protocol nor the few intervention studies designed to reduce the prevalence of abuse during pregnancy (Curry, Durham, Bullock, Bloom, & Davis, 2006; McFarlane & Wiist, 1997; Parker, McFarlane, Soeken, Silva, & Reel, 1999) explicitly consider the unique contextual circumstances imposed by pregnancy. While we unequivocally support the importance of screening pregnant women for abuse and offering pertinent education and information, we also believe that in order to design interventions that meet the needs of pregnant women experiencing abuse, a theoretical understanding of the interacting and competing behavioural processes is needed.

Developing Our Construct

An inductive and deductive approach that integrated clinical experience, two separate studies, and a re-examination of the literature was used to develop the construct of double binding. While the first author (KL) was

publishing her dissertation data on women's experiences of abuse during pregnancy, she realized for the first time that our current approach to abuse screening and intervention does not take into account the normal maternal process of becoming a mother. At the same time, the other authors asked KL to consult with them on the analysis of qualitative data they had collected as part of a larger intervention study (Curry et al., 2006; Libbus et al., 2006). During the resultant consultation, the construct of double binding emerged, which is the two internal opposing forces encountered by pregnant women in abusive relationships: becoming a mother and being in an abusive relationship. Clinically, the construct made enormous sense to all of the authors, who collectively have well over 50 years of nursing experience with pregnant women. At this point, the literature on maternal role attainment and process theories of abuse were critically re-examined. The next step was a presentation, given by MAC, of the construct to members of the Nursing Research Consortium on Violence and Abuse, who supported its conceptual integrity. Following that, KL and MAC each systematically examined the existing qualitative data from two studies for exemplars of the construct. We then read all of the selected exemplars from both of the studies and reached agreement on their appropriateness. We chose those exemplars that best fit the construct of double binding. Exemplars were subsequently organized according to the tasks of becoming a mother. Those exemplars and the organization were then shared with all of the authors, all of whom had been involved with data analysis in the original studies and the analytic discussion regarding double binding. Although there were other examples that fit the construct, only those that best illustrated the different tasks of pregnancy and the construct of double binding were included. While some data appeared to contradict the construct of double binding, overall the construct seemed to fit well with the majority of the interview data.

In the remainder of the paper, we will first review the theories of becoming a mother and the process theories of being in an abusive relationship, then briefly describe the methods used and the findings of two qualitative studies, and, finally present exemplars that support the construct of double binding.

Becoming a Mother

Mercer recently proposed that the term "becoming a mother" replace the term "maternal role attainment" in order to more accurately reflect the dynamic process that women engage in during pregnancy and motherhood (Mercer, 2004). The term is used here to describe the multiple biological, psychological, social, and transitional changes (Mercer, 1986;

Rubin, 1984) that women experience during pregnancy. Rubin was among the first to recognize the cognitive work that pregnant women perform in the process of becoming a mother from the perspective of the women experiencing it (Rubin). Her theory includes four maternal tasks: (1) seeking and ensuring safe passage for mother and infant, (2) securing and ensuring acceptance of the pregnancy and the new family member by significant others, (3) binding-in to the child, and (4) giving of oneself to the dependent, valued child. Binding-in to the pregnancy is the process that a woman undergoes as she realizes that she will become a mother; it is characterized by ensuring safe passage for herself and the unborn child. Part of seeking safe passage for the child is the task of promoting social acceptance of the child, beginning with the acceptance of the child by its father. Consequently, the quality of the mother's relationship with the father of the baby influences all of her maternal tasks, but most significantly whether and how he accepts and supports the pregnancy and the developing child. Incorporated into the father's acceptance of the baby is the maternal dream of having an ideal, loving, supportive family, and home.

Therefore, the ideal suggested by the binding-in process becomes a goal for pregnant women even with the wide variations in family structure and complex or hazardous social conditions. The appearance of a welcoming, stable, and loving environment for the infant may conceal a partner's abuse and project optimism about the family's future, a future that is in reality threatened. For women who are in abusive relationships, the process of binding-in to the child involves trying to maintain the appearance of a secure relationship and doing whatever is necessary to be a good mother. Although women negotiate the maternal tasks of pregnancy in a style that is unique to each pregnancy (Mercer, 2004), how the context of abuse affects women's achievement of these tasks has not been considered. While a few studies have reported the negative effects of marital ambivalence, conflict (Porter & Hsu, 2003), and role strain (Mercer, 1986) and the positive effects of the husband being a good father (Paris & Helson, 2002) on becoming a mother, the effects of abuse have not been measured. Furthermore, most studies on becoming a mother have been limited to married, cohabiting couples.

Similarly, pregnant women's decisions regarding abusive relationships have not been considered in the context of the developmental tasks of becoming a mother. Thus, little is known about how a woman executes these maternal tasks and becomes a mother while making decisions about her relationship with an abusive intimate male partner who jeopardizes the family unit and the safety of the woman and the unborn child.

Process Theories of Intimate Partner Violence

For women in abusive relationships, another process of binding occurs. According to Landenburger's (1989) process theory of abuse, all women experience an initial, or binding, phase and may or may not progress to the phases of enduring, disengaging, and recovering. The process of binding refers to the period when the woman begins to realize that there is something wrong with the relationship but believes that the abusive behaviour can be fixed. Women often initially believe that the abuse is their fault and that they have the power to change their partner's behaviour. They feel that they can construct a loving relationship — that is, they bind to the relationship. As a woman becomes more certain that she is in an abusive relationship, she still desires a loving relationship with her partner, without the abuse; this desire continues to bind her to the relationship. Wishing for this loving relationship, overlooking warning signals, working on the relationship, and wondering what it is about her that provokes the abuse are components of binding.

In the enduring phase the woman perceives herself as putting up with the abuse. The good in the relationship is valued and is used as a mechanism for blocking out the abuse. This phase is marked by placating, feeling responsible, covering up the abuse, and shrinking one's self. During the disengaging phase the woman begins to identify with other women in similar situations. This phase consists of labelling the relationship as abusive, seeking help, reaching a breaking point, reclaiming a sense of self, and leaving or considering leaving. The final stage, recovery, is a time of readjustment after leaving the abuser, which continues until the woman regains balance in her life. This phase is marked by struggling for survival, grieving for the relationship, and searching for meaning. Campbell and Campbell (1996) postulate that during pregnancy most women will probably be in the binding or enduring phases; because the relationship is likely to be new, they want to make it work, and they want to believe that things will get better when the baby is born. Other researchers describe similar process stages of abusive relationships (Dienemann, Campbell, Landenburger, & Curry, 2002; Merritt-Gray & Wuest, 1995). A limitation of Landenburger's model is that it is based on data from women who left their abusive relationship, whereas not all women leave an abusive relationship.

Double Binding

Double binding refers to the simultaneous and often conflicting psychological and social processes of binding-in to the unborn child and the abusive intimate partner that women experience as they engage in the developmental tasks associated with becoming a mother while living in

an abusive partnered relationship. The tasks of ensuring safe passage for herself and the baby and securing and ensuring acceptance of the pregnancy by the baby's father and significant others are inextricably linked with the realities of being abused by the baby's father. Binding-in to the abusive partner by working harder on the relationship, ignoring warning signs, and hoping that things will get better may be a way of coping with this internal conflict. A consequence of double binding is the sense of living in two separate worlds (Lutz, 2005a, 2005b). One life is public, reflecting the pregnancy, the other private, reflecting the abuse. The public life represents the external, idealized view of the woman's life, pregnancy, and family. The private life represents the reality of abuse that the woman comes to recognize but does not wish to publicly acknowledge.

Qualitative Studies

Methods used to collect the original qualitative data in each of the studies will be summarized. Detailed descriptions can be found elsewhere (for the first study, Lutz, 2005a, 2005b; for the second, Libbus et al., 2006). Both studies were conducted in accordance with methods approved by the Institutional Review Boards associated with the research sites and academic institutions.

Study 1: Women's Experiences of Abuse during Pregnancy

The purpose of this study was to generate a theoretical understanding of women's experiences of intimate partner abuse during pregnancy using a grounded theory method, dimensional analysis (Schatzman, 1991). Twenty-one in-depth interviews were conducted with a convenience sample of 12 ethnically and sociodemographically diverse women over a 1-year period. Participants were English-speaking women who screened positive for physical or sexual abuse on the Abuse Assessment Screen (McFarlane & Parker, 1994) or reported experiencing emotional abuse by an intimate male partner during a current ($N = 5$) or previous ($N = 7$) pregnancy. Each participant experienced emotional abuse and some form of physical abuse during pregnancy or postpartum. Their ages ranged from 18 to 43 at the time of the interview. See Table 1 for demographics.

Data were collected through in-depth audiotaped interviews that lasted about 2 hours. Consistent with the grounded theory method, interview questions evolved to clarify concepts and conceptual linkages and to allow for theoretical sampling. A grounded theory of living two lives emerged from the data. Living two lives was a result of disparities between the two concurrent phenomena of abuse and pregnancy.

Table 1 *Demographic Characteristics*

Variable	Study 1 (N=12)		Study 2 (N=18)	
	Mean	Range	Mean	Range
Age	29.7	18–43	26.7	16–34
Number of pregnancies	3.1	1–9	2.8	1–7
Number of children	2.0	0–5	1.1	0–4
	Number	%	Number	%
<i>Race</i>				
Caucasian	6	50	9	50
Black	4	33	6	33
Hispanic	–	–	2	11
Arab American	2	17	–	–
Bi-racial	–	–	1	5
<i>Marital status during abuse</i>				
Married	6	50	6	33
Single	3	25	12*	67
Divorced	3	25	–	–
<i>Educational status</i>				
College graduate	6	50	2	11
Some college	3	25	5	28
High school or GED	1	8	10	56
Less than high school	2	17	1	5
*Of these women, five (28%) were single and living with their partner and seven (39%) were single and not living with their partner. In the first study, women were classified by marital status alone.				

Pregnancy provided the impetus for reinvesting in the partnered relationship and constructing a family. Few women left their abusive relationship during pregnancy; they left only under certain circumstances, such as increasing violence.

Study 2: An Intervention Study for Abused Pregnant Women

Those enrolled in a larger randomized clinical trial of a nursing case-management intervention for pregnant abused women (Curry et al., 2006) who screened positive for current intimate partner abuse on the Abuse Assessment Screen (McFarlane & Parker, 1994) were invited to take part in the qualitative arm of the study (Libbus et al., 2006). Eighteen ethnically and sociodemographically diverse women ranging in age from

16 to 34 completed a total of 43 in-depth face-to-face interviews. See Table 1 for demographics. Interview data were collected using a semi-structured interview guide developed in collaboration with Landenburger to incorporate pivotal features of her process theory of abuse described earlier (Landenburger, 1989, 1993). Women completed up to four interviews, two during pregnancy and two following delivery. Most women completed multiple interviews; six completed all four, one completed three interviews, five completed two interviews, and six completed one interview. The interviews lasted from 1 hour to over 2 hours. The majority of the women became trapped and endured violent relationships if they believed that remaining with the partner was in the best interests of their unborn child. Fears about reporting the violence, chaos, instability, and lack of personal and community resources contributed to the women's decision to remain in the abusive relationship.

Exemplars of Double Binding

Qualitative data from both studies suggest that the inextricably linked and yet conflicting realities of being pregnant and experiencing abuse by the baby's father made the developmental task of becoming a mother extraordinarily challenging. The maternal process of binding-in to the baby and seeking safe passage for the woman and the baby was fraught with difficult choices. For a few women this meant leaving the abuser, but for the majority it meant binding-in to the relationship with the baby's father in order to achieve safe passage for mother and baby and to secure his acceptance of the pregnancy in order to realize the goal of being part of a "normal" family. To protect the participants, the names used in the exemplars are aliases.

Ensuring Safe Passage for Self and Baby

Binding-in to the father of the baby provided some women with the tangible and emotional support needed to seek safe passage. Janice presented an example of tangible support:

Another reason I don't want to leave is because right now he's supporting us... I can't go back to school or get a job. I have to take care of the baby, you know. And if I ever did leave him, I wouldn't have anything to fall back on. So that's one reason I want to stick it out, because he's trying for us... I have [thought of leaving] but then I wouldn't have any way to let my baby have a good future.

The women's desire for emotional support from their partners was compelling: "Well, behind my decision to stay with him is just the fact that somebody wants me and loves me" (Sarah); "I don't want to do it

alone, either. Who wants to do it alone, because it's a lot of stress? ...a lot of people, believe it or not, want somebody to lean on" (Anne).

I didn't want to be alone during pregnancy. My last pregnancy I felt like I was alone, even though I was married, because [my husband]...was so detached from the pregnancy. He didn't hold my son until he was 6 months old. So...I didn't want to be alone. That reflected my attitude. I was a huge wreck when I first became pregnant. I mean, I was awful... I wasn't very nice. And then when things... [began to get worse]...and it was just — it was bad — and then I realized that it was best for both me and the baby just to get out of it. But I didn't want to be alone, I didn't want that at all... I tried everything, because I wanted that family. I wanted us to be together, and so I could put up with a lot.... I think you do put up with a lot. Every woman wants that family when they are pregnant, you know, they don't want to be alone. (Tammy)

Securing and Ensuring the Father's Acceptance of the Pregnancy

The desire to secure the father's acceptance of the pregnancy and his involvement in the baby's life was another reason for binding-in to him. As Martha explained:

I think...everything that's been going on, as far as not getting along, arguing a lot, I think it kind of made me think about we're going to have a child together and do I want to just have this child, you know, with a father that's not around. I think it made us try to work harder at staying together. Sometimes I go, "Maybe I should leave, maybe I should stay"... I was like that before, but now, since I'm pregnant, I'm leaning more [towards] staying together.

To Jana, pregnancy was both a sign that she should not end the relationship and a beacon of hope that things would change and the family would have a future:

I think that the pregnancy was like a sign...of how you are supposed to be married to that person, that you're not meant to be independent. I think that having left so many times and then to have to come back, after a while I began to feel defeated and, like, it was hopeless. And I think that those feelings are probably more...pronounced during pregnancy, but also I think that there is this almost family inclusion kind of thing that happens when you're pregnant that's sort of, like, something new maybe to you...maybe the future will be different, and just this whole emphasis on family that really detracts from any thoughts of leaving.

Securing and ensuring the father's acceptance of the pregnancy also allowed the women to achieve the appearance of a "normal" family. As Raina put it, "I always wanted somebody that we could sit at home on

Friday or Saturday nights and watch movies, talk, eat popcorn, and play board games, and I'm happy because...that's what adults do." However, achieving this goal sometimes meant having to choose between having the father of the baby involved or gaining the acceptance of significant others, particularly family members. Sadly, for some women it meant losing the support of their own mother during pregnancy. Rachel's experience was not uncommon:

And then my mother — and I love my mom so much; she has helped me so much — and she wants me, she sees that I hurt, she wants to help me. And so she said she would help me move out with the condition that he'd never move in. I can't promise her that because I feel so controlled by things that he says or does, so I couldn't promise that to her. So I told her I couldn't accept it because I couldn't. She said that it would hurt our relationship, that I couldn't bear to do that to her. So, I mean, I have people that want to help me with the condition that he's out of the picture, but he'll never totally be out of the picture because he'll have contact with his children and with me.

A way of circumventing this choice was to maintain secrecy or silence about the abuse. Nancy's solution was to not let her mother know: "She suspected but she wasn't sure. When I did come around, it was just like she knew that we had been fighting. I just didn't want her to see me." [Question: But you never told her?] "No." Susan explained that by not telling people about the abuse, a woman could delay making the decision about staying or leaving until she was ready to do so:

I didn't talk to my mom about it, or my parents, because...I thought they might just get on a plane and get out here and inflame everything more, and I didn't know what I wanted to do, so I was afraid to talk to people about it because I didn't know what to do...and then I'm going to have to make a decision, and I'm not ready yet. I'm too stressed out. And I remember when I was thinking about getting a divorce when I was pregnant, my dad — one of the only words of wisdom that my dad has ever given me that I thought was worth very much — but he said, "This probably isn't the time to be making big decisions." I just kept coming back to that, you know, this probably is not the time to be making big decisions. Because the last thing I wanted to do was do something and feel like it was the wrong thing or second-guess myself or whatever.

Some participants had never revealed the abuse to anyone other than the researchers. One woman said, "I never talk to anyone and I don't think I ever will, because...some things are just too painful to talk about." Maintaining secrecy about the abuse did not come without a cost, however:

Most of my friends that I talk to are very critical. They want to save me... I have a really good friend at work, really good friend, and she said, "Don't tell me any more. I don't want to know." My sister is the same way. So I don't feel like I can really talk to anybody... that's a stress even more, because you can't release any of it. (Rachel)

Binding-in to the Child

For many of the women, binding-in to the child occurred in a different manner from what might be considered typical behaviour, such as attending childbirth classes, stopping smoking, or seeking information about breastfeeding. Binding-in for the women who were abused during pregnancy was often focused on meeting basic needs, such as finding stable housing and procuring baby supplies in the absence of financial support from the baby's father. Another significant act of binding-in was protecting the fetus from the abuse. The few participants who did leave their abusers during pregnancy felt compelled to do so in order to protect their unborn child or their other children, sometimes fearing for their own lives or those of their children. In these instances, the breaking point ranged from a physical assault to the abusive partner's requesting a DNA test before agreeing to buy baby equipment, causing the woman to view the intimate relationship from a different perspective and preventing further binding-in to the abusive partner. For the women who remained with the baby's father, protecting the fetus often meant seeking ways to reduce the violence or modifying one's own response to the violence. "I don't think it's worth getting upset and angry about," said Nina. "I've got to worry about this baby, and it's not going to do any good with everything else that I have going on with me and carrying this baby." Similarly, Rose, who had physically fought back in the past, had changed her response during pregnancy:

Well, he would make me mad, you know, call me names and build up my anger so bad that I would just slap him in the face, but now that I'm pregnant, I won't... I don't want to be touched, because I'm afraid, like, the baby, you know, something will happen, so I have kept my hands to myself and I feel like I've grown up a lot more.

In summary, the data collected from women who experienced abuse during pregnancy challenge traditional notions of specific behavioural responses during the process of becoming a mother. For many of these women, the process of becoming a mother occurred not through drastic shifts in behaviour or attitude, but in subtle, often incremental changes not readily discernible to others and not necessarily interpreted as "true" maternal behaviour.

Discussion

The results of this study should be interpreted cautiously, as they are limited by the methodology of the study, which included extracting exemplars representing an a priori construct and a small sample size. However, the integration of existing process theories of intimate partner violence and becoming a mother into the construct of double binding may provide a more contextually appropriate lens for investigating and intervening with women who experience abuse during pregnancy. Incorporating the developmental tasks of becoming a mother in future studies of violence during pregnancy would further enhance our understanding of the processes that result in women's behavioural choices regarding their intimate relationships and their health behaviours during this time. For example, the literature typically refers to women who remain in violent relationships as facing barriers to leaving, such as fear of the perpetrator, limited financial options, or lack of community resources (Cloutier et al., 2002). While we realize that these are solid reasons for not leaving, we believe that for many pregnant women there are equally compelling reasons for remaining in an abusive relationship, reasons that are grounded in the desire to be a good mother and to provide a stable and loving home and family for the baby. The construct of double binding offers a developmentally relevant perspective for considering some of these other factors, such as ensuring safe passage for the woman and the baby, securing and ensuring acceptance of the pregnancy by the father and significant others, maintaining an outward appearance of a "normal family," and binding-in to the baby.

The construct of double binding provides an opportunity to design appropriate clinical interventions for women who experience intimate partner violence during pregnancy. While we support current recommendations regarding education and intervention, we believe that protocols could be more responsive and appropriate to the needs of pregnant women who are abused by their partners. For example, recommendations concerning abuse disclosure should include the acknowledgement that pregnant women have good reasons for wanting to maintain privacy concerning their abuse experiences and that the information will be safe (within the confines of reporting laws) and their public image protected.

Education should include the recognition that pregnancy can add to women's conflict about whether to stay in an abusive relationship and that the decision is usually made with the baby's best interests in mind. A review of a woman's choices should include an evaluation of the importance to her of the abusive partner's acceptance of the pregnancy and his role in providing support. If she chooses to stay with her partner,

then strategies will have to be developed to address her material and emotional needs. The focus should be on helping the woman to take care of herself and the baby, with or without the partner's support. Recognizing and reinforcing maternal behaviours, even subtle behaviours such as decreasing smoking, making healthy nutritional choices, or choosing to avoid confrontation with the abusive partner may constitute important means of support for a woman who is struggling to do what is best for her baby and her family. The extent to which a woman has kept the violence a secret from family and friends, particularly from her mother, should be taken into account. Ways must be found to help the woman stay safe within the abusive relationship, such as by protecting the fetus by choosing not to fight back. We also recommend that the woman's risk for homicide be evaluated using the Danger Assessment (Campbell, 1999) and that other options be explored, such as calling the police or obtaining an order of protection. If the woman's choice is to leave the abusive partner, we recommend that, in addition to providing safety planning and referrals for community domestic violence resources, an evaluation of her needs for pregnancy-specific support be carried out.

Recommendations for research include additional studies specifically designed to test the strength of the construct of double binding. Development and evaluation of abuse screening and intervention protocols for pregnant women that incorporate the construct of double binding are also needed. We strongly recommend that these protocols be developed with and evaluated by women who have experienced abuse during pregnancy. We also recommend that a variety of screening, education, and intervention approaches be considered, including confidential computer-assisted interviews, secure Web-based programs, and inclusion of information regarding pregnancy violence in popular literature and patient-education materials. Finally, we suggest that researchers focused on theoretical issues related to pregnancy and motherhood, such as attachment or maternal role attainment, begin to incorporate double binding and other violence-related constructs into their work. Likewise, researchers focused on violence during pregnancy should explore theoretical issues relevant to this developmental period.

References

- Bacchus, L., Mezey, G., & Bewley, S. (2003). Experiences of seeking help from health professionals in a sample of women who experienced domestic violence. *Health and Social Care in the Community, 11*, 10–18.
- Campbell, J. (1999). If I can't have you no one can. *Reflections*, Third Quarter, 8–12.
- Campbell, J. C., & Campbell, D. W. (1996). Cultural competence in the care of abused women. *Journal of Nurse-Midwifery, 41*, 457–462.

- Cloutier, S., Martin, S. L., Moracco, K. E., Garro, J., Clark, K. A., & Brody, S. (2002). Physically abused pregnant women's perceptions about the quality of their relationships with their male partners. *Women and Health, 35*(2/3), 149–163.
- Curry, M. A., Durham, L., Bullock, L., Bloom, T., & Davis, J. (2006). Nurse case management for pregnant women experiencing or at risk for abuse. *Journal of Obstetric, Gynecologic and Neonatal Nursing, 35*(2), 181–192.
- Curry, M. A., Perrin, N., & Wall, E. (1998). Effects of abuse on maternal complications and birth weight in adult and adolescent women. *Obstetrics and Gynecology, 92*, 530–534.
- Dienemann, J., Campbell, J., Landenburger, K., & Curry, M. A. (2002). The Domestic Violence Survivor Assessment: A tool for counseling women in intimate partner violence relationships. *Patient Education and Counseling, 46*, 221–228.
- Horon, I. L., & Cheng, D. (2001). Enhanced surveillance for pregnancy-associated mortality – Maryland, 1993–1998. *Journal of the American Medical Association, 285*, 1455–1459.
- Krulewicz, C. J., Pierre-Louis, M. L., de Leon-Gomez, R., Guy, R., & Green, R. (2001). Hidden from view: Violent deaths among pregnant women in the District of Columbia, 1988–1996. *Journal of Midwifery and Women's Health, 46*, 4–10.
- Landenburger, K. (1989). A process of entrapment in and recovery from an abusive relationship. *Issues in Mental Health Nursing, 10*, 209–227.
- Landenburger, K. M. (1993). Exploration of women's identity: Clinical approaches with abused women. *AWHONN's Clinical Issues in Perinatal and Women's Health Nursing, 4*, 378–384.
- Libbus, M. K., Bullock, L. F. C., Nelson, T., Robrecht, L., Curry, M. A., & Bloom, T. (2006). Abuse during pregnancy: Current theory and new contextual understandings. *Issues in Mental Health Nursing, 27*, 927–938.
- Lipsky, S., Holt, V. L., Easterling, T. R., & Critchlow, C. W. (2003). Impact of police-reported intimate partner violence during pregnancy on birth outcomes. *Obstetrics and Gynecology, 102*, 557–564.
- Lutz, K. F. (2005a). Abused, pregnant women's interactions with health care providers during the childbearing year. *Journal of Obstetric, Gynecologic and Neonatal Nursing, 34*, 151–162.
- Lutz, K. F. (2005b). Abuse experiences, perceptions, and associated decisions during the childbearing cycle. *Western Journal of Nursing Research, 27*, 802–824.
- McFarlane, J., & Parker, B. (1994). *Abuse during pregnancy: A protocol for prevention and intervention*. New York: National March of Dimes Birth Defects Foundation.
- McFarlane, J., & Wiist, W. (1997). Preventing abuse to pregnant women: Implementation of a “mentor mother” advocacy model. *Journal of Community Health Nursing, 14*, 237–249.
- Mercer, R. T. (1986). Predictors of maternal role attainment at one year postbirth. *Western Journal of Nursing Research, 8*, 9–32.

- Mercer, R. T. (2004). Becoming a mother versus maternal role attainment. *Journal of Nursing Scholarship*, *36*, 226–232.
- Merritt-Gray, M., & Wuest, J. (1995). Counteracting abuse and breaking free: The process of leaving revealed through women's voices. *Health Care for Women International*, *16*, 399–412.
- Murphy, C. C., Schei, B., Myhr, T. L., & DuMont, J. (2001). Abuse: A risk factor for low birth weight? A systematic review and meta-analysis. *Canadian Medical Association Journal*, *164*, 1567–1572.
- Neggers, Y., Goldenberg, R., Cliver, S., & Hauth, J. (2004). Effects of domestic violence on preterm birth and low birth weight. *Acta Obstetrica et Gynecologica Scandinavica*, *83*, 455–460.
- Paris, R., & Helson, R. (2002). Early mothering experience and personality change. *Journal of Family Psychology*, *16*, 172–185.
- Parker, B., McFarlane, J., Soeken, K., Silva, C., & Reel, S. (1999). Testing an intervention to prevent further abuse to pregnant women. *Research in Nursing and Health*, *22*, 59–66.
- Porter, C. L., & Hsu, H. C. (2003). First-time mothers' perceptions of efficacy during the transition to motherhood: Links to infant temperament. *Journal of Family Psychology*, *17*, 54–64.
- Reichenheim, M. E., & Moraes, C. L. (2004). Comparison between the Abuse Assessment Screen and the Revised Conflict Tactics Scales for measuring physical violence during pregnancy. *Journal of Epidemiology and Community Health*, *58*, 523–527.
- Rubin, R. (1984). *Maternal identity and the maternal experience*. New York: Springer.
- Saltzman, L. E., Fanslow, J. L., McMahon, P. M., & Shelley, G. A. (1999). *Intimate partner violence surveillance: Uniform definitions and recommended data elements, Version 1.0*. Atlanta: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.
- Schatzman, L. (1991). Dimensional analysis: Notes on an alternative approach to the grounding of theory in qualitative research. In D. R. Maines (Ed.), *Social organization and social process: Essays in honor of Anselm Strauss* (pp. 303–314). New York: Aldine De Gruyter.

Authors' Note

Research support was provided by the National Institute for Nursing Research (T32NR07061; F31NR07336) and a Woodrow Wilson-Johnson & Johnson Dissertation Grant in Women's Health from the Woodrow Wilson National Fellowship Foundation to Dr. Lutz, and by the National Institute for Nursing Research (RO1NR02696-06) to Dr. Curry, PI.

Gratitude is extended to the women who participated in our studies, as well as to Ramona Mercer, PhD, RN, FAAN; Barbara Parker, PhD, RN, FAAN; Louise Martell, PhD, RN; Barbara Bowers, PhD, RN,

FAAN; Karen Pridham, PhD, RN, FAAN; and Sue Riesch, DNSc, RN, FAAN, for their review of and suggestions for this paper.

Comments or queries may be directed to Kristin Lutz, University of Wisconsin – Madison, K6/354 Clinical Sciences Center, 600 Highland Avenue, Madison, Wisconsin 53792-2455 USA. Telephone: 608-265-2190. Fax: 608-263-5458. E-mail: kflutz@wisc.edu

Kristin F. Lutz, PhD, RN, is Assistant Professor, School of Nursing, University of Wisconsin – Madison, United States. Mary Ann Curry, DNSc, RN, is Professor Emeritus, School of Nursing, Oregon Health and Science University, Portland, Oregon, United States. Linda C. Robrecht, DNSc, CNM, is Associate Professor Emeritus, School of Nursing, Oregon Health and Science University. M. Kay Libbus, DrPH, RN, is Professor, Sinclair School of Nursing, University of Missouri – Columbia, United States. Linda Bullock, PhD, RN, FAAN, is Associate Professor, Sinclair School of Nursing, University of Missouri – Columbia.

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

**Fiona Webster, Michelle Sangster Bouck,
Bonnie Lynn Wright et Pam Dietrich**

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

**Fiona Webster, Michelle Sangster Bouck,
Bonnie Lynn Wright, and Pam Dietrich**

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.

References

- Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing*. Menlo Park, CA: Addison-Wesley.
- Bryant, S., & Spencer, G. A. (2002). Domestic violence: What do nurses practitioners think? *Journal of the American Academy of Nurse Practitioners, 14*, 421–427.
- Campbell, J. (1999). If I can’t have you, no one can. *Reflections, 3*, 9–12.
- Campbell, R., & Wasco, S. M. (2005). Understanding rape and sexual assault: 20 years of progress and future directions. *Journal of Interpersonal Violence, 20*, 127–131.
- Canadian Centre for Justice Statistics. (2005). *Family violence in Canada: A statistical profile 2005*. Ottawa: Statistics Canada.
- Dickson, F., & Tutty, L. M. (1996). The role of public health nurses in responding to abused women. *Public Health Nursing, 13*, 263–268.
- Early, M. R., & Williams, R. A. (2002). Emergency nurses’ experience with violence: Does it affect nursing care of battered women? *Journal of Emergency Nursing, 28*, 199–204.
- Feder, G. S., Hutson, M., Ramsay, J., & Taket, A. R. (2006). Women exposed to intimate partner violence: Expectations and experiences when they

- encounter health care professionals: A meta-analysis of qualitative studies. *Archives of Internal Medicine*, 166, 22–37.
- Ford-Gilboe, M. (2001). Making connections: A vehicle for developing a nursing response to violence against women and children in Canada. *Canadian Journal of Nursing Research*, 32(4), 125–133.
- Guba, E. G. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. *Educational Communication and Technology*, 29, 75–91.
- Guba, E. G., & Lincoln, Y. S. (1989). *Fourth generation evaluation*. London: Sage.
- Haggblom, A. M. E., Hallberg, L. R. M., & Anders, R. (2005). Nurses' attitudes and practices toward abused women. *Nursing and Health Sciences*, 7, 235–242.
- Hart, L., & Jamieson, W. (2001). *Responding to abuse during pregnancy*. National Clearinghouse on Family Violence. Ottawa: Health Canada.
- Health Canada. (1999). *A handbook for health and social service professionals responding to abuse during pregnancy*. Retrieved May 1, 2006, from http://www.phac-aspc.gc.ca/ncfv-cnivf/familyviolence/pdfs/pregnancy_e.pdf
- Johnson, H. (2005, April 11–14). *Assessing the prevalence of violence against women in Canada*. Expert paper presented at meeting of UN Division for the Advancement of Women, Geneva, Switzerland.
- Kramer, A. (2002). Domestic violence: How to ask and how to listen. *Nursing Clinics of North America*, 37, 189–210.
- Lutz, K. F. (2005). Abused pregnant women's interactions with health care providers during the childbearing years. *Journal of Obstetric, Gynecologic and Neonatal Nursing*, 34, 151–162.
- McFarlane, J., Christoffel, K., Bateman, L., Miller, V., & Bullock, L. (1991). Assessing for abuse: Self-report versus nurse interview. *Public Health Nursing*, 8, 245–250.
- Middlesex-London Health Unit. (2000). *Task Force on the Health Effects of Woman Abuse*. London, ON: Author.
- Miller, W. L., & Crabtree, B. F. (1999). Clinical research: A multimethod typology and qualitative roadmap. In B. F. Crabtree & W. L. Miller (Eds.), *Doing qualitative research* (2nd ed.) (pp. 3–30). Thousand Oaks, CA: Sage.
- Moore, M. L., Zaccaro, D., & Parsons, L. H. (1998). Attitudes and practices of registered nurses toward women who have experienced abuse/domestic violence. *Journal of Obstetric, Gynecologic and Neonatal Nursing*, 27, 175–182.
- Murphy, C. C., Schei, B., Myhr, T. L., & DuMont, J. (2001). Abuse: A risk factor for low birth weight? A systematic review and meta-analysis. *Canadian Medical Association Journal*, 165, 1567–1572.
- Patton, M. Q. (1990). *Qualitative evaluation and research method* (2nd ed.). Newbury Park, CA: Sage.
- Pearlman, L. A., & Maclan, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology Research and Practice*, 26, 558–565.
- Protheroe, L., Green, J., & Spiby, H. (2004). An interview study of the impact of domestic violence training on midwives. *Midwifery*, 20, 94–103.

- Rhodes, K.V., & Levinson, W. (2003). Interventions for intimate partner violence against women: Clinical applications. *Journal of the American Medical Association*, *289*, 601–605.
- Schauben, L. J., & Frazier, P. A. (1995). Vicarious trauma: The effects on female counselors of working with sexual violence survivors. *Psychology of Women Quarterly*, *19*, 49–64.
- Stayton, C. D., & Duncan, M. M. (2005). Mutable influences on intimate partner abuse screening in health care settings: A synthesis of the literature. *Trauma, Violence and Abuse*, *6*, 271–285.
- Stern, P. H. (1985). Using grounded theory method in nursing research. In M. M. Leininger (Ed.), *Qualitative research methods in nursing* (pp. 149–160). New York: Grune & Stratton.
- United Nations General Assembly. (1993, December 20). Proceedings of the 85th Meeting of the Declaration on the Elimination of Violence against Women, Geneva.
- Varcoe, C., & Wuest, J. (2001). A call to focus our “passion for substance” on family violence. *Canadian Journal of Nursing Research*, *32*(4), 11–19.
- Waltermaurer, E. (2005). Measuring intimate partner violence (IPV): You may only get what you ask for. *Journal of Interpersonal Violence*, *20*, 501–506.
- Walton-Moss, B. J., & Campbell, J. C. (2002, January 31). Intimate partner violence: Implications for nursing. *Online Journal of Issues in Nursing*, *7*(1), Manuscript 5. Available: http://www.nursingworld.org/ojin/topic17/tpc17_5.htm
- Wasco, S. M., & Campbell, R. (2002). Emotional reactions of rape victim advocates: A multiple case study of anger and fear. *Psychology of Women Quarterly*, *26*, 120–130.
- Wathen, C. N., & MacMillan, H. L. (2003). Interventions for violence against women: Scientific review. *Journal of the American Medical Association*, *289*, 589–600.
- Wuest, J., & Merritt-Gray, M. (2001). Beyond survival: Reclaiming self after leaving an abusive male partner. *Canadian Journal of Nursing Research*, *32*(4), 79–94.

Authors' Note

This study was financially supported by the Public Health Research and Development (PHRED) Program.

The researchers would like to thank the participants for sharing their time and thoughts. Without their participation, this project would not have been possible.

Comments or queries may be directed to Michelle Sangster Bouck, Research Associate, PHRED Program, Middlesex-London Health Unit, 50 King Street, London, Ontario N6A 5L7 Canada. E-mail: michelle.sangsterbouck@mlhu.on.ca

Fiona Webster, MA, is Assistant Director, Knowledge Translation, Institute of Circulatory and Respiratory Health, Canadian Institutes of Health Research; at the time of the study she was Associate Scientist, London Health Sciences Centre, London, Ontario, Canada. Michelle Sangster Bouck, MA, is Research Associate, Middlesex-London Health Unit, Public Health Research and Development (PHRED) Program, London. Bonnie Lynn Wright, RN, PhD, is Manager, Sexual Health, Middlesex-London Health Unit; at the time of the study she was Nurse Researcher/Educator, Middlesex-London Health Unit, PHRED Program. Pam Dietrich, RN, MScN, is Year 3 Coordinator, University of Western Ontario Fanshawe Collaborative BScN Program; at the time of the study she was Young Families Team Manager, Middlesex-London Health Unit.

Happenings

Nursing Network on Violence against Women, International

Nancy Glass

Introduction

The Nursing Network on Violence against Women, International (NNVAWI), is a not-for-profit, volunteer organization founded in 1985 at the University of Massachusetts at Amherst during the first National Nursing Conference on Violence against Women. Its mission is to contribute to the elimination of violence against women through education, practice, research, and public policy. Since 1985, the Network has widened its national focus to include education, practice, and research collaboration with nurses and other health professionals in Canada, New Zealand, Australia, England, and South Africa. Thus it is a truly international effort at eliminating violence against women.

14th International Conference and Award Recipients

One of the priorities of NNVAWI is the sponsorship of international conferences that link researchers, educators, providers, and advocates working in the area of violence against women. In April 2006 NNVAWI sponsored its 14th international conference, *Joining Forces, Joining Voices: Including Diverse Peoples and Communities in Violence Prevention Research, Practice and Advocacy*. Two hundred nurses, physicians, researchers, victim advocates, community activists, social workers, mental health counsellors, and students gathered in Portland, Oregon, to share innovative research and best practices centring on collaboration among health and human service providers, violence prevention/intervention advocates, and diverse communities so that women and children can live longer, healthier lives.

Among those attending the conference were three individuals recognized for their outstanding contributions to ending violence against women through their teaching, practice, and research. Barbara Zust,

Assistant Professor of Nursing at Gustavus Adolphus College in St. Peter, Minnesota, was awarded the NNVAWI Excellence in Education award. Dr. Zust was recognized for developing and implementing two innovative undergraduate courses on intimate partner violence that not only educate students on issues related to violence against women but also challenge students to examine their own beliefs and values in relation to the problem and contribute to active solutions in their communities.

Phyllis Sharps, Associate Professor at the Johns Hopkins University School of Nursing, was awarded the NNVAWI Excellence in Practice award. Dr. Sharps was recognized for her outstanding clinical practice and supervision of students in providing health care to battered women and their children at the House of Ruth shelter clinic in Baltimore, Maryland.

Marilyn Merritt-Gray, Professor at the University of New Brunswick School of Nursing, was awarded the NNVAWI Excellence in Research award. Professor Merritt-Gray was recognized for the quality of her empirical work and her demonstrated excellence in working with communities and in applying research to policy and practice.

NNVAWI Leadership

During the 2006 conference, Network members elected new officers and board members to serve a two-year term (2006–08). These officers and board members, who come from Canada, New Zealand, and the United States, are Nancy Glass, PhD, MPH, RN, President; Tracy Evanson, PhD, RN, Vice-President; Barbara Zust, PhD, RN, Secretary; Natalie McClain, PhD, RN, Treasurer; and members-at-large Nancy Fishwick, DNSc, CNM, RN; Patti Janssen, PhD, MPH, RN; Ursula Kelly, PhD, MSN, ANP, CS, RN; Annie Lewis-O'Connor, PhD, MSN, APRN; and Jane Koziol-McLain, PhD, RN.

The officers, members-at-large, and membership recognize the outstanding leadership of Janice Humphreys, PhD, RN, FAAN. Dr. Humphreys served as President of NNVAWI for two terms (2002–06) and will continue to support and enhance the mission and work of the organization in her role as Past President.

15th International Conference

Plans are already underway for NNVAWI's 15th international conference. The School of Nursing at the University of Western Ontario will host this event, *Complexities and Diversities: Creating Change in a Global Context*, on October 18–20, 2007, at the Hilton Hotel in London, Ontario. Please mark the dates for this exciting conference on your calendar.

Call to Action

I would like to share a concern that has arisen in the United States, in the hope that our colleagues in Canada and around the world will prevent a similar situation from occurring in their own countries. Nurse scientists who have been involved in the development of our collective understanding of prevention and intervention strategies and programs to reduce health disparities for survivors of violence (e.g., intimate partner violence, workplace violence, sexual violence) have been informed by the National Institutes for Health/National Institute of Nursing Research (NINR) staff that they should not seek funding for themselves or their PhD students, as eliminating violence against women and learning more about how violence influences health and health care are not relevant to the strategic plan of the Institute.

Recently, a well-qualified PhD student application for funding was turned down (even though it was scored well within funding range), because staff decided the study did not match the strategic plan of NINR, essentially overruling the scientific review process on which we all depend for objectivity. This decision by NINR staff is worrisome, in three respects. First, it reflects a narrow and limited understanding of research in the area of violence against women and children. In the case of this particular application, the study aims to develop an intervention based on survivors' information and resource needs, and the facilitators and barriers for abuse disclosure and help-seeking during pregnancy. Violence in pregnancy represents a serious threat to the health of both mother and child. Pregnancy also represents a significant opportunity for intervention, as it may be the only time in a woman's life when she has frequent contact with nurses.

The study both builds upon and extends the solid body of nursing science in violence, by developing an intervention that is both pregnancy-specific and developed collaboratively with survivors. Further, the study proposes to engage racial and ethnically diverse and impoverished women, those who are the most vulnerable to violence and its consequences and the least likely to disclose abuse or access formal resources. Therefore, the study is directly linked to the NINR strategy to address and eliminate health disparities.

Interventions to reduce disparities in health access, health-care quality, and health outcomes are not simple — there is no targeted therapy. To eliminate health disparities, researchers and funders must be committed to understanding the effects of intersectionality of race, ethnicity, class, gender, and sexual orientation on the health of individuals, families, and communities. To suggest that nurse researchers and promising PhD students can develop interventions to reduce disparities in pregnancy

outcomes without addressing gender-based violence is to show a lack of understanding of the complexity of health disparities and violence against women. Although the study received an excellent score from an objective scientific review process, the applicant was told by staff that it put too much emphasis on violence and abuse and therefore was inconsistent with NINR's funding priorities.

Second, we place the integrity of the scientific review process in jeopardy when we allow proposals with the highest scientific merit to go unfunded because staff (who may or may not have experience or expertise in the area of research) decide to overrule the process. Third, NINR staff decisions to not fund promising scholars affects our efforts to train new investigators in violence research as well as to address the critical shortage of nursing teachers and researchers.

As a nurse researcher committed to the elimination of violence against women and children, I am clearly biased in my position on the attitude of NINR staff towards our students and our science. However, it is important for us to call our nursing colleagues to action: it may be your science or your students' science that is the next to be removed from funding consideration by the staff of national and international funding agencies.

Join NNVAWI

Whether you are renewing your NNVAWI membership or considering joining for the first time, I encourage you to be part of this innovative group of individuals working collaboratively to eliminate violence against women. You can find information on NNVAWI and membership forms at www.nnvawi.org, or contact us at 1-888-909-9993.

Nancy Glass, PhD, MPH, RN, is Associate Professor, School of Nursing, Johns Hopkins University, Baltimore, Maryland, United States; Principal Investigator of studies related to woman abuse funded by the National Institute of Nursing Research and the Centers for Disease Control and Prevention; and President, Nursing Network on Violence against Women, International.

Book Review

Forensic Nursing: A Handbook for Practice

Edited by Rita M. Hammer,
Barbara Moynihan, and Elaine M. Pagliaro
Mississauga, Ontario: Jones & Bartlett, 2006
ISBN 0-7637-2610-9

Reviewed by Janet Ericksen

This is a well-written and informative resource book. The editors are well qualified. Hammer and Moynihan are professors of forensic nursing and Pagliaro is Assistant Director of a forensic science laboratory. They have brought together the latest information about the field of forensic nursing and the range of situations encountered by forensic nurses. The editors define forensic nursing as an evolving field focused on collaboration to meet the needs of those affected by violence as well as those in non-violent forensic-related situations such as natural disasters and Internet safety. Chapters written by experts in the fields of nursing, law, criminology, social work, and public policy provide a comprehensive overview of the scope and theoretical foundations of forensic nursing.

The book is divided into five parts, each with several chapters. Each chapter has a concise introduction, a list of key terms, an extensive reference list, and a list of questions for discussion. Four appendices to the book detail guidelines regarding search and seizure of evidence, evidence-collection guidelines, selected assessment tools, and Internet resources.

Part 1 thoroughly lays out the foundations of forensic nursing science. The first chapter provides an extensive overview of forensic nursing, including roles, history, and challenges. Other chapters describe the nature of forensic science theory and focus on concepts essential to forensic nursing such as the epidemiology of violence, sociocultural diversity, and multidisciplinary collaboration. The chapter on law deals solely with the American justice system, so Canadian and other non-American nurses would need to augment the book with resources on their respective justice systems.

Part 2 concentrates on the populations served by forensic nurses. Included here are chapters on both survivors and perpetrators of violence, including children and adolescents, and populations at risk. As well, there is a detailed chapter on posttraumatic stress disorder. The unique challenges of providing care to these populations are clearly elucidated.

Part 3 contains specific information on the practical aspects of forensic nursing such as evidence collection and documentation. Entire chapters are devoted to the processes of sexual assault intervention and death investigation. Additionally, the nature of biological evidence, including DNA, is clearly described. Especially noteworthy are the many practical tips provided throughout these chapters.

Part 4 provides details on specialized forensic nursing roles, including correctional nursing and disaster and emergency management. One chapter is devoted to expert witness testimony.

Part 5 discusses “concepts for the 21st century.” Included here are chapters on media management, leadership, public policy, and education. Again, the authors provide both theoretical and practical information for the reader.

In the preface, the editors state that “this handbook was developed in recognition of the need for a resource that could enhance the ability of the forensic nurse to function effectively in this new and evolving role” (p. xvii). While at over 800 pages this volume is too big to be a handbook, the editors have succeeded in developing a valuable resource for forensic nurses, students, and educators.

Janet Ericksen, MA, RN, is Nurse Clinician, Sexual Assault Service, Children's and Women's Health Centre, and Assistant Professor Emeritus, School of Nursing, University of British Columbia, Vancouver, Canada.

Problèmes méthodologiques liés à l'utilisation de différentes limites d'inclusion pour catégoriser les variables de résultats

Mayer M. El-Masri et Susan M. Fox-Wasylyshyn

La connaissance des facteurs qui contribuent aux temps d'attente dans le recours au traitement médical en cas d'infarctus aigu du myocarde (IAM) permettra de déterminer des interventions visant à faciliter le recours rapide aux soins. Toutefois, les définitions opérationnelles des temps d'attente varient selon les recherches. L'utilisation de limites d'inclusion différentes pour faire la distinction entre les retards et les non-retards risque de compromettre la comparabilité et le caractère généralisable des résultats obtenus dans les différentes études. L'objectif de cet article est d'examiner l'impact d'une opérationnalisation incohérente des temps d'attente, en termes de limites d'inclusion, sur la validité des résultats des recherches visant à déterminer les prédicteurs desdits temps d'attente. Une analyse des données secondaires a été effectuée à partir d'un échantillon de 73 patients qui avaient récemment subi un IAM hors de l'hôpital et conclu que leurs symptômes étaient d'ordre cardiaque. Plusieurs modèles de régression ont été élaborés afin d'examiner l'influence de l'usage de différentes limites d'inclusion (temps d'attente médian de 1, 2, 3, 6 et 12 heures) sur le nombre et la nature des prédicteurs des temps d'attente dans la recherche de soins en cas d'IAM. L'impact des différentes limites d'inclusion sur la variance expliquée, la sensibilité, la spécificité et le coefficient de prévision associés à chaque modèle de régression a été examiné. L'utilisation de différentes limites d'inclusion a donné lieu à différentes séries de prédicteurs indépendants, qui variaient en nombre et en nature. La variance expliquée par les différents modèles de régression ainsi que leurs indices de classification n'étaient pas les mêmes d'une fois à l'autre. L'utilisation de différentes limites d'inclusion pour la définition du temps d'attente a donné lieu à des résultats incohérents. Par conséquent, il est recommandé que des critères soient établis parmi les cliniciens et les chercheurs en ce qui a trait à la définition opérationnelle du temps d'attente dans le recours aux soins en cas d'IAM.

Mots clés : Définitions opérationnelles, limites d'inclusion, infarctus aigu du myocarde, temps d'attente dans le recours aux soins, sensibilité et spécificité du modèle, résultat

Best Practices in Research Methods

Methodological Issues Associated with Using Different Cut-off Points to Categorize Outcome Variables

Mayer M. El-Masri and Susan M. Fox-Wasylyshyn

Knowledge of the factors that contribute to delay in seeking medical treatment for acute myocardial infarction (AMI) provides the basis for interventions that are intended to facilitate prompt care-seeking behaviour. However, operational definitions of delay time vary across research studies. The use of inconsistent cut-off times to distinguish between delayers and non-delayers is likely to compromise comparability and generalizability of the findings across studies. The purpose of this paper is to examine the impact of inconsistent operationalization of delay, in terms of cut-off times, on the validity of research findings pertaining to identifying its predictors. Secondary data analysis was performed using a sample of 73 patients who had recently experienced out-of-hospital AMI and concluded that their symptoms were related to the heart. Several regression models were built to examine the influence of using different cut-off times (1, 2, 3, 6, and 12 hours, median delay) on the number and nature of predictors of AMI care-seeking delay. The impact of varying cut-off times on the explained variance, sensitivity, specificity, and predictive values associated with each regression model was examined. The use of different cut-off times produced different sets of independent predictors, which varied in number and nature. The variance explained by the different regression models as well as their classification indices varied. Use of different cut-off times for the definition of delay time led to inconsistent results. Thus, it is recommended that criteria be established among clinicians and researchers with regard to operationally defining care-seeking delay for AMI.

Keywords: Operational definitions, cut-off times, acute myocardial infarction, care-seeking delay, model sensitivity and specificity, dichotomization, outcome

Operational definitions of outcome variables have a significant impact on the validity and generalizability of research findings. Dichotomization of continuous variables represents one situation in which generalizability, comparability, and synthesis of findings across studies can be compromised. This is because different authors may select varying criteria to determine the cut-off point at which subjects are classified as having or

not having the outcome of interest. The purpose of this paper is to demonstrate how the use of different cut-off points to dichotomize a continuous variable, delay in deciding to seek care for acute myocardial infarction (AMI), compromises the validity of research findings.

Given that effectiveness of reperfusion therapies used in the treatment of AMI is time-dependent, many researchers have investigated the phenomenon of delay in seeking treatment for AMI. However, review of the literature suggests that investigators (Burnett, Blumenthal, Mark, Leimberger, & Califf, 1995; Clark, Bellam, Shah, & Feldman, 1992; Dracup & Moser, 1997; Johnson & King, 1995; King & McGuire, 2000; McKinley, Moser, & Dracup, 2000; Wu, Zhang, Li, Hong, & Huang, 2004) have used a wide variety of approaches to operationalizing delay time. This is because, when used as a continuous variable, delay among AMI patients tends to have severe positive skew due to a common tendency for a small proportion of patients to delay seeking medical attention for a relatively long period (i.e., days vs. hours). One approach to the management of skewed data is mathematical transformation. However, mathematical transformation produces scores that can be difficult to interpret because they no longer carry the unit of analysis of the original data. For example, in our data set, the base log of delay time of 0.5 hours was $-.30$, which is clearly difficult to explain and/or compare in terms of actual/exact time. In addition, mathematical transformation procedures may sometimes fail to produce a normal distribution when the departure from normality is severe (Tabachnick & Fidell, 2001). In such cases, investigators often choose to dichotomize the variable into two categories (i.e., delayers and non-delayers). Unfortunately, the selection of the cut-off time used to distinguish subjects as delayers or non-delayers differs widely among studies. A review of the literature suggests that 1 hour (Al-Hassan & Omran, 2005; Carney, Fitzsimons, & Dempster, 2002), 2 hours (Dempsey, Dracup, & Moser, 1995; Turi et al., 1986), 3 hours (King & McGuire; Reilly, Dracup, & Dattolo, 1994), 6 hours (Schmidt & Borsch, 1990; Sheifer et al., 2000), and 12 hours (Ruston, Clayton, & Calnan, 1998) have all been used as cut-offs for defining care-seeking delay. These inconsistent operationalizations of delay across studies present a challenge to the understanding and generalizability of the research findings that pertain to delay among AMI patients. Therefore, the purpose of this study was to examine the impact of using varied cut-off values for operationalizing delay on the validity of research findings pertaining to identifying its predictors. Specifically, this study examined how the use of various cut-off times impacts: (a) the number and nature of predictors, (b) the magnitude and direction of relationships, (c) the amount of explained variance, and (d) classification indices (i.e., sensitivity, specificity, positive predictive value, and negative predictive value) of a regression model.

Methods

Sample

Secondary data analyses were performed on data that were collected after ethical approval was granted to examine the factors that impact care-seeking delay among patients who had experienced a recent AMI (Fox-Wasylyshyn, 2005). The database represented a sample of 73 AMI patients who concluded, prior to seeking medical care, that their symptoms were heart-related. Patients were recruited from two hospitals in southeastern Michigan and two in southwestern Ontario. The participants were over 18 years, deemed to be in stable physiological condition, and able to speak English. Data were collected using a structured interview technique during the first 24 to 96 hours post-admission.

Variable Definitions

History of AMI was defined in terms of whether or not a participant experienced AMI prior to the one for which he or she was currently admitted. *Symptom congruence* was defined as the degree to which one's AMI symptom experience was consistent with pre-conceived notions about the nature of AMI symptoms. It was measured using a 10 cm horizontal visual analogue scale on which participants were asked to indicate with a vertical line how similar or different their heart attack symptoms were in relation to how they had previously thought a heart attack would feel (0 = not at all similar; 10 = exactly as expected). *Emotion-focused coping* was measured using the Coping with Heart Attack Symptoms Scale (CHASS), a five-item Likert scale (Fox-Wasylyshyn, 2005). Factor analysis suggested that the CHASS measured a single concept in which item loadings ranged from .54 to .87, a reflection of good construct validity. The CHASS items were internally consistent (Cronbach's alpha: 0.76) (Kline, 1998). *Time to cardiac symptom attribution (CSA)* refers to the time interval between AMI symptom onset and when the participants concluded that their symptoms were heart-related. This variable was operationally defined as the time (in hours) from symptom onset until the participant determined that the probable cause of his or her symptoms was the heart. *AMI care-seeking delay* was defined as the time interval (in hours) between the onset of AMI symptoms and the decision to seek medical treatment. AMI care-seeking delay comprised the intervals between: (a) symptom onset and CSA, and (b) CSA and the decision to seek medical care.

Data Analysis

Data analysis procedures were performed using the Statistical Package for Social Sciences (SPSS) computer program (version 14.0; SPSS Inc.). Prior

to the analysis, data were explored for missing data, multicollinearity, and deviation from normality. Time to CSA and AMI care-seeking delay were positively skewed. Time to CSA was transformed to the Base log (Lg10) of its value. For the purpose of this paper, AMI care-seeking delay was dichotomized using five different cut-off times (1, 2, 3, 6, and 12 hours). Basic descriptive statistics such as means, medians (*mdn*), standard errors (*se*), frequencies, and percentages were performed to describe the sample. Five logistic regression models, one for each cut-off time, were built to assess the impact of different cut-off times on the results. The same independent variables were entered into each regression model using a forward stepwise approach. These variables were time to CSA, emotion-focused coping, history of AMI, symptom congruence, age, gender, country of residence, and level of education. The variables ethnic background and medical insurance were excluded from analysis because their categories had more than a 90% split, which could have truncated correlation coefficients with other variables (Tabachnick & Fidell, 2001). The regression models were compared in terms of their independent predictors, variance explained, and predictive accuracy. The predictive accuracy of each model was determined by the specificity, sensitivity, positive predictive value, and negative predictive value of that model. A 95% confidence interval (95% CI) was set as the criterion to establish significance.

Results

The sample mean age was 59 years ($SE \pm 1.42$). The majority of participants were non-Hispanic white ($n = 66$; 90.4%), with men making up 71.9% ($n = 97$) of the sample. Most participants ($n = 51$; 69.9%) were in the hospital for their first AMI. Fifty-six participants (76.7%) lived in Canada, while the remaining 22 (30.1%) lived in the United States. With respect to education level, 44 participants (60.3%) had a high school education or less. The mean AMI care-seeking delay time was 8.48 hours ($mdn = 1.0$ hour; $SE \pm 2.30$), while the mean time to CSA was 5.97 hours ($mdn = .33$ hour; $SE \pm 2.2$).

Table 1 presents the results of the five logistic regression models that were built to identify the predictors of care-seeking delay using different cut-off times to classify participants as delayers or non-delayers. The results show that Model 4 explained the smallest proportion of variance (13.9%), whereas Models 1 and 5 explained the largest proportion of variance (40.8% and 47.8%, respectively) in care-seeking delay. The results also show that each model identified a different set of independent predictors of care-seeking delay, which varied from as few as one predictor (Models 2 and 4) to as many as five predictors (Model 5).

Table 1 *Summary of Results of Logistic Regression Models Using Varied Cut-off Times to Dichotomize AMI Care-Seeking Delay*

Model	Cut-off Time (hours)	Variance (%)	Independent Predictors of Delay	OR	95% CI
1	1*	40.8	Country of residence History of AMI Education Time to CSA	0.14 10.57 5.93 3.89	0.02–0.81 2.12–52.85 1.53–22.98 2.02–7.51
2	2	21.3	Time to CSA	2.67	1.40–4.81
3	3	25.0	History of AMI Education Time to CSA	5.16 3.50 2.38	1.40–19.04 1.04–11.76 1.40–4.05
4	6	13.9	Time to CSA	2.33	1.33–4.09
5	12	47.8	Country of residence History of AMI Education Emotion-focused coping Time to CSA	13.00 0.07 0.09 0.87 0.20	1.44–117.35 0.01–0.40 0.02–0.45 0.75–0.99 0.09–0.45

*Median time delay.

Table 2 *Classification Indices^a Associated with Logistic Regression Models*

Model	Cut-off Time (hours)	Classification Indices			
		Sensitivity (%)	Specificity (%)	PPV (%)	NPV (%)
1	1	75.0	81.1	79.4	76.9
2	2	76.7	83.7	76.7	83.7
3	3	57.7	80.9	62.5	77.6
4	6	33.3	100.0	100.0	82.1
5	12	79.4	79.5	77.1	81.6

^aClassification indices are based on a threshold of 0.5.

Results of Models 1 and 3 suggest that a history of AMI is a risk factor for prolonged delay ($OR = 10.57$ and 5.16 , respectively), while Model 5 suggests that it was inversely related to delay ($OR = .07$). Table 2 shows that the models had different classification indices, with sensitivity ranging from 33.3% (Model 4) to 79.4% (Model 5) and specificity ranging between 79.5% (Model 5) and 100% (Model 4).

Discussion

The findings of this study demonstrate that the selection of various cut-off times produces varying results with regard to (a) the nature and number of independent predictors of AMI care-seeking delay, (b) the direction and magnitude of relationships between predictors and AMI care-seeking delay, (c) the amount of explained variance, and (d) the classification indices of the overall regression models. Such variations present a challenge to the comparability, generalizability, and synthesis of research findings, and thus limit our understanding of the risk factors of care-seeking delay.

The findings demonstrate that using different cut-off times is likely to yield different results with regard to the nature and number of risk factors of delay. While Models 2 and 4 each had one independent predictor, Model 5 had five predictors (Table 1). In addition, the nature of predictors varied among models, as none were identical with regard to their independent predictors. For instance, emotion-focused coping was an independent predictor of delay only in Model 5, despite the fact that all five models were built from the same data. This finding is concerning when the primary purpose of a study is to identify the predictors of a given outcome so that they can be used to identify those who are at risk, to conduct intervention research, and to provide clinicians with specific targets upon which they can intervene.

The findings demonstrate that the magnitude and direction of the relationship between care-seeking delay and its risk factors are dependent on the cut-off time that is used to classify subjects as delayers or non-delayers. For example, Model 1 demonstrates that those who had a history of AMI were 10.6 times more likely to delay seeking care than those without a history of AMI, while Model 3 suggests that they were only five times more likely to delay. Although Models 1 and 5 had four independent predictors in common (Table 1), the relationships between the predictors and the outcome were in opposite directions in the two models. For instance, while country of residence was associated with shorter delay in Model 1, it was associated with longer delay in Model 5. Further, history of AMI, education, and time to CSA were positively associated with delay in Model 1 but were inversely related to delay in

Model 5. The aforementioned findings pertaining to the magnitude and direction of relationships are likely due to the fact that some subjects move from one category to another (delayers vs. non-delayers) each time a different cut-off time is established. For instance, a patient who waits 1.5 hours prior to deciding to seek medical care would be classified as a non-delayer when a cut-off time of 2 hours is selected, but would be classified as a delayer when a cut-off time of 1 hour is selected.

The results show that the amount of explained variance in care-seeking delay was different across all five models, ranging from 13.9% (Model 4) to 47.8% (Model 5). For example, although time to CSA was the only predictor of care-seeking delay in Models 2 and 4, the variance it explained in these two models was different (21.3% and 13.9%, respectively). Again, this difference in variance is likely a function of the change in patients' classification (delayers vs. non-delayers) among models, and the change in the nature and number of independent variables included in each model.

Logistic regression modelling provides researchers with classification indices from which the specificity, sensitivity, positive predictive values, and negative predictive values of the model can be assessed. These indices provide information to determine the clinical value of a model in terms of its ability to accurately classify patients with respect to an outcome variable. In our study, model specificity refers to the proportion of patients who did not delay and were correctly classified as such by that model. Sensitivity refers to the proportion of patients who delayed and were correctly identified as such by the model. The model's positive predictive value refers to the probability that it correctly predicts a patient as a delayer. The negative predictive value of the model refers to the probability that it correctly predicts that a patient will not delay.

The sensitivity and specificity of a model have a significant impact on its predictive values. For instance, models with greater sensitivity are likely to result in more false negative predictions (i.e., classifying true delayers as non-delayers). Likewise, an increase in model specificity tends to increase its positive predictive values, thus increasing the likelihood of false positive predictions (i.e., classifying true non-delayers as delayers). However, the predictive value of a model (positive and negative) is not completely dependent on the sensitivity and specificity of that model. The prevalence of the outcome (in this case, care-seeking delay) has a significant impact on a model's predictive value, especially when the outcome is a rare one. For instance, regardless of how specific the model is, positive predictive values tend to be largely false when the prevalence of the outcome is very low. Our data show that using different cut-off times yields vastly different positive predictive values that vary from 62.5% (Model 3) to 100% (Model 4), and sensitivity scores that vary from

33.3% (Model 4) to 79.4% (Model 5). This is likely due to the change across models in the prevalence of delay that results when the cut-off time used to define care-seeking delay is changed — that is, as the cut-off time increased from 1 through 12 hours, the proportion of subjects in the sample who were classified as delayers decreased from 55.6% to 22.2%.

The data show that Models 1, 2, and 5 have the best classification indices (all exceeded 75%). However, Model 5 has a cut-off time of 12 hours, and thus it may not be clinically meaningful due to the time-dependent nature of reperfusion therapies. In addition, contrary to expectations, it suggests an inverse relationship between delay and time to CSA such that individuals who take longer to attribute their symptoms to the heart are likely to have a shorter delay. This finding further highlights the problem with using 12 hours as a cut-off time for delay. Given that Model 1 explains almost twice the variance explained by Model 2, and that the cut-off times used in both models can be considered to be clinically relevant (1 and 2 hours), Model 1 is probably preferable, as it explains the greater proportion of variance, has reasonably high sensitivity and positive predictive values, and uses a clinically meaningful cut-off time.

The aforementioned discussion demonstrates that lack of consistency with regard to the cut-off time used to dichotomize care-seeking delay has a multifaceted impact on the validity of results. The findings demonstrate that variation in cut-off times impacts on the nature and number of predictors, the magnitude and direction of the relationship between a predictor and the outcome, and the amount of variance that a model explains. These variations are likely to compromise the validity of research findings pertaining to delay and limit meaningful comparisons among different studies. Further, they may limit our understanding of the nature of the true relationships between care-seeking delay and its risk factors, which may subsequently limit our ability to implement effective interventions intended to decrease AMI care-seeking delay. We therefore recommend that, whenever possible, researchers operationalize delay as a continuous variable (actual hours or minutes). If the variable is not normally distributed, then dichotomizing the variable can be used with the stipulation that selection of cut-off scores is based on sound theory or clinical judgement. When success of therapy is time-dependent, as in the case of reperfusion therapy, it is important that the cut-off point used to operationally define care-seeking delay be carefully considered — that is, researchers should use theoretical and/or clinical evidence to guide the definition of the time frame that constitutes delay. In fact, it might be helpful if the Heart and Stroke Foundation and the American Heart Association developed benchmarking criteria pertaining to the opera-

tional definition of delay. Such benchmarking is likely to allow clinicians and researchers to compare and synthesize findings of different studies and improve our understanding of the risk factors of delay.

Despite the study limitations related to retrospective data collection and small sample size, the results indicate that using different cut-off times has a significant impact on the validity of findings.

References

- Al-Hassan, M. A., & Omran, S. M. (2005). The effects of health beliefs on health care-seeking decisions of Jordanian patients with myocardial infarction symptoms. *International Journal of Nursing Practice*, *11*(1), 13–20.
- Burnett, R. E., Blumenthal, J. A., Mark, D. B., Leimberger, J. D., & Califf, R. M. (1995). Distinguishing between early and late responders to symptoms of acute myocardial infarction. *American Journal of Cardiology*, *75*, 1019–1022.
- Carney, R., Fitzsimons, D., & Dempster, M. (2002). Why people experiencing acute myocardial infarction delay seeking medical assistance. *European Journal of Cardiovascular Nursing*, *1*(4), 237–242.
- Clark, L. T., Bellam, S. V., Shah, A. H., & Feldman, J. G. (1992). Analysis of prehospital delay among inner-city patients with symptoms of myocardial infarction: Implications for therapeutic intervention. *Journal of the National Medical Association*, *84*, 931–937.
- Dempsey, S. J., Dracup, K., & Moser, D. K. (1995). Women's decision to seek care for symptoms of acute myocardial infarction. *Heart and Lung*, *24*(6), 444–456.
- Dracup, K., & Moser, D. K. (1997). Beyond sociodemographics: Factors influencing the decision to seek treatment for symptoms of acute myocardial infarction. *Heart and Lung*, *26*(4), 253–262.
- Fox-Wasylyshyn, S. (2005). *Delay in seeking treatment for acute myocardial infarction*. Unpublished doctoral dissertation, Wayne State University.
- Johnson, J. A., & King, K. B. (1995). Influence of expectations about symptoms on delay in seeking treatment during a myocardial infarction. *American Journal of Critical Care*, *4*(1), 29–35.
- King, K. B., & McGuire, M. A. (2000). Symptom presentation and delay in seeking care for women and men with myocardial infarction. *Circulation*, *102*(18, Suppl 2), p. 671.
- Kline, R. B. (1998). *Principles and practice of structural equation modeling*. New York: Guilford.
- McKinley, S., Moser, D. K., & Dracup, K. (2000). Treatment-seeking behavior for acute myocardial infarction symptoms in North America and Australia. *Heart and Lung*, *29*(4), 237–247.
- Reilly, A., Dracup, K., & Dattolo, J. (1994). Factors influencing prehospital delay in patients experiencing chest pain. *American Journal of Critical Care*, *3*(4), 300–306.
- Ruston, A., Clayton, J., & Calnan, M. (1998). Patient's action during their cardiac event: Qualitative study exploring differences and modifiable factors. *British Medical Journal*, *316*, 1060–1064.

- Schmidt, S. B., & Borsch, M. A. (1990). The prehospital phase of acute myocardial infarction in the era of thrombolysis. *American Journal of Cardiology*, *65*(22), 1411–1415.
- Sheifer, S. E., Rathore, S. S., Gersh, B. J., Weinfurt, K. P., Oetgen, W. J., Breall, J. A., et al. (2000). Time to presentation with acute myocardial infarction in the elderly: Associations with race, sex, and socioeconomic characteristics. *Circulation*, *102*(14), 1651–1656.
- Tabachnick, B. G., & Fidell, L. S. (2001). *Using multivariate statistics* (4th ed.). Boston: Allyn & Bacon.
- Turi, Z. G., Stone, P. H., Muller, J. E., Parker, C., Rude, R. E., Rraabe, D. E., et al. (1986). Implications for acute intervention related to time of hospital arrival in acute myocardial infarction. *American Journal of Cardiology*, *58*, 203–209.
- Wu, Y., Zhang, Y., Li, Y. Q., Hong, B. L., & Huang, C. X. (2004). Factors associated with the extent of care-seeking delay for patients with acute myocardial infarction in Beijing. *Chinese Medical Journal*, *117*(12), 1772–1777.

Authors' Note

Comments or queries may be directed to Maher M. El-Masri, RN, PhD, Faculty of Nursing, University of Windsor, Health Education Centre, Room 322, 401 Sunset, Windsor, Ontario N9B 3P4 Canada. Telephone: 519-253-3000, ext. 2400. Fax: 519-973-7084. E-mail: melmasri@uwindsor.ca

Maher M. El-Masri, RN, PhD, is Associate Professor and Research Coordinator, Faculty of Nursing, University of Windsor, Ontario, Canada. Susan M. Fox-Wasylyshyn, RN, PhD, is Associate Professor, Faculty of Nursing, University of Windsor.

Qualité des soins infirmiers : le rapport entre processus et résultats

Naomi E. Ervin, Shu-Pi Chen et Harry S. Upshaw

L'étude propose un examen, à la lumière d'une analyse transversale et corrélative, des rapports entre les variables d'un modèle conçu dans le but d'évaluer la qualité des soins infirmiers dispensés à domicile. À l'aide d'instruments mis au point pour tester les sept variables du modèle, on a interrogé chez eux 60 patients ayant reçu leur congé d'une agence de soins à domicile. Selon l'hypothèse avancée ici, la prestation des soins infirmiers touche trois aspects du processus interpersonnel, soit le soutien affectif, la justesse de l'information sur la santé et le pouvoir de décision, auxquels se rattachent trois résultats : l'adhérence, les symptômes et le bien-être. Les résultats confirment l'existence de liens entre les dimensions techniques et interpersonnelles. Ils révèlent notamment un rapport significatif entre la justesse de l'information sur la santé et l'adhérence, ainsi qu'entre le pouvoir de décision et le bien-être. En perfectionnant le modèle, concluent les auteurs, on contribuera à l'établissement d'une assise solide pour l'étude et la prestation de soins infirmiers de qualité.

Mots clés : qualité des soins infirmiers, processus et résultats

Nursing Care Quality: Process and Outcome Relationships

Naomi E. Ervin, Shu-Pi Chen, and Harry S. Upshaw

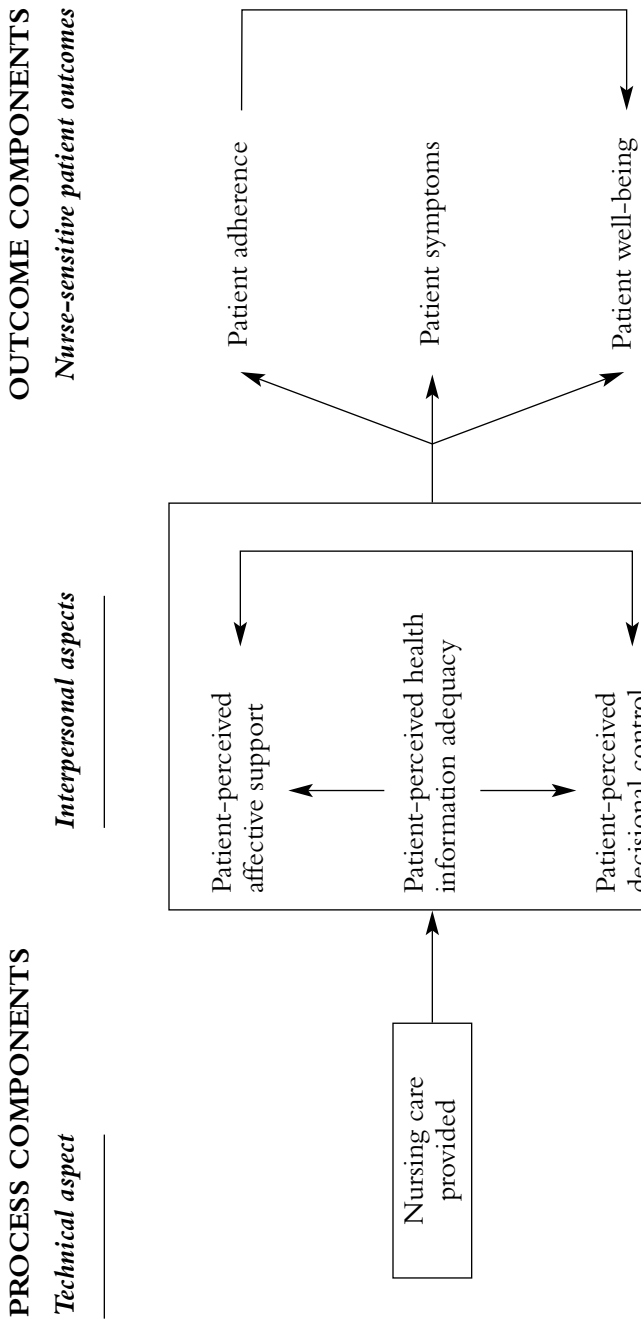
The relationships between variables in a proposed model for the quality of nursing care provided in the home were examined using a cross-sectional correlational design. Sixty patients discharged from a home-care agency were interviewed in their homes using instruments to measure the model's 7 variables. It was proposed that nursing care provided is related to 3 aspects of the interpersonal process — affective support, health information adequacy, and decisional control — and that these 3 variables are related to 3 outcomes — adherence, symptoms, and well-being. The findings support relationships between technical and interpersonal process components. Significant relationships were found between health information adequacy and adherence and between decisional control and well-being. The authors conclude that further refinement of the model will help to build a stronger foundation for the study and provision of quality nursing care.

Keywords: Nursing care quality, nurse-sensitive outcomes, process and outcomes

Many researchers have examined the quality of care provided by nurses in patients' homes. Studies of care in the home by home-care nurses, public health nurses, community health nurses, and advanced practice nurses have shown improvement in patient outcomes in some cases. These findings have given us confidence that nursing care provided in the home can be beneficial in several areas — for example, in pregnancy outcomes, prevention of child abuse and neglect, and cost savings (Brooten et al., 1994, 1995, 1986; Naylor et al., 1999; Olds, Henderson, Chamberlin, & Tatelbaum, 1986; Olds, Henderson, Tatelbaum, & Chamberlin, 1986; York et al., 1997) — in addition to its long-term benefits (Olds et al., 1997, 1998, 2004). However, findings thus far are inconsistent regarding the effectiveness of home-care nursing in some areas — for example, functional status, physical functioning, and preventing re-hospitalization (Brooten et al., 1994; Naylor et al.).

For the most part, studies on home-care nursing have not been guided by theoretical frameworks that link patient needs with nursing activities (process) and nurse-sensitive patient outcomes (e.g., Brooten et al., 1994, 1995, 1986; Olds, Henderson, Chamberlin, et al., 1986; Olds, Henderson, Tatelbaum, et al., 1986). The need for theory use and building in the area of nursing-care quality is recognized by nurse researchers (Sidani, Doran, & Mitchell, 2004). Lamb, Jennings, Mitchell,

Figure 1 Community Nursing Care Quality Model



and Lang (2004) point out that the lack of systematic theory-building has hampered the implementation of quality of care research. With a view to developing a theoretical framework for home-care nursing that links nursing processes to nurse-sensitive patient outcomes, a model was drawn up. This article reports the results of testing the relationships between model process and outcome variables in a home-care setting. We hope the model will be helpful to other researchers in developing a theoretical foundation for the quality of nursing care provided in the home.

The Community Nursing Care Quality Model is based on the work of Cox (1982) and Donabedian (1966) and has two components: process and outcomes (see Figure 1). The third component of Donabedian's model, structure, is not addressed in this model because it concerns the nurse-patient relationship in the home, or what has been labelled the micro patient level (Mitchell, Ferketich, & Jennings, 1998). The process component consists of the technical and interpersonal aspects of care. The technical aspect is the application of the health sciences to the management and prevention of personal health problems and to health promotion. The interpersonal aspect is the management of social and psychological interactions between patient and provider (Donabedian, 1980). Outcomes refers to any "change in a patient's current and future health status that can be attributed to antecedent health care" (Donabedian, 1980, pp. 82-83).

Nursing care makes up the technical aspect of care quality. Three variables derived from the Interaction Model of Client Health Behavior (IMCHB) (patient-perceived affective support, patient-perceived health information adequacy, and patient-perceived decisional control) (Cox, 1984) define the interpersonal aspects. The IMCHB comprises three elements: client singularity, client-community health nurse interaction, and health outcomes. Assumptions upon which the IMCHB are based are that clients are able to make choices about their health behaviour and that these choices are influenced by the client's singularity (characteristics) and the client-nurse relationship (Cox, 1984). The Community Nursing Care Quality Model is based on the notion that the technical (nursing) aspect of care is related to the three interpersonal variables and that these three variables are related to three outcomes, which are also specified conceptually in the IMCHB: adherence, symptoms, and well-being (see Figure 1).

Starting at the right-hand side of the model, the three outcomes of interest — patient adherence to nursing and medical recommendations, presence or absence of symptoms, and general well-being — are interrelated. Further, these outcomes are influenced directly by the interpersonal process components — affective support, health information adequacy, and decisional control.

In addition, if patients perceive affective support, have adequate health information for their condition(s), and participate in decision-making regarding their care, they are more likely to adhere to the prescribed regimen, have fewer and/or less severe symptoms, and experience greater well-being (Cox, 1982, 1984; Cox, Miller, & Mull, 1987).

There are multiple interrelationships among the interpersonal process variables (Cox, 1982; Cox & Kaeser, 1986). Having decisional control over one's health care is a manifestation of affective support and assumes active acquisition and use of adequate health information. According to previous studies (Cox, 1982; Cox & Kaeser), these relationships are bidirectional. Finally, the left-hand side of the model indicates that the nursing care provided has a direct effect on the interpersonal processes: the patient's perceptions of affective support, health information adequacy, and decisional control (Cox, 1984).

The purpose of this study was to examine the relationships between the model's variables by testing four propositions: (1) *The technical (nursing) aspect of care is related to the three interpersonal variables: patient perceived affective support, patient perceived health information adequacy, and patient perceived decisional control.* (2) *The three interpersonal variables are related to the three outcome variables: adherence, symptoms, and well-being.* (3) *There are multiple interrelationships between the three interpersonal variables.* (4) *The three outcome variables are interrelated.*

Method

The relationships between the model's variables were examined by means of a cross-sectional correlational study. The project was approved by the university's Institutional Review Board before the commencement of data collection.

Sample

For this exploratory study, the convenience sample comprised 60 patients discharged from a large Medicare-certified home-health-care agency in a large Midwestern city in the United States. The sample size was based on recommendations that it be as large as resources allow, provided it include at least five cases for each observed variable (Brink & Wood, 1994; Tabachnick & Fidell, 1989). Individuals whose names were supplied by the agency and who met the following criteria were invited to participate: the interview could be conducted within 6 weeks of discharge from the agency; maximum service benefit achieved as defined by third-party reimbursement criteria (i.e., based on assessment by the nurse and the physician, the patient could not improve with continued care); and participant spoke English, was at least 18 years of age, and was able to

respond competently and provide informed consent. Data were collected during in-home face-to-face interviews arranged at the convenience of the participant.

The sample consisted of 76.7% females and 23.3% males with a mean age of 65.6 years ($SD = 16.7$) and an age range of 18 to 89 years. Just under 32% were widowed, 26.7% were married, 20% had never been married, and 21.6% did not report their marital status. Education level ranged from less than grade school to master's degree. The sample was almost evenly divided between White (48.3%) and Black participants (48.3%). All but two participants had multiple medical diagnoses. The most common diagnoses were congestive heart failure, cancer, diabetes, and gangrene. The number of completed home visits ranged from 2 to 74, with a mean of 12.7 ($SD = 11.3$).

Instruments

Nursing care provided was assessed using the Ervin Quality Assessment Measure (EQAM) (Ervin, Chen, & Upshaw, 1989). This 14-item checklist covers four components of the nursing process: assessing, planning, implementing, and evaluating. Sample items are as follows: "data were documented to support identified problems" (assessing); "spacing of home visits was based on care plan" (planning); "nursing interventions were executed for the identified problems" (implementing); "the family was involved in implementation of the nursing care plan" (implementing); and "patient outcomes or progress with plan of care was stated" (evaluating). Completion of the tool requires professional judgement on retrospective chart reviews, to determine whether a criterion of nursing care quality was or was not met and the extent to which it was met on a scale of 1 (*slightly*) to 5 (*totally*). The generalizability coefficient, G , was reported as .55. Generalizability coefficients are calculated from variance estimates (Shavelson & Webb, 1991). Evidence of content validity has been reported as a function of the process used to develop the instrument (Ervin et al., 1989). In this study, the alpha coefficient for the total instrument was .88.

Quality of care on the interpersonal aspects was measured using the Patient Perceived Affective Support (PPAS) instrument, the Patient Perceived Health Information Adequacy (PPHIA) instrument, and the Patient Perceived Decisional Control (PPDC) instrument (Ervin, Walcott-McQuigg, Chen, & Upshaw, 1992). Each instrument consists of 10 sets of items, each measured on a visual analogue scale. Examples of items on each instrument are: caring, supportive, and giving (PPAS); teaching, useful, and informative (PPHIA); and control, competent, and participation (PPDC). Participants record their scores by placing a mark at the point on the 100 mm line that best describes their opinion about

each of the three aspects of care provided (affective support, health information adequacy, and decisional control) over the course of one entire episode of care in the home — that is, from admission to discharge. A score for each scale was calculated by summing the number of millimetres for each visual analogue scale and dividing by 10. Cronbach's alpha coefficients were reported as PPAS, .95; PPHIA, .95; and PPDC, .90. Evidence of content validity has been reported (Ervin et al., 1992). In this study, alpha coefficients were PPAS, .95; PPHIA, .96; and PPDC, .94.

To measure the outcome variables, three previously tested instruments were used. Adherence to the medical and nursing regimens as prescribed was measured on the Compliance Questionnaire (Hilbert, 1988). This measure addresses 11 areas of potential patient adherence: medications, diet, weight loss, physical activity, exercise, stressful situations, smoking, alcohol use, caffeine intake, sexual activity, and work. Each area has 5 to 10 questions that are read to the participant. One item in each of the 11 areas is scored on a Likert-type scale (1 = *none of the time*, 5 = *all of the time*) for both a self-report, the wife's report of her husband's compliance, and an interviewer-judged score. A total score is derived by summing the scores for all applicable recommendations and dividing by the total possible score. Interrater reliability was determined by a second rater listening to the taped interviews. Interrater reliability was reported as .96 for the interrater agreement between the self-reported rating and the wife's rating; .84 was the interrater reliability reported for the judged scores. Content validity was determined by a panel of nurses with expertise in cardiac rehabilitation (Hilbert). In this study, the correlations between participant-reported scores and scores judged by the assistant interviewer ranged from .74 (for medications) to 1.00 (for work, sexual activity, and caffeine intake).

The Symptoms Index (Sullivan & Armignacco, 1979) was used to measure the number and kind of symptoms that might be functionally limiting. It is a 14-item scale of symptoms read to the subject and answered on a four-point Likert-type scale from *never* to *often*. A 15th item, "other," allows the individual to state symptoms not included on the list. The instrument is scored by summing the participant's answers and dividing by the number of applicable items. The unequal-length Spearman-Brown reliability coefficient for the initial use of the scale was reported as .73. In more recent studies with the elderly, alpha levels have ranged between .81 and .88 (Cox & Kaeser, 1986; Cox et al., 1987; Mull, Cox, & Sullivan, 1987). Validity has been demonstrated by an inverse correlation of the measure with health status (Cox & Kaeser). In this study, the Cronbach's alpha coefficient was .65 with all 15 items and .66 with 14 items. Evidence of validity was demonstrated by a statistically significant negative correlation between symptoms and well-being.

The General Well-Being Schedule (GWBS) (Fazio, 1977) was used to measure patient well-being. This 18-item instrument has six subscales that measure health worry, energy level, satisfying-interesting life, depressed-cheerful mood, emotional-behavioural control, and relaxed versus tense-anxious affect. The schedule is administered to subjects by interview and responses are given on a six-point Likert-type scale from 1 to 6, with varying responses according to the item. For example, the scale for "How have you been feeling in general?" is from 1 (*in excellent spirits*) to 6 (*in very low spirits*). Internal consistency rating is reported as .91 for males and .95 for females. Evidence of validity has been shown through correlations of the GWBS with scales that measure depression and anxiety (Fazio). Cronbach's alpha coefficient for the instrument used with the elderly has been reported as .92 (Himmelfarb, 1984). In this study, the alpha coefficient was .87; evidence of validity was demonstrated by a statistically significant negative correlation between symptoms and well-being.

Procedure and Data Analysis

A large home-health-care agency agreed to participate in the study. Each potential participant who met the study criteria and whose name was supplied by the agency was contacted by telephone and asked to agree to a face-to-face interview. Approximately 75% of the individuals contacted agreed and were scheduled to be interviewed in their homes within the 6-week post-discharge timeframe.

Upon arriving at the participant's home, the interviewer, who was a graduate nursing student, described the study again, answered questions, and obtained the participant's signature on the consent form. One copy of the consent form was left with the participant. No one declined to participate after the study was described. The interviews took about 1 hour to complete. To assess the quality of the technical aspect of care, two registered nurses with community health experience reviewed the participant's clinical chart using the EQAM. The nurses were trained by one of the investigators in how to conduct chart reviews using the EQAM instrument. Relationships between variables were analyzed using Pearson product-moment correlation.

Results

Statistically significant coefficients were found between the technical (nursing) quality of care and all three interpersonal quality variables. Statistically significant relationships were found between all three interpersonal quality variables (PPAS, PPHIA, and PPDC). Among the outcome variables, patient symptoms and patient well-being were signif-

Table 1 *Intercorrelation of Variables*

	Nursing Care	PPAS	PPHIA	PPDC	Adherence	Symptoms	Well-Being
Nursing Care	–						
<i>Interpersonal</i>							
PPAS	.43**	–					
PPHIA	.44**	.54**	–				
PPDC	.38*	.52**	.49**	–			
<i>Outcomes</i>							
Adherence		ns	.27*	ns	–		
Symptoms		ns	ns	ns	ns	–	
Well-Being		ns	ns	.39*	ns	-.45**	–

Note: PPAS = patient-perceived affective support; PPHIA = patient-perceived health information adequacy; PPDC = patient-perceived decisional control.
 * $p < .05$; ** $p < .01$.

icantly correlated in the negative direction. The relationships between patient symptoms and adherence and between patient well-being and adherence were non-significant (see Table 1).

Analysis of relationships between interpersonal variables and outcome variables showed a significant relationship between health information adequacy and adherence and between decisional control and patient well-being. Patient symptoms were not correlated with any interpersonal variables. The intercorrelations between model variables are displayed in Table 1.

Discussion

In this exploratory study, the relationships between process and nurse-sensitive patient outcomes were examined using a nursing care quality model. Support for some model relationships was found. One limitation of the study was the small size of the convenience sample, which does not permit generalization. Convenience sampling is useful in exploratory studies such as this (Burns & Grove, 2001). It was our intention to explore relationships between the model's variables and encourage related work by other investigators.

Major Findings

The proposition that the technical quality of nursing care is related to the patient's perceptions of affective support, health information adequacy, and decisional control (Cox, 1984) was supported. To our knowledge, this finding has not been reported previously in relation to care provided in the home. Several studies have emphasized the importance of interpersonal aspects of nursing care (process) for home services (Gomby, Culross, & Behrman, 1999; Olds & Kitzman, 1990). This finding provides evidence on what constitutes the nurse-patient interpersonal aspect of care.

The second group of findings concern the relationship of the three interpersonal process variables (PPAS, PPHIA, and PPDC) with the outcome variables. Relationships between health information adequacy and patient adherence and between patient perceived decisional control and well-being were significant. The latter finding has been reported for a number of measures over the last few decades (Langer & Rodin, 1976; Reinardy, 1992). There is a growing body of knowledge on the relationship between decisional control and patient outcomes in other settings. It has been found, for example, that patients differ in their desire for decisional control, whether shared or not shared with the care provider (Degner & Russell, 1988; England & Evans, 1992; Kallio & Sime, 1980). We found no previous studies on the relationship between decisional control and well-being in relation to nursing care provided in the home.

All three interpersonal variables (affective support, health information adequacy, and decisional control) have been reported as positively related to the outcome variable adherence (Harvey & Peet, 1991; Stanton, 1987; Wood & Gray, 2000). In our study, health information adequacy was the only variable of the interpersonal aspect of care that had a statistically significant relationship with adherence.

The third group of findings is the relationships between the interpersonal variables of affective support, health information adequacy, and decisional control. The relationships between these variables were supported in the model. One study that included the interpersonal variables was conducted with mothers and children in a home visit and school intervention developed to address affective support, decisional control, and health information adequacy; it resulted in improved outcomes for mothers and children (Cowell, McNaughton, & Ailey, 2000).

There was a statistically significant negative correlation between patient symptoms and patient general well-being, a result that is compatible with those of previous studies. Cox and Kaeser (1986) found an inverse correlation of the Symptoms Index (Sullivan & Armignacco, 1979) with a measure of health status. The Symptoms Index has a higher score as patients report more symptoms and more severe symptoms.

Future Research

The descriptive cross-sectional design was not intended to explore causal relationships. Establishing the existence of relationships between factors is the first step in the exploration of causality. High correlations between two variables do not indicate causal relationships. However, the possibility of a causal relationship becomes greater as the strength of the correlation increases (Burns & Grove, 2001). As a next step, the model could be tested with other designs; this would allow for the exploration of causality through the use of such techniques as path analysis and structural equation modelling.

The relationships between the outcome variables were mostly not supported. If the relationships between symptoms and adherence and between well-being and adherence are examined in future studies, we may learn how to improve adherence, which is reported to be between 10% and 85% among patients in the United States (Burke & Dunbar-Jacob, 1995; DiMatteo, 1994).

Adherence is a complex behaviour. Many researchers have focused on factors related to adherence and how to improve it, and numerous tools have been used to measure adherence or compliance (Peterson, Takiya, & Finley, 2003; Roter et al., 1998; Williams et al., 1998). The Compliance

Questionnaire (Hilbert, 1988) was chosen for this study because it includes the usual categories of medical and nursing advice, with regard to medications, diet, and exercise, to patients with a variety of diagnoses. The measure has been used with patients who had myocardial infarction (Hilbert), but in this case it may not have been specific enough for nurse-sensitive outcomes; several participants did not report recommendations in some Compliance Questionnaire categories — for example, stressful situations, alcohol use, and caffeine intake.

Longitudinal studies would provide an opportunity to examine the temporal relationship of affective support to health information adequacy and decisional control. Is affective support, as perceived by the patient, a prerequisite to the patient's being able to accept health information and feel comfortable exerting the type and level of decisional control needed to interact with the nurse? The exploration of answers to this question would provide more information about effective nurse-patient relationships.

Theory Development

The Community Nursing Care Quality Model is seen as having two perceptual orientations, that of the nurse and that of the patient. We propose that the nurse's perceptions be elicited through the use of instruments that measure the technical quality of care. A technical quality of care variable could be added to the model to examine care provided by the family. This variable could also be measured by using the nurse's perception. The addition of family care provided would make the model more complete, as much of patient care in the home is provided by family members. Other models that address nursing care quality in acute care settings do not include variables related to care provided by the family (Irvine, Sidani, & Hall, 1998; Yen & Lo, 2004). This unique feature of nursing care in the home merits attention because of the important role played by the family in keeping a family member safely at home. An instrument to measure family care has been developed and tested (Ervin & Chen, 2005). The other six variables should be measured based on the patient's perception. It has been proposed that both perceptions are needed, as they can differ significantly (Lutz & Bowers, 2000; McCauley, Lowery, & Jacobsen, 1992; O'Neill & Sorensen, 1991; Shulka & Turner, 1984).

Investigators have attempted to identify those components of the nurse-client relationship (McNaughton, 2005) and the nurse-patient relationship (Lotzkar & Bottorff, 2001) that lead to better and more consistent outcomes. Instructing nursing students in how to develop evidence-based relationships with patients and clients requires an evidence base. The findings of this study contribute to the research base on what has

been labelled the nursing process “black box,” or those aspects of nursing care that result in desirable patient outcomes.

Adherence is only one of three nurse-sensitive patient outcomes included in the model. Other patient outcomes could be added in future testing. Since some studies have shown inconsistent outcomes or have failed to demonstrate the effectiveness of home visiting for some outcomes, further work is needed in exploring the relationship of nursing care to other outcomes. For home health care that involves several professional providers, some outcomes may be more sensitive to an interdisciplinary approach or to interventions by care providers other than registered nurses. Research priority should also be given to patient outcomes that have cost-saving potential — for example, prevention of low birth weight and delay of diabetes complications.

Analyses that explore the relationships among several independent and several dependent variables would be valuable in the very complex situation of the relationship of process to nurse-sensitive outcomes. A tested, mature model of care quality may also include more outcome variables than those tested in the proposed model.

Clinical Significance

In the early development and testing stage of a model, clinical significance is negligible. A tested model that demonstrates the relationships between what the nurse does and patient outcomes would be of great benefit to evidence-based practice. Furthermore, if specific interventions, based on the nursing care provided and interpersonal relationships, proved to be effective with specific types of patients, nursing education and nursing practice could take great steps forward in helping nurses to be more effective.

Establishing effective nurse-client relationships takes time. Community health nursing services should evaluate the cost-effectiveness of providing a limited number of home visits (e.g., one or two) to a client, patient, and/or family (McNaughton, 2005). In order to move nursing knowledge forward, studies should be replicated and findings validated in the practice setting (Chinn & Kramer, 2004). The model presented in this paper may have clinical significance after it is subjected to the rigour of several studies.

The model requires further testing and refining. Because it was developed to examine the nursing care quality of various community nursing services delivered in the home, the model should be tested with public health nursing and other home-visiting services. Intervention studies would be useful for examining its application to nursing practice and making refinements, thus strengthening the foundation of the study and the provision of quality nursing care.

References

- Brink, P. J., & Wood, M. J. (1994). *Basic steps in planning nursing research* (4th ed.). Boston: Jones & Bartlett.
- Brooten, D., Kumar, S., Brown, L. P., Butts, P., Finkler, S. A., Bakewell-Sachs, S., et al. (1986). A randomized clinical trial of early discharge and home follow-up of very-low-birth-weight infants. *New England Journal of Medicine*, *315*, 934–939.
- Brooten, D., Naylor, M., York, R., Brown, L., Roncoli, M., Hollingsworth, A., et al. (1995). Effects of nurse specialist transitional care on patient outcomes and cost: Results of five randomized trials. *American Journal of Managed Care*, *1*(1), 45–51.
- Brooten, D., Roncolt, M., Finkler, S., Arnold, L., Cohen, A., & Mennuti, M. (1994). A randomized trial of early hospital discharge and home follow-up of women having Cesarean birth. *Obstetrics and Gynecology*, *84*, 832–838.
- Burke, L. E., & Dunbar-Jacob, J. (1995). Adherence to medication, diet, and activity recommendations: From assessment to maintenance. *Journal of Cardiovascular Nursing*, *9*, 62–79.
- Burns, N., & Grove, S. K. (2001). *The practice of nursing research: Conduct, critique, and utilization* (4th ed.). Philadelphia: Saunders.
- Chinn, P. L., & Kramer, M. K. (2004). *Integrated knowledge development in nursing* (6th ed.). St. Louis: Mosby.
- Cowell, J. M., McNaughton, D. B., & Ailey, S. (2000). Development and evaluation of a Mexican American family support program. *Journal of School Nursing*, *16*, 4–11.
- Cox, C. L. (1982). An interaction model of client health behavior: Theoretical prescription for nursing. *Advances in Nursing Science*, *5*, 41–56.
- Cox, C. L. (1984). Individual as client. In J. A. Sullivan (Ed.), *Directions in community health nursing* (pp. 129–172). Boston: Blackwell.
- Cox, C. L., & Kaeser, L. (1986). *Quality of life nursing care: A research and demonstration project*. Final report. Chicago: University of Illinois at Chicago.
- Cox, C. L., Miller, E. H., & Mull, C. S. (1987). Motivation in health behavior: Measurement, antecedents and correlates. *Advances in Nursing Science*, *9*(4), 1–15.
- Degner, L. F., & Russell, C. A. (1988). Preferences for treatment control among adults with cancer. *Research in Nursing and Health*, *11*, 367–374.
- DiMatteo, M. R. (1994). Enhancing patient adherence to medical recommendations. *Journal of the American Medical Association*, *271*, 70–83.
- Donabedian, A. (1966). Evaluating the quality of medical care. *Milbank Memorial Fund Quarterly*, *44*, 166–203.
- Donabedian, A. (1980). *Explorations in quality assessment and monitoring. Vol. 1: The definition of quality and approaches to its assessment*. Ann Arbor, MI: Health Administration Press.

- England, S. L., & Evans, J. (1992). Patients' choices and perceptions after an invitation to participate in treatment decisions. *Social Science and Medicine*, *34*, 1217–1225.
- Ervin, N. E., & Chen, S. C. (2005). Development of an instrument measuring family care. *Journal of Nursing Measurement*, *13*(1), 39–50.
- Ervin, N. E., Chen, S. C., & Upshaw, H. (1989). Development of a public health nursing quality assessment measure. *Quality Review Bulletin*, *15*(5), 138–143.
- Ervin, N. E., Walcott-McQuigg, J. A., Chen, S. C., & Upshaw, H. S. (1992). Measuring patients' perceptions of care quality. *Journal of Nursing Care Quality*, *6*(4), 25–32.
- Fazio, A. (1977). *A concurrent validation study of the NCHS General Well-Being Schedule*. Washington: Department of Health, Education and Welfare.
- Gomby, D. S., Culross, P. L., & Behrman, R. E. (1999). Home visiting: Recent program evaluations — analysis and recommendations. *The Future of Children*, *9*(1), 4–26.
- Harvey, N. S., & Peet, M. (1991). Lithium maintenance: 2 effects of personality and attitude on health information acquisition and compliance. *British Journal of Psychiatry*, *158*, 200–204.
- Hilbert, G. (1988). The measurement of compliance as a nursing outcome. In C. F. Waltz & O. L. Strickland (Eds.), *Measurement of nursing outcomes. Vol. 1: Measuring client outcomes* (pp. 80–107). New York: Springer.
- Himmelfarb, S. (1984). Age and sex differences in mental health of older persons. *Journal of Consulting and Clinical Psychology*, *54*, 844–856.
- Irvine, D., Sidani, S., & Hall, L. M. (1998). Linking outcomes to nurses' roles in health care. *Nursing Economic*, *16*(2), 58–64, 87.
- Kallio, J., & Sime, A. (1980). The effect of induced control on the perception of control, mood state, and quality of nursing care of clients in a critical care unit. *Advances in Nursing Science*, *2*, 105–107.
- Lamb, G. S., Jennings, B. M., Mitchell, P. H., & Lang, N. M. (2004). Quality agenda: Priorities for action. Recommendations of the American Academy of Nursing conference on health care quality. *Nursing Outlook*, *52*, 60–65.
- Langer, E. J., & Rodin, J. (1976). The effects of choice and enhanced personal responsibility for the aged: A field experiment in an institutional setting. *Journal of Personality and Social Psychology*, *34*, 191–198.
- Lotzkar, M., & Bottorff, J. L. (2001). An observational study of the development of a nurse-patient relationship. *Clinical Nursing Research*, *10*(3), 275–294.
- Lutz, B. J., & Bowers, B. J. (2000). Patient-centered care: Understanding its interpretation and implementation in health care. *Scholarly Inquiry for Nursing Practice: An International Journal*, *14*, 165–187.
- McCauley, K. M., Lowery, B. J., & Jacobsen, B. S. (1992). A comparison of patient/nurse perceptions about current and future recovery status. *Clinical Nurse Specialist*, *6*(3), 148–152.

- McNaughton, D. B. (2005). A naturalistic test of Peplau's theory in home visiting. *Public Health Nursing, 22*(5), 429–438.
- Mitchell, P. H., Ferketich, S., & Jennings, B. M. (1998). Quality Health Outcomes Model. *Image: Journal of Nursing Scholarship, 30*, 43–46.
- Mull, C., Cox, C. L., & Sullivan, J. A. (1987). Religion's role in health and well-being of elders. *Public Health Nursing, 4*, 151–159.
- Naylor, M. D., Brooten, D., Campbell, R., Jacobsen, B. S., Mezey, M. D., Pauly, M. V., et al. (1999). Comprehensive discharge planning and home follow-up of hospitalized elders: A randomized clinical trial. *Journal of the American Medical Association, 281*, 613–620.
- Olds, D. L., Eckenrode, J., Henderson, C. R., Jr., Kitzman, H., Powers, J., Cole, R., et al. (1997). Long-term effects of home visitation on maternal life course and child abuse and neglect: Fifteen-year follow-up of a randomized trial. *Journal of the American Medical Association, 278*, 637–643.
- Olds, D. L., Henderson, C. R., Jr., Chamberlin, R., & Tatelbaum, R. (1986). Preventing child abuse and neglect: A randomized trial of nurse home visitation. *Pediatrics, 78*(1), 65–78.
- Olds, D. L., Henderson, C. R., Jr., Cole, R., Eckenrode, J., Kitzman, H., Luckey, D., et al. (1998). Long-term effects of nurse home visitation on children's criminal and antisocial behavior. *Journal of the American Medical Association, 280*, 1238–1244.
- Olds, D. L., Henderson, C. R., Jr., Tatelbaum, R., & Chamberlin, R. (1986). Improving the delivery of prenatal care and outcomes of pregnancy: A randomized trial of nurse home visitation. *Pediatrics, 77*, 16–28.
- Olds, D. L., & Kitzman, H. (1990). Can home visitation improve the health of women and children at environmental risk? *Pediatrics, 86*(1), 108–116.
- Olds, D. L., Robinson, J., Pettitt, L., Luckey, D. W., Holmberg, J., Ng, R. K., et al. (2004). Effects of home visits by paraprofessionals and by nurses: Age 4 follow-up results of a randomized trial. *Pediatrics, 114*(6), 1560–1568.
- O'Neill, C., & Sorensen, E. S. (1991). Home care of the elderly: A family perspective. *Advances in Nursing Science, 13*(4), 28–37.
- Peterson, A. M., Takiya, L., & Finley, R. (2003). Meta-analysis of trials of interventions to improve medication adherence. *American Journal of Health-System Pharmacy, 60*, 657–665.
- Reinardy, J. (1992). Decisional control in moving to a nursing home: Post-admission adjustment and well being. *Gerontologist, 32*, 96–103.
- Roter, D. L., Hall, J. A., Merisca, R., Nordstrom, B., Cretin, D., & Svarstad, B. (1998). Effectiveness of interventions to promote patient compliance. *Medical Care, 36*, 1138–1161.
- Shavelson, R. J., & Webb, N. M. (1991). *Generalizability theory: A primer*. Newbury Park, CA: Sage.
- Shulka, R. K., & Turner, W. E., III. (1984). Patients' perception of care under primary and team nursing. *Research in Nursing and Health, 7*, 93–99.

- Sidani, S., Doran, D. M., & Mitchell, P. H. (2004). A theory-driven approach to evaluating quality of nursing care. *Journal of Nursing Scholarship*, 36(1), 60–65.
- Stanton, A. L. (1987). Determinants of adherence to medical regimens by hypertensive patients. *Journal of Behavioral Medicine*, 10, 377–394.
- Sullivan, J. A., & Armignacco, F. (1979). Effectiveness of a comprehensive health program for the well elderly by community health nurses. *Nursing Research*, 28, 70–75.
- Tabachnick, B. G., & Fidell, L. S. (1989). *Using multivariate statistics* (2nd ed.). New York: Harper & Row.
- Williams, G. C., Rodin, G. C., Ryan, R. M., Grolnick, W. S., & Deci, E. L. (1998). Autonomous regulation and long-term medication adherence in adult outpatients. *Health Psychology*, 17, 269–276.
- Wood, W., & Gray, J. (2000, January 14). An integrative review of patient medication compliance from 1990–1998. *Online Journal of Knowledge Synthesis for Nursing*, 7(1). Retrieved July 15, 2003, from <http://www.stti.iupui.edu/VirginiaHendersonLibrary/articles/070001.pdf>.
- Yen, M., & Lo, L.-H. (2004). A model for testing the relationship of nursing care and patient outcomes. *Nursing Economic*, 22(2), 75–80.
- York, R., Brown, L. P., Samuels, P., Finkler, S. A., Jacobsen, B., Persely, C. A., et al. (1997). A randomized trial of early discharge and nurse specialist transitional follow-up care of high risk childbearing woman. *Nursing Research*, 46, 254–261.

Authors' Note

Comments or queries may be directed to Naomi E. Ervin, 29580 Belfast Street, Farmington Hills, Michigan 48336 USA. Telephone: 734-487-6901. Fax: 734-487-6946. E-mail: neervin@hotmail.com

Naomi E. Ervin, PhD, RN, APRN, BC, FAAN, is Professor and Director, School of Nursing, Eastern Michigan University, Ypsilanti, Michigan, United States. Shu-Pi Chen, DrPH, RN, is Professor, School of Nursing, St. Xavier University, Chicago, Illinois, United States. Harry S. Upshaw, PhD, is Professor (Retired), University of Illinois at Chicago.

Points de vue des infirmières autorisées sur la réduction du tabagisme : enquête dans l'Ouest canadien

Annette S. H. Schultz, Joy L. Johnson et Joan L. Bottorff

Le traitement des maladies associées au tabagisme prend une place de plus en plus importante en soins infirmiers, les infirmières étant appelées notamment à faire de l'accompagnement au sevrage. La présente étude rapporte les points de vue et les pratiques des infirmières relativement à la réduction du tabagisme. On a mené une enquête auprès des infirmières autorisées ($N = 365$) employées dans deux hôpitaux de taille moyenne situés dans l'Ouest canadien et obtenu un taux de réponse de 43 % ($n = 101$) et de 86 % ($n = 113$) respectivement. Les répondantes admettent qu'elles auraient un rôle à jouer dans la réduction du tabagisme; toutefois, hormis l'évaluation de l'usage du tabac chez les patients, la plupart n'ont adopté aucune des pratiques exemplaires recommandées à cet égard. Les auteures présentent les points de vue des infirmières sur le soutien organisationnel, l'autoefficacité, les attentes des patients et la réduction du tabagisme. Les répondantes ont ouvertement rapporté ne pas se sentir préparées à accompagner des patients en sevrage et ne jouir que d'un soutien organisationnel limité pour le faire. Par ailleurs, les différences dans les réponses entre les établissements indiquent qu'intégrer la réduction du tabagisme aux soins infirmiers exigera un engagement en ce sens de la part des infirmières comme des hôpitaux.

Mots clés : tabagisme, réduction du tabagisme

Registered Nurses' Perspectives on Tobacco Reduction: Views from Western Canada

Annette S. H. Schultz, Joy L. Johnson, and Joan L. Bottorff

Treatment of tobacco-related health conditions have increasingly become a significant part of nursing practice and nurses are being challenged to also provide cessation support as part of their care. This study describes nurses' views of and practice related to tobacco reduction. Registered nurses ($N = 365$) employed by 2 Western Canadian mid-sized hospitals were surveyed; response rates were 43% ($n = 101$) and 86% ($n = 113$). The respondents agreed that they had a role to play in tobacco reduction; however, beyond assessment of smoking status, best practice guideline activities had not been integrated into the practice of most nurses. Nurses' perspectives related to institutional support, self-efficacy, and perception of patient expectations, and their attitudes towards tobacco reduction, are described. The nurses candidly reported feeling unprepared and having limited institutional support for assisting with cessation. Additionally, response differences between hospital sites suggest that the integration of tobacco reduction into practice will require a commitment by both nurses and hospitals.

Keywords: Tobacco use, smoking cessation, clinical nursing research

Introduction

As we enter the 21st century a significant issue facing all health practitioners is the treatment of tobacco-related health conditions. Tobacco use is reported to be a leading cause of preventable mortality and morbidity (World Health Organization [WHO], 2000), associated with a variety of cancers, cardiovascular diseases, and pulmonary conditions (France, Glasgow, & Marcus, 2001; Kozłowski, Henningfield, & Brigham, 2001; Rice & Stead, 2004; Rigotti, Munafo, & Stead, 2001). Additionally, tobacco use can exacerbate other health conditions, such as surgical outcomes (Ratner et al., 2004) and a variety of cancer-related treatments and outcomes (Wakefield, Olver, Whitford, & Rosenfeld, 2004). Accordingly, health practitioners are increasingly being encouraged to extend their practice beyond the treatment of tobacco-related conditions to include tobacco-reduction strategies (Canadian Nurses Association, 2001a, 2001b; Fiore et al., 2000).

One group of health practitioners believed to have an integral role to play in tobacco reduction is nurses (International Council of Nurses [ICN], 1999; Rice & Stead, 2004; WHO, 1999), mainly because nurses

are the largest group of health professionals, have the most contact with patients, and are trusted by the public (ICN, WHO, 1999). While globally nurse scientists and governance bodies have begun to engage in the issue of tobacco reduction (Schultz, 2003), we have limited insight regarding the engagement of direct-care nurses in tobacco reduction. Moreover, in Canada there are no published studies concerning the integration of tobacco-reduction strategies into acute-care nursing practice. This paper is intended to shed light on this deficit by presenting findings from a study focused on the work of acute-care registered nurses in the province of British Columbia.

Tobacco Use in British Columbia

British Columbia is reported to have the lowest rate of tobacco use in Canada, at 17% (Health Canada, 2003). Estimates that 18% of the non-smoking population is exposed to second-hand smoke daily (Vancouver Coastal Health Authority, 2004) indicate that approximately 35% of British Columbians, or about 1.5 million people, are at increased risk of developing tobacco-related health conditions. In British Columbia approximately 6,000 people die each year from tobacco-related diseases (British Columbia Ministry of Health Services [BCMHS], 2004a) and over \$500 million is spent annually on direct care for tobacco-related illnesses (BCMHS, 2004b). Health care for individuals with conditions associated with or exacerbated by tobacco use is, therefore, a significant feature of the practice of many health practitioners.

Acute-Care Registered Nurses and Tobacco Reduction

Hospitalization may be an ideal opportunity to initiate conversations with patients about tobacco use, the health effects of tobacco use, and stopping smoking, because tobacco-use patterns are interrupted during a hospital stay and smokers often contemplate cessation when faced with a health crisis (Fiore et al., 2000; France et al., 2001; Ratner et al., 2004; Rigotti et al., 2001). Given that most nurses work in acute-care hospitals (Canadian Institute for Health Information, 2003), these nurses should be encouraged to move beyond providing care for tobacco-related health conditions to integrate tobacco-reduction activities into their practice.

A meta-analytic review of studies evaluating the efficacy of nurse-delivered cessation interventions suggests that nurses can significantly influence tobacco-use patterns and rates (Rice & Stead, 2004). Moreover, evidence-based best practice guidelines have been published to guide health clinicians in effective ways of delivering tobacco-reduction interventions (Commonwealth Department of Health and Aged Care, 1999; Fiore et al., 2000; Raw, McNeil, & West, 1998). The guiding framework for supporting the integration of tobacco reduction into practice is the “four A’s,” with each *A* representing a series of possible actions. The first

A pertains to *asking*, which includes assessment of tobacco use, interest in quitting, and documentation of this information. The second *A* stands for providing *advice* regarding the health risks and benefits associated with tobacco use and cessation, along with advice for stopping. The third *A*, *assist*, focuses practitioners on providing information about quitting, coping with relapse, and nicotine-replacement therapy. The final *A*, *arrange*, encompasses arranging follow-up or referral to a cessation expert or program. While all of these activities are expected to be integrated into practice, research has demonstrated that even brief interventions comprising assessing and advising can influence tobacco-use patterns and cessation (Rigotti et al., 2001; Tsoh & McClure, 1997). Rice and Stead suggest that the next step for the nursing profession is to have cessation interventions become a standard of care, their vision being that tobacco users are provided the opportunity at every health-care visit to talk about tobacco use and stopping.

The tobacco-reduction practices of oncology registered nurses in the United States (Sarna, Brown, Lillington, Rose, et al., 2000), American acute-care registered nurses (McCarty, Hennrikus, Lando, & Vessey, 2001) and Australian acute-care nurses (Nagle, Schofield, & Redman, 1999) have been described. Sarna, Brown, Lillington, Rose, and colleagues surveyed a random sample of members of the Oncology Nursing Society of the United States (38% response rate; $n = 1,508$). They report that the majority of nurses were assessing and documenting tobacco use; however, far fewer were assessing patient interest in stopping (38%), advising patients to stop smoking (32%), teaching cessation strategies (16%), and referring patients to cessation experts (5%). In a survey of acute-care registered nurses working on adult in-patient wards at four hospitals in the United States (68% response rate; $n = 397$) (McCarty et al.), only 30% stated that they frequently counselled smokers in cessation and 11% reported advising all smokers (patients) to quit. A study with acute-care nurses in seven hospitals in Australia (Nagle et al.) (88% response rate; $n = 335$) reports that although almost two thirds of the nurses believed that tobacco reduction was an expected part of their role and that all smoking patients should be educated in tobacco reduction, only 10% thought patients who use tobacco received such care. These researchers found that key factors supporting the integration of tobacco reduction into nursing practice were patient interest in stopping, the health benefits associated with cessation, and a belief that nurses have a role to play in addressing tobacco use. Identified barriers to the integration of tobacco-reduction practices were lack of time, low confidence in ability to support cessation, an inadequate knowledge base, and lack of leadership.

The purpose of this study was to contribute to the nascent global discussion by providing a Canadian perspective on the integration of

tobacco-reduction activities into nursing practice. Specifically, the study investigated the practice of registered nurses working in acute-care hospitals and addressed four research questions: *To what degree are nurses integrating tobacco-reduction activities into their practice? What are nurses' attitudes concerning tobacco use and tobacco reduction? What are the perceived barriers and motivators to providing tobacco-reduction activities? Are there differences in the degree of integration of tobacco-reduction strategies, attitude towards tobacco reduction, and perceptions of influencing factors concerning tobacco reduction among nurses working in hospitals situated in communities with diverse population smoking rates?*

Methods

Background

The findings discussed are a result of a cross-sectional survey design, which was part of a larger mixed-methods research project investigating the use of tobacco-reduction strategies by acute-care registered nurses in their practice. The study was approved by the University of British Columbia Behavioural Research Ethics Board as well as by the ethical review board of each participating hospital.

Study Sites

Sampling decisions were guided by the larger research project design of comparing two populations of nurses and their workplace culture. The first selection criterion was the provincial regions with the lowest and highest rates of tobacco use, which ensured an initial contextual tobacco-related difference between study sites. We then selected mid-sized hospitals in these two regions, because hospitals of this size tend to serve the immediate surrounding communities and have a variety of adult in-patient wards. In one region there was only one mid-sized hospital, so based on that bed size we selected one comparable hospital in the other region. A comparison of the study hospitals is shown in Table 1.

Participants

The sample included all registered nurses employed for at least 6 months at the study hospitals who had worked at least one shift on an adult in-patient ward (surgery, medicine, rehabilitation, cardiac, or psychiatry) during the data-collection period. Eligible nurses were identified via human resources records: 235 for site A and 134 for site B. Differences in the number of eligible nurses reflected hiring practices: site A used more casual staff than site B. Of the sample, 101 nurses from site A and 113 nurses from site B completed questionnaires (response rates of 43% and 86%, respectively).

Table 1 *Description of Differences and Similarities in Study Sites*

<i>Differences</i>	
Site A	Site B
Southern region	Northern region
294-bed acute-care hospital	260-bed acute-care hospital
Population smoking rate: 20% (Ipsos Reid, 2003) ^a	Population smoking rate: 31% (Ipsos Reid, 2003)
Nicotine-replacement therapies not available on the hospital formulary	Nicotine-replacement therapies available on the hospital formulary
No in-hospital smoking cessation expert	In-hospital referral program, including most hospital pharmacists and clinical nurse specialists, all educated through the Mayo Clinic Nicotine Dependence program in Rochester, Minnesota, United States
Minimal community resources, including local community pharmacists and general practitioners	Established community program, initiated through a public health nursing office
<i>Similarities</i>	
<ul style="list-style-type: none"> • Smoking status assessment requested on admission history form • Established smoking-restriction policies • No hospital policies or protocols regarding tobacco reduction • No tobacco-related in-service education for registered nurses • No published tobacco-reduction best practice guidelines available in hospital • Limited availability of patient-education materials 	
^a Ipsos Reid survey results include BC regional population smoking rates.	

Survey Questionnaire

Construction of the self-administered questionnaire was informed by studies that investigated nurses' perspectives on tobacco use and reduction (Sarna, Brown, Lillington, Rose, et al., 2000; Sarna, Brown, Lillington, Wewers, & Brecht, 2000), a survey developed by the Ontario Tobacco Research Unit to investigate the practice and perceptions of community pharmacists (Brewster et al., 2005), best practice guidelines related to tobacco reduction (Fiore et al., 2000), and an extensive review of the nursing literature on tobacco reduction (Schultz, 2003). To strengthen content validity, two nurse researchers, who were tobacco-reduction experts and had extensive experience in survey construction, reviewed the questionnaire for completeness and relevance for the health-care

context in British Columbia. Finally, the questionnaire was pretested with 16 registered nurses working on acute adult in-patient wards in hospitals other than the study sites; their feedback was obtained through individual interviews, which informed minor changes to enhance clarity.

The questionnaire included items in four areas. *Nurses' tobacco-reduction activities* were assessed by asking respondents the frequency with which they engaged in 14 activities with patients who used tobacco. The items drew on the work of Sarna, Brown, Lillington, Rose, and colleagues (2000) but also included newly constructed items to reflect activities related to the "four A's" outlined in tobacco-reduction best practice guidelines (Fiore et al., 2000). The response choices were *almost always*, *frequently*, *seldom*, and *almost never*. The second group of items, *nurses' attitude towards tobacco reduction and their role*, was assessed with nine items using a four-point Likert format (*strongly agree* to *strongly disagree*). These items were compiled from several sources and included questions assessing nurses' attitudes about what tobacco-related actions nurses should be engaged in (Sarna, Brown, Lillington, Wewers, et al., 2000), what tobacco-reduction activities their colleagues were engaged in (new items), and their beliefs concerning tobacco reduction (Brewster et al., 2005) and supporting cessation (Brewster et al.; Sarna, Brown, Lillington, Wewers, et al.). *Barriers and motivators* to addressing reduction of tobacco use were measured using an instrument containing 19 items (Sarna, Brown, Lillington, Rose, et al.). A four-point Likert format employed response options ranging from *strongly agree* to *strongly disagree*. Categories of barriers and motivators included: associated health concerns, concern for the patient (i.e., not wanting to make patients feel guilty), knowledge and confidence, and institutional factors. *Demographic* items included age, sex, marital status, smoking status, nursing education, length of nursing career at the hospital, current nursing position, and perception of tobacco use among patients. Additional psychometric testing of items has been published elsewhere (Schultz & Johnson, in review).

Procedure

One week prior to delivery of the survey, introductory flyers about the study were posted on each nursing ward to raise awareness about the study and encourage nurses to participate. The survey was packaged in an unsealed self-addressed envelope marked "confidential" and respondents were asked to return the completed survey in the self-addressed envelope through internal hospital mail to a special research-project mailbox. Copies of the surveys were available on each ward for a 2-month period. During the data-collection period, reminder flyers were posted weekly regarding the survey, along with response rates.

Table 2 Personal and Professional Characteristics of Participants		
Variable	Site A (n=101)	Site B (n=113)
Personal		
Age: Mean (range) in years	40.1 (22–64)	40.5 (23–64)
Sex (%)		
Female	95	96
Marital Status** (%)		
Single	28	11
Partnered/married	57	77
Separated/divorced/widowed	15	11
Smoking Status (%)		
Current smoker	19	16
Former smoker	27	32
Never smoked	55	52
Professional		
Education (diploma/degree) (%)	76	74
Number of years at the hospital		
Mean (range)	9.9 (1–31)	9.5 (1–26)
Position (%)		
Full time	61	67
Part time	23	21
Casual	15	11
Ward (%)		
Surgery	31	30
Medicine	54	48
Psychiatry	16	22
Nurses perceived <i>almost always</i> or <i>frequently</i> working with patients who smoke** (%)	83	96
** $p < .01$		

Analysis

Descriptive statistics were used to summarize demographic-item responses. The responses to four-point Likert items (nurses' tobacco-reduction activities, attitudes towards tobacco use and reduction, and perceived motivators and barriers to addressing tobacco reduction with

Table 3 *Nurses' Tobacco Reduction Activities in Everyday Practice^a*

Sentence Stem and Items <i>With your patients who use tobacco how often do you...</i>	Site A (n=101) %	Site B (n=113) %
Ask		
Assess smoking status on admission	85	90
Chart smoking status*	68	81
Assess interest in quitting	51	57
Advise		
Talk about health effects of smoking	39	51
Talk about health benefits of stopping*	34	47
Advise patient to stop smoking*	32	46
Advise patient to cut down	46	49
Assist		
Discuss stopping strategies*	21	35
Discuss strategies to cope with relapse	12	15
Discuss nicotine replacement therapies***	30	59
Recommend nicotine replacement therapies for a patient***	36	66
Have a conversation with a family member**	9	24
Arrange		
Refer a patient to in-hospital expert***	0	38
Refer a patient to a community-based program*	3	12
^a Items presented in this table represent the percentage of respondents whose response to the item was either <i>almost always</i> or <i>frequently</i> . * $p < .05$; ** $p < .01$; *** $p < .001$		

patients) were recoded into two response options: affirmative and negative. Chi square analysis was used to determine response differences between site A and site B participants (Hazard Munro, 2001).

Results

Participant Demographics

The personal and professional characteristics of the participants were similar across the two sites in every regard except marital status ($\chi^2 (2, n = 212) = 12.089$) (see Table 2). Perceptions of tobacco use among patients differed by site: 96% of site B nurses compared to 83% of site A nurses reported *almost always* or *frequently* working with patients who were smokers ($\chi^2 (1, n = 211) = 10.369$).

Representativeness of the samples was assessed by comparing sample demographic data with population data obtained from the human resources department at each site. Population data obtained included age, number of years employed at the hospital, description of position (full time, etc.), and the primary ward for the nurse's position. Based on available data, the samples for each site appear representative of the population, with one exception: the sample of respondents from site A included a higher percentage of full-time nurses than in the target population (Schultz, 2005).

Nurses' Tobacco-Reduction Activities

Between-group differences were noted for at least one of the items for each of the four categories of tobacco reduction activities (see Table 3). Site B participants reported a greater likelihood of charting smoking status ($\chi^2(1, n = 212) = 4.595$), talking with patients about the health benefits of stopping ($\chi^2(1, n = 212) = 3.812$), advising patients to stop smoking ($\chi^2(1, n = 212) = 4.516$), talking to patients about strategies to support cessation ($\chi^2(1, n = 212) = 5.361$) and the use of nicotine-replacement therapies ($\chi^2(1, n = 212) = 17.805$), recommending the use of nicotine replacement ($\chi^2(1, n = 212) = 19.208$), and talking with family members about tobacco reduction ($\chi^2(1, n = 208) = 8.078$). Moreover, site B participants reported referring patients to in-hospital ($\chi^2(1, n = 211) = 47.241$) and community smoking-cessation resources more frequently than site A participants ($\chi^2(1, n = 208) = 5.972$).

Nurses' Attitudes towards Tobacco Reduction and Their Role

Responses to items assessing nurses' attitudes towards tobacco reduction and their related role were similar at the two sites, with one exception (see Table 4). More site B than site A participants reported that their registered nurse colleagues were likely to discuss stopping smoking with patients ($\chi^2(1, n = 213) = 10.153$).

Motivators and Barriers to Providing Tobacco-Reduction Activities

Responses to items related to associated health concerns demonstrated no between-group differences (see Table 5); however, the other three categories demonstrated between-group differences. In comparison with site B respondents, site A nurses were less likely to report having confidence in their ability to support cessation ($\chi^2(1, n = 208) = 4.081$) and having positive experiences with helping people to stop ($\chi^2(1, n = 208) = 5.789$). Additionally, site B nurses were more likely than site A nurses to agree that the following two institutional factors supported their involvement in addressing tobacco issues with patients: administrative support for providing smoking-cessation counselling ($\chi^2(1, n = 209) =$

55.840), and physicians' requests for nurse assistance with cessation ($\chi^2(1, n = 209) = 7.371$). Finally, site B nurses were less likely than site A nurses to report that a perceived sense of non-motivation to stop smoking by a patient would be a barrier to their addressing tobacco use ($\chi^2(1, n = 211) = 5.260$).

Table 4 Nurses' Attitude towards Tobacco-Reduction and Their Role^a

Item	Site A (n=101) %	Site B (n=113) %
1. Nurses who agree that relief of withdrawal symptoms is important for successful stopping	98	97
2. Nurses who perceive that on their ward nurses assess tobacco use status on admission	90	93
3. Nurses who perceive a need for additional training/skills in assisting people to stop	88	90
4. Nurses who agree that it is important for nurses to set a good example by not smoking	87	85
5. Nurses who agree it is important for nurses to talk with their patients about tobacco use	87	85
6. Nurses who agree that it is important that nurses actively encourage patients to stop smoking	76	75
7. Nurses who agree that most smokers can stop if they really want to	68	66
8. Nurses who agree that smokers appreciate it when nurses provide smoking cessation advice	47	55
9. Nurses who agree that with most smokers nurses can be effective in promoting cessation	45	50
10. Nurses who perceive that on their ward nurses discuss stopping smoking with their patients**	25	46
11. Nurses who perceive that on my ward nurses chart about nursing care provided that relates to tobacco	31	41
12. Nurses who agree that when a person has been smoking for many years, there is not much point in trying to stop	8	6

^a Items presented in this table represent the percentage of respondents whose response to the item was either *strongly agree* or *agree*.
 ** $p < .01$

Table 5 Motivators and Barriers to Integrating Tobacco Reduction^a		
Sentence Stems and Items	Site A (n=101) %	Site B (n=113) %
Motivators <i>I address stopping smoking with my patients because...</i>		
Associated Health Concerns		
1. Nurses who agreed there are health benefits for their patient	99	98
2. Nurses who agreed stopping smoking will decrease risks of tobacco related health effects	99	98
3. Nurses who agreed that if a patient stopped smoking, it would influence treatment side effects	71	69
Concern for the Patient		
4. Nurses who are motivated by a patient wanting to stop smoking	81	87
Knowledge and Confidence		
5. Nurses who agreed they have personal experience with stopping	41	41
6. Nurses who agreed they have confidence in their ability to help someone stop*	24	36
7. Nurses who agreed they have past positive experiences with assisting people with stopping*	19	34
Institutional Factors		
8. Nurses who agreed it is an expected part of my role	57	61
9. Nurses who agreed there is administrative support on their ward to assist a patient in stopping***	10	60
10. Nurses who agreed physicians request nurses' involvement in assisting with stopping**	17	34
11. Nurses who agreed they have adequate time to provide assistance with stopping	12	21
12. Nurses who agreed there is recognition for assisting with stopping	0	4

Table 5 *cont'd*

Barriers <i>I avoid addressing stopping smoking with my patients because...</i>		
Associated Health Concerns		
1. Nurses who agreed that stopping smoking would make no difference due to poor prognosis	22	22
2. Nurses who agreed that smoking is not a health priority	5	11
Concern for the Patient		
3. Nurses who agreed when a patient is not motivated or interested*	84	71
4. Nurses who agreed when they don't want to add to their patient's stress	54	43
5. Nurses who agreed they feel it is an invasion of privacy	37	35
6. Nurses who agreed they don't want their patient to feel guilty	30	21
Knowledge and Confidence		
7. Nurses who agreed they lack adequate knowledge about how to assist my patient in stopping	58	46
^a Items presented in this table represent the percentage of respondents whose response to the item was either <i>strongly agree</i> or <i>agree</i> . * $p < .05$; ** $p < .01$; *** $p < .001$		

Discussion

The findings from this study provide the first description of the attitudes and practice of Canadian registered nurses related to tobacco reduction in acute-care hospital settings. While the level of involvement in tobacco-reduction interventions is slightly higher than rates reported for nurses in other countries (McCarty et al., 2001; Nagle et al., 1999; Sarna, Brown, Lillington, Rose, et al., 2000), many opportunities to address tobacco use with patients continue to be missed. As well, findings from this study suggest the presence of institutional influences on the integration of tobacco-reduction activities and provide important information on nurses' views about addressing tobacco use with patients and their perceived ability to provide support for stopping smoking.

The positive influence of the availability of tobacco-reduction resources appears to be reflected in the findings. The participants reported regularly assessing and charting tobacco use, with significantly more nurses at site B reporting that they charted smoking status. This difference might reflect the accessibility of in-hospital and community cessation resources at site B. At both sites, only half of the nurses indicated that they assessed interest in quitting, and fewer provided advice regarding tobacco use and reduction. Nevertheless, nurses with greater access to tobacco-related resources (site B) reported higher rates of talking with patients about the benefits of stopping as well as providing advice about stopping. Assisting with smoking-cessation activities was restricted to nicotine-replacement therapy, with significantly more nurses at site B than at site A reporting that they had incorporated these activities into their practice. Arranging follow-up for patients interested in reducing their use of tobacco was not a frequent activity among respondents, although 37% of nurses at site B reported that they *almost always* or *frequently* referred such patients to an in-hospital expert. Finally, nurses working at site B reported higher levels of tobacco-reduction activity among colleagues. While these differences suggest a positive relationship with accessibility to tobacco-related resources, they are particularly interesting because the two sets of nurses reported similar attitudes towards tobacco use. Even though nurses believe tobacco use is an important health issue and ought to be addressed, the institution likely plays an important role in shifting practice norms.

Previous research suggests that institutional commitment to tobacco reduction influences the successful integration of tobacco-reduction interventions by clinicians (Cooke, Mattick, & Campbell, 1998; Fiore et al., 2000; Vaughn et al., 2002), and, in general, a positive relationship between institutional commitment to practice guidelines and practice norms has been reported (Grimshaw, Eccles, & Totes, 2004; Wall, 2005). One workplace factor commonly noted as influencing the uptake of research evidence into practice is the availability of resources to integrate new practice activities (France et al., 2001; Hutchinson & Johnston, 2004; Varcoe & Hilton, 1995). While findings from this study concur that tobacco-related resources are likely an underlying factor in between-site differences in reported practice norms, other noteworthy plausible influences include perceived administrative support to address tobacco use and physician expectation for nurses' involvement in tobacco reduction. In addition, lack of time to address patients' tobacco use is commonly reported as a workplace environmental barrier (Block, Hutton, & Johnson, 2000; McCarty et al., 2001; Nagle et al., 1999; O'Loughlin et al., 2001; Sarna, Brown, Lillington, Wewers, et al., 2000; Vaughn et al.), a finding that was reflected in the responses of the majority of nurses in

this study. Interestingly, despite between-site similarities in perceived availability of time to address tobacco use, nurses at site B reported higher rates and a greater range of tobacco-reduction activities. Thus, perceived availability of time appears to be unrelated to reported practice norms.

Hospitalization has been proposed as an ideal opportunity to address tobacco use (France et al., 2001; Ratner et al., 2004; Rigotti et al., 2001); however, it has been speculated that health-care providers are reluctant to discuss tobacco use with their patients for fear of straining the relationship and heightening stress for a person who is already facing a health crisis (Block et al., 2000; Kozlowski et al., 2001). Interestingly, the majority of nurses in this study did not believe that addressing tobacco reduction would increase patients' sense of stress or guilt or would represent an invasion of privacy. Additionally, almost all nurses reported that patient interest in stopping would motivate them to address tobacco reduction; yet nurses from site B (those with greater access to resources) were less likely to be deterred from addressing tobacco use because a patient was perceived to be unmotivated to stop smoking.

The majority of participants agreed that registered nurses ought to talk with patients about tobacco use and actively encourage them to stop smoking. Similar findings are reported in the literature (McCarty et al., 2001; Nagle et al., 1999; Sarna, Brown, Lillington, Wewers, et al., 2000). While there was agreement that attempting to stop is worthwhile for any smoker and that smokers *can* stop successfully, only half of the respondents believed that smokers appreciate support provided by nurses and that such efforts are efficacious. There was also solid agreement that the relief of withdrawal symptoms is essential to cessation. Thus, although the respondents portrayed a fairly positive attitude towards cessation, less than half thought their colleagues were discussing tobacco reduction with patients. These findings point to a gap between what nurses think they ought to be doing and what they perceive is being done in their practice environments. This could be explained in part by beliefs that cessation support is ineffective and that patients are not interested in addressing tobacco reduction.

The respondents were candid about their lack of preparedness for intervening with patients concerning tobacco use. Just under half of the nurses believed they possessed adequate knowledge to support the integration of tobacco-reduction activities into their practice. As well, less than one third reported having confidence in their ability to assist a patient with stopping smoking. The results of previous studies suggest that higher levels of self-efficacy related to engaging in tobacco reduction improve integration of cessation support (Aquilino, Goody, & Lowe, 2003; McCarty et al., 2001; Nagle et al., 1999; O'Loughlin et al., 2001; Sarna, Brown, Lillington, Wewers, et al., 2000; Vaughn et al., 2002). A

Canadian initiative focused on preparing nurses to address tobacco use includes the dissemination of best practice guidelines for nurses (Registered Nurses Association of Ontario [RNAO], 2003b) and an e-learning course related to the guidelines (RNAO, 2003a). While the results of pilot testing the e-learning course include an increase in knowledge, e-learning was not sufficient to improve skills for counselling patients on tobacco use and reduction. However, when tailored educational materials, along with brief one-to-one follow-up training sessions, are used to support the use of clinical practice guidelines on tobacco reduction for nurses working with pregnant and postpartum women, nurses report increased confidence in providing tobacco-related interventions (Hyndman, 2004). Less intensive educational strategies may also have merit. Site B nurses were more likely than site A nurses to report confidence in their ability to provide tobacco-reduction support and to report positive past experiences with supporting cessation efforts. This difference existed even though neither hospital provided specific in-service tobacco-reduction education for nurses. It is possible that the in-hospital cessation experts at site B were role models for the nurses in addressing tobacco use and/or provided informal learning opportunities for nurses.

This study has a number of limitations. Since whole-population sampling was used, generalizability of the findings beyond the study participants is not possible. The response rate at site A was lower than expected; however, based on the available population data, the participants appear representative. No further information about the non-responders is available. Level of integration of tobacco reduction is based on self-report and no attempt was made to check for accuracy; therefore, response bias might have influenced reported rates. Still, these findings provide a basis for discussing the views and practices of Canadian registered nurse related to tobacco reduction.

Conclusion

The findings from this descriptive study add to the evidence showing that nurses commonly assess smoking status and that, beyond this activity, addressing tobacco use has not become a regular part of the practice of acute-care registered nurses. While the nurses believed they had a role to play in tobacco reduction, they felt unprepared to support tobacco reduction with patients. Logical ways of addressing this gap would include providing relevant in-service education along with clarification and standardization of which tobacco-reduction activities could reasonably be integrated into practice. However, as has been noted previously, the uptake of practice guidelines will not be successful if solutions rest

solely within the domain of practitioners (Grimshaw et al., 2004). The successful integration of tobacco reduction by practitioners will depend on the commitment of health-care institutions to provide such care. As Fiore and colleagues (2000) note, our ability to attenuate the health effects of tobacco use will be restricted if we focus solely on the practice of the individual clinician; a systemic approach encompassing strategic planning for health institutions and health-care systems to integrate tobacco control is required.

References

- Aquilino, M. L., Goody, C. M., & Lowe, J. B. (2003). WIC providers' perspectives on offering smoking cessation interventions. *MCN: American Journal of Maternal/Child Nursing*, 28(5), 326–332.
- Block, D. E., Hutton, K. H., & Johnson, K. M. (2000). Difference in tobacco assessment and intervention practices: A regional snapshot. *Preventive Medicine*, 30, 282–287.
- Brewster, J. M., Ashley, M. J., Laurier, C., Dioso, R., Victor, C., Ferrence, R., et al. (2005). On the front line of smoking cessation: Canadian pharmacists' practices and self-perception. *Canadian Pharmaceutical Journal*, 138(3), 32–38.
- British Columbia Ministry of Health Services. (2004a). *BC's tobacco control strategy: Targeting our efforts*. Victoria: Author.
- British Columbia Ministry of Health Services. (2004b). *Ruling paves way to recover health costs of tobacco use*. News release. Victoria: Author.
- Canadian Institute for Health Information. (2003). *Workforce trends of registered nurses in Canada*. Ottawa: Author.
- Canadian Nurses Association. (2001a). *Position statement on reducing the use of tobacco products*. Ottawa: Author.
- Canadian Nurses Association. (2001b). *Tobacco: The role of health professionals in smoking cessation: Joint statement*. Ottawa: Author.
- Commonwealth Department of Health and Aged Care. (1999). *The National Tobacco Strategy 1999 to 2002–3: A framework for national action*. Canberra: AusInfo.
- Cooke, M., Mattick, R. P., & Campbell, E. (1998). The influence of individual and organizational factors on the reported smoking intervention practices of staff in 20 antenatal clinics. *Drug and Alcohol Review*, 17, 175–185.
- Fiore, M. C., Bailey, W. C., Cohen, S. J., Dorfman, S. F., Goldstein, M. G., Gritz, E. R., et al. (2000). *Treating tobacco use and dependence: Clinical practice guideline*. Rockville, MD: US Department of Health and Human Services, Public Health Services.
- France, E. K., Glasgow, R. E., & Marcus, A. C. (2001). Smoking cessation interventions among hospitalized patients: What have we learned? *Preventive Medicine*, 32, 376–88.
- Grimshaw, J., Eccles, M., & Tetroe, J. (2004). Implementing clinical guidelines: Current evidence and future implications. *Journal of Continuing Education in the Health Professions*, 24, S31–S37.

- Hazard Munro, B. (2001). *Statistical methods for health care research*. Philadelphia: Lippincott.
- Health Canada. (2003). *Canadian Tobacco Use Monitoring Survey*. Ottawa: Author. Available online: <http://www.hc-sc.gc.ca/hecs-sesc/tobacco/research/index.html>
- Hutchison, A. M., & Johnson, L. (2004). Bridging the divide: A survey of nurses' opinions regarding barriers to, and facilitators of, research utilization in the practice setting. *Journal of Clinical Nursing, 13*, 304–315.
- Hyndman, K. (2004, November 11–13). *Registered nurses' experiences using nursing clinical practice guidelines related to tobacco reduction*. Paper presented at the AWOHNN Canada 15th National Conference, Regina, Saskatchewan.
- International Council of Nurses. (1999). *Tobacco use and health: Position statement*. Geneva: Author.
- Ipsos Reid. (2003). *Smoking prevalence in British Columbia: Final report*. Vancouver: Author.
- Kozlowski, L. T., Henningfield, J. E., & Brigham, J. (2001). *Cigarettes, nicotine and health: A biobehavioral approach*. Thousand Oaks, CA: Sage.
- McCarty, M. C., Hennrikus, D. J., Lando, H. A., & Vessey, J. T. (2001). Nurses' attitudes concerning the delivery of brief cessation advice to hospitalized smokers. *Preventive Medicine, 33*, 674–681.
- Nagle, A., Schofield, M., & Redman, S. (1999). Australian nurses' smoking behavior, knowledge and attitude towards providing smoking cessation care to their patients. *Health Promotion International, 14*(2), 133–144.
- O'Loughlin, J., Makni, H., Tremblay, M., Lacroix, C., Gervais, A., Dery, V., et al. (2001). Smoking cessation counseling practices of general practitioners in Montreal. *Preventive Medicine, 33*, 627–638.
- Ratner, P. A., Johnson, J. L., Richardson, C. G., Bottorff, J. L., Moffat, B., MacKay, M., et al. (2004). Efficacy of smoking-cessation intervention for elective-surgical patients. *Research in Nursing and Health, 27*, 148–161.
- Raw, M., McNeil, A., & West, R. (1998). Smoking cessation guidelines for health professionals: A guide to effective smoking cessation interventions for the health care system. *Thorax, 53*(Suppl 5), part 1: S1–19.
- Registered Nurses Association of Ontario. (2003a). *Helping people quit smoking: Nursing best practice guideline. Final report: Smoking cessation; e-learning for health professionals*. Toronto: Author.
- Registered Nurses Association of Ontario. (2003b). *Integrating smoking cessation into daily nursing practice*. Toronto: Author.
- Rice, V. H., & Stead, L. F. (2004). Nursing interventions for smoking cessation (Cochrane Review). *Cochrane Library*, Issue 1.
- Rigotti, N. A., Munafo, M. R., & Stead, M. F. G. (2001). Interventions for smoking cessation in hospitalized patients. *Cochrane Database of Systemic Reviews, 3*.
- Sarna, L., Brown, J. K., Lillington, L., Rose, M., Wewers, M. E., & Brecht, M. L. (2000). Tobacco interventions by oncology nurses in clinical practice. *Cancer, 89*(4), 881–889.

- Sarna, L., Brown, J. K., Lillington, L., Wewers, M. E., & Brecht, M. L. (2000). Tobacco-control attitudes, advocacy and smoking behaviors of oncology nurses. *Oncology Nursing Forum*, 27(10), 1519–1528.
- Schultz, A. S. H. (2003). Nursing and tobacco reduction: A review of the literature. *International Journal of Nursing Studies*, 40(6), 571–586.
- Schultz, A. S. H. (2005). *The integration of tobacco reduction activities into the practice of acute care nurses: A mixed methods research project*. Unpublished doctoral dissertation, University of British Columbia.
- Schultz, A. S. H., & Johnson, J. L. (In review). Investigating causal mechanisms underlying nurses' uptake of tobacco reduction. *Research in Nursing and Health*.
- Tsoh, J. Y. & McClure, J. B. (1997). Smoking cessation 2: Components of effective intervention. *Behavioral Medicine*, 23(1), 15–27.
- Vancouver Coastal Health Authority. (2004). *Tobacco reduction strategy: Targeting a smoke free future*. Vancouver: Author.
- Varcoe, C., & Hilton, A. (1995). Factors affecting acute-care nurses' use of research findings. *Canadian Journal of Nursing Research*, 27(4), 51–71.
- Vaughn, T., Ward, M., Doebbeling, B., Uden-Holman, T., Clarke, W., & Woolson, R. (2002). Organizational and provider characteristics fostering smoking cessation practice guideline adherence: An empirical look. *Journal of Ambulatory Care Management*, 25(2), 17–31.
- Wakefield, M., Olver, I., Whitford, H., & Rosenfeld, E. (2004). Motivational interviewing as a smoking cessation intervention for patients with cancer. *Nursing Research*, 53(6), 396–405.
- Wall, S. (2005). Commentary: The role of organizational context and culture in research uptake. *Nursing Leadership*, 18(1), 46–48.
- World Health Organization. (1999). *International Council of Nurses Centennial Conference session on "Celebrating Nursing's Past—Claiming the Future—Organizational Visions," WHO's vision for health*. Available online: http://www.who.int/director-general/speeches/1999/english/19990630_london.html
- World Health Organization. (2000). *Tobacco free initiative: Addressing the worldwide tobacco epidemic through effective, evidence-based treatment*. Geneva: Author.

Authors' Note

This study was supported by a Research Fellowship from the CIHR Health Services and Policy Research Institute and by a CIHR Strategic Training Program in Tobacco Research Fellowship.

Comments or queries may be directed to Annette S. H. Schultz, Helen Glass Centre for Nursing, University of Manitoba, 89 Curry Place, Winnipeg, Manitoba R3T 2N2 Canada. Telephone: 204-474-6351. Fax: 204-474-7240. E-mail: Annette_Schultz@UManitoba.ca

Annette S. H. Schultz, PhD, RN, is Assistant Professor, Faculty of Nursing, University of Manitoba, Winnipeg, Canada. Joy L. Johnson, PhD, RN, FCAHS, is Professor, School of Nursing, University of British Columbia, Vancouver, Canada. Joan L. Bottorff, PhD, RN, FCAHS, is Professor, Faculty of Health and Social Development, University of British Columbia Okanagan, Kelowna, Canada.

2006 Canadian Health Research Awards

**The Peter Lougheed / CIHR New Investigator Award:
*Canada's Premier Young Researcher***

has been awarded to

DR. NICOLE LETOURNEAU



Nicole Letourneau, PhD, MN, BN, RN
Associate Professor & Research Fellow
University of New Brunswick, Fredericton

The Peter Lougheed/CIHR New Investigator Award: Canada's Premier Young Researcher is CIHR's most important career development award, given to Canada's brightest young researchers at the beginning of their careers. This five-year award represents an important incentive for young researchers to pursue their work in Canada. Through this award, which is co-funded by the Peter Lougheed Medical Research Foundation, former Alberta Premier Peter Lougheed continues his legacy of championing health research in Canada.

Every child deserves the best start in life — but not all children get it. Dr. Nicole Letourneau wants to change that. She designs and tests interventions to promote the healthy development of vulnerable children, particularly those who are exposed to domestic violence or whose mothers suffer from depression.

As part of her research, Dr. Letourneau has led a clinical trial to evaluate the effect of home-based peer support on mothers' interactions with their infant children, the children's health outcomes, and postpartum

depression. Her application, titled “Supporting Mother-Infant Relationships Affected by Intimate Partner Violence,” was the highest-rated application in CIHR’s 2005 New Investigator competition.

Dr. Letourneau’s research makes clear the link between early caregiving and children’s development. It will help policy-makers and social program delivery organizations to implement effective interventions that allow children to overcome a poor start in life and help to create healthy adults.

Dr. Letourneau received her bachelor’s degree in nursing from the University of New Brunswick in 1991, followed by her master’s degree (1994) and PhD (1998), both in nursing, from the University of Alberta. After completing postdoctoral studies in 2003, she was presented with the Outstanding New Investigator in Research Award by the Canadian Association for Nursing Research and the Alumni Horizon Award for early achievement by the University of Alberta. In 2004, she received a CIHR Regional Partnerships Program New Investigator Award. Dr. Letourneau is also a Canada Research Chair (elect) in Healthy Child Development and a member of the Advisory Board of CIHR’s Institute of Gender and Health.

Source: The Peter Lougheed / CIHR New Investigator Award: Canada’s Premier Young Researcher, pg 10-11, Canadian Health Research Awards Program 2006. Ottawa: Canadian Institutes of Health Research, 2006. Reproduced with the permission of the Minister of Public Works and Government Services Canada 2006.

2006 Canadian Health Research Awards

CIHR Partnership Award

has been awarded to

DR. ANNE SNOWDON



Anne W. Snowdon, RN, BScN, MSc, PhD
Coordinator, Health, Safety and Injury Prevention Theme – AUTO21 NCE
Associate Professor, Faculty of Nursing, University of Windsor
Director, Centre for Religion, Culture and Health, Assumption University, Windsor

The CIHR Partnership Award recognizes partnerships with one or more external partners from the private, voluntary, or public sectors which exemplify excellence by bringing health research communities together to create innovative approaches to research questions; to develop research agendas that are responsive to the health needs, concerns, and priorities of Canadians; and to accelerate the translation of knowledge for the benefit of Canadians.

Each year, about three classrooms worth of elementary school children die in road crashes in Canada. DaimlerChrysler Canada Inc. has entered into a unique and innovative partnership to increase knowledge among Canadians of effective child safety system use in vehicles.

DaimlerChrysler Canada provides funding and a team with expertise in safety system design, crash avoidance strategies, and government regulations. Health researchers on the team, led by Dr. Anne Snowdon of the University of Windsor, brought their expertise in family research and population health. Their combined efforts resulted in “Bobby Shooster

Rides Safely in His Booster,” a multimedia education program for families.

The education program, when tested in Ontario, led to a significant increase in parents’ knowledge of accurate use of safety seats for children. The program is now being tested in six Canadian provinces, again with support from DaimlerChrysler Canada.

DaimlerChrysler Canada’s support has also contributed to the transfer of knowledge from this research. The Canadian Association of Chiefs of Police has endorsed the research program. The program has also stimulated a partnership with Magna International to develop a prototype booster seat for school-aged children. The recent launch of the seat at the Ontario Science Centre was a resounding success.

DaimlerChrysler Canada’s commitment of company time, personnel, and resources is a clear indication of the company’s commitment to the safety of Canadian families and children.

Source: CIHR Partnership Award, pg 20-21, Canadian Health Research Awards Program 2006. Ottawa: Canadian Institutes of Health Research, 2006. Reproduced with the permission of the Minister of Public Works and Government Services Canada 2006.

CUMULATIVE INDEX CUMULATIF

Authors / Auteurs

Volume 38: 2006

- Anderson, J. M.** Discourse: Reflections on the Social
Determinants of Women's Health: Exploring Intersections:
Does Racialization Matter? 38(1) 7
- Armstrong-Stassen, M.** See Bergeron, S. M.
- Balas, M. C., Scott, L. D., & Rogers, A. E.**
Frequency and Type of Errors and Near Errors
Reported by Critical Care Nurses 38(2) 24
- Bassett-Smith, J.** Book Review: *Women's Health in Canada:
Critical Perspectives on Theory and Policy* 38(3) 149
- Beanlands, H., McCay, E., & Landeen, J.**
Strategies for Moving beyond the Illness in
Early Schizophrenia and in Chronic Kidney Disease 38(3) 10
- Bédard, M.** See Decaire M. W.
- Bergeron, S. M., Cameron, S., Armstrong-Stassen, M.,
& Pare, K.** Diverse Implications of a National Health Crisis:
A Qualitative Exploration of Community Nurses'
SARS Experiences 38(2) 42
- Berman, H., Irías Girón, E. R., & Marroquín, A. P.**
A Narrative Study of Refugee Women Who Have
Experienced Violence in the Context of War 38(4) 32
- Bierlein, C., Hadjistavropoulos, H.,
Bourgault-Fagnou, M., & Sagan, M.** A Six-Month
Profile of Community Case Coordinated Older Adults 38(3) 32
- Bol, N.** See Ward-Griffin, C.
- Bottorff, J. L.** Guest Editorial: Risk and Safety:
The Current Landscape in Health Promotion
and Health Care 38(2) 7
- Bottorff, J. L.** See Schultz, A. S. H.
- Bourgault-Fagnou, M.** See Bierlein, C.
- Brennand, E. A.** See Vallianatos, H.
- Bullock, L.** See Lutz, F. F.
- Cameron, S.** See Bergeron, S. M.
- Campbell, J. C., & Henderson, A.**
Guest Editorial and Discourse:
A Further Celebration of Nursing Research in Violence 38(4) 11
- Chen, S-P.** See Ervin, N. E.
- Choi, M.** See Lipscomb, J.
- Clarke, S.** Editorial: Reviewing Peer Review:
The Three Reviewers You Meet at Submission Time 38(4) 5

Cumulative Index

- Cohen, B.** Barriers to Population-Focused Health Promotion:
The Experience of Public Health Nurses in the
Province of Manitoba 38(3) 52
- Cooke, A.** See Loisel, C. G.
- Curry, M. A.** See Lutz, K. F.
- Dannenbaum, D.** See Vallianatos, H.
- Decaire, M. W., Bédard, M., Riendeau, J., & Forrest, R.**
Incidents in a Psychiatric Forensic Setting:
Association with Patient and Staff Characteristics 38(3) 68
- Dietrich, P.** See Webster, F.
- El-Masri, M. M., & Fox-Wasylyshyn, S. M.**
Best Practices in Research Methods: Methodological Issues
Associated with Using Different Cut-off Points to Categorize
Outcome Variables 38(4) 162
- Ericksen, J.** Book Review: *Forensic Nursing:
A Handbook for Practice* 38(4) 159
- Ervin, N. E., Chen, S-P., & Upshaw, H. S.**
Nursing Care Quality: Process and Outcome Relationships 38(4) 174
- Esplen, M. J.** Happenings: Mapping the Human Genome:
Psychosocial Impacts and Implications for Nursing 38(2) 115
- Foley, J.** See Lipscomb, J.
- Ford-Gilboe, M.** See Hollingsworth, R.
- Ford-Gilboe, M., Wuest, J., Varcoe, C., & Merritt-Gray, M.**
Translating Research: Developing an Evidence-Based
Health Advocacy Intervention for Women Who Have
Left an Abusive Partner 38(1) 147
- Forrest, R.** See Decaire, M. W.
- Fox-Wasylyshyn, S. M.** See El-Masri, M. M.
- Geiger Brown, J.** See Lipscomb, J.
- Glass, N.** Happenings: Nursing Network on
Violence against Women, International 38(4) 155
- Gottlieb, L. N.** Editorial: Conflicts between
Professional Associations and Their Journals
Strike at the Heart of Professionalism 38(2) 3
- Gottlieb, L. N.** Editorial: ICMJE Guidelines for
Assigning Authorship and Acknowledging Contributions 38(3) 5
- Hadjistavropoulos, H.** See Bierlein, C.
- Healey, F.** Letter to the Editor 38(3) 3
- Henderson, A.** See Campbell, J. C.

Cumulative Index

- Hollingsworth, R., & Ford-Gilboe, M.**
Registered Nurses' Self-Efficacy for Assessing
and Responding to Woman Abuse in Emergency
Department Settings 38(4) 54
- Hughes, J.** Commentary: Violence and Health:
The Challenges of How We Talk about, Conceptualize,
and Address Violence 38(4) 27
- Irías Girón, E. R.** See Berman, H.
- Johnson, J. L.** See Schultz, A. S. H.
- Johnston, C.** Happenings: Canadian Academy of Health Sciences 38(3) 147
- Kelly, U.** "What Will Happen If I Tell You?"
Battered Latina Women's Experiences of Health Care 38(4) 78
- King, K. M., LeBlanc, P., Sanguins, J., & Mather, C.**
Gender-Based Challenges Faced by Older Sikh Women
as Immigrants: Recognizing and Acting on the Risk
of Coronary Artery Disease 38(1) 16
- Lambert, S. D.** See Loiselle, C. G.
- Landeen, J.** See Beanlands, H.
- LeBlanc, P.** See King K. M.
- Libbus, M. K.** See Lutz, F.F.
- Lipscomb, J., McPhaul, K., Rosen, J.,
Geiger Brown, J., Choi, M., Soeken, K.,
Vignola, V., Wagoner, D., Foley, J., & Porter, P.**
Violence Prevention in the Mental Health Setting:
The New York State Experience 38(4) 96
- Loiselle, C. G., Lambert, S. D., & Cooke, A.**
The Searching, Processing, and Sharing of Breast Cancer
Information by Women Diagnosed with the Illness 38(3) 82
- Lutz, K. F., Curry, M. A., Robrecht, L. C.,
Libbus, M. K., & Bullock, L.** Double Binding,
Abusive Intimate Partner Relationships, and Pregnancy 38(4) 118
- MacKinnon, K., & McIntyre, M.**
From Braxton Hicks to Preterm Labour:
The Constitution of Risk in Pregnancy 38(2) 56
- Manias, E.** Book Review:
Quality Work Environments for Nurse and Patient Safety 38(2) 123
- Marck, P.** Discourse: Field Notes from Research
and Restoration in the Backcountry of Modern Health Care 38(2) 11
- Marroquín, A. P.** See Berman H.
- Mather, C.** See King K. M.
- McCay, E.** See Beanlands, H.

Cumulative Index

- McDonald, C.** Lesbian Disclosure:
Disrupting the Taken for Granted 38(1) 42
- McIntyre, M.** See MacKinnon K.
- McPhaul, K.** See Lipscomb, J.
- Merritt-Gray, M.** See Ford-Gilboe, M.
- Molzahn, M. E., & Pagé, G.**
Field Testing the WHOQOL-100 in Canada 38(3) 106
- Morse, J. M.** Response 38(2) 95
- Morse, J. M.** The Safety of Safety Research:
The Case of Patient Fall Research 38(2) 74
- Oliver, D.** Commentary 38(2) 89
- Oudshoorn, A.** See Ward-Griffin, C.
- Pagé, G.** See Molzahn, M. E.
- Pare, K.** See Bergeron, S. M.
- Patrick, L.** See Snowdon, A. W.
- Petawabano, B.** See Vallianatos, H.
- Polgar, J.** See Snowdon, A. W.
- Porter, P.** See Lipscomb, J.
- Raine, K.** See Vallianatos, H.
- Riendeau, J.** See Decaire, M. W.
- Ritchie, J. A.** Book Review: *Introduction to
Evidence-Based Practice in Nursing and Health Care* 38(3) 151
- Robrecht, L. C.** See Lutz, K. F.
- Rogers, A. E.** See Balas, M. C.
- Rosen, J.** See Lipscomb, J.
- Sagan, M.** See Bierlein, C.
- Samuels-Dennis, J.** Relationship among Employment Status,
Stressful Life Events, and Depression in Single Mothers 38(1) 58
- Sangster Bouck, M.** See Webster, F.
- Sanguins, J.** See King, K. M.
- Schultz, A. S. H., Johnson, J. L., & Bottorff, J. L.**
Registered Nurses' Perspectives on Tobacco Reduction:
Views from Western Canada 38(4) 192
- Scott, L. D.** See Balas, M. C.
- Snowdon, A. W., Polgar, J., Patrick, L., & Stamler, L.**
Parents' Knowledge about and Use of Child Safety Systems 38(2) 98
- Soeken, K.** See Lipscomb, J.
- Solberg, S. M.** Happenings:
Researching the Social Determinants of Women's Health 38(1) 169

Cumulative Index

- Spenceley, S. M., & Williams, B. A.**
Self-Care from the Perspective of People Living with Diabetes 38(3) 124
- Stamler, L.** See Snowdon, A. W.
- Stephen, Q.** See Vallianatos, H.
- Truong Donnelly, T.** The Health-Care Practices of
Vietnamese-Canadian Women: Cultural Influences on
Breast and Cervical Cancer Screening 38(1) 82
- Upshaw, H. S.** See Ervin, N. E.
- Vallianatos, H., Brennand, E. A., Raine, K.,
Stephen, Q., Petawabano, B., Dannenbaum, D.,
& Willows, N. D.** Beliefs and Practices of First Nation
Women about Weight Gain during Pregnancy
and Lactation: Implications for Women's Health 38(1) 102
- Varcoe, C.** See Ford-Gilboe, M.
- Vignola, V.** See Lipscomb, J.
- Wagoner, D.** See Lipscomb, J.
- Ward-Griffin, C., Bol, N., & Oudshoorn, A.**
Perspectives of Women with Dementia
Receiving Care from Their Adult Daughters 38(1) 120
- Webster, F., Sangster Bouck, M., Wright, B. L.,
& Dietrich, P.** Nursing the Social Wound:
Public Health Nurses' Experiences of Screening
for Woman Abuse 38(4) 136
- Williams, B. A.** See Spenceley, S. M.
- Willows, N. D.** See Vallianatos, H.
- Wright, B. L.** See Webster, F.
- Wuest, J.** Guest Editorial: Towards Understanding
Women's Health through a Social Determinants Lens 38(1) 3
- Wuest, J.** See Ford-Gilboe, M.

CUMULATIVE INDEX CUMULATIF

Titles / Titres	Volume 38: 2006
<p>Barriers to Population-Focused Health Promotion: The Experience of Public Health Nurses in the Province of Manitoba Cohen, B.</p>	38(3) 52
<p>Beliefs and Practices of First Nation Women about Weight Gain during Pregnancy and Lactation: Implications for Women's Health Vallianatos, H., Brennand, E. A., Raine, K., Stephen, Q., Petawabano, B., Dannenbaum, D., & Willows, N. D.</p>	38(1) 102
<p>Best Practices in Research Methods: Methodological Issues Associated with Using Different Cut-off Points to Categorize Outcome Variables El-Masri, M. M., & Fox-Wasylyshyn, S. M.</p>	38(4) 162
<p>Book Review: <i>Forensic Nursing: A Handbook for Practice</i> Ericksen, J.</p>	38(4) 159
<p>Book Review: <i>Introduction to Evidence-Based Practice in Nursing and Health Care</i> Ritchie, J. A.</p>	38(3) 151
<p>Book Review: <i>Quality Work Environments for Nurse and Patient Safety</i> Manias, E.</p>	38(2) 123
<p>Book Review: <i>Women's Health in Canada: Critical Perspectives on Theory and Policy</i> Bassett-Smith, J.</p>	38(3) 149
<p>Commentary: Violence and Health: The Challenges of How We Talk about, Conceptualize, and Address Violence Hughes, J.</p>	38(4) 27
<p>Discourse: Field Notes from Research and Restoration in the Backcountry of Modern Health Care Marck, P.</p>	38(2) 11
<p>Discourse: Reflections on the Social Determinants of Women's Health: Exploring Intersections: Does Racialization Matter? Anderson, J. M.</p>	38(1) 7
<p>Diverse Implications of a National Health Crisis: A Qualitative Exploration of Community Nurses' SARS Experiences Bergeron, S. M., Cameron, S., Armstrong-Stassen, M., & Pare, K.</p>	38(2) 42

Cumulative Index

- Double Binding, Abusive Intimate Partner Relationships, and Pregnancy**
Lutz, K. F., Curry, M. A., Robrecht, L. C., Libbus, M. K., & Bullock, L. 38(4) 118
- Editorial: Conflicts between Professional Associations and Their Journals Strike at the Heart of Professionalism**
Gottlieb, L. N. 38(2) 3
- Editorial: ICMJE Guidelines for Assigning Authorship and Acknowledging Contributions**
Gottlieb, L. N. 38(3) 5
- Editorial: Reviewing Peer Review: The Three Reviewers You Meet at Submission Time**
Clarke, S. 38(4) 5
- Field Testing the WHOQOL-100 in Canada**
Molzahn, M. E., & Pagé, G. 38(3) 106
- Frequency and Type of Errors and Near Errors Reported by Critical Care Nurses**
Balas, M. C., Scott, L. D., & Rogers, A. E. 38(2) 24
- From Braxton Hicks to Preterm Labour: The Constitution of Risk in Pregnancy**
MacKinnon, K., & McIntyre, M. 38(2) 56
- Gender-Based Challenges Faced by Older Sikh Women as Immigrants: Recognizing and Acting on the Risk of Coronary Artery Disease**
King, K. M., LeBlanc, P., Sanguins, J., & Mather, C. 38(1) 16
- Guest Editorial: Risk and Safety: The Current Landscape in Health Promotion and Health Care**
Bottorff, J. 38(2) 7
- Guest Editorial: Towards Understanding Women's Health through a Social Determinants Lens**
Wuest, J. 38(1) 3
- Guest Editorial and Discourse: A Further Celebration of Nursing Research in Violence**
Campbell, J. C., & Henderson, A. 38(4) 11
- Happenings: Canadian Academy of Health Sciences**
Johnston, C. 38(3) 147
- Happenings: Mapping the Human Genome: Psychosocial Impacts and Implications for Nursing**
Espen, M. J. 38(2) 115
- Happenings: Nursing Network on Violence against Women, International**
Glass, N. 38(4) 155

Cumulative Index

- Happenings: Researching the Social Determinants of Women's Health**
Solberg, S. M. 38(1) 169
- The Health-Care Practices of Vietnamese-Canadian Women: Cultural Influences on Breast and Cervical Cancer Screening**
Truong Donnelly, T. 38(1) 82
- Incidents in a Psychiatric Forensic Setting: Association with Patient and Staff Characteristics**
Decaire, M. W., Bédard, M., Riendeau, J., & Forrest, R. 38(3) 68
- Lesbian Disclosure: Disrupting the Taken for Granted**
McDonald, C. 38(1) 42
- A Narrative Study of Refugee Women Who Have Experienced Violence in the Context of War**
Berman, H., Irías Girón, E. R., & Marroquín, A. P. 38(4) 32
- Nursing Care Quality: Process and Outcome Relationships**
Ervin, N. E., Chen, S-P., & Upshaw, H. S. 38(4) 174
- Nursing the Social Wound: Public Health Nurses' Experiences of Screening for Woman Abuse**
Webster, F., Sangster Bouck, M., Wright, B. L., & Dietrich, P. 38(4) 136
- Parents' Knowledge about and Use of Child Safety Systems**
Snowdon, A. W., Polgar, J., Patrick, L., & Stamler, L. 38(2) 98
- Perspectives of Women with Dementia Receiving Care from Their Adult Daughters**
Ward-Griffin, C., Bol, N., & Oudshoorn, A. 38(1) 120
- Registered Nurses' Perspectives on Tobacco Reduction: Views from Western Canada**
Schultz, A. S. H., Johnson, J. L., & Botorff, J. L. 38(4) 192
- Registered Nurses' Self-Efficacy for Assessing and Responding to Woman Abuse in Emergency Department Settings**
Hollingsworth, R., & Ford-Gilboe, M. 38(4) 54
- Relationship among Employment Status, Stressful Life Events, and Depression in Single Mothers**
Samuels-Dennis, J. 38(1) 58
- The Safety of Safety Research: The Case of Patient Fall Research**
Morse, J. M. 38(2) 74
Commentary by Oliver, D. 38(2) 89
Response by Morse, J. M. 38(2) 95
Letter to the Editor 38(3) 3

Cumulative Index

- The Searching, Processing, and Sharing of Breast Cancer Information by Women Diagnosed with the Illness**
Loiselle, C. G., Lambert, S. D., & Cooke, A. 38(3) 82
- Self-Care from the Perspective of People Living with Diabetes**
Spenceley, S. M., & Williams, B. A. 38(3) 124
- A Six-Month Profile of Community Case Coordinated Older Adults**
Bierlein, C., Hadjistavropoulos, H., Bourgault-Fagnou, M., & Sagan, M. 38(3) 32
- Strategies for Moving beyond the Illness in Early Schizophrenia and in Chronic Kidney Disease**
Beanlands, H., McCay, E., & Landeen, J. 38(3) 10
- Translating Research: Developing an Evidence-Based Health Advocacy Intervention for Women Who Have Left an Abusive Partner**
Ford-Gilboe, M., Wuest, J., Varcoe, C., & Merritt-Gray, M. 38(1) 147
- Violence Prevention in the Mental Health Setting: The New York State Experience**
Lipscomb, J., McPhaul, K., Rosen, J., Geiger Brown, J., Choi, M., Soeken, K., Vignola, V., Wagoner, D., Foley, J., & Porter, P. 38(4) 96
- “What Will Happen If I Tell You?” Battered Latina Women’s Experiences of Health Care**
Kelly, U. 38(4) 78

Cumulative Index

Reviewers / Révisseurs**Volume 38: 2006**

CJNR is indebted to the persons below who served as reviewers for Volume 38. 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.

CJNR est reconnaissante envers les personnes ci-dessous nommées pour avoir révisé son volume 38. 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.

Jan Angus University of Toronto	Sheryl Boblin McMaster University
Jane Armer University of Missouri-Columbia	Diane Bohn University of Minnesota
Heather Arthur McMaster University	Nana Bosompra McMaster University
Sibylle Artz University of Victoria	Angela Bowen University of Saskatchewan
Megan Aston Dalhousie University	Kathleen Brown University of Pennsylvania
Peri Ballantyne University of Toronto	Annette Browne University of British Columbia
Lynda G. Balneaves University of British Columbia	Rula Btoush UMDNJ – School of Nursing
Sylvia Barton University of Northern British Columbia	Joy Buck University of Pennsylvania
Andrea Baumann McMaster University	Linda Bullock University of Missouri-Columbia
Marcia Beaulieu McGill University	Vicky Bungay University of British Columbia
Karen Benzies University of Calgary	Sheila M. Bunting Medical College of Georgia
Helene Berman University of Western Ontario	Sheila Cameron University of Windsor
Kristin Björnsdóttir University of Iceland	Connie Canam University of British Columbia
Margaret Black McMaster University	Franca Cantini Jewish General Hospital, Montreal
Mike Bleich University of Kansas	Nancy Carter McMaster University

Cumulative Index

- | | |
|---|---|
| Catherine Caulfield
University of Alberta | Gail Donner
University of Toronto |
| Donna Ciliska
McMaster University | Diane Doran
University of Toronto |
| Alexander M. Clark
University of Alberta | Margaret Dykeman
University of New Brunswick |
| Sean P. Clarke
University of Pennsylvania | Joan Evans
Dalhousie University |
| Tracey Colella
Laurentian University | Robin Evans
University of Saskatchewan |
| Christopher Coleman
University of Pennsylvania | Nancy Feeley
McGill University |
| Sherrill Conroy
University of Alberta | Nancy J. Fishwick
University of Maine |
| Cheryl Cott
University of Toronto | Linda Flynn
Rutgers, The State University
of New Jersey |
| Karen L. Courtney
University of Pittsburgh | Cheryl Forchuk
University of Western Ontario |
| Margaret H. Crighton
University of Pittsburgh | Marilyn Ford-Gilboe
University of Western Ontario |
| Mary Ann Curry
Oregon Health Sciences University | Elaine Gallagher
University of Victoria |
| Susan Dahinten
University of British Columbia | Faye Gary
Case Western Reserve University |
| Danielle D'Amour
Université de Montréal | Lan Gien
Memorial University of
Newfoundland |
| Alice S. Demi
Georgia State University | Angela Gillis
St. Francis Xavier University |
| Victoria Dickson
University of Pennsylvania | Nancy Glass
Johns Hopkins University |
| Liz Diem
University of Ottawa | Lisa Goldberg
Dalhousie University |
| Jackie Dienemann
Johns Hopkins University | Rosa Gonzalez
University of Miami |
| Pamela DiNapoli
University of New Hampshire | Pamela Grace
Boston College |
| Gweneth Doane
University of Victoria | Pat Griffin
University of Ottawa |
| Elizabeth Domm
University of Saskatchewan | |

Cumulative Index

- | | |
|---|--|
| Su-Ero Guo
University of British Columbia | Linda Johnston
University of Melbourne |
| Wendy Hall
University of British Columbia | Colleen Keller
Arizona State University |
| Pam Hardin
University of Utah | Dawn Kingston
McMaster University |
| Dena Hassounch
Oregon Health and Science
University | Sheryl Reimer Kirkham
Trinity Western University |
| Barbara Hayes
University of Victoria | Jane Koziol-McLain
Johns Hopkins University |
| Maureen Heaman
University of Manitoba | Judith Kulig
University of Lethbridge |
| Angela Henderson
University of British Columbia | Andrea-Maria Laizner
Université de Montréal |
| Keith Hill
Royal Melbourne Hospital | Kathryn Laughon
University of Virginia |
| Edith Hillan
University of Toronto | Beverly D. Leipert
University of Western Ontario |
| Sandra Hirst
University of Calgary | Jane Lipscomb
University of Maryland |
| Robert D. Hiscott
University of Waterloo | M. Cynthia Logsdon
University of Louisville |
| Anne T. Hofmeyer
University of Alberta | Judith Lynam
University of British Columbia |
| Joanna Holsten
University of Pennsylvania | Mary R. Lynn
University of North Carolina |
| Jean Hughes
Dalhousie University | Martha Mackay
University of British Columbia |
| Kathryn Hyndman
Brandon University | Martha MacLeod
University of Northern
British Columbia |
| Susan Jack
McMaster University | Basanti Majumdar
McMaster University |
| Sonya Jakubec
University of Calgary | Patricia Marck
University of Alberta |
| Nadine James
University of Southern Mississippi | Marilyn Mardiros
University of British Columbia
Okanagan |
| Patricia Janssen
University of British Columbia | Dianne McCormack
University of New Brunswick |
| Carol Jillings
University of British Columbia | |

Cumulative Index

- | | |
|---|--|
| Judith McFetridge
Dalhousie University | Kärin Olson
University of Alberta |
| Kathy McGilton
Toronto Rehabilitation Institute | Linda O'Mara
McMaster University |
| Marjorie McIntyre
University of Victoria | Ann Marie Pagliaro
University of Alberta |
| Kathleen McPhaul
University of Maryland | Barbara J. Parker
University of Virginia |
| Donna Meagher-Stewart
Dalhousie University | Barbara Paterson
University of New Brunswick |
| Jennifer Medves
Queen's University | Alison Phinney
University of British Columbia |
| Marilyn Merritt-Gray
University of New Brunswick | Jenny Ploeg
McMaster University |
| Judy Mill
University of Alberta | Joanne Profetto-McGrath
University of Alberta |
| Jane Milliken
University of Victoria | Louise Racine
University of Saskatchewan |
| Phyllis Montgomery
Laurentian University | Linda Reutter
University of Alberta |
| Debra Morgan
Institute of Agricultural Rural and
Environmental Health | Chris Richardson
University of British Columbia |
| Lynn M. Nagle
Mount Sinai Hospital | Donna Rolin
University of Pennsylvania |
| Regina Nailon
University of Pennsylvania | Cynthia K. Russell
University of Tennessee |
| Wendy Nicklin
Canadian Council on Health
Services | Elizabeth Saewyc
University of British Columbia |
| Colleen M. Norris
University of Alberta | Phyllis W. Sharps
Johns Hopkins University |
| Beverly O'Brien
University of Alberta | Souraya Sidani
University of Toronto |
| John Oliffe
University of British Columbia | Lynn Skillen
University of Alberta |
| David Oliver
University of Reading | Vicki Smye
University of Victoria |
| Joanne K. Olson
University of Alberta | Erna Snelgrove-Clarke
Dalhousie University |
| | Dawn Stacey
University of Ottawa |

Cumulative Index

- | | |
|--|--|
| Gail Blair Storr
University of New Brunswick | Arie van der Arend
University of Maastricht |
| Rachel M. Sturke
Johns Hopkins Bloomberg
School of Public Health | Colleen Varcoe
University of British Columbia |
| Janette Taylor
University of Iowa | Elyssa Vasas
University of Pennsylvania |
| Sally Thorne
University of British Columbia | Joyce Verran
University of Arizona |
| Lillian Tom-Orme
University of Utah | Bilkis Vissandjee
Université de Montréal |
| Carrie Tompkins Stricker
University of Pennsylvania | Stella Volpe
University of Pennsylvania |
| Ann Tourangeau
University of Toronto | Janice Waddell
Ryerson University |
| Joan Tranmer
Kingston General Hospital | Robin Whittemore
Yale University |
| Deborah Trautman
Johns Hopkins University | Susan Wong
University of British Columbia |
| Lorraine Tulman
University of Pennsylvania | Linda A. Wood
University of Guelph |
| Connie Ulrich
University of Pennsylvania | Nancy Woods
Johns Hopkins University |
| Mandana Vahabi
University of Toronto | Judy Wuest
University of New Brunswick |
| Cheryl Van Daalen
York University | Lynne Young
University of Victoria |