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**Through The Looking Glass:  
Nurses' Responses to Women Experiencing Partner Abuse**

A thesis presented in partial fulfilment of  
the requirements for the degree  
of Master of Arts  
in Nursing at  
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## Abstract

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Battered women are referred to as a 'health problem in disguise', yet they generally go unrecognised or are ignored by health professionals, including nurses. The aim of this study was to describe nurses' responses to women presenting to emergency departments and general practices with injuries suggestive of partner abuse. A qualitative research design, using semi-structured interviews to gather data from six participants was undertaken. Grounded theory guided the analysis of data, revealing that nurses did not identify or respond effectively to battered women. A core category *The Looking Glass*, describes the differing perspectives nurses have when responding to battered women. The themes *Not Seeing*, *Seeing But Not Seeing*, and *Seeing But Acting Ineffectively* describe the differing responses of nurses to women experiencing partner abuse. The needs of nurses to respond effectively are outlined in a further theme *Seeing For Effective Action*. Educational Preparation is necessary to develop knowledge and skills related to partner abuse, while Workplace Assistance provides guidance to respond through the use of protocols, and support for personal and professional development. Improving the effectiveness of nurses in order to meet the needs of battered women is essential in reducing not only the personal costs to the women themselves, but in reducing the health care costs. Implications and recommendations for the education, practice, and further research are made.

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## Chapter 1

### Introduction

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The study, *Through The Looking Glass: Nurses' responses to women experiencing partner abuse*, came about from my personal experience as a survivor of long term battering and abuse, and now being in a position to make a contribution to increasing the knowledge in the area of partner abuse and health care. While reviewing the literature related to the area of family violence, it became obvious in the international literature that nurses were either not recognising or not acting when women presented to health care agencies with signs of being battered. This triggered an experience I had, whereby my injuries were treated and I was sent on my way home. It was obvious on reflection that I was, at this time, experiencing shock related to a traumatic experience. My inability to talk about that experience did not assist in getting the appropriate help I needed to ensure my physical and emotional safety. It became apparent from the international literature that my experience was not isolated. I began asking the question how did nurses in New Zealand respond to women who presented with injuries that were either not explained or were inconsistent with the explanation provided.

Before embarking any further, it is essential to clarify the terminology which will be used in this thesis as the terminology utilised in relation to violence against women is varied. The terms *partner abuse* and *battered women* will be used in this thesis, in an attempt to clarify the position where women are situated within the conundrum of terminology utilised. Terms such as *family violence*, *domestic violence*, and *abuse* are broad and often encompass a variety of abuse experienced across the lifespan. For example, family violence includes not only violence against women, but also child and elder abuse. In addition these terms cover various types of abuse,

such as sexual and emotional abuse. It is argued that these broader terms either conceal or dilute the nature of the physical violence against women by their intimate partners. As Schechter (1982) and Hoff (1992) contended, these terms are vague and trivialise the reality of the violence, mutilation, and even death which may occur. Therefore, in order to aptly describe the violence against women by their partners, the term *partner* abuse will be used. It is also acknowledged in this study, that the physical abuse experienced by battered women may also be accompanied by less obvious forms of abuse, such as emotional and/or sexual abuse and can occur in either heterosexual or homosexual relationships.

In using the term *battered women* in this study, it is recognised that some may see the use of this terminology as negative and victim based. However, the rationale for using *battered women* is that it provides a clear description of the phenomenon from the women's experiences. The use of *battered women* in this study is not intended to evoke or create a victim status, but is intended to acknowledge the physical experiences these women have survived and thus clearly recognise the type of abuse they have been subjected to.

Societal violence is the cause of extensive consternation, nationally and internationally, and is seemingly escalating out of control. Women, have across the ages, been subject to domination and control by men - a phenomenon which has historically been socially accepted by both men and women. Yet, the issue of partner abuse as a social problem is relatively young, emerging in the 1970s feminist campaigns according to Lempert (1992). The prevalence and extent of violence against women by their partners is difficult to accurately ascertain due to its social acceptance and the consequent underreporting of partner abuse. Difficulties exist in addressing partner abuse, as the belief that women are the property of men, and can therefore be treated accordingly, has been one supported by Western Christian religious beliefs, and the patriarchal and hegemonic

structures, which have persisted over time. An attempt to evoke social and institutional change regarding the societal acceptance of partner abuse within the New Zealand context, required legislative changes. The costs of partner abuse are not confined solely to personal costs, with expenditure also being accrued in the health care and other sectors of society. Snively's (1995) work conservatively estimated the annual costs of partner abuse in New Zealand to be \$1.235 billion, with the health care sector spending \$140,721 million annually.

Battered women are considered by some (Ryan & King, 1992; Tilden, 1989) to be a 'health problem in disguise'. These women not only present to the health care system with injuries attributable to the violence inflicted upon them by a partner, but also present with a diversity of physical and psychosomatic complaints associated with being repeatedly abused, physically, psychologically, and sexually. Women who experience partner abuse are high users of health care services and this continues as the cause for their health care problems goes unrecognised. Health professionals, in general, are not immune to the social beliefs and myths about battered women, and therefore tend to focus on the presenting illness or injury. Nurses are not excluded from these accusations, functioning in a manner reflective of society in general, and as a result of a lack of educational preparation in the knowledge and skills required to respond to women who present with injuries suggestive of partner abuse.

The embedded historical, social, and cultural nature of partner abuse makes it difficult to identify and subsequently break its cycle of violence. Yet the costs to the women, as individuals, and to the health care system are astronomical. In order for health care providers to intervene effectively with battered women, the health care services require a close examination as to why the needs of this group of women are not being met. Nurses are seen to be in an ideal position to intervene, especially as nurses encounter women across the wide variety of contexts which exist within nursing.

However, nurses like other health care professionals are not recognising or responding to battered women.

The majority of literature reviewed in relation to this study is discussion based. The literature accentuates the problems encountered by battered women when they enter into the health care system. Campbell (1992a) cited studies whereby 10-25 percent of women presenting to emergency departments, despite wanting help in relation to their abuse, were not identified. Campbell (1992a) also described nurses acting on societal myths and using a paternalistic model of behaviour when dealing with battered women. Other studies (Davies, Harris, Roberts, Manion, McCosker & Anderson, 1996; Fanslow, Spinola, Stewart & Norton, 1996; Hatrick, 1996; Howden-Chapman, 1994; Lempert, 1992; McMurray & More, 1994; Sugg & Inui, 1992) reviewed clearly indicated problems with not only the identification of women experiencing partner abuse, but also in the implementation of effective interventions.

The review of the literature revealed a profound lack of research undertaken with nurses and how they responded to battered women and the issues of partner abuse. According to Jezierski (1994), Murphy (1993), and Ozmar (1994), nurses maintain a pivotal role in the health care system and are in a prime position to positively intervene and break the cycle of violence. Nurses, such as those in general practices and emergency departments, are often the first point of contact women have with health care professionals. Improving the responsiveness of health care professionals to battered women is a key research area in New Zealand according to Fanslow and Norton (1994) and Leibrich, Paulin and Ransom (1995); a research agenda supported internationally. Thus it was justifiable to undertake the current study in order to identify what emergency department and practice nurses within the New Zealand context did, and thereby contribute to both the practice and knowledge arenas.

The aim of the study, therefore, was to describe and make recommendations regarding the responses of nurses to women who present to either emergency departments or general practices with injuries suggestive of partner abuse. The approach taken was a qualitative research design, underpinned by grounded theory in order to guide the data collection and data analysis phases of the study. The use of a qualitative research design was seen as appropriate for the study as no theoretical frameworks appeared to exist in relation to this area and most of the knowledge accumulated has been in other disciplines or anecdotal in nature.

While evidence already existed indicating that nurses do not effectively respond to battered women, this study was designed to ascertain how nurses themselves view their responsiveness. The investigation of the nurses' personal experiences of partner abuse and its impact on a nurse's practice is also acknowledged as important and does require investigation. However, due to the limited size and scope of this study it was confined solely to looking at nurse's responses and their perceived educational needs.

It is also acknowledged that ascertaining the perspective of the battered women about their health care experiences is vital in improving the responsiveness of health professionals. However, other studies have been undertaken which have focused upon the battered women's perspectives, but little has been done to elicit a self-assessment by nurses.

The chapters are titled in a traditional manner. The background literature explored in Chapter 2, firstly situates the issue of partner abuse, together with the place of women in society, historically and socially. An examination of the notion that battered women are a health problem in disguise is made prior to reviewing the relevant research literature. The review begins with a broad exploration of the issues pertaining to battered

women and progresses to the specific literature concerning nurses, nursing and battered women.

In Chapter 3 the research method used in this study is outlined. The process of the selection of participants and the use of semi-structured interviews is reviewed. As a grounded theory approach was used in the data analysis to elicit a rich description, a section entitled methodological underpinning is included. Due to the preliminary nature of the study, generation of theory was not attempted. The process of collecting the data and then analysing it is outlined, together with a description of the relevant legal and ethical issues and the establishment of the study's trustworthiness.

The findings of the study are outlined in Chapter 4. A metaphor *The Looking Glass* is used to describe the differing perspectives taken when nurses encounter battered women. The nurses' descriptions of what education is required to develop knowledge and skills to intervene effectively is also outlined.

A discussion related to the findings in Chapters 3 and 4 occurs in Chapter 5. The method and issues which arose are discussed. The study's findings are then located in relation to the existing literature about how nurses recognise, intervene, and follow-up women. The ability of nurses to respond is explained using concepts situated within the psychological literature. Developing the nurses' abilities to respond through educational preparation and workplace assistance is explored. Nursing concepts of caring, (w)holism, advocacy, and partnership were not evident in the participants' practice and are therefore discussed in relation to the practice of nurses working with battered women. The study and its findings, are summarised in Chapter 6 and recommendations are made for practice, education, and further research.

This study and the process of undertaking it has been a journey of both development and revelation. While it could be considered that the findings of the study are not positive in terms of the care battered women receive, what it does do is reveal an insight into how nurses themselves respond to these women. The metaphor *The Looking Glass* and the associated themes of *Not Seeing*, *Seeing But Not Seeing*, and *Seeing But Acting Ineffectively* describe the various responses of nurses who encounter battered women in their practice. *Seeing For Effective Action* is the participants' articulation of what is required to develop the required knowledge and skills to effectively respond to battered women. The insight and subsequent knowledge generated by this study will contribute to the development of an effective and efficient health care service when women experiencing partner abuse seek assistance for the injuries and associate health problems they may have. This study provides nurse educators at both pre- and post-registration levels with an indication of the content which needs inclusion in curricula and short courses. Also highlighted are further areas for exploration and research.

## Chapter 2

### Background Literature

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#### **Introduction**

Partner abuse violence is a social problem deeply embedded in the cultural and social beliefs surrounding the place of women in society and the relationship women have to men. It is a modern problem with strong historical antecedents, transmitted through the inter-generational socialisation of family members. The impact of partner abuse occurs at both a micro-level (the individual and family) and a macro-level (which includes government, legislation, society, and ideology). In this chapter, an exploration is made of the literature which provides a background to the research undertaken in this thesis.

Firstly, the historical and present day prevalence and trends of violence against women will be explored. Myths and metaphors associated with the relationship between men and women will be examined in order to locate women in relation to men and illustrate the impact popular beliefs have upon gender socialisation. Secondly, the significance of the personal costs and the costs to the health services of women who have been battered will be noted, together with how health professionals have responded. A search of the literature revealed a gap in knowledge, specifically regarding how nurses respond to women who have experienced partner abuse. The paucity of research and the need for strategies to prepare nurses to recognise and act appropriately, prompted the current study.

## **Prevalence and Trends**

Partner abuse is the focus of national concern, receiving attention from a variety of sources, such as the police, justice, health, and media. Accurate research related to the extent and scope of partner abuse in New Zealand is difficult to obtain (Committee of Inquiry into Violence, 1987; Dominick, 1995; Leibrich et al. 1995; Norris & MacPherson, 1990). Surrounding issues, such as the private nature of partner abuse and the low rate of reporting such violence, contribute to the difficulties in obtaining accurate research data. Thus, the collection of reliable statistics and other data is fraught with difficulty and has not been assisted by agencies such as health, justice, and the police failing to keep accurate records over time.

Despite the difficulty in obtaining an accurate assessment of the rate of partner abuse, research available in New Zealand does indicate the enormity of the problem. The National Collective of Independent Women's Refuge (NCIWR) statistics for 1994 provide some awareness into the magnitude of the problem in New Zealand, with 13,299 users of the service over the year of which 5,017 were women and 8,282 were children. In addition, there were 2,198 re-admissions of which 727 were women and 1,471 were children (NCIWR, 1995). These statistics rose for the period of 1994/1995, with 8,763 women and 12,130 children seeking assistance from women's refuges (Dept of the Prime Minister and Cabinet, 1996). Of the 523 reported homicide cases in New Zealand during the period of 1978 to 1987, 39% were domestically related (Department of Justice, 1993). Both Dominick (1995) and Elvidge (1997) have estimated the incidence of partner abuse in New Zealand to be around 14%.

More recently, surveys undertaken by the Ministry of Justice (1997) in response to the need to measure the incidence and prevalence, effects of, and responses to victimisation give an indication of the prevalence. More than 40% of women with current partners and the vast majority of women

with recent partners (currently not living with a male partner but lived with one within the last two years) experience psychological abuse in the form of controlling behaviour. At least one act of physical or sexual abuse had been experienced by 25% of the women with current partners and 75% of women with recent partners, while two percent of women with current partners and 22% of women with recent partners had experienced at least ten or more acts of physical or sexual abuse. One percent of women with a current partner and eight percent with recent partners had been either treated or admitted to hospital, with one percent with current partners and seven percent being treated medically by a doctor. The prevalence of the above findings in Maori women is greater than in non-Maori women.

Although research undertaken in New Zealand is not abundant, what has been undertaken reveals that violence by an intimate partner is a significant issue. Cox and Irwin (1989) undertook a study whereby women completed an extensive questionnaire about the violence they had personally experienced. Forty-three percent (N=304) of the women indicated domestic violence was a significant personal experience. Of these women, 70% were physically injured, (of which 19% sought medical attention at a hospital, and 24% from their own doctor). Forty-six percent described the violence they experienced as on-going. Cox and Irwin (1989, p.117) concluded: "Violence is alive and well in New Zealand today", despite the tendency of women to downplay the severity of their experiences.

Leibrich et al. (1995) researched 2,000 men to determine their attitudes towards women. The research aimed to describe the personal characteristics, attitudes towards abuse, and abusive behaviour of New Zealand men. A further 200 men were surveyed yielding information on their perceptions of the causes of abuse, control issues related to women, importance of control of women and loss of control of their anger expressions, and the issue of the loss of control of anger. This research revealed that 35% of the men admitted to physically abusing their partner,

and 62% engaged in psychological abuse. Gendall (1996) however, disputed the findings of Leibrich et al. (1995) claiming the definition utilised by the researchers was too broad and therefore trivialised more serious violence toward women. The definitions used by Leibrich et al. (1995) for physical abuse ranged from "pushed, grabbed or shoved her" to "threatened her with a knife or gun" (p.82); and for psychological abuse, "insulted or swore at her" to "made her do something humiliating or degrading" (p.83). It could be argued that the broad definition Gendall (1996) claimed was used, in reality acknowledged the seriousness of all forms of violence toward women.

The change in New Zealand legislation, brought about by the Domestic Violence Act 1995 (enacted on 1 July 1996), highlights the enormity of the problem. Within the first three months of the Act coming into force 2,000 applications for protection were made. Atkin (1996) extrapolated this data and estimated 8,000 applications would be made annually. Other authors, Telford (1995) and Field (1990), also alluded to the continued increase in the number of New Zealand men who abuse women.

The battering of women in domestic situations is not confined to New Zealand. It is an international problem which cannot be attributed to any one demographic variable such as age, race, culture, education, profession, or socio-economic background (Boychuk Duchscher, 1994; Woods & Campbell, 1993). As Ussher (1991, p.264) stated: "Cases of murder are only the tip of the iceberg: the number of women brutalized and battered by their partners is incalculable. We cannot know the reality of it for many women remain silent".

Chez (1994) claimed that in the United States of America 90% of the violence against women in partner battering is by men. This compares with Cox and Irwin's (1989) study in New Zealand which revealed 97% of partner battering was by men. Sampsel (1991) suggested the prevalence actually

exceeds the number of reported cases. In an American study undertaken by Parker, McFarlane, Soeken, Torres, and Campbell (1993), 691 pregnant women were surveyed on their first antenatal visit. Twenty-six percent reported experiencing physical or sexual abuse within the previous year, with the rate in teenagers rising to 31.6%. This study also revealed that psychological abuse significantly correlated with physical abuse.

Societal acceptance of violence within relationships has resulted in the problem continuing with minimal and ineffective interventions. The Committee of Inquiry into Violence in New Zealand (1987, p.96) described the incidence of partner abuse to be "...a problem of frightening proportions". Disparities existed, however, in the incidence of reported offences and the resultant convictions. The Committee cited an average of 16,739 complaints per year being attended by the police between 1979 and 1984. Despite the high attendance rate only 280 males were charged resulting in 176 convictions. Obviously little effective intervention was occurring 10 years ago in New Zealand and no deterrents existed to curb the violence by men toward women. Police and others involved in such disputes regarded battering offences as domestic problems, not the criminal acts they are, and the prevailing attitude was not to intervene. Police non-intervention reinforced societal beliefs regarding the sanctity of the family.

One solution to address the problem was to produce legislation to ensure reporting became mandatory. In support of legislation being developed, the Hamilton Abuse Intervention Pilot Project (HAIPP) trialed an integrated agency approach toward the issue of domestic violence (Dominick, 1995), modelled on the Domestic Abuse Intervention Project in Duluth, Minnesota (Pence, 1985). HAIPP arose as a result of the ineffectiveness of having a variety of independent agencies involved in family violence. No messages had been conveyed to men that abusive behaviour was unacceptable, and interventions to protect women were not working. One of the HAIPP interventions was the mandatory arrest by the

police of men who had assaulted their partner. The success of HAIPP was variable, due to personal attitudes toward partner abuse resulting in inconsistent support from both the police and community. Doone (1997), however, claimed HAIPP was a policy before its time.

Nine years after the Committee of Inquiry into Violence (1987), Atkin (1996, p.82) stated "The culture of the recent past which treated happenings in the home as private and not appropriate for State intervention is showing signs of disappearing". In 1995, the New Zealand Government intervened at a policy and legislation level with the passing of the Domestic Violence Act. At the time, the New Zealand Government Statement on Family Violence (Dept for the Prime Minister and Cabinet, 1996) outlined principles for action and an overview for strategic directions aimed at breaking the cycle of violence. This document built on The New Zealand Crime Prevention Strategy which targeted the reduction of family violence as one of its goals (Dept for the Prime Minister and Cabinet, 1994). The Domestic Violence Act 1995 has enabled the onus to be taken away from women experiencing partner abuse. While the Domestic Violence Act 1995 empowered women who experience partner abuse to take legal action, it also enabled a third party to make an application to make an application for protection on behalf of the woman.

Doone (1997) has described the changes made within the New Zealand Police in an effort to effectively intervene in partner abuse. Policies introduced aim to protect the victim, hold the offender accountable, and achieve consistency amongst agencies delivering family violence related services, which contrast with the previous mediation approach. Internally, police officer education challenges attitudes attempting to improve police effectiveness when attending partner abuse incidents. According to Doone (1997), the 1994 launch of the family violence campaign increased the reporting rate by 80% over two years, with 8,000 prosecutions resulting from 30,000 partner abuse situations attended in 1996.

Partner abuse is predominately a male problem, with men committing violent and abusive acts against women. It is recognised, however, that a small number of violent acts are those committed by women against men (Campbell, 1995; Committee of Inquiry into Violence, 1987; Schechter, 1982). Acts of violence toward men by women are not seen in the same light as those by men against women, primarily because women are not in positions of power and control over men. Much of the violence committed by women within the context of partner abuse are seen to be the result of self-defence and an attempt to stop the abuse which they experience (Committee of Inquiry into Violence, 1987).

### **Myths and Metaphors**

To appreciate the deeply ingrained nature of violence against women, in particular 'wife-beating', the historical relationship between men and women necessitates a brief exploration. Brownmiller (1975, p.12), writing about the domestic sexual violation of women, stated it is "...through the tools of historical analysis we may learn what we need to know about our current condition". Until recently, the historical accounts of family violence available were those made by male commentators with a subsequent male bias. This bias has influenced the development and maintenance of patriarchal and hegemonic structures within the Western world. It is commonly believed that Man was the traditional provider with Woman being the dependent homemaker. The term 'Man-the-Hunter', described by Miles (1988), is a metaphor illustrating this provider role. In the following section, the metaphor of 'Man-the-Hunter' and the myths which have grown around the division of roles between men and women, will be examined in order to locate women in relation to men within intimate relationships.

The metaphor, "Man-the-Hunter", has provided credence to male dominance and hegemonic structures on which society is based and the

subsequent subjugation of women. Yet this was not always so. In early gathering communities, as outlined by women writers of history, such as de Beauvoir (1953), Campbell, (1981), Lerner (1986), and Miles (1988), women played a pivotal role in the provision and maintenance of the community within which they lived. Miles (1988) described the relationship between men and women as one based upon working together, rather than dominance or exploitation. The consistent nature by which women provided food from gathering, along with other activities such as the making of clothes and tools, enabled gathering communities to exist. The male role of hunting for food was undertaken on a casual basis and provided an intermittent and unreliable supply of food. The hunting exercise also drained the men, requiring them to rest and restore their energy for the next hunt.

Societal acceptance of wife-beating also stems from both the myths which surround the deeply embedded cultural and societal beliefs and norms about the role and function of men as “protectors” of women and children. In response to this protection, property was assigned to men. This gives rise to difficulties in addressing issues related to partner abuse. The perpetrator is excused while the victim is blamed.

Myths range from the belief that abuse is not common or widespread and a problem of those experiencing poverty to those which excuse male behaviour. Such excuses include male characteristics or developmental defect giving rise to violent behaviour, uncontrollable animal urges, acceptance of physical prowess as an attractive masculine trait, and need as provider and protector to demonstrate dominance. Some excuses promote myths suggesting that women are either the cause of the violent behaviour or like it. Women have been accused of inviting assault by their dress or behaviour, thereby inciting their batterer. (For example, “She must have done something to deserve it”, or “She would leave if she doesn’t like it”). These myths are perpetuated in the media and advertising.

Myths are also reinforced by social beliefs and norms which uphold the sanctity of the family and the family's right to privacy (Sampsel, 1991; Tilden, 1989). Indeed Scott (1968) described the whipping of women publicly moving to the private arena because there were no government regulations preventing the whipping of women in private. An English Court of Appeal in 1891 is quoted as saying "The husband hath by law power and dominion over his wife and may keep her by force within the bounds of duty, and may beat her, but not in a violent or cruel manner (cited in Moore, 1997, p.1)". It is that privacy which has made the enormity of the problem of family violence so difficult to assess. Other societal attributes, described by Sampsel et al. (1992), which support violence against women are the devaluation of women, and power inequity.

Despite the place women may have held in early society, the notion of man being the hunter, and thus the provider, has persisted over time. The image of the caveman with his club in one hand, dragging a woman by her hair in the other is still portrayed in cartoons. This image is not dissimilar to the images and accounts of women who, at the hands of their partners are in situations where they are beaten and controlled. The predominate view of man being the head of the household and the family's provider reinforces the "Man-the-Hunter" metaphor. This metaphor is a myth, yet it has been perpetuated over thousands of years as women have become the property of men.

### **The Acceptance of Partner Abuse**

As New Zealand's current social and political structure derived out of British colonial roots, the acceptance of partner abuse will be discussed within the European (Western) historical context. The existence of a patriarchal society supported the emergence of women as property, an ideology which was reinforced by the church. According to Lerner (1986), patriarchy was created over 2500 years ago by men, and along with the

passive co-operation of women has evolved into the current structure of society. Authority and power in the patriarchal family belong to men, whether the nature of the relationship with women is one of polygamy or monogamy. Campbell (1981) suggested the mystique surrounding reproduction led to a fear of women by men. According to Figes (1986), the early Christian church achieved the oppression of women through a process of demonising women and the creation of a God who was a male effigy. Playing on the mystique of women's reproductive ability, the church expounded women as sexually sinful and evil, capable of emasculation and draining a man's strength. Women were seen to be an object of lust and thus blamed for the dark uncontrollable side of men (Campbell, 1981; Figes, 1986). The demonic nature of women also extended to women being accused of witchcraft, with witches being blamed for anything that went wrong in the community (Figes, 1986; Willis, 1994). In order to subordinate the distinctive role of women within society, there was a need by the early Christians to destroy pagan ceremonies (mostly associated with fertility Gods and Goddesses), and replace them with a unitary Christian God.

Western Christian religion and its biblical narratives reinforced the position of men as head of the family. The hegemonic structure of the family was a reflection of both society and religion, whereby males were seen to be dominant. Priests and scribes gave new Christian religion its reality, writing the laws and codes, and subsequently were responsible for the subordination of women. As Figes (1986, p. 41) claimed, "The voice of God is the voice of man". According to Miles (1988), this is in contrast to traditional tribal communities, to this day, whereby women are situated centrally with men on the periphery.

The control of women in Western society was evident with no rights to property and inheritance (as this was patrilineal); the denial of access to education; the treatment of women as a resource to be acquired and disposed of as land was; reference to husbands as "master"; and the use of

violence as a control mechanism (Lerner, 1986). According to Figs (1986), the maintenance of male dominance goes beyond the grave, with power and property being handed down to the sons. The Old Jewish Testament and the Bible placed great importance on the male 'seed' and the lines of male descent. This reduced the role of women to the bearers of male children.

Prior to the concept of marriage, Brownmiller (1975) described the process of "bride capture", whereby women were forcibly abducted and raped. This act of violence was a way of acquiring women. Women belonged to, and were controlled by their fathers, and on marriage they were given to a husband until his death. In commenting on the manner in which women were passed from father to husband in marriage, de Beauvoir (1953, p. 448) stated "...the girl seems absolutely passive; she is married, *given* [sic] in marriage by her parents. Boys *get* [sic] married, they *take* [sic] a wife". The subordinate position of women within marriage was reinforced by the traditional church wedding vows requiring women to "obey" the husband.

While some historians supported the idea of matriarchy (control by women), Lerner (1986) claimed matriarchal societies did not exist. Societies are structured primarily on the distribution of power and power relationships. However, evidence is not available where the status held by women together with the power and control they had over men existed. While women do share power with men, this is usually a privilege afforded to women of high status.

Patriarchy and the place women have within it, has continued to be accepted and exists over time. While it could be said that the women's movement of the 1970s brought about the freedom of women, this is an illusion. The patriarchal system continues unchanged, which means men still hold the balance of power. As previously mentioned, the continuance of patriarchy is multi-factorial. Up until this century, men have been legally entitled to beat their wives with this rooted in the concept that women were

their property (Scott, 1968; Sampsel, et al., 1992). This entitlement still exists as a right in some cultures and has been described in the autobiographical/biographical accounts of Ali (1995) and Gillespie (1995). Socialisation of gender roles results in males being encouraged to be competitive, aggressive, superior, and not to hold women in high esteem. Females, however, are socialised to be submissive and inferior (Myers, 1993).

Misogyny (women hating) has evolved from the patriarchal social system and is fundamental to violence against women (Campbell, 1981; Ussher, 1991). Ussher (1991) contends misogyny dismissed battered women as mad, a label which is emotive and associated with a history of social stigma, but effectively silences women. Another factor is the threat of being cast out with no way of being able to survive, as a result of the subordinate and dependent position women have. Fear of being cast out is a reality for many women to this day and is likened to enslavement. Lerner (1986) has indicated the oppression of women was an antecedent to the process of enslavement by men. The process of enslavement includes the isolation from 'home', rape, physical terror, and a psychological attachment to the husband through coercion. Dishonour induced the subordination necessary to enslave and oppress a woman.

Examples of violence against women can be seen throughout history and many cultures are briefly described by Campbell (1981). The Chinese practice of footbinding ensured women were totally dependent upon their husband or father. The Indian practice of *suttee* resulted in women being burnt to death in their husband's funeral pyre based on the belief that she was responsible for his death. The Middle Eastern and African practice of female genital mutilation left a woman's sexual activity under the control of her husband. The latter practice is still prevalent in New Zealand, despite being illegal. In Western society, the practice of gynaecology was used to cure a variety of afflictions experienced by women, including "insanity". The

witch-hunts and witch-burning are an example of how women, who violated the norms of appropriate behaviour, were vulnerable for accusation and ultimately a violent death. Willis (1994) believed the witch-hunts were evidence of violence associated with family problems, and were often supported by women. In summing up the lack of unity amongst women, Willis (1994, p. 105) pointed out that "...patriarchal beliefs and practices often have the effect of dividing women against one another; because of their dependence on men, many women attempt to distinguish themselves from and even attack women who refuse to conform to patriarchal rules". To this day, women will often attack other women when the wrong-doing is perpetrated by men. This behaviour by women further reinforces the lack of unity amongst women and sets women against women - characteristic of an oppressed group according to Friere (1972).

Women receive messages about their place in society from a variety of sources. For example, romantic fiction provides evidence of the support for male dominance and control over women. In reviewing some popular fiction (Brockman, 1995; George, 1996; Hart, 1996; Merritt, 1995; Metcalfe, 1996; Reid, 1996; Worth, 1996), two main themes are evident. The first is *Betrayal of body*, where the women's mind and emotions say one thing (for example, "no" to sexual or intimate episodes), yet the body does the opposite and yields to the man's demands. The message portrayed continually is that the betrayal of the body is acceptable despite the confusion of feelings created which are to be of no concern. The second theme that emerged is *male persistence always wins*. The continual persistence and coercion of the male portrayed in popular fiction always wins, despite the efforts of resistance by the woman. The message provided quite clearly states that men will get what they want. These are the messages that both men and women writers of fiction portray to their audience of women and are accepted without challenge. It could be asked, however, are the writers of romantic fiction providing the messages the public want, in order to continue the status quo in society?

Unchallenged myths and metaphors continue over time, with the status quo, that is male dominance and control, continuing. Moore (1997, p.3) commented on the survival of the myth, and stated "It survives not because there is evidence to support it but because its constant reiteration is unquestioned". The patriarchal and hegemonic structures created thousands of years ago exist today from the level of the family to the level of government and religious control. History was written and commented by men from their viewpoint, resulting in women having no history of their own. This in turn gave them no alternatives but to accept the system of patriarchy (de Beauvoir, 1953). The denial of the right of women to education further compounded the acceptance of patriarchy and its effects on women. The connectedness women had to the family was divisive and was the antithesis of the development of solidarity and cohesiveness amongst women in order to resist or rebel against patriarchy. Male dominance and control has endured with the co-operation of women. Despite the women's movement attempting to overcome the oppression of women, patriarchy continues along with the lack of solidarity and cohesion amongst women themselves. The control of women, which can be violent in its nature, is seen in today's society. The subjugation of women is reinforced through a variety of media, including the popular press whereby women reinforce the patriarchal messages of dominance. The accepted place women have in relation to men within relationships sets the scene for the acceptance of violence within the family.

### **Current Prevailing Attitudes**

Despite having diminished resources and being in a position of vulnerability, battered women have historically been charged with the responsibility to solve the problem of partner abuse alone. While it is popular belief that women choose to remain in violent relationships, Schechter (1982) contended that battering may be one more aspect of life to

be endured when women do not have the resources to change their situation. This contrasts with the belief that women are accepting of the situation. The existence of a prevailing attitude that it is the woman's responsibility to solve partner abuse is likely to ensure its continuance.

In order for change to occur, it must be acknowledged that violence against women is a multi-factorial problem at both a micro-level and a macro-level, requiring urgent social change. Campbell (1981) and Schechter (1982) both maintained that for preventive measures to be instituted, patterns and theories must be examined, such as gender socialisation, family relationships, and influences outside the family which maintain and perpetuate violence. A variety of theories exist at both the micro-level and the macro-level regarding the cause and continuance of the battering of women.

Theories at the micro-level, that is at the level of the individual and the family, offer a variety of perspectives. These perspectives on partner abuse, relate to psychoanalytic theory, grief, learned helplessness, personality, behaviour, socialisation, parenting, and family interaction.

Freud's psychoanalytic theory (1940s), was an early theory which proposed male aggression as a natural component of sexual instinct. This aggression arose developmentally in response to the frustrated urge to explore and master the environment. This in turn created repressed aggression in adulthood (Storr, 1968). Campbell's (1981) discussion of the psychoanalytic theory focused on the stereotyped roles for women, with women who violated these roles being labelled as defective and mentally ill. Psychoanalytic theory expounded motherhood as the only acceptable role for women and blamed mothers for psychiatric ailments. This theory legitimised the oppression of women and misogyny.

In attempting to explain the response of battered women, Campbell (1989) offered two perspectives. The Grief Model (based on work by Campbell, 1985; Pagelow, 1981; Parkes, 1972; Skinner & Connell, 1986; Straus, Gelles, & Steinmetz, 1980, cited in Campbell, 1989) explained depression in battered women as a situational reaction to the potential or anticipated loss of the relationship, along with the loss of other aspects in their life. Campbell (1989) believed the reactions are similar to those seen in people experiencing trauma in general. Grief constituted a combination of stressors and powerlessness (related to the perception of control and the ability to access resources in order to attain outcomes and perceived loss). The Learned Helplessness Theory (based on Abramson, Seligman, & Teasdale, 1978; Walker, 1979, cited in Campbell, 1989) is explained by a combination of the perception of control, internal blame, an unstable situation, and negative self-esteem and self-care agency resulting in battered women learning to be helpless. Deficits are claimed to exist in the women's motivation, cognition, and affect, and explain the cycle of leaving a relationship and returning to it. Tilden (1989), however, claimed the lack of relationship between the responses women make and the subsequent outcomes is due to low self-esteem and engagement in avoidance behaviours. Avoidance behaviours occur when the women learn to avoid situations when presented with warning signs (Baron, Byrne, & Kantowitz, 1980).

Explanations for individual male perpetrators are varied. Storr (1968) described greater aggressive behaviour being habitually demonstrated in boys, which persisted beyond childhood into adult life. Myers (1993) contended that biological influences such as heredity, blood chemistry, and the brain play a part in aggressive behaviour. Dysfunctional personality is cited by Gage (1991) and Noel and Yam (1992) as an explanation, although Schechter (1982) pointed out that personality characteristics are varied. The personalities of those who batter women are characterised by immaturity (Tilden, 1989); feelings of powerlessness which lead to controlling behaviour

(Campbell, 1981; Schechter, 1982; Tilden, 1989); an inability to tolerate frustration (Myers, 1993; Schechter, 1982); high stress with poor coping mechanisms resulting in the belief that it is their right to use violence, batter, and dominate women in order to reduce stress (Schechter, 1982; Tilden, 1989); and substance abuse (Gage, 1991). Poor impulse control is also cited by Schechter (1982) and Tilden (1989), although Schechter maintained this does not explain why battering usually occurs in the privacy of the home. Myers (1993) also believed that violent behaviour is learned through experience and observation, with men learning that the use of violence has benefits. Although these factors go some way to explaining the violent behaviour of men, Schechter (1982, p.212) stated: "Although they 'act out of control', most batterers know what they are doing".

The family, including the extended family, can be considered a learning ground for violence, with its members being either a potential victim or abuser. It is the place where the developing young learn the roles of dominant male and submissive female, and the man's exclusive right to abuse his partner. The inter-generation cycle of violence is proof for some, that membership to a violent family results in the witnessing of the mother being battered, and the experience of being battered (Noel & Yam, 1992; Schechter, 1982). Violent families normalise violence as a way of dealing with anger and frustration (Ritchie, 1993), thereby contributing to its perpetuation into the next generation. Schechter (1982, p.215) states:

Male children from violent families, following socialization and cultural patterns, may identify with the aggressor, learn to use physical force, and become violent. Female children may become withdrawn and frightened in families where the father is abusive. Yet in these cases, people are not indiscriminately learning victim and aggressor roles; they are learning about their proper place and the correct way to behave within a male-dominated family and culture in which violence has been institutionalized.

Ritchie (1993), following years of research into the parenting styles of New Zealanders, found that parenting was based upon an ideology of physical punishment. This ideology represents an appropriateness to use physical force in conflict situations, and that it is okay to hit the ones you love and for you to be hit by the ones that love you. Ritchie (1993) and Ritchie and Ritchie (1993) maintained that unless this aspect of parenting was addressed, the family will ensure the continuance of violence, not only within the family, but also in society as a whole.

Robinson, Wright, and Watson (1994) criticised theoretical models for their lack of recognition of partner abuse as a pattern of family interaction. The Family Systems Theory (Robinson et al., 1994; Tilden, 1989) was used to explore dysfunctional family interactions present in violent families, specifically the interactions which maintain the violence and perpetuate victim blaming. Robinson et al. (1994) proposed a modification, the Systemic Belief Approach, which maintained families constrain levels of functioning and beliefs about violence at both the level of individual members and the family as a whole.

Various perspectives are also proposed at a macro-level. The macro-level includes traditional, societal, cultural, and feminist perspectives. Gage (1991) described the traditional view, characterised by fixed gender roles, learned responses, and the use of violence as an acceptable problem-solving technique. Gage (1991) criticised this perspective as it does not explain why some men brought up in a violent environment do not batter women, and also denies the role of family interaction.

The notion that violence is a product of society rather than the result of individual pathology is supported by various views regarding the role of society in family violence and its acceptance. According to Boychuk Duchscher (1994), women are the subject of objectification and portrayal as vulnerable and desiring to be dominated. Subsequently, society not only

condones, according to Tilden (1989), but also promotes partner abuse via a system based on patriarchy and power imbalances. As Schechter (1982) contended, this is a socially structured right to control and psychologically abuse. Stress, power imbalances, poor conflict management skills, inter-generational transmission, and unemployment, as described by Noel and Yam (1992), all contribute to violence in society.

Cultural patterns determine the structure and roles which evolve within societies. Wolfgang's and Ferracuti's (1967) culture of violence theory, as described by (and cited in Boychuk Duchscher, 1994), contended that as a consequence of gender based roles, gender inequity, and the belief that women are the property of men, the majority of society accepts the use of interpersonal violence. A social culture which values male domination, promotes battering as one vehicle to attain conformity. This is achieved by punishment when norms are violated, despite those norms being neither clearly defined or made explicit at times. According to Schechter (1982), a capitalist culture also reinforces male domination and violence through inequitable economic status and vulnerability of women on men and their subsequent economic dependence.

The novel and film *Once Were Warriors* (Duff, 1990) portrayed to the world a rather unyielding reality of the violence which exists within the Maori gang culture of New Zealand. While violence against women appears to be a hallmark of the gang culture, it is difficult to determine the extent of the problem. Certainly, Howden-Chapman's (1994) study would indicate that Maori report violence at a much higher rate; 15.9% compared to 4.5% of non-Maori women who presented to a city refuge. However, anecdotal evidence indicates that the type of violence used is indicative of the socio-economic status. That is, the violence committed by Maori men towards women is spontaneous and obvious. This contrasts with that committed by their non-Maori counterparts which is often deliberately hidden, with a higher incidence of psychological abuse being utilised.

The feminist perspective views violence against women as a gender issue, whereby the central issue is power inequity, resulting in the control over women and their ultimate oppression (Noel & Yam, 1992). Noel and Yam (1992) suggested the question that should be asked, from a feminist perspective, is "what prevents women from leaving a violent relationship?", rather than the usual questioning as to why they stay. Boychuk Duchscher (1994) believed a feminist perspective may assist in resolving the problem of partner abuse as it affirms gender equity, valuing of people, and the possession of sovereignty by women over their bodies. This approach however, does not address the issues relating to the structure of society, and how men would be coaxed into relinquishing their current dominant status.

Gage (1991) proposed another view, whereby family violence occurs on an expressive-instrumental violence continuum. Expressive violence aims to cause pain and injury in response to emotional upset and poor impulse control. The aim of instrumental violence is to control behaviour through the use of pain and injury, and exploitation. Gage (1991) believed this approach allowed the identification and utilisation of appropriate treatment options which are more meaningful.

The preceding discussion outlines some of the various viewpoints which exist on partner abuse. Yet these theoretical frameworks have their limitations. They do not explain why some men and women, involved in the family violence cauldron, are not violent despite exposure to violence during their developmental years (Schechter, 1982). Campbell (1981) criticised theories of violence, and claimed they are carried out by males, often on males. According to Tilden (1989), theoretical frameworks can be limiting, as they often have a narrow focus. What the variety of viewpoints highlight, is that partner abuse cannot be explained simply as it is multi-factorial.

O'Neill and Patrick (1997, p.21) summarise the difficulties following a review of the literature:

In one model men are independent rational intentional beings who are responsible for their choices of behaviour (instrumental power), in another they are at the mercy of inner passions and drives which are difficult to control (tension release)...Still other discourses position violent men as relatively passive agents caught up in the logic of their cultural heritage (social system) and as products of their own individual learning experiences (learning discourse) which places responsibility for their violence outside of the individual. In opposition to this the 'pathological' model tells us that men's violence is the outcome of sick individuals whose minds are functioning at an abnormal level of ill-health.

Until an eclectic approach is adopted in explaining and planning interventions to halt the violence against women, this phenomenon will continue, as efforts to curb its incidence may be in vain.

### **Battered Women: The Health Problem in Disguise**

Ryan and King (1992), and Tilden (1989) referred to battered women as a 'health problem in disguise', experiencing a wide variety of health problems according to Woods and Campbell (1993). It is also alleged that battered women present to the health services for injuries and health related problems in greater numbers than are realised by health professionals (Bergman & Brismar, 1991; Bohn & Holz, 1996; Ratner, 1995; Tilden, 1989; Tilden et al., 1994). The nature of the health problems experienced by battered women are not only a cost to themselves personally, but are also a cost to the health care system.

Woods and Campbell (1993) pointed out that abuse by an intimate partner is a chronic stress event. Women who experience partner abuse live

with fear, shame, guilt, self-doubt, a low self-esteem, and low self-confidence. Lorig and Smith (1994) likened the difficulty of leaving an abusive relationship to traumatic bonding, which Tilden (1989) referred to as hostage response behaviour. Traumatic bonding is evident in the cycle of abuse. It is characterised by women who cling to their abusive partners in the hope they will fulfil their promise to change, despite the continuing and intermittent emotional and physical abuse (Lorig & Smith, 1994). The difficulty in leaving is also highlighted in the findings of Frisch and MacKenzie (1991) and Landenburger (1989). According to Woods and Campbell (1993), the length of a violent relationship ranges from six months to 19 years, with the average length being 7.6 to 7.86 years.

The health problems experienced include a multiple of acute and/or chronic physical or medical problems, such as injuries, gastro-intestinal problems, gynaecological, or unspecified disorders (Bergman & Brismar, 1991; Bohn & Holz, 1996; Boychuk Duchscher, 1994; Holtz & Furniss, 1993; Lorig & Smith, 1994; Noel & Yam, 1992; Ratner, 1995; Tilden, 1989; Woods & Campbell, 1993). They also include somatic illness, where Bohn and Holz (1996) claimed women repeatedly visit health services with varied and vague symptoms of which no physical causes can be found.

Emotional or psychological health problems are cited to include a multitude of problems, such as depression, anxiety-related disorders, fears, low self-esteem, disassociation, and posttraumatic stress disorder (Bergman & Brismar, 1991; Bohn & Holz, 1996; Boychuk Duchscher, 1994; Holtz & Furniss, 1993; Lorig & Smith, 1994; Noel & Yam, 1992; Ratner, 1995; Russo, 1990; Tilden, 1989; Woods & Campbell, 1993). Noel and Yam (1992) reported 30-50 % of psychiatric patient histories included abuse and 40 % of alcoholism existed within the context of ongoing abuse. Woods and Campbell (1993) viewed battering as a traumatic event, characterised by the existence of serious harm or threat to life. Both Russo (1990) and Woods and Campbell (1993) highlighted the impact of abusive experiences, which if

left unresolved develop into depression and posttraumatic stress disorder, thereby affecting the battered woman's mental health.

Health problems experienced by battered women also impact upon their social and interpersonal interactions, their behaviour, and sexual activity. Battered women may also engage in self-destructive behaviours, ranging in severity from neglect of self-care activities, such as undertaking regular smears or breast checks, to eating disorders, self-mutilation, and suicide attempts (Bohn & Holz, 1996; Noel & Yam, 1992; Ratner, 1995). Noel and Yam (1992) reported 25% of battered women attempt suicide, and Boychuk Duchscher (1994) claimed battered women were six times more likely to attempt suicide, and eight times more likely to complete suicide or die prematurely than women who were not battered.

Pregnant women are not exempt from battering. As mentioned earlier, Parker, McFarlane, Soeken, Torres, and Campbell (1993) cited 26% of pregnant women in their study experienced physical or sexual abuse in the year prior to their first antenatal visit. McFarlane, Parker, and Soeken (1996) interviewed 1203 pregnant American women on their first antenatal visit. On the first visit 24.3% of the women reported physical or sexual abuse, of which 60% reported two or more episodes of violence throughout their pregnancy. They also discovered ethnically, white women experienced more episodes of more severe battering, when compared to Hispanic and African American women. Pregnant women who have been battered are more likely to abort, have premature labour and deliveries, and have low birth weight babies.

Many women who present to health services, are treated, only to present again for treatment in the future. Harris (1991) referred to the repeated use of health services as the 'revolving door' of violence. The high usage of health care services by battered women results in high resource costs for health services. The low rate of both the identification of partner abuse and

the use of appropriate interventions, contributes to the costs for health services used by battered women. Tilden (1989) reported 18% of trauma is the result of battering, yet only three percent are identified.

The following studies illustrated the high usage of health services. Bergman and Brismar (1991) compared 117 battered women to a control group for hospital admissions over a five year period. They found that battered women used hospital services at a higher rate for medical, gynaecological, psychiatric, and unspecified disorders, including suicide attempts. The admission rate was 420 compared to 119 for the control group. Ratner (1995) randomly surveyed 406 married women using 30 potential indicators, a combination of the General Health Questionnaire (GHQ) for psychiatric morbidity (Goldberg & Hillier, 1979, cited in Ratner, 1995); CAGE for alcoholism (Ewing, 1984, cited in Ratner, 1995); Conflict Tactics Scales (CTS), Form N (Straus, 1979, cited in Ratner, 1995); and physical health items constructed by Ratner (1995), to measure exposure to wife abuse. Forty-three percent of the women reported being abused in the previous years. The study also revealed 20% of abused women utilised emergency departments compared with eight percent of women who were not abused. Forty-two percent had contact with a psychiatrist, with 24% having psychiatric morbidity, and 35% experiencing alcoholism. Nineteen percent had been hospitalised. The New Zealand research undertaken by Cox and Irwin (1989) (described on page 9), revealed that of women experiencing partner abuse, 43% sought medical attention from either their own doctor or the hospital.

Ozmar (1994) pointed out that the costs to the health care system coupled with the loss of productivity was "staggering". Snively (1995) produced a report which outlined the economic cost of family violence in New Zealand. Snively recognised that family violence not only incurred human and social costs, it also incurred economic costs at the level of the individual, family, and community. The annual costs of family violence were

estimated to be between \$1.187 and \$5.302 billion. Working on a conservative cost of \$1.235 billion dollars, which did not account for factors such as underreporting and loss of the women's work productivity, Snively (1995) claimed the economic costs to the individual would be \$398,569, while the costs to the health care system would be \$140,721 million dollars annually.

Instead of the health service utilisation being minimised by effective interventions, battered women continually and repeatedly use services which are ineffective. Bohn and Holz (1996, p.449) warned:

This 'Band-Aid' approach to health care is, in the long run, more costly and time consuming. It ensures that abuse survivors will present for health care again and again with many symptoms and problems that are the sequelae of abuse.

The cost of battering at a personal level and at the level of the health services, warrant the examination of how health professionals respond to battered women. Such an examination would provide insight into the 'revolving door' phenomenon, whereby women are treated only to return again, and lead to actions aimed at reducing the use of health services by these women.

### **The Responses of Health Professionals to Battered Women**

Victims of partner abuse characteristically do not disclose their experiences (Attala, Oetker & McSweeney, 1995; Holtz & Furniss, 1993; Ozmar, 1994). There is a reluctance and/or lack of knowledge by the woman, the abuser, and the health professional in identifying the problem exists. Subsequently these women become repeated and high users of health services (Chez, 1994). The Injury Prevention Unit in New Zealand,

established that the abuse of women was a major public health issue (Fanslow & Norton, 1994).

A fear of being found out for seeking medical treatment exists according to Heywood-Jones (1988). Women, will however, disclose their abuse if they feel they are in a safe and confidential environment, they will be listened to without judgement, and their decisions will be respected (Holtz & Furniss, 1993; Kennedy, 1994; Lempert, 1992). Howden-Chapman (1994) supervised a qualitative study exploring women's perceptions of health workers' attitudes and behaviours in a New Zealand women's refuge. The study revealed, that despite all the participants hoping the health professional would discover the abuse without having to tell, health professionals experienced problems with the identification and treatment of women presenting with health problems related to their abuse. Lempert's (1992) American study revealed that with escalating violence, women are willing to disclose their abuse in a hope it will stop. Both Lempert (1992) and Sampsele (1992) suggested that the validation and the valuing of the women's experience is basic to their empowerment. Unfortunately, many health professionals appear reluctant to question women with unexplained injuries either directly or appropriately, and therefore fail to establish a contextual diagnosis and effective interventions (Bohn & Holz, 1996; Butler & Snodgrass, 1991; Esposito, 1993; Feiner, 1994; Holtz & Furniss, 1993; Howden-Chapman, 1994; Lorig & Smith, 1994). As Mackey (1992, p.187) stated:

Societal processes that initiate domestic violence are often perpetuated by negligent health care systems. So, like the child victim who turns to the paternal object believed to be protective and is betrayed, the battered woman is betrayed by the health care system when it fails to even identify her victimization.

Bohn and Holz (1996, p.449) went further, stating "Failure to address violence against women sends the message that such abuse is unimportant,

forgivable, and perhaps even condoned". Weingourt (1996) proposed battered women subordinate their own interests, and when those around her (including health professionals) are either unresponsive or negate her experience she becomes disconnected in an attempt to make herself "acceptable". The process of disconnection is often mistaken by health professionals, according to Weingourt (1996) for depression, withdrawal, and a reticence to utilise the services. McFarlane, Christoffel, Bateman, Miller and Bullock (1991) in their American study found that the rate of reporting abuse increased by 22% if nurses, during their assessment, questioned women rather than relying upon women to self-report as to whether they had been abused.

Women who present repeatedly to health services, often with signs of physical battering, frequently do not receive specific attention regarding their abuse or battering. One reason cited is the inadequacy of the medical model in dealing with social problems. Warshaw (1989) revealed a deficit on the health professionals part in obtaining a history which included the emotional and social aspects of the woman's life; identification of the relationship of the woman to her abuser; the medicalisation of the complaint; failing to connect the injury to how it happened; and the use of disembodied language, which contributed to battered women being overlooked. Mandt (1993) challenged the medical model, saying it was inadequate in dealing with social problems such as violence.

The high profile of family violence does not mean there is understanding or that the right actions are being taken, according to Lydon (1996). Health professionals are accused of lacking in helpful or effective interventions (Attala et al., 1995; Henderson & Eriksen, 1994; Jenkins, 1991; Lorig & Smith, 1994), and of the misdiagnosis, over-medication, and labelling women with psychiatric diagnoses (Holtz & Furniss, 1993), or responding in a derogatory, judgmental, and insensitive manner (Butler & Snodgrass, 1991; Ryan & King, 1993). Butler and Snodgrass (1991), Feiner (1994), and

Howden-Chapman (1994) claimed battered women silently wish health professionals would recognise their situation and actively inquire. Yet, partner abuse often goes unrecognised, untreated, and unspoken of by health professionals. The result is the health care system being a weak link in responding to battered women.

The health profession tends to narrowly focus on the physical injuries, stigmatises, and victim blames (Boychuk Duchscher, 1994; Davis & Hagen, 1992; Mandt, 1993; Murphy, 1993), and does not routinely assess for partner abuse (Esposito, 1993). Murphy (1993) and Bohn and Holz (1996) referred to the inadequacy of the health care system in dealing with battered women as contributing to the societal conspiracy of silence about partner abuse and perpetuating its secrecy. Bohn and Holz (1996) claimed barriers to the identification and the implementation of interventions by health professionals were the result of social attitudes; profit-driven health care delivery systems whereby time equates with money; frustration with the women's non-compliance and a lack of 'quick-fix' solutions; lack of education and poor attendance at education sessions; and personal biases and prejudices.

The failure to identify battered women is compounded by health care professionals misunderstanding and subscription to societal myths and commonly held beliefs about battering, such as '*she must like it or she'd leave*' or '*she must have asked for it*' (Henderson & Ericksen, 1994; Ryan & King, 1992; Ryan & King, 1993; Tilden, 1989). Such beliefs are based on unfounded assumptions, which are both judgmental and insensitive in their nature, leading to victim blaming and disempowerment (Boychuk Duchscher, 1994; Henderson & Ericksen, 1994; Ryan & King, 1992; Tilden, 1989). These beliefs are reinforced further when a woman returns to the home situation. However, as Esposito (1993) defended, a battered woman is an expert on her own environment, knowing when it is safe to leave and when it is not. Battered women are often accurate judges of their partners emotional

ups and downs. Fanslow (1996) also warned that more women may be murdered when attempting to leave the abusive relationship.

Findings in research studies conducted by McKeel and Sporkowski (1993) and O'Brien and Murdock (1993) indicated there was a relationship between the attitudes and views held by shelter workers and the management of women who have been battered and abused. Shelter workers who believed the partner was responsible for the abuse and unable to stop it were more likely to support women to leave an abusive relationship. Conversely, shelter workers who believed that both the woman and the partner were equally to blame for the abuse were more likely to encourage women to stay in the abusive relationship.

A study undertaken in the United States by Sugg and Inui (1992) explored physician's experiences of women presenting with signs of partner abuse to determine the barriers to recognition and intervention within a primary care setting. Barriers identified included lack of comfort, fear of offending, powerlessness, loss of control, and time constraints associated with opening a perceived "Pandora's box". Head and Taft (1995) undertook a qualitative study in Australia which examined the responses of General Practitioners, and abused women's perspectives, using thematic interviews. The major barriers to management of battered women were a lack of training in the area of partner abuse and an uncertainty of their role in responding. The majority of women perceived the responses from their General Practitioner as being negative. Head and Taft (1995) recommended that there was a need for improved training and education together with guidelines for the identification and management of domestic violence.

The quality of health care received, according to Ryan and King (1993), by battered women determines whether they follow through with referrals to the police, legal, social services, and other health care agencies. However,

the health service is also recognised as potentially damaging as battered women report being victimised by not only a violent partner, but also by the health service itself (Henderson & Ericksen, 1994). Nurses are not exempt from the accusations regarding the absence of quality care provided to battered women. McMurray and Moore (1994) succinctly described violence against women as the 'antithesis of caring'. Caring is one of the foundations nurses claim nursing practice is based upon. Yet nurses, like other health professionals, have a tendency to treat the injuries, ignore the cause, and send women back into the environment where the problem exists with little or no support or resources (Chez, 1994; Esposito, 1993; Henderson & Ericksen, 1994; Mc McFarlane et al., 1991; Ryan & King, 1992; Ryan & King, 1993; Sampsele, 1991; Tilden et al., 1994; Woods & Campbell, 1993).

### **Summary of Nursing Related Literature**

Of the literature reviewed, the majority is discussion rather than research based. Highlighted is the existence of real problems battered women encounter when they enter the health care system. The problems also relate to nurses. Research is predominantly quantitative in nature, and there is an obvious absence of research undertaken with nurses and how they respond to battered women and the issues of partner abuse. The following is a summary of the research undertaken in the literature reviewed.

Ulrich's (1991) study of 51 battered women regarding the reasons for leaving a physically abusive relationship, revealed categories of safety, dependency, and personal growth. Ulrich (1991, p. 472) maintained that "...environments that support the women in processing their experiences and that provide opportunities for the women to plan and to question pave the way for self-change". Rodriguez's (1989) descriptive survey of 50 battered women in America highlighted the need for nurses to become aware of the health needs of battered women.

McMurray and Moore (1994) used a phenomenological approach to examine the difficulties faced by women experiencing partner abuse when they entered the hospital system in Australia. The themes which emerged from the data were: disengagement and loss of status; disempowerment and lack of control; stigma and social isolation; and a sense of being misunderstood. These themes related to the nurses attitudes and interventions, where the women described experiencing humiliation, being judged, made to feel unworthy, and nurses turning away from them. The questioning nurses used was superficial, and the women felt they were neither listened to nor acknowledged.

Hatrick (1996) studied the women's experiences of their interactions with General Practitioners in New Zealand. It was apparent that General Practitioners were missing opportunities to intervene with battered women and needed to be aware that the women frequently presented with depression, stress, and anxiety. This study also dispelled some of the assumptions made by health professionals. For example, women would often drop "hints" about feeling unhappy or distressed, and will disclose if they are directly questioned. The study also revealed Practice Nurses and Emergency Department nurses being the most likely possible sources of help, together with the General Practitioners.

The research undertaken by Hatrick (1996), McMurray and Moore (1994), Rodriguez (1989), and Ulrich (1991) provides nurses with valuable knowledge and information from the womens' perspective of their experiences. On the other hand, exploring the insight of nurses into how they respond to women (as proposed in this study), is essential in the development of future directions for research, and in attempting to address the problems experienced by battered women in the health care system.

Lydon (1996) observed and asked questions in a United Kingdom Accident and Emergency Department. Staff, knew the women were 'lying'

but were reluctant to approach them; reinforced myths and rationalised partner abuse; viewed partner abuse as a part of life; and “passed the buck” as Accident and Emergency was not perceived as being an ideal setting and lacked privacy. It is unclear, however, if this study by Lydon (1996) was a formal research study or based on anecdotal observation and questions.

McKeel and Sporkowski (1993), O'Brien and Murdock (1993), and Lydon (1996) contributed attitudinal and behavioural information related to those working with battered women. The studies by McKeel and Sporkowski (1993), and O'Brien and Murdock (1993) describe the attitudes of shelter workers. They do not, however, describe who shelter workers are - it could be construed that this group are not trained health professionals *per se*. Lydon's (1996) description of the attitudes and behaviours of those working in an Emergency Department is relevant to the current study, which aims to ascertain how nurses do behave when confronted with women experiencing partner abuse.

Research into the area of battered women also confirms that there is a tendency not to identify women who have been battered, with only their injuries being treated (Campbell, 1992a). In studies conducted by Drake (1982), Goldberg & Tomlanovich (1984), Stark et al. (1981) (all cited in Campbell, 1992a), women were interviewed in emergency departments and it was found that 10-22% and possibly up to 25% had significant injuries from being beaten and wanted specific help from health professionals regarding their abuse. Yet these authors claimed only two to eight percent of the women were identified as having been abused. These studies also revealed that the perception that battered women hide the signs of their battering from health care professionals, and/or find questions intrusive, is a myth. King and Ryan (1989, cited in Campbell, 1992a) explored nurses' attitudes and found that nurses tended to use a paternalistic rather than empowering model when dealing with battered women, and suggested a need for training existed.

Tilden et al. (1994) mailed a survey questionnaire, which was completed by 1521 respondents. It aimed to measure health professionals' assessment and management of suspected abuse. The study found that nurses tended to consult with other health professionals, whereas the other health professionals tended to discuss the suspected abuse with the patient. The study also revealed that there was a lack of family violence education in professional training programmes, a large number of the respondents believed that abuse was infrequent among patients and a significant number did not view themselves as responsible for intervening. Gender also influenced the management of suspected abuse patients, with women taking a more collaborative approach, consulting and reporting to others, while men preferred to handle the situation alone and discuss the problem with either the patient or the family.

The studies described in Campbell (1992a) and by Tilden et al. (1994) indicate a need to explore the actions of nurses. When nurses responses are identified, this can assist in improving not only the rate of identification, but what effective interventions are required. Research involving nurses will assist in determining what is needed in terms of education and training to intervene effectively.

Nurses are predominately female. One aspect which has been alluded to by Attala et al. (1995) is the incidence of nurses who have either been abused or are currently in an abusive relationship. Attala et al. (1995) undertook a descriptive correlational study to determine the prevalence of partner abuse among 243 nursing students. They found that partner abuse was prevalent, with eight percent experiencing physical abuse and 18.9 % experiencing psychological abuse. This research by Attala et al. (1995) exposed an important and pertinent area. Nurses with unresolved abuse, or those who are experiencing abuse, may well be affected in their ability to effectively work with other women experiencing partner abuse. However, the

purposes of this study do not intentionally incorporate the nurse's personal experiences with family violence and partner abuse.

Davies et al. (1996) undertook a qualitative study exploring the barriers to the identification, assessment, and intervention of violence against women. Twenty-eight rural Queensland community health workers, half of whom were nurses, participated in focus group interviews. The focus groups centred on issues of training, service delivery gaps, and the adequacy of referral and support networks. Three main themes were identified: *barriers to identification*, which included the participant's belief that it was not their responsibility, not having sufficient time to receive training, and the attitudes and perceptions held about partner abuse; *barriers to assessment* related to participants not knowing what to do, primarily due to a lack of training regarding intervention strategies, and a lack of protocols and policies in the workplace; and *barriers to intervention* resulted from a perceived lack of resources and a fear for the participants own safety. These authors made recommendations for information to be included into training programmes. These recommendations relate to this study as it aims to identify not only the responses of nurses, but also their educational and training needs.

Fanslow, Spinola, Stewart and Norton (1996) reviewed patient records in order to evaluate the implementation of the OASIS protocol in one New Zealand hospital. OASIS is an acronym standing for Observe, Ask, Assess, Intervene, Support and Refer. The OASIS protocol was designed to "...provide guidelines for the identification, acute management and referral of women who are victims of partner abuse..." (Fanslow et al., 1996, p.1). The evaluation demonstrated a significant increase in the identification of women experiencing partner abuse, the use of appropriate interventions, and a trend toward an increase in documentation of abuse. With the introduction of the protocol, Fanslow et al. (1996) suggested the study underestimated the incidence of partner abuse and an increase in the findings may have

occurred if emergency department staff conducted routine screening for abuse. While this study demonstrates the impact protocols have on improving the identification and use of appropriate interventions, it is not totally relevant to the current study. However, nurses may identify the use of protocols in terms of their response to battered women.

The above research contributes to knowledge in the arena of partner abuse, providing insight into various aspects. It is clear from the studies reviewed that problems exist not only in the identification of women experiencing partner abuse, but also in the implementation of effective interventions. While the research reviewed has explored health professionals in general and to a lesser extent the women's perspectives, specific research with nurses is not abundant.

### **Justification for the Current Study**

Nurses play a pivotal role within the health care system. They are seen to be in a unique and excellent position to intervene in a positive manner and interrupt the cycle of violence (Jezierski, 1994; Murphy, 1993; Ozmar, 1994). Nurses encounter a wide variety of women across its speciality areas, such as practice nursing, child and maternal health, emergency department, mental health, and surgical nursing. Jenkins (1991) described nurses as agents of change. According to Murphy (1993), nurses have the ability to provide a variety of information to women in general as a way of letting them know that they recognise the violence they endure is a health problem, and that they are prepared to help. Esposito (1993) recognised that the identification of support for battered women is very important, even if no immediate change in their circumstances occurs. The tendency for nurses not to recognise violence against women and effectively intervene, as outlined in the literature, reinforces the need to explore the nurse's perspective as to how they work with battered women.

Sampsel (1992) described nursing as a tradition which embraces prevention. The area of violence against women is seen as an important issue for nursing's research agenda (Campbell, 1992a; Dyehouse, 1992; Koss, 1990; McBride, 1992; Mackey, 1992; Russo, 1990; Sampsel, 1992). Fanslow and Norton (1994) and Leibrich et al. (1995) identified improving the responsiveness of health care professionals to abused women as a key research area in New Zealand. This is a research agenda supported internationally by the United Nations (1989). By expanding nursing knowledge concerning the issues of violence against women and the related health problems, interventions can be developed which support these women within the context of their realities. Nursing research in this area, particularly within New Zealand does not appear to be abundant. Most of the literature reviewed pertains to the North American culture. Family violence and its effects are currently a national concern and are the foci of media exposure aimed at preventing its high incidence. The proposed study is designed to explore and describe how nurses respond to women who present with physical injuries suggestive of partner abuse within the New Zealand context. The study will also examine the educational preparation the nurses have, and perceive they require, in order to respond to the needs of women effectively.

### **Summary**

Partner abuse is defined in this study as violence against women by men. It is an issue of national and international concern. It is difficult to ascertain an accurate prevalence rate due to underreporting by women experiencing partner abuse, and to a history of poor record-keeping by those providing services to battered women. Within the New Zealand context, actions are being taken at a government level in an attempt to effect change, making partner abuse socially unacceptable. It is however, an issue which has deeply ingrained roots in history and social acceptance, resulting in the

relationship between men and women being typified by domination, control, and abuse.

Unchallenged myths and metaphors transgressing time have allowed the abuse of women to occur, in addition to patriarchal and hegemonic social structures. The maintenance of men believing women are their property and the subsequent institutional acceptance of the beating and abuse of women has evolved from the social structures, with the support of the Western Christian religion. Various theories exist which attempt to explain the existence and continuance of family violence and partner abuse. While the theories have their value, they have limitations and lack an eclectic approach necessary to resolve a multifactorial issue such as partner abuse. Underlying issues of power and control are in existence despite the historical nature of violence against women.

Battered women are an unacknowledged health problem. Women experiencing partner abuse, present to health services in high numbers with not only injuries directly attributable to partner abuse, but with a diverse range of medical, social, and mental health problems. The costs of partner abuse to individuals, families, and health services are enormous, requiring urgent attention. Yet overwhelming evidence exists that the responses of health professionals are anything but effective. Health professionals either ignore or don't recognise women who present with injuries suggestive of partner abuse. Health professionals are not immune to the societal attitudes, and they often operate on false beliefs and myths about the battered woman. What is evident is the lack of education regarding the issues surrounding family violence and partner abuse in professional education.

The area of family violence is both a national and a nursing research agenda. A deficit exists in this area of research, particularly in nursing within a New Zealand context. In responding to the deficits, a qualitative research

design, using grounded theory as a data analysis tool, (outlined in the next chapter), will be used to explore and describe nurses' responses to battered women and the educational preparation required to effectively respond to these women.

## Chapter 3

### Method

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#### Introduction

As described in the previous chapter, international and New Zealand literature indicate that battered women present a major health problem (Bergman & Brismar, 1991; Bohn & Holz, 1996; Ratner, 1995; Ryan & King, 1992; Tilden et al., 1994; Tilden, 1989). Battered women utilise a variety of health services for a diverse range of health problems, yet the underlying abuse pathology is not exposed. Often these women present with obvious signs of physical injury, however, the cause is either not recognised or is ignored. Family violence in New Zealand has become the focus of a media campaign for the express purpose of exposing the problem and delivering the message that violence will no longer be tolerated by society (Dept of the Prime Minister and Cabinet, 1994; Dept of the Prime Minister and Cabinet, 1996; Domestic Violence Act 1995; Doone, 1997).

The literature raised questions as to how nurses recognise, and work with battered women. Given the reported enormity of the family violence problem (Department of Justice, 1993; NCIWF, 1995) and the nature of nurses' work, the likelihood nurses will encounter women who have been battered increases. The focus of this thesis concerns such women who enter the New Zealand health care system and how the provision of nursing care may impact on their health care experience.

The aims of the research are to elicit a rich description and make recommendations regarding the nurses' response to women who present to

either general practices or emergency departments with unexplained physical injuries suggestive of domestic violence. In this chapter a qualitative research design using semi-structured interviews and thematic analysis will be described, including the steps taken to establish the research rigour and maintenance of an ethical approach.

### **Participant Selection**

Points of initial contact for participants were with registered nurses working in general practices and emergency departments. A combination of purposeful sampling and network sampling was used in this study. While purposeful sampling was used in order to identify the group under study and to ensure the selection of participants met the study's needs, network sampling, a form of convenience sampling (Polit & Hungler, 1991) was incorporated in order to access additional participants. Network sampling takes advantage of social networks (Burns & Grove, 1993; Polit & Hungler, 1991; Morse, 1991).

Purposeful sampling is defined by Katzer, Cook, and Crouch (1982) as a "...nonrandom sampling technique in which researchers use their knowledge of a *population* [sic] to select a *sample* [sic] for a given purpose" (p.212). It occurs when the participants are selected according to their specific traits and to the needs of the study (Morse, 1991; Polit & Hungler, 1991). Polit and Hungler (1991) defined network sampling as the "...sampling of subjects based on referrals from other subjects already in the sample" (p.650).

Participants in the study were asked for their assistance in accessing other nurses who met the criteria for participation in the study. This was done by the participants providing the researcher's contact details to potential participants. According to Morse (1991), network sampling is based on the underlying assumptions that the participants are able to

distinguish “insiders” from “outsiders”; they know who would fit into the study’s criteria; and they are qualified to recommend who would provide the best information or interview.

The decision to use purposeful sampling of nurses from general practices and emergency departments was made to reduce variability by defining a relatively homogenous population of nurses with similar practice experiences. This was based upon the assumption that women were more likely to leave the confines of their home and present to nurses in general practice and emergency departments for health reasons related to themselves. By contrast when nurses or midwives visit women in their homes, the visit may be related to other reasons, such as the health of a child.

Polit and Hungler (1991) have suggested that extraneous variables, such as factors influencing the heterogenous nature of the participant group should be identified and reduced. They also noted the risk of bias attached to this form of sampling exists in the selection process. In the case of the present study, the researcher and participants decided who was appropriate for inclusion in the study - that is, the population and potential participants, respectively. Network sampling also results in participants being less independent of each other. Morse (1991), however, believed the sampling bias of purposeful and network sampling facilitates the production of rich and accurate descriptions of the phenomena under study in qualitative research.

## **Inclusion Criteria**

Six participants were included in this study. The criteria for participant inclusion in the study derived from the study’s aims. Participants were registered nurses who were required to have had contact with a woman or women with unexplained physical injuries within their nursing practice. The range of nursing experience was between 10-30 years. They were also

required to be able to reflect upon their experience(s) and articulate how they responded to, and worked with these women.

Access to potential participants in emergency departments was gained by liaising in writing to the Chief Executives of the local Crown Health Enterprises (CHE). A request was made to the Chief Executives of the CHEs for pamphlets (Appendix I) to be distributed to emergency department nurses requesting participants for the study.

Concurrently, pamphlets were posted to individual practice nurses whose names were known, or addressed to 'The Practice Nurse' of a general practice where names were not known. (While it was anticipated that practice nurses would be accessed primarily through the local practice nurse group, this group was apparently not well attended by practice nurses in the area. Contact with a group member suggested the information be sent to individual practice nurses.) Participants were also accessed by the network method. The relationship which was established with a participant was utilised in order to contact other participants.

## **Informed Consent**

Potential participants were given information and told how to contact the researcher if they wished to participate. All pertinent information concerning participation, interviews, analysis, management of the data, and dissemination of the study's findings, were contained in an Information Sheet (Appendix II). Formal consent to be interviewed was gained prior to the participant commencing in the study and recorded on the prepared Consent Form (Appendix III). Assurance was given to potential participants of the right to anonymity, confidentiality, and the right to withdraw either wholly or partly from the study. Opportunities were given for potential participants to ask questions and seek clarification on any matter prior to agreeing to take

part. Time was provided for the participants to consider the information before they consented to being part of the research project.

### **Methodological Underpinning**

The use of grounded theory in this study provided a structured framework to inform and guide the collection of data and its analysis. Grounded theory has its theoretical underpinnings in symbolic interactionism (Benoliel, 1996; Chenitz & Swanson, 1986; Corbin & Strauss, 1990). Symbolic interactionism:

focuses on the meaning of events to people in natural or everyday settings...The reality or meaning of the situation is created by people and leads to action and the consequences of action (Chenitz & Swanson, 1986, p.4).

Grounded theory is oriented towards discovery, and the explanation of fundamental patterns which occur in social life. Therefore, a focal point of grounded theory is its grounding in the data, and relevance to nursing practice as any theory or knowledge generated is grounded in practice (Chenitz & Swanson, 1986). The focus of this study is on rich description of the responses of nurses toward women experiencing partner abuse, rather than on generating theory. However, the knowledge generated from this study is grounded in the nurse's experiences and will direct further areas of research.

The data collection and analysis occur simultaneously in grounded theory - a feature of constant comparative analysis. Comparative analysis is the analysis of incidents which are compared for similarities and differences. The analysis of data occurs through a process of coding, and the writing of memos which become increasingly complex and deep as the data analysis proceeds. Abstractions of the coded data formulates the categories of

theoretical codes which are intended to bring together multiple perspectives into patterns and processes of action and interaction (Glaser & Strauss, 1967; Glaser, 1992). The properties of the categories and the context within which they occur can then be identified and related to each other.

The debate between Barney Glaser and Anselm Strauss (Benoliel, 1996; Glaser, 1992), the original proponents of grounded theory, is worthy of a mention. Glaser (1992) criticised both Strauss and Corbin for entering into 'forced' questioning of the data during analysis and thereby compromising the grounding of the theoretical codes (categories) in reality. Glaser (1992, p.4) stated:

The researcher must have patience and not force the data out of anxiety and impatience while waiting for the emergent. He [sic] must trust that emergence will occur and it does.

While the framework used was one outlined by Corbin (1986a, 1986b), the process used in this study responded to Glaser's plea that patience and trust are required for the emergence of the categories. The patience and trust in the data relevant to this study will be discussed in the section related to data analysis.

### **Data Collection**

Semi-structured audiotaped interviews were carried out with individual participants in order to elicit their stories of how they responded to women with unexplained physical injuries. Interviewing, which uses a variety of approaches, is a common means of collecting data in qualitative research (Burns & Grove, 1993; May, 1991). The data was recorded by using a combination of audio-taping the interviews, and the keeping of detailed field notes.

Burns and Grove (1993) have recommended that careful preparation for interviews be undertaken, including appropriate dress and punctuality. In order to establish an environment whereby participants felt comfortable and safe, participants selected the environment in which they wanted to be interviewed. The only condition placed on the selection of the environment was that it was quiet enough to allow the audiotaping of the interview, and that it was free of interruptions. Therefore, the environments were varied, such as the participants' homes and workplaces.

Pre-interview preparation also included ensuring the participant understood what was involved. A full explanation of what was required; reiteration of the purpose of the study; the fact that the interview would be tape recorded; that the researcher would take notes as the interview proceeded; that all responses would be kept anonymous; that at any stage the participant had the right to withdraw from the study; and that the possibility for publication of the research findings existed, was made prior to the interview commencing.

The semi-structured approach to the interviews maintained the flexibility necessary to explore issues and areas of interest as they arose. Participants were asked questions such as *Tell me about a time when a woman presented to you with 'unexplained' physical injuries? How did you respond? On reflection, how effective were you in those situations? Could you have been better prepared? Do you think you were prepared to effectively respond to these women? Tell me about the preparation you have received? In your view what preparation do you think nurses require?* An attempt was made to keep the questions open-ended to elicit individual nurse's stories, yet focused enough to ensure the aims of the study would be covered. These questions were developed to reduce ambiguity and minimise researcher bias.

A high quality tape recorder, placed strategically, was used to record the discussion. As May (1991) recommended, the tape recorder was left running until the researcher left the interview environment. If this was not possible and any important information was divulged during the termination phase of the interview, either field notes were made or an addendum to the audiotape was recorded. Each interview and audiotape was coded. For example, an interview with a practice nurse was given a '10' code, and an interview with an emergency department nurse was given a '20' code. Then each participant was allocated a number from one to six, for example, and this number was then added after the 10/20 code. An interview would, therefore, be coded, for example 101 or 204.

The audiotapes were transcribed *verbatim* as soon as possible after each interview to enable the analysis of each individual interview to be undertaken, and a comparison between each of the interviews to be made. The transcribing of the interviews was undertaken by the researcher and a person employed to transcribe the audiotapes. The person employed to transcribe the audiotaped data was required to sign a Declaration of Confidentiality (Appendix IV). The participant's anonymity and confidentiality was ensured by each participant being given the option to choose a pseudonym or be assigned one. The master copy of names and codes were kept in a locked cabinet separate from the data, along with the signed consent forms.

A record was also kept by the taking of unobtrusive notes during the interview, and the making of fuller notes immediately after the interview had been terminated. These were kept in a journal entitled *Field Notes* (Chenitz, 1986) and formed part of the data for analysis. A reflective journal was also kept by the researcher throughout the research, recording critical insights and reflections upon the study. The reflective journal in research according to Lipson (1991), encourages the development of self-awareness. The journal allowed the documentation of the researcher's personal position,

whereby personal biases and feelings were disclosed, along with ideas, fears, problems and the process for solving them, and the 'a-ha' experience. The reflective journal also formed part of the data for analysis, especially any observations which had been made in its entries.

### **Data Analysis**

The interview transcripts, field notes, reflective journal, and literature formed the data for this study and were subjected to analysis. The analysis of data used a grounded theory approach. Due to the size of this study and the time limits involved in producing a thesis, it was intended to elicit a rich description and make recommendations rather than a theory from the data collected.

As previously stated, the approach taken was that described by Corbin (1986a; 1986b) and Swanson (1986). The data was initially coded into categories. Coding was achieved through a process of comparative analysis, and by asking questions of the data, and reducing the data into incidents and facts by undertaking a line-by-line analysis. Once the data was coded, categories (abstractions of the data) were formulated. These categories were defined and developed by establishing the properties for each category, the conditions under which the category occurred, strategies undertaken, and the consequences for actions.

Saturation of the categories occurred when no additional data was discovered to further develop a category (Glaser & Strauss, 1967). Saturation was identified by recurring and similar incidents or facts. Theoretical sampling was used where data was gathered from later participants using open-ended questions specifically related to evolving categories. The categories were then examined for similarities and differences. This process used a variety of data, which included past experiences, literature, and any conceptually related situation.

Memos were made for each category, and formed a written record of the analytical process which were filed in folders. The memos were dated, titled, and cross-referenced to the piece(s) of data which triggered the memo. Initially, each memo summarised the piece of data under analysis and was followed by a description of the analytical process undertaken. Interpretations of data were checked by the research supervisor reviewing unmarked transcripts and comparing the researcher's findings. The memos were invaluable in tracing previous thought patterns and the decision-making processes.

### **Establishing Research Rigour**

Due to the study's qualitative methodology, it was essential to establish its rigour or trustworthiness. This enables the reader of the final report to audit the events, influences, and actions of the researcher. The constructs of credibility, transferability, dependability, and confirmability, as outlined by Lincoln and Guba (1989), were used to establish the study's rigour. An audit trail (Appendix V) based on the auditing concept described by Halpern (1983, cited in Lincoln & Guba, 1989), was developed to enable the researcher to ensure the study's trustworthiness. The audit trail also enabled any reader to audit the research process and the influences of the researcher on the data collection and analysis throughout the study.

Credibility is the criterion where the study's findings are found to be credible by the reader of the research report. The study used activities which assured the likelihood of the findings and interpretations being credible. These activities, as described by Lincoln and Guba (1989), included:

- (a) Prolonged engagement whereby the researcher became familiar with the context, minimised distortions in interpretations, and built up a trust relationship;
- (b) Persistent observation which enabled relevant characteristics and factors to be identified;
- (c) The utilisation of different data sources;
  - i. as the findings of the study emerged they were compared with different sources of information, such as literature;
  - ii. all documentation related to the study was kept to enable its verification.
- (d) Peer debriefing which allowed the external checking of the process. Regular 'analytic' sessions were held with the research supervisor to expose aspects of the inquiry which could covertly remain with the researcher;
- (e) Referential adequacy was achieved by the data collected being available for later analyses and interpretations;
- (f) Member checks, whereby interpretations and findings were informally checked with members of the groups from which data was collected.

Transferability was achieved by providing a description in sufficient depth for the study's findings to fit into contexts outside of the situations described in the study. Therefore, nurses other than practice or emergency department nurses would recognise and make judgments about the study's findings transferable to their own contexts.

Dependability was achieved by providing a clear and detailed description of the decision trail which enabled the research process to be audited. The audit trail (Appendix V) allowed the process of inquiry and records to be authenticated for accuracy, thus establishing the criterion of dependability.

Confirmability was gained by keeping a reflective journal and memos which demonstrated the way in which data findings, interpretations, and recommendations were made. Confirmability also required the establishment of credibility, transferability, and dependability, thus dovetailing into the audit trail.

### **Ethical and Legal Issues Related to the Study**

The ethical and legal issues related to research have become a serious issue in the formulation of a research proposal and then undertaking it. Certainly in New Zealand since the National Womens' Hospital *Unfortunate Experiment* (Coney, 1988), as it became known, the ethics related to research have become an important issue. Therefore, in designing this study the ethical and legal considerations were an important feature, not only in protecting the participants, but also in ensuring this study achieved ethical and legal credibility.

The research proposal which was developed for this study was submitted to the Massey University Human Ethics Committee and the Bay of Plenty Ethics Committee (a regional committee set up under the Regional Health Authority (RHA)). In the development of the research proposal the ethical issues of access to participants; informed consent; anonymity and confidentiality; potential harm to participants, the researcher, and the university; participants right to decline to take part; uses of the information; and conflict of interest were carefully explored and the implications considered. The following legal issues and legislation were also explored and any implications considered within the context of the study: Intellectual property; Human Rights Act 1993; Privacy Act 1993; Health and Safety in Employment Act 1992; Accident Rehabilitation Compensation Insurance Act 1992; Employment Contracts Act 1991.

## **Summary**

In order to describe how nurses recognise, and work with battered women, a qualitative research design was used in this study. Semi-structured interviews were conducted with registered nurses working in general practices and emergency departments. Each interview was analysed utilising a grounded theory approach, through a process of coding data into categories, which were then defined and developed. The ethical and legal issues relevant to this study were described. An audit trail was also constructed in order to ensure the study's trustworthiness. The following chapter will present the findings of the study.

## Chapter 4

### Data Analysis

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#### **Introduction**

The analysis of data revealed four themes relating to the nursing experiences and practices of the participants: *Not Seeing*, *Seeing But Not Seeing*, *Seeing But Acting Ineffectively*, and *Seeing for Effective Action*. These themes relate to a core concept entitled *The Looking Glass* (Figure 1). *Through The Looking Glass* offers different perspectives of similar situations. These perceptual differences are dependent not only upon who is looking into and beyond the *Looking Glass*, but what they have brought with them. This may be prior knowledge and understanding of a situation, personal experience along with personal and institutional biases, and prejudices. The analogy of *The Looking Glass* describes how the participants' responses to women experiencing partner abuse differed. The differences were dependent upon prior preparation for working with women who have experienced partner abuse, and personal experiences.

The themes:

*Not Seeing* relates to the non-recognition of women who experienced partner abuse.

*Seeing But Not Seeing* involves an awareness of women who presented with injuries and other ailments related to partner abuse, but for various reasons the choice not to see the injuries or the women was made.

*Seeing But Acting Ineffectively* relates to the recognition of women who experienced partner abuse, however, as a result of inadequate

preparation in the area of family violence subsequent actions are essentially ineffective.

*Seeing For Effective Action* differs from the previous three themes in that it does not directly relate to how nurses respond to battered women. It does however, reflect the participant's recognition and articulation of the preparation required to enable them to act effectively.

Each of these themes will be described in detail in this chapter.

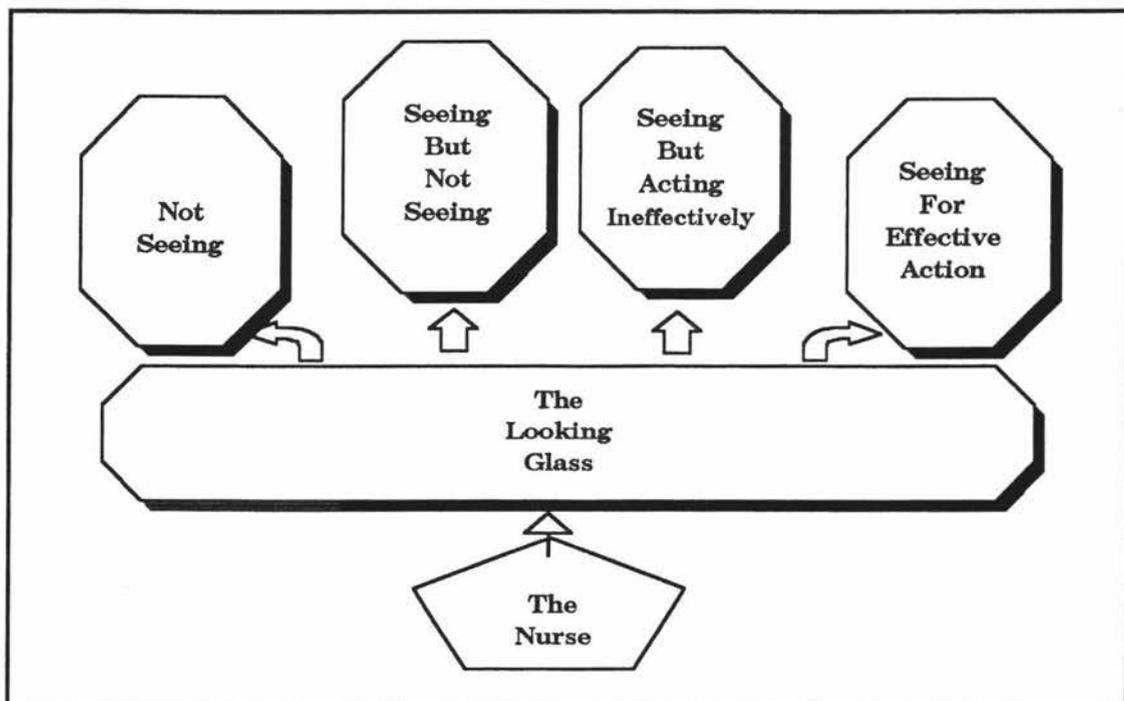


Figure 1. Through The Looking Glass

### **Not Seeing**

*Not Seeing* refers to nurses who do not recognise or acknowledge women who have either experienced partner abuse, or who present with injuries suggestive of partner abuse in the course of their practice. *Not Seeing* is reflected in a number of ways: the response rate to the study; those potential participants who stated they had not seen any abused

women; the contrast between early practice and later practice; and the nurse's lack of preparation in the area of family violence.

The response during the participant selection phase of the study was disappointing. While it was difficult to calculate the exact response due to the use of both convenient and network sampling, an indication of the degree of the response was ascertained. Pamphlets requesting participants were sent to 92 General Practices, who employed one or more practice nurses, and to three Emergency Departments with a total of 56 Emergency Department nurses. Six nurses volunteered to participate in the study, with three coming from network sampling, working in areas where no pamphlets were received.

One prospective participant, writing on behalf of herself and another nurse, stated:

*...we don't feel we have anyone suitable for your study... (file letter)*

A number of prospective participants verbally expressed an interest in participating in the study, however excluded themselves on the basis that they did not meet the study's criteria. These nurses all anecdotally stated they had not seen any women in their nursing practice with injuries suggestive of partner abuse. As prospective participants were required to reflect upon an incident in their practice, the inability to identify such an incident created an inability to participate. One potential participant provided some interesting anecdotal evidence, following the data analysis phase, supporting the finding that nurses were not seeing women experiencing partner abuse. This nurse described looking after a woman who had re-presented with injuries suggestive of partner abuse. The request to participate in this study triggered her to reflect on what she was seeing. What followed was a realisation that she had in fact seen women fitting this profile in her prior nursing practice. While '*Not Seeing*' women who have

experienced partner abuse could account for the poor response rate, the reticence of nurses generally to engage in research could also be a contributing factor.

A contrast existed between what one participant termed early practice and later practice. Early practice depicted a period of 'Not Seeing' abused women due to the nurse's immaturity and naivety; functioning on stereotypes, such as only connecting abuse with aspects such as bruising to the eyes and arms; altered emotional states in the women; and a lack of preparation in the area of family violence, resulted in participants not being able to identify battered women. The following epitomises this situation:

*...looking back to situations that I had earlier in my working life, I shudder then to think about...all these women that I didn't even notice, but I guess that's, you know that's life and experience and you know...we all learn as we go along [laughs]. (101/10)*

The participant went on to describe how a lack of awareness contributed to 'Not Seeing':

*And I'd have to say initially I'd never saw [sic] any women that had been physically abused and...obviously...I had seen, but I just hadn't been aware of what they were. (101/3)*

Awareness of abuse signified a turning point in nursing practice. This awareness brought about a recognition of suspicious stories and circumstances, and incongruence between the woman's story and the nature of her injuries. This was illustrated by a participant's account:

*...I still didn't see any [women] and was not 'til quite a few years later that I started recognising...suspicious stories and...circumstances that made me suspect that all wasn't what it appeared to be. (101/4)*

Maturity, life experiences, awareness, and confidence marked later practice. Up until this time, women experiencing partner abuse were not seen in the participant's nursing practice.

A lack of, or inadequate preparation, contributed to *Not Seeing*. Participants simply did not know what to look for. While it was acknowledged that nurses received preparation during their pre-registration education in areas such as communication skills, this was viewed as unhelpful. The preparation which did occur, happened "on the job" and through life experiences, as was aptly described by one participant:

*It's a situation you find yourself in and you learnt from, you learn as you go basically. It's not something that is actually taught on how to deal with these situations. What's the best way to approach things. And it is a tricky one - you know I think you have to be careful about what you say to people (201/5).*

A need for practical knowledge in the area of family violence was evident. Until this occurs and nurses are adequately prepared in issues of partner abuse, womens' explanations of why they have presented will be accepted blindly without question.

### **Seeing But Not Seeing**

For some nurses, an awareness of partner abuse existed and extended to the point of recognising the incongruence in a woman's story and the injuries she presented with. An awareness of partner abuse arose via a variety of informal sources. Life experience was one way participants gained an awareness. Other avenues were by reading, statistical information, and talking with others. Formal preparation regarding family violence and partner abuse was non-existent. These nurses, however, chose not to see the abuse, engaging in nursing activities directed at treating the injury to the

exclusion of the underlying cause of the woman's injury. These nurses were *Seeing But Not Seeing*. The choice not to see was dependent upon both situational factors and personal factors. Situational factors included aspects such as privacy, time, and a lack of protocols directing nursing actions. Personal factors include the sense of trust and safety, the nurse's sense of helplessness, the belief that it is someone else's problem, and the nurse's past experience.

Various situational factors influenced the decision to choose not to recognise a woman who presented as a result of partner abuse. The appropriateness of an environment impacted on privacy. A lack of privacy was a frequently cited reason for not exploring any incongruence detected in a woman's story and the injury with which she presented. Time was also another factor. A perceived lack of time placed constraints for firstly, building a rapport, then exploring any apparent incongruence, and finally for dealing with the resultant issues following disclosure. As one participant said:

*...you've got to spend some time building up a rapport with them [women] you can't launch into what could be, you know, quite a serious situation and also then if they do spill the beans you've got to know you have the time to deal with them. (101/4-5)*

The analogy of opening a 'can of worms' was used, whereby it was seen to be a lot easier to keep the can closed:

*...I don't know whether I would of sort of tried too hard to open up something you just didn't know where it was going to land up. (101/5)*

The reticence to open a 'can of worms' related to a lack of experience in dealing with any issues that may have arisen, as well as the time factor involved. Both the Emergency Department and General Practice were seen as a place to treat injuries and refer on. The acute setting was viewed as

inappropriate to intervene in, and explore any social issues a woman may have had:

*...really it's none of your business to go into that sort of area of social work and things like that. I mean as an ED [sic] nurse your first line is actually get them in a safe situation and treat their injuries and refer on because, I mean, it's obvious that you haven't got the skills, you know. (203/18)*

*...you know the way general practice is, it is just too busy, too pressured, not appropriate space all the time... (101/15)*

Actions by participants were primarily directionless and self-initiated as an absence of protocols to guide actions existed. It was recognised that while policies existed for child and elder abuse, no policies or protocols related to partner abuse. This gave rise to individuals interpreting what needed to be done. One participant functioned on a belief that a policy decision existed to provide only basic care, yet the confusion about what should be done is evident in the following passage:

*As far as I'm aware it is a policy decision that we're there to give..the basic care. We're not necessarily there to make assumptions and to assume that this man has beaten this woman up, and so therefore, we should refer her to 'Battered Women'. What we should do in fact is refer them to the Police and let them take it from there. In practice I don't know. Again it depends on the severity. (202/6)*

Personal factors also impact on whether a nurse chooses to see the abuse or not. The establishment of trust and safety, while seen as imperative, paradoxically created a situation whereby issues of abuse were not explored further, and thus contributed to the choice not to see. The nurses' need for the woman to trust the nurse was apparent. It was felt that the establishment of trust or rapport was essential in order to question any

perceived incongruence. This was further complicated by the perceived development of a trusting relationship requiring not only time and privacy, but also the ability to develop interpersonal relationships. One participant described a deficit in being able to develop a rapport:

*...If we don't have any easy rapport with people to start with, there is no way we are going to learn how to confront somebody about an issue...because I guess you have to have a lot of confidence in yourself, in your communication... (101/12)*

The issue of safety was highlighted by the participants with regard to challenging a woman over any perceived incongruence in her story and the injuries she presented with. Challenging a woman was seen to constitute abuse:

*We can accept what people say, I mean if it's really obvious, I've never actually faced a woman down and said, "No you're lying to me.", because I don't think there's a need for that, because basically in my mind anyway what I'm doing is abusing her by calling her a liar and she's already been abused and that's you know, that's not acceptable, not on my behalf. (202/11)*

Some things made it difficult to establish rapport and safety. Women who are either non-communicative or who presented under the influence of alcohol, resulted in the development of rapport being perceived as problematic:

*...she was quiet...very quiet and non-communicative, you know as far as talking to the staff even about just general things she was quite withdrawn as far as communicating with us. (201/3)*

*Most of the time the women that I deal with are drunk and it's very difficult sometimes to create any sort of rapport with someone who's drunk, it's really quite hard sometimes. (202/18)*

Also who was present with the woman made the development of a rapport difficult, especially if that person was the woman's partner. The presence of a partner evoked a concern for the woman's safety.

A lack of trust also existed with regard to the follow-up processes and the role of other agencies. While the need to follow-up was recognised, this did not necessarily occur. For some, there appeared to be a blind faith that follow-up occurred, despite processes not being put in place for it to happen. Women experiencing partner abuse, also expressed a lack of trust or safety in being referred to other agencies. A participant working in the community commented:

*...she was very distrustful of other agencies. Oh that was the other thing, she said she'd had contact with them before and nothing happened. She didn't. They were Government agencies and she wasn't happy with them. She wasn't happy to just talk about really what had happened there and 'Women's Refuge', she didn't want that either so it just, yeah that was her choice. (103/1)*

The nurse's continuity in the community was seen by participants to provide women with a sense of safety. Women approached nurses outside of the working environs and hours, on a social basis.

*..some of these women I see out...at a tangi or gathering. So some of the responses have not been necessarily in my role as a nurse practitioner but...they know I'm a nurse but I'm not at work...(103/7)*

At this time, these women would disclose the abuse they were experiencing from their partners and seek help and advice.

Feelings of helplessness when working with women experiencing partner abuse were prevalent. The inability to get through to a woman and to spend time with them contributed to feelings of frustration, powerlessness, a lack of control, and the perception of not doing a proper job. The feelings of helplessness engendered reactions, such as sadness, stress, anger, self-blame, and worry. Compounding the feelings of helplessness was a lack of preparation for working with women experiencing partner abuse. The following comments illustrate the helplessness experienced by the participants:

*I feel really sad for...and I do, I worry about them. I know that doesn't achieve anything, but I do...you know it does concern me...I guess if I feel that they haven't really listened or they haven't taken it on board, I think maybe I haven't done it properly. (101/9)*

*A bit helpless...Especially when you know somebody is a repeated victim of abuse but you can't get through to them, you know, that there is help available. (201/3)*

*...it makes me angry. And part of that anger I also think though is directed at the women too. Not so much for allowing herself to be in that position, but...because sometimes I see women, the same women come back and I think why, what are we doing, how come, no matter how many times we tell people, until they make the decision themselves they are not going to listen to you. (202/7-8)*

*And that's really frustrating, that's really hard as nurses and women to sort of, like, see people do that, you know, they're going back to the same situation. That's really hard, I won't cope with that very well. (203/6)*

*I think you just sort of, you get immuned [sic] to it. I mean there's nothing more you can do. A couple of times I've tried, you know, like I'll*

*ring up...the social worker and say, "Look, you know I'm really concerned about this lady"...and she'll come and see them but that's all you can do. You know you can't do any more, I mean that's it. And it is frustrating especially if it's sort of like someone...that's the third or fourth time that they've come in you just think, "Oh no not again." (203/6)*

*...you actually feel quite, so powerless you know, and you just feel like sort of shaking them, you know, thinking and saying, "Well look, you know why are you letting this happen to you," but I mean they just do, I don't know why. You do feel powerless. (203/8)*

*I asked her if there were any other bruises or injuries and she said, "No," and...I felt that I had to sort of really leave it at that...and she seemed reasonably happy in herself, she wasn't distressed or anything like that so...although I felt that I hadn't done a very good job. (101/1)*

Helplessness resulted in inaction, especially when previous attempts to act positively were thwarted.

While the participants readily dealt with the presenting injuries and ailments of women, they were less than willing to deal with the issues of partner abuse. This extended to the point of not confirming partner abuse as an underlying cause for a woman's presentation at an Emergency Department or General Practice. A readiness to refer onto someone else perceived to be in a better position to deal with the situation was evident - such as, the Police, the Social Worker, Womens' Refuge. This effectively passed the problem onto someone else. In some situations, the participants did not provide any of the choices available for battered women, it was someone else's task:

*...my view is that I take what I can do and then refer onto these so called other experts [not specified]. (103/12-13)*

*...certainly I try very hard to find some reason to refer them to the counsellor (101/3)*

The assumption was made by one participant that the Emergency Department was not the place for these women to take on information.

*I think in...cases where there is suspected abuse or something...in, like, in the A & E [sic] Department that perhaps a referral needs to be sent to a Social Worker, or somebody should come and talk to that person within that next day to either confirm or establish that there is no abuse going on so that person is covered... whether or not they [woman] take the help that is offered, but if it is not offered they can't take it...I don't think you can give those choices straight away to somebody who's in pain, who's just presented to A & E with, they can't take all that sort of information. (201/8)*

Choosing not to see occurred when nurses acted upon assumptions not validated. For example, the participant, referred to earlier, who did the "basics", left a woman to the doctor and was astounded to receive feedback, by way of a complaint, that she was inconsiderate of the woman's needs:

*...I'll do the bits and pieces that need to be done, and you know basic courtesies and then I'll leave because I knew that people were coming in as well and I knew that the doctor that was attending was an absolute sweetie...so I went in there, introduced myself, did the very basics and left...About two or three weeks later I got this complaint and it was really quite interesting that the woman herself felt that I was inconsiderate to her needs. (202/26)*

One participant's story, included a personal history of family violence and partner abuse. Recognition of the nurse's personal experience of family violence and its impact upon the nurse's ability to be effective in her/his actions in situations involving partner abuse is vital, and may account for some nurses *Seeing But Not Seeing*. The enmeshment of a nurse in a

personal relationship marked by abuse and violence, may impact on her ability to firstly, recognise others in a similar situation, secondly be able to make appropriate decisions, and thirdly to act without the “baggage” which comes from such relationships.

### **Seeing But Acting Ineffectively**

*Seeing But Acting Ineffectively* refers to the recognition by nurses of women experiencing partner abuse, however their actions are ineffective. Ineffective actions are primarily related to the inadequate preparation of nurses, therefore leaving them to rely upon learning derived from trial and error practices, and the beliefs and stereotypes they bring with them. *Seeing But Acting Ineffectively* involves women not behaving as expected, the belief in the women’s right of choice, and subsequent ineffective actions:

*...the cases that I have seen have been in general, you know sort of like...that, “I want you to know, and there’s no way you’re going to find out,” and the other ones are that you know, even if you do know, they don’t want to talk about it...(203/23)*

The above example typifies the difficulty nurses have when women experiencing partner abuse present. These women do not always behave as expected. The stories women tell in order to explain their injuries range from being convincing to being obviously unbelievable. Obviously unbelievable stories resulted in participants detecting incongruence in the women’s stories when related to the presenting injuries. Detection of an incongruence is aided by a knowledge of how injuries occur:

*Things like they’ll say, “I walked into a wall or a cupboard,” but you know, like, I mean if it’s in their eye you know they’ve got a cut on their eye. Walking into a cupboard you’d usually have a puncture mark or something below the eye or around the socket, whereas a punch in the*

*eye you usually split the top of your eye. Those sort of things you know. One to the side of the head, they'd say, "Oh, I fell," or something, but usually if you actually fall on your head you usually don't split the bottom ear. Whereas if somebody slaps you or hits you often you've split that ear, if they've got earrings in especially... (203/11-12)*

Some participants, however, stated the incongruence in terms of telling lies:

*...with the way the injuries are and how they did it. People lie, women lie, I don't know, you know, why they lie. (202/1)*

*...sometimes they can let out clues that they're telling lies... (103/8)*

Attempts to validate any incongruence were often unfruitful, yielding neither a disclosure or adequate explanation, with some receiving a simple statement to the effect that it is none of the nurse's business. The women would often not engage in any discussion:

*...We just say to them, point it out that it is unlikely that this would happen falling down the stairs when you've got...a cut underneath the chin...and they usually just say, "Well, that's what happened," you know or shrug their shoulders and just not answer you. (203/11)*

*...only occasionally do they say and then they've always qualified it - "but he doesn't always do it," or...you know there is always a reason or excuse. (101/8)*

In describing the socio-cultural make-up of the women who present to Emergency Departments, there is recognition that women experiencing partner abuse have few options in terms of their health care. One participant stated:

*...if you go to hospital for your injuries you don't have to pay...and a lot of these women, well most battered women as far as I'm concerned*

*don't have any money because it's another way of men having power over them. (203/20)*

While the economic plight of these women is a reality, nurses do hold stereotypes regarding women experiencing partner abuse, explaining why women do not appear to behave as could be expected.

Stereotypes related to the expectations about the nature of the injuries the women present with. For example, one participant expected women to present with visible bruising and an alteration in their emotional state. Thus, any forthcoming explanations about an injury were often accepted without doubt. Participants often had no way of knowing whether an explanation was congruent or not, and relied upon the stereotypes they held to assist them in assessing a situation, such as a woman's emotional state. There was also an expectation that the woman needed to be in an established male-female relationship, and therefore one participant would not expect a male or someone not in an 'established' relationship to be a recipient of partner abuse. If a woman had been drinking, this also raised suspicion:

*Because if they've been drinking...I think then if they've been drinking maybe their partner has been drinking...a bit there is perhaps more likelihood of things happening. (101/8)*

A partner being present affected the way in which women behaved, appearing faithful, happy, and made excuses. This facade, which appeared to be aimed at the woman preserving her safety, created difficulties for nurses to act effectively:

*Well they appear to be happy, I mean I'm not you know I haven't followed them all up, but they certainly are very, they seem very faithful to their partners...it's very easy to excuse their behaviour, "Oh, it's just the drinks, he's fine when he's not full." (203/10)*

Normalisation of abuse by the women, themselves, makes it difficult for the women to realise that the abuse they endured is not something which needs to be endured. This in turn makes it difficult for the nurses to act in an effective manner:

*...if the family, you know where your mother has been pushed around by your dad...they don't see it as abuse. I mean it maybe just part of family life...a lot of times, okay it might be just a bruised arm or...a graze or something, and the woman doesn't understand that...potentially it could be a lot worse. (101/4)*

Women also presented with ailments seemingly unrelated to partner abuse. One participant observed women going to the doctor for something related, for example, to their menstrual cycle. However, the participant noted that when these women spoke to her, it was often family-related and indicative of "mental abuse":

*...The ones I've seen don't do that [disclose], they come in with an excuse or something. (103/7)*

The woman's right of choice influenced whether the participants choose not to see, even if the woman's story was not believed. The right of choice extended to allowing obviously inaccurate stories to be left, to leaving the women to talk or not to talk, to declining interventions, and to choosing to go back home to their partner. One participant succinctly stated:

*But I guess it's like you can lead a horse to water but you can't make them drink...I sort of think well if they don't really want to talk about it, I can't. I can't actually do a lot" (101/9)*

The right of choice, however, also went hand-in hand, for some, with the belief in the provision of support until the woman decides she has had enough and decides to leave - a process recognised to take time:

*All that you can do is give her the support that she needs or as much support as she wants and that's it until she decides that she's had enough. (202/25)*

The right of choice occurred to the exclusion of the nurse validating what the woman wanted and appeared at times that the nurses acted on assumptions not validated. One participant, as previously mentioned, described doing the "basics" for a woman, leaving her in the hands of the doctor, then was astounded when the woman described her as inconsiderate. The participant had assumed that the woman did not want her around.

While effective actions were used, these were a rarity rather than the norm. For example, one participant did use an effective opening question when working with these women, "...do you want to talk about it?" The provision of space and "being with" a woman was also seen as an effective way to communicate understanding and support by one participant. This approach often resulted in disclosure, despite no expectations being placed on the woman to disclose; the participant simply did not want the woman to be alone:

*...[I] didn't have to say anything, just sit there, look at them, and just feel that something's not right and put my hand on their shoulder or whatever and then they start crying. If they don't openly tell you, "Oh, I've come in because my husband's hit me," because they don't, - the ones I've seen don't do that, they come in with an excuse or something. (103/6-7)*

The primary underlying reason for the nurses' ineffective actions lies in the lack of preparation nurses receive, related to working with issues surrounding family violence, particularly partner abuse. Ineffective actions can result from a variety of reasons, such as the woman's non-

communicative nature, a lack of time and rapport, or due to an inappropriate environment.

There was a tendency for the participants in this study to refer the women onto someone else, missing opportune times to provide women with information and options. An assumption was made that someone would follow-up the woman. While it was recognised that a need for follow-up existed and was necessary, one participant described a quandary as to who was undertaking the follow-up:

*...I mean it's sort of like the next day that someone usually, because it's...2-3 o'clock in the morning or late at night and...they're tired, they need to rest, so you sort of follow up the next day. So I'm not sure...of who actually follows them up... (203/5)*

Some participants carried on as normal, not saying anything to the women, while others maintained an injury focus, prioritising interventions based on the 'ABCs' (Airway, Breathing, Circulation). While a revolving door was maintained whereby women are treated only to return again, this reinforced a doubt as to how far to go with nursing actions for a woman who was only going to return again. The use of subterfuge was also employed in both the recognition of abuse and referrals:

*I asked her to take her clothing off and I did not give her the opportunity, the privacy which I normally would you know, "You take your clothes off, pop this gown on, I'll be back in a minute," I stayed in the room sort of puttering around, and she had bruising all over her back, all over her rib cage, and she had thumb marks, finger marks on her hip...and she miscarried... (202/12-13)*

*If they say they are not sleeping terribly well I sort of say, "Well, a counsellor could give you some strategies of how you might be able to help sleeping," then I would make an appointment and have a chat to*

*the counsellor and ...express what my concerns are. So I guess I try to get them there under false pretences [laughs]. (101/3)*

Actions were also influenced by the attitudes of others:

*...it's really hard because when they [police] come in with these people you know they often say to you, "Well, this is the second time in the last three months that we've brought this woman into you," and it's really frustrating for them because they've twice gone to Court and she's pulled out or something like that, and so they're sort of...lack of sympathy for want of a better word, does actually rub off on you when they come in. In that sort of case I wouldn't...attempt to sort of make sure that anyone rung a social worker, and that, and I mean is that wrong? It sounds wrong when you're talking about it, but in the situation you think oh it's not worth it... (203/16-17)*

A general inability to explore any incongruence existed. Non-disclosure resulted in a tendency not to press the women for an explanation, although opportunities were sometimes provided for a woman to give more information:

*We just give them information generally that, "It's unlikely that this would have happened falling down a stairs. Do you want to you know, give me any more information... (203/4)*

Previous negative reactions to the exploration of incongruencies often thwarted future attempts to explore them.

### **Seeing For Effective Action**

The apparent inadequate preparation of, and support for nurses to work in the area of family violence, specifically with women experiencing partner

abuse, has led to an inability to meet the needs of these women. This study highlights the need for a specific course related to partner abuse, especially as battered women are high users of a broad spectrum of health care services:

*I think, maybe, some sort of courses or teaching sessions could be run on how to...approach the issue if you suspect something, how to approach it, what is the best way to approach it...Some ways are quite confrontational and other ways are not, so...I think its being taught the best ways to go about asking questions that will not alienate or put the back up...that person... (201/6)*

All participants were able to clearly articulate the requirements to become more effective when working with women experiencing partner abuse. *Seeing For Effective Action* can be divided into two main areas: Educational Preparation and Workplace Assistance.

Educational Preparation incorporates two foci - recognition of partner abuse and enabling disclosure. While it was acknowledged that some aspects of the preparation identified were components of pre-registration education, these were seen to be both inadequate and unhelpful:

*Training in nursing is lost. It hasn't been learnt properly, or assume its been learnt. Nurses take on another stance or ignore it and go along. Ethical considerations are ignored. Instead of "bucking the system", nurses go with the flow. How is training nurtured? (103/14)*

Also apparent was the lack of development in the area of communication skills post-registration, with trial and error learning being predominate. Any course developed requires an appropriate balance between theoretical, up-front learning, and experiential learning methods, such as role play, scenarios, and psychodrama.

Recognition of partner abuse encompasses the broad and specific issues related to family violence and partner abuse. The content identified included prevalence, the context within which abuse occurs, abuse pathology (including the psychological aspects involved), behaviours women present with (including traumatic bonding, hostage response, and posttraumatic stress syndrome), mechanisms and patterns of injury, relevant legislation, and breaking the cycle of violence.

Enabling disclosure is aimed at the development of knowledge and skills essential for improving the nurse's ability to relate to battered women. It also involves creating a safe environment conducive to the non-judgmental acceptance required, enabling women to disclose the underlying reasons for their presentation to health services. Enabling disclosure covers content areas such as communication skills, self, environment, and the facilitation of self-determination by women. Communication skills includes listening skills, therapeutic relationships, counselling skills, conflict resolution skills and confronting incongruent explanations and observations. The development of self aims at developing an ability to be supportive and less threatening, as well as learning to trust instincts or intuition. It is about being safe when working within a battered women's culture. Creating a safe environment, in the broader sense, is a component of communication skills, as the nature of the environment influences the establishment of an effective relationship. In order to assist women in their ability to make decisions, nurses require knowledge regarding the facilitation of self-determination.

The need for Workplace Assistance was apparent, in the forms of guidelines for action, Employee Assistance Programmes, clinical supervision, and critical incident stress debriefing. Agencies currently lack guidelines or protocols aimed at guiding the actions of health professionals working with battered women. The development of guidelines covering aspects such as expected actions, referral processes, documentation, and

the identification and use of community resources is essential to enable nurses to act effectively:

*...you've got to have a guideline or a system in place that is actually going to take someone through and not just leave them at the doorstep on their way home...it's mainly...knowing what you can do, and having a system in place that actually works. (203/19-20)*

Critical incident stress debriefing is necessary for the development of nurses, especially in addressing the emotions experienced associated with helplessness, such as anger, frustration, sadness.

*...a training issue, you'd need to look at yourself, you'd need to go through you own personal baggage ... (103/12)*

While it was acknowledged by participants that experience was essential for learning in the area of family abuse, that experience was not used or developed in a constructive manner. Critical incident stress debriefing would enable nurses to work through the experiences of working with battered women, undergoing an examination of self and the impact that self on the relationships established with women experiencing partner abuse.

## **Summary**

The analysis of data revealed a core concept of *The Looking Glass*. *The Looking Glass* provides the observers of women experiencing partner abuse with differing perspectives. *Not Seeing*, the non-recognition of battered women is the result of the inexperience and naivety of early practice, together with the lack of preparation in the area of family violence. *Seeing But Not Seeing* is the choice not to see battered women despite being aware of their presence. This choice is based upon situational factors, such as trust and safety, helplessness, the absolving of responsibility, and past

experience. *Seeing But Acting Ineffectively*, is the recognition of battered women, yet subsequent actions are devoid of effectiveness. The ineffective actions derive out of inadequate preparation, misunderstanding, the behaviours of women, and the belief in the right of choice. *Seeing For Effective Action* differs from the previous themes, but reflects the participants' responses and outlines the support required for the development of effective action. The foci are educational, which enables the recognition of abuse and disclosure, and workplace assistance in the form of protocol development and support such as critical incident stress debriefing. The findings related to the data analysis will be discussed in the following chapter.

## Chapter 5

### Discussion

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#### **Introduction**

The metaphor, *Through The Looking Glass*, provides an explanation of why nurses as the observers of women experiencing partner abuse, view and subsequently act with differing perspectives. The findings of this study contribute to the literature which already exists relevant to partner abuse. Both anecdotal and research based literature support the findings. That is, the nurses, as health professionals are not responding to the health care needs of battered women, and they require education and support to improve their responsiveness. The use of grounded theory to guide the analysis of the data has resulted in the findings being grounded in the practice experience of nurses. Limits did, however, exist in the use of grounded theory and these were essentially related to coming to terms with the constructs of grounded theory, which occurred as the methodology was put into practice.

This section will focus on a discussion related firstly, to the strengths and limitations of the research design and method, and secondly, to the findings, and finally to strategies aimed to improve the nurses' responses. Various aspects have arisen out of the method used and the findings, such as the nurse's ability to respond, connecting with the women, and the development of response. These are worthy of further exploration and discussion in relation to the findings of this study. Also discussed will be the concepts considered to be either fundamental or central to nursing practice. The concepts of caring, (w)holism, advocacy, and partnership will be discussed in

relation to the findings and the rhetoric which exists within the nursing literature.

## **Research Design and Method**

### **The Use of Grounded Theory**

The core category and themes which emerged are reflective of the data collected and are grounded in the participant's responses. An attempt was made to stay true to the method, and this was achieved through the processes of comparative analysis, coding the data, and in the formulation of the categories in order to describe the findings. Saturation of the categories occurred with relative ease, and therefore made the findings more relevant to the realities of practice. As this study is a preliminary study, grounded theory was used to provide a rich description rather than the generation of a theory.

Being a neophyte researcher did pose difficulties in explicating the grounded theory methodology. An underlying urge existed to leave the analysis until all of the data was collected. However, this opposes the notion of theoretical sampling which requires prior data to be analysed in order to inform the next phase of data collection. This concept required working through, to enable the theoretical sampling to be used more effectively. The organisation of data (which will be explained in more depth in a following section) was essential in enabling the processes of comparative analysis, coding, and category formation to be undertaken.

### **Participant Selection**

Participants in this study were confined to Practice Nurses and Emergency Department nurses for the purpose of having a relatively homogenous group in terms of experience, and in the reduction of variability. The participants were required to have had contact with women presenting

with injuries suggestive of partner abuse, and possess an ability to reflect upon, and articulate their experiences. This posed a difficulty in the participant selection phase, as feedback from interested nurses together with the findings of the study revealed that these women were not necessarily being recognised by nurses. Another issue, highlighted by a participant was the use of the term "unexplained physical injuries". As the participant rightly pointed out:

*...most of them, no in fact all of the ones that I've dealt with, they've had a reason. (202/1)*

The term was intended to attempt to probe beyond the level of suspicion, that is explore what nurses did when the presenting injuries were inconsistent with their explanation or an admission of being battered existed. In planning the pamphlet (Appendix I) which went to participants, for the sake of simplicity the use of "unexplained physical injuries" replaced "injuries inconsistent with the explanation provided". A pilot study of the pamphlet was not undertaken. It could be questionable as to whether it did make a difference, however, a pilot study may have highlighted this anomaly. According to Burns and Grove (1993), a pilot study is useful in identifying problems and refining research instruments.

An invitation was extended by one Crown Health Enterprise (CHE) to introduce the study to potential participants and answer any queries the nurses may have had. The pamphlets had been circulated the week prior to the meeting. The setting was an Emergency Department staff meeting, which had some staff coming and going. One staff member in the early stages of my presentation enthusiastically volunteered to participate, which was heartening. However, at the conclusion of the presentation the other staff were blank and non-committal in their expressions with only one question being asked. At the completion of the data analysis phase of the study, one of the staff at the meeting recounted how at the time she believed she had

not seen any battered women. Since this time she realised that not only had she encountered such a woman, the meeting also triggered a further realisation that she had in fact seen many women when she reflected upon prior incidents - she had not recognised what she was seeing. Another meeting with a Unit Manager at a different CHE spoke of battered women in terms of radiological referrals. She also went on to say that although assessments were part of the nurses role, battered women were not assessed and not seen to be part of the Emergency Department nurses role. Sadly, this person was unaware of the valuable contribution she had to make to this study. Street (1991, p.1) argued that for nurses to survive they switch into 'autopilot' which enables nurses to "...meet the context-specific and idiosyncratic challenges of patient care". Subsequently, the 'autopilot' mode which enables the nurse to function does not incorporate the process of reflection.

## **Response Rate**

Researcher anxiety existed, related to the poor response rate of nurses volunteering to participate. Initially, it was anticipated that the study would involve 10 to 16 participants. It became apparent that this was not going to happen. Locally, nurses appeared to have an apathy toward being involved in research. This is often related to a variety of legitimate reasons, such as a lack of time, other commitments, and a mystification related to the research process. As the data was analysed, and anecdotal feedback was received, it became apparent that the poor response was reflective of the study's findings. A necessary reminder was also required regarding the small sample sizes used in qualitative research designs (Burns & Grove, 1993) and the value of rich data which evolved from the interviews. The richness of qualitative data is the cornerstone of qualitative research, allowing an in-depth examination of a situation, and as Sandelowski (1991) described, provides access and insight into the way human beings carry out their lives.

## Data Collection

Semi-structured interviews were used to collect data for the study. According to Burns and Grove (1993), interviews have the advantage of being a flexible technique which allows greater exploration of an area under study. Whilst a series of open-ended questions were compiled for use, a flexible approach was necessary as some participants provided detailed accounts, answering several questions at once; others required prompting or a change of questions. Some answers also required further exploration of an area as it arose.

Interviews, however, are not without their challenges as May (1991) phrases it. Burns and Grove (1993) commented on the need to assume that the information being provided is accurate. The participants in this study gave no indication that the information they provided was anything but accurate. The frankness with which they described their practice was seen as contributing to the richness of the data. Burns and Grove (1993) pointed out the issue of inconsistency between interviews, and this was evident in this study as no two interviews were the same. However, May (1991, p.193) stressed the need to balance consistency with flexibility and advised:

Consistency in qualitative research does not require that every informant be asked all the same questions; rather, the goal is to assume that questions, which appear to be important at a given point in the data collection phase, are asked of as many informants as possible, so that subsequent interviews can be informed by them.

Conducting the interviews in a flexible manner invited the risk that questions and hunches which arose from other interviews would not be explored when an interview took an unanticipated tangent. A strategy suggested by May (1991) was utilised in the preparation phase, where a systematic review of the field notes and previous interviews highlighted areas to be explored. While this was undertaken, difficulties did arise when two interviews were

conducted closely together, and the timeframe did not allow for a review of the first interview.

Other challenges described by May (1991), included the ability to use self effectively in developing rapport, gaining information, dealing with anticipated problems, recording, and managing large amounts of data. The establishment of rapport did not appear to be an issue in the study with all the participants appearing to be comfortable and willingly shared the information required for the study. The use of open-ended questions, non-specific language, and the reframing of questions in order to seek clarification and elaboration assisted in the gaining of information. In critically reviewing the transcripts, it was noted that a fine line existed between clarification and leading the participant, when reframing questions to reduce misunderstanding. In one incidence, the transcript revealed evidence of leading the participant, although this was a minor transgression as it did not influence the overall findings.

Effort was made to ensure a suitable environment was selected whereby comfort and privacy was maintained for the participants. All participants chose the environment selected. In one instance, however, the best laid plans went astray when the participant had workmen call unexpectedly to repair a kitchen appliance. This necessitated a shift in venue following the interruption, at the beginning stages of the interview. What resulted was a problem in audiotaping the interview, with the interview being mistakenly recorded with the tape in the LISTEN position. The value of taking notes at the time of the interview was highlighted, together with the writing up of a detailed summary of the interview on the discovery of the blank tape.

Another unanticipated problem, which caused some disruption during an interview, was that of dying batteries in the tape recorder. In trying to ascertain why the tape was not turning correctly, it took some time to realise

the problem was the batteries. This situation also stressed the need to carry spare batteries at all times.

Using a high quality tape recorder and a controlled interview process with only one person speaking at a time was beneficial in having the tapes transcribed and resulted in clear transcriptions. Leaving the tape recorder running until the interview had been fully terminated was also beneficial, as additional information of value to the study was shared in the process of being farewelled.

The management of data became an issue requiring systems to be set up. Each interview was coded, as described in Chapter 3. When each interview was transcribed, a wide right hand margin was created to allow for notes to be made, and the transcripts were double-line spaced. Following transcription, the transcripts were filed in labelled folders with dividers for each interview. Another folder, with dividers, was created for filing the codes and themes which emerged from the data. This also included the memo's written. Library searches and correspondence related to the study was also filed in a similar manner. A computerised programme was used to catalogue the literature used in the study. Roundtree (1996) also wisely recommended that one manilla folder be kept for each chapter of the study, whereby information related to a chapter could be filed and used in the writing up stages. This system for the management of data and related information was exceedingly useful.

## **Data Analysis**

The process undertaken for data analysis was that outlined in Chapter 3. While a Grounded Theory approach was used to guide the analysis of the data in order to elicit a rich description, it was not intended to be used to generate a theory. The data analysis was a process which required not only patience, but an implicit trust in the data - that it would come together.

Certainly, for a long time, especially when the data was coded, it appeared to be suspended in an orbit; moving, intangible, and elusive to being either categorised or named. Saturation of the codes occurred with relative ease, however, categorising them into meaningful categories and themes took time. This phase required the engagement of a lot of thinking about the data, not trying to force it, or place any preconceptions onto it. The old adage of "reward comes to those who wait" was particularly pertinent. Glaser (1992, p.45) stressed codes, categories, and names would "...just occur in the analyst's head as he [sic] immerses himself [sic] in the data..." Glaser (1992) goes further to describe the patience and trust required in the emergence of codes as they slowly become relevant. This process can be likened to the "a-ha" experience.

The use of field notes and a reflective journal was particularly valuable. Field notes were compiled by taking unobtrusive notes during the interview and the making of fuller notes after the interview had been terminated. These were kept in a journal entitled *Field Notes* and formed part of the data for analysis. A reflective journal was also kept, recording critical insights and reflections upon the study. According to Lipson (1991), the reflective journal encourages the development of self-awareness by allowing the researcher to document personal biases, feelings, ideas, fears, and the working through of problems. For example, the shock experienced and the perceived impact this had on the interview process was worked through in the reflective journal when a participant forcefully called women liars at the beginning of an interview. The reflective journal, especially the observations made within it, also formed part of the data analysis.

## **Ethical and Legal Considerations**

This study obtained ethical approval from both the Bay of Plenty Ethics Committee and the Massey University Human Ethics Committee. No ethical concerns related to this study were raised. To ensure anonymity, it was

helpful during the tape recording of the interviews and the subsequent transcription of the interviews to avoid using the names of the participants. The avoidance of using the participant's name during the interview was explained prior to commencing the interview.

One legal concern which has been emphasised by this study is related to the Health and Safety in Employment Act 1992, specifically to employee inaction being defined as a 'hazard'. The non-recognition by nurses of women who have experienced partner abuse, or the ineffective actions or inactions of nurses may be an actual or potential cause or source of harm as defined under the Act. Under section 15 employees are required to take steps to ensure employees actions or inactions will not harm any other person, in this study battered women. The findings, especially *Seeing For Effective Action*, would be helpful for employers of nurses, who may come into contact with battered women, to develop strategies for nurses to become more effective and manage risk.

## **Establishing Research Rigour**

As outlined in Chapter 3, it is essential to establish the study's rigour or trustworthiness when utilising a qualitative methodology. Lincoln and Guba's (1989) constructs of credibility, transferability, dependability, and confirmability were used to establish the study's rigour.

In establishing credibility, the researcher spent a prolonged time period engaged with the participants and the data in order to establish familiarity with it and the context. The process required a persistent engagement in order for the categories and themes to emerge which are both relevant and credible to the reader. The findings were compared with other sources of information, such as literature, and all the relevant data for the study was filed and stored for future verification. Peer debriefing occurred in the form of regular conversations with the research supervisor. These sessions proved

valuable in critically exploring issues as they arose, in checking and reviewing unmarked transcripts for discussion, and presenting alternative perspectives on the data. Member checks were carried out informally by discussions with nurses regarding the findings as they arose.

Transferability was achieved by documenting the findings in a way that could be applied to contexts outside those which the study explored, that is practice nurses and emergency department nurses. Rather than being specific to either situation, the final core category and themes which emerged were abstractions of the raw data and thus transferable to other health professionals in a similar context to that of the study (Corbin, 1986b). Dependability was achieved in the provision of a detailed description of the decision trail which allows the research process to be audited. An audit trail (Appendix IV), adapted from Halpern's (1983) work (cited in Lincoln & Guba, 1989) outlines the processes and records which can be verified for accuracy relevant to the study. The reflective journal and memo's indicated the way in which the data was interpreted and recommendations were made, together with the other constructs for establishing rigour established the study's confirmability.

### **The Findings**

The findings of the study can be summarised in two ways. Firstly, the inaction or ineffective action by nurses in the recognition, intervention, and follow-up of women experiencing partner abuse was evident. These findings were supported by the literature which exists relating to the experiences of battered women with the health care system. The literature revealed that not only nurses, but other health professionals do not question women about abuse; fail to establish a contextual diagnosis; and undertake interventions which are either ineffective or inappropriate (Bohn & Holz, 1996; Butler & Snodgrass, 1991; Eposito, 1993; Feiner, 1994; Hatrick, 1996; Holtz & Furniss, 1993; Limandri & Tilden, 1996; Lorig & Smith, 1994; Mackey, 1992).

Also present in the study's findings and supported by the literature (Boyчук Duchscher, 1994; Davis & Hagen, 1992; Mandt, 1993; Murphy, 1993), was the tendency to focus on the physical injury or presenting problem and excluding the exploration of areas, such as the emotional and social dimensions of the person, together with the absence of routine assessment of women for abuse.

Secondly, the findings demonstrated that nurses clearly identified what they required to enable them to act effectively; a repertoire of knowledge and skills, which was obviously lacking. The skills required to establish effective interpersonal relationships were usually acquired at a pre-registration level. These were considered inadequate by the participants for working with women who presented with injuries suggestive of partner abuse. No further development of these skills was undertaken at the post-registration level. Knowledge related to the issues of partner abuse was also absent. Support can be found in the literature for these findings in relation to the educational needs of nurses (Campbell, 1992b; Campbell, 1995; Cowley, Rush, Lenton, Lukasik-Foss, 1996; Davidhizar & Newman-Giger, 1996; Denham, 1995; Hegge & Condon, 1996; Hotch, Grunfeld, Mackay, & Ritch, 1996; Kohm et al., 1996; Mandt, 1993; Roberts, Raphael, Lawrence, O'Toole, & O'Brien, 1997; Ross & Hoff, 1994). Discussion related to specific issues arising from the findings will be undertaken in this and the following sections.

## **The Use of Metaphor**

Beliefs are embedded in the imagery that is used in everyday language. Burns and Grove (1993, p.576) stated:

A metaphor uses figurative language to suggest a likeness or analogy of one kind of idea used in the place of another.

Metaphors are a powerful tool for communicating meaning and conveying images which reveal insights and understandings about familiar and unfamiliar concepts. Cade (1987) and, McAllister and McLaughlin (1996) claimed metaphor promotes dialogue between people by making abstract notions more easily understood and able to be shared. The use of metaphor also assists the reader to observe the whole rather than particular aspects, as Cade (1982) claimed conscious mental 'sets' which are limiting are often held by people. The messages contained within metaphors can challenge mental 'sets' in a less threatening manner.

The metaphor of *The Looking Glass*, provides not only a reflection of what is seen, but enables an ability to look beyond what is initially seen. The ability to look beyond *The Looking Glass* paradoxically provides a view which is both one of superficiality and one of depth, the images of which may portray what appears to be an unreal situation. Lewis Carroll's (1872) *Through the Looking-Glass* recounts a seemingly unreal situation to outside observers:

Then she began looking about, and noticed that what could be seen from the old room was quite common and uninteresting, but that all the rest was as different as possible. For instance, the pictures on the wall next the [sic] fire seemed to be all alive, and the very clock on the chimney-piece (you know you can only see the back of it in the Looking-glass) had got the face of a little old man, and grinned at her (Carroll, 1872, p. 164).

Despite the sense of a lack of reality to observers, a reality exists for those involved in the situation and its unpredictable changing nature.

This study's use of *The Looking-Glass* metaphor, captures the seemingly unreal and unpredictable responses which battered women encounter from nurses. It encompasses the commonality which emerged in the study's findings based upon what the participants saw or did not see; the *Looking*

*Glass* communicates the diversity in seeing which existed. While nursing purports a profession based on principles such as caring, helping, and advocacy, this study revealed a different situation. The nurses involved in the situation, however, are enmeshed in a long history of social beliefs and stereotypes regarding partner abuse which influences their view of reality.

## **Ability to Respond**

The question could be asked why the nurses' ability to respond effectively to battered women was both inconsistent and seemingly impaired. While it is easy to enter into a crystal ball gazing exercise about why this should be, the area of psychology can be useful in providing some explanation. This section will briefly explore the issue of the nurses' ability to respond with reference to the psychological literature.

According to Myers (1993), social information is ambiguous and open to multiple interpretations. While Myers (1993) claimed beliefs influence the interpretation of information, Vaughan and Hogg (1995) believed the impressions or perceptions of others forms the basis for deciding how to act and feel. The issues surrounding women in society and partner abuse are steeped in social biases and misconceptions, resulting in a diversity of beliefs and behaviours about and toward women who experience partner abuse. The themes *Not Seeing*, *Seeing But Not Seeing*, and *Seeing But Acting Ineffectively* describe the diversity which exists in responding to battered women. The seemingly simple stimulus of a battered woman evokes not only different perceptions amongst nurses, but also differing behaviours. Certainly the description of early and later practice demonstrates how changing beliefs can influence the way in which a situation is perceived.

A stereotype is described by Vaughan and Hogg (1995, p.29) as a "Widely shared and simplified evaluative image of a social group and its members". There can be no doubt that stereotypes related to battered

women exist, and contribute to the difficulty in resolving partner abuse. It is these beliefs that contribute to the choice not to see described in *Seeing But Not Seeing* and to *Seeing But Acting Effectively*. Gender stereotypes are overwhelming according to Myers (1993). Nurses hold stereotypes related to battered women (Henderson & Eriksen, 1994; Ryan & King, 1992; Tilden, 1989) and these undoubtedly influence not only the way in which a nurse perceives a situation in which a woman presents with injuries suggestive of partner abuse, but also the way in which they respond. Unfortunately the very nature of stereotypes is self-perpetuating, as victims of stereotypes often adopt those characteristics of which they are accused of (Myers, 1993). Therefore, battered women may come to believe they deserved what they got and not actively seek help which is immersed in self-blame, as previous attempts to overcome the misinterpretation implicit in the stereotype have failed. This creates a double jeopardy situation making the issue of recognition problematic.

The theory about how we attribute others' behaviours is applicable here and highlights biases in the way in which this process is carried out. Humans have a tendency to attribute the behaviour of others to internal traits or causes (that is, there is something wrong with the person), rather than to situational causes (Baron et al., 1980; Myers, 1993). Certainly women experiencing partner abuse have internal causes attributed to their behaviour to the exclusion of the situational causes, reflected in the socially embedded nature of family violence. Studies undertaken by McKeel and Sporakowski (1993) and O'Brien and Murdock (1993) demonstrated how attributions made by shelter workers affected the outcome of working with battered women. In these studies where internal attributions were made, shelter workers were less likely to assist in a manner aimed at working with the women to break the cycle of violence.

The theme, *Seeing But Not Seeing* highlights feelings of helplessness by nurses. Seligman (1974) stressed the importance of individuals being able to

have a sense of control over their lives, and the consequences of helplessness on the health of individuals. Baron et al. (1980, p. 170) saw helplessness resulting from an "... exposure to a lack of control, [and] individuals come to believe that their behaviour and outcomes are unrelated". Consequently individuals give up, lacking a contingency to influence the outcomes; as occurs with the nurses responses to battered women. Clements and Cummings (1991) described the helplessness and powerlessness of nurses caring for patients in pain and describes an analogy of mental pain experienced by the nurses. The helplessness manifested in behaviours such as avoidance of patients, frustration, apathy, and reacting in passive and negative ways. Avoidance behaviours outlined by Baron et al. (1980) occur commonly, whereby escape from an aversive stimuli is sought. Therefore, in perceived situations of helplessness nurses may avoid patients in an attempt to cope. These behaviours are not dissimilar to those described in this study. Clements and Cummings (1991) found that standards of care and protocols were not clearly defined, and on the development of these staff were supported in both the assessment and management of the patient experience. For the women experiencing partner abuse, nurses avoid feelings of helplessness by choosing not to see the abuse and thus simply treat the presenting problem.

Another form of avoidance, is that of diffusion of responsibility seen in the Bystander Effect described by Myers (1993) and Vaughan and Hogg (1995). Vaughan and Hogg (1995, p.295) defined the Bystander Effect as "People are much less likely to help in an emergency when they are with others than when alone. The greater the number, the less likely it is that anyone will help". Although the Bystander Effect relates to group situations some parallels can be drawn with this study. The readiness of nurses to refer women to someone else perceived to be better equipped to deal with the situation is a diffusion of responsibility. Vaughan and Hogg (1995), in describing the work of Latané and Darley (1976), found diffusion of responsibility occurred when the assumption was made that others would

take responsibility, resulting in an outcome where no-one takes responsibility. This study exposed not only the willingness of nurses to refer, but also a lack of follow-up to ascertain whether anything was being done for the women who had been referred.

The personal history of nurses experiencing family violence or partner abuse may have an effect on the way in which a nurse interacts with the women who present with injuries suggestive of partner abuse and their ability to deal effectively with the situation. Attala et al. (1995) highlighted the need for more research to be done in this area following their study of student nurses personal experiences of partner abuse. Certainly Holm, Cohen, Dudas, Medema, and Allen's (1989) study of nurses' personal experiences of pain and their ability to assess pain, indicated that personal experience did have an impact on a nurse's practice. The unresolved emotions related to partner abuse are both isolating and inhibiting for nurses. Shea (1997) believed nurses who have personal experiences of partner abuse are vulnerable to intense feelings which may result in the nurse being unable to care for a battered woman or exhibiting avoidance behaviours.

In estimating the extent of the problem within the New Zealand nursing workforce, the previously mentioned prevalence rate of 14% of women experiencing partner abuse (Dominick, 1995; Elvidge, 1997) can be extrapolated into the nursing population. It should also be noted that this figure could be considered conservative given the difficulty in attaining accurate statistics and in comparison to some of the overseas prevalence rates cited. A study undertaken by Hegge and Condon (1996) in Northwest Iowa explored the educational needs of nurses, and revealed that 17.4 percent of nurses had either current or previous personal experiences of battering. Approximately 40,000 nurses are currently registered or enrolled with the Nursing Council of New Zealand. As nursing is predominantly a female profession, it's population could be considered reflective of the experience of females in society. By extrapolating the prevalence rate for

partner abuse into the nursing population, approximately 5,600 nurses would then experience partner abuse. It should be noted that this extrapolation has been completed in the absence of evidence or statistics, and does not account for the males who are members making up the total number of registered or enrolled nurses. However, as Attala et al. (1995) pointed out, nurses experiencing partner abuse or family violence may well need support and counselling in order to undertake their roles effectively when working with others experiencing partner abuse or family violence. This highlights an area for future exploration.

## **Strategies**

### **Connecting with Women**

The ability to connect with battered women influenced whether nurses questioned or used other strategies, such as being present with women whose injuries were inconsistent with their explanations. The development of a relationship with a woman was seen as essential for further exploration to occur. The sense of knowing the patient, as described by Radwin (1996), is important to nursing practice and also related to positive patient outcomes. Nurses need to feel needed by patients, according to Bryne and Heyman (1997), yet paradoxically will avoid difficult conversations in order to prevent their own feeling of discomfort.

An important component of the relationship identified was the development of trust which was seen as necessary in order to explore areas perceived as crossing the professional boundary. It was recognised by the participants that the development of trust required time, however, this was problematic. Often the nurses would not see a woman again and their initial interaction was short in duration. Johns (1996) described trust as an important aspect of the nurse-patient relationship, as not only did it convey

belief, hope, and confidence, it was antecedent to patients' perceptions of the nurse's competence, reliability, and trustworthiness. Yet Shea (1997) pointed out that disclosure by women is often met with behaviours by nurses such as avoidance, ignoring the message, or accusing women of lying. This results in the women entering into a game of "you don't want to hear, so I won't tell you".

While trust is an important aspect for the nurses, women on the other hand require an environment which is safe and private; to be listened to without judgment; and to have their decisions respected (Holtz & Furniss, 1993; Howden-Chapman, 1994; Kennedy, 1994; Lempert, 1992). The sense of being connected to a battered woman through the development of a relationship may be an unrealistic expectation on behalf of the nurses. Farrell (1996) and Weingout (1996) described a process of emotional disconnection in women who experience partner abuse. This disconnection renders them unresponsive and difficult to establish relationships with. These behaviours are often misunderstood and are not cognisant of a potential lack of an established relationship a battered woman has with herself as an individual, let alone being able to establish a relationship with others. It is important that further research is undertaken, exploring the battered woman's health care experience in order to identify what women require out of the nurse-patient, or the health professional-patient relationship.

One participant described being present as an effective way in which to connect with a battered woman. Nurses are trained to be effective and to 'do for' patients according to Benner (1984), yet simply listening to a patient can be more effective. "To presence oneself with another means that you are available to understand and be with someone" (Benner & Wrubel, 1989, p.13). According to Benner and Wrubel (1989), being present is making contact, and is the interface between the nurse's understanding of the patient's affliction, and the patient's experience. Being present conveys an

acceptance and understanding to the patient. Benner (1984) pointed out, however, that being present requires the nurse to possess self-esteem and self-confidence in order to value the presence with patients.

One reason cited for not exploring a woman's explanation or lack of explanation for her injuries was her rights. That is, her right not to explain, and her right to choose. Yet this is often an assumption on the nurses' behalf, and is not validated. It conveys a message of the nurse knowing best. Tschudin (1992) described this as a form of paternalism which is both unhelpful and unethical. We currently live in a "rights" oriented world which can sometimes provide a convenient excuse for inaction. Evidence exists (Butler & Snodgrass, 1991; Feiner, 1994; Lempert, 1992; Roberts et al., 1997) which demonstrates that often battered women will respond to direct questioning by health care providers who convey a non-judgmental genuineness. In New Zealand, the 1996 Health and Disability Commissioners Code of Consumer Rights affords consumers of health care services rights which require health professionals to communicate honestly, and provide sufficient information on which to make informed decisions without discrimination. Therefore, nurses need to change the way in which they respond to women experiencing partner abuse to ensure battered women of their legislated rights. That is, making assumptions about their right to disclose or respond is at the least breaching the right to honest communication and information.

Having policies and protocols was considered to be a necessary component for effective action. Policies and protocols assist in the identification of the battered woman and in the implementation of appropriate interventions (Campbell, 1995; Hotch et al., 1996; Kohm, McNally, & Tiivel, 1996). Kohm et al. (1996) claimed the presence of policies and protocols increases the identification of abusive situations, improves efficiency and effectiveness, standardises responses, informs staff of their obligations, and conveys the important role health care professionals play in addressing

partner abuse, additional to providing a guide for staff to act. Paramount with the introduction of policies and protocols is the institution of a planned education programme. Such a programme would raise the awareness of staff about the pathology of partner abuse amongst other aspects, such as responding to women who present with injuries suggestive of partner abuse. At the time of writing this thesis, New Zealand's Ministry of Health (Public Health Group, 1997) is in the consultative phase of the development of guidelines for providers of health care services to develop practice protocols in response to the *New Zealand Crime Prevention Strategy* (Dept of the Prime Minister and Cabinet, 1994) to reduce family violence. These guidelines outline principles which address the provision of a quality service which is responsive to the needs of those experiencing any of the forms of family violence; the training development of those working in the Health and Disability Sector; and in promotion and prevention strategies.

### **Development of Knowledge and Skills to Respond**

A need to develop skills and receive support in order to effectively respond to women presenting with injuries suggestive of partner abuse was identified in the study. A profound lack of educational preparation related to the issues of family violence and partner abuse have been identified. This also goes hand-in-hand with the need for adequate preparation in skills to deal with difficult situations, such as communication skills, conflict resolution, and the development of interpersonal relationships within the nursing practice context. The learning nurses relied upon, tended to be derived from experience and a trial and error approach. However, as Deane and Campbell (1985, p.28) warned: "Experience alone does not necessarily lead to learning". This statement certainly bears relevance to this study, whereby it was evident that learning as one goes along is not always productive.

Before going further it is important to note that this study focused on the nurse-battered woman relationship in acute, episodic settings. The findings of this study, therefore need to be confined to such settings. Nurses and

midwives working in community settings, such as public health nurses and independent midwives develop a relationship with women which could be considered long-term in nature. Therefore, the dynamics of the relationship developed will be significantly different and may have an impact on the identification and intervention with a woman recognised to have been battered. The areas of nursing where long-term relationships are established require further research in order to identify how nurses or midwives in those situations respond.

It is apparent that undergraduate programmes are not preparing nurses appropriately or adequately to work effectively in the area of partner abuse, nor are nurses, post-registration, receiving any further educational development of knowledge or skills in this area. The literature (Campbell, 1992b; Campbell, 1995; Cowley et al., 1996; Davidhizar & Newman-Giger, 1996; Denham, 1995; Hegge & Condon, 1996; Hotch et al., 1996; Kohm et al., 1996; Mandt, 1993; Roberts et al., 1997; Ross & Hoff, 1994; Woodtl & Breslin, 1996) supports the need for not only specific education and training at a pre-registration level, but also ongoing education post-registration. Studies undertaken by Cowley et al. (1996), Hegge and Condon (1996), and Roberts et al. (1997) revealed the significant impact education has on knowledge, attitudes, and practice. Education is considered the key component to effecting appropriate prevention, assessment, and intervention. Not only are nurses viewed as being in an ideal position to intervene, they are also in an ideal position for preventive education according to Denham (1995).

The findings indicate that an education approach based upon mixed delivery methods is required. While some content could be delivered by an 'up-front' teaching approach, experiential methods are also seen to be essential. Deane and Campbell (1985) recommended Kolb's Experiential Learning Model as a viable framework. Kolb's model utilises concrete experiences which are observed and reflected upon in order to form abstract

concepts and generalisations for application in new situations. According to Deane and Campbell (1985, p. 19), "Experiential learning occurs when one is provided the opportunity to integrate theory with practice and thought with action".

In addition to actual experiences, other methods can be used effectively to simulate experiences such as role play. Role play is a technique utilising drama, whereby participants act out roles and situations in a controlled manner. Role plays afford the opportunity to apply knowledge to practice, rehearse skills, and receive feedback in a safe learning environment. Coutts and Hardy (1985) and Whitman, Graham, Gleit, and Boyd (1992), advised that role play develops not only psychomotor, cognitive, and affective skills, but is also a medium which develops empathy, understanding, and coping skills.

Essential in any programme aimed at developing the nurse's ability to respond effectively is related to keeping battered women safe. As Bradshaw (1997) and Esposito (1993) stressed, the battered woman is an expert about her own situation. Bradshaw (1997, p.6) summarised the situations as follows:

An environment in which policy and practice are analysed in terms of the messages they send women, and where practical assistance and non-judgmental support are offered is crucial. So is the acknowledgment that women are the experts on their own situations and that a woman's assessment of the risk she faces is an expert opinion based on her years of observation of the offender's responses to particular situations. We need an environment where her timetable and process for leaving is respected even if it does not comply with our timetable for her, our busy workloads and our belief that we know what is best for her.

Nurses must not only recognise, but respect the notion of the 'battered woman as expert'. This involves firstly, trust on the nurse's behalf to support

a woman to make her own decisions and act as she deems. It must be remembered that some women are murdered when they attempt to leave their situations (Fanslow, 1996). Battered women have the insight into their batterer's behaviour that the nurse or other health professional could never have. Secondly, when a nurse suspects partner abuse, efforts need to be made to provide a private room which enables a freedom to speak and interact. If a battered woman suspects her batterer will discover any disclosure or truth-telling, her fear of retaliation will outweigh her need to speak. Safety requires the development of a partnership based upon trust. However, the notion of partnership is one of the aspects not strongly evident in this study.

The need for a specific course related to partner abuse, focusing on the recognition and enabling disclosure emerged in the findings. Recognition of partner abuse is predominantly cognitive in nature. Enabling disclosure, on the other hand, requires not only skill development but also an examination of self (which may be both attitudinal and affective in nature). The concept of cultural safety would provide an appropriate educational framework. While the concept of cultural safety in New Zealand was first mooted to address the health status of Maori, similarities exist with women experiencing partner abuse and their health experience often being inappropriate and inaccessible. The similar experiences of battered women makes it a culture with specific and special needs. Battered women's health and subsequent health care is compromised as a result of deeply embedded historical, political, and social influences.

The Nursing Council of New Zealand (1992, cited in Nursing Council of New Zealand, 1996, p.9) defines cultural safety as:

The effective nursing of a person/family from another culture by a nurse who has undertaken a process of reflection on own [sic] cultural identity and recognises the impact of the nurse's culture on own nursing practice. Unsafe cultural practice is any action which diminishes,

demeans or disempowers the cultural identity and wellbeing of an individual.

Cultural safety broadly encompasses a variety of cultural groups in addition to those related to ethnic origins. The education framework for cultural safety requires learners to examine their own realities and attitudes they bring to the practice arena; the historical, political, and social impact on the health of people; and ways to establish flexibility in relationships with those different from self.

In addition to educational preparation, workplace assistance was also seen as important in the development of an ability to respond effectively. The feelings of helplessness, anger, and frustration experienced by nurses which arise from working with battered women are left unattended and the situation not examined for alternative ways of interacting and intervening with battered women. As previously mentioned, there are nurses who may be experiencing or who have experienced, partner abuse and have personal issues they may need to deal with. Assistance in the workplace may need to be multifaceted. Firstly, Employee Assistance Programmes (EAP) are designed to assist employees who have personal issues which may or are impacting on their work performance. Counselling, one of the services offered under EAP, may be beneficial for nurses with personal experiences of partner abuse.

The availability of clinical supervision facilitates the professional development of nurses on an individual basis. Fisher (1996, p.100) defined clinical supervision as "...an exchange between practising professionals with the intention of developing their professional skills". Clinical supervision has three central functions: educational, support, and managerial (Fisher, 199; McGibbon, 1996). The educational function utilises the reflection on experience in order to develop knowledge and skills. The supportive function provides support in relation to the clinical area. Clinical supervision has a lot to offer in the development of nurses and could be especially useful for

nurses working with women experiencing partner abuse, given the personal influence of beliefs and attitudes on practice.

The need for critical incident stress debriefing is also apparent, and would be beneficial not only to nurses working with battered women, but also in the long-term to the women themselves. Critical incidents according to Johnson (1997, p.793) are "...any situation that occurs suddenly and unexpectedly, disrupts values and beliefs, and challenges basic assumptions of how the world operates". Incidents involving battered women often disrupt the values and beliefs of the nurses working with them, and challenges the assumptions they hold. Critical incident stress debriefing offers a session focusing on the critical incident within 24 to 72 hours of the incident occurring. The aim is to defuse any cognitive and affective disruption as soon as possible after the incident occurs. The use of critical incident stress debriefing may assist in nurses dealing with the issues as they arise, rather than leaving incidents whereby thoughts and feelings over time may become distorted.

### **Missing Aspects**

It became apparent when analysing the data that there were aspects missing in the nursing practice, when nurses worked with battered women. Nursing lays claim to some fundamental concepts which are unique and central to its existence. The concepts that were resoundingly absent in the findings of this study were those of caring, (w)holism, advocacy, and partnership. Debate exists as to whether it is feasible that these concepts represent the hallmarks of the nursing profession. It is difficult to ascertain whether it is realistic to expect these concepts to be present in a nurse's practice when dealing with an issue such as partner abuse, which is also deeply entrenched in historical, social, and political processes. The documentation of the nurse's findings and suspicions of the existence of partner abuse was also non-existent and described by one participant:

*Document only if disclosed. I don't say "I had a funny feeling about this woman". Would document, "Appeared agitated," or "Didn't feel like talking." Don't put, "Injuries are non-accidental," unless she disclosed. If I had some discrepancy and wanted her to see the Doctor, I would discuss it verbally with the doctor. (103/13)*

Caring in nursing, while promoted and articulated by some nurse authors, such as Watson (1985) and Noddings (1984), is problematic. Caring appears to be an obscure and nebulous concept, meaning different things to different people. The tendency for nurses to either ignore or not respond appropriately to women experiencing partner abuse brings into question whether such acts could be considered caring. Whilst the nurses may possess internalised feelings of caring, these were not obviously evident in this study. In fact, internalised feelings on the part of the nurse lack a relevance to others. As Gadow (1995, p.214) stated: "Situations that nursing encompasses [sic] are existential places to be explored, and the only vantage points for exploration are the perspective of people living there". Research into the battered woman's perspective would be a valuable contribution to the developing knowledge related to the health care of women experiencing partner abuse. The recipients of nursing practice often have their stories to tell, and nurses need to listen to them and incorporate that feedback into their practice.

(W)holism is more than the sum total of its parts. Therefore, it is doubtful whether nurses can ever truly practise (w)holistically because of the compartmentalised approach to (w)holism taken by nurses. Certainly there was a tendency for nurses in this study to focus on the presenting injury or illness to the exclusion of every other dimension of the person. While (w)holism offers a comprehensive framework on which to base nursing practice, there was an absence of nurses utilising either a (w)holistic philosophy or (w)holistic framework. The use of a (w)holistic framework would be beneficial when working with battered women, as social, emotional,

and psychological aspects would need to be included in the nurse's assessment and subsequent interventions.

An ongoing debate exists as to whether nurses can be advocates to patients. Indeed, this study revealed nurses attending to women experiencing partner abuse demonstrated no evidence of being advocates for the women. "An advocate is one who pleads the cause of another", according to Tschudin (1992, p.100). Yet battered women are at worst not identified at all, and at best the recipients of either inappropriate or ineffective care. Gates (1995) and Mallik and McHale (1995) believed advocacy is an idealistic claim, sustained by the 'advocacy rhetoric' in the literature. As Kelly (1996, p.31) rightly stated:

Rarely do we think much of speaking up when we are among those who are likely to agree with us. However, speaking up when in the company of those with whom we know we disagree is entirely another matter.

Other issues problematic to nurses being effective advocates to battered women (as a client or patient) are the loyalty and obedience which underpins employment (Gates, 1995; Nelson, 1988); putting patients into dependent roles; the inadequate educational background of nurses; and the inability to act independently (Gates, 1995). Certainly the lack of preparation nurses have to work with battered women does not place them in a position to be able to act as an effective advocate.

Identified in this study, was the need to develop the individual nurse's communication skills, as communication with battered women was either ineffective or inappropriate. Battered women represent a population who could benefit from a partnership approach during their health care experience, yet evidence of nurses working in partnership with the women was lacking. Indeed Cramer and Tucker (1995) argued that the notion of partnership is based upon the communication skills of the individual nurse.

One participant, whose description of being present goes some way to the development of a partnership, did not appear however, to enter into a mutual working together on health outcomes for the woman's experience. Nursing is amidst an era whereby there is a move for patients to actively participate in the achievement of health care outcomes. This requires a mind shift on the part of the health professionals, in general, as the paternalistic approach to practice is no longer seen by consumers of health care as acceptable.

For patients to be involved in the determination of their health outcomes, the nurse is required to enter into a partnership with the patient. Cramer and Tucker (1995, p.54) described partnership as follows: "The role of the patient as recipient of care given by the provider has evolved into a partnership in which patients, as consumers, and care providers share responsibilities". Christensen (1990) described *The Nursing Partnership* involving the mutual work of both the nurse and patient which is directed to assisting the patient through the passage of the health related experience. The work of the nurse involves activities such as attending, enabling, interpreting, responding, and anticipating, while the work of the patient involves managing self, surviving the ordeal, affiliation with experts, and interpreting the experience. At the interface of the work of the nurse and the patient, the partnership is negotiated depending upon the needs of the patient at any point in time. In addition to a nursing focused partnership, the Code of Health and Disability Services Consumers' Rights (1996) is a legislated requirement for health and disability providers to work with patients on a partnership basis in New Zealand. Therefore, any educational programme to assist nurses to work with women experiencing partner abuse, must incorporate a partnership framework on which to base their practice.

Documentation is another area identified in this study as lacking. According to Orloff (1996), nurses are in a unique situation to identify the signs and symptoms and to act upon this information. Documentation is essential for effective interventions to be planned for battered women. Yet

this does not occur. Often the nurses may suspect partner abuse, yet will not document suspicions in the clinical records. One participant highlighted this situation in describing her approach:

I wouldn't even...attempt to sort of make sure that anyone rung or wrote to a social worker...I mean is that wrong? It sounds wrong when you're talking about it, but in the situation you think, "Oh, it's not worth it," why should I write a half page letter for somebody else to get hold of them to come back to the hospital...it just goes round and round again. (203/17)

The oral approach taken, however, does not allow for wider communication of the information. Rodriguez (1989) stressed the importance of nurses being proactive and documenting the health needs of battered women. Documentation, which also includes the use of body maps for injury identification and photographs, provides not only legal evidence, but also contributes to the development of a history of abuse, and alerts the next health care provider when a woman presents with vague and poorly defined injuries (Davidhazir & Newman-Giger, 1996; Orloff, 1996; Sheridan, 1996). Also advocated by Feiner (1994) and Sheridan (1996) is the routine screening of all women for abuse. Routine screening assists in the documentation process by guiding nurses in what needs to be documented. Sheridan (1996) produced a definition list for wound identification which clearly identifies wounds and assists in a standardised understanding of a variety of wounds. Nurses need to document, at a minimum, the situation and what a woman presented with, along with any other pertinent information, the intervention(s) undertaken, and the outcome of the intervention(s). Failure to document fully does not mean the women will go away, conversely they keep returning. However, accurate and detailed documentation can contribute to breaking the cycle of violence.

## **Summary**

A grounded theory approach was utilised in this study as a framework for the collection of data and its analysis, in order to develop a rich description of how nurses respond to women who experience partner abuse. This process accentuated the need for both patience and trust in the data for the core category and themes to emerge. While some difficulties were encountered with the method used, these were in part due to the neophyte status of the researcher. The use of a grounded theory framework was found to be of immense use and will be used to underpin future research in this area..

The study's findings were supported with existing literature in terms of nurse inaction or ineffective action in the recognition, intervention, and follow-up of battered women. The need for educational development and workplace assistance identified in the study was also supported in the literature. The metaphorical description provided a useful tool in describing the findings and in conveying the meaning of the core category and themes.

The ability of nurses to respond in part can be explained by concepts contained within the psychological literature. The feelings of helplessness and the resultant behaviours occur when there is a lack of control over a situation. The embedded nature of partner abuse in historical, social, and political processes, leaves nurses just as vulnerable to the ambiguity of social information and stereotypical behaviours. The identified diffusion of responsibility results from the avoidance of a situation, and also the tendency to operate on the assumption that others will take responsibility. A nurse's personal experience of partner abuse may influence his or her ability or inability to interact and work effectively with battered women. The prevalence of nurses experiencing partner abuse themselves is underestimated and is an area which needs addressing to improve the nurse's response to battered women.

Connecting with a battered woman and the development of the nurse-patient relationship for disclosure of the abuse, is viewed by nurses as important. However, the nurse's expectation in developing a meaningful relationship may not be what is required by the women themselves. Evidence exists which indicates what women need and want is a safe, private environment, and a nurse with a non-judgmental attitude. Further evidence indicates that battered women are in a state of disconnection and are therefore unable to establish a relationship with themselves let alone anyone else. The concept of being present, however, may be effective as it conveys an acceptance and understanding of the woman. A need exists for policies and protocols which would improve the current situation and assist in the identification of a battered woman and in the implementation of appropriate interventions.

Developing an ability to respond is a two-fold process. Educational preparation is required at both a pre- and post-registration level. The delivery of educational programmes need to utilise mixed delivery methods, such as up-front teaching and experiential learning methods. Keeping battered women safe must be a focus of any programme developed. The use of the concept of cultural safety would be an appropriate framework on which to develop nurses' abilities to respond. Workplace assistance is also required, not only in the form of guidelines but in the form of support such as EAP, clinical supervision, and critical incident stress debriefing.

The icons of nursing; caring, (w)holism, advocacy, and partnership, did not appear to be evident in these nurses' practices. While the concepts of caring and advocacy are subject to professional debate regarding their appropriateness to nursing practice, (w)holism and partnership are useful frameworks on which to develop nursing practice when working with women who experience partner abuse. The discussion in this chapter has raised some issues which require further exploration. Recommendations arising from this study will be made in the following chapter.

## Chapter 6

### Conclusions and Recommendations

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#### Conclusions

*Through The Looking Glass* describes the responses of registered nurses to women who present to either general practices or emergency departments with injuries suggestive of partner abuse. The metaphor, *Through The Looking Glass*, captures the differing perspectives of battered women as viewed by the nurses. The nurses' experiences fell into one of the themes which emerged, or moved across the themes as their practice evolved. The theme *Not Seeing*, relates to the non-recognition of battered women. This was evident in early practice and hallmarked by professional inexperience and naivety, and symptomatic of a lack of professional preparation in the area of family violence. *Seeing But Not Seeing* described the nurse's choice, based upon situational factors (such as trust, safety, helplessness, the diffusion of responsibility, and past experience) not to see battered women. This theme contrasts with *Not Seeing* in that the nurses were aware of a battered woman's existence. *Seeing But Acting Ineffectively* featured the nurses' recognition of a battered woman, but were ineffective in their actions. The ineffectiveness was related primarily to inadequate preparation, misunderstanding, the manner in which women presented, and the firm belief in the woman's right to choice. *Seeing For Effective Action* reflects the participants' insight in relation to the support they identified they needed to assist in the development of effective actions. It was suggested such support would be achieved by either educational assistance or workplace assistance.

The aims of the study were to elicit a rich description and make recommendations in relation to the nurses' response to women with injuries

suggestive of partner abuse, who presented to either general practice or emergency departments. The acute setting was chosen in order to reduce variability and thereby achieve homogeneity. The information provided by the participants was both frank and rich, leading to the ability to formulate the core category, *The Looking Glass*, and the associated themes. What was resounding in the findings was the nurses' clear insight into what they felt they needed to become more effective in responding to the needs of battered women. The findings therefore, provide valuable information about how nurses respond to battered women and what is required both in the workplace and educationally at both the pre-registration and post-registration levels.

The findings of this study resulted from the use of a qualitative research design which was methodologically underpinned by grounded theory to guide the data collection and data analysis phases. The data was collected through the use of audiotaped semi-structured interviews. The interview transcripts were then analysed using constant comparative analysis, in order to code and categorise the data into abstract themes. An audit trail was used to ensure the study's trustworthiness. While no ethical or legal issues arose in the study, the study's findings may have implications for employers in relation to the Health & Safety in Employment Act 1992. The nurses' responses revealed in this study could be defined as inaction in some instances, and therefore be considered a hazard under the Act's definition, which employers are legally bound to minimise.

Difficulties did arise in the recruitment of participants. While the number of participants was sufficient for a qualitative research design and the study's status of a preliminary study, researcher anxiety did abound. The recruitment difficulties could, in part, be explained by nurses resistance (for whatever reasons) to be involved in research. However, the participant numbers could also be explained as being reflective of the study's findings.

The utilisation of the grounded theory methodology to guide the data collection and analysis phases of the study while valuable, did present some tension. The concept of theoretical sampling, and the analysis starting with the first collection of data took some time to come to terms with. However, patience and trust in the data were beneficial attributes as the themes emerged from the data over a period of time.

Some challenges arose in the interviews. Firstly the unexpected interruption in one of the interviews resulted in the interview not being taped. This highlighted the need to take field notes and write more fuller details at the completion of the interview. Secondly, a technical aspect of tape recording became apparent during one interview. Knowing the signs and symptoms of dying batteries can provide immense assistance and save on time and tapes when blindly wondering why the tapes are not turning properly. It also stressed the need to always carry spare batteries when embarking upon an interview.

There can be no doubt that partner abuse is an issue of national and international concern. It is an issue with deep roots in historical and social acceptance making it difficult to address the enormity of the problem. While steps are being taken at a government level, within the New Zealand context to make partner abuse socially unacceptable, generations of its acceptance as a norm mean it may take generations to eliminate its acceptability. One reason for the perpetuation of its social acceptance is the gender relationships which are epitomised by domination, control, and abuse. Myths and stereotypes about the role of women within a relationship, which have arisen out of an imbalance in power relationships, support their perpetuation. Institutional acceptance at both micro and macro levels also exists, with a combination of Western Christian ideology, and patriarchal, hegemonic social structures. The social acceptance of violence against women has occurred over time, including the belief by men and with the co-operation of women, that women are their property.

Health care problems are a consequence of partner abuse. Indeed battered women have been referred to as a 'health problem in disguise' (Ryan & King, 1992; Tilden, 1989). The costs related to partner abuse are prohibitive from an individual, health care, and social perspective. Yet health professionals are ineffective in responding to the health care needs of battered women. Health professionals simply either do not recognise women who present with injuries suggestive of partner abuse or ignore them. Evidence exists to support the notion that health professionals demonstrate the same societal attitudes (myths and false beliefs) which operate in society at large. Despite nursing being a female dominated profession, nurses are not immune to the myths and beliefs regarding partner abuse which exist in the wider society - nursing appears to represent a microcosm of society in general in this area.

Research and anecdotal evidence, both nationally and internationally (as described in Chapter 2), accentuates the responses of health professionals as being either non-existent or ineffective. Nurses are also featured in some of the literature which highlight the concern that battered women tend not to be recognised in the health care system. Indeed this study's findings confirm previous research and anecdotal evidence.

The psychological literature has offered some explanation about the responses of nurses to women who present with injuries suggestive of partner abuse. Nurses, like other groups of people may undertake avoidance behaviours when they encounter battered women. These avoidance behaviours may range from diffusion of responsibility (operating on the assumption that others will address the issue at hand) to simply focusing on the presenting illness or injury to the exclusion of all other indicators of abuse. Nurses are also vulnerable to the misinterpretation of ambiguous social information and stereotypical behaviours. Symptomatic of a nurse's perceived lack of control over the presenting situation, are feelings of helplessness. A sense of helplessness itself nurtures a lack of response

to some situations. One area requiring further research, is the influence of nurses' personal experience of partner abuse on their ability to interact with battered women.

The ability to establish a relationship built on trust appeared to be an important influence on the nurse's willingness to explore dissonant areas. However, while nurses required this sort of relationship, evidence exists (Holtz & Furniss, Howden-Chapman, 1994; 1993; Kennedy, 1994; Lempert, 1992) which indicated that battered women themselves require a safe, private environment, and a nurse with a non-judgmental attitude. In fact, other evidence (Farrell, 1996; Weingout, 1996) indicated that battered women, due to the mechanisms which assist them to survive in a violent relationship, such as disconnection, suggest they are unable to form and develop meaningful relationships with others. Nurses, who themselves are experiencing partner abuse, may also experience an inability to form meaningful relationships with others, including their patients. This would exacerbate the ability to respond effectively to battered women.

The participants in this study clearly articulated what they required in order to develop the necessary skills and knowledge to respond effectively. The need for educational preparation before and after registration, along with workplace assistance, is supported by other research studies (Campbell, 1992b; Campbell, 1995; Cowley et al., 1996; Davidhizar & Newman-Giger, 1996; Denham, 1995; Hegge & Condon, 1996; Hotch et al., 1996; Kohm et al., 1996; Mandt, 1993; Roberts et al., 1997; Ross & Hoff, 1994; Woodtl & Breslin, 1996) and anecdotal evidence. The inadequacy of the preparation in the area of communication skills and the virtual non-existence of specific information regarding partner abuse and family violence in a nurse's education, was apparent in the findings. The need for policies and protocols in the workplace was essential, so that nurses' actions could be supported and guided. A need also existed for the counselling of staff through various means, such as critical incident stress debriefing, clinical supervision, and counselling for personal issues. The support discussed

above, both educational and workplace, was seen by the participants as vital in assisting them to respond to battered women effectively.

Some of the icons nursing purports to be fundamental and unique to nursing practice, were not evident in the nurses' practices. These icons included caring, (w)holism, advocacy, and partnership. While caring and advocacy have attracted debate as to their appropriateness in nursing practice, the concepts of (w)holism and partnership provide useful frameworks on which to base nursing practice when nurses work with women who experience partner abuse. While these aspects are only indirectly related to the study, what is highlighted is the need for nurses to explore the suitability of practice icons which are not necessarily evident in a nurse's practice.

This study has contributed further information to the field of partner abuse, in particular to the battered woman's health care experience. In the New Zealand context, a paucity of research exists in the area of partner abuse, and is non-existent in relation to how nurses interact with battered women. The contribution of this study, is valuable information of how nurses respond to battered women, and the knowledge and skills they require to work more effectively with battered women before and after registration. Further areas for both national and international research and investigation have also been identified. On an international level, this study has confirmed the findings of previous research and anecdotal evidence related to responses by health professionals. It has also contributed a description of how nurses themselves respond to women who present with injuries suggestive of partner abuse, and identified their needs in order to respond effectively. The practice implications and future areas for research arising from this study are outlined in the recommendations section.

## **Recommendations**

- A review of undergraduate nursing curricula be undertaken, focusing on the adequacy of skills teaching (such as communication, assessment, and documentation) and the content related to family violence, including partner abuse.
- The development of programmes for post-registration nurses as part of their ongoing education with the content based upon recognition of partner abuse and enabling disclosure.
- Post-registration education on how to document the contextual aspects and incongruence about women who present with injuries suggestive of partner abuse.
- Provision of workplace assistance and support by employing agencies aimed at improving the effectiveness of nursing staff working with battered women, and thereby reducing the costs associated with partner abuse, such as the high usage of health care services by battered women.
- Initiation of training and development strategies by employing agencies to improve the effectiveness of nursing and other staff working with battered women aimed at minimising the risk of inaction by staff being considered a hazard under the Occupational Health and Safety Act 1992.
- Research be undertaken into the health care experiences of battered women and the expectations they have of health care providers, specifically nurses.
- Research be undertaken into the magnitude of nurses personally experiencing partner abuse and the impact this has on a nurse's

ability to work with battered women. The researcher intends to undertake this as a doctoral study.

- Comparative research be undertaken in areas where nurses and midwives have established long-term relationships with women, and areas where short, episodic relationships are common.

In addition and complementary to the findings in this study:

- Research into and debate about the icons the nursing profession purports to be fundamental and unique to nursing practice, continues focusing on whether these icons are in fact appropriate and can be realistically achieved in the various contexts in which nursing practice occurs.

## Appendices

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Appendix I: Pamphlet

Appendix II: Information to Participants

Appendix III: Consent Form

Appendix IV: Declaration of Confidentiality

Appendix V: Audit Trail

***Appendix I: Pamphlet***

***How do You Become a Participant?***

If you are interested in becoming a participant, contact:

**Denise Wilson  
Te Puna Whai Ora - Faculty of Health & Social  
Sciences  
Waiariki Polytechnic  
Private Bag 3028  
ROTORUA**

**Phone 07-346.8913**

This phone has a voice mail, so if I am unavailable please leave your name and contact phone number.

Please mark any correspondence "*Confidential*"

I will reply and arrange to send you an Information Sheet and Consent Form for your perusal.

**To all  
Emergency Department Nurses  
and  
Practice Nurses**

**Research  
Participants  
Needed.**

***Are you interested?***

My name is Denise Wilson. I am a graduate student of the Department of Nursing & Midwifery at Massey University.

I am currently enrolled in the Master of Arts in Nursing programme.

### ***What is the Aim of the Study?***

To describe how nurses respond to, and manage women with unexplained physical injuries and the preparation you, as nurses, perceive is required to manage these women. This study has grown out of a concern for women experiencing violence or abuse from a partner. I am interested in your experience of working with women with unexplained physical injuries.

### ***What are the Criteria for Participation in this Study?***

1. You have had contact with a woman or women with unexplained physical injuries suggestive of domestic violence during the course of your work.
2. A willingness to reflect upon and share your experience(s).

### ***What is the Time Commitment You Can Expect?***

You will be required to participate in an audio-taped interview lasting one to one and a half hours.

There is also the possibility of a follow-up interview to confirm or clarify any details of the research findings.

MASSEY  
UNIVERSITY

A L B A N Y

FACULTY OF SOCIAL SCIENCES  
DEPARTMENT OF NURSING AND MIDWIFERY***Appendix II: Information to Participants******THE NURSE'S RESPONSE TO, AND MANAGEMENT OF WOMEN  
WITH UNEXPLAINED PHYSICAL INJURIES*****INFORMATION SHEET**

My name is **Denise WILSON**. I am a graduate student of the Department of Nursing and Midwifery at Massey University. I am currently enrolled in the Master of Arts in Nursing programme and intend to use this study as my thesis in order to complete this degree. I am a Registered General and Obstetric Nurse and for the last ten years I have worked as a nurse educator. I currently lecture in a Bachelor of Nursing programme.

This study has grown out of a concern for women experiencing violence or abuse from a partner. I am interested in your experience of working with women with unexplained physical injuries. The aim of the study is to describe how nurses respond to, and manage women who present with unexplained physical injuries and the preparation nurses perceive they need to manage these women.

**If you consent to participate you will be asked to:**

- a. Participate in an interview, lasting one to one and half hours, where you discuss your experiences of working with women you have nursed with unexplained physical injuries, including your perceived needs for training in this area.
- b. The interview being recorded on an audio-tape. On the completion and examination of the thesis, the tapes will be erased or returned to you on request.
- c. My taking notes, as the researcher, throughout the interview. After the examination of the thesis, these notes will be shredded.

- d. The supervisors and the transcriber of the tapes of my research seeing the original information collected during this study. These will be the only persons who will have access to any of the original information. The transcriber of the tapes is required to sign a confidentiality agreement.
- e. Any follow-up interview, to confirm or clarify any details of the research findings.
- f. Use of the research findings for the purposes of publication and/or presentation at conferences.

**If you take part in the study, you have the right to:**

- \* Refuse to answer any particular question(s), and/or disclose any information you do not wish to.
- \* Request the tape recorder be turned off at any time.
- \* Withdraw from the study at any time without any consequence.
- \* Provide information on the understanding that your identity will remain completely confidential to me as the researcher. All information transcribed from the audio-tapes will use false names of participants, third parties, or agencies. It will not be possible to identify you or any participants in any reports prepared from this study.
- \* Receive a copy of the interview transcript and a summary of the study's findings after the thesis is submitted for examination.

**The supervisors of this study are:**

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 Senior Lecturer /Supervisor  
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**I can be contacted at:**

**Work:** Te Puna Whai Ora - Faculty of Nursing Education & Health,  
 Waiariki Polytechnic, Private Bag 3028, Rotorua.  
 Phone (07) 346 8913

***If I am unavailable please leave your name and phone number on my voice mail and I will return your call as soon as I am available.***

# A L B A N Y

FACULTY OF SOCIAL SCIENCES  
DEPARTMENT OF NURSING AND MIDWIFERY

## **Appendix III: Consent Form**

### **CONSENT FORM**

#### **THE NURSE'S RESPONSE TO, AND MANAGEMENT OF WOMEN WITH UNEXPLAINED PHYSICAL INJURIES**

I have read and I understand the information for volunteers participating in the study designed to describe the nurse's response to, and management of women with unexplained physical injuries suggestive of domestic violence. I have had the opportunity to discuss this study and to ask questions which have been answered to my satisfaction.

I understand that participation in this study is voluntary and that I have the right to withdraw my consent at any time, and to decline to answer any particular questions in the study.

I understand that my participation in this study is confidential and that no material which could identify me or any other person will be used in any reports or publications arising from this study.

I understand that the investigation will be discontinued if it should appear harmful to me.

I agree to the interview being taped. I understand that I have the right to request the tape recorder to be turned off at any time.

I understand that the procedure has been approved by the Massey University Human Ethics Committee and the Bay of Plenty Ethics Committee. If I have any concerns I may contact the Chairperson of the Bay of Plenty Ethics Committee at Phone (07) 322.8116.

I \_\_\_\_\_ (*full name*) hereby consent to take part in this study.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Name of Researchers: Denise Wilson  
Dr Gillian White      Research Supervisor

Contact phone number: Denise Wilson, phone: 07-346.8913

## ***Appendix IV: Declaration of Confidentiality***

### **DECLARATION OF CONFIDENTIALITY**

I, \_\_\_\_\_ hereby declare that I will not disclose any details of the research participants or the content of the taped interviews I receive from Denise Wilson to transcribe.

I will ensure that the tapes I receive for transcription and the transcripts will be stored in a secure place while in my possession.

I understand that any disclosure of information related to the tapes and their transcription will be in breach of the Health Information Privacy Code 1994.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Appendix V: Audit Trail

AUDIT TRAIL					
Classification		File Types		Evidence	
1	Raw Data	(A)	Audiotapes (and transcripts)	(a)	dialogue; social interactions (and tapes)
		(B)	Field notes (1) interview records (2) observational records	(b)	descriptions of phenomena, events, feelings, of and by participants
				(c)	descriptions of events, characteristics of environment, & behaviours of participants
				(d)	records
2	Data Reduction and Analysis	(A)	Write up of field notes (1) descriptions	(a)	summarised transcripts
		(B)	Summaries (1) Condensed notes (a) events (b) behaviours (2) Units of information (a) themes (b) behaviours (c) ideas (d) concerns	(b)	category cards; lists of units of information
		(C)	Theoretical notes (1) working memo's (2) concepts (3) hunches		
3	Data Reconstruction and Synthesis	(A)	Categorical structure (1) themes (2) definitions (3) relationships	(a)	hierarchies of concepts and categories
		(B)	Findings and conclusions (1) interpretations (2) inferences	(b)	explanations of concepts
		(C)	Final report (1) connections to existing literature (2) integration of concepts, relationships, and interpretations	(a)	explanations of hierarchies and structure
				(a)	completed and published documents
4	Process Notes	(A)	Methodological notes (1) procedures (2) decisions (3) strategies (4) rationale	(a)	daily activities
				(b)	decision-making rules and procedures
				(c)	sampling techniques
				(d)	descriptions of emerging design
				(e)	explication of analytic strategy
				(f)	instrument development
		(B)	Trustworthiness notes (1) credibility (2) dependability (3) confirmability	(a)	peer debriefing interactions
				(b)	member checks, interactions
				(c)	triangulation reactions
				(d)	prolonged engagement and role
				(e)	process of selection of auditor, peer debriefer, and member checker

		(C)	Audit trail notes (1) substance of trail (2) structure of trail	(a) (b) (c) (d)	indexes dates cross-references linkages
5	Intentions and Disposition	(A)	Proposal (1) goals, objectives, and inquiry questions (2) intended methodology (3) relevant literature (4) information on current theory	(a) (b)	written document reference list
		(B)	Personal notes (1) reflexive notes (2) motivations	(a) (b) (c) (d)	self-evaluation and criticism theoretical preferences methodological preferences doubts
		(C)	Expectations (1) predictions (2) intentions		
6	Instrument Development	(A)	Preliminary schedule of questions	(a)	rough drafts
		(B)	Observation formats	(b)	final product
		(C)	Surveys	(c)	feedback notes

Adapted from:

Halpern, E. S. (1983). Appendix A Audit trail categories, file types, and evidence. In Y. S. Lincoln & E. G. Guba. (1989). *Naturalistic inquiry* (pp. 382-384). Newbury Park, CA: Sage.

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