THE PROCESS OF FACILITATING DISCLOSURE OF PHYSICAL ABUSE: THE ROLE OF THE NURSE CLINICIAN

by

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To Scott and Gina Weakley, my children,
As long as the three of us are together, we can do anything.

To Jim and Afa Schimpf, my parents,
Who taught me the value of achievement.

To Michael Goss, my husband,
My loving and trusting sailor, we weathered another tour.

To Stephen Fernbach, my best friend and mentor,
You know.

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For eighteen years I have provided health care to women. Many of them were bruised, battered, beaten, humiliated, and shamed. I watched as they gave birth in hospital environments and tried to maintain a family unit in turbulent circumstances. I have seen women assume the responsibility for violence while blaming it on "hormones" and "menopause". I have seen women juggle and sacrifice for educational opportunities, only to be slapped down by insecure and jealous partners. But it wasn't until I saw my daughter grow and mature that I realized I want it to be an easier journey to be a woman. It was not until my son started becoming a man that I wanted him to respect the value and rights of women. I decided it was time to make a difference. It was time to impart that violence against women is not OK.

I set out on my journey to develop the knowledge that would provide others with the tools to help empower victims. I started with the people most like me, the people that I could influence and understand, my colleagues the nurses. From these nurses, I learned much about the profession, much about patient interaction, and much about myself. I am grateful to the nurse participants for sharing their stories. I thank them for their contributions for victims, women, and fellow nurse clinicians.

Doctoral study requires the commitment of professionals and experts who will unconditionally give. Give of their time, expertise, and energy. Rob

Slaughter and Kathy Lee inherited this project, and took the challenge without hesitation. Thanks to both of you for your dedication.

There are no words to commend Jeanne DeJoseph for the hours of time and her labor of love that went into this dissertation. She taught me the value of difference: in methods, in professional nursing, in thought, in persons, but above all, in women. Dr. DeJoseph is more than a mentor, more than a role model. She is a gift.

THE PROCESS OF FACILITATING DISCLOSURE OF PHYSICAL ABUSE:
THE ROLE OF THE NURSE CLINICIAN

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Uncovering information regarding sensitive issues poses a great challenge to nurse clinicians. Topics that evoke feelings of shame and stigmatization are not openly discussed, thus remain concealed. The reluctance to admit or disclose these situations interferes with the delivery of comprehensive health care, as well as the study of such problems. More specifically, is the issue of disclosure of physical abuse by an intimate partner. For nurse clinicians interacting with women on a daily basis, facilitating disclosure of domestic violence creates a great dilemma in clinical practice. This dilemma involves the following: 1) facilitators of disclosure, 2) barriers to disclosure, and 3) exploring why a woman stays.

A qualitative study was conducted to examine the processes of disclosure of physical abuse to nurse clinicians in the women's health care setting. This study utilized the focus group interview methodology. A total of five focus groups were

held in Hawaii, Alabama, Massachusetts, Texas, and California. Nurses interfacing with women in their clinical practice were invited to participate in the study. Verbal and written consent was obtained and audio taping was done.

Grounded theory techniques were the basis for analysis. Findings from the focus groups addressed the process of facilitating disclosure of domestic violence in the context of clinical nursing practice. The process of uncovering physical abuse is influenced by many interacting factors. Emerging themes surrounding these factors include personal knowing, handling the disclosure,blaming the victim, gender roles, and the deconstructing the medical patriarchy. Collectively, these focus groups have provided a framework to guide nurse clinicians in the process of facilitating disclosure of physical abuse.

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CHAPTER I

INTRODUCTION

A woman arrives at the police department accompanied by her spouse. She has suffered minor head injuries that are evident. Her spouse expresses great concern for her condition, and is extremely attentive toward his wife. He relates the story of the injury that does not refer to any domestic dispute. The woman only wants "to go home". Years later during a deposition relating to litigation involving spousal abuse, the woman is asked why she didn't request health treatment for her head injuries or divulge the real cause of the injury, domestic violence, to the police. She says, "I was too embarrassed".

The above vignette illustrates the complex issues encountered by women when they disclose the presence of domestic violence. These issues include shame, embarrassment, and guilt. Frequently, there is a reluctance on the part of the patient to admit physical abuse, which results in the underreporting of this type of violence. Practice guidelines have recently been changed to reflect new awareness of domestic violence. They encompass social policy and legislation, and mandate the recognition and reporting of incidents of domestic violence. Nurse clinicians and others cannot report physical abuse if they do not know it exists.

Uncovering battering is not an easy task. A posture of secrecy has been adopted and accepted in this society. This privacy myth creates an awkward

situation for nurse clinicians who care for women in the health care system. The paradox of the expectation and professional responsibility of disclosure, coupled with the privacy belief, complicates the role of the nurse. A clinician cannot offer treatment if the condition is not uncovered. Moreover, a woman will not admit domestic violence to the nurse, unless an opportunity for disclosure is present. Women become included in the health care system around certain events, one of which is pregnancy. The question that arises is, what is needed to facilitate the exchange of information between women and the nurse clinician.

Nurse clinicians working with childbearing women are familiar with the special needs of pregnancy, and use this time to address vulnerabilities and sensitive issues. Fortunately, the childbearing period brings women into contact with the health care system frequently and consistently. Pregnancy serves as a "ticket" into the health care system, and assessments and interventions are more likely to occur (Personal Communication, Jeanne DeJoseph Oct. 20, 1994). It seems reasonable that this time of interaction would provide an opportunity to address the problem of domestic violence. However, physical abuse remains the most underreported crime in this nation (Federal Bureau of Investigation, 1991).

Much of the nursing research addressing domestic violence has focused on the victim's perspective, the misdiagnosis of domestic violence as trauma, and the training guidelines for nurses dealing with domestic violence. Few studies explore the nurse's view regarding physical abuse. Moreover, the

published information fails to address the social, individual and family influences that comprise the context specific phenomenon of violence against women.

The following chapters present a qualitative look at the process of disclosure of physical abuse among nurse clinicians and female patients. The specific aims of the research were to: 1) evaluate the nurse clinician's knowledge of assessment protocols for the physically abused women in the perinatal setting, and, 2) explore the nurse clinician's role in facilitating disclosure of physical abuse among female patients in the perinatal setting.

The dissertation begins with a thorough review of the literature regarding violence against women. The historical underpinnings of violence and the influence of these factors in a context specific approach is presented. The early reports of violence against women are defined within Walker's (1979) Cycle of Violence, with subsequent research aimed at establishing a prevalence of abuse in our society. Battering during pregnancy is highlighted in this literature review, with the research targeting prevalence, assessment techniques, consequences of abuse, and the neonatal sequellae. Provider attitudes and effects on the interface with victims follows. The chapter concludes with an overview of research that attempts to explain why women stay in abusive relationships.

Several theories have been formulated to support the development of research about women and violence. Chapter III includes an in-depth discussion of one of these theoretical frameworks: social exchange theory.

Concepts of exchange patterns are presented which can guide the nurse-patient interaction and facilitate the disclosure of physical abuse. The foundation of this theory as presented in this dissertation, is to describe the individual and social importance of violence against women via the implicit values, assumptions, and propositions. A specific focus on the nurse clinician's role in weighing the process of disclosure is emphasized. The theoretical processes are defined and applied to the health care marketplace of exchange behaviors.

Methodology is presented in Chapter IV. The qualitative paradigm is explored, with a strong case made for the unique suitability of utilizing focus group interviews. A critique of the strengths and weaknesses of existing research highlights the support of the selected method. I have addressed a comprehensive list of issues and concerns within this methodology, while presenting the data in a relevant fashion. The salient points of study design, with interview guidelines, participant selection, and data collection are explained. The essays offered on power, gender, and research roles are topics that enhance the method. Credibility of the research is addressed utilizing existing criteria from previous works.

The process of disclosure is discussed in Chapter V. From the focus group data, a process is defined, with nurse clinicians elaborating on facilitators and barriers to the disclosure patterns. During the focus group discussions, participants inevitably began dialogue about why women stay in abusive relationships. Therefore, the findings are continued in Chapter VI with an in-

depth description of the paradox of "why a woman stays". Insights, thoughts, and practice behaviors are shared through the nurses' stories during the interview process. The valuable words from nurse clinicians in five sites across the United States honor the complex phenomenon of facilitating disclosure of physical abuse among women in the perinatal setting.

Conclusions and recommendations for practice are presented in the closing chapter. Implications for nurses are enumerated. Existing guidelines are reinforced, and new avenues of thought are offered.

As I reviewed the comparative body of literature, I found it necessary to define specific terms I have used throughout this research process. Battering, intimate violence, spousal abuse, and domestic violence are accepted terminology for the problem of violence against women. Although these words are frequently interchanged when delineating victims and perpetrators, domestic violence appears to be the most "accepted" and familiar phrase in this society. Therefore, "domestic violence" is used interchangeably throughout this paper with "violence against women by a male partner".

The use of the term "victim" has been challenged by many feminists and scholars. The term "survivor" is favored by many who have commitments to the battered women's movement. My view, however, is in the direction of terming physically abused women as "victims". My perspective of physical abuse by a male partner is that once a woman suffers at the hand of an intimate male partner, the victimization never leaves her. She carries the stigma of an "abused women" or "abused wife" always. Being violated, battered, degraded,

and stripped of dignity cannot be forgotten. Although the victim "survives", she learns only to manage the victimization, not forget its existence. She is still a captive of social circumstance. Further, survival implies a battle has been fought and somebody "wins". The battered women's movement is far from "won". Because of these personal perspectives, I choose to reference the battered woman as a victim.

Finally, a note about myself as the researcher. I am a nurse clinician and have been involved in women's health care for 18 years. My experience deals with women's health care needs throughout all phases of their lifespan including contraception, fertility, childbearing, menopause, and violence in the lives of women and children. In truth, I have not always been consistent in my process of facilitating disclosure of physical abuse.

I am a novice nurse researcher. Although I have secured extramural funding for different quantitative studies, qualitative work is a new experience. A pivotal moment in the development of this study came during the critique of McFarlane's (1989) study on the nurse's influence during assessment for physical abuse. Dr. McFarlane's contribution coupled with my clinical practice experience gave me the insight needed to develop the methodology utilized in this research.

I am a woman in an upper middle class environment. Some might classify my life as "privileged". I have practiced professional nursing in a male dominated medical community. I have established a collaborative model of practice with varying levels of health care providers involving both genders. I

have achieved higher education surrounded by a rural community of thought that places a low value on advanced practice nurses, and a high value on traditional sex roles. I have raised and reared two children, one male, and one female, in a blended family. They respect safety, the value of education, the worth of both gender roles, and the right to live violence free. Indeed, I am "privileged".

I have "personal knowing" with domestic violence. I am a victim. Today, I have accepted the challenge and become empowered.

Because of my personal, professional, and social experience, conducting the focus groups was a challenge. Being an observer only during the interviews was not conducive to adequate data collection. I found it necessary to participate in differing roles throughout the research process. These fluctuations are evident as the data are reported. When quotations are used, the data are taken verbatim from the nurse participants. The names have been altered to ensure privacy and anonymity, including my own.

CHAPTER II

A REVIEW OF THE PHENOMENON

"Who Invented Domestic Violence Anyway?"
SF, age 50, Neonatologist

Historical Underpinnings: The Birth of Misconceptions

Violence against women is historically deep rooted. Over the centuries, it has permeated all aspects of society, cultures, and religions. Christianity, its viewpoint reflected in the early books of the Bible, clearly considered women to be sinful successors of Eve. Judaism focused on the uncleanliness of women, when during the menses (niddah) many behaviors are restricted. The view of the Judeo-Christian doctrine is that it supports domestic violence as illustrated in advocating punishment of women for talking back, refusing intercourse, having miscarriages, being sodomized, masturbating, scolding and nagging, and other minor encounters (Martin, 1976). In societies where women were considered to be the "property" of men, fit only to procreate and bear children to carry on the male family name, purity and virtuousness were the most desirable attributes in the female spouse.

Historically, many cultures have supported customs that demean and mutilate women. Foot binding of women in China was performed solely because men valued small feet. A Muslim tradition known as Purdah, secluded women from contact with men outside the immediate family. In many

societies, clitoridectomy was/is performed to reduce libido in females. Some Middle Eastern and Arab cultures dictate that women and female children eat separately and last, fostering malnutrition and starvation in times of famine (Martin, 1976). More subtle approaches to the devaluation of women involve losing the maiden name in marriage, lay healers being viewed as "witches" and promising to obey the male spouse in the marriage vows. A popular example of the debasement of women is the "Rule of Thumb" law, that stated a man could beat his wife with an object no bigger than the width of his thumb. This law became entrenched and a part of the British legal code until the end of the 1800's.

These historical underpinnings directly influence the cultural context of the roles of women. Western society revolves around a patriarchal model. This model is operationalized by the service role of women, in which performance of domestic chores serve as an opportunity for women to show appreciation for male favor. In contrast, male dominant characteristics are associated with violence, machismo and other so-called manlike qualities that reinforce control over his family, home, and wife, as well as the social construction of the patriarchal influence. With this perception of patriarchal power, by both males and females, men have dominated the enactment of laws and the formation of social and economic policy. Virtually all decision making authority has been under the domain of men. In addition, the privacy myth in coupled heterosexual relationships, where domestic harmony is associated with safety and security, provides a pseudo sanctuary against a violent society.

Violence against women by a male partner is not a singular experience, but consists of many influences that are perpetuated in a patriarchal society. Theoretical origins, cultural aspects, religious teachings, historical outlooks, and contemporary attitudes are major subsets that exist within the context of and shape the discourse around the study of, violence against women. Unfortunately, many of those in helping professions are not fully aware of the complex ring of influences that affect battered women. Subsequently, clinical practice reflects only those subsets that are familiar and comfortable to the practitioner. Many times nurses disregard the value and importance of disciplines and resources that are seldom utilized in day to day practice. Because of the fragmentation and tunnel view of violence against women, it is imperative to look at a context specific research agenda to examine the problem in its totality.

The context specific approach deals with violence through the nature of social settings and situations in which it occurs (Dobash & Dobash, 1979). If domestic violence is viewed by looking only at isolated clues, such as characteristics of individuals or backgrounds of persons, a distorted view results. Accurate knowledge and awareness of the dynamics involved in domestic violence rests on the understanding of the integrated roles between individuals, society, and the prevailing cultural influences. A context specific approach focuses on these interacting factors.

An ideal lens to view the context specific approach falls within the constructs of social exchange theory. This framework encompasses the influences of

society, the victim and the health care provider within it's implicit values. Chapter III explores this theoretical stance, and applies the principles to the phenomenon of domestic violence and the qualitative paradigm.

The Cycle of Violence:

The Beginning of an Era to Address Domestic Violence

Lenore Walker (1979) was the first psychologist to develop a theoretical model specific to battered women. Although the view is quite specific to the perpetrator-victim dyad, a thorough understanding of the framework is germane for the nurse clinician and woman in order to comprehend the increasing health risk of physical abuse. Moreover, the dynamics associated with Walker's Cycle of Violence offer an intervention and treatment modality for victims of physical abuse.

Lenore Walker (1979), in her classic qualitative study, interviewed 120 volunteers about their experience with violence. In contrast to more quantitative methodologies, Walker's work concentrated on the commonalities expressed by the battered woman. Each woman's story itself was the definition of abuse. Walker contended that the battered woman rarely exaggerates, in fact she tends to minimize the abuse, and allowing her to tell her story was the sole method of data collection. From over 120 detailed stories, repeated analysis of interview tapes and listening to help sources for battered women, the theoretical framework, The Cycle of Violence, was derived. In order to provide a

background profile of the abused woman, I will discuss the three phases of the cycle as reported by Walker.

Phase I, the tension building phase, is characterized by the escalating loss of control by the perpetrator. Minor incidents occur, which the perpetrator uses as a reason to demean his victim. In her response, denial is the coping mechanism most often identified. The woman accepts responsibility for the perpetrator's behaviors and displays an attitude that she "deserves" the abuse. She may attempt to control as many external factors as possible. The batterer becomes even more oppressive, increasingly jealous and possessive. Eventually the tension culminates in a battering incident which initiates the next phase.

In Phase II, the acute battering incident results in the loss of control. The length and severity of Phase II is individualized to each dyad and cannot be predicted or explained. An interesting phenomena identified by Walker and substantiated in later research (Gondolf, 1993; Okun, 1986) is the fact that batterers do not accurately remember their actions. This inability to describe the incident is seen as evidence that batterers realize the behavior is inappropriate, and the desire for secrecy and privacy is a further argument that batterers may well be in control at some level. In contrast, the victim has an inordinate amount of concentration and she can clearly remember every detail of the abusive encounter. Amazingly, only when her injury becomes severe or life threatening will this woman interface with the health care system. Both the

perpetrator and the victim, for separate reasons, may wish to cover up the abuse.

Phase III, or the honeymoon phase, is the most complex time of the cycle. During this phase, loving reconciliation occurs and an unusual calm ensues. The theme of this phase centers around the batterer's remorse and his despair that the woman he abuses may leave him permanently. The victim, on the other hand, relies on denial as a defense mechanism to cope with the abuse and the shame in allowing it to happen. Therefore the relationship continues.

Phase III is the most difficult dynamic for health care professionals to comprehend. This drastic change from violence to intimacy feeds the domestic violence myths inherent in our society. According to King & Ryan (1989) these myths surround the misconceptions regarding the prevalence of abuse, the reasons women remain in abusive relationships, and the social class in which violence occurs. They postulate that health professionals may actually be hiding from uncovering abuse by not asking women about violence (p. 56). Furthermore, the reasons women remain in abusive relationships revolve around many factors, (e.g. economic, emotional, and religious issues). A commonly held misconception is that the violence must not be that terrible, or the woman would leave.

The qualitative nature of Walker's research has been subject to much criticism. Sampling issues, lack of adequate definitions, and inadequate identification of variables has hindered further theory development and testing.

Despite these limitations, the original work remains credible and is frequently referenced.

The Problem Called Domestic Violence

Violence against women, historically referred to as domestic violence, family violence, and wife abuse is epidemic in the United States (Finkelhor, 1983; Koss, Gidyez & Wisniewski, 1987). Family court records and police reports indicate up to 2 million or 21% of the U.S. female population report instances of physical abuse by their male partners. This translates to a battering every 15 seconds. Moreover, as much as 91% of intimate violence may never come to the attention of the police (Barnett & LaViolette, 1994). The Department of Justice estimates that 43% of violence against women by a male partner is underreported, making it the most underreported crime in America (Federal Bureau of Investigation; 1990).

A landmark epidemiological study conducted by sociologists Strauss, Gelles, & Steinmetz (1980) brought domestic violence to the foreground. This telephone survey of 2,143 American families was used to establish the National Data Base on Family Violence. The findings reported an overall rate of violence to be 113 per 1000 couples. Although this research established a true prevalence of abuse, misinterpretations of the types of violence, the severity of assault, and the naming of the perpetrator of the violence was not reported. Thus, many misconceptions were extrapolated from this work. For example,

aggression as well as physical contact were defined as forms of violent behaviors.

The health care system's response to violence is equally disturbing. Existing medical and nursing research showed a reluctance to address, and a failure to report, injuries or conditions as related to domestic violence (Goldberg & Tomlanovich, 1984; Kurz, 1987; McNeer & Anwar, 1987; 1989; Stark, Flitcraft & Frazier, 1979; Sugg & Inui, 1992). These studies reported that of 22% of the injuries resulting from partner violence, only 5% are documented in the medical chart as such. Other researchers reported that domestic violence is often misdiagnosed as depression, hypochondria, substance addiction, or hysteria (Bowker & Maurer, 1987; Stark, Flitcraft & Frazier, 1979). Therefore the treatment modalities offered to victims include medications, tranquilizers, antidepressants, and psychotherapy (Dobash & Dobash, 1979; Goldberg & Tomlanovich, 1984), but failed to address the true source of the violence, the perpetrator. In essence, the health care system has condoned family violence by failing to confront all players.

Responses of the health care provider to interventions regarding domestic violence protocols suggested the importance of education and training to increase identification and reporting of physical abuse. Tilden & Shepard (1987) developed and tested a protocol for emergency department nurses. Following an intensive training program, the prevalence rate of reported abuse by nurses in emergency departments increased from 5.6% to 30%. McNeer & Anwar (1989) utilized a similar approach of education and protocols for

professionals, showing a five-fold increase in physical abuse identification rates.

The research indicates that at least 30% of trauma injuries are directly attributed to domestic violence, but do not get reported as such. Interestingly, findings from these studies addressed this failure of reporting by offering the explanation of psychological distancing by the health care provider. Feelings of frustration were engendered in the health care provider when the victim continued the intimate relationship with the perpetrator. In addition, the professionals felt inadequate when they failed to provide solutions for the victim, thus creating a distant environment (Tilden & Shepard, 1987).

Recent studies indicated a reluctance on the part of the health care provider to approach victimization resulting from domestic violence. This hesitation is based, in part, on the misconceptions about violence, prevailing attitudes toward female victims, and time constraints (King & Ryan, 1989; McFarlane et al., 1991; Sugg & Inui,1992).

Health care providers, researchers, and health care policy makers agree that a problem exists. They disagree about the magnitude of the problem. This difference is mostly the result of inconsistent definitions coupled with discrepancies in reporting mechanisms. Reporting inconsistencies with an underestimation of violence against women has fueled the debate over the scope of the problem. The lack of consensus has fomented an antagonistic arena between policy makers, health care providers and researchers. Regrettably, this resulting conflict has delayed legislation, contributed to the

lack of resources, and limited public awareness of domestic violence, prevention strategies, treatment modalities, as well as availability of resources.

Self Report vs. Nurse Interview: How Best To Facilitate Disclosure

When reviewing the literature on the nurse clinician's role in the disclosure of physical abuse, McFarlane's et al. (1991) study stands out as the most accurate accounting of nursing interventions. This investigation compared the prevalence rates of physical abuse reported in women using self report questionnaires versus nurse interview format. There were 473 women randomly sampled for self report of abuse and 300 women received nurse interview. Information was gathered using a questionnaire that targeted physical abuse, social history, medical history, and demographic data. The validity and reliability of the interview tool had been previously established by Helton (1987a). The results were tabulated and there was a statistically significant difference that existed between the response rates of self report (7.3%) compared to nurse interview (29.3%). These results suggested that because of the sensitive nature of the topic, battered women are hesitant to report their plight to the health care professional without the benefit of face to face personal interaction. Self report is not conducive to the development of trust and rapport between the nurse and client. Furthermore, the analysis showed no statistical difference in the assessment of emotional problems, legal problems and changes in living arrangements. This study illustrated the

need for personal interview interaction when assessing for domestic violence. Without the rapport that is established during face to face interviews, the reporting of abuse to the health care system is severely decreased.

While the study illustrated the overwhelming number of women experiencing trauma related to violence, as well as the system's propensity to conceal it, it demonstrates more importantly the difference a health care professional can make in the reporting mechanisms. It is only when the problem is disclosed and the woman is believed credible, that a window of exchange offers hope for successful interventions. Why is it that, despite the empirical evidence, nurses and physicians are reluctant to uncover violence against women? Is it because nurses subscribe to existing socio-cultural beliefs, myths and expectations? Is it because of a lack of knowledge about domestic violence? Are there limited resources, thus hindering adequate recognition of the problem of abuse (Kurz, 1987)? Is there a window of opportunity for the unbiased, well informed nurse that allows for identification and reporting of this tragic problem that may go unnoticed? Finally, the research supports the value of education regarding domestic violence, but what allows for continued assessment? These questions formulate the basis for the dissertation research.

Battering During Pregnancy: The Silent Victims

With the research targeting the problem of domestic violence, of particular interest is the startling rate of battering during pregnancy. Numerous researchers have reported an overall prevalence rate of physical abuse among

pregnant women to be 8-10% nationally (Amaro et al, 1990; Bullock & McFarlane, 1988; Drake, 1982; Gelles, 1975; Helton et al., 1987a; Hilberman & Munson 1978; Hillard, 1985). However, the research focusing on battering during pregnancy was virtually nonexistent prior to 1980. Gelles (1974, 1975), was the first investigator to report abuse during pregnancy. This sociological research is considered a landmark study since prior reports did not systematically address abuse during pregnancy. Various disciplines included antedotal findings of abuse during pregnancy, namely prevalence rates and perinatal consequences of battering during pregnancy, as part of broader studies, (Bowker, 1983; Dobash & Dobash, 1979; Fagen, et al., 1983; Flynn, 1977; Gayford, 1978; Hilberman & Munson, 1978; Stacey & Schupe, 1983; Stark, Flitcraft & Frazier, 1979). Subsequently, the literature began to reflect the changing social and political climate surrounding violence against women, and a body of health care research was published that included assessment during pregnancy, prevalence rates among pregnant women, and the consequences of battering during pregnancy.

Assessment of Abuse During Pregnancy

Hillard's (1985) research offered valuable insights into the area of assessment, reporting, and treatment of the abused woman, specifically focusing on the timing of identification, the medical conditions, and the characteristics of battered pregnant women. A convenience sample of 742 women from a community prenatal clinic was assessed by a registered nurse.

Questions about physical abuse were incorporated into the health history. A control group consisted of women from the same population who did not report physical assault. The findings demonstrated that 11% of the women reported abuse during this and prior relationships, and 4% reported abuse during the current pregnancy. The timing of assessment emerged as an important factor (i.e., early in the first trimester) since many instances of abuse and assault begin later in pregnancy. Reports demonstrated a range of patterns of abuse including increases in the incidence (24%), decreases in abuse (36%), and 40% had no change.

Parker, et al. (1993), assessed a stratified prospective cohort of 691 ethnically diverse pregnant women for the prevalence, frequency, and severity of abuse and the association of abuse with entry into prenatal care. Utilizing the Abuse Assessment Screen, Conflict Tactics Scale, Index of Spouse Abuse, and Danger Assessment Screen, data were collected by self report. Findings indicated a higher level of abuse (60%) than previously noted. This significant increase was postulated to be influenced by repeated assessments through the trimesters, and in the private practice environment which patient-provider rapport and continuity of care is theoretically more common. These abused women were twice as likely to begin prenatal care in the third trimester. The frequency and severity of abuse during pregnancy was higher for white women, and sadly, teenagers reported multiple perpetrators of abuse (i.e. boyfriends and family members).

Prevalence of Abuse During Pregnancy

The hallmark nursing research efforts pertinent to violence during pregnancy were conducted by Helton, McFarlane and Anderson (1987a). In this classic descriptive study, a random sample of 290 culturally diverse women was assessed for physical abuse during the current pregnancy and violence prior to entry into prenatal care. The patients, equally divided according to ethnicity, were recruited from a large metropolitan area. A 19-item questionnaire, the Abuse Assessment Screen (AAS), developed by a panel of doctorally prepared experts, was administered at the time of the prenatal visit. Reliability was established by the test-retest method with a 1.0 value. Descriptive statistics were used for analysis and an 8% prevalence rate of physical abuse in the current pregnancy was reported. Fifteen percent of the sample reported they had experienced abuse prior to parturition, thus 23% of the sample had lived with violence. Prior abuse was determined to be the primary predictor of battering during pregnancy.

A model was developed from their study to address four independent variables that are applicable to the prevention strategies of battering during pregnancy (Helton et al., 1987b). The conceptual framework included: 1) behavioral change, 2) individual change, 3) continuing professional change and, 4) social system change. Each variable was addressed with different interventions and program objectives. A pretest/posttest design was utilized to measure all behavioral changes. A statistically significant change in knowledge and attitude was evident in the health care provider following

intervention. The generalizations of this research pointed to the importance of education about violence against women for clients, society, and providers. The authors contended that education is a major contributor in helping to prevent battering during pregnancy.

As an extension of this study, Helton & Snodgrass (1987) reevaluated the data and concentrated on the battered women's awareness of resources available to cope with an abusive mate. Descriptive analysis of the 291 women originally sampled focused on the questions specific to the lack of awareness concerning available community or personal resources. The investigation was limited by the sampling technique of the original study, where participants were recruited from a public clinic. While the family was the most frequently reported resource, none of the battered women identified the health care professional as a potential resource. More specific implications for practice, and research involve educating families about the value of the health care professional as a resource. In addition, the health care system must be made aware of their responsibility to provide clinicians with primary, secondary, and tertiary prevention strategies when dealing with violence against women.

Consequences of Battering During Pregnancy

The health consequences to the mother resulting from battering during pregnancy include conditions of hemorrhage, preterm labor, delayed prenatal care and substance abuse. Campbell et al. (1992) examined the relationship of adequacy of prenatal care and other variables to birth outcome. Interview

technique utilizing open-ended and fixed-choice questions were used for data collection with this convenience sample. Domains addressed in the interview included descriptions of the pregnancy and prenatal care, content of prenatal care, health behaviors, demographics, emotional support and data pertaining to physical violence. Results indicated a strong correlation between physical abuse and inadequate living conditions; abuse, and anxiety and depression; as well as battering and drug and alcohol abuse.

Amaro et al. (1990) examined substance abuse and violence among 1,293 pregnant women. Convenience sampling was employed and included consenting English and Spanish speaking patients. Due to the confidential nature of drug use, the women were protected from prosecution by a Writ of Confidentiality. Interviews were held during the pregnancy and financial incentives were offered to decrease the possibility of attrition. Closed ended, forced choice questions were asked about various aspects surrounding substance abuse. Drug abuse was documented by positive urine sampling. The results indicated a 7% prevalence rate of violence during pregnancy. Abused women had a greater risk of depression, more attempted suicides, and less emotional support. Moreover, drug use during pregnancy was associated with a 39% prevalence of domestic violence.

Neonatal Consequences of Battering During Pregnancy

The neonatal consequences of battering during pregnancy were studied by Bullock and McFarlane (1988). A sample of 589 pregnant women was

obtained from private and public practices in the southern part of the United States. Of the sample, 289 were randomly selected and interviewed post delivery using the Abuse Assessment Scale. Because low birth weight (LBW) has been correlated with smoking and alcohol use, the women were assessed for these behaviors, and these data were analyzed with chart review information. The findings suggested an increase in LBW infants born to mothers who are physically battered (12.6%) compared to non abused women (6.6%) ($X2=5.4$; $p<.02$). The number of LBW infants was not statistically different in public or private patients when comparing battered women against the non battered sample. This finding was attributed to the confounding variable of socioeconomic status which was difficult to control. The study indicated a strong correlation between physical abuse and LBW. Controlled studies are needed to examine the variables that influence adverse outcomes of pregnancy and how they interface with physical abuse.

Emotional Responses to Physical Abuse

The health care system contributes to the emotional turmoil experienced by battered women. This milieu is perpetuated by the perceived insensitivity of health care providers. Research has alluded to patient dissatisfaction with the system, an unwillingness to confide in health care professionals, and a fear of being judged as major contributors to lack of comfort in the health care system (Drake, 1982: Kerouac et al., 1986). These findings pose important questions. If an abused woman feels judged and has few social resources available to

her, how can she seek help for health risks? Who will uncover adverse health practices in a battered woman when she cannot tell her story?

Provider Attitudes and Responses To Domestic Violence

Other studies have been directed toward the health care system's approach to domestic violence in the area of attitudes, beliefs, and socialization of the provider. While the majority of studies have focused on Emergency Department triage and protocols for physical abuse, a limited number of studies have quantitatively and qualitatively identified certain barriers in the progress of interfacing with violence against women by a male partner. These studies examine cultural measures (Dobash & Dobash, 1993; Yllo, 1983), attitude dimensions, and responses to help seeking behaviors by victims and providers (Greenblat, 1985; Kalmuss, 1987). The research has been criticized for limitations of reliability and validity testing, social desirability responses, and the lack of an adequate instrument to explore the given constructs.

One of the earliest nursing studies of attitudes and responses was by Lichtenstein (1981) who utilized a 45-item questionnaire administered to advertisement respondents and shelter residents to examine information about physical abuse. The questionnaire was not tested for validity and reliability, and was used for descriptive analysis only. Results from the 28 surveys reported, the most commonly cited resources and support were medical and legal services. In 60% of the responses, the medical provider (not

defined) at the time was viewed negatively. The legal system was unsatisfactorally perceived by 70% of respondents.

Rose and Saunders (1986) reported the responses and attitudes of physicians and nurses to battered women. Eighty six physicians and 145 nurses responded to a two-page Likert-type questionnaire that examined the following health dimensions: beliefs about wife beating, (reliability .71-.79) and opposition to wife beating. A statistically significant difference existed between the two provider groups, suggesting that female gender rather than professional socialization is an influencing factor. Further, nurses and physicians with the most education in domestic violence held the stronger beliefs about helping behaviors for battered women.

Utilizing ethnographic interviews, Sugg & Inui (1992) explored the responses of physicians to the problem of domestic violence. Drawing from an urban health maintenance organization, 38 physicians were interviewed. Open-ended semi-structured questions were asked concerning assessment techniques, intervention strategies, and personal attitudes and experiences with violence. Content analysis was done by listening to and coding audio tapes. The major theme was described as opening "Pandora's Box" when it came to the issue of domestic violence. "Loss of control," "powerlessness," "risk of offending the patient," "too close for comfort," and "the time schedule battle" were the other themes voiced (p. 3158-3159). While ethnicity was adequately represented in the participants, the study was weakened by the close socioeconomic relationship between the women and providers.

The limitations of much of the early research revolved around the sampling techniques. For the most part, over representation occurred due to the fact many women were recruited from shelters, emergency rooms and other crisis populations. Many of the clinics were located in lower socioeconomic areas, skewing the variables of class, economic status and ethnicity. This furthered the myth that domestic abuse is a problem of the poor, uneducated and minority populations.

The findings of these studies raise many issues in regard to health care practices. The Pandora's Box Syndrome reinforces the myth that abuse is a private matter. Confronting the false illusion of the perfect family, especially among upper socio-economic class families, epitomizes the threat of the loss of control by physicians. It is difficult for the health care provider to address a problem that carries such stigma with little possibility for reconciliation. In addition, offending a patient is of great concern to health care providers when faced with the competitiveness of health care and the push toward patient satisfaction. The well known complaint of the limited time factor is once again an obstacle in comprehensive service delivery. With the increasing number of women reporting physical abuse, the provider is faced with the conflict of dealing with the epidemic and its social ramifications versus "cranking" out the patient visits to keep up with the volume of scheduled appointments.

Why Women Stay or Why are Men allowed to Abuse?

The most frequently asked question when dealing with violence against women by a male partner is "why do women stay?" This question implies that the violence will stop when a woman leaves. Paradoxically, when a woman is physically out of the relationship, emotional abuse and harassment often escalated to the level of stalking and homicide (Campbell, 1986). The woman's ambivalence about remaining in an abusive environment confuses and frustrates the health care provider who feels powerless when dealing with these patients. It is estimated that half of women who seek medical aid for abuse return to their violent partner. Battered women continue to live in a dangerous environment of escalating risk even though they understand the seriousness of the situation (Okun, 1986). The understanding of this dynamic is crucial for the health care professional who is trained to offer safe and timely interventions for severe health risks, yet fear for the patient who returns to the environment.

Many disciplines have postulated theories of why women stay in a violent relationship and created a "picture" of the union. Pagelow, a sociologist, (1981) analyzed 350 questionnaires completed by women in shelters. Her findings suggested diminished educational resources to be the major reason for staying in abusive relationships. These findings were substantiated by Strube and Barbour (1983) and Fagen, Hansen, & Stewart (1986) who reported that economic dependency was the major reason cited for staying in the violent

relationship. Interestingly, this factor is moderately correlated with low educational level.

Strube and Barbour (1984) replicated their original study (1983), examining 251 battered women for the reasons of staying in or ending a violent relationship. When contacted after leaving the shelter, 29.5% of the women continued to live in the abusive relationship. Multiple regression analysis identified the following independent predictors of staying in the relationship: employment status, length of the relationship, economic hardship, love, and ethnicity. The important aspect of this analysis that affects health care providers is the complex interrelationships among the objective and subjective variables. Concrete issues such as substance abuse, history of violence, number of separations, and having a place of refuge is intertwined with the abstract concerns of love, respect, and self esteem. The complexities of the intimate nature of physical abuse, injury, and reconciliation were very difficult concepts for health care providers to accept.

Fagen, Stewart and Hansen (1983) conducted face to face interviews with 270 battered women from domestic violence projects across the country. Using descriptive analysis, they reported that 60% of the women had separated from the abuse at some point during the relationship. According to the authors, these women demonstrated resilience and problem solving capacities, crucial concepts in the understanding of resources needed for empowerment. Since termination eventually happened, these data dispel the myth that "abused women always stay".

Okun (1986) offered the explanation that separation is used as a coping strategy for the abused woman. Analysis from 300 questionnaires completed by women in shelters showed that 30.5% of the women never resumed cohabitation and 43% of the women eventually terminated the relationship. Significant findings ($p<.005$) illustrated that women who were the main bread winners were likely to leave immediately. Of the couples where the assailant was employed, 26.6% had immediate breakup. When the perpetrator was not employed, 78% had immediate termination of the relationship. Finally, the average number of previous terminations for those women who resumed cohabitation was 2.42 compared to 5.07 among the shelter residents who never resumed cohabitation. These data support the original premise that termination of an abusive relationship is more likely to happen in men who provided fewer material resources, and that separation serves as a primary coping mechanism during the "process" of leaving, and offers hope of successful interventions in that the woman does not always stay. In Chapter VI data about the nurse clinician's view of this phenomenon and how it affects the process of disclosure is discussed.

Discussion

Violence has become the focus of social policy construction. The health care agenda includes efforts to enhance the recognition of physical abuse against women and encourage reporting as a strategy to reduce violent behaviors. The nurse's role in meeting these goals includes the identification

and assessment of abuse. The perinatal period, a time of frequent and consistent contact with the health care system, is an optimal time for these nursing interventions. It is during this exchange that a woman has a legitimate ticket into the health care arena. It is then that she reaches out with minimal fear of retribution. However, in order for the nurse to provide an accepting, non-judgmental, and trusting atmosphere for patient interaction, the assessment environment must be void of the myths and misconceptions surrounding domestic violence. This will enable the nurse to address this health care problem with credibility and confidence. Since professional nurses have the commitment to promote optimum health through prevention strategies and a holistic perspective, assessment and identification of abuse without the threat of misinterpretations is a major nursing priority.

The health care provider derives professional satisfaction from the ability to obtain information from patients, piece together the diagnostic puzzle and prescribe intervention strategies. A problem that plagues health care providers is the traditional view of problems that require a sociological level of intervention. The traditional approach to health care delivery, as established by the medical model views violence by the level of injury or amount of trauma, but fails to acknowledge the broader scope of the problem. Hence, the context specific lens is abandoned. Historically, nurses have been trained in this model. Although this level of practice is clinically sound, a major threat to empowerment is evident by "partial" treatment of the condition known as

domestic violence. This tunnel vision severely limits the development of new, innovative, and alternate forms of interventions.

When a sensitive topic or stigmatized condition is encountered, the nurse clinician must discard the superficial assessment techniques and offer more seasoned tactics to elicit a true history and disclosure. Social values, the prevailing culture, and the patient's vulnerability are considerations that must be factored into the assessment of domestic violence in clinical practice. The task of addressing these variables, while developing a suitable treatment plan, challenges even the most knowledgeable nurse clinicians. As a result, the problem of physical violence has been deferred, for the most part, to the criminal justice system and social services.

The literature review presented above heightens the awareness of areas in need of study. Most research has concentrated on the victim, and her responses, behavior patterns, physical and emotional attributes. These studies yield much of the same information, clearly illustrating that a quantifiable problem exists. In addition, there is limited evidence alluding to depression, decreased self esteem, and poor health habits among battered women, conditions that greatly impact the possibility of empowerment. The deficiencies of these reports center around the sample selection and the lack of interface with society as a whole. Also, the quantitative data gathering measures have low reliability when applied to battered women. It is time to pursue another avenue of inquiry.

Qualitative research efforts are broader in scope, in that more societal influences can be examined in the context of physical abuse. Nursing research, as well as medical investigation, find attitudes and misconceptions taint the health care provider and impede the progress of empowerment strategies. However, these studies are small in comparison to the research that heavily emphasizes the prevalence of abuse and the victim's perceptions of physical violence.

In critical review of the literature on domestic violence, the following limitations are common to most studies. The majority of research efforts target the victim and her experience. Subsequently, locating participants for study, (i.e. a shelter) limits the settings for investigation. In reality, only a small percentage of battered women utilize shelter services . However, it is the shelters that have provided ready access for researchers, and a woman in crisis will disclose her situation more readily in this forum. This has created research findings that are generalized to all battered women, and falsely bias the profile of the abused woman. The phenomenon may have different ramifications for women who do not implore shelter resource. It is conceivable that a vast body of knowledge remains undiscovered about victims in other settings. This information may help define the problem and offer treatment in another context. These victims are accessible through the perinatal health care arena, where advocates, families, and societal influence come together for a short time in the experience of the battered women.

The health care provider is central to the 'treatment' concept of domestic violence. If the problem of physical abuse surfaces through adequate assessments, early contact with patients, and unsolicited disclosure, what, besides social service, can the nurse draw upon as intervention? A review of the research indicates that this issue has not been addressed. With increased awareness of violence against women and the legislative mandates surrounding the professions, nursing is committed to provide services specific to domestic violence. These services are individualized by considering the degree of violence, the varying involvement of players, and the level of readiness of the woman to receive intervention. If nursing is to function interdependently with other members of the health care team, then the repertoire of interventions must be organized. The only way to formulate this agenda is to ask the perinatal nurse clinicians what resources are needed for victims of abuse, and in what context or exchange will the patient receive them. Finally, the provider must be educated about the appropriateness of these interventions.

The literature substantiates the value of education regarding domestic violence in increasing the identification of abuse in many health care settings. There are guidelines that provide a "recipe" for conducting an intake interview. And the evidence strongly suggests that personal interaction far outweighs self report methods for identification of cases. However, do perinatal nurses continually assess for physical abuse against women? After the "honeymoon" from attending an educational presentation, are assessment behaviors still

performed? What factors are involved in keeping the health care provider in tune with the special needs of battered women? In what context will disclosure of violence against women occur?

Conclusion

Violence against women exists despite the recent efforts to eliminate it. While nurses are making a major contribution, much of the conducted research looks at one portion of this complex phenomenon, the victim, while scant inquiry exists about the health care provider, specifically the nurse clinician. The professional nurse's scope of practice includes the art of assessment, the availability of limited interventions, and the societal perception of a helping hand. These attributes coexist with the nurse's social, cultural, and historical make up that collectively comprise the nursing role. This perspective has not been adequately explored. The impact that clinical nursing, especially in the childbearing arena, is making on the issue of domestic violence, cannot be overlooked. Because primary prevention as a major goal rests within the professional scope of nursing practice, the research aims are raised with a qualitative tenet and explored in a qualitative paradigm in the conduct of this dissertation research.

CHAPTER III

FACILITATING DISCLOSURE; A SOCIAL EXCHANGE PERSPECTIVE

It is difficult to explain the aggressive and violent behaviors that occur between intimates. Individuals expect safety and nurturing when they enter into partnered relationships. Moreover, the concept of living with ongoing violence, escalating health risks, and the increasing potential for physical harm is foreign to most people. This paradox confuses and frustrates health care professionals whose diligent efforts to interface with victims of domestic violence seems futile, at best. The exchange behaviors between nurse clinicians and victims of physical abuse are not always in an open and honest forum. This inconsistency challenges the basic premise of the delivery of health care, namely, safe reciprocal expectations.

The search for an explanation for the domestic violence epidemic leads researchers to examine various theoretical perspectives for causation and explanatory frameworks for violence. Upon analysis however, no one theory is encompassing or embracing of all facets of the dynamic of domestic violence. The disciplines have derived concepts from many theoretical stances and integrated these propositions into programs of research. The quest for explanations for violence against women has centered on a theoretical basis that reflects the needs of society, the victim, the family, and the relationship.

Social exchange theory, primarily developed by Blau (1964), Homans (1958, 1967) and Levi-Strauss (1969), contains the conceptual framework to address both macro-societal and micro-societal needs, making it applicable to the health care provider's interface with victims of domestic violence. Although much criticized for a utilitarian or monetary focus, social exchange theory provides a broad foundation, far removed from the cost emphasis of early theorists. This contemporary exchange perspective allows health care professionals to understand the phenomenon of violence against women and explore alternative avenues of inquiry impacting clinical practice and the delivery of health care services.

This chapter presents theory and interpretation, based on social exchange concepts, applicable to the health care provider as well as the victim of domestic violence. Utilizing the health care visit as the marketplace of prenatal care, the interactions, interfacing behaviors, and exchange patterns between the women and nurse clinicians are presented.

The issues addressed within a social exchange framework embrace epistemological and ontological attitudes from sociology, psychology, anthropology, family theory, and social science. These positions define patterns of behavior and the dynamics of relationships, which provide stability, promote reciprocity, and prevent imbalances. Social exchange is based on the assumption that interactions are guided by the pursuit of rewards and the avoidance of punishment and costs (Gelles & Cornell, 1990). Each aspect of the interaction contains satisfaction, reciprocity, fairness, commitment, and trust (Sabatelli & Shehan, 1993), whereby stability and reciprocity offset imbalances. These concepts are inherent to the nurse/patient relationship and can be applied when approaching sensitive health risks with vulnerable patients.

Although a singular theoretical basis for a phenomenon as complex as domestic violence has been elusive, an integrated presentation of social exchange theory is offered. Before further exploration of the postulated approach to social exchange theory within the context of violence against women, three of the more popular theories will be reviewed. Frameworks and theoretical perspectives can heavily influence how society views domestic violence, how the health care professional approaches physical abuse, and how the victim is able to disclose the presence of domestic violence. Relevant theories for examining abuse with the dyadic relationship can include Psychopathology, Social Learning Theory and the Stockholm Theory for Survivors. These frameworks are not isolated constructs, but they are interrelated and heavily affect the current development of social exchange theory.

Psychopathology

The causal orientation of pyschopathology provides the domestic violence epidemic with "excuses" for aggressive and violent behaviors. Although utilized primarily by child abuse researchers, this theoretical stance has been cited in early reports that implicate alcohol and drug abuse as the causative factor for violent behaviors against wives (Snell, 1964). The prevalence of these adversive behaviors has served to provide the perpetrator with "deviance disavowal" and "time out" excuses as normal and acceptable behavior (Gelles & Straus, 1979). Unfortunately, psychopathology has been accepted by society, and much of current social policy and legislation relies on this defense. To compound the problem, this approach has failed to differentiate the abnormal behaviors specific to violence or resolve the circularity of violent acts as

indicators of mental illness (Strauss & Gelles, 1978). As an example, the "crimes of passion defense," in which homicide is excused, and more importantly, *accepted* as a result of temporary loss of sanity because of jealousy, is increasingly effective.

The influence that this approach has on exchange behaviors is the effect on the philosophical attitude of the players in that exchange. When violent behaviors are excused or sanctioned, they become accepted bargaining pieces in the exchange marketplace. Thus, when entering into a social exchange pattern, the violent acts are not considered a cost, since the perpetrator does not "pay the price" for his actions. It is not common for this price to include monetary costs, or a loss of social standing or respect from the peer group. In fact, it is conceivable that gain of power within his circle occurs by "keeping her in line" and "showing her who is boss."

Social Learning Theory

Based on Bandura's (1963) theoretical framework, the research of Steele & Pollack (1974), reported a widely publicized account of child abuse arising from individuals from abusive homes. The explanatory component of this work indicated that abused children grew up amid psychological disorder that produced a generation of violent and aggressive behaviors (Gelles & Straus, 1978). They postulated that the family serves as a training ground for violence by example when families cope with stress and frustration in a dysfunctional manner. Since children are born with a "clean slate", violent behavior is learned, including the art of justification of violent behaviors. Conversely, children who grew up in non violent homes did not exhibit these violent behaviors as adults. Later research efforts were focused on this premise, further developing the

transgenerational perspective (Elbow, 1982). These theories identified the concepts of internalization and externalization, whereby the batterer rationalizes his violence and the victim accepts responsibility and blame for the behaviors. She assumes the posture of blame to avoid feeling helpless.

Although these models offer some plausible justification for generational transmission of violence, they are deficient in adequate methodological construction. Each example concentrates on a single unit of analysis, (e.g. child abuse, the abuser, or the victim). When viewing the issue of violence against women, a macro-societal lens is needed, where the unit of analysis must include a multidimensional process, not a single individual or construct.

The influence of social learning theory on social exchange is illustrated by societal acceptance that "men have always beaten their wives". This view is demonstrated in history, in the literature, in the arts, in the media and in legislation. Not only is violence a learned pattern from direct exposure to abusive behaviors, but it influences the prevailing societal norms, merely by the fact that violence is accepted in U.S. culture.

Stockholm Survivor Theory

The psychological model, the Stockholm Survivor Syndrome is based on the experiences reported by captors and their victims (McClure, 1978). Graham (1994) describes a bizarre reaction in which hostages and captors mutually bonded to one another. A source of security and deep emotional feelings existed, despite the danger and life threatening circumstances surrounding the terrorization. The Syndrome consists of four principles of behavior specific to hostage survival. This perspective has been viewed through a feminist perspective as a response to domestic violence. These principles, derived from

traumatic bonding theory (Dutton & Painter, 1981) and power imbalance (Walker, 1979) attempted to parallel the experiences of other forms of victimization. These characteristics include: 1) the perception of or actual threatening behaviors, 2) inability for escape, 3) isolation, and 4) degree of kindness from the perpetrator.

This theory has properties that are conducive to explain the phenomenon of violence against women. These include *power domination,* (men being in control and women being subordinate), *pathological transference*, (a passive posture adopted by the woman to cope with rape and physical abuse), and *intermittent violence*, (characterized by tension building, battering and a honeymoon phase). Based on these elements, this theoretical stance seems plausible and accurate for explaining domestic violence; however, further feminist analysis reveals incongruencies. Hostages are mostly male, and physical abuse is primarily against women. Captivity is rarely voluntary, while marriage is presumably voluntary. Violence against women can endure for years, with the emergence of such consequences as low self esteem, isolation, and self doubt. In contrast, the Stockholm Syndrome was developed from an ordeal of shorter duration including groups in addition to single hostage situations. Finally, where hostages are concerned, outside intervention is sought and negotiation for safety and intervention readily occur. Victims of domestic violence characteristically are not viewed with sympathetic concern, and their problems are treated as a *"private matter"*.

Although this theoretical model has features that partially portray the phenomenon, it does not explain nor explore societal influences concentrating on victimization. While the Stockholm Syndrome describes aspects of the problem, the context-specific view of domestic violence is not addressed. The strength of

this framework is its emphasis on the psychological interventions for victims of violence, not the societal implications that surround the phenomenon.

Various theorists, sociologists and researchers have attempted to employ other theories to explain family violence. These include systems theory, symbolic interactionism, feminist theory, and conflict theory. A critical review of these conceptualizations indicates the same limitations as the three theories reviewed. These criticisms are important in illustrating the problems of contextualizing the phenomenon of violence against women by a male partner, as well as the problem of explaining the diverse elements that comprise domestic violence. These considerations are: 1) a micro-societal only view of physical abuse, 2) the inability to contrast and compare characteristics of non abused women to abused women, 3) the over research of individuals residing in crisis environments, and 4) the failure of explanatory propositions to embrace the entire societal interface with victims, families, financial resources, social support, and the perpetrator.

The Theoretical Origins of Social Exchange Theory

Utilitarianism, the foundation of social exchange theory is open to criticism. This contribution implies that human beings enter into exchanges in a marketplace in order to maximize their material benefits. A basic assumption contained within this "utility" is that people have access to all necessary information, consider all available alternatives and select options that maximize the tangible benefits. Another important assumption is the cost factor that enters into exchange behaviors, where decisions regarding alternatives are based upon which decisions will yield the best payoff. Talcott Parsons (1937) reformulated this economic premise to develop a perspective on social action. This view

produced important assumptions that had a sociological component that renounced the material aspects of exchange behaviors. Later theorists developed alternative assumptions that provided the basis for contemporary exchange theory.

The classic principles that apply to the current discussion about exchange theory involve the individual's knowledge of the "profit" to be gained from interactions. A person does not always seek to maximize his profit, but always expects some gain. In addition, the players are not fully aware of all available resources, but they recognize alternatives in the exchange. Persons are not limited in the number of exchange behaviors, but by the resources at hand. Profit in this context may be defined as sentiments, services, symbols, or goals (Turner, 1994).

In a very early report, Frazier (1919) identified the influence that power and privilege exerted on exchange theory. These observations contributed to another exchange principle, namely that exchange processes operate to differentiate groups in terms of their access to valued commodities, and results in differences in the resources of power, privilege and prestige. This assumption has had great influence on contemporary theorizing about exchange theory.

Malinowski (1922) interpreted his social exchange observations in a functionalistic framework. He postulated that the psychological meaning rather than economic needs define social behavior. He further theorized that exchange relations extended beyond the immediate players, and operated to maintain extended social networks. Thus, social exchange serves as a function for social life.

Social behavior among individuals is a major theme of exchange theory. These behaviors are contingent on the social environment, and are greatly

influenced by the "life space" or psychological field of the individual (Lewin, 1951). Exchange patterns are not independent of these factors, therefore Lewin's (1951) functional tradition helps to understand social exchange in relation to behaviors and social norms.

The philosophical debate over social exchange theory has also been posited as collectivism versus individualism. *Collectivism*, or the macro-societal influence, defines the structuralism argument that individual's behavior in social relationships emerges in response to the social system. This stance influences the maintenance and stability of social systems. The behavior of individuals is regulated by the goals of the social system. *Individualism* proposes that social structure emerges as a result of the individuals attempt to fulfill his/her own needs. Societal norms are born because they provide individuals with an avenue of self fulfillment. The major evolution resulting from these perspectives are the social factors that allow society to function. Within the context of these principles are the forces that allow the patriarchal norms to prevail in our society, directly and indirectly perpetuating violence against women.

The macro-societal view encapsulates society by sanctioning the patriarchal influence on violence against women, where there is little or no cost, and sometimes zero price for physical abuse inflicted against women. This is illustrated with Mauss (1954) who stated that exchange represents the moral code of the group, where the patriarchal norms of "business as usual" is conducted in accordance with this code. Group morality, or *sui genris* as Durkheim (1951) defines it, serves a certain group that was created and reinforced by the prevailing male dominant norm. Other aspects of social life follow, when reinforcement of these exchange activities is present. Machismo qualities, toughness and harshness, for example, regulate all other social forces.

This is analogous to the situational norms of the role of women, where service oriented opportunities prevail, limited educational resources are available, and the traditional sex role orientation predominates.

The micro-societal, or individualistic viewpoint, applies to the interaction of an abused woman with the health care provider when she does not disclose her health risk of violence because she perceives no gain in doing so. The nurse does not perform the assessment because of a lack of resource. Thus the norm of keeping domestic violence a private matter is supported. Society accepts this posture of secrecy. The woman must draw upon her own resource for survival and the social relationship is terminated.

In summary, social exchange theory evolved from initial work incorporating the disciplines of economics, anthropology and sociology. Exchange theory has a utilitarian heritage that embraces an economic lineage where humans rationally seek to maximize their material benefits, or utility from exchanges with others in the marketplace (Turner, 1994). The structural, functional, collectivist and behaviorist influence have contributed to modern day exchange theory principles. From this tradition, two categories of social exchange were developed to characterize interactions between 1) individuals or micro-societal approach, and 2) large organizations and groups, or the macro-societal venue (Burr, 1974).

Homans' Influence on Social Exchange Theory

Homans' (1967) view of exchange theory developed from an anthropologic view. Homans believed that the focus of sociology should be on patterns of reinforcement. His first order abstractions included activities, interaction and sentiments. Activities pertained to what people do, interaction was the process,

and sentiments referred to the internal psychological states that manifested from actions that lead to social approval. Sentiments referred to those characteristics specific to social approval. A generalized reward includes love, respect, prestige, influence, admiration or any other attribute that is socially acceptable or rewarding to the individual. Conversely, disapproval constitutes a cost.

Homans (1958) postulated that behavioralism reflects societal relationships involving reciprocating rewards that are mutually gratifying within the context of social intercourse. On the contrary, when unfair exchanges occur, one member feels anger while the disadvantaged partner reflects guilt. This interaction will reduce the rewards and decrease the possibility of continued association (Boss, 1993). There are valued attributes to be exchanged, and the player agrees to undergo the cost of the exchange. Thus, the justice principle evolves, and persons stay in relationships as long as they perceive fairness and equity.

In concert with Levi-Strauss (1969), Homans believed there is an underlying historical influence regarding interactions, the assumption being that humans make choices and initiate action. They carry with them into any exchange learned patterns of how they are to behave. Furthermore, social behavior that is repeated is contingent on past experiences of the individual (Burr, 1973) Thus, an important proposition emerged, behaviors that have been proven rewarding will be repeated.

Homans' (1967) rigid experimental methodologies used inductive techniques to build his sociological theory via the development of empirically derived propositions (Duke, 1976; Turner 1994). Descriptive observations enabled Homans to label the interactions of groups in their activities, interactions and sentiments. This strategy led to the explanation of higher order schemes for the deductive stance regarding empirical propositions (Homans, 1967). The key

concepts/themes that drove the theoretical concepts can be identified as the following axioms: value, reward, and action (Turner, 1994). The behaviorist principles identified two more critical propositions that are applicable to the context of domestic violence. Repetition of behaviors will occur only as long as they continue to yield rewards, and the higher a person's social rank the larger the number of persons who originate interaction for him or her.

A major criticism of Homans' contribution centers around reductionism to the individual, with the broader view of society discounted. The view provided an intense perspective for the macro-societal application of exchange theory to flourish. This lens allowed an avenue for elaboration viewing of a context specific approach, where the micro-societal orientation dominates.

Blau's Influence on Social Exchange Theory

Contrasting with the behavioralistic approach of Homans, Blau's macro orientation turned his attentions towards the structural properties of exchange theory. Rather than developing a rigorous system of propositions, Blau enumerated concepts that captured fundamental process at diverse levels of societal organization (Turner, 1994). Societal life is perceived as a marketplace and negotiation is the basis of exchange. Exchange only occurs when rewards are expected and received (Turner, 1994). Justice and fairness are attributes germane to exchange transactions. When rewards are not received as expected, inevitable imbalances occur.

Producing a less deterministic and more interpretive view, Blau's premise is economically derived, and is based on associations involving actions that are contingent on rewarding the actions of others. These rewards, however, can take on tangible or non-tangible characteristics. Because humans rarely pursue

a single goal to the exclusion of others, the utilitarian view, where the costs are tangible, is of limited value. Non-tangible reward however, is the key and includes: money, social approval, esteem, respect, and compliance. Social norms and rules enter into exchange where trust and reciprocation are expected behaviors. Social power is the control of valued rewards and resources, and in turn is equated with differences in power.

Implicit Values

Regardless of the theoretical foundation that is cited, exchange theory revolves around central themes that are the fundamental traits of the framework. The players of social exchange are the individuals in the interaction exchanging behaviors in the marketplace. Figure 1.1 defines the players in the health care marketplace. Three implicit values are inherent to social exchange theory which are *rewards*, *costs*, and *profit* (Nye, 1979). These concepts apply to the macro-societal level as well as the micro-societal approach to exchange behaviors, thus are essential to the application of the theory to real life events.

Rewards

Rewards are what a person gains from an interaction. Early reports focused on the monetary rewards of money, tangible goods, or utility from a free marketplace. Behaviorialists replaced utility with rewards that are primarily psychological. Thiabout and Kelly (1959) expanded this view to include personal gratifications such as status, relationships, and satisfying experiences. Rewards take on intrinsic and extrinsic characteristics, where personal and social gain occur respectively.

Costs

Costs, on the other hand, imply those behaviors that a person dislikes. Negative connotations, loss of identity, feeling disliked, and loss of status are common costs. Costs also include foregone rewards. (Thiabout & Kelly, 1957).

Profit

The final concept is profit, or what is enjoyed from an interaction. Like the previous assumptions, profit can be tangible or non-material. It is the profit aspect of interaction that fails in unsuccessful reciprocal behavior. When profits are forthcoming, social interaction continues. Conversely, when exchange fails to yield profit, interaction ceases. Viewing these three values, the equation for social exchange theory reads:

Rewards (R) - Costs (C) = Profit (P)

An example of social exchange principles is presented in the following scenario. A victim of domestic violence becomes pregnant. She wishes to seek prenatal care (P) to ensure a healthy infant (R). However, she must take the risk that her domestic situation will be uncovered (C), the possibility the pepretrator will find out, and the health care professional will judge or label her by the disclosure. Conversely, the health care provider upon intake and assessment of this woman, must provide adequate prenatal services (P). This action will produce a positive outcome (R). This provision of care implies that the nurse will approach the 'taboo' subject of domestic violence (C). By doing so, the nurse may not have the skill, resource, or ability to impact the situation (C). Unless the costs (C) are perceived as less than the reward, reciprocity will not occur, and the continuation of exchange is endangered. Figure 1.2 conceptualizes this equation in the perpsective of disclosure.

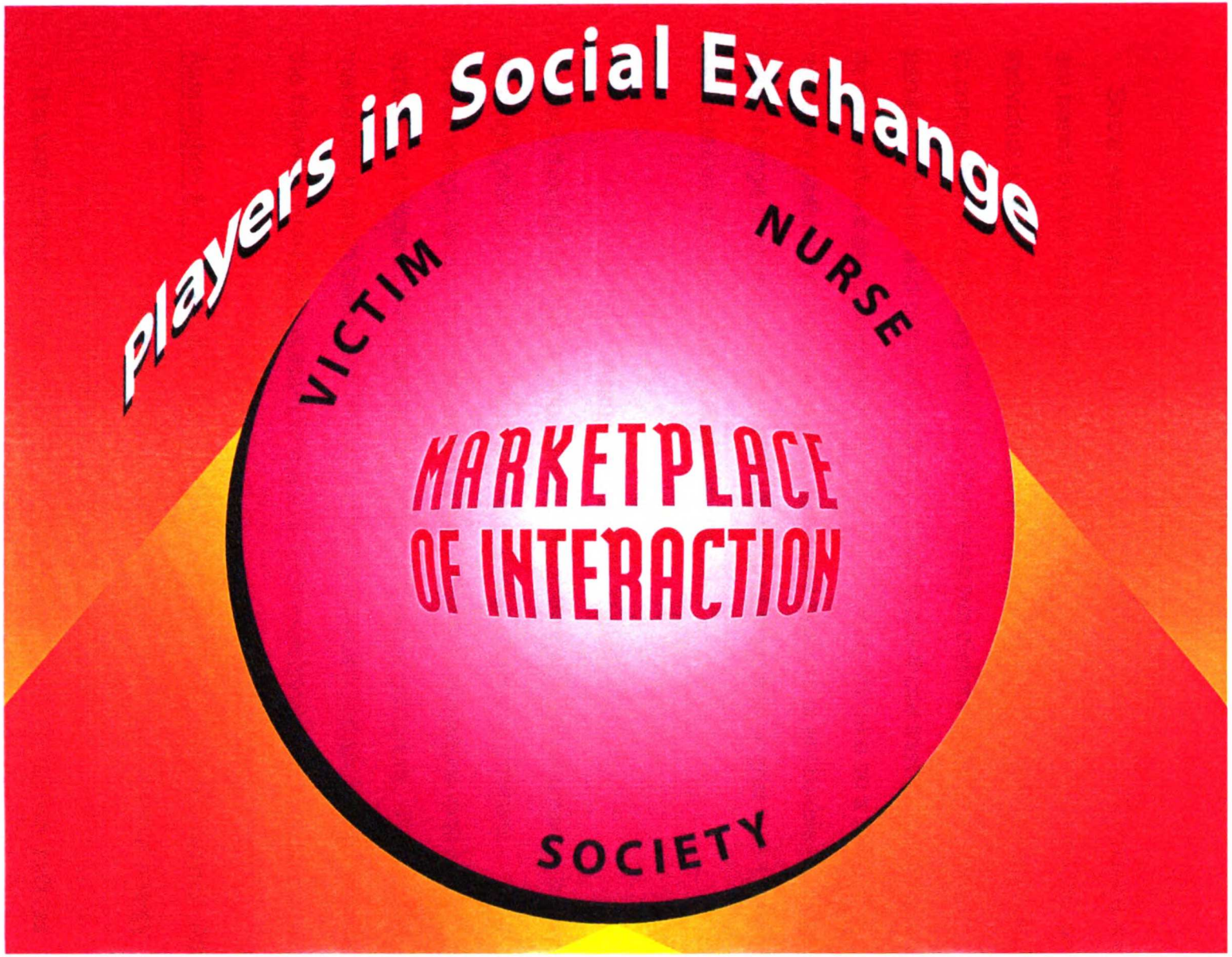


Figure 1.1

Basic Processes

Social exchange behaviors and patterns involve the players of exchange and are based on the processes of social attraction. As Blau (1992) pointed out, an individual is attracted to another if he/she expects the association with the other to conclude in a rewarding manner. There are two distinct aspects of reward, namely, intrinsic and extrinsic. Intrinsic rewards are those associations that are derived within a psychological context. Extrinsic rewards take on a more monetary posture. According to Blau, this basic process is applicable to theexchange between abused women and nurse clinicians, in that both types of associations are needed to facilitate disclosure.

Assumptions of the Theory

Each theoretician has outlined assumptions basic to social exchange theory. Although philosophically similar, these assumptions reflect a different epistemiologic lens of the individual theorist. These assumptions define the actions that occur in the marketplace during exchange behaviors. Viewing the marketplace as an interaction between a nurse clinician and an abused woman, the following assumptions apply in a social exchange framework:

Assumption #1 "People must undergo costs in order to obtain rewards. All behavior is costly, in that it requires expenditure of energy that might otherwise produce rewards."

It is well recognized that battered women seek outside assistance, such as from the health care system, when injury is evident. Dobash & Dobash (1993)

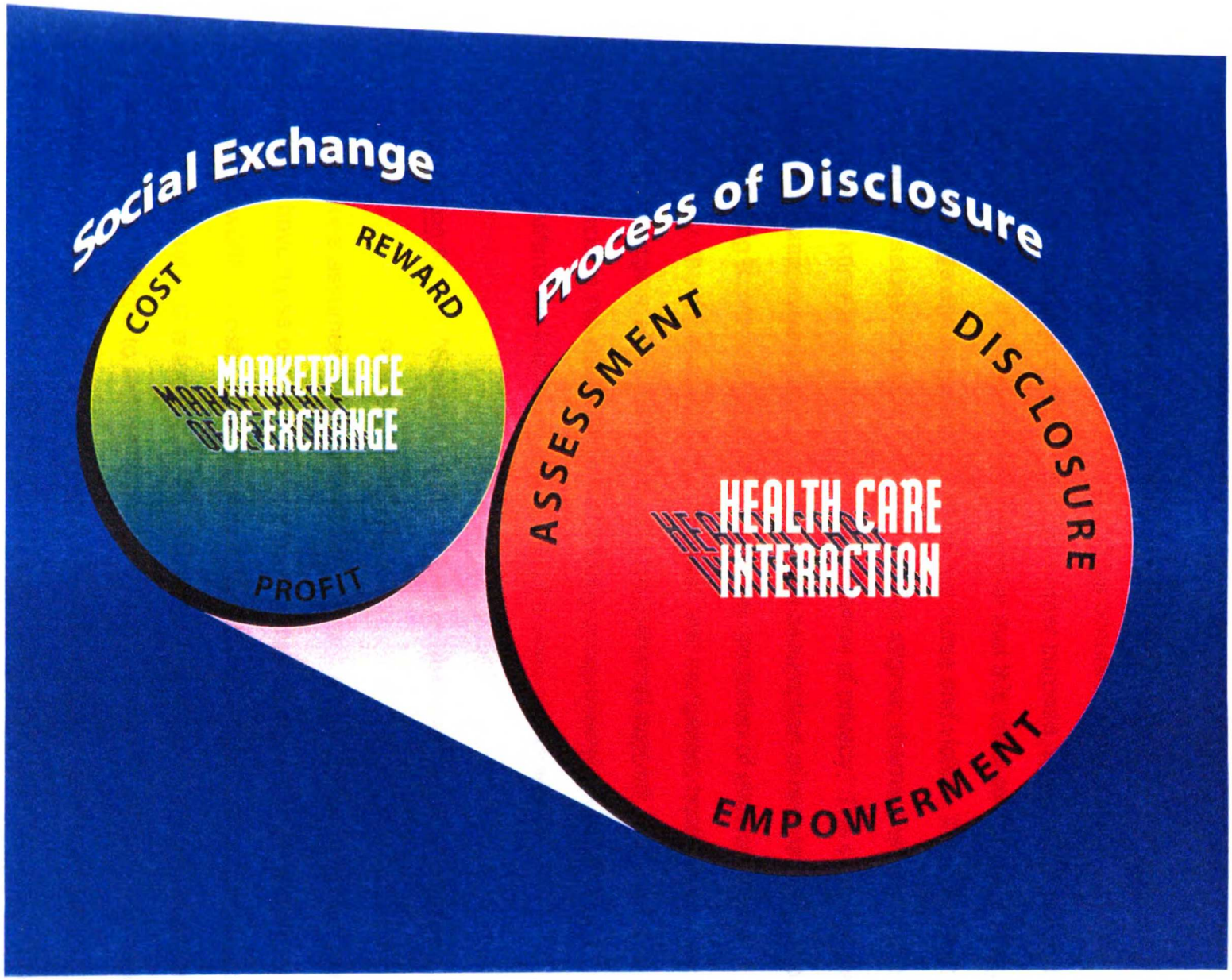


Figure 2.1

stated that, in addition to the physical attack, women who experience such violence eventually tire of both the man's justifications as well as her own personal failure to unilaterally resolve the problem of continued violence. Hence, they finally seek an external resource. This occurs most frequently during a health care exchange arranged for some other purpose, specifically, during the prenatal period. It is important to remember that this initial exchange is fraught with misgivings and trepidation, by both the nurse and victim. The costs for the patient to disclose domestic violence includes stigma, shame, the potential for the male to know about disclosure, and invasion of privacy. The costs for the nurse clinician involves time constraints, the assumption of responsibility and the fear of failing to provide viable options for the resolution of physical abuse. Conversely, the rewards the patients obtain are: competent health care, problem solving strategies, a healthy infant, and interpersonal support. The nurse's rewards include the satisfaction of delivering comprehensive health care services, ultimately improving the health of women and children.

Assumption #2 "Social behavior will not be repeated unless it has been rewarded in the past."

Everyone assumes values and opinions that are part of the concept of the self. To have these opinions and values rejected, disregarded, or not having a sense of worth is costly to individuals. Obviously, behaviors will not be repeated if the personal cost is too great. Only when a nurse secures honest disclosure will she/he continue to assess for physical abuse. Patients will relate instances of abuse only if they perceive rewards for the disclosure. Simply stated, disclosure of domestic violence will not occur if the value of the reward is less than the cost of the disclosure.

Assumption #3 "Those who receive what they feel they deserve feel satisfied, while those who receive less, feel anger, and those who receive more, feel guilty."

Although not directly implicated in this particular narrative of exchange behaviors, this assumption indirectly embraces many of the basic characteristics of victims. When battered women believe that they deserve their violent situation, they experience shame and guilt. The resultant posture is to reinforce the privacy myth, making disclosure to the nurse unlikely. These traits are challenging to the health care professional trying to optimize the exchange behaviors during health care interactions.

Assumption # 4 "All behavior is rational although much of it may be based on inadequate information and faulty prediction of future events."

It is well documented that prevailing myths and misconceptions surrounding domestic violence interfere with adequate treatment (King & Ryan, 1989; Rose & Saunders, 1986). For example, although a nurse clinician may intellectually recognize that battered women eventually leave the abusive situation, she cannot philosophically comprehend the common paradox of "why they stay?" In many instances, the nurse forms her personal judgment based on the prevailing societal myths. The nurse's inherent values can be a stumbling block that hinders the facilitation of disclosure. This phenomenon colors the attitudes and behaviors of many nurse clinicians.

Propositions

Blau's implicit exchange principles (Turner, 1994) can be adapted to present a framework linking the disclosure of physical abuse to nurse clinicians. *Power, value, conflict , rationality, reciprocity, justice, marginal utility and imbalance* are the underlying concepts applied to the phenomenon. Homan's work heavily influences the development of the following propositions.

Proposition #1: Power

> "Actors that have resources that others value are in a position to extract compliance from those seeking these resources."
>
> "Those who control valued resources have power over those who do not."

Power is concerned with dual function, those resources one needs, and the scarcity of those resources. If a health care provider has resources that a battered woman needs, for example in a crisis situation such as pregnancy or injury, they are in a position to extract compliance. Nurse clinicians have power over their own attitudes including assigning blame, dispensing treatment and providing resources. Nurses also have perceived power by lay persons who put value and credibility in the delivery of health care services. Therefore, great potential for imbalances occurs when power is not appropriately exercised in the marketplace of exchange.

Proposition #2: Value

According to Simmel (1963), value is idiosyncratic and ultimately tied to an individual's impulses and needs. Cultural and social patterns circumscribe the particular value. Unfortunately, much exchange involves efforts to manipulate

situations. Thus, the intensity of needs for the value is concealed and the availability of the value is made to seem less than what it actually is (Simmel, 1963). An example of this scenario is evident in women hiding the prevalence of abuse by failing to disclose while the nurse fails to provide adequate assessment for domestic violence. Exchanges occur when both parties perceive the object given is less valuable than the one received. The concept of disclosure can take on two postulates. The value of disclosure is less than the value of empowerment, satisfaction, treatment, and shelter. On the other hand, privacy is more valuable than the risk of labels and stereotyping. Furthermore, nurses will adequately assess when they receive internal value for doing so. The non-tangible rewards of control, responsibility, and accountability are patterns of value.

Proposition 3#: Rationality

> "The more profit expected from an activity, the more likely the activity to take place."

Entry into the health care system carries a set of expectations that focus on a "reward"' for doing so. When a woman seeks health care services she expects accurate diagnosis and treatment. Conversely, the practitioner expects compliance with prescribed regimens. More importantly, are the psychological gains that nurse clinicians offer to patients. These rewards specifically focus on profits that include self esteem, satisfaction, and commitment by both the nurse and the patient.

A woman will weigh the value of exiting her normal milieu, a controlled environment in the cycle of violence and the social silence, against the value of entering into an exchange whereby she has no control and risks lowering her self

esteem. Only if the exchange is rewarding and a value is associated with the action, will she enter the health care system according to the rules of the exchange.

Proposition #4: Reciprocity

> "The more frequently people exchange, the more obligations emerge, guiding subsequent exchanges among individuals."
>
> "The more obligations are violated, the more deprived parties will sanction those parties negatively violating the norm."

When entering the health care system, the woman encounters an arena of high expectations. This is especialy true in the example of perinatal care which involve lifestyle modifications, compliance with prescribed regimes, and commitment to the state of pregnancy. These expectations apply to health care providers, patients, and their social support systems. Health care providers must adequately assess and explain the proposed expectations of the treatment plan. The patients must subscribe to the treatment modalities with rigor and an element of faith. The social support system must uphold the environment so the woman feels safe and comfortable with the process of the treatment. As long as all parties exchange according to the rules and reciprocal expectations, the more a continued interaction is likely to occur. Violation of the expectations occurs when an unsympathetic tenor is encountered among the social support network. For example, if a health care provider fails to reciprocate the appropriate attitude towards the abusive relationship, the woman will not disclose the abuse. This posture keeps the problem of domestic violence a secret. *We cannot intervene if we do not know.* Negative social exchange will occur when a patient delays interaction with the health care system due to the perception of unfair treatment.

The woman seeking health care services expects and deserves reciprocal exchange to occur within the context of providers, family, and social support.

Proposition #5: Justice

"The more exchange relations are established, the more likely for fairness."

"When aspects of fairness in justice are violated, the more likely are the negative sanctions against those involved."

The role of the nurse clinician is based on establishing rapport, health assessment, and intervention strategies. Approaching sensitive issues in an appropriate manner predisposes the disclosure of potential health risks. When the patient does not honestly and candidly reveal an abusive situation, the justice principle is violated. Negative interactions will follow.

An example of this proposition is the pregnant patient who expects that she will receive access to care, a non-judgmental, empathetic provider, and social acceptance and support from those close to her. In exchange, she will comply with the 'norms' of women's health care, schedules of obtaining health care, provide a safe environment for the unborn child, prepare for parenting, and prepare for mid-life health issues. More importantly, the patient is expected to disclose those health behaviors that directly effect the health decisions regarding care. When a physically abused woman is stereotyped as a victim and emotional cripple, the potential for disclosure is impaired. Combine this phenomenon with the lack of support and societal acceptance and there is little incentive for a woman to continue in this place of unfair exchange. There is little incentive for the nurse to continue to assess when inaccurate information is exchanged. An

abused woman must receive fair and equal rewards that encompass time and money as well as the non tangible profits associated with self esteem.

Proposition #6: Marginal Utility

> "The more expected rewards have been forthcoming from an activity, the less valuable the activity and emission."

The concept of adequate health care for women is not unique. Across the nation, health care reform is addressing this issue by increasing services, providing more practitioner roles, improving access to care and financial reimbursement. The concern facing the health care provider encountering violence against women is that of awareness of the problem and the adequacy of treatment. The premise is that, if the content of service, includes inadequate assessment, or appropriate interventions are lacking, merely increasing the quantity of service will not affect the adequacy of the care provided. Research holds that curricula for health care professionals fail to include the subject of domestic violence (Campbell, 1993). Furthermore, resources available to abused pregnant women are sparse. Even if early contact with the health care system occurs, the problem of unmet expectations and perceptions remains.

Proposition #7: Imbalance

> "The more stabilized and balanced some exchange relations in social units are, the more likely other relations are to be unbalanced."

There is a balance that exists between society and an abusive partner, that allows violent behavior to continue. Violence is sanctioned in the form of relaxed legislative statutes, cultural acceptance of battering, and the notion that family violence is a private matter. The greater the 'forgiveness' by society, the greater

the imbalance against the victim. The abused woman is branded for remaining in her situation, chastised for allowing violence to continue, and slowly isolated from all supportive resources. The more a woman attempts to hide domestic violence and misrepresent the situation, especially to health care providers, the more conflict is born resulting in imbalances. Pregnant women are uniquely imbalanced because society places a high price on the safety of an unborn child while failing to recognize the importance of the safety and well being of the mother.

Conclusion

Domestic violence is an epidemic social and health condition in this nation. The reports indicate that up to 2 million women report abuse each year. It is recognized that these statistics are deceiving, and an estimated 43% of underreporting occurs (Federal Bureau of Investigation, 1990). The health consequences for these women include low birth weight, late entry into prenatal care, suicide, and homicides. Furthermore, the economic and medical costs add up to the millions of dollars annually.

As health care providers, we have to ask "why does underreporting occur?" Battered women do not disclose their plight for fear of stigmatization, judgment and the perception of unfair treatment. Furthermore, day to day life with an abusive partner reinforces isolation, low self esteem and depression, conditions which interfere with healthy patterns of exchange behaviors. Concurrently, many nurses deny or are reluctant to approach domestic violence due to fear of consequences, unfamiliarity with the topic, and a reluctance to accept the responsibility of knowing. With these pre-existing biases, beliefs, and

characteristics, disclosure of the domestic violence epidemic is hindered if not althogether thwarted.

Contemporary social exchange theory provides a framework to optimize interactions between patients and advanced practice nurses. Nurses can facilitate the process of disclosure of domestic violence only if they are aware of their important role in recognition, by their acceptance of professional responsibility. During the health care visit, a marketplace is available and the opportunity for the discovery of physical abuse is present. By uncovering the problem, meaningful interventions, which facilitate reciprocity between patients and health care providers will result.

The health care professional must be attuned to this unique opportunity. Nurse clinicians must put aside their own personal biases, prejudice, preconceptions and become sensitive to the plea of the victim. If the health provider is callous or afraid to intervene, the conspiracy of silence is maintained. Conversely, if the exchange between the nurse and the patient is reciprocal and rewards are derived, a shared responsibility between nurses and victims occurs.

It is when the abused woman can learn to trust the health care provider, the cost of disclosure brings reward. The blueprint for this pattern of exchange behaviors is presented within the social exchange framework. Together the nurse and patient will exchange strategies to empower the woman, ultimately improving the outcome for the mother and the unborn child.

CHAPTER IV

FOCUS GROUP INTERVIEW:

A QUALITATIVE PARADIGM

> "First and foremost, the report is a useful guide to individual and group interviewing, shaped by a sophisticated grasp both of theories of social exchange and of the scientific requirements for gathering data and testing hypotheses. " The Focused Interview

Uncovering information regarding sensitive issues poses a great challenge to nurse researchers. Topics that invoke feelings of shame and stigmatization are not openly discussed. Historically these topics have been kept behind closed doors by both society and families. Therefore, only a research method which helps the participant overcome the subjective feelings of shame and fear of stigmatization will be a successful avenue of inquiry. In pursuit of accurate and honest information, previous researchers have used quantitative methodologies as the predominant paradigm of scientific inquiry. Results from these methodologies indicated that little progress toward disclosure of sensitive health care issues was achieved.

Quantitative scientists have used objective measurements with preselected variables, which can strip the context and social meaning of the phenomenon (Leininger, 1985). In contrast, the researcher who uses a subjective approach in a safe and comfortable setting is allowed entry into the private world and

experiences of the participant. This substantiates Leininger's (1985) perspective that health and illness are embedded in cultural values, economic conditions, religious views, and the social environment of human expression.

The unique suitability of the qualitative approach is an ideal paradigm for exploring the process of facilitating disclosure of physical abuse among women victims. Focus group interaction, where nurse clinicians shared experiences and generated clinical vignettes, was a powerful data collection method. This approach was the blueprint for the dissertation research. This chapter outlines the goals and assumptions of qualitative research, briefly discusses socially sensitive research, and outlines ethical issues for this kind of inquiry. A thorough discussion of the focus group interview methodology is presented.

Goals of Qualitative Methodology

Historically, the scientific method utilizing quantitative techniques was the major avenue of valid and reliable nursing knowledge. However, with the birth of nursing research which focused on the holistic and humanistic sides of inquiry, the use of the positivist approach alone was no longer sufficient for examination of all phenomena of interest to nurses.

The use of naturalistic perspectives and qualitative methodology have been a very successful venue in the disciplines of anthropology and sociology. These methods provide a rich and fruitful alternative to the quantitative research agenda. Leininger (1985) states the goal of qualitative inquiry is to document and interpret as fully as possible the totality of whatever is being studied in particular contexts from the people's viewpoint or frame of reference (p. 5).

An important development of the qualitative paradigm rests in the refinement of the definition of the method by nurse researchers. Nurse researchers such as Cobb & Hagemaster (1987), have succinctly redefined qualitative investigation. The following principles demonstrate a contrast to quantitative methods and reflect the foundation for the naturalistic tradition: 1) Attention is given to the social context in which events occur and have meaning, 2) Emphasis on understanding the social world from the point of view of the participant, 3) The overall approach is primarily inductive, 4) Major data collection techniques include participant observation, interviewing, examination of printed materials and personal documents, 5) Data gathering is subject to ongoing revision in the field, 6) Discovery and description are major factors and concerns, 7) Hypotheses are usually developed during the research process, and 8) Analysis is usually presented in the narrative form.

These comments indicate a context-specific approach, viewing the phenomenon as a continuum within the social arena in which it exists. This evolution of the qualitative approach, viewing all interacting and influencing factors, makes it an excellent avenue for the study of the social problem of domestic violence and disclosure of physical abuse to nurse clinicians interacting with female patients.

Assumptions of the Method

There are basic premises germane to qualitative inquiry. These premises explain the nature of the method and provide valuable insights into study design, analysis, and interpretation. The following assumptions are derived from many researchers and sources. The assumptions are presented in

integrated and concise statements: (Cobb & Hagemaster, 1987; Denzin & Lincoln, 1994; Duffy, 1985; Leininger, 1985; Morse, 1994; Strauss, 1987).

Assumption 1. The natural environment provides rich and meaningful data.

Assumption 2. The ability to understand and comprehend an informant's conception of his\her private world is a crucial factor including objective and subjective experiences.

Assumption 3. Language, symbols, history, oral, and written accounts provide data.

Assumption 4. Cognition of symbols, philosophy, religion, myths, material and non-tangible goods reflect attributes that influence data.

Assumption 5. The concept of how people experience their world is a critical piece of qualitative methodology.

Assumption 6. Entry into the participant's world allows the researcher a first-hand vision of the humanistic experience.

In qualitative study the researcher is the main instrument for the method. Data are collected, interpreted, and represented via the researcher. Assumptions about the researcher include:

Assumption 7. The qualitative researcher believes first-hand experience.

Assumption 8. The researcher is concerned with the changing nature of reality.

Assumption 9. The researcher attempts to gain a complete and

holistic view through an array of data gathering techniques.

Assumption 10. The qualitative scientist is flexible, exploratory, and discovery oriented.

Assumption 11. It is essential for the researcher to understand the meaning that a person attaches to events.

Assumption 12. Qualitative data are collected primarily in the natural context where the phenomenon occurs.

Assumption 13. The researcher concentrates on truth, represented through the data, being a very vulnerable concept, subject to interpretation.

Socially Sensitive Research

Defining socially sensitive research is difficult due to the social context in which the issue exists for both the researcher and those being studied. What is considered a taboo subject for one, may indeed be acceptable to another. This posture depends on the social environment encountered during the research process. Conceivably, at any given time, any topic could be considered sensitive. Thus, sensitive research refers to studies where there are potential social consequences or implications (Sieber & Stanley, 1988).

The necessity or reasons for conducting sensitive research is such that it allows a view of concerns which are considered "darker" corners of society. Disclosing private taboo information produces pluralistic ignorance (Lee, 1993). Individuals only know the meaning of their behavior, however, they cannot judge how normal that behavior is compared to other people. This creates an arena where costs are potentially incurred for the disclosure of

these topics. These costs take on a variety of contexts, involving guilt, shame, embarrassment, discovery or sanctions (Lee & Renzetti, 1990).

Lee (1993) outlined three areas defining sensitive research. First, is the area of intrusive threat, implicating those issues that are private, stressful, or sacred. The second area entails those conditions concerned with deviance and social control. This includes topics that may reveal information which is stigmatizing or incriminating. Finally, sensitive topics can involve research that is political, where interests include powerful people, institutions, or the exercise of coercion and dominance. It is possible that one topic encompasses all of these areas.

The researcher conducting this type of inquiry must create and maintain a delicate balance with the individuals and their cost of disclosure, while providing a comfortable and trusting research environment. This is vital to increase the level of credibility, validity, and audibility of the findings. (Beck, 1993).

Ethical Considerations

Conducting research on sensitive issues commands a stringent ethical approach which values both the participant and the researcher. The researcher who elects to explore socially sensitive topics must address the stigma associated with conducting the research. The researcher's obligation to disseminate all findings may create even more socially sensitive issues for all players in the exchange. The researcher must also handle the personal conflicts encountered during the study process.

The participant considerations are more clearly delineated (APA, 1982). Of the many concerns, the major issue is the confidentiality and anonymity of the

participant and information. To address the complexities of ethical considerations of socially sensitive research, the American Psychological Association developed guidelines to conduct this type of research. While this publication does provide a valuable resource, it does not resolve all ethical problems.

Sieber & Stanley (1988) integrated the APA guidelines with a four point taxonomy to address ethical dimensions of socially sensitive research. These areas are: 1) formulating the research question, 2) conducting the research, 3) participants within the institutional context, and 4) interpretation and application of research findings. Within each of the four aspects, 10 issues were identified and addressed. With regard to researching disclosure of socially sensitive issues, the following matrix addresses the major concerns of analysis; privacy, confidentiality, sound and valid methodology, deception, informed consent, justice and equitable treatment, scientific freedom, ownership of data, values of epistemology, and risk benefit. By utilizing these principles, the value of the work is increased and the credibility of the overall research process is elevated, therefore providing research that is beneficial to society, and maximizes the yield of generalizing knowledge. The risks to the participants are controlled and minimized.

Researching Disclosure of Domestic Violence

The social enigma of domestic violence has been researched by scientists in multiple disciplines, including anthropology, sociology, medicine, and nursing. Each discipline approached the study of physical abuse using different epistemiolgic lenses. The instruments used for investigation were of divergent methodologies. Interestingly, the postmodern avenues were

distributed among both quantitative thinkers as well as qualitative researchers. A critique of the classic studies and the instruments used with the methods are presented. For the following critique, it is very important to delineate what is considered domestic violence, therefore, for the purpose of this research domestic violence is defined as violence against women by a male partner. This differs somewhat from the more global view in which of all forms of family violence,(i.e. child abuse and elder assault) are labeled as domestic violence.

Instruments to Measure Domestic Violence

The early attempts to "measure" domestic violence resulted in the development of the Conflict Tactic Scale (CTS) (Strauss, 1979). This instrument was designed to measure the use of reasoning, verbal aggression, and violence between and among family members. The initial sample consisted of 2,143 families completing the questionnaire.

Although the CTS has been referenced repeatedly in the literature, it has limited use in present day research surrounding domestic violence. The scope of the scale is overly broad, (i.e. all family members rather than coupled violence). The instrument uses gender specific terminology, (i.e. husband/wife rather than partner or couples). The instrument fails to differentiate the type of violence and the severity of violence, and does not adequately delineate the recipient of the violent behaviors. Finally, the instrument is self administered instead of researcher initiated, which has been shown to provide less desirable results (McFarlane, et al., 1991).

The Symptoms Checklist List (SCL-90) is a 90-item self report scale that was adopted for use in domestic violence research. This tool was initially designed to inventory and reflect individual psychological symptom patterns in

patients (Dergotis, 1974). The SCL-90 has a credible history pertaining to reliability and validity issues, having been utilized in many languages and with many medical conditions (Albeoff, 1974; Bolelouchy & Horvath, 1974; Harper & Steiger, 1978; Kim, Kim, & Won, 1983; 1983b). Kerouac et al. (1986) adapted the SCL-90 to address anxiety, depression and somatization as dimensions of health frequently encountered in battered women and their children. The final analysis was limited by the small sample size, sampling bias and confounding variables. This method of inquiry with its inherent limitations was not suitable for studying the complexities of violence with a context specific perspective.

More recent quantitative instruments include those developed by nurse researchers (Campbell, 1986; Helton et al., 1987a). Campbell identified the significance of assessing danger to predict the threat of homicide among female victims of domestic violence. She developed the Danger Assessment (DA), a 15-item yes/no questionnaire, based from her in-depth interview data.

The DA provides a global viewpoint of physical abuse against women. Many categories, (i.e. sexual abuse, prevalence of firearms, and child abuse), were included in the analysis. However, as attractive as this many faceted tool appears, it tells us little about the processes involved in which women disclosure escalating danger. In fact, Campbell reported that the in-depth interview used to develop the content for the tool was most fruitful and most informative. In my estimation, the qualitative approach was the more helpful of the strategies.

The most closely related quantitative study to the phenomenon of disclosure of violence to a health care practitioner is demonstrated in a report from McFarlane et al. (1991). Utilizing the 19 item Abuse Assessment Scale (AAS), McFarlane found that significant differences in reporting the prevalence of

abuse to a provider occurred when direct interview instead of self report techniques were utilized. The prevalence of abuse by self report on the AAS (7.5%) increased when the nurse took the time to directly ask the patient (29.3%). This comparative-descriptive study demonstrated the importance of the health care provider in the process of disclosure. However, it does not tell us the "what" behind the success.

Data Collection

Presented in the previous chapter is the how of approaching the process of disclosure utilizing the principles of social exchange theory. Although the theoretical foundations of social exchange provide the primary framework for facilitating disclosure of physical abuse, the feminist lens is ever present in the backdrop of this research. A feminist perspective allows the why of such study, while the qualitative paradigm gives us the way of this research.

The goals of feminist fieldwork involve a commitment to oppressed people that confronts systematic injustices based on gender (Chinn & Wheeler, 1985). Further, the feminist researcher incorporates benefit and a loyalty to one's own academic career where gender can influence the presentation and dissemination of research, both positively and negatively (Warren, 1986).

According to Yllo (1983) feminist researchers are particularly sensitive as to how data are interpreted and shared among both professionals and the general population. Qualitative research, although considered a feminist approach, confronts the issue of gender by valuing all people, and reporting all findings, regardless of gender (Chinn & Wheeler, 1985). In contrast, quantitative paradigms have been questioned as male oriented or patriarchal

(Bograd & Yllo, 1988) where gender and /or power have not been "factored" into the central focus of the work.

Importantly, Chinn & Wheeler (1985) acknowledged that the relationship between feminism and nursing has been obscure. This has been evident by lack of awareness and denial of nursing's own culture. They point out that we as nurses do have a history and culture that is worth exploring. This research study, guided by the feminist view, looks at the value of nurses, interactions among nurses, their historical experience, and their sharing of world views. This interaction among nurses allows insights into the clinical applications of knowledge and respects the struggles apparent to patients, nurses, and the interactions between them.

The dilemma of data collection and the most appropriate process of such, plagues most researchers. The traditional mode of collecting data is via a neutrally detached observer (Kleinman & Copp, 1993). This view was meant to prevent contamination and to limit bias. However, feminists are sensitive to the power/control relationships that are constructed in society (Bograd & Yllo, 1988). Feminist lines recognize the patriarchal interpretations of data that situate the problem of violence in a causal framework, for example using behavior as an explanation for violence. This posture ignores the context specific view of violence in which the social, individual, and family influences are important implications. The feminist perspective provides an alternative to the historical mode of data collection. The researcher-participant relationship is defined by the researcher, rather than a positivist posture of pre-defined criteria for the researcher.

Without specific delineation of the various roles and relationships of the research players, as well as a definite understanding of the varying contexts of

these relationships, the paradox of the quasi-positivist can occur. This malady transpires when we (the researchers) allow only particular emotions to evolve, denying emotions we deem inappropriate (Kleinman & Copp, 1993). This can have detrimental effects on the interpretation, the meaning, and the overall value of the work.

To address these potential pitfalls mentioned, the focus group interview methodology is presented. In addition to the method, the areas specific to the researcher-participant relationship that influence the data collection process are outlined. These areas are power, gender, and researcher-roles. By delineating and defining these characteristics within the context of the focus group interview, a research environment is created for data collection exploring the sensitive issue of domestic violence.

Focus Groups Interviews

The focus group interview is a qualitative research technique for studying ideas in a group context (Morgan, 1988). Focus group interviews have been used in previous nursing research. This method containes a cognitive approach and used preselected questions and topics permitting the individual to express perceptions of events that are normally held private (Affonso, et al., 1993). This avenue enters into the context that explains beliefs, thoughts, and intentions underlying behavior. This qualitative approach leads one to learn about populations with respect to conscious, semi-conscious, and unconscious psychological characteristics and processes (Basch, 1987).

Morgan (1988) argued that the hallmark of focus groups is the explicit use of group interaction to produce data and insights that would be less accessible without the interaction found among members in groups. This stance defines

the difference between focus groups where the interactions in the group provides the data, as opposed to group interview where the researcher asks questions and the participant responds. The focus group interview method taps into the attitudes and perceptions of humans and relates it to their needs, products, and perceptions (Krueger, 1994). In essence, the group is focused on a collective activity (Kitzinger, 1994).

Historical Overview

Although the focus group interview is new to nursing science, the focus group interview is not novel to other disciplines. Marketing researchers identified the strengths of focus groups as early as the 1920s (Bogardus, 1926; Merton, 1956). Merton and Lazarfeld used group interview techniques to evaluate public service announcements to improve the morale of civilian and military personal during World War II. Over the ensuing years, the technique lagged in popularity. It wasn't until the 1970 's push for consumerism that the method was reintroduced.

Marketing specialists and commercial programs rely heavily on focus group interview for advertising and product development. Exploring the thinking of consumers, through a method that provides believable results, while keeping the cost low, makes the focus group ideal for manufacturers and product analysts (Krueger, 1994). This advertising strategy became of interest to social scientists who wanted to look at how people regarded an experience, idea, or event. Thus, the focus group, covering various aspects of the research process by addressing the exploratory context, the clinical uses, the phenomenological uses, and the confirmatory uses became an attractive avenue for the applied social sciences (Susssman et al., 1994).

Health education and nursing researchers followed the trend in the late 1980s by utilizing the focus group interview to explore such topics as tobacco use, HIV, drinking and driving, contraception, childbearing, and program planning (Affonso et al. 1993; Basch, 1989; Heinman-Ratain et al. 1985; Nyamathi & Shuler, 1990; Stewart & Shamdasani, 1990, 1989).

Developing the Questions

The challenge with interview development is to identify thoroughly the goals of the research while constructing the content within a one to two hour time frame. Adequate preparation with literature reviews, expert panel consultation, and familiarity with the method will produce an interview guide to keep the group on task and focused, as well as address validity issues. Kingrey and colleagues (1990) outlined principles for the development of a successful interview. They are : 1) start with an introductory statement of the purpose of the interview, 2) go from general to specific, and neutral to sensitive, and 3) progress from non-threatening to threatening issues. Dilorio (1994) cautioned that researchers who plunge into focus group discussions without clearly identifying the goals risk unproductive group sessions resulting in gathering little meaningful interview data.

Based on these principles, a general interview guide was developed for the research study. An extensive review of the literature with expert consultation was done. Four areas of interest are addressed in the guide. These are: 1) knowledge of assessment techniques for physical abuse in women, 2) perceived barriers to nursing assessments regarding violence against women, 3) reporting procedures specific to physical abuse, and 4) recommendations

to improve the assessment environment for physical abuse between the female patient and the nurse clinician. (See Attachment A)

Sampling Issues

Typically focus groups include four to twelve participants (Basch, 1987; Krueger, 1994). Krueger contends that 6-10 participants are ideal so everyone has the opportunity to share insights. The group must be comprised of enough individuals to provide diversity of perceptions and instigate group interaction, yet small enough for "crowd" control (Personal communication David Langford, July 25,1993).

Since selecting participants is based on the common experiences of the individuals, a key principle involves forming a homogeneous focus group while eliciting a range of experiences, opinions, and ideas (Kingry, Tjedge & Friedman, 1990). The theoretical sample is an ideal method for selecting groups. The researcher identifies the direction of the study and the purpose of the research, then selects informants that possess commonalities or parallel interest in the phenomenon. The goal of qualitative sampling for focus groups is not generalizability, but to seek and describe (Brink, 1989).

To evaluate the sampling techniques for focus groups, it is appropriate to use the criteria outlined for general qualitative studies. Morse (1986) proposed the use of appropriateness and adequacy. The criteria of appropriateness answers the following: "Does the sampling technique provide representation of the information requested and does it fit the purpose of the study?" and "Is understanding facilitated by the informants?" When considering adequacy, the researcher evaluates the quality and amount of information contributed by participants, not the number of informants. The adequacy of the information in

this study was in great detail and in depth quality, evidenced by the transcripts and analysis of data from the five conducted groups..

One concern of the researcher is to determine how many groups are sufficient? Traditional guidelines suggest planning three to four focus groups, but realizing that flexibility is essential. In general, the goal is to do as many groups as required to provide an adequate answer to the research question (Morgan, 1988). The participants in this study are described below. The groups were carefully chosen according to site and background, representing various cultures and ethnicities. (Attachment B) Information was gathered on each participant and included age, years in practice, ethnicity, marital status, and gender.

The Participants

A convenience sample of five focus groups was recruited from academic settings, public health departments, ambulatory care clinics, and acute care facilities. Each focus group consisted of five to ten nurse clinicians employed in women's health care. The focus group sites were Northeastern University, Texas Women's University, Hilo, Hawaii, University of South Alabama Medical Center, (USAMC) and University of California, San Francisco (UCSF).

This research study addressed ethical concerns and ensured the integrity of the participant as well as the researcher. The protocol was approved by the Committee on Human Research at the University of California, San Francisco# H-10956-01.

Northeastern University, located in Boston, Massachusetts, agreed to participate in the proposed study. A focus group interview was conducted in the graduate school of nursing and consisted of students currently employed in the

women's health care setting and pursuing an advanced degree. Six nurses were recruited from the women's health care section of the graduate school.

The second site was Harris County Clinic, a perinatal care center affiliated with Texas Women's University in Houston, Texas. This site was chosen because much of the original nursing research regarding battering during pregnancy was initiated in this institution. The focus group consisted of ten nurse clinicians in the prenatal clinic, who deliver care to a large underserved population of pregnant patients.

As part of a joint prenatal project between the Hilo Public Health Department, Emory University, and the National Institute of Health, five public health nurses were employed to provide a form of prenatal case management to pregnant women of Hawaiian descent. These nurses agreed to participate in the focus group interview.

The University of South Alabama Medical Center is a large academic/tertiary care center for the southern region of Alabama. The perinatal service consists of Certified Nurse Anesthetists, Certified Nurse Midwives, Clinical Nurse Specialists, and staff nurses. The nurse clinicians employed in the acute care facility deliver nursing care services to antepartum, intrapartum and postpartum patients. Five providers participated in the interview process.

The final site was the Ambulatory Care Clinic at UCSF. Nurses working in the Ambulatory Gynecology clinic as well as the Obstetric Clinic Department were asked to be interviewed in a group setting. A total of seven nurse clinicians participated in the focus group.

A contact person was established at all five sites. Letters of support were forwarded to Human Subjects at UCSF and added to the originally approved application.

The inclusion criteria for participants consenting for study were the following: 1) possess a valid RN license from their state of employment, and 2) current employment in a Women's Health Care System providing care to women during the childbearing period. There was no requirement about length of employment in the setting or the field. There were no restrictions on the age of participants. Female and male nurse clinicians were invited to participate in the interviews. All participants were English speaking and willing to participate. Table 1.1 summarizes the groups and participants of the interviews.

The participants were made aware of the risks of the possibility of loss of anonymity and loss of privacy, as well as possible discomfort associated with talking about the sensitive issue of intimate violence against women. The participants were informed that they could choose not to answer any question or terminate the interview at any time. The study records and tapes were kept as anonymous as possible by assigning a code number to each interview. The tapes were transcribed verbatim, analyzed, and erased at the end of the dissertation defense. Written consent was obtained utilizing the approved consent form. (See Attachment C)

Continuing education regarding violence against women and the nurse clinician's professional responsibility was offered to the staff members following the completion of data collection. Sample protocols to help nurses deal with domestic violence were made available to all group members who were interested.

Setting

An important issue for focus group research is the physical environment of the interview. According to Basch (1987) the setting is comprised of the

TABLE 1.1 DEMOGRAPHIC DATA

SITE	AGE	YRS. IN NURSING	YRS. IN WOMENS HEALTH	MARITAL STATUS	ETHNIC BACK GROUND
Hilo (6)	35-45	8-18	2-18	M (6)	Asian (5) Cauc. (1)
Boston (6)	25-50	5-25	1-20	M (5) S (1)	Cauc (6)
Houston (10)	30-50	10-25	8-20	M (7) S (3)	Hisp. (1) Cauc (10)
USAMC (6)	30-60	5-30	10-15	M (5) S (1)	AA (4) Cauc. (2)
UCSF (8)	35-45	12-25	8-20	M (3) S (5)	AA (1) Cauc. (7)

physical and emotional space of the interview. The physical space should consist of a comfortable, sizable room, but small enough to be conducive to small group interaction. The room should be free of interruption, well lighted, and ventilated. This arrangement is conducive to audio taping. During this research study, refreshments were offered at all focus groups as an incentive to promote participation and comfort. Smoking was not permitted.

Defining the emotional space was the more challenging task. In order to obtain honest interchange and promote interaction among participants, a positive climate is essential. The key elements include a group facilitator who

has a non judgmental posture, who supports all views, who makes room for all to participate, and who promotes an atmosphere for freedom of expression, confidentiality, and emotional safety (Basch, 1987; Diolorio, 1994). The facilitator strives to ensure that these characteristics are transferred to the group members as well.

Moderator

One of the most important aspects of focus group research is the moderator who may also be the researcher. Kingrey et al (1990) defined the role of the researcher/moderator as the following: 1) question development, 2) facilitating the sessions, 3) documentation, 4) analysis, and 5) interpretation of the results. These researcher skills directly influence obtaining the study data. Furthermore, effective data collection is dependent on the researcher's ability to cover a range of relevant topics, provide specific data, foster interactions that explore feelings at some depth, and take the personal context of the participant into account within a limited time frame (Merton, 1956).

The likelihood of successful focus group research is heavily influenced by the researcher facilitating the interview. Creating a permissive environment that nurtures different perceptions and points of view without pressuring participants to vote, plan or reach consensus is essential to the mastery of the focus group (Krueger, 1994, p.6). This non-threatening environment enhances the participation of group interaction. This is especially valuable when sensitive issues and vulnerable topics are being evaluated. With this approach, these topics are more likely to be openly discussed.

Gaining entree into the focus group is another challenge of the moderator\researcher. Contrary to Krueger (1994) who argued that the

moderator is not an educator, but observer, Merton (1956) offers the view of depth, where the moderator interjects certain perspectives to guide the interview. This particular vision of the moderator's role is especially attractive, in that it allows flexibility and permits a reciprocity principle in the research process. For example, in this research, the researcher fluctuated within the roles of participant, colleague, researcher and educator. These various roles provided a reciprocal process, whereby an even exchange of dialogue occurred between all parties. This created a free flowing environment, enhancing data collection.

Power

The concept of power permeates the phenomenon of violence against women. Because violence in the lives of women is situated around diverse and conflicting power struggles, researching the problem in a non-threatening venue is a difficult task. Viewing the nurse-patient relationship as the marketplace for exchange, the following statement by McLaren (1991) is applicable, "..researchers engage so that they may gain entree into the field site, establish an ongoing rapport with participants through the generation of a reciprocal trust, maintain confidentiality, and achieve longevity." (pg. 149). He also offered that people do not possess power but produce it, and are produced by it (pg. 153).

An insightful philosophy offered by Kleinman and Copp (1993) says that qualitative researchers only gain control of their projects by first allowing themselves to lose it. This loss of control is germane to establishing mutual power relations with participants who are asked to explore sensitive issues in a public forum.

An example of giving power and reestablishing power occurred during one of the focus group interviews. The interview began, and almost immediately the group was participating, recounting a specific experience with an abused pregnant patient. The nurse manager was present. As the momentum of the group escalated, the manager was quick to regain her control, and place of importance among the group:

> "Can I call time right now? Are we going to be doing to do the interview right now?" "I have to coordinate some things,so you can turn that (tape recorder) off right now. I'm calling time out. " (Peggy)

It was difficult to recapture the enthusiasm of the group after this confrontation, but the interactions began anew and rich data collection eventually resulted. This power struggle illustrated important insights into the nature of the relationships that existed among these professional nurses that ultimately affected the clinical setting and professional roles. The data reflected the immense amount of power one nurse exerted on the practice setting, thus affecting the interaction among the patients and staff. Morgan (1993) wrote about this exact phenomenon as an advantage of focus group interviews, by providing a greater depth of understanding about the relationships between the members of a particular setting (p. 32).

Power is also equated with knowledge. Possessing knowledge by thoroughly reviewing the phenomenon gives credibility and power to the researcher. Additionally, the quest for knowledge by conducting research elevates the indirect power of the researcher. During one focus group, I seized the opportunity to use the forum as an avenue to dispel some of the myths and misconceptions regarding domestic violence. This preamble made me feel powerful among the group and initiated more dialogue and data collection:

> "You know one of the myths that we as providers carry around is that abused women are weak, they just get beat up and they want to stay. They are really very strong people inside." (Gay)

To illustrate the example of power by virtue of conducting research, the following excerpt was taken from the data analysis. A personal message was imparted to the participants utilizing the group forum as a captive audience.

> "And when we take care of patients. That's why I try to get across to the people, you can't judge them by your values." (Gay)

The give and take, the see-saw of power relations during research makes for a solid journey of self discovery and knowledge generation (McLaren, 1991).

Gender

There are many issues relating to gender in the data collection process. Warren (1986) defined gender as the way in which biological sex roles are culturally elaborated to the values, beliefs, technologies, and general fates to which we assign men and women (p. 13) Another view of gender according to Sampselle (1990) outlined two specific principles related to gender, that of gender equality and gender-free social roles. Gender equality challenges the view of male supremacy, while gender free roles attempt to downplay the service and supporting role inflicted upon women. These accounts addressed the importance that gender has on the disclosure of sensitive issues. The data reflected these salient points.

> "I think it's testosterone, I think it's a part of the male, men are stronger, and they were meant to be the more aggressive force in society, they were meant to be the hunters, and the fighters and the protectors. The women's bodies were designed for endurance and carrying children, the men were meant to go off to battle." (Debra)

Later in the interview this same nurse had the following comment and a reflection of her clinical practice:

> "It would be much harder for me to ask a patient who is coming in for her annual breast check and pap smear who was wearing a three piece suit and employed if she might be a victim of domestic violence." (Debra)

A second tier of gender issues directly include nursing as a profession. Hoff (1988) pointed out that a hospital cannot survive without nurses, and she questioned why the nursing profession had been dominated by hospitals and medicine for over 100 years, and accepted a subservient role? This question is of particular interest to the present research, because the phenomenon of this study fouses on the nurse's interface with physical abuse, most having affiliation in an acute care setting, and close clinical practice with medical professionals.

The literature repeatedly characterizes the medical profession as patriarchal, unsympathetic, and callous to the problem of violence against women (Rose & Saunders, 1986; Sugg & Inui, 1992). Nurses are a product of this patriarchal culture and training (Sampselle, 1990). However, more recent practice guidelines for nurses promote a feminist stance for the delivery of health care. This produces an incongruent situation for nurses trained in one

world view and expected to practice in another. The data clearly illustrated this concept.

> "It was an interesting response to grand rounds on domestic violence, even Dr. X and Dr. Y were saying, "you know, this is something we need to pay attention to." I don't know if it was a physician who gave grand rounds, but they all came back, like WOW. I don't know why it struck them that way." (Ellie)

> "And you know if it had been a woman on MediCal getting up there, they probably wouldn't have been impressed at all." (Debra)

Researcher Roles

Traditionally, the role of the researcher in focus group methodology has been one of bystander/moderator (Krueger, 1993; Morgan, 1988). This is in direct contrast with much of the feminist writing where researchers engage in the active production of both the data and analysis (McLaren, 1991). Stewart & Shamdasani (1990) refer to the relationship of moderator as intimacy when dealing with sensitive issues. The researcher is both the subject and object of the research. Basically, with group study, the researcher does with the group, not on the group.

An important consideration of focus group methodology is the amount of direction provided by the moderator\researcher (Stewart & Shamdasani, 1990). An appropriate balance between facilitating the discussion of specific research questions and allowing free flowing dialogue for data collection must be maintained. One method of guiding the discussion is to begin with a general or broad topic and gradually focus the group to a more specific dialogue. Another avenue of facilitation is to only offer probes to keep the group discussion going.

Frey & Fontana (1994) offered other views of the moderator role, that of a passive nondirective approach, or a degree of directive and active participation. The role is defined by the research interest, level of formality of the group, and personality of the researcher.

According to Morgan (1988), the goal of the focus group is to learn something new from the participants by allowing them to speak for themselves. Most experts advocate low level moderator\researcher involvement during the interview to limit bias and produce results that reflect the participant's view point (Krueger, 1994; Morgan, 1988; Stewart & Shamadasani, 1994).

Carey (1994) cited that the focus group is not intended to provide education or emotional support. However, in the present study, I participated fully and created many different roles as I collected the data. The research self, the concept of other, and personal situatedness allowed varying facets of the moderator role to evolve. In the following excerpt, the role as a nurse participant was evident.

> "I work in our county's system, so do you, sometimes the right foot does not know what the left foot is doing. This is nursing, this is the county, this is the family practice clinic, and even though we are all working towards the same basic goal, I don't even know who runs the family practice clinic because I'm so busy trying to stay afloat in my own department." (Gay)

In contrast to the preceding descriptions, a nontraditional researcher role evolved during one of the focus group interviews. This role involved educating the nurses regarding the professional responsibility surrounding domestic violence. In each group, there was a time when the group wanted information. This somewhat paralleled Krueger's (1994) description of the "expert consultant", where the moderator is sought out by the participant (p. 105).

"Who do I report to? You know, Do I ? What do I, Who do I call?" (Anne)

'Well, the law as of, the law reads right now, AB 1652 are you guys familiar with that one? 1652, that is the mandatory reporting law for all nurse practitioners, L&D nurses, ER nurses, Surgery Center nurses, and physicians. The social workers, however, are exempt. Cause they got on the bandwagon and they do not have to report it." (Gay)

"To whom?" (Anne)

"To the authorities, it has to, the way the law reads I ..." (Gay)

"What are the statistics on not just with children but like the adult with the women. How often does sexually abuse and physical abuse." (Fran)

"It's almost the same, but then you have to say how do you define marital rape? (Gay)

The nature of domestic violence brings attention to feelings and emotions that are uncomfortable and difficult to approach. Many people do not express the pain, the stigma, and the oppression associated with physical abuse. This is due to the discomfort and uncertainty felt by those who experience domestic violence, as well as those who have not had direct exposure to abuse. Socialization may also play an integral role in this hestitation. However, the focus group environment created an emotional space conducive for self disclosure. During one of the focus groups, self disclosure by the nurses occurred and much dialogue around victimization, the rights of women and children, and self esteem was generated from these testimonials. The moderator's role became one of a women and mother sharing in the pain of the nurse's stories.

" Boy oh boy but see now she get strength from seeing, we were talking how abused women are not weak, that the one myth that people have that we are weak and we can't do anything but that is not true there is a

> tremendous amount of strength and resources A) live in it B) to get out if you do get out and C) to protect what little self-respect and self-esteem you have left. And people don't understand that they think the stereotype of the abused woman is, you know, some poor woman of color that doesn't, you know, and that is not true." (Gay)

The Rigor of Qualitative Research:

Evaluating Focus Group Interviews

According to Burns (1989), the evaluation of qualitative research is based on the following assumptions; data are gathered over time, data are context specific, events are understood in relation to their meaning, and data change over time (p. 44). These assumptions indicated a need for abandoning the traditional quantitative critique, and establishing evaluation criteria that are tailored to the intricacies of the qualitative paradigms.

Sandelowski (1986) outlined factors that influence the rigor of qualitative work. The factors include: lack of boundaries, the tendency to use quantitative guidelines, and the varieties of qualitative methods. Other researchers use the phrase 'establishing trust-worthiness' to evaluate the thoroughness and complexities of the work. Brink (1989) used a 'third ear' to establish reliability and validity in research.

These varying postulates created a template for the present study's evaluation criteria. The concepts that were utilized were reflexivity, auditability, fittingness, and credibility.

Reflexivity

Reflexivity is the researcher's self examination. According to Lamb and Huttenger (1989), reflexive thought can be described as self awareness and an awareness of the relationship between the investigator and research

environment. DeGroot (1988) offered characteristics to the "method" selection of scientific inquiry that influence reflexivity. A partial list includes the interpersonal factors encompassing the nature of human beings, the nature of knowledge and truth, the nature of nursing science, cognitive style, the world view, and experience.

Reflexivity also involves a second tier of influences that directly affects the research labeled the extrapersonal factors. These biases are inherent in the indivdual, institution, and society where the exchange patterns occur. Issues in context involve historical, sociological, economic, and cultural considerations of the research project.

A concept pertaining to reflexivity is in the following personal testimonial. My view of collaborative practice with social service has been, at times, on a confrontational platform. My experiences with this interdisiplinary conflict has fostered bias against a working partnership with certain social workers. As a result, during open coding I realized I was not acknowledging the data collected that pertained to the nurses' perceptions of the concept of shared responsibility with social service. This reflexive moment was further influenced by a second reviewer who validated the importance of the developing category. It was this reflexivity, initially inhibited, that led to defining shared responsibility, a significant discussion item in the research's conclusion.

Auditability

Auditability is parallel to reliability in quantitative work. Lincoln and Guba (1985) referred to auditability as the ability of another researcher to follow the decision trail of the work. Ensuring auditability equates to consistency of the research. Beck (1993) referred to the "audit trail" of research, that is

established by the tools of qualitative researchers and includes memos, field notes, descriptions, and transcripts.

This study's "audit trail" is comprised of documented memos, transcriptions from the audio taped interviews, hand written field notes, and a book of open coding and categorizations. A personal journal was developed during the dissertation exercise and used for auditability and reflexivity as well.

Fittingness

The concept of fittingness is applicability of the findings of qualitative work (Lincoln & Guba, 1985). In contrast to quantitative work, where generalizability and validity concerns are paramount, the qualitative paradigm is focused on how well the assumptions "fit" in another context. In other words, can an audience view the data and findings to be meaningful and applicable in their own experiences?

With focus group data, where the participant groups are small in number, and verbal data are relatively large, generalizability and projection are not within the scope of the method (Krueger, 1994). Therefore, the analysis of this study should be evaluated on the basis of the "fit" of the finding to the context of the researcher and reader.

Fittingness of the focus group data was assessed according to Beck's (1993) suggestions. The participants were uniform in their requirements for study, yet were representative in demographics, (i.e., race, gender, location, and nursing specialty). The nurse clinicians shared insights, experiences, and a common philosophy of women's issues. Fresh perspectives and rich dialogue, that were paralleled across the focus groups, resulted from the data generated.

Credibility

Truth and value of qualitative research is referred to as credibility. Beck (1993) defined credibility as a measure of vivid and faithful descriptions of the phenomena. The focus group research addressed the following criteria for establishing credibility. Field notes were kept on a variety of emotions, media events, and group interactions. Although the researcher did not "go native", varying roles emerged within each group in response to the participant-researcher relationship as described earlier in this chapter. The data were reviewed with participants after analysis, as well as validated with a second and third qualitative researcher. The conclusions, discussions, and analysis were viewed and understood in a similar context among the reviewers. There was agreement on the interpretation of the data.

Advantages of the Focus Group

There are several advantages to focus group interviews. According to Krueger (1994), the method is socially oriented. There is an increased tendency to obtain valid information regarding sensitive issues. The method is flexible, allowing for both probing and free form dialogue.

A unique advantage of the focus group is the compatibility to the quantitative paradigm. This technique is an excellent avenue to incorporate into a triangulation effect. The blending of the methodologies increases the validity of quantitative questionnaires items, thus producing results that are believable to many different researchers.

The focus group interactions were positive and well received. During one interview, a professional relationship was generated among two nurse participants who were not previously acquainted

"Who are the two states? Do you know?" (Glenda)
"They told me, I'll let you know." (Hannah)
"We need to talk, you and me.." (Carol)
"Yes, definitely." (Hannah)

As it turned out these nurses shared strategies for improving the communications between women's shelter services in neighboring communities.

Disadvantage of Focus Groups

The limitation of focus groups involves the dynamics of the group. Social desirability, conformity, and disagreement among members are included in these threats (Diolorio, 1994). Unless the moderator is proficient in group dynamics, and can control individuals who dominate and monopolize the forum, forced compliance by the participants is possible. Finally, the inability to generalize findings is a major drawback of the method.

An example of a disadvantage of focus group interviewing took place during one interview, when participant domination occurred for a short time. The dicussion was monopolized by a victim advocate who had a strong voice regarding the violence issue. The nurse offered a monolithic sequence of data. The researcher did not intervene and allowed the exchange to occur. The data

was coded and memoed, yet exchange was hampered for a moment during the interaction.

Analysis of Data

Because focus group methodology is relatively new to health care research, few guidelines are available that apply solely to the method. Krueger (1994) stated some basic principles for researchers to use when performing analysis. Analysis must be: 1) systematic, 2) verifiable, 3) focused, and 4) practical. In addition, Krueger advocated allowing adequate time for analysis and not delaying between data collection and data analysis.

A four-step process of data analysis was followed as outlined by Koniak-Griffin and colleagues (1994). Step one was transcription of the audio tapes and comparisons to written notes for accuracy. Step two involved the techniques of grounded theory. Memoing and field notes were kept to augment coding procedures. Line by line analysis, utilizing open coding principles highlighted the recognition of axial and in-vivo codes. I defined themes and developed categories from this technique. The third step in analysis, constant comparative procedures, both within and among groups was performed on an ongoing basis. Data collection and analysis continued until saturation was reached (Straus & Corbin, 1990). Finally, step four provided a method of validating the findings. In this research, two methods of validation were utilized. One method involved an outside researcher familiar with the focus group methodology, but uninvolved with the data collection to evaluate the findings. The second avenue was a type of respondent validation, whereby volunteers from one group reviewed the findings and gave feedback.

Conclusion

In the course of clinical practice, nurse clinicians are charged with obtaining information from patients who are unwilling to freely disclose, due to subjectively held feelings of embarrassment and shame. These difficulties also present a challenge to nurse researchers. Therefore, the dilemma of researching social sensitive issues is a quest for information from participants' professional and personal world views. This information is available through properly conducted qualitative research.

Although relatively new in nursing inquiry, the focus group interview was an ideal method to uncover and elaborate upon the strategies associated with nurse-patient interactions. The focus group interview relies on the interchange among members to generate data. Therefore, common threads can be woven to create an analysis that explains or describes behavior. The group produces a climate for interaction, thereby initiating and elaborating on topics that might otherwise remain hidden. Because domestic violence has been considered taboo, and socially sensitive, the method of focus group interviewing provided an environment to share and explore the dynamics involved with addressing the presence of physical abuse among female patients by their male partners.

The nature of discussing sensitive issues can be costly to group members. It can be an emotional and psychological expenditure to divulge feelings about topics that are socially sensitive. These costs directly apply to the conduct of clinical practice and the context wherein practice continues. However, the

reward for expending the emotional energy results in the validation of practice skills and the nurse's personal experience. This profit is invaluable to clinicians. The interactions of this type are found when the focus group interview is correctly conducted. We cannot discount that these costs also pertain to the researcher, who moderates and invests emotionally in this type of research.

The focus group interview, with its tradition in the qualitative paradigm, and its compatibility with the positivist methodologies, is an attractive venue for the nurse researcher. By generating group interaction, producing credible data, and validating the participants contribution, this method was an ideal environment for examining the nurse clinician's role in the process of facilitating disclosure of domestic violence between female patients and male partners and how to access these women.

CHAPTER V

OPENING THE DOOR: FACILITATING DISCLOSURE OF PHYSICAL ABUSE

> "I say, how are things with you and your partner? Has he hit or struck or threatened you in any way? (Yea, I was doing great.) The patient said, 'he hit me in the stomach.' She wouldn't have told me if I didn't ask. You need an entree I think." (Fran)

One of the most difficult tasks for clinical nurses is the questioning of a patient regarding private or taboo subjects. Many nurses felt as if they are intruding on the client's privacy when they approach sensitive issues. Because domestic violence has been deemed a "family problem" this feeling of intrusion is especially prevalent. As one nurse stated:

> "You know, its almost impossible for me to be able to talk to them about domestic violence. I don't know why. Maybe I feel like I'm prying into their personal life." (Fran)

Interestingly, these sentiments were paralleled by another nurse from across the country. She voiced her feelings of difficulty confronting domestic violence by the following statement:

> "Before it was not a comfortable thing to even ask without feeling like I'm intruding." (Angie)

The nurses' statements denoted a posture of hesitation and reticence that is often present when approaching domestic violence. This reluctance is rooted in a multitude of factors that affect nursing practice. These issues in context involve

values and beliefs of the nurse, professional training, socialization of the provider, feelings of responsibility, and available resources. Darlene described these circumstances when she commented on two aspects of socialization and gender roles that affect the process of disclosure of physical abuse.

> "It goes back to the whole idea of domestic violence being a personal issue between two people, and you know it goes back to the Bible and all that business." (Darlene)

> "For a lot of the women in this town, he never touches the children, and that might be the cultural Portuguese thing, the place of the woman is in the home, she deserves a smack now and again...." (Carol)

Fran reiterated the socialization of her early years of nursing practice when she offered the following:

> "I think years back how hard it was for me to ask, "Are you people having difficulty in your sex life, now that used to be big!" (Fran)

Although nurses are adept at gathering information and interviewing techniques, eliciting information regarding physical abuse remains obscure and the clinical responsibility of such, elusive. In reality, nursing practice includes the training of assessment techniques for all adverse health conditions, with the majority of nurses feeling comfortable with their interview skills. The specific issue of domestic violence, however, is much more complex and has been missing in professional curricula. Thus, nurses do not feel as sophisticated in their approach to domestic violence as opposed to other sensitive health care situations, (i.e. smoking, substance abuse and sexual practices). Lana illustrated this posture when she stated:

"We tell people not to smoke. We do other kinds of health behaviors, why don't we invest in this one?" (Lana)

The clinical responsibility of assessment behavior pertaining to domestic violence was the premise that guided the focus group discussions addressing the process of facilitating disclosure of physical abuse. Two separate processes were identified during the focus groups. The first category, Facilitators, described actions that increased the likelihood of facilitating disclosure. These included indirect interventions, direct interventions and personal knowing. The second process of disclosure was defined by the nurse clinicians as Barriers. Barriers encompassed conduct that impeded the reciprocal behaviors of disclosure and included the themes of inconsistency, lack of training, and time constraints. Collectively, these concepts contribute to the patterns of exchange that occur between victims and nurse clinicians when addressing domestic violence.

The implicit values for successful social exchange are contained within the constructs of the focus group data. The following dialogue examines the relationship of profit, reward, and cost in the context of the health care visit with nurse clincians and victims as the players. Interactions between the patient and nurse clinician are explored specifically focusing on the clinical responsibility of assessment for physical abuse. (Figure 2.1)

Facilitators of Disclosure

Indirect Interventions

Many nonverbal attributes act as facilitators of disclosure. These unspoken cues help to build a relationship between a nurse and a victim that is vital for the exposure of abuse. The indirect interventions were identified and described by

The Process of Disclosure in a Social Exchange Context

Figure 2.2

the nurses during the focus group interviews. These constructs existed on an emotional or conceptual plane and relied heavily on the nursing experiene of the participants. Sabrina related this concept when she is "clued in" about the possibility of abuse. She subsequently took advantage of the emotional space created to offer advice from her own experiences.

> "You know, we can talk to them on a personal level and say, you know you have choices and you don't have to go back there. I know you are pregnant and you think you are the only one, you're not, and maybe its time you made a decision." (Sabrina)

Listening to the patient's story is another example of an important indirect intervention utilized by Renee. She handles disclosure by her patients in the following dialogue by giving back during the exchange in a non threatening manner. A balance of exchange behavior is evident as Renee engages in a reciprocal problem solving atmosphere.

> "Is it OK for you? What are you going to do about it? Can I help you in any way? And they say no, I just want you to listen. OK I'll do that." (Renee)

While the nurse listens to the patient's story of physical abuse, she must convey the attitude of an attentive listener portraying belief in what the patient is saying. For example, Jill believed the following:

> "We can listen to everything she says she's going to need an outlet, whether or not she stays there. You can talk to her, but she really wants you to listen and believe her. Telling her you are there if she needs you or coming back or sitting down. She does not feel safe at home, she does not feel safe even in her family. She needs a disinterested third party. (Jill)

Another important indirect intervention is the notion of understanding. Understanding is vital to the exchange space, where the nurse must comprehend and validate past experiences. The patient's need for privacy, her fear, and the self consciousness she feels are concepts that the nurse clinician must grasp in order to create the disclosure environment. Understanding the woman's fear assumes a dual meaning and must be comprehended in both contexts. For example, fear of the perpetrator, as well as fear of stigmatization by the violence being brought out into the open, are crucial concerns the nurse must address in facilitating the process of disclosure. One nurse eloquently stated this position.

> "There are some women because of their past and their need for privacy and fear, they will not be honest with you." (Renee)

A genuine ear for listening to the patient, and earnestly hearing what the victim is saying is the beginning of the dissolution of emotional boundaries. This emotional reciprocation establishes a foundation for a relationship between the nurse and client. A soft, trusting, and friendly attitude must be adopted for this environment to ensue. The following dialogue illustrated this theme.

> "Every encounter, every check, every imprompt call is all based on very open, very soft, never pushy, never push her into a corner or square she can't fit." (Cathy)

> "I think as the relationship develops and you get more trust and they start to open up and they become more needy again, and the crisis starts again..." (Cathy)

These indirect interventions, based on individualized interactions, are specific to the context of the violence, and unique to the victim's concept of self, and need time to develop. The bittersweet notion of a therapeutic nurse-patient

interaction being established in one 15-minute visit is unrealistic. However, constructing this relationship is critical to the exchange forum and is theoretically a powerful facilitator. Yet, in clinical practice, it is difficult to achieve. In essence, the basis for successful facilitation of disclosure is primarily based on the assessment environment created by the health care provider.

> "You know, my schedule is not set up where I can spend hours that are needed to take care of this difficult situation." (Sally)
>
> "It's like each visit gets easier and easier. It's easier to go back to the old way of the getting information out of the woman in a talk story kind of way. Let's forget the formalities, so you want to tell me something new? By the way, let's try and build a relationship here. It takes time." (Cathy)

As the nurse participants described, they viewed the health visit as the marketplace that provides the foundation for immediate exchange, as well as subsequent interactions with the victims. If successfully created during intake assessments, this subtle milieu is the beginning of a safe atmosphere for victims. Thus, disclosure is possible and can result in profits for the nurse -patient relationship.

Direct Interventions

Direct interventions are those behaviors and clinical skills that the nurse performs, observes, or intuitively identifies. These direct assessments are done when the nurse picks up on "cues" or clinical indicators of the presence of physical abuse. More specifically defined, these indicators are the "triggers" that provide valuable criteria for pursuing the issue of domestic violence. Various nurse clinicians recounted situations in practice that described this concept.

"And when you have someone who drops in with a black eye and you know..."(Ellie)

"And this particular patient came in and her breast would be black and blue. And she never told anybody." (Madge)

"We had one girl come in with a scarf around her neck. She took off the scarf and had bruises around her neck. She had sunglasses on and had bruises around her eye." (Renee)

"But a lot of times, you know, if the woman is more educated they (the perpetrator) are not going to put the bruises where they can be seen." (Madge)

"Even though the impressions are there, this is bizarre, you get someone in the exam room, and they act real strange on the table." (Donna)

"They maybe act a little scared but some of them are totally inappropriate for the exam." (Donna)

An interesting caveat was that these focus group nurses tended to facilitate disclosure more readily when they "see" the injury. If the injury wasn't visible, the direct interventions was also not visible, and often not done. Lana voiced exasperation when she couldn't see the wound, but knew it was there. She felt powerless, as if she could not offer any intervention at the time.

"Well I actually never saw any, she didn't come in after the incident, but she would tell us about them later or a relative would call and tell us, I never saw any physical signs on her. It was scary to think what he might do to her." (Lana)

Other cues that triggered the pursuit of disclosure mentioned by the nurses surrounded the demeanor of the patient and the actions of the perpetrator. The nurse identified the following "cues".

"If she doesn't feel like answering the questions, it puts a trigger in my brain." (Angie)

"It took me three visits to get through to her. I had some concerns and suspicions, because she seemed so reserved." (Cathy)

'A lot of times you can look at how he is when he brings her to the hospital, he's like, hovering over her and you can't do anything." (Sabrina)

The focus group data relating to direct interventions indicated an optimistic outlook for interactions with female victims. Succinctly, when faced with domestic violence, nurse clinicians knew what to look for, they knew how to approach the issue, and they did intervene. Renee was very definite in her clinical agenda for victims, and demonstrated a resourceful plan of intervention.

"If they have seen a professional or reconciled it or worked through it in any way. We connect them with some program, activists groups, or a psychologist or support group that meet regularly, any kind of therapy that the woman wants." (Renee)

"Nursing has seen our roles empowering people, you know, give them knowledge, teach them self care." (Darlene)

"We can kind of get a team approach to capture them while they are here for a while, and get the message out to them and the resources." (Debra)

The question now becomes, "If the nurse is aware of the crime, and knows how to identify the violence, why is it that this injustice remains unreported?"

Personal Knowing: "I Bear No Pain In Telling Them"

Nursing practice incorporates many facets of the clinician. Professional training, personal values, life experiences, and social-cultural considerations

make up the individual nursing venue. An important category emerged during the focus groups that dealt specifically with these attributes, or as one nurse stated, "personal knowing". "Personal knowing" or "inside knowledge" comes from having personally experienced some aspect of domestic violence. The following data came forth from the nurses' self disclosure of family violence during one of the focus groups. This intimate experience with domestic violence significantly affected the delivery of nursing care to patients. The following two nurse clinicians had private experience with domestic abuse. Each nurse had confronted her situation and left the abusive relationship. This personal experience allowed different approaches of intervention to be offered to patients.

Sabrina reflected on her clinical practice with the intervention of advice giving following the facilitation of disclosure.

> "cause I've had a couple of patients and I always told them, it has happened to me, you can get out, and I bear no pain in telling them." (Sabrina)

Madge confronted the presence of domestic violence with the resulting posture.

> "I don't care how much money we put into it, or how much support we give, its not going to do any good until she makes up her mind to leave." (Madge)

Sabrina felt adamantly that every victim, regardless of her situation, deserved the same individual consideration and respect.

> "That is what she should do" You can't say that until you've walked in someone's shoes." (Sabrina)

And Glenda contributed the value of her personal story.

"And I'm thinking, I can make an impression on these nurses by sharing my story." (Glenda)

The process of facilitating disclosure consists of three important parameters. As evidenced by the data, these are direct interventions, indirect interventions and personal knowing. Having described these categories, it is imperative to comment on the context in which the attributes affect facilitation. The process in context is based on the "comfort level" of the interaction and involves the themes of "unloading" and the "readiness" factor. These concepts are interdependent with the Facilitators to Disclosure, and contribute to the overall exchange behaviors of both the nurse and the victim

Initially the comfort level of the nurse was an important factor in facilitating disclosure. To achieve an adequate comfort level in the appropriate context, nurses needed to "unload." Unloading pertained to both the victim and the nurse. The patient needed time to tell the story and be given a choice for disclosure. Moreover, the nurse clinician needed time to digest the information regarding the presence of abuse, and have time to think 'it' through. This task was described was difficult to accomplish because domestic violence is situated in a society defined by privacy, silence, discomfort, and traditional values. Without the safety net of "unloading", continued assessments and compliance to practice mandates surrounding domestic violence were considered unrealistic. This insightful debriefing does created a forum to handle the costs of disclosure. In addition, nurses were able to share stories and strategies for practice when they had the opportunity for "organized unloading." The following nurses eloquently defined this process.

"And my heart was pounding. We were both crying. I remember thinking it was so emotional, but it was very cleansing for her, I remember thinking she needs to unload." (Angie)

"The kinds of work we do is laden with emotion. It brings up all kinds of personal stuff." (Hannah)

"You need support groups to deal with it. You need organized unloading." (Carol)

"In order to unload some of that, (Feelings about victims) to download or whatever, you have to trust, we (nurses) need to feel exactly what we are trying to provide for these women. (Carol)

"I find it bizarre you can't sit down with your colleagues and discuss the emotional issue. I think it's very bizarre." (Bob)

"There is no way you can exist in a system that is dysfunctional in a lot of levels. You can't be there and be healthy, you will get physically sick." (Bob)

"There's are not any kind of support group for their staff and I mean you feel battered yourself." (Glenda)

"If she's abused and I find out about substance abuse. I can't make the referral, it's not allowed. Its almost like I am penalized for putting all this time and effort into it (Carol)

"It's really horrendous they wouldn't let you do that." (Hannah)

"We had our support group, and it was not happy at all, we were very depressed so we just said we have to do something about this. (Darlene)

A final comment on the context of facilitating disclosure involves the readiness of the victim. The nurse participants recognized that the victim must have a degree of readiness, regardless of the exchange climate, before disclosure will occur. The readiness was described by the nurses in various vignettes. In a

sense, the readiness concept gave "permission" to the victim to be abused, whereby she felt comfortable sharing her story.

> "She became ready. She took the guns out of the house. And if her instincts told her, things are getting really violent, she had an exit plan. She was ready to do that." (Angie)

> "It (violence) becomes an issue that's causing a lot of conflict in their present relationship, affecting their self esteem, affects their future planning, and it's basically that they are still are so wounded and I worry a lot about their postpartum adjustment." (Renee)

Carol offered this example of the concept of readiness involving the nurse and acted upon by the victim.

> "And they certainly have a lot of power to help themselves, which you know which we find, once we begin to help people motivate themselves, they make tremendous changes in their lives, because the power is always there." (Carol)

Barriers To Disclosure

The process of facilitating disclosure of physical abuse is greatly affected by the category entitled Barriers. These are conditions the nurses identified they lacked, either personally or in the course of their professional role, that interfered with successful facilitation. These barriers constituted great cost in the exchange cycle of health care interactions. The overriding themes of inconsistency of assessments, lack of training, and time constraints had a loud and recurrent voice among the participants.

Inconsistency

A uniform inconsistency existed among practicing nurses when it came to confronting physical abuse. This inconsistency was evident throughout all of the focus group data by the nurses' testimonies of inadequate and incomplete assessment patterns. Even though mandatory reporting laws and ethical considerations were foregrounded, the nurses were very candid about the practice omissions in their current nursing role.

> "Sometimes we would ask, sometimes they automatically would tell . It was not consistent for every woman. The nurses were doing their own thing." (Angie)
>
> "On physical appearance depends on what we get into. I don't routinely ask." (Anne)
>
> "I try to every time remember." (Lana)
>
> "And I think society presented for so long, that it doesn't happen to the affluent you know its the picture perfect life of somebody who lives in the up side of town, so you don't interrupt the perfect life." (Gloria)
>
> "Of the women in the charts that had been reviewed, actually reported sexual abuse and these were women that were three decades after the abuse, 90% had never been asked. We don't ask the question of women." (Bob)
>
> "Its hard to screen for things you can't offer help. So we don't." (Hannah)

This inconsistency was partially explained by values and beliefs entrenched within the philosophy of the individual clinician. No one is spared from developing the misconceptions regarding domestic violence, thus barriers get erected. Breaking these down constituted a great cost to all players in the exchange interaction. These barriers were partly responsible for judgments and

stereotyping that continued to prevail in the health care exchange. Debra had the courage to admit an inner belief she held and shared it in the data.

> "I know on a intellectual level that it crosses all social and economical cultures but on an emotional level it would be much harder to ask a patient who is coming in for her annual breast check and pap smear who was wearing a three piece suit and employed, to ask her if she is a victim of domestic violence." (Debra)

This discrepant manner of assessing domestic violence is also influenced by job expectations imposed on the nurse clinicians. An example is the pretense described by Cathy.

> "To get anywhere it takes a long time, because of her expectation of every visit is what I have to do for her to make her think I'm doing good. What do I have to pretend to do that will make her feel happy and she will write down what she needs to." (Cathy)

Angie made it clear that her "job" was not that of social service, and vented frustration over the lack of clarity of responsibilities.

> "You know what would be really nice? I'm not a social worker, when she doesn't want to see a therapist, when it's (violence) really new to me and her, I don't want it to be so foreign". (Angie)

Obviously, the existence of this type of environment where deceit, prejudgements, misinterpretation, and preconceived notions regarding the victim, can only impede the process of disclosure. The comfort level of the players is inhibited and the amount of trust in the marketplace is diminished.

Inconsistency was also defined by the actions and reactions of other disciplines. The nurse participants seemed very confused over the roles, preparation, and referral mechanisms practiced by other members of the health care team. The data suggested an isolated perspective and ignorance of the varying components of empowerment. Realizing that domestic violence should not and could not be 'fixed" solely by nurses, the participants voiced major concerns over the inconsistency by other members of the community team.

> "How effective are these diversion programs? Does that mean they go see a therapist?" (Anne)
>
> "You know we beep somebody, we only have a social worker 60% of the time, and she's not here when I am busiest." (Fran)
>
> "Like with domestic violence, I am sure that there are women employees that are facing the issues of domestic violence as well. Until the super structure becomes sensitive to the issues and facilitate them, budget cuts and social service hours are dwindling down." (Debra)
>
> "People are denied access to health care because they are victims, because they can't get health insurance. " (Hannah)
>
> "But they really don't have good judge training, judges are the big problem. We have a diminishing number of social service supports in terms of welfare and child support." (Carol)
>
> "In fact we did a community assessment and the police response was listed as the major gap." (Cindy)

It appears in viewing the barrier of inconsistency, that nurse clinicians were merely one player in the context of domestic violence. In order to facilitate the process of disclosure, the entire social cast must be addressed, whereby their strengths and weakness identified. Through this identification, myths are

addressed, stereotyping can be diminished and a collaboration of services is attempted. By confronting the inconsistency barrier, an increase in the profits associated with facilitating disclosure of physical abuse in the proper context specific marketplace of disclosure is possible.

Time Constraints

No one can argue that health care is undergoing major changes at a phenomenal rate. Practice guidelines, reimbursement issues, levels of providing care, and the professional's preparation, are areas that are immediately noted. The focus group participants referred to many regulatory agencies having become keynote and responsible for this climate of change. The nurse participants were vocal in their perceptions of these interventions and organizations, as well as the impact on their practice. Scheduling issues, time conflicts, and patient volume were repeated themes cited as barriers in the marketplace of disclosure.

> "The frustrating part is when you don't have a social worker, or psychologist, or counselor, someone there who can offer immediate intervention because my focus and my schedule is not set up in a way where I can spend the hours that are needed to take care of this very difficult situation." (Anne)
>
> "So you know, as far as the psycho social how ya doing, how ya feeling you know you don't have time for that." (Cathy)
>
> "You know I ask every pregnant woman for the first visit, has she ever been physically or sexually abused and I just hope she says no, because I know if she says yes, well I got over an hour and my next patient is going to be late. (Sally)

"Not that you shouldn't deal with it (domestic abuse), but I can tell you I had to reschedule patients cause I had one tell me that she was abused and then everything pours out afterward, you know, and then they're sobbing and you know (pause)..." (Ellie)

"I worked at some HMO where they were telling me to see a patient every 15 minutes, and suddenly somebody comes in (abused)....." (Debra)

"She wanted a Pap, she got a Pap. What about her heart and lungs and thyroid. But that was her 13 minutes." (Glenda)

"I'm listening to you (Glenda), and its getting scarier and scarier, the system is allowing us to do more, this and that, are we ever going to be able to get to that?" (Carol)

"I'm sure there are people who as they incorporate their own stuff into the abuse assessment form, but I do think that there are constraints and there will be further constraints on us to do the kinds of thing that we know we want to do..." (Debra)

Maybe it is time to re evaluate how nurse clinicians spend the minutes and hours in the practice setting. Since more women die at the hands of a male partner than in motor vehicle accidents, (Campbell, 1986), is it not feasible to elaborate on the domestic violence assessments and protocols outlined by various agencies? Jill enlightened us with the following wisdom:

"It has a lot to do with risk taking, we as women have not been encouraged to take risks, when you ask her about her violence you are taking a risk. And great fear to nurse is that she will say yes, you know and then what will I do with this? Like one nurse says, I know its going to take me 30 minutes to deal with this and my next patient will be late. But it's OK. It's the same reasoning, we should not stop doing breast self exams because we are afraid we'll feel a lump early. Thats why we do it." (Jill)

Lack of Training

The issue of professional training and the fact that participants lacked formal preparation specific to addressing domestic violence was a universal deficit. The nurses interviewed were very direct and honest when they self identified their perceived lack of knowledge regarding physical abuse, appropriate interventions, and the available resources for adequate "treatment" of domestic violence. The data were very definite and precise in this category. Below are statements that illustrated the paucity in training among nurse clinicians.

> "The first time I heard I just said oh no, I'm scared. So I just said to her I'm scared for me cause I want to help you. **And I don't know how.**" (Renee)
>
> "I was scared because I hadn't prepared myself. I wasn't trained on how to handle it. " (Angie)
>
> "You know about their secrecy. They don't want to share how vulnerable they are to anyone, not even the abuser. Why would they share with us strangers? I just want to learn to do better. Somebody teach me." (Renee)
>
> "But I don't know this. This is one question I would like the answer for. What do I do if someone says yes? Am I suppose to tell then to leave. I mean I'm fairly well educated, but the legal realities do terrify me, and I don't know what I'm suppose to do about it. Who am I suppose to report to. What do I do? Who do I call? (Fran)
>
> "We didn't start until 1989 asking when one nurse came here and started teaching us. She did a program." (June)

Interestingly, nurses were aware of assessment strategies for sensitive subjects. Moreover, when they did obtain the needed training, preparation, and familiarity specific to domestic violence, nurses become enthusiastic and

compliant over tackling the problem of physical abuse. Angie wanted the training in an open forum, to learn alternate ways of dealing with violence among victims. She described a basic principle of social exchange theory in the reciprocal patterns of interaction.

> "I want to hear other people's stories that are involved, that I can access or hear their stories about whatever worked for the woman. I can learn from that. I can be a little more sharper, kinder, trusting, sensitive and I'll make a better opportunity to share with me." (Angie)

However, the current health care environment is not as enlightened and capable of accommodating the process of disclosure as the trained nurse clinician. The data illustrated a very authentic and sad reality.

> "We inform people about domestic abuse, having a pregnancy in particular, and we had a check sheet that we used in a formal manner. It had complaints, actual injuries. The self report form established a base, and we talked to the individual. You know, we don't have that kind of luxury now." (Donna)

Maybe its time to look at practice priorities and create the luxury?

CHAPTER VI

WHY DOES SHE STAY?

> "The things that men do in my experience is they spend a lot of their time making you feel like you are nothing that nobody else want you or anything and you buy into it and you really think that I am not worth anything nobody else wants me. I got to the point where I was staying awake at night wondering if I poisoned him will they find out will I go to jail? I didn't want to go to jail." (Sabrina)

A common frustration the health care providers encountered when dealing with victims of domestic violence was the fundamental question of why a woman stays. This complex phenomenon was described as a constant struggle between victims, the professionals rendering health care, and resource services that were offered to battered women. The following data excerpts illustrate the polarizing feelings that reflected the misconceptions encountered during the health care exchanges between victims and clinicians.

> "I guess my thing is that we (nurses) see they (victims) have a choice, and they don't see that." (Sabrina)

> "And the places they wind up in is a shelter. We can talk to them on a personal level and say, you know you do have choices, you don't have to go back there, I know you are pregnant and you think you are the only one, you're not. Maybe its time you made a decision." (Madge)

> "Most of the time they are going to walk out of my office and go right back into the situation that they are in." (Anne)

> "We were really concerned that he would kill her. She'd call us and say I have to talk to you, but I can't do it in front of him. And then she would come in, talk a little, she wouldn't do anything about it. Nothing." (Lana)

In addition, these conflicting and disconcerting attitudes were mirrored in comments about other disciplines that collaboratively provide resources for battered women.

> "My husband's cousin is a policeman and whenever they call him he has to go to a domestic call. You go in and these guys are beating on these women. You pull them off, handcuff them, get them out to the car, and she's coming out of the house, saying don't lock him up. You get him down to the police station and she already sends somebody down there to get him out." (Sabrina)

The reasons for the conflicting perceptions of the victim's behaviors and "why she stays" were multidimensional. The nurse clinicians identified several of these dimensions which include categories I have identified as: 1) the medical patriarchy, 2) blaming the victim, and 3) gender role stereotyping. The following text explores these categories in the context of "why does she stay?"

Deconstructing The Medical Patriarchy

Health care delivery has long since been dominated by the male influence, where the medicalization of domestic violence has fostered a dependent role for victims (Dobash & Dobash, 1990; Stark, Flitcraft, & Frazier, 1980). They reported that the typical treatment plan focused on the physical injury, not on how or why the injury was allowed to occur.

Until recently, a woman who entered the health care system was offered care by providers who were predominantly male physicians. A confounding factor in this encounter is the manner in which males respond to illness and

conditions such as domestic violence. This differs from the female's experience of these situations. These differences are the voice in which illness is communicated and the way health is heard. Rose and Saunders (1984) validated these differences by looking at the nurse and physician responses to abused women. Their findings implied that gender, not medical socialization, accounted for this discrepancy in treatment. The male influence in health care delivery is definitely a pervasive one. Hannah offered her view of the medical model's influence in the treatment of victims.

> "It feeds back to the patriarchy of the medical system, and the medical system wants to help, and you have to want to be helped in order for that to work. So the more power and the more ways in which they (medical doctors) can create that feeling of dependency or victimization in their clients the more they feel that they have done their job. We (nurses) fight that I think. That is one of the biggest issue to through to the medical community, is the sense of quality, and stand back, and hands off, um you know rather than superimposing the treatment plan, in that medicalized sort of way." (Hannah)

What explanations can be offered for the condition of gender difference among health care providers and delivery of care? Dyehouse (1992) has written about the male-female power differential between patients and physicians. She proposed three distinct patterns which contribute to this imbalance. These are: the woman as other, the woman's way of experiencing illness, and the patterns of health care utilization.

The attitude of "the physician knows best" has fostered an unjust power distribution where the woman is viewed as "other", instead of a partner in the health care interaction. The typical diagnosis and treatment based medical model, where pathophysiological explanations are prized, handles poorly

problems without such a diagnostic base. The physician, in order to remain in a position of power, quests for a physiological link. This link is elusive for the problem of domestic violence where a physiological basis for abuse is obscure. Thus, the medical patriarchy has for many years managed to over look the real context of violence. Carol and Darlene recognized this deficiency when they examined the view of the nursing role.

> "Well, nursing is like we've always seen our roles as empowering people, you know, give them knowledge teach then how to self care, and medicine has not been empowering, they are just learning how to do that." (Carol)

> "There has been a very big philosophy change in nursing, I think. I came from the old days of nursing when you did things more for people and the patient are not as much a part of the plan." (Darlene)

Feminist scholars have identified the differences in the way women experience health and illness (Belenky et al. 1986; Dyehouse, 1992). Women's health care has been mired in male values where self reliance, self sufficiency, and action oriented solutions are prevalent. Little attention has been paid to explore the way in which women value and perceive health. This perception envelops sensitivity, nurturance, and heightened awareness. Subsequently, the female voice is not heard in the traditional male dominated marketplace of health care exchange, and often times her strengths are not respected. The data illustrated the nurse's perceptions pertaining to these issues of physician attitudes, differences in male interactions, and female qualities.

> "Well we were sitting here talking about this issue, how we interface with it. With a group of male physicians. So here they are, with a nurse, like what are you going to teach me? The way they interface with it is

different, because men relate to women on a different, like men are from from..." (Glenda)

"Men are from Mars, and women are from Venus". (Sally)

"Sometimes my jaw drops open, when I listen to a woman and see a woman go through this process and how she moves through the relationship. It amazes me, and like you say how much strength they have. How creative they are how strong they are. How they deal with the doctors, schools, the violence, and the stuff from the past. (Angie)

"You get into things and women would be very honest, and forthcoming with the information, but I was sitting here wondering, would they (men) be honest about that because I know it would never be admitted. " (Jane)

"If someone came to me for a physical, we ask female questions. I wouldn't ask a male." (Darlene)

Failing to honor the differences and diversity specific to the woman's experience, reinforces a subservient role in the medical marketplace. A victim is not considered unique, and her problems are not validated when gender becomes a central issue in the treatment decision. Domestic violence is a prime example of this gender relation, as the medical marketplace bases the treatment plan largely on gender bias.

Consider the scenario of the woman who has been victimized by the hands of a male intimate. She is placed in a belief system of the perpetrator and is then forced into a patriarchal medical system where the beliefs are further reinforced. It's no wonder that she chooses not to disclose her situation and continues to stay. The nurses commented on this bias in the data.

"A lot of times you see the same woman going out of court and she keeps dropping the charges and that becomes very frustrating. A lot of

> the reason this happens is that she is again is left with the choice of going back to the batterer or not having the social support in place she chooses him yet for there police officer that sees the bruises and not the pain of worrying about feeding the children." (Carol)
>
> "Men communicate differently. So if a woman says to him (physician), I'm being abused, or you know I got this black eye because I got the shit beat out of me. They (physicians) look at, they don't; wasn't to know how she got it, they don't know how to get down emotionally. Cause they are different, I know I am making a generalization....." (Glenda)
>
> "They (physicians) don't know how to acknowledge what they are confronted with." (Debra)
>
> "They are uncomfortable, and basically there are two things, one is the time issue, they don't have time to stitch her up and then get to the MI in the next gurney. Second, why should I, she's going back to him anyway and I don't have to deal with a problem I can't fix." (Glenda)

Ways in which women access and employ the medical system have been criticized and misrepresented in our society. Women have been blamed for their patterns of health care use. Interestingly, women are chastised and reprimanded for not seeking care, (i.e. during the prenatal period), yet blamed for repeat visits in the emergency room for injuries resulting from domestic violence. An unclear message is sent to the victim and unmet expectations arise. Tiffany remembered a specific patient who was inadvertantly blamed for an impossible situation.

> "One case in particular, there were bruises all over her. And the husband tried to come in Labor and Delivery to get at her and wed to have a very interesting fight, had to have security take them out. But then we just knew she was going to get out of the situation, but he was right there when she delivered, with her the whole time, we couldn't believe it!!" (Tiffany)

Dyehouse (1992) suggested that women have been offered an increased number of prescriptions and surgical interventions as opposed to education, mutual respect, and participation in the decision making process. This report was partially substantiated in the data by the following nuses. One concept that is undisputed is that women are the ones who most frequently access the health care system, and therefore receive more attention for their health care needs. Unfortunately, the treatment plan does not always include empowerment strategies.

> "And how many of you come into contact with the perpetrator? And treat them? Or have day to day contact with them? It's the women that we see. That's only half of the problem." (Glenda)
>
> "I think you are right and I don't think we see that many men in health care, women are the ones who access health care." (Darlene)
>
> "Nurses have seen our roles as empowering people, actually nursing hasn't always been that way. We haven't been educated to provide that sort of thing (self help) to patients. I'm coming into this nurse practitioner thing, and having to get involved...." (Darlene)

The health care system further supports gender differences by the disparate way in which men and women are entertained during the health care exchange. It is common and accepted for women to undergo thorough health assessments, with providers probing into her private life and personal habits. Emotional issues pertaining to personal relationships are glossed over at best.

In contrast, the interaction with men in the health care system does not follow the same format. During the health care exchange, males are

approached with a posture of sensitivity for their privacy. Ironically, an air of secrecy is understood. Further, the content of health care visits does not consistently include provisions for behavior counseling. This can be explained partially in that, traditionally men have not been exposed to the health care system as frequently as women. Bob recognized the differences and offered the following comment.

> "You know, sometimes we don't ask the question of women, if they've ever been abused. And we don't ask men either. We don't ask, Do you ever have trouble controlling your temper? Do you ever have trouble not forcing yourself on your partner sexually? Or ask any of those kinds of questions to men. We don't screen for that." (Bob)

> "What if we tried to apply the same message to a man? If a woman feels that she is in fear for being assaulted or attacked, we ask what is your safety plan? What are you going to do next? But how do you turn that around to a man who is about to commit an assault? What do you tell him? (Hannah)

Viewing these differences in interactions among patients, a sketchy and non standardized approach to social problems such as domestic violence is evident. The patriarchy has created a situation that fails to empower the woman by its inconsistencies. The Band-Aid approach of treating domestic violence includes addressing the injury, initiating a minimal form of crisis intervention, and discharging the patient. This scenario is less than an optimal form of intervention. Failure to confront violence, the nurse's inability to offer resources, and the system's propensity to ignore the consequences for violent behaviors, maintain the presence of abuse. The victim remains accountable for the violent actions of her intimate. Therefore, it is unlikely she will initiate meaningful changes and lifestyle modifications for her current situation. The nurse clinicians described this concept.

> "We think we are going to do magic. We found out that. Social service is going to do something magical, but they have not been able to do anything, and that's fine."(Madge)
>
> "I equate this battering business to perinatal grief and loss or even substance abuse, we take care of them while they are here in the hospital, and we give them the baby stuff, the lock of hair or give social service consult, or drug test them, and get them all hooked up. Then they go home, and maybe two weeks later, all of the sudden we go away, so they are left to grieve on their own. They are left to deal with the batterer on their own, because we're on to the next patient so we can put this quick fix on all of these problems." (Glenda)
>
> "We don't have a list of resources of how to find a social worker, if she happens to be here that day I happen to be here." (Tiffany)

In essence, we now have a situation where providers of care have assumed great personal cost in addressing domestic violence in both the physical and psychological arenas where little reward is received for doing so. Not only does the clinician expend considerable time and emotional energy, but also faces threats to personal safety by the perpretrator. The courage to assess for domestic violence is rendered powerless, when conditions of interventions are not plausible or expected. When rewards are not forthcoming, it is unlikely that the process of disclosure will enuse. Without continued reward and profit, victims are forced to remain in a powerless situation. One nurse remembered a specific incident that is an example of these time and safety issues, that impacted the health care interaction between the victim and nurse.

> "We had a patient just a couple of weeks ago just threw her food tray and pitcher and everything at her husband and unknowing to the nurse that they just argued when she walked in the room. This was a patient who was diabetic, but refused to learn how to give herself insulin. So the nurse was going to teach her. The nurse did not know the husband and wife had just argued when she went into the room and she was showing him how to draw up the insulin. The patient went crazy. I'm not going to let him stick me...." And then she refused social service, told us everthing that had been going on at home with no family support, expected to take care of everything with the two kids and all, and then went home with him. (Tiffany)

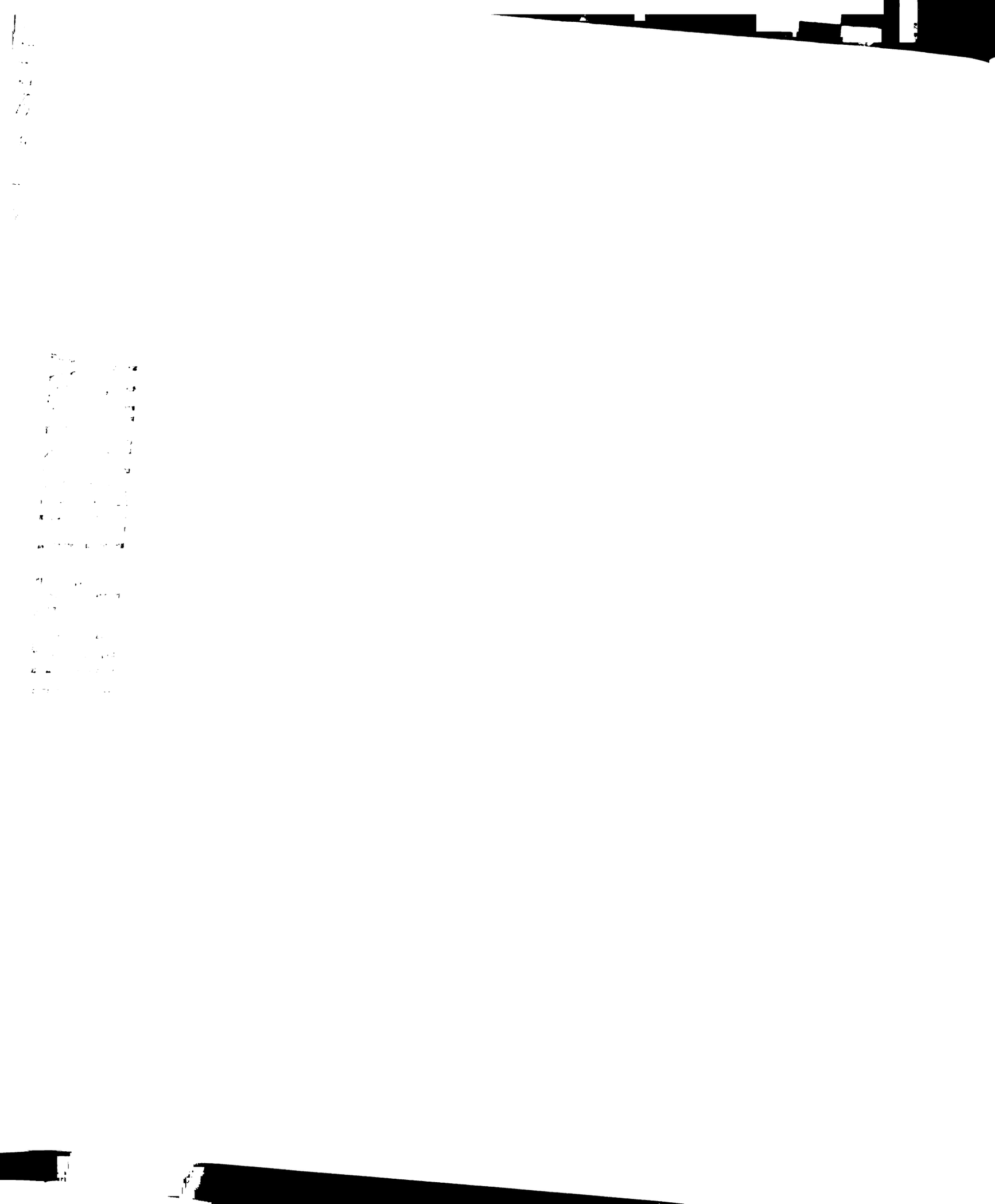
The patient was discharged home, and remained in the situation. It is difficult for those in helping professions to accept this outcome, where the perception of little profit has resulted from their actions.

Another factor that contributes to "the staying" of victims is the lack of co-operation among people providing resources. How often is there positive collaboration between shelters, social service, law enforcement, and health care? More specifically, how often do nurses actually set forth and confront this social issue? The inconsistency of assessments and interventions evidenced in Chapter V supports this description. The following data illustrated the ignorance and lack of unity among resource services.

> I want to know what programs are out there that she can access, that will make her leaving a little easier. A lot of women will stay in the relationship not only because she loves him but because she doesn't know what's out there, there is anything out there for her and they don't think they can survive out there." (Angie)

> "How can I help show her there are places out there to help her survive when I don't know myself. I don't know enough about the system to say chuck the system." (Cathy)

> "I work in our county's system, so do you, sometimes the right foot does not know what the left foot is doing." (Glenda)



> "It wasn't that long ago the police were involved and there were a number of restraining orders and the police never did anything. The police don't have the manpower to do anything." (Darlene)

Before the changes in the role of nursing occurred, many nurses did not recognize the assessment for domestic violence as part of "their job". Many nurses who were trained in this era continue to offer health care services to victims. As a result, the problem of domestic violence has been addressed by the medical model and social service in the areas of making decisions regarding referral, documentation of the circumstance of injury, and the provision of a nurturing environment. Many of these providers are not well versed or trained in all of these areas. This disparity fuels the victim's uncertainty, reinforcing the option of staying with the perpetrator, instead of evaluating empowerment. One nurse stated the following in relation to the delineation of duties.

> "Many fail to even ask those questions. I'm a person from the sixties, when I graduated from nursing school, people didn't ask those questions. I mean in the seventies we were barely asking." (Darlene)

This hit and miss approach to confronting domestic violence leaves the victim powerless. Failure of the system to recognize the community resources or to ignore the alternatives available, is a disservice to the battered woman and perpetuates disempowerment. For example, a clinician in the labor and delivery department who identifies a victim of domestic violence will most likely call social service as part of a standard protocol. The assumption is that social service has community contacts and is networked into the battered woman's

movement, and can offer the victim avenues for safety needs, financial resources, and possibly transitional housing. The reality, however, is illustrated in the data.

> We have a good shelter service, but a diminishing number of social support services and social workers. If Well's plans (legislation) go through, its going to have a serious impression on domestic violence. (Hannah)

> ""We don't have any resources. It would be nice to have a list of places a list of people to call. I don't know what to do. I have no idea. " (Doris)

Nurse clinicians for the most part are uninformed regarding available resources for tertiary prevention and the professional role of other providers after initial disclosure occurs. One more time the problem of domestic violence is punted back and forth between the disciplines.

> ""This is the one question that would like an answer for. What do I do when someones says yes that they are abused? You are not suppose to tell them they have to leave, you don't need anybody to do that anymore. The legal realities do scare me, and I don't know what I am suppose to do about it. Who am I suppose to call? Or report to?" (Doris)

The victim does not remain oblivious to this "pass the buck" posture. She may feel that her problem is devalued when providers do not themselves follow through, rather rely on other individuals to deal with the problem. She may feel hopeless over the lack of collaboration between the disciplines. She may feel powerless because of the powerlessness that is felt and communicated by the clinician who remains inadequately trained in the current procedures.

> "To do our job, we need reaffirmation that it is OK for me to ask women and then it's how do we ask , how do we approach the subject? There is a fear of intrusion that you will push them away because you are asking too many of those kind of questions, and the feeling of responsibility of knowing. How much do you do cause once you find out then what do you do? Knowing the difference that you are not responsible that she's responsible. Getting the tools and information about how to deal with it." (Angie)

> "I want something in front of me, so I won't have to look it up." (Cathy)

> "I have so much time to do a history and physical, and get them out of the door. But if I had something on site, where I could beep someone and some over for someone in crisis. We are trying to work on that." (Fran)

Consequently, the battered woman does not regain control nor learn to make empowering decisions. When the victim is advised to get out, instantly her safety is jeopardized, her social standing is criticized, her credibility is questioned, and her financial status is dramatically altered. It appears her options are few. Staying or returning to the batterer is familiar and predictable. The woman learns how to manage her violence. This coercive dynamic is endorsed by the health care system by treating the injury, not the cause. A battered woman feels more power equality in her violent situation compared to "getting out" and the perceived disorganization of health care and social services society offers her.

> "Well it's hard to convince the woman that she's better off leaving a battering relationship, especially if it is you know, severe battering. The perspective of, well he hits me once every nine months, but in between I have a nice car and a nice home, and he pays the children's college. If I leave all of this stops. I can take it once every nine months." (Carol)

> "She has to decide, my choices are getting beat when I go home, or every time he gets drunk, or mad, or on the weekend, or living in a shelter until I pull it together and get a job They say they are not ready for that, she's just going home and face even worse than what she would have been if she hadn't left at all." (Betty)

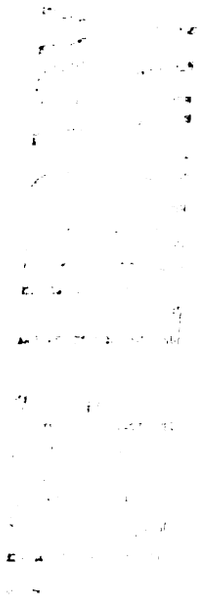
An explicit and powerful example by Yvonne Ulrich (1993) expands on the context of "why they stay". Women who managed to rebuild their lives recount the advice they received from therapists. The women were encouraged to continue a relationship with abusers who threatened their life by continued involvement with mediators, the interaction with the children, her social circle, and contact with extended family members (p.389). We expect battered women to adjust to society's conceptions and misconceptions of abusive relationships. This view is often-times a perception of the situation being less violent than it truly is. In addition, women are stalked, their children endangered, and their lives are in constant fear. In many instances, the battered woman feels trapped with no latitude for change.

> "When you get to the question of why these women stay, why are they if they had any power at all, they would leave, not realizing that you have to get into yourself and get that power out." (Carol)

> "One of the hardest things is when you see the situation where people do get these restraining orders or whatever and they're murdered."(Hannah)

> "The O.J. thing has brought this into every one's home, not just the murder of a spouse, but the other kind of abuse, stalking." (Debra)

No wonder she stays.



Blaming The Victim

A strong voice echoes in our society that implicates a women for the battering she endures. The blame is evident in law enforcement, social service, friends, family, and society. This blaming, however, creates a confusing paradox for victims, who seek help and guidance for domestic violence by those who are charged with helping abused women, and are then blamed for its existence.

> "Unless you have a certain degree of human psychology, it's on the point, she deserves it if she wasn't living in that situation if she didn't have three children by three different men, she wouldn't be battered." (Carol)
>
> "It is a clear perception (by society) that this woman deserves to have the shit beat out of her." (Sally)
>
> "I find a lot of women will think they deserved it. Like, well we got in a fight and I was hitting him back so it wasn't really physical abuse." (Ellie)

Victims internalize their feelings to hide the shame and embarrassment they feel. She learns to hide the emotional scars that stay with her for a lifetime. By necessity, she learns to exist in an isolated existence. She turns to the perpetrator for understanding and acceptance because the health care system, law enforcement, and the prevailing societal norms have failed her. She is blamed. She accepts the blame. The price of a "cure" for her injuries is to admit total dependence and accept the blame. The message that is imparted to the battered woman is that it is her fault this behavior occurred and continues to happen. Tiffany pointed out the difficulties an adolescent encountered when she realized her plight and confronted change.

> "Then there are the teenage girls that we would see frequently over in L&D they would be 15 or so. Rebelled against Mom and Dad, I will move in with an older boyfriend and here they are pregnant and abused in this situation, but yet it is harder for them to get out because, one, that would mean having to go back to mama and Dad and here there is not an open door for them, that would mean defeat to them." (Tiffany)

> "You know, society protects a child until she has sex." (Glenda)

> "These girls see no way out because there is no where for them to go, except on the streets". (Tiffany)

> "Yes, its the cost of adolescence." (Debra)

In addition, blame is placed on the woman in ways she cannot immediately change. The system endorses a situation where economic survival is contingent on the woman remaining in the relationship. When she refuses to leave, she assumes the blame for accepting the behavior and "staying put".

Law enforcement has historically implicated battered women for their plight. The manner in which response to calls is handled, the legislative climate, and the lack of collaboration are factors that illustrate this position. Law enforcement is also a patriarchal domain. Police officers, judges, legislators, sheriffs, bailiffs, and others traditionally have been men. What kind of message is conveyed to a woman when she cries for help only to be surrounded by more male dominant attitudes? The participants offered their observations and interpretations of law enforcement's role in this social problem.

> "Law enforcement sees the same woman, but I think a lot of the reason that happens, again left with the choice of going back to this batterer or not having the social support in place she chooses him, yet for that police officer who sees her with the bruises, maybe a month before he cannot see the pain of worrying about feeding the children. Or where the next dollar is coming from." (Carol)

> "You know, I talked with a group of policeman. They said two things. First, they waste their time going out there pulling them (males) off and she got him out of jail in a few seconds, and guy comes after them and its dangerous." (Glenda)

> "And it has happened, when she'll turn on the policeman and everything, and it's a bad situation where they (police) are coming to help the woman and they do arrest the man sometimes the woman turns on the policeman." (Betty)

> "Police officers are like everybody else, you have some that are very aggressive and proactive toward women and some that are not." (Chris)

Society has also contributed to the blaming of victims for her abusive situation. The responsibility of disclosure is mishandled by failing to share the stories of victims, failing to provide adequate support, and failing to hear the victims' voice. Thus, the secrecy is an alias for the blame. Angie and Cathy expressed exasperation with the social support system as it exists.

> "I had a woman that was a victim of domestic violence for maybe four or five years, which was extremely violent, multiple hospitalizations, she is still paying the bills. Being beaten, thrown naked in the middle of a sugar cane field, and he takes off. She wasn't sure what to do. She didn't know her bearings she was in a totally different neighborhood. She was embarrassed." (Angie)

> "'She (victim) has her sisters and her coworkers, and she's been in that job for 5 years. You would think she would have established some kind of friendship where she could have unloaded somewhere along the lines." (Cathy)

Nurses are not immune to the art of blaming the victim. The inadvertent use of "being a party to it", implicates the woman for the situation when in reality the victim is powerless. Cathy had the following to offer.

> "It happens at this stage of the project. We are able to assess and explore if the women have been a **party** to it (domestic violence) or victims of it or still are." (Cathy)

Madge took another posture of accepting the violent behaviors and then reprimanded the patient for her conduct.

> "We were talking about some cases and she and her boyfriend had been in the hospital and she said she shot him. I said you shot him? She said I shot him in the leg. I said why did you do that? She said he beat me, he hit me in the head with my crutches. And I said why did you allow him to do that why didn't you just leave?" (Madge)

Other nurses blamed the woman for abusive behaviors because of their personal experience with violence. Tiffany recounted her story.

> "Why do some women never get out? Just like my grandmother, I could tell you stories about my grandfather that would make you just cry. I have a lot of very hard feelings for my grandmother because I don't see how she stayed in that home." (Tiffany)

Finally, society does not allow abuse to be validated by not acknowledging its existence. Factions of society do not belive the woman's story. Individuals believe the woman deserves abuse and blames her for abuse. The nurses gave examples of these beliefs.

> "The issue we are saying that it is only recently that women don't deserve this. Its very recent that women are now suddenly being looked at as people." (Darlene)

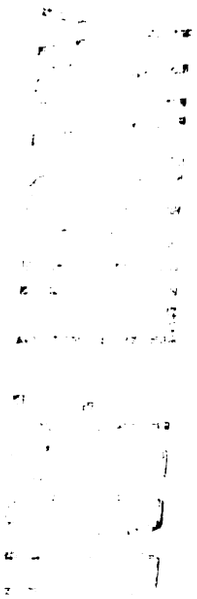
> "There was an article, Fader was commenting on the statistics on domestic violence. He took exception to the number of domestic violence cases in the country. Just what level of violence does he feel is appropriate for women?" (Carol)
>
> "And I think society presented it so long that this doesn't 't happen to the affluent. You know in the upside of town, it's happened to her because she is bad." (Gloria)

Why would a woman leave if she is not believed, if her plea is ignored, her financial stability altered and her self worth challenged?

No wonder she stays.

Gender Role Stereotyping

Feminist theorists and scholars make a conscious effort to disseminate understanding of difference in role expectations by gender (Hansen & Haraway, 1993). Dominance and control by males with power coupled with the service role that has been imposed on women, are the prevailing concepts questioned by feminists. Although the feminist view of domestic violence does not always account for time and space issues, these differences are prevalent in contemporary life illustrated in the work experience, home life, economic situation, and emotional makeup identified with gender roles. The distinct role differences and their effect on the problem of domestic violence were recognized by the nurse clinicians. This awareness influenced the nurse's perception of the way in which women are situated in our society. Perhaps the data brings into focus the influence of gender role and subsequent reasons battered women make the choices they make.



"They have cultural blinders (society). You weren't supposed to have sexual feeling if you were a female, and God forbid that something would happen to you because it became your fault, its always been our problem." (Sally)

"I think it's testosterone, the male, men are stronger, and they were meant to be the more aggressive force in society they were meant to be the hunters and the fighters and the protectors, when you look back on the industrial age, the women were designed for endurance and carrying children, and men were designed to go out to battle." (Debra)

"It's kind of interesting what usually gets woman out or makes her change is pregnancy and when the violence turns to the kids." (Glenda)

"In our own STD clinic are like 80% men and 20% women." (Donna)

"My husband and I were shocked when our daughter went to private school, coming home saying things obviously separating the boys from the girls." (Donna)

"You know they separate girls from boys, needlessly, they segregate them needlessly and words that go along with that. You engender the idea is that there is a difference, and one may or may not be better than the other." (Donna)

"And I said, when you are pregnant you don't go confronting him about another woman. I mean you just don't go confront them." (Madge)

"This gender role thing, like the guys go fishing, they go to the races they go to ball games and drinking with their buddies. And we're supposed to drop all of our friends to marry some guy and stay at home." (Glenda)

"If you look at the culture though, altogether, black people from hence-forth had to be strong because the men were always taken away, the men were taken away and put into slavery and the woman was left at home, so black women had to have strength. Black women always had to be strong. They were always the ones that were doing." (Madge)

The gender role inequality that exits in our society is real. For centuries, battered women have been told to "stay," "fix it," "keep quiet," and "you made your bed now lie in it." This is reinforced in a patriarchal manner when clergy,

law enforcement officers, physicians, and to some extent nurses, condone the presence of violence by denying its existence through cultural blinders and ignorance. The cycle has continued and the rights of women, specifically the right to live without violence, are elusive. The data confirmed this.

> "I want to comment. You can go back quite some years, and my grandfather was a minister and my mother and father were married. I'm the fifth child. He always went out on the ship, they call it at that time the banana boat. They were sitting up in the country, houses were miles and miles apart, so he would come home and abuse my mother, on the train. One day she finally left. (Evelyn)

> "I came from an abusive home, my mother had eight kids, she came from a country town, she never worked, my father worked and just took advantage. If she went anywhere, he was there he was abusive and it just went on for many years." (Corine)

In a postmodern, feminist framework the question has to be reworded and become, what allows a woman to go back to the violence? What rewards can be expected from health care providers and victims in our society that enable a woman to disclose, be believed, and be offered a choice for change? The answers are simple, succinct, and concrete. Yet, viewing these answers through a context specific lens entails complex and elaborate social policy construction.

Debra stated her feelings about the long haul of services needed for victims. She felt the superstructure was not looking at how many times a woman utilizes services coming in with all of the various needs to be addressed. Finances, transportation, child care, education, legislative change, punitive consequences, safety, stigmatization, and self esteem are implicated. Simple yet complex. No wonder she stays.

CHAPTER VII

CONCLUSIONS AND FUTURE DIRECTIONS

> "The turning point for me was when we got a research assistant, and she brought the forms, and the reaffirmation that it is OK for me to ask. How do we approach the subject? The fear of intrusion, the fear that you will push them away because your are asking too many of those kind of questions. And the feeling of how much responsibility of knowing? How much do you do once you find out? (Renee)

In choosing a phenomenon as emotionally charged as domestic violence to study I knew there were many obstacles to overcome. The idea of an a priori theory in a qualitative venue was the first constraint. Second, the prospect of a nurse studying nurses was another hurdle. Third, conducting focus groups made up predominately of women, was challenging because of the need to limit the "men bashing" dialogue and stay directed toward nursing practice. Lastly, because of my various researcher roles, keeping a clear picture of the reason for this project, examining the process of facilitating disclosure of physical abuse was paramount.

So, where do we start to address the issue of facilitating disclosure? The participants told us how nurses can create an environment conducive to disclosure by female victims of male battery. First, indirect interventions must be considered. These include listening, understanding, and trust within the nurse patient interaction. This posture allows for a marketplace or exchange of

valuable patient information. In this "marketplace," a balance of power is constructed between victims and clinicians.

As nurses, we need to take our training and skills and apply them specifically to the phenomenon of violence. By taking our craft to the center of the marketplace of exchange, which in the case of domestic violence has been up to now unfamiliar and kept behind closed doors, we will enhance disclosure and empowerment for the victim. The data suggested that nurses accomplish this task by looking for the triggers and cues in women as a guide to their assessment techniques. Examples from the data include observing the patient's and perpetrator's demeanor while evaluating the level of injury, assessing the storyline of the victim, and noticing the victim's attire. These are essential starting points for uncovering abuse.

> "She has on a scarf around her neck and sunglasses. She had gotten herself into a ugly situation." (Angie)
>
> "The situation is a little bizarre for some reason, and they (victim) act very strange on the exam table." (Donna)

In some fashion, violence exists everywhere, everyday, in everyone. This personal life experience with physical violence can be used as a facilitator to the process of disclosure. Nurse clinicians need to take advantage of the presence of violence and how they manage it on a day to day basis to examine and dissect the problem and use the pieces to increase our understanding of human aggression. Personal knowledge of the phenomenon can provide empathy and compassion, attributes that have been lacking in previous

interactions with victims. The clinician's introspection about his/her values and beliefs provide valuable knowledge and insights into the dynamics of violence. Professional training increases the nurse's knowledge base and contributes to the rise of social consciousness in the marketplace of exchange of behaviors.

The process of disclosure also entails confronting and mending the barriers. The barriers for nurses are inconsistency in assessments, lack of training, and time constraints. Change in practice cannot occur unless the old and obsolete methods of health care delivery are reevaluated and a new generation of nursing practice is introduced. This means uprooting and eliminating old myths, misinterpretations, and the posture of secrecy surrounding domestic violence. It is crucial to impart that domestic violence is a social problem not just a private one for the victim.

Structuring time into the schedule so that meaningful interventions will occur is key to challenging the barriers to disclosure. Obtaining training and disseminating information, in conjunction with culturally competent and time relevant knowledge, is a substantial method of breaking through the barriers. Moreover, being consistent in the assessments and nursing care delivered to women in all health care situations will be a catalyst for perpetual disclosure interactions. By allowing sufficient time for trained nurses to perform nursing assessments, a consistent pattern of exchange is created and a design of interaction established. We must tackle these barriers one by one, then put together a collective nursing model that is informed, timely, and consistent with an element of individuality for each and every woman.

The exchange forum must embody an atmosphere of respect: respect for the woman, respect for her position, and respect for nursing practice. A woman stays in a violent situation because society does not allow her to leave. Men batter women because society does not "encourage" them to stop. Until the situation is changed, and the blame and consequence is properly placed with the perpetrator, health care providers must not condemn a woman's decision. The nurse clinician must continue to respect the choices a woman makes, even though the values of the players may not be congruous with their own. The nurse must not attempt a control and rescue mission.

> "Until she makes up her mind, hey I'm not going to tolerate this anymore. And when I see that they have a choice I go all out. Yes, I have even taken people home. I have done that. What usually happens is my frustration level goes up, I get upset, and they're home. And I'm the one who is mad and upset." (Madge)

What we must do is start to provide primary prevention strategies that enable women to live a safe and violence-free existence. Then and only then will the dilemma of "why a woman stays" be itself irrelevant.

It is time to confront the traditional patriarchal concepts in the medical field which place the physician in a dominant position and fosters a dependent role in nurses and victims. The data in Chapter V identify the role delineation of health care providers and the need for rearranging these constraints. Coupling the tremendous strides in nursing education with a desire to assume a more challenging leadership role, nurses can forge new health care partnerships.

When we speak of equity, we must consider that blame must be placed where it belongs, on the perpetrator. Chapter VI describes the participants'

recognition of the turmoil created within the health care visit, when victims are failed by the system. The message imparted to an abused woman is that it is her fault the battering occurs. Time and time again, the blame is reinforced in the health care system by the secretive and docile manner with which it is approached. The directive must be to collaboratively and courageously facilitate disclosure of the abuse. This will pave the way for exchange and empowerment.

The strict gender role delineation in our society limits the choices a woman makes in regards to employment, parenting, education, sexuality, victimization, and patterns of socialization. The long standing debate over the role of women in society is changing to include more forceful and dynamic choices available to females. This is another avenue of equality in an arena historically occupied by males. We need more women at the forefront of research and clinical practice. Victims and advocates should also be involved so that a cohesive presence is assumed. This united presence is the marketplace for empowerment with support, power, and safety issues to be gained. This climate is a basis for change in the lives of battered women.

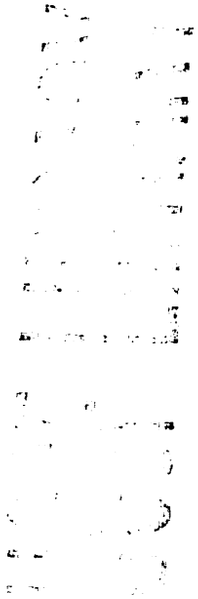
I identified seven salient points in the process of my research. These points are meant to raise the consciousness of nurses regarding domestic violence. I hope that the study's findings will enlighten and challenge nurses to look at their own experiences and use them in a positive venue when interacting with victims. I hope that these particulars will improve the image of nursing and contribute to the empowerment of women. The following seven items are my

specific recommendations for the process of facilitating disclosure of physical abuse. These points are derived from thoughts and insights based on the data, the interactions with the participants, the social influences upon us, and my personal experiences with the phenomenon.

Obtain Training

Training is the cornerstone of intervention. The importance of education regarding assessment techniques, intervention strategies, and the understanding of the social context of physical abuse now commands the attention of health care providers. Programs that target professional preparation for dealing with physical abuse were virtually non existent until recent years. Existing research indicates that with the proper training and education programs, identification of abuse increases in certain settings (Tilden & Shepard; 1987). Moreover, through the reported research and victim advocacy, the legal and ethical responsibilities of health care providers, as well as educational recommendations have risen dramatically. Fortunately, with this flurry of activity the training opportunities are now more readily available to deal with the varying aspects of professional responsibility associated with domestic violence.

What is the best way to provide this training? Initially, education must be available in the basic generic curriculum in professional programs. A baseline knowledge must be obtained early in the schooling of professionals. As the



skill level of the provider becomes more sophisticated, so must his/her knowledge about abuse.

Secondly, continued information regarding practice updates, state regulations, social movement, and the role of support services must be maintained. This is done by staying politically informed, and networked into the community.

Finally, it is imperative that nurses cross over the "boundaries" that are drawn between disciplines and become familiar with the scope of resource services for victims of domestic violence. For example, a nurse must become familiar with and conversant with the type of training of other professionals as well as the services offered by various agencies. Simply by honoring the work and background of the resource team, meaningful and reciprocal roles among the services can result. Confusion and unmet expectations are less likely to occur with this cross fertilization of shared information. Thus, the victim has a safe and consistent course throughout the process of disclosure.

Take Off The Cultural Blinders

It is undisputed that there exists a prejudice toward battered women in this society. This is evident in the data, by the dialogue regarding "the three piece suit" (p. 113). Society and practitioners adopt the stereotype of victims to be a woman of color, poor and helpless. It is time to take off these cultural blinders and view the dilemma where it is situated, as a global social problem.

If nurses do not approach each individual woman with the same risk for abuse, regardless of her color, home, or occupation, primary prevention is not being practiced. This cultural blinder perpetuates shame among all victims. Shame for being poor and abused, shame for being "white" and abused, and shame for being a woman and abused.

The way in which we discard these blinders is to view every patient with dignity, respect, options, choices, and consistency. We then reinforce our commitment by individualizing the victim's response to disclosure.

Discard The Myths

Myths, misconceptions, misinterpretations, and outright falsehoods about domestic violence abound in the reported literature on the subject (King & Ryan, 1989; Rose & Saunders, 1986). The impact of this distorted history on domestic violence affects all individuals regardless of chosen professions. What is personally disturbing to me is that these beliefs are all too frequently seen in the nursing profession. In my data, Madge pointed out:

> "We (African-American women) talk about it (domestic violence) more than the Caucasian race".

Her comments indicate that she believes domestic violence has a racial overtone.

Religious beliefs, cultural views, past relationships, and family history are other pivotal factors which are continually imprinted on the consciousness of the nurse's personal attitude toward domestic violence. Why do nurses whose

clinical training and didactic curricula includes crisis intervention in psycho-social concepts and health assessment, still cling to these outmoded and inaccurate beliefs? Quite possibly the answer is that these deeply held preconceptions about domestic violence are so entrenched in a social context, that one short course of professional instruction cannot overcome or eliminate these years of personal pre-conditioning.

In order to break down these personal barriers, the nurse must daily remind herself to shed her own "cultural blinders" before she interviews and assesses her patient for the presence of physical abuse. What avenues can be taken to overcome the myths that exist and facilitate disclosure? The answer is to start with a global view of the problem in a social context and include interventions at all levels of nursing practice.

Addressing the myths and prejudices in school age children is an ideal beginning. In the pediatric setting, for example, nurses can get the message out that violence is not acceptable by consistently assessing behaviors surrounding television, conflict resolution, and viewing family violence. Training children at an early age that violence is not a private issue, and that it is appropriate to discuss violence in an open forum, is a method of primary prevention. Providing children with safety plans and avenues of refuge, dispels the privacy myth, and makes help seeking acceptable.

In the adolescent arena, a nurse practitioner who offers contraception information can incorporate assessments regarding abuse and date violence. Informing young women that responsible sexual practices include pregnancy

counseling, contraceptive options, and being able to say "no" to violence and forced sex is a fundamental empowerment strategy.

Women in the child bearing years come into contact with the health care system more frequently than at any other time in the life span. The safety of an unborn child is partially contingent on a violence free environment. A nurse clinician can take this window of opportunity to provide education about safety for both patients.

When abuse has been a long standing issue for a patient, the nurse clinician can offer a marketplace of exchange conducive to disclosure for a victim who chooses to maintain a violent relationship. This level of interaction allows for a safe and understanding experience for approaching health risks, exit planning, and options needed for victims. In a global health care role, public health providers can offer educational principles in a non racial or socioeconomic venue by posters, pamphlets, presentations, and verbal dialogue.

Share The Responsibility

As stated in Chapter V, physicians have for many years tried to "fix" the problem with physiological principles but minimal context specific interventions. Hence, abuse continues to exist in epidemic proportions. Shelters cannot offer treatment for serious injuries resulting from abuse. Social service cannot provide transitional housing. Psychotherapy cannot provide employment. The clergy cannot provide on going child care. Day care

cannot provide law enforcement. Law enforcement cannot provide shelter. A ring of influences is evident. No one discipline can "fix" domestic violence. It takes shared responsibility.

As with any political or social problem, ownership becomes a crucial pawn. Popular social movements vie for economic resources, hired personnel, time allocations, and legislative considerations. The acquisition of the resources allow certain players to obtain positions of power. Thus, territories are constructed and ownership can often obstruct progress. The problem labeled domestic violence cannot afford to be belabored by further power, control, and ownership. It already exists in this context. Conversely, because domestic abuse is so complex, many players choose to "give it up" prior to completion of their designated assignments. Neither scenario is conducive to disclosure. If and when the problem is uncovered, a shared collaboration and commitment is necessary to facilitate improvement. "Passing the buck" among disciplines or "turf claims" by certain services are equally detrimental to empowering women.

The participants suggested various activities that would initiate a sharing of responsibility. A main theme of "organized unloading", whereby all members of the health care team involved with an abusive situation convene to talk about individual cases, was a very popular idea among the nurse participants. This strategy addressed the strain and emotional pressure professionals experience when dealing with the frustrations of working with battered women.

This venue is ideal for training and learning from each other's interactions with victims.

Another concept of "unloading" defined by the nurses was the debriefing that occurs among staff members to discuss issues that affect each other in the workplace. Because interaction with victims is an intensive and exhausting endeavor, this time is well spent for emotional support for each other. Personal situations can also be discussed in this forum. This platform is used to promote trust and respect among the health care team. When a collaborative and shared marketplace is created, facilitating disclosure becomes less threatening to nurses and victims and an opportunity for empowerment is initiated.

Join The Movement

Domestic violence has been "behind closed doors" for centuries. Only in recent decades have women's rights advocates and leaders diligently tried to open that door by fomenting a movement to end domestic violence and open the door to empowerment and launch empowerment. Law enforcement, legislators, shelter advocates, health care providers, social services, legal counsel, feminist groups, industry, and private individuals have slowly recognized and joined the movement. Because the nurse clinician is an integral and central player in the marketplace of women's issues, nurse clinicians could employ strategies to advance the movement and give honor to victims.

Utilizing proper terminology when addressing the patient is vital to the movement. For example, asking first before referring to the woman as Miss, Mrs., Ms., or Dr., is a major step in empowerment. Recognizing that the victim has an identity and respecting her individuality and desires is key to establishing self worth. The nurse is in a prime position to accomplish this during the assessment intake. The health care visit is an opportune platform for approaching the victim with dignity and respect.

The gender role stereotyping that occurs in society, joined by the forces of class and race, has created a power imbalance among nurses, victims, resources, and health care exchange. As discussed in Chapter VI, this stereotype affects the view of women in our society, and represents the intersecting oppressions impacting on all players in the health care exchange. The stereotyping influences the manner in which nurses approach victims. Joining the movement is a beginning in closing the gap between the gender role expectation. Simple statements that honor domestic roles elevate the image of women's work, and respects a woman's choice of occupation is vital for empowerment. As Sabrina states:

> "We (women) do a lot of back biting and until we begin to realize that everybody is important, and that we have a lot to offer and just because the man is up here does not mean I have to be down here. I can walk level with him" (Sabrina)

Fostering sensitivity to women's issues is a direct goal of the movement. The health care arena is now in the forefront with recent attention to issues

such as breast cancer, HIV, abortion rights, childbirth, menopause, and domestic violence. Nurse clinicians, with their knowledge base and training, may disseminate information to the public in a non-threatening manner. Organizing or participating in festivities that address women's health care issues not only elevates the image of women, but elevates the image of the nursing profession as well. Health care providers are viewed in a position of power in society, therefore when health professionals support a cause, more credibility in that cause is generated. When society takes notice that women and violence are important issues, then domestic violence will be addressed with the force, the focus, and the seriousness this issue deserves.

Ask The Question

The subject of domestic violence is an uncomfortable one. The words them selves conjure up images most people choose to ignore. In the past it was not unusual for a poor, downtrodden, battered woman arriving at the emergency room to be ignored and disgraced. Typically she was not questioned appropriately about her injuries. The tragedy is compounded when the victim is assessed, treated and then reprimanded for the situation.

Asking the question regarding domestic violence goes against the traditional values that have been imposed by society mores. The secrecy that was expected in violent relationships is now challenged among health care providers. Nurse clinicians are now required by law to "Ask the Question".

The data reflected both a willingness to conform to practice changes, as well as a reluctance to do so. The participants knew they were expected to "Ask the Question," although they did not consistently do so. The nurse clinicians identified concrete reasons for these omissions of assessment by lack of training, feelings of intrusion, and time constraints. When they did ask the question, many nurses perceived they did not have the resources needed to deal effectively with the situation. The question I raise is "What is the intervention when the question is asked?'

The "job" of the nurse is not to "fix" the problem of domestic violence. The "job" if you will, is to bring the phenomenon into an arena where it can be challenged with discourse. By opening the door and bringing the problem to the forefront, the issue will be in a forum for people to deconstruct violence. We can begin to rebuild in a context specific atmosphere with proper resolution and empowerment. This approach will challenge the societal norms, the practice of health care and the image of women in our society.

A crucial piece to this deconstruction is the acknowledgment of domestic violence. Validating the problem is premier to empowerment. A health care provider cannot offer any steps for equity and safety if violence is not uncovered. Thus, the nurse clinician begins by "Asking the Question". After this intervention, shared responsibility takes over, and the collaborative forces are put into motion.

Participate in Research

The nursing literature regarding violence against women is scant. Research studies have been divided among the disciplines and nursing research is but a small portion of these reports. It is time to develop a body of knowledge that is comprehensive, examines the interactions in the health care setting, tests interventions offered to battered women and their children, and explores the ramifications of disclosure of physical abuse.

The nurse clinician is in an optimal position to develop this knowledge base due to the integral role she/he has with women and children. The daily contact in the practice setting, and the provision for follow up care within family nursing, is a fertile research environment available to nurse clinicians. What better avenue to inform, to ensure safety, and empower women than conduct nursing research in the clinical setting?

Today, the funding opportunities for women and violence are unprecedented. The social climate is favorable for researching this silent epidemic. Many nurse clinicians are now prepared in the research role. Women in the health care system are willing to participate for empowerment. It is time to heed the call and conduct organized investigation that will yield a knowledge base specific to the role of the nurse, and of a broad enough scope to include the context specific lens. This grass-roots approach will allow clinical practice to inform research and vice versa.

I reiterate the question, "What is the intervention one employs when disclosure has occurred?" The answer is a balance of two pieces of the exchange. First, when the process of disclosure is effective, the victim will dictate the degree of involvement she desires from the interaction. Within a social exchange perspective, this will happen at a comfortable pace when profit, reward, and costs are appropriately negotiated. Secondly, the nurse clinician must be ready to face this challenge of disclosure by the following actions: 1) Obtain the training to do the "job", 2) Find out about the training necessary for the entire cast of players involved with the movement, 3) Do not be afraid to cross the boundaries and become familiar with the needed interventions expected for victims. This includes those individuals outside the health care domain, 4) Consciously work on discarding the myths and misconceptions about violence, so that blame and unfair judgment are not imparted to the victim, and 5) Be consistent in assessments, so that each woman is offered the appropriate degree of service. Establishing a routine for each patient interaction will address the time constraint problem felt by many clinicians, and increase the familiarity with the phenomenon of abuse.

Conclusion

Domestic violence has a steadily increasing and all pervasive presence in our society. Every day, we read about this problem in our morning newspapers, we see reports on the evening newscasts, and hear about it from our family and friends. Domestic violence is so common-place, the U.S.

Surgeon General declared it epidemic in our nation (March of Dimes, 1987). Despite the increasing awareness, and watershed legislative changes, factions of society continue to deny the magnitude of the problem. What can be offered as an explanation for this denial? Possibly incomplete definitions associated with domestic violence cloud the picture of awareness. We do not call it what it is, Violence Against Women. Perhaps health care is an overworked system that expects to do too much. We have trouble informing patients that no "cure" is readily available for problems we cannot immediately "fix" such as domestic violence. We tend to ignore these difficult diagnoses. Or maybe, society is unwilling to accept a change in its traditional historical foundations and structural boundaries which socially created such vast differences in the treatment of men and women. Now is the time to develop new strategies which address these concerns and allow nurse clinicians to improve the care rendered to victims.

The practice of professional nursing is changing at an unparalleled pace. The nurses' role development, agency involvement, mandatory reporting laws, and revisions in health care administration describe many of the influences affecting practice. The nurse clinician faces practice modifications that have been introduced before adequate training of the health care team and societal acceptance has occurred. The context specific lens which addresses larger structural and functional changes is not fully understood by many nurse clinicians. Unfortunately, the nurse's perception of these practice changes is to

"fix' the problem instead of contributing his/her part to the context specific empowerment of victims.

The newly defined advanced practice nursing roles,(i.e. certified nurse midwives, nurse practitioners, clinical nurse specialists, and nurse researchers), provide an opportunity for intimate and consistent interaction with female patients. The nurse participants recognized this changing philosophy and trend for the role of nurses. For example, more nurses are now providing primary perinatal care, therefore an assumption exists that early and consistent advocacy develops. Nurses voiced that a more empowering role from the nurse is the contemporary expectation. Theoretically more patient rapport is apparent with scheduled visits, reimbursement guidelines, and the philosophical posture of advanced practice nurses. The participants fear the reality to be that health care reorganization creates more responsibility, more volume, less continuity, less time, and less reimbursement. As referenced in the Barriers to Disclosure in Chapter V, the data support this argument by the espoused frustration of the "dwindling resources," "15 minute visits," and "doing more with less".

Nurse clinicians are experiencing more autonomy than ever before. The hand-maiden image, where nurses follow strict instructions from the physician, is being replaced by collaborative practice with common goals. In accepting this expanded role, nurses must be prepared to recognize their responsibility regarding patient disclosure. This does not mean that nurses must deliver all interventions to "fix" the problem, but simply provide their part of the shared

responsibility. A paradox is created when nurses have been mandated to alter their practice without being given the tools to transition effectively. This includes developing the skill to address disclosure, define the protocols for intervention, and change the overall perception of nursing care delivery to the battered women.

As health care "reform" becomes a permanent part in the political and private sector, more regulations are inevitable. Domestic violence is in the forefront of these current revisions across the country. Some of these new roles send confusing messages to the health care provider. For example, in Massachusetts, the nurse participants reported that the insurance industry recently denied a battered woman coverage due to a preexisting condition diagnosed as domestic violence. The Joint Commission on the Accreditation of Health Care Organization requires hospitals to address domestic violence in an organized fashion, with education, training, and assessment protocols. And most recently, some state agencies are necessitating domestic violence training for licensure. Ironically, the attention to the old problem of domestic violence is new to all of these agencies.

A very serious influence on the practice of professional nursing is mandatory reporting of domestic disputes. This controversial law precipitated great debate and concern over the multitude of consequences of such new responsibility for health care providers. The discourse concerning the eventual impact of this legislation continues with little real understanding of the ramifications. Compounding the problem, the new law was conceived before

complete guidelines, protocols, or training programs were unified and standardized. Advocates of this statute hope to encourage punitive consequences to perpetrators, aid abused women in litigation, and to increase the awareness of domestic violence. These may indeed be initial steps in the empowerment of women. Whatever the outcome, the data support the undisputed fact that nurse clinicians are not informed of this timely and critical practice responsibility. Only time will determine if this law impacts the facilitation of disclosure.

Health care providers, society and women, are viewing a political moment in time that has never before occurred in relation to women's issues. In all probability, it might not be repeated again. There are unprecedented funding opportunities for shelters, research, law enforcement, and education. Legislative changes are happening at a cataclysmic rate. The media is focused on the issue of domestic violence. Nurses must go forward, and make the commitment to be a part of this growth. The climate is politically, socially, and culturally favorable to do something for women and children. Nurses must take the plunge, and "Ask the Question" and continue to "Ask the Question". The rewards are worth the cost.

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ATTACHMENT B

CITE_____

What is your current age? _____ years

Circle the number that best describes your ethic group:

American Indian or Alaskan Native.....1
Asian or Pacific Islander 2
African American.....3
Caucasian/White 4
Eurasian.....5
Hispanic 6
Other (SPECIFY) _____7

How long have you been working in health care? _____ years or _____ months

How long have you been working in women's health care? _____ years or _____ months

Circle the number that best describes your marital status NOW.

never married 0
first marriage 1
second marriage 2
third or greater marriage 3
living with partner.....4
separated.....5
divorced.....6
widowed 7

How satisfied are you with:	NOT AT ALL			MIXED		EXTREMELY SATISFIED	
your marriage or partnership?	1	2	3	4	5	6	7
him/her as a spouse or partner?	1	2	3	4	5	6	7
your relationship with him/her?	1	2	3	4	5	6	7

Attachment C

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
Consent to be a a research subject

A. Purpose and Background

Gay L. Goss, N.P., a Doctoral Student in Nursing is doing a study about the nurse's professional role in dealing with violence against women by a male partner in which I am being asked to participate.

B. Procedures

If I agree to be in the study, the following will happen:

1. I will attend one interview with Ms. Goss to talk about and my professional role in taking care of women who are physically abused by their male partner. This interview is expected to last 60-90 minutes.
2. If I agree, this interview will be audio taped and transcribed.
3. During the interview, I may ask questions at anytime.
4. I may terminate the interview at any time.

C. Risks/Discomforts

1. I may feel that it is inconvenient for me to participate in this study. If so, I am free to refuse to participate. Some of the questions may make me feel uncomfortable or upset. If I am upset, or I find a particular question uncomfortable, I can refuse to answer the question or withdraw from the study. I will meet with Ms. Goss in a place which is comfortable for me and will not interfere with my employment.

2. Anonymity: Study records and tapes will be kept as anonymous as possible. No individual identities will be used in any reports or publications resulting from the study. Study information will be coded with a number, and kept in locked files at all times. Verbatum data will be published without identification of individual source. Only study personnel will have access to the files and audio tapes. The tapes will be erased when the study is complete.

D. Benefits

There will be no direct benefit to me from participating in this study. The anticipated benefit of this study is a better understanding of violence against women by a male partner and my professional role interfacing with these patients.

E. Alternatives

I am free to choose not to participate in this study. I can leave the group at any time.

F. Costs

There will be no costs to me as a result of taking part in this study.

G. Reimbursement

There will be no reimbursement, although I may participate in the continuing education program after the interview and receive sample domestic violence protocols and guidelines.

H. Questions

I have talked with Gay Goss about this study and have had any questions answered. If I have any further questions about the study, I may call her collect at (209)576-3702.

If I have any questions or comments about participating in this study, I should first talk with Ms. Goss. If for some reason, I do not wish to do this, I may contact Dr. Kathryn Lee the academic advisor at 415-476-4442, or the Committee on Human Research, which is concerned with the protection of volunteers in research projects. I may reach the committee office between 8:00AM and 5:00 PM, Pacific Coast Time, Monday through Friday, by calling (415) 476-1814, or by writing to the Committee on Human Research, Suite 11, Laurel Heights Campus, Box 0962, University of California, San Francisco, Ca. 94143.

I. Consent

I have been given a copy of this consent form to keep.

PARTICIPATION IN RESEARCH IS VOLUNTARY I am free to decline to be in this study, or to withdraw from it at any point. My decision as to whether or not to participate in this study will have no influence on my present or future status as an employee or student in this facility.

DATE_____

Subject's Signature_____

Person Obtaining Consent_____

Attachment A

INTERVIEW GUIDE

I. Knowledge of Assessment

1.Tell me what you know about violence against women.

2. What, if any, kinds of techniques do you use when assessing for physical abuse against women?

3. What literature do you read regarding violence against women? Have you read any professional literature that has been particularly helpful?

4. Can you tell me about the different assessment protocols and tools available?

5 Can you tell me about the physical environment when assessing for abuse?

II. Barriers To Assessment

1. Are there any barriers to performing adequate assessments regarding physical abuse against women?

2. Tell me about your training surrounding domestic violence.

3. There are lots of myths surrounding violence against women. Share with me some that you have heard.

4. What do you think of beating up women?

III. Reporting Procedures

1. Are you familiar with any laws or protocols specific to reporting physical abuse against women? Tell me what they are or how you go about documenting and reporting.

2. In your present nursing role what kinds of resources, if any, do you think battered women need?

IV. Recommendations

1. Tell me, in your opinion, what kinds of things would enhance your ability to deal with violence against women?

2. What is your biggest weakness in dealing with these patients?

3. What is your biggest strength in dealing with physically abused women?

4. What does all this mean to you?

ATTACHMENT B
CITE_____

1. What is your current age? _____years

2. Circle the number that best describes your ethic group:
   - American Indian or Alaskan Native.....1
   - Asian or Pacific Islander 2
   - African American.....3
   - Caucasian/White 4
   - Eurasian.....5
   - Hispanic 6
   - Other (SPECIFY) _____7

3. How long have you been working in health care? _____

4. How long have you been working in women's health care?_____

5. Circle the number that best describes your marital status NOW.

   never married 0
   first marriage 1
   second marriage 2
   third or greater marriage 3
   living with partner.....4
   separated.....5
   divorced.....6
   widowed 7

6. How satisfied are you with:your marriage or partnership?
   1 2 3 4 5 6 7

Attachment C

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
Consent to be a a research subject

A. Purpose and Background

Gay L. Goss, N.P., a Doctoral Student in Nursing is doing a study about the nurse's professional role in dealing with violence against women by a male partner in which I am being asked to participate.

B. Procedures

If I agree to be in the study, the following will happen:

1. I will attend one interview with Ms. Goss to talk about and my professional role in taking care of women who are physically abused by their male partner. This interview is expected to last 60-90 minutes.
2. If I agree, this interview will be audio taped and transcribed.
3. During the interview, I may ask questions at anytime.
4. I may terminate the interview at any time.

C. Risks/Discomforts

1. I may feel that it is inconvenient for me to participate in this study. If so, I am free to refuse to participate. Some of the questions may make me feel uncomfortable or upset. If I am upset, or I find a particular question uncomfortable, I can refuse to answer the question or withdraw from the study. I will meet with Ms. Goss in a place which is comfortable for me and will not interfere with my employment.

2. Anonymity: Study records and tapes will be kept as anonymous as possible. No individual identities will be used in any reports or publications resulting from the study. Study information will be coded with a number, and kept in locked files at all times. Verbatum data will be published without identification of individual source. Only study personnel will have access to the files and audio tapes. The tapes will be erased when the study is complete.

D. Benefits

There will be no direct benefit to me from participating in this study. The anticipated benefit of this study is a better understanding of violence against women by a male partner and my professional role interfacing with these patients.

E. Alternatives

I am free to choose not to participate in this study. I can leave the group at any time.

F. Costs

There will be no costs to me as a result of taking part in this study.

G. Reimbursement

There will be no reimbursement, although I may participate in the continuing education program after the interview and receive sample domestic violence protocols and guidelines.

H. Questions

I have talked with Gay Goss about this study and have had any questions answered. If I have any further questions about the study, I may call her collect at (209)576-3702.

If I have any questions or comments about participating in this study, I should first talk with Ms. Goss. If for some reason, I do not wish to do this, I may contact Dr. Kathryn Lee the academic advisor at 415-476-4442, or the Committee on Human Research, which is concerned with the protection of volunteers in research projects. I may reach the committee office between 8:00AM and 5:00 PM, Pacific Coast Time, Monday through Friday, by calling (415) 476-1814, or by writing to the Committee on Human Research, Suite 11, Laurel Heights Campus, Box 0962, University of California, San Francisco, Ca. 94143.

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DATE_____

Subject's Signature_____

Person Obtaining Consent_____