

**EMERGENCY HEALTH CARE PROVIDERS' PERSPECTIVES ON PROVIDING  
CARE TO RACIALIZED IMMIGRANT WOMEN EXPERIENCING INTIMATE  
PARTNER VIOLENCE**

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## Abstract

**Background:** Intimate partner violence (IPV) can impact all Canadian women regardless of socioeconomic status, race, age, or ethnicity. In Canada, prevalence rates are estimated to be 6% to 8%, but many experts argue that rates may be even higher. As well, racialized immigrant women experiencing IPV are likely to face interpersonal and structural barriers to care when accessing services and engaging with health care providers (HCPs). To date, research focusing on emergency department (ED) health care professionals' perspectives and experiences caring for racialized immigrant women experiencing IPV has been limited.

**Purpose:** The purpose of this study was to explore and better understand ED HCPs' perspectives on providing care for racialized immigrant women experiencing IPV. The research was conducted at a large urban hospital located in the Lower Mainland of British Columbia (BC). A significant percentage of the population that the hospital serves are foreign-born immigrants originating from India and are of Punjabi-Sikh descent. Given this demographic, it is highly likely that HCPs have cared for Punjabi-Sikh women in the ED.

**Method:** This study used a qualitative descriptive research design. Cultural safety was the theoretical framework used in this study. A convenience sampling approach was used to recruit 5 HCPs. The HCPs consisted of ED nurses, forensic nurses, and social workers who were primarily employed in the ED. This study used individual interviews and a thematic approach to analysis.

**Findings:** The provision of adequate care to racialized immigrant women with IPV issues in the ED was hindered by several issues including the absence of resources, HCPs' biases, lack of privacy in the ED, long waiting hours, and a lack of time to deal with IPV cases. The study also suggested that ED nurses had to identify IPV cases amongst racialized immigrant women.

**Implications:** Future research should focus on the availability of information and training of ED HCPs to improve care provision for racialized immigrant women. This study also proposed that evidence-based research could help with understanding the unique IPV problems faced by racialized immigrant women, and help to facilitate the provision of efficient care in the ED.

### **Lay Summary**

Racialized immigrant women experiencing IPV are likely to face barriers to care when accessing services and engaging with HCPs. The purpose of this study was to explore and better understand ED HCPs' perspectives on providing care for women experiencing IPV who are seeking care in the ED. The research was conducted at a large urban hospital located in the Lower Mainland of BC. Qualitative description was used, and 5 HCPs were recruited. The HCPs consisted of a mix of ED nurses, forensic nurses, and social workers, who were primarily employed in the ED. The study suggested that the provision of care to racialized immigrant women in the ED was hindered by various factors including HCPs' bias and a lack of resources. This study recommended the provision of adequate resources to ED HCPs, and using evidence-based research to improve care provision and health care outcomes for racialized immigrant women experiencing IPV.

## **Preface**

This dissertation is original, unpublished, independent work by the author, B.Mattu. The research conducted in this study received harmonised approval from the University of British Columbia's Research Ethics Board [UBC REB # H16-00851] and the Fraser Health Research Ethics Board.

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## **Chapter One:**

### **Introduction**

#### **Background**

One of the health issues affecting women of different ages globally is IPV. According to the World Health Organization (WHO, 2012), IPV encompasses “behaviours and actions in close relationships that result in mental, physical and sexual harm to one party” (p. 1). The WHO (2012) estimated that 35% of women globally have undergone IPV at one point in their lives. Women are considered to be more vulnerable to IPV and are more likely to suffer physical abuse than men (Statistics Canada, 2013). In a further analysis of the susceptibility of women to IPV, Cherniak, Grant, Mason, Moore and Pellizzari (2005) stated that all women risk experiencing IPV, regardless of their social status, age, sex, race, health status, or partner presence or absence. In Canada, prevalence rates are estimated to be between 6% to 8%, but many experts argue that rates may be even higher (Cherniak et al., 2005; Statistics Canada, 2013).

British Columbia is one of the Canadian provinces that is highly affected by the menace of IPV. Thirty-two percent of female teenagers have suffered different forms of violence from their partners. The highest risk group, however, are the women between the ages of 24 to 34, who are considered more susceptible to IPV than those in other age groups (Statistics Canada, 2013). IPV has significant impacts on morbidity and mortality in women. For instance, women with IPV-related issues have a range of psychological disorders such as stress and PTSD, suffer sexual and physical health issues, and are more likely to engage in substance abuse (Cherniak et al., 2005; Heenan & Astbury, 2002; Karakurt, Smith & Whiting, 2014; McCauley et al., 2015). The aforementioned medical conditions highlight the serious health impact that IPV has on women experiencing violence, and the high likelihood that health care providers (HCPs) will

care for, and interact with, women experiencing, or at risk for, IPV (Hyman, Forte, Du Mont, Romans & Cohen, 2009).

### **IPV and Racialized Immigrant Women**

IPV has a range of effects on Canadian women, including psychological, financial, and physical impacts. However racialized immigrant<sup>1</sup> women are the most severely affected due to poverty and the existence of several barriers to health and societal well-being (Cherniak et al., 2005; Holtmann & Rickards, 2018). In 2011, 20.6% of the Canadian population were foreign-born and had arrived as immigrants; most of the foreign-born populations were from South Asia (Statistics Canada, 2016). Immigrant women encompass 20.2% of the Canadian female population, and 55% of these immigrant women are visible minorities (Statistics Canada, 2015). Hence, immigrant women represent a significant proportion of the Canadian population. The terms “visible minority”<sup>2</sup> and “immigrant” are often used interchangeably by the Canadian government when collecting census information about the Canadian population. While debate exists about the use of terms such as “visible minority” and “immigrant,” the importance of considering racialization should be highlighted, as it draws attention to the structural context and power relations that are associated with racism (Canadian Research Institute for the Advancement of Women (CRIA-W), 2005; Ng-See-Quan, 2005). Visible minority “is used to denote the difference in skin tone and the word ‘minority’ to denote numerical smallness or weakness in power relations” (Pendakur, 2005). In this study, the expression “racialized

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<sup>1</sup> “Immigrant” refers to a person who is or was a “landed immigrant...A landed immigrant/permanent resident is a person who has been granted the right to live in Canada permanently by immigration authorities...Most immigrants are born outside Canada, but a small number are born in Canada” (Statistics Canada, 2015).

<sup>2</sup> Visible Minority “includes persons who are non-Caucasian in race or non-white in colour and who do not report being Aboriginal” (Statistics Canada, 2015).

immigrant women” was used to outline the significance of understanding the societal, historical, political, and economic factors that shape the lives of this population group in BC, as well as their experiences, risks, and medical needs linked with IPV.

The Canadian Research Institute for the Advancement of Women (CRIAW, 2005) stated that the term “racialized” refers to women who:

Are subjected to discrimination owing to their races, accent, culture or religion . . . [and includes women], women with different birth countries including Canada who are targets of racism...The racialized women have family norms, religions, life experiences and histories that differ from each other. The only factor which unites them is their racialization, which makes them feel different from other members of the communities in which they live (p. 2).

Using the term “racialized” acknowledges the fact that the obstacles that women encounter are entrenched “in the historical and contemporary racial prejudice of society and are not a product of our own identities or shortcomings” (City for All Women Initiative (CAWI), 2016, p. 2).

Women of all ages and ethnic groups, the racialized immigrant women included, face several challenges and obstacles when disclosing IPV. These challenges make provision of care difficult.

### **Personal, Family, Emotional, Social, and Economic Costs of IPV**

IPV impacts women and their families, including children who are exposed to IPV.

Children who are exposed to IPV face greater risks for engaging in violent behaviour than those who do not, as well as being more likely to suffer from depression and anxiety (Kennedy, Bybee & Greeson, 2015; Visser et al., 2015). Being depressed in childhood also predisposes children to be depressed in adolescence and adulthood (Kennedy et al., 2015). Studies also show that the exposure of children to IPV impacts negatively on their education as they can no longer



concentrate on their studies (Kennedy et al., 2015; Visser et al., 2015). Consequently, the future of such children is jeopardised. While investigating the effects of IPV on young female children in the U.S., it was established that female children who were exposed to IPV had higher chances of experiencing IPV later in life (Kennedy et al., 2015; Visser et al., 2015).

IPV has significant personal, physical, mental, and financial impacts on women's lives; the impact being even greater for racialized immigrant women living in poverty, and women lacking access to the social determinants of health (Cherniak et al., 2005; Holtmann & Rickards, 2018). These impacts of IPV extend beyond the lives of individual women, having social and economic costs that influence systemic resources necessary to both prevent and tackle violence. For example, women who seek care for IPV in the ED may or may not have access to care and resources to adequately address their needs (Zhang, Hoddenbagh, McDonald & Scrim, 2012). Compared to the general population of women, racialized immigrant women face even greater barriers and challenges related to complex systemic obstacles that influence the disclosure of violence (Hyman et al., 2009). For racialized immigrant women, the risks for, and rates of, IPV are exacerbated by social, cultural, and political barriers; including social isolation, language barriers, discrimination, fear of deportation, an unwillingness or inability to displace themselves and their children from the nuclear family; along with the cultural meaning of divorce (Ahmad, Driver, McNally, & Stewart, 2009; Du Mont & Forte, 2012; George & Rashidi, 2014).

Racialized immigrant women may also face financial barriers limiting their access to health care services. Racialized immigrant women were more likely to be in a low-income bracket than non-racialized immigrant women, and 28% of racialized immigrant women were considered low-income compared with 14% of non-racialized immigrant women (Statistics Canada, 2011). Furthermore, racialized immigrant women who were not experiencing violence

tend to underutilise health care services (Ahmad et al., 2009; George & Rashidi, 2014; Hyman et al., 2009). Thus, racialized immigrant women who are experiencing IPV may also be unlikely to utilise health care services and seek help due to multiple barriers within the health care system, such as racism and discrimination and a lack of specific resources such as translation services (Lipsky, Caetano, Field & Larkin, 2006; Setia, Quesnal-Vallee, Abrahamowics, Tousignant & Lynch, 2011). HCPs can play a critical role in reducing the barriers to health care for all women experiencing IPV; effective IPV prevention and care also requires knowledge of the specific dynamics and experiences of women in order to tailor policy and practice within health care settings.

The economic, social, and family costs of IPV are, therefore, extensive. IPV not only impacts the woman and the family, but also has an impact on every member of Canadian society, from the spouse to the children, the employers who support workers who work with women experiencing IPV, schools that the children of these women attend, as well as policy-makers and governments that allocate public funds for IPV (Zhang et al., 2012). From an economic perspective, it is estimated that IPV cost Canadians \$7.4 billion, or \$220 per Canadian, in 2009 (Zhang et al., 2012). Health-related economic costs of IPV are estimated to be at \$2.05 billion nationally. The economic costs of IPV in BC alone are \$502 million, and estimated costs of women leaving their abusive partners are approximately \$6.62 billion (Zhang et al., 2012). The Canadian ED visits by women experiencing IPV cost the health care system \$5.9 million, and acute hospitalisations cost the health care system \$14.8 million in 2009 alone. IPV is also economically disadvantageous to women due to lost wages. In 2009, it was estimated that women experiencing IPV lost \$33.7 million in wages (Zhang et al., 2012). IPV-related costs are estimated to be at \$6 billion, consisting of medical attention, hospitalization, lost wages, lost

education, and pain and suffering (Zhang et al., 2012). It appears that women experiencing IPV are likely to be economically challenged and are likely to face economic hardships due to IPV. As well, globally, a significant amount of health care resources are being targeted towards caring for women living with IPV (Feder, Hutson, Ramsay & Taket, 2006).

### **IPV Care in the Emergency Context**

Based on estimates from the National Violence Against Women Survey conducted in the United States (U.S.), approximately one-third of the 5 million IPV incidents perpetrated against women resulted in medical attention, with the majority of women receiving treatment and care in the ED (Lipsky et al., 2006). In the U.S., it is also estimated that 11-55% of women experiencing IPV will visit an ED in their lifetime (Sormanti & Shibusawa, 2008).

One U.S. study estimated that 4% to 20% of women experiencing IPV visited the ED (Raj & Silverman, 2002). A Canadian study estimated that 13.9% of women experiencing IPV visit the ED (Hollingsworth & Ford-Gilboe, 2006). Medical practitioners in the ED are the first people to see female patients with IPV-related health conditions who are seeking medical care (Leppakoski, Astedt-Kurki & Paavilainen, 2010). Thus, the ED is an important resource that women living with IPV may turn to for care. Rates of IPV recognition by HCPs are dismal; some studies suggest a figure of only 2% to 8% of women being correctly recognised (Furniss, McCaffrey, Parnell & Rovi, 2007). Many physicians and nurses still feel uncomfortable asking patients questions about IPV (DeBoer, Kothari, Kothari, Koestner & Rohs, 2013; Furniss et al., 2007; Leppakoski et al., 2010). Some of the reasons why HCPs feel uncomfortable making patient inquiries about IPV are a lack of knowledge on how to deal with positive responses, the lack of confidentiality in the ED, the inadequacy of time to make patient inquiries, and personal biases of HCPs (DeBoer et al. 2013; Leppakoski et al. 2010). Since a significant number of

women experiencing IPV are likely to visit the ED, it is critical to understand HCPs experiences and perspectives of caring for women who are experiencing IPV.

There is a lack of research focused on how to provide effective, safe, ethical, and responsive care to racialized immigrant women experiencing IPV within the ED. The emphasis on screening for IPV in the ED setting places primary emphasis on the reliability of the instruments and tools used for detecting IPV (Svavarsdottir & Orlygsdottir, 2009), while research is limited on providing effective care for racialized immigrant women. In Chapter 2, I discuss this research evidence further to underscore the importance of the completed research.

### **Health Care Providers**

HCPs such as social workers, do encounter women experiencing IPV (McMahon & Armstrong, 2012). Social workers facilitate the assessment, identification, intervention, advocacy, and the provision of the necessary resources and guidance to women experiencing IPV and the policy-makers (McMahon & Armstrong, 2012). However, research shows that only 10% of social workers routinely ask women if they are experiencing IPV, despite literature detailing best practices for social workers recognising women experiencing IPV (McMahon & Armstrong, 2012). There is also literature within the nursing discipline that provides best practices on caring for pregnant women experiencing IPV (Anderson, Marshak & Hebbeler, 2002; Decker et al., 2012; McMahon & Armstrong, 2012). Best practices include “assessing for health and safety [and] identifying support systems” (McMahon & Armstrong, 2012, p. 14). While studies exist on practices for some HCPs, there is less research focused on nurses and social workers providing IPV care in the ED context. Another study discussed best practices for HCPs when caring for women who have a history of strangulation (Faugno, Waszak, Strack, Brooks & Gwinn, 2013). The authors of this study all came from nursing backgrounds, but there was no actual mention

what type of HCPs the study was aiming to target. However, in the case study examples they used forensic nurses in the scenarios (Faugno et al., 2013). This demonstrates that literature pertaining to HCP experiences regarding IPV in the ED is not specific enough to drive recommendations for specific HCPs such as social workers and nurses.

The ED is a common point of contact for women experiencing IPV (Van der Wath, Van Wyk & Janse van Rensburg, 2013). However, women experiencing IPV are not often identified by ED nurses. Therefore, the prevalence rates used in detecting IPV by HCPs are low (Du Mont & Forte, 2012). The ones who are detected usually do not receive the necessary care and treatment, and experience multiple challenges (DeBoer et al., 2013; Furniss et al., 2007; Leppakoski et al., 2010). Reasons for lack of detection include stereotypes held by ED nurses, discomfort with the subject matter of IPV, lack of training and education and personal experiences of IPV (DeBoer et al., 2013; Furniss et al., 2007; Leppakoski et al., 2010). One phenomenological study aimed to understand the essence of ED nurses' experiences caring for women experiencing IPV (Van der Wath et al., 2013). Findings in this study included emotional distress and anger when caring for women experiencing IPV, and recurrent and intrusive memories long after providing the care (Van der Wath et al., 2013). Again, understanding ED nurses' perspectives on IPV is important to providing safe and ethical care.

### **Health Care System Barriers for Racialized Immigrant Women**

Racialized immigrant women who experience IPV face specific barriers in seeking help when compared to Canadian-born women (Cherniak et al., 2005; Hyman et al., 2006). Different factors contribute to the challenges of access to health care for racialized immigrant women seeking health care due to IPV. These factors include the ability to access resources, the age of the women, the time since immigration, and the ability to communicate in English when

interacting with HCPs. Depending on the age of the woman, the time since migration, and access to resources, even if racialized immigrant women are able to communicate in English, they may also face significant communication barriers when interacting with HCPs. In situations where intimate partners/perpetrators are providing translation and are present with their partners during interactions with HCPs, women can lack the privacy necessary for them to feel safe and comfortable in disclosing their abuse. Cherniak et al. (2005) stated:

Language barriers, social isolation, and lack of direct questioning by clinicians act as significant barriers to the disclosure of abuse . . . many women may fear deportation or the breakdown of sponsorship agreements, loss of community status and respect, and loss of child custody . . . there may be familial or religious pressure to maintain the sanctity of the marriage and family integrity. . . This also complicates the recognition and experience of abuse and adds to fears of disclosing and reporting to authorities (p. 371)

Racialized immigrant women also face unique challenges reporting IPV due to actual experiences of discrimination and racism from police and HCPs (Bauer, Rodriguez, Quiroga, & Flores-Ortiz, 2000). These interpersonal and systemic barriers impact how HCPs communicate with and act to support racialized immigrant women; experiences that may not be shared by Canadian-born women living with IPV (Ahmad et al., 2009; Du Mont & Forte, 2012; George & Rashidi, 2014). Effective IPV care for racialized immigrant women within the ED requires understanding ED HCPs perspectives through research and empirical evidence.

### **Problem Statement**

To date, research focusing on ED health care providers' perspectives and experiences caring for racialized immigrant women experiencing IPV has been limited despite the fact they face disproportionately more barriers to effective care.

## **Purpose**

The purpose of this study was to explore and better understand ED HCPs perspectives on providing care for racialized immigrant women experiencing IPV who are seeking care in the ED. The study was administered in a large urban tertiary hospital in the Lower Mainland of British Columbia. A significant percentage (40.5%) of the population in this community are foreign-born immigrants, and 37.6% of these immigrants who live in this community stated that their place of birth was India, and 33% of these immigrants reported speaking Punjabi at home. The most frequently reported religion in this community is Sikhism, at 22.6% (Statistics Canada, 2014). Given this population demographic, it is highly likely that HCPs recruited for this study would have been providing care for Punjabi-Sikh women in the ED setting. Given the importance of tailoring IPV prevention and care within the ED context, it is necessary to investigate HCPs perspectives on caring for women experiencing IPV who access care in the ED.

## **Research Questions**

What are ED health care providers experiences of:

- 1) Providing care for women living with IPV?
- (2) The ED environment for how it shapes care for women experiencing IPV?
- (3) Assessment and care for racialized immigrant women experiencing IPV?

## **Justification for the Study**

Exploration of these questions revealed potential insight into how ED health care professionals can better care for women experiencing IPV, and can help inform nursing practice. Findings from this study will be essential in the formulation of policies to enhance the protection of racialized immigrant women against IPV and their improved access to health care. The results

of this study may help inform policy-makers and enhance ED care for women impacted by IPV. Policy-makers may inject more resources and funding to enhance care for women experiencing IPV due to the insights provided by ED HCPs.

**Conclusion**

IPV has significant social, emotional, physical, and economic implications for women and society as a whole, and impacts the whole health care system. Racialized immigrant women experiencing IPV face even more barriers and challenges, making it critical for research to be conducted to inform care for women.



## **Chapter Two:**

### **Literature Review**

#### **Introduction**

ED HCPs play an important role in caring for women experiencing IPV. Therefore, it is crucial to understand HCPs' perspectives on caring for racialized immigrant women experiencing IPV in order to inform professional practice. This literature review focused on what is known about ED HCPs' practice in relation to IPV. As stated in Chapter one, the purpose of this study was to explore and better understand ED health care professionals' perspectives on providing care for racialized immigrant women experiencing IPV who are seeking care in the ED.

#### **Search Strategy**

A literature review was conducted with no limits placed on the search date in order to maximise the number of search results. The following combinations of search terms and phrases were used: "IPV", "domestic violence", "family violence", "domestic abuse", "health risks", "health impact", "impact", "emergency department", "ER", "emergency", "nursing", "nurse", "health care professional", and "multidisciplinary" and "interdisciplinary". The search engines used were the Cumulative Index to Nursing and Allied Health Literature (CINAHL), Science Direct, OvidSP, ProQuest, Web of Science, PubMed, Statistics Canada, Canadian Research Index, and Canadian Public Policy Collection. Some relevant articles were found pertaining to HCPs and care in the ED; most were related to screening and detection, however more articles were found pertaining to ED health care experiences and perspectives on caring for women experiencing IPV.

### **IPV Impacts for all Women**

It is estimated that 1 in 3 women have experienced IPV globally (WHO, 2013). Women are adversely affected by IPV regardless of their race, social class, or religion. Moreover, IPV not only impacts women, but also affects the family network. For instance, several researchers revealed that children of women experiencing IPV have a greater chance of developing physical and behavioural problems, unlike the children of women who do not experience IPV (Alhusen, Bullock, Sharps, Schminkey, Comstock & Campbell, 2014; English, Marshall & Stewart, 2003). Neonates of women experiencing IPV are more likely to be low birth weight which has been associated with increased risk for diabetes and coronary artery disease for these neonates in adulthood (Alhusen et al., 2014; Barker, Eriksson, Forsen & Osmond, 2002).

With regards to personal effects, IPV increases the chances of substance abuse among the women experiencing IPV. According to Weaver, Gilbert, El-Bassel, Resnick & Noursi (2015), substance abuse cases are higher among women experiencing IPV than those who do not report incidences of IPV. Women experiencing IPV are also more likely to use alcohol and drugs than women who are not experiencing IPV, which negatively impacts their health outcomes (Weaver et al., 2015). IPV in women's lives also has an impact on their relationships, surrounding decisions to stay or leave a violent partner; research highlights the complex issues for women such as shame, family pressure to remain in the relationship, fear of deportation, and lack of financial, social, and family supports (Ahmad et al., 2009; George & Rashidi, 2014; Thandi & Lloyd, 2011).

### **IPV-related Health Consequences**

IPV has negative health-related consequences for women. For instance, women undergoing IPV suffer a range of psychological disorders such as PTSD, depression, anxiety, and

sleep disorders, as well as physical health problems such as acute pain (Ahmad et al., 2009; Aldarondo and Sugarman, 1996; Bauer, Rodriguez, Perez-Stable, 2000; Campbell, Jones & Dienemann, 2002; Coker, Smith, Bethea, King & McKeown, 2000; Health Canada, 1999, Hegarty, Gunn, Chondros, Small, 2004; Plichta & Falik, 2001; Wuest et al., 2009).

Although IPV may stop after some time due to divorce, its physical and mental effects still persist long after the abuse has stopped (Campbell et al., 2002; Coker et al., 2000; Guruge, 2012). Nevertheless, women who do not experience IPV do not utilise health care services in hospitals as often as those who are subject to IPV. Women who suffer from physical injuries related to IPV usually have injuries to their face, head, back, neck, breast, and abdomen (Campbell et al., 2002; Coker et al., 2000; Guruge, 2012). IPV also results in neck and back pain, arthritis, headaches and migraines, hypertension, peptic ulcers, and irritable bowel syndrome (Breiding, Black, & Ryan, 2008; Campbell et al. 1997; Coker et al. 2000; Letourneau, Holmes, & Chasedunn, Roark, 1999). Mental health problems accompanying IPV include depression, anxiety, post-traumatic stress disorder, substance use and dependence, and suicidal thoughts (Barrett, Teesson, Mills, Katherine, 2014; Gibson, Callands, Magriples, Divney & Kershaw, 2015).

Apart from negative physical and mental health impacts of IPV, IPV also causes sexual and reproductive health problems. For instance, women experiencing IPV have menstrual irregularities, unwanted pregnancies, sexually transmitted infections, and chronic pelvic pains (Ahmad et al., 2009; Guruge, 2012; Lee & Hadeed, 2009; Raj, Liu, McCleary-Sills & Silverman, 2005; Wuest et al., 2009; Zarif, 2011). Children of women who experience IPV are known to have poorer physical, mental, and social development, as well as poorer temperaments; females are more likely to experience IPV themselves later in life, and males are more likely to be IPV

perpetrators, also later in life, when compared to children of women who do not experience IPV (Gibson et al., 2015; Islam et al., 2017). Children of women experiencing IPV are more likely to have low birth-weights, and higher mortality rates overall (Bogat, DeJonghe, Levendosky, Davidson, von Eye, 2006; Burke, Lee & O'Campo, 2008).

IPV-related medical issues create substantial societal and health care system costs. The economic costs of IPV in the U.S. are close to \$5.8 billion, including medical and mental health care services, lost productivity, reduction in lifetime earnings, and physical and psychological injuries (National Center for Injury Prevention and Control, 2003). Canadian employers are also impacted by IPV with losses estimated at \$77.9 million (Zhang et al., 2012). Social and family costs to all Canadians are equally as extensive; for example, children exposed to IPV are more likely to suffer from hyperactivity, physical aggression and mental health issues, with associated medical costs of \$1.1 million, and more likely to earn less with estimated losses of future income consisting of \$227.9 million attributed to social and emotional disorders than compared to children not exposed to IPV (Dauvergne and Johnson, 2001; Zhang et al., 2012).

Women experiencing IPV are more likely than women not experiencing IPV to access health care services and interact with HCPs such as nurses (DeBoer et al., 2013; Hollingsworth & Ford-Gilboe, 2006). Nurses must have the necessary skills and knowledge to be able to care for and recognise potential women experiencing IPV in order to provide support and resources for women. Nurses also need to learn about the context of women's lives to create safe spaces which may increase the potential for disclosure that can connect women to appropriate resources, safety planning and community services. Thus, research focusing on HCP perspectives on caring for women in the ED can contribute to improved care for women.

### **Specific Contexts of Women's Lives that Create Greater Risk for IPV**

Individual and social risk factors have been reported that are associated with increased risk for IPV; such as age, poverty, lack of education, pregnancy, migration, and lack of social and family supports (Alhusen & Wilson, 2015; Association of Women's Health, Obstetric and Neonatal Nurses, 2015; Bhandari, Levitch, Ellis, Ball, Everett, Geden & Bullock, 2008; Li, Kirby, Sigler, Hwang, LaGory & Goldenberg, 2010). In addition, women experiencing IPV are more likely to have had partners exposed to IPV and/or experienced physical abuse in childhood than compared to partners who were not exposed and/or experienced physical abuse (Bhandari et al. 2008; Gibson et al., 2015; Guruge, 2012; Islam et al., 2017; Lee & Hadeed, 2009; Li et al., 2010). These risk factors combined with being exposed to IPV as a child increases the chances exponentially of perpetrating and experiencing IPV later in life creating a cycle of IPV that may be passed on to future generations.

Women who are pregnant or post-partum are also at increased risk for IPV (Agrawal, Ickovics, Lewis, Magriples & Kershaw, 2014). Post-partum women are more likely to be at increased risk for depression, and unintended pregnancies (Agrawal et al., 2014; Eckhardt, Murphy, & Sprunger, 2014). Mothers who are experiencing IPV are more likely to have infants experience sleeping problems than mothers who do not experience IPV (Agrawal et al., 2014). Age also plays a factor in women experiencing IPV as women between the ages of 16 to 24 are more likely to experience IPV than older women and IPV risk doubles in pregnant women under the age of 20 years (Agrawal et al., 2014; Stöckl, March, Pallitto & Garcia-Moreno, 2014). Women who are adolescent mothers are also at risk for experiencing IPV due to poverty and having limited support networks (Bhandari et al. 2008; Eckhardt et al., 2014; Kennedy et al., 2015; Li et al., 2010).

Living in poverty, with limited socioeconomic resources and exposure to higher rates of violence and crime has also been linked to IPV. For example, living in poverty contributes to IPV as financial concerns act as a significant stressor for perpetrators who enact IPV towards their partners (Agrawal et al., 2014; Bhandari et al., 2008; Eckhardt et al., 2014; Kennedy et al., 2015; Li et al., 2010). Women who experienced IPV are also more likely to have been exposed to childhood physical and sexual abuse and more likely to have been exposed to IPV as children, than compared to women who did not experience childhood physical and sexual abuse. Women who are homeless are also more likely to experience IPV than women who are not homeless (Bazargan-Hejazi, Kim, Lin, Ahmadi, Alireza, Khamesi & Teruya, 2014; Kennedy et al., 2015). Women suffering from depression and/or depressive symptoms are more likely to have experienced IPV than women who have not experienced depression (Bazargan-Hejazi et al., 2014; Kennedy et al., 2015). Women with lower education levels were also more likely to experience IPV, as well as substance abuse amongst IPV perpetrators were also evident with rates as high as 50 to 70% (Bhandari et al., 2008; Capezza, Schumacher & Brady, 2015; Coulter & Mercado-Crespo, 2015; Li et al., 2010).

### **Racialized Immigrant Women**

Newly migrated women are also at risk for IPV due to negative experiences continuous with immigrating to a new country such as language barriers, adapting to a new country's norms, particularly if they are living in Canada for less than 2 years and seeking asylum for threats to personal and family safety (Stewart, Gagnon, Merry & Dennis, 2012).

If the social context of women's lives is highly influential on their risk and exposure to IPV, then women experiencing racialization face additional barriers; yet, research detailed the nature of these barriers is lacking within the context of IPV. Several studies reported racialized

immigrant women do not disclose IPV-related to communication and language barriers, fear of deportation, a lack understanding of sponsorship agreements, a fear of loss of status and community isolation, and pressure to remain married in order to maintain family integrity and status (Cherniak et al., 2005; Thandi & Lloyd, 2011). Lee and Hadeed (2009) also claimed racialized immigrant women are less likely to report IPV to authorities and face challenges accessing care and treatment for IPV-related injuries influenced by language, and social and institutional barriers. Specific to emphasis on disclosure in the literature, Ahmad et al.'s (2009) study findings make the following claims about why racialized immigrant women may not disclose abuse: social stigma; women's gender roles (silence, marriage obligations, subordination); children's well-being; lack of social support; and knowledge gaps and myths. Most of the reasons at the root of delayed help-seeking were linked to the socio-culturally prescribed values and norms and/or the immigration context. The latter was more dominant when participants discussed their children's well-being, social support and knowledge of available services (p. 617).

Women experiencing IPV from one study spoke about social stigma and shame related to disclosure of IPV and these disclosures were perceived to bring suffering and loss of respect to their family (Ahmad et al., 2009). The women in this study reported feeling obligated to stay within their marriage for their children's sake and well-being and expressed worry about how to support their children on a single-income and provide adequate food and shelter. The findings emphasised how the women expressed difficulties in child-minding as they did not have family members to take care of their children when working. Other factors reported included how women's circumstances contributed to remaining in violent relationships further exacerbated

social isolation, thereby reducing their chances of building relationships with others in their new country (Ahmad et al., 2009).

Several studies have also demonstrated racialized immigrant women are more likely to experience barriers to health care and report racial discrimination when attempting to access services (Hyman et al., 2009). According to one Canadian study, 1 in 5 minorities have experienced racism within the Canadian health care system (Ali, Massaquoi, & Brown, 2003). In several Canadian studies, the strongest predictor of help-seeking behaviour amongst racialized immigrant women was the severity of IPV, and number of incidents (Cherniak et al., 2005; Hyman et al., 2009). Women who experienced more than one incident of physical/sexual violence and feared for their lives, were more in danger and more likely to seek help. Factors women consider when deciding to leave or stay was dependent on the housing situation, access to income and benefits, immigration status, racism and sexism, and responses from service providers (Cherniak et al., 2005; Hyman et al., 2009). Whether women stay or leave their partners is complex and the tendency to see the issue as simply one of “just leaving” can undermine the support and care women need. Similarly, emphasising the priority of women’s disclosure of IPV can obscure the critical focus on barriers created by HCPs and within larger health care systems. Focusing on women leaving abusive partners and emphasising disclosure of IPV, while a focus in research, can detract from the importance of reducing barriers to care that arise from HCPs and health care systems; therefore, this thesis aimed to contribute knowledge for optimal care within the ED.

### **IPV Care and the Emergency Department**

Women experiencing IPV may not be aware of where and how to seek IPV-related care (Spencer, Shahrouri, Halasa, Khalaf & Clark, 2014). Some women may reach out for help from



family members and/or friends and may be encouraged to not to contact authorities and to resolve IPV-related issues in the household and not to disclose IPV to authorities and HCPs (Spencer et al., 2014).

Yet, despite a reported lack of awareness of IPV care resources and services, women in the US experiencing IPV are three times more likely to visit the ED and access health care services than women not experiencing IPV (Campbell, 2002; Feder, et al., 2006). In several studies, women living with IPV did not discuss their situation unless asked by nurses, social workers or physicians; reported detection rates for IPV by ED nurses in several studies was estimated at only 10% (Efe & Taskin, 2012; Elliott, Nerney, Jones & Friedmann, 2002; Valente, 2000). These findings highlight the importance of ED nurses having the knowledge and skill to build relationships where women may feel safe to disclose IPV. The emphasis on screening women for IPV in research focused on language and cultural barriers, women experiencing IPV partners being present, lack of knowledge and training, time constraints, lack of resources, and uncertainty of what to do with a positive response (Furniss et al., 2007; Zarif, 2011). Some women, but not all women experiencing IPV, welcome HCPs asking about IPV; however, in one study it was reported HCPs do not take advantage of this opportunity (DeBoer et al. 2013).

Research pertaining to IPV and the ED department has focused on screening and detecting IPV amongst female patients with an emphasis on why ED nurses and other HCPs' hesitate in screening and asking patients about IPV (Boursonnell & Prosser, 2010; Efe & Taskin, 2012; Reisenhofer & Seibold, 2007; Ritchie, Nelson & Willis, 2009; Robinson, 2010; Tower, Rowe & Wallis, 2012; Yonaka, Yoder, Darrow & Sherck, 2007). Despite these studies, few best practices exist to guide HCPs caring for women experiencing IPV in the ED environment, and literature on understanding challenges HCPs experience when caring for women impacted by

IPV. Thus, research is needed to better understand HCPs' experiences, particularly within a context where women living with IPV are seeking care.

### **Women's Experiences with Health Care Providers**

Women experiencing IPV have reported negative interactions and experiences with HCPs such as social workers, nurses and physicians when seeking care (Feder et al., 2006; Tower et al., 2012). Women described receiving poor quality assessments and labelling of their health concerns which led them to feeling stigmatized and judged (Tower et al., 2012). They felt their health concerns were not taken seriously and they received incompetent care (Tower et al., 2012). As a result, they resisted care and did not feel comfortable confiding with HCPs about experiencing IPV, further isolating themselves from potentially helpful resources (Tower et al., 2012). Yet, there are important factors reported in the literature that impact HCPs responses to IPV (Feder et al., 2006; Furniss et al., 2007; Yonaka et al., 2007). For example, HCPs felt care for women experiencing IPV was outside of their professional boundaries, perceived IPV as a personal or private issue, lacked knowledge and education, conflict with personal attitudes and values on IPV, and reported lack of time (Feder et al., 2006; Furniss et al., 2007; Reisenhofer & Seibold, 2007; Yonaka et al., 2007). As well, in other studies, structural constraints, and how acute service management are arranged and orientated were mentioned as other barriers limiting HCPs responding to women experiencing IPV (Hollingsworth & Ford-Gilboe, 2006; Hyman et al., 2009; Reisenhofer & Seibold, 2007; Tower et al., 2012). The biomedical focus of care dominates in the ED and has been argued that care for women living with IPV may be undermined. Tower et al. (2012) found in their study physicians felt the ED was not an appropriate place to assess and treat women for IPV due to its physical layout and lack of privacy and maintaining confidentiality (Tower et al., 2012).

## **IPV Screening and Health Care Providers**

According to a Jordanian study, screening for IPV can increase detection rates of women experiencing IPV (Al-Natour, Gillespie, Felblinger & Wang, 2014). However, screening rates by nurses are estimated to be anywhere to be 10% to 39% (Al-Natour et al., 2014; Malecha, 2003; Thurston, Tutty, Eisener, Lalonde, Belenky & Osborne, 2007). One study conducted in Ontario found IPV detection rates to range from 4.1% to 17.7% (Beynon, Gutmanis, & Tutty, Wathen & MacMillan, 2012; MacMilan et al., 2006). These variances in screening in the literature is problematic as it highlights the fact there are inconsistencies in the evidence that support screening. Despite the lack of robust evidence in the US, IPV screening is recommended for all women seeking care in the ED as well as staff training as per professional organisations such as American College of Nurse-Midwives and American Nurses Association (Btoush, Campbell & Gebbie, 2009). However, this contradicts the WHO, Canadian Task Force, and the UK's Health Technology Assessment Programme, stating insufficient evidence to support if screening for IPV is effective (Jewkes, 2013). However, one study stated early detection leads to early referrals to resources for women experiencing IPV may need (Al-Natour et al., 2014). However, there are other studies stating the fact screening does not lead to positive health outcomes and reducing IPV (Falb et al., 2014). It is unclear, although, if screening is considered unfavourable due to it being ineffective or the lack of HCPs adherence to screening protocols. It is also unclear if perhaps reducing IPV is correlated to the strength and amount of resources offered and provided by health care organizations to HCPs (Falb et al., 2014). One Jordanian study stated nurses were more likely to screen women for IPV who were seeking care for physical injuries than any other chief complaints (Al-Natour et al., 2014).

Another study stated HCPs were more likely to screen women for IPV who are exhibiting depression and anxiety (Smith, Danis & Helmick, 1998). This is problematic as this indicates some HCPs only screen woman with physical injuries, depression and anxiety instead of screening all women HCPs encounter. In addition, the U.S. Preventive Services Task Force (2004) states evidence to support screening women for IPV in primary and acute care settings is lacking, of poor quality, and benefits and harms of screening cannot be determined. In a Canadian study investigating screening for IPV, it was established that there was insufficient proof to recommend for or against screening for IPV (Canadian Task Force for Preventive Health Prevention and Treatment of Violence against Women, 2001).

As mentioned earlier, at the current moment, screening has not generated significant evidence to ensure its favourable uptake with HCPs and due to several barriers reported in the literature. Common barriers to screening by HCPs include: not having time to screen and disinterest in screening, lack of confidence in referring women to appropriate resources, lack of support from management, family/partner presence, and lack of IPV education and training (Al-Natour et al., 2014; Beynon et al., 2012). Other barriers include not believing women experiencing IPV will have access to social work support and mental health resources, blaming women experiencing IPV for their situations, uncomfortable asking women if they are experiencing IPV, and believing screening is not part of a nurse's or physician's occupation (Al-Natour et al., 2014; Beynon et al., 2012).

Another important reason for lack of screening are concerns about safety as “nurses have concerns and fears about their own and victims' safety when screening for IPV” (Al-Natour et al., 2014, p. 1483). Nurses are concerned about their own safety due to perceived lack of security in ED settings, and women experiencing IPV fearing retaliation from IPV perpetrators, and

severity of IPV after disclosure (Al-Natour et al., 2014; Häggbloom & Möller, 2006). This information highlights the fact IPV screening may put nurses and women who disclose IPV at risk for even more violence which most likely deters HCPs from screening and women for disclosing in the first place. Even if screening is positive for IPV, HCPs encountered challenges when attempting to refer women to appropriate resources and unaware how to access and navigate the health care system to help these women. However, when screening for IPV, nurses were more likely to refer women experiencing IPV to social workers than any other HCPs (Al-Natour et al., 2014).

### **Health Care Providers Perspectives on IPV**

While studies have focused on HCPs' providing care for women living with IPV, there is limited research focused on HCPs' in the ED and racialized immigrant women experiencing IPV. However, research does exist on HCPs' perspectives on IPV such as highlighting problematic responses of HCPs who label and stigmatize women experiencing IPV. In one study, the authors detail HCPs' responding with anger and frustration towards those seeking care especially if they have visited the ED before due to IPV (Häggbloom & Möller, 2006). HCPs' who are older and experienced and have experienced IPV themselves are reported to be more likely to screen for IPV (Beynon et al., 2012). In the same study by Häggbloom and Möller (2006), the findings indicated a "strong sense of nurses 'engagement and concern to respond to women survivors of violence'" (p. 1079). In the same study, HCPs reported consoling women who were experiencing IPV to the best of their ability even though they felt ill-equipped to do so; they reported using intuition when suspecting IPV to screen patients (Häggbloom & Möller).

Nurses also express stress, anxiety and shock when seeing women with extreme IPV-related physical injuries and anger towards physicians who showed little to no concern toward

these women experiencing IPV (Kaplan & Komurcu, 2017). HCPs' also stated feeling ill-equipped when dealing with women experiencing IPV and reported frustrations over the lack of support and resources from other HCPs and decision-makers and leaders. HCPs who have specialized training in assessing women experiencing IPV felt more comfortable caring for these women and noted changes within themselves about negative attitudes towards IPV and victim-blaming (Kaplan & Komurcu, 2017).

## **Conclusion**

IPV results in a range of negative consequences for the women experiencing IPV including psychological problems, reproductive health issues, and physical injuries (Cherniak et al., 2005). Racialized immigrant women are greatly affected by IPV and have several structural and interpersonal barriers that hinder them from accessing medical care and engaging relevant professionals. Their susceptibility to IPV is also higher than the other women due to lack of community and family support and high poverty levels which make them economically unstable (Ahmad et al., 2009; Dasgupta, 2007; George & Rashidi, 2014; Hyman et al., 2009).

Compounding these contexts of risk, women living with IPV are also likely to experience negative interactions with HCPs that further discourage seeking care and treatment. When women do seek care, they come to EDs; yet, there is limited literature to guide HCPs such as nurses, physicians and social workers to care for women who are living with IPV. Racialized immigrant women who are experiencing IPV face unique challenges in disclosing IPV due to language barriers, isolation and pressure not to disclose IPV. In the next chapter I will discuss the study design and research methodology that was undertaken for the research.

### **Chapter 3:**

#### **Methodology**

In this chapter, the research design, theoretical framework, and methods will be discussed. Sample selection and recruitment, data collection, data analysis, and ethical considerations will also be discussed. As stated in Chapter 1, the purpose of this study was to explore and better understand ED health care providers' perspectives on providing care for racialized immigrant women experiencing IPV who are seeking care in the ED.

#### **Research Method**

This study utilised qualitative description as its research method. Qualitative description uncovers the experiences, and describes the events or phenomena from data collection in everyday language; description is the focus with less emphasis on interpretation (Sandelowski, 2000). Sandelowski (2000) stated that qualitative descriptive research studies require researchers to be in close contact with the participants or events in question. Findings that are constructed using a qualitative descriptive approach are less subject to multiple layers of interpretation, which means that there is less focus on detailing the multiple potential meanings within the data.

Qualitative descriptive research draws from a naturalistic inquiry approach and employs convenience sampling techniques (Sandelowski, 2000). Data collection techniques include using open-ended individual, and/or focus group interviews that can be semi-structured or unstructured. The qualitative descriptive method of research was selected for this study as it is considered to be appropriate for a Master's thesis, and is suitable for novice researchers. As this was the first research study I have undertaken, qualitative description was an appropriate choice. I learned to immerse myself in the data, while also learning about how to identify patterns within

the data, and how to construct themes that were reflected in the participants' data. I focused on the meanings contained within the participants' data.

### **Theoretical Framework–Cultural Safety**

The theoretical framework that guided this qualitative study drew from the principles of cultural safety. The concept of cultural safety emerged in the 1980s, based on the work of a group of Maori nursing students and faculty members who were concerned about health care practices that were perceived as disempowering and disrespecting the well-being and health of the Maori people and their culture. This was also reflected in the inability to recruit and retain Maori nurses (Nursing Council of New Zealand, 2011). The Maori people are Indigenous to New Zealand. Cultural safety is a framework that delivers more appropriate health services while respecting the unique cultural identity of the patients. Originally, cultural safety mostly applied to health care delivery to Maori and other Indigenous groups, but now may be applied to any racialized and/or marginalised population. For example, people living with disabilities, facing homelessness, or in poverty also face marginalization; the principles of culturally safe care extend beyond ethnicity and consider structural barriers and power relations within health care, therefore considering the 'culture' of health care itself (Cultural Connections for Learning, 2013; Nursing Council of New Zealand, 2011).

The term "cultural safety" refers to the determination of the most effective nursing practices for patients by the patients themselves, or their families (Nursing Council of New Zealand, 2011). The culture of a people encompasses a variety of features, including religion, age, beliefs, disability, and socioeconomic status. Nurses who provide care to patients must, therefore, evaluate themselves and recognise the effects of their cultural affiliations on their



professional practices. Unsafe cultural practices are comprised of any actions that diminish, demean, or disempower the cultural identity and well-being of an individual (p. 7).

Cultural safety includes actions that require recognition and respect of cultural identities, as well as reflection on one's own culture and beliefs (Cultural Connections for Learning, 2013). As part of the theoretical alignment for this research, cultural safety helps in understanding the significance of cultural awareness in health care institutions, as well as its place in the lives of individuals accessing health care. The concept of cultural safety is not only applicable to ED nursing, but also to other health care fields such as medicine and social work. To integrate cultural safety into a health care professional's practice involves 3 key elements:

1. **Cultural Awareness** involves acknowledging that there may be differences between the beliefs and practices of the health care provider and the patient (Cultural Connections for Learning, 2013; Nursing Council of New Zealand, 2011). For instance, a HCP caring for a woman experiencing IPV may recognise the power dynamic and the vulnerability of the patient, which could also be applied to any marginalised populations interacting with the health care provider (Cultural Connections for Learning, 2013; Nursing Council of New Zealand, 2011).
2. **Cultural Sensitivity** alerts HCPs of the differences that may exist between the provider and the client. This involves a process of self-reflection and exploration of the HCPs' own culture, beliefs, and experiences that may have an impact on their practices, and how it may hinder developing therapeutic relationships between HCPs and women experiencing IPV (Cultural Connections for Learning, 2013; Nursing Council of New Zealand, 2011).

3. **Cultural Safety** involves encouraging the development of a culturally safe environment where the patient feels safe when accessing care, which involves mutual respect between the HCP and the patient (Cultural Connections for Learning, 2013; Nursing Council of New Zealand, 2011).

The rationale for using cultural safety as the theoretical framework for this study underscored the importance of understanding how HCPs and racialized immigrant women interact within the ED context, by specifically focusing on how HCPs contribute to creating safe environments for their patients. In addition, because power dynamics are inherent within health care interactions, and cultural safety draws attention to power and context, this perspective drew my attention to how the HCP participants described their perspectives on caring for racialized women living with IPV within a context imbued with power. Thus, cultural safety informed my analysis by highlighting barriers to creating safe spaces, as shown within the data, based on women's experiences with accessing ED care. Specific attention to power dynamics and the culture of the ED were also foremost in my analysis, which was informed by the principles and concepts of cultural safety.

### **Sample Size, Selection and Recruitment**

Using a convenience sample approach, I set out to recruit up to 10 health care providers from an ED located in a large urban hospital in the FHA region. The HCPs consisted of a mix of ED nurses, forensic nurses, social workers, and ED physicians who were primarily employed in the ED. The justification for this diversity of HCPs was that a range of HCPs interact with women experiencing IPV in the ED setting. (Boursnell & Prosser, 2010; Reijnders, Giannakopoulos & de Bruin, 2008; Ritchie et al., 2009). The inclusion criteria included participants that had at least 3 years of ED experience, and ideally were employed in permanent

part-time or full-time positions. The rationale for these criteria reflected the view that a minimum of 3 years' experience in the ED would increase the likelihood that the HCPs had a depth of ED experience where they could share valuable experience and information about caring for women experiencing IPV. Using HCPs who had stable employment in the ED ensured that the HCPs had sufficient experience in the ED setting, and could best speak to the phenomena being studied.

However, I was only able to recruit 5 participants, which included 3 forensic nurses, 1 ED nurse, and 1 social worker. I was unable to recruit any ED physicians. I had discussed if I should continue trying to recruit more participants with my primary supervisor; however, we determined that given my novice level and the requirements for a Master's thesis, five participants would allow me to immerse myself in a reasonable amount of data to learn about the process of thematic analysis.

I used convenience sampling to select the study participants. Convenience sampling involves "selection of the most readily available persons as participants in a study" (Polit & Beck, 2012, p. 724). This type of sampling approach was appropriate for this study; I contacted ED educators and managers to distribute information about my study, and within a short period of time I had five participants. Recruitment of participants was undertaken through posters (see Appendix A) displayed in highly visible areas, and invitations were also sent out via email to ED clinical educators, supervisors, and managers, to send to all ED staff (Appendix B). Eight participants contacted me. However, only five of them met the criteria for inclusion in the study. The three participants who were excluded were excluded based on the fact that one had only been employed as an RN for two years, whose primary employment was as a diabetic RN, and the other worked as an ED RN outside the FHA. I asked potential participants to share the above information to capitalize on the "snowball technique" as the convenience approach only yielded

5 participants. “Snowball sampling” entails the “selection of participants through referrals from earlier participants” (Polit & Beck, 2012, p. 743). However, I was unable to recruit any further participants through snowball sampling. In the end, the sample was comprised of 3 forensic nurses, 1 ED nurse, and 1 social worker. The demographic information of the participants can be found in Appendix D.

### **The Research Site**

The research was conducted by recruiting HCPs from a large urban hospital in the Lower Mainland of BC. The city where the study was conducted is projected to have the largest population growth as compared to other cities within the Fraser Health region (Fraser Health Authority, 2012). Forty percent of BC immigrants live within the Fraser Health region, and immigrants form 32% of the total population; 52% of these immigrants identify as female. Women within the Fraser Health region are more likely to speak languages other than English when compared to males (FHA, 2012). According to Statistics Canada (2014), 40.5% of the people in the study area are foreign-born immigrants, as compared to 27.6% of BC’s population in general being foreign-born immigrants. Thirty-seven-point-six percent of immigrants who live in the city where the research was conducted stated that their place of birth was India, and 33% of these immigrants speak Punjabi at home. Furthermore, 52.6% of the people in the study area belong to a visible minority group, and 26.2% of the population belong to the South Asian ethnic group.

The most frequently reported religion in the city where this study was conducted is Sikhism, at 22.6% (Statistics Canada, 2014). Therefore, a significant percentage of the population are of Punjabi-Sikh descent. When asking participants to reflect on and share about their experiences of caring for racialized immigrant women experiencing IPV, there is a

significant likelihood, although this cannot be certain, that they are able to speak about caring for racialized immigrant women such as Punjabi-Sikh women who seek care in the ED. In addition, Fraser Health also has the highest rate of IPV, approximately 2.5 times more than the provincial average, and the city where the study was conducted had the second highest rate of IPV within the Fraser Health region (FHA, 2012; Statistics Canada, 2013).

### **Data Collection**

Data gathering for this study was done through semi-structured interviews. I organised a private room where I spent time interviewing one respondent at a time. The interview was guided by open-ended questions (See Interview Guide attached as Appendix E) focusing on the participants' experiences with providing care for women seeking care who may or may not disclose IPV. Participants were advised that the interview was expected to last 60 to 90 minutes. However, most interviews only lasted 30 to 60 minutes, with an average time of 45 minutes. Interviews were audio-recorded by two different devices; one was a backup recorder should one device fail to function, which did not happen. During the transcription of the audio files, pseudonyms were used to protect the participants' identities.

### **Data Analysis**

#### **thematic analysis.**

The researcher assessed the data collected through thematic analysis. This involved analysing and identifying recurrent themes or patterns within the research findings (Braun & Clarke, 2006). All interview data was transcribed verbatim, and were re-checked to ensure that the data was accurately transcribed. All of the interviews were transcribed using transcription services. All transcripts were reviewed, cleaned, and reviewed several times to allow for immersion within the narrative data. All data were coded, and recurring themes and patterns

were identified until no new insights arose; data saturation was considered complete when no new themes were identified, and only redundant information had been yielded (Polit & Beck, 2012). My supervisor oversaw analysis of the first interview transcripts, and read over subsequent interview transcripts to ensure that a coherent approach was used, and to ensure that my analytical processes were transparent. The research questions and the theoretical framework – cultural safety – guided my analysis, where I went back and forth between reading the transcripts and highlighting any data that was linked to my research questions. All data was coded and numbered and organised by patterns and similarities.

### **enhancing trustworthiness.**

To ensure that the findings remained true to the participants' data, I aimed to generate trustworthiness during data collection and analysis by being reflexive and aiming to create dependability, confirmability, and credibility. Dependability refers to data and findings that are stable and consistent (Polit & Beck, 2012); I created dependability by maintaining an audit trail, by taking field notes, recordings, and transcriptions of my activities during the research process. The second criterion, confirmability, refers to how well the results are actually derived from the participants themselves, and not from the researcher (Polit & Beck, 2012). To maintain confirmability during data collection and analysis, I was reflexive about how my past experiences and professional context may have shaped my analysis during the interview process and during data analysis. Reflexivity “encompasses self-examination and assessment while paying attention to the personal values that could impact data gathering and interpretation” (Polit & Beck, 2012, p. 179). It was important that I was reflexive to ensure my own personal biases did not influence the data and its analysis, rather, that they enhanced the study's credibility. As a Canadian-born Punjabi-Sikh female, I have my own beliefs and opinions that may influence the

results, as I am very passionate about IPV prevention and care. It is my responsibility to be aware of potential biases and to be critically conscious of how my own experiences may influence data collection and analysis. Taking reflexive notes helped me to create the ongoing critical consciousness required from my practice and personal experiences that are closely connected to the topic under study. Some biases that I had were connecting culture and race with IPV. However, when I would have these biases, I made sure I was aware of these biases, and they were not intentionally communicated to the participants.

Using my intuition during the qualitative description process also enhanced the trustworthiness of the analysis (Polit & Beck, 2012). It “occurs when researchers remain open to the meanings attributed to the phenomenon by those who have experienced it” (Polit & Beck, 2012, p. 496). As mentioned earlier, I worked at being reflexive of my values, experiences, and preconceptions, therefore working to be open to the meanings and interpretations during the interview process, and thus demonstrating intuiting. In addition, by intuiting I was also demonstrating reflexivity. Reflexivity “is the process of reflecting critically on the self and of analysing and making note of personal values that could affect data collection and interpretation” (Polit & Beck, 2012, p. 179). I also attempted to enhance the trustworthiness of the data by demonstrating credibility. Credibility is a principle used in qualitative studies, referring to the confidence of the research findings and how accurately the findings represented the truth (Polit & Beck, 2012). I also established credibility by focusing on the trustworthiness, dependability and confirmability of the data; these processes mutually reinforce each other. I also enhanced the credibility of my research findings by using interpretive triangulation. Triangulation refers to using multiple ways to collect and interpret findings (Polit & Beck, 2012). I triangulated the interpretation of the research findings through discussion with my supervisor, in order to ensure

that important ideas and themes had not been overlooked, which may have been the case if the findings were only analysed by one researcher instead of two.

### **Ethical Considerations**

The researcher obtained consent from the University of British Columbia's (UBC) Research Ethics Board (REB), and Fraser Health Research Ethics Board (FHREB) before commencing this study to ensure that this study was conducted in the uppermost ethical and confidential manner. Participants were advised about their rights as research participants, and were allowed to withdraw from the study at any time without any negative consequences. None of the participants, however, withdrew from the study. Their privacy and confidentiality were protected, and participants were identified by pseudonyms such as, P1, P2, P3, etc. All participants were asked to sign consent forms, and participants were given my phone number and email address if they had more questions and/or needed more information (Appendix D). Participants were interviewed and were given a \$25 Starbucks gift card for their participation in this study. All electronic transcribed records, field notes, and audiotapes were kept on a password protected computer on a secure network drive at UBC, and were encrypted using full-disk encryption that was provided by UBC's IT department; any paper documents were kept in a locked filing cabinet in my home. Before commencing any interviews with participants, participants were again advised about the study and were told that they may withdraw from the study at any time. I also asked participants if they were interested in receiving information about the final research findings, which all of the participants were.

### **Conclusion**

This qualitative study utilized a descriptive approach to better understand ED HCPs' experiences caring for women experiencing IPV. Participants included one ED nurse, one social



worker, and three forensic nurses, all of whom were employed at a large urban hospital.

Convenience sampling techniques were used to recruit the participants. Posters and emails were sent to all ED staff to generate interest in the study. Data was collected by conducting one-to-one interviews with all research participants at the study site. Trustworthiness during data collection and analysis was done by demonstrating principles of dependability, confirmability, and credibility. Additional strategies used were reflexivity and intuiting during the data collection and analysis. Thematic assessment was used in the identification of themes and patterns from the data until data saturation had occurred; the research findings were also triangulated. All participants' rights to confidentiality and privacy were respected and consent was obtained. Participants were advised that they may withdraw from the study anytime, and approval from the UBC REB as well as FHREB was obtained before the study was conducted.

## **Chapter 4:**

### **Findings**

#### **Introduction**

This chapter presents the results from the analysis of the data collected from the study participants. The purpose of this qualitative study was to explore emergency department (ED) health care providers' (HCPs) perspectives on providing care for racialized immigrant women experiencing intimate partner violence (IPV) when they sought care in the ED. The research was set out to answer the following questions: What are ED health care providers' experiences of: (1) Providing care for women living with IPV? (2) The ED environment for how it shapes care for women experiencing IPV? (3) Assessment and care for racialized immigrant women experiencing IPV?

I organized the findings of the study into five overarching themes, namely: HCPs perspectives on care provision for racialized immigrant women experiencing IPV, IPV resources, support and collaboration in ED care for racialized immigrant women experiencing IPV, the motivation to provide care, barriers to care provision for the women experiencing IPV, the assessment of care for the target group, and safety planning for the vulnerable and racialized immigrant women. These themes were further divided into subthemes such as the experiences of the ED HCPs while caring for the racialized immigrant women, resources and IPV care, the existing barriers to ED HCPs' care provision to the target population by the ED HCPs, and the perceptions of the HCPs regarding the provision of care to racialized immigrant women.

#### **Theme 1: HCPs' Perspectives on Care Provision**

The first theme that was identified by the researcher in this study was the ED HCPs' perceptions of the provision of care for women with cases of IPV. This theme was organized into

two subthemes, namely, the motivation of the HCPs to provide care for the target population, and the experiences of the HCPs while caring for the women presenting IPV in the ED.

**motivation for care.**

One of the concerns of this study was the identification of what influenced HCPs in the ED to deliver care to racialized immigrant women experiencing IPV. This subtheme correlated with the study purpose, which was to provide an analysis of the perspectives of ED HCPs on care provision to racialized immigrant women experiencing IPV. This theme also had a direct correlation with the first research question, which investigated the experiences of HCPs in the ED in caring for racialized immigrant women in EDs.

Out of the five participants of the study, one of the participants stated that they were influenced to provide good care to women impacted by IPV due to their past experiences of IPV in their own marriage, while another two of the participants mentioned their past interactions with women suffering IPV as their inspiration to provide care. Overall, this study suggested that the motivational factors for care provision to the women with IPV issues in the EDs were motivated by the past experiences of the HCPs and their dealings with women impacted by IPV. Some excerpts from the interviews are presented below:

Excerpt 1: I know this is kind of off-topic, but I also have been [experiencing] IPV [and] that was my first relationship, my first marriage, so I'm keenly aware of the struggle of leaving and so we don't want to put that pressure on women to have to leave, to have to report. The only real discussion is whether or not they feel safe, they feel they have resources and they know how to get help should they be ready to. When we say choice and readiness there's always the impact that [they] may or may not have choice there because of their relationship or lack of resources, especially in certain types of communities, it's a struggle (Participant).

Excerpt 2: I did have a patient once and she sort of was a catalyst for me to become more involved. It was a warm summer day and she was wearing long sleeves, it ended up that we needed to provide her some sedation. The reason for her visit didn't ring any alarm bells as far as violence, even the long sleeve shirt. Everybody else in the [ED] that day was wearing short sleeves and staff [were] dressed more appropriately for the weather. It

ended up that she required some sedation, and while she was under sedation, she had a very dysphoric reaction, she was crying, and she ultimately stated that she was being terribly abused at home. She was very particular about her IV being started in her hand; she didn't want anyone to lift her sleeves. That was sort of a catalyst for me, this was not on our radar, we ask every single question we are supposed to, and I always ask. I had asked her is everything safe for you at home and in your relationships and those things. She had indicated everything was fine but anyway, she was definitely the catalyst. I need to get more involved and do more because it was hard to watch her leave (Participant One, Forensics Nurse).

### **experiences of caregivers.**

The second subtheme that emerged from the analysis of the data was the experiences of the ED HCPs while caring for racialized immigrant women who were subjected to IPV. This subtheme was considered important in this study since it helped to answer the first research question. The study participants were asked to provide comprehensive descriptions of their encounters while dealing with these women with cases of IPV in the ED.

Of the five respondents from the study, four of them reported that their experiences with the women experiencing IPV were frightening, as most of them accessed health care after repeated sexual and physical abuse due to their low socioeconomic status. One of the respondents, however, reported that racialized immigrant women were similar to other patients seeking ED services due to IPV, and there were no unique experiences dealing with them. Overall, the study suggested that ED HCPs had a lot of new and frightening experiences while dealing with racialized immigrant women impacted by IPV. Below are some of the responses from participants:

Excerpt 3: Dealing with women, particularly minority women presenting with IPV-related issues, is the most difficult and scary part of my job. First, IPV sexual violence especially, is more of a personal issue and should not be handled by the ED practitioners. I think there are doctors out there who should be dealing with such issues and I feel that it is totally outside my professional boundaries (Participant Three, ED Nurse).

Excerpt 4: I handled a case of a woman who was assaulted by her boyfriend. One time she said when she was at home reading her book, about 10 o'clock, he was high on

alcohol or drugs and he stormed in, obviously had the key, so there was no break and enter, and he started to beat her and sexually assault her as well. And, that wasn't bad enough but on top of that, for some reason, the neighbours were watching, so they didn't even help her. When she came in, she couldn't believe what she had gone through because she's never experienced something like that. She was so taken aback that it was done by somebody that was close to her, someone that she's been kind to and she thought they were friends. It wasn't even what he did that bothered her; it bothered her that it was a friend. And that's what she kept repeating, how could he do this to me, how could he do this to me? And by the time she left, she was a little bit better and I think a lot of women that come through, when we've checked them all over, we've healed their wounds a little bit, given some pain killers, emotionally kind of calm them down, she felt a little bit better when she left, but it takes months to get over that. But when I did see her, in court recently, she looked very good (Participant Two, Forensics Nurse).

Excerpt 5: We deal with a lot of cases involving IPV against women in the ED. Women who are South Asian seem to have the worst cases of both physical and sexual abuse by their husbands. Most of the cases are scary and difficult to handle as we do not have the right infrastructure and services to handle them. I think such cases should be referred to specialized doctors (Participant Three, ED Nurse).

## **Theme 2: IPV Resources, Support, and Collaboration**

The second thematic element that was identified in this study was the utilization of IPV resources, support, and collaboration in the provision of ED care to racialized immigrant women. Through this theme, the researcher was capable of suggesting whether the provision of resources, collaboration, and support in the ED shaped care for the women experiencing IPV. The subthemes that were identified in this case included resources and care provisions and interprofessional collaboration and support.

### **resources and care provision.**

The first subtheme that arose from the analysis of data in this study was the impact of resource availability on care provision to racialized immigrant women with IPV issues in the ED. The researcher intended to propose whether or not the HCPs provided the patients with necessary information on IPV, and whether there was any collaboration between the professionals in the provision of necessary resources to the patients. This subtheme was considered critical to the

research as it was linked to the research question on how the ED environment shaped the HCPs' care provision to racialized immigrant women impacted by IPV.

Of the five ED HCPs that participated in this study, two of them reported that they provided the patients with the required information on IPV, such as the numbers to call and the kind of medical treatments needed, especially when the women were abused sexually. The professionals warned that the brochures provided had to be made in such a way that the information contained in them could not be accessed by the partners. The other three of the participants stated that they did not have enough information regarding IPV and the required resources to deal with the problem, hence many IPV-related issues for the women experiencing IPV went unmet. Overall, the study suggested that ED HCPs did not provide enough information to the women experiencing IPV, and this had a negative impact on the health outcomes of the women. Some texts from the interviews are sampled below:

Excerpt 6: She wanted resources, she wanted information. However, our social worker had these business cards that folded up so small; it was a brochure that folded up so small that it ended up looking like a business card. It had some sort of phony information on the front, but it had lots of information once you opened it. So, it wouldn't necessarily be on his radar in case he saw it in her wallet or in her purse (Participant One, Forensics Nurse).

Excerpt 7: I just wish I knew of more resources that appeal to women of South Asian origin. Because that is so much of our [ED] population because then I could also refer them and say you know there are places where you can go where language isn't an issue, and there are staff there that understand such an environment. I know there are a lot of safe places for women to go who are in IPV situations, I just don't know of any that are focused, on South Asian women, which I feel like it'd be nice if there were ED nurses to offer care. I'd started thinking about a support group, I don't really know how to get something like that started, but a support group of women who are strong and have been in that situation, or in that situational crisis, you fear that there is no way out and there's no reprieve and there's nothing beyond this situation and I think speaking with somebody who has been through IPV from such a community would be helpful. It's just hard to set that up in emergency, especially ours because it's so busy (Participant Three, ED Nurse).

Excerpt 8: I can't really think of anything that is available to me, aside from social workers, they're usually the first ones I go to, and I wish I did know of more resources that were available to me to provide to other women, aside from listening for that few

minutes that you can usually spare in emergency. If there were pamphlets available, maybe in multiple different languages saying this is a number you can call, [or] safe places to go, or support groups you can talk to, I think that would be helpful. I don't remember any in nursing school that talked about IPV. I don't remember any particular education or situations or having somebody come in and speak from a support group or provide resources for women who are in intimate partner violent situations [there] are things you can provide. I think that's why I have a hard time referring to anybody other than Social Work, I wish I could talk to Social Work about the resources [they] provide so I can also provide them because I feel I don't know what else to tell them except I'm getting the social worker to come and talk to you, and we're get this all figured out. So currently no, I don't think there's anything that I've heard or seen or received education about in order to help better provide better care as an ED nurse to women experiencing abuse. But I think in the ED we're good at identifying when there's a situation where there could be IPV, the identification piece I think is a lot stronger than what to do once you identify it (Participant Three, ED Nurse).

Excerpt 9: I know that one of the things we're struggling with is the inconsistent response from our community partners because their funding model has changed. We had very strong support; we had an S.M.A.R.T. worker on every case around the Olympics when the health personnel partnership came in, so we had 24-hour coverage. But then the sum of money they were using to fund that finished and now they're having to find alternate ways to finance it [S.M.A.R.T.] so now they're using grad students or students (Participant Two, Forensics Nurse).

### **interprofessional support and collaboration.**

The second sub-thematic concern that was identified in this study is the support and collaboration between different HCPs dealing with cases of IPV in the ED. The researcher aimed to identify whether the study participants supported and worked together to improve medical care for racialized immigrant women with IPV problems in the ED.

Of the five participants that were interviewed, four reported that they worked closely with other HCPs in the ED to effectively understand the medical conditions presented by racialized immigrant women who reported IPV to the ED. The participants further mentioned that working closely with other ED HCPs allowed them to provide quality services to patients compared to when they worked alone. One of the participants, however, mentioned that collaboration resulted in time wastage and conflicts among ED HCPs, thus preferring dealing with patients personally.

Overall, the researcher suggested that HCPs dealing with IPV cases in the ED supported and collaborated with each other, thereby improving the medical outcomes for the women. Below are some of the excerpts from the interviews.

Excerpt 10: We work closely with the S.M.A.R.T Team. . . . We work really closely with them and they do a lot of follow-up safe care planning and things like that. So, the immediate assessment and interview is fairly independent. We do try as much as possible to work with an S.M.A.R.T. team worker as well. So, they'll be present for the initial interview they're often here first for whatever reason . . . so they do some sort of preliminary intro and support. Our interview part is often done with the S.M.A.R.T team. Any physical exam that we have to do, just for dignity, [we do in private]. We work with S.M.A.R.T workers which are often social workers. They're the ones that we see the most. We get our referrals from other nurses and from physicians. If we have any concerns about certain things that are beyond our scope of practice, we collaborate with the physicians or the nurse practitioners (Participant One, Forensics Nurse).

Excerpt 11: I usually ask the social worker myself, like hey, could you check in with them or do you have any suggestions for me. Sometimes when there are kids involved then automatically Ministry of Children and Family Development (MCFD) has to get involved, and then it ends up getting bigger and bigger. Often, I will consult social workers first because I feel they're so good with dealing with that kind of stuff and in emergency, it's always so hectic that you're not the one person that they see the whole time they are there. So, I do refer them to social workers because sometimes they have resources and stuff in the community that I don't even know about (Participant Three, ER Nurse).

Excerpt 12: We work with forensics quite a lot but always referring for sexual assault and then it wasn't I think until the last maybe year or so that I realised personally that they also did domestic violence cases as well, and it didn't necessarily need to involve sexual assault. I will refer, but I find personally that South Asian women are less willing to go that route than women from other cultural backgrounds. I actually don't know why; one woman just said to me no, no, no, I don't want to get the police involved and I said you don't have to necessarily get the police involved. This is just somebody you can speak with who will explain things to you a little better and collect evidence should you wish to proceed in the future about anything. But I think it's that fear of getting police involved or getting anybody in trouble that kind of prevents that further (Participant Three, ED Nurse).

Excerpt 13: I get a report from the primary ED nurses whenever I have a case, so I'm always making contact with them. I try very hard to make sure a social worker if not already called and involved is then called or called by me. I would say most of my cases; a social worker has seen them first. They've been in at least to say hi, I'm here and my role when I get here, one of the things I do is touch base with them (Participant Four, Forensics Nurse).



### **Theme 3: Barriers in Care Provision**

The third theme that the investigator identified when analysing the data from the respondents was that there were barriers to care provision to racialized immigrant women seeking medical services in EDs. This theme was considered important since it helped in answering the first two research questions, namely, how the HCPs provide care for the women experiencing IPV in the ED, and how the ED environment impacts care provision to racialized immigrant women. To analyse this theme effectively, the researcher divided it into a number of subthemes, including bias of the HCPs, prolonged period of waiting, lack of awareness of IPV services that should be provided to patients in EDs, lack of protection of information provided, and privacy of the patients, and the lack of support for children of women impacted by IPV.

#### **health care provider bias.**

The first subject that was identified under the barriers of care provision to racialized immigrant women is the personal bias of the HCPs. The researcher sought to examine whether HCPs showed biases against the women experiencing IPV, and if the biases impacted on their care provision to the women experiencing IPV.

Of the five participants, two of them reported that sometimes bias was shown against women with IPV issues, impacting negatively on care provision. Two of the five HCPs, however, reported that they try as much as possible to minimize their negative perceptions of the women and to provide them with quality care. Overall, the study suggested that negative social perceptions were common among ED HCPs dealing with cases of IPV amongst racialized immigrant women. The researcher also suggested that these negative social perceptions resulted in poor medical care for the patients. Results from the interviews are presented below:

Excerpt 14: Sometimes the women that we see live vulnerable lifestyles. I can see where judgment has, at times, gotten in the way. Understanding the triage system, I understand

that if somebody has reported interpersonal violence or a sexual assault, that they have a triage level, they just do, it's kind of the nature of the ED. So, the waiting I think can be really hard for people. It takes so much courage to walk in there and tell people the beginning of your story and then have [them] go sit there and we'll come back to you and it's a long wait. So, I think that they've sort of combatted that by doing a lot of nurse to nurse referrals (Participant Four, Forensic Nurse).

Excerpt 15: I did have an experience where the patient was very street-entrenched, sex-trade worker, severe, persistent mental illness, and ultimately, she wasn't able to consent to services provided by [the] ER department. However, when she was in a bed and she had a nurse assigned to her, so when I went to speak to her, she wasn't necessarily forthcoming with information and I said well, I'm on call all day, I'd be very happy to come and meet with you later. I just went to provide some collaboration with the nurse who was attending to her and she said, she'll probably be gone later, she does this all the time, I'm sure she wasn't assaulted . . . well, she said she was and that's kind of not [laughs] our place to figure out, right? [Pause] particularly with sex trade workers, if they have reported a sexual assault, the comments just start that this is theft under a hundred dollars, it's not a sexual assault. And then [pause] my blood pressure goes up (Participant One, Forensic Nurse).

### **long wait times.**

The second barrier to provision of quality care to racialized immigrant women visiting the ED experiencing IPV was the long wait times in the ED. The researcher asked the health care providers whether their patients received treatment immediately after they reported to the ED, or if they had to wait for a long time before being seen. Out of the five study participants, four of them reported that most of the women who visited the ED with IPV-related issues had to wait as they attended to other patients. Only one of the five respondents indicated that they considered the cases of IPV as important as the other cases in the ED and addressed them with similar efforts. Overall, the researcher found that ED HCPs did not treat the cases of IPV with urgency, meaning that women would wait longer to receive medical treatment. This tendency to de-prioritize IPV-related care reduces the timeliness and quality of care to women:

Excerpt 16: If I could wave a magic wand and say what would I change, be different for [women] to access care, I think it would be nice to have a special women's place for them to come to, not just a place where there's other people there and they're all there for different needs. And sometimes women might feel that their need is not bad they haven't

got a broken leg and they're not physically injured, and they may think that they're not there for any reason. They may make it into nothing. I think something specifically lined for women would be a good idea, sensitive to their needs. Reducing the waiting period would be great. Although we are pretty good at getting them in through the doors very quickly and our response time is pretty quick, but sometimes they have waited a little bit longer and then they've just left because they just don't want to wait that long once they get into ER maybe in a line-up or something and then when they're triaged it might be a bit slow cause they're busy. Then by the time the doctor's made them medically fit for us to be called, it all takes time and it all adds up. And sometimes when a patient comes in, they may be high on alcohol or drugs. By the time they've slept it off, they've changed their mind whatever the delay and sometimes we come in and they tell us they don't want to have an exam or they just, walk away (Participant Two, Forensic Nurse).

Excerpt 17: Sometimes all a patient needs is time to share their story. And sometimes it's hard to find that time to sit and listen to that story. There isn't as much time to talk about this in comfort as you would like, and even, we have two social workers on, and even [pause] they don't have time, it's such a busy department that there isn't anybody who can walk you through and support you. There is, for our sexual assault cases, there's a support person who can come and stay with you; I wish there was something like for women who come in with IPV who can have somebody who's not necessarily a partner, like from a health care point of view who can come and support you through the health care process. I wish there was somebody like that. I mean there is, for some cases, like with sexual assaults, but not necessarily for women who are going through IPV. It's hard to provide the care that I would like to provide because I feel like there's no time, no time in emergency. If there were pamphlets available, maybe in multiple different languages saying this is a number you can call, safe places to go, or support groups you can talk to, something like that I think would be helpful (Participant Three, ED Nurse).

Excerpt 18: Well, in emergency it's so incredibly rushed, it's so busy. The person having the STEMI, the heart attack is priority than the person who's got the broken wrist you have to triage, and you have to give care to the people who are the sickest and we focus so much on the medical sickness that sometimes the sickest people are the ones where you don't see the injuries, the physical injuries. I think in emergency, especially in an emergency as busy as xxx, there really isn't the time to sit and listen. We refer [these women] to somebody but then they're sitting and waiting, and social work is busy with that trauma case and it takes a while to get there and sometimes I have had women just say I'm okay, I think I'm just going to go and leave. I think [that] is unfortunate (Participant three, ED Nurse).

### **lack of awareness of IPV services.**

The researcher sought to suggest whether HCPs in the ED had enough knowledge on their roles in care provision for the women experiencing IPV and the services required by those patients. Of the five participants in the study, three of them reported that they lacked knowledge

on how to deal with the cases of IPV among women visiting the ED. Generally, the study suggested that HCPs in the ED lacked awareness on the methods of dealing with women with IPV cases in the ED. Below are some comments from the respondents:

Excerpt 19: It's a fairly new profession, it's a new service, it's fairly new even though it's been around since about '95, a lot of people still don't know about it. Nurses I work with that ask me what I do, and I say I'm a forensic nurse, they haven't got a clue and if nurses don't know, people out there do not know. I have recently been doing some outreach work with the RCMP and different detachments; a lot of the police do not know so when the police are the first people that meet these people outside on the street somewhere or wherever, they get called to the scene, they don't know what to do with them. So, they may, just say go home or go to a friend's house, they haven't got a clue just like we say in forensic nursing the days like today I'm on call, I didn't get called, it doesn't mean it didn't happen, there's a lot of violence happening to women out there but they're just not accessing care. So, it happens every day (Participant Four, Forensic Nurse).

#### **difficulty in protecting the privacy of patients.**

The researcher also sought to suggest whether the HCPs in the ED maintained the privacy of the patients and the information provided and how this impacted on health outcomes for racialized immigrant women presenting cases of IPV in Canada. Of the five participants that were interviewed in this study, four of them indicated that maintaining the privacy of the patient information in the ED was a difficult task, as the practitioners shared the information provided by the patients with one another to ensure better ways of addressing the problems of their patients. The remaining one of the five respondents reported that confidentiality of patient information was an important ethical consideration in the ED and that information was shared only when necessary. The data from the study participants are presented below:

Excerpt 20: The only thing I can suggest is sometimes just a bit more privacy because we're trying to get the doctors to keep the privacy of the patients and especially in the triage admission area. I wished they'd ask every time if the patient wants their doctors to be notified, the GP, because that's another privacy issue. They may not want their GP to know. I'll just tell you a little case I had recently. It was a staff member but she was so concerned she wanted to see me but she was so concerned about privacy and I guaranteed that everything would be private but there was something in the system that was, some blood work was done or whatever, and, I think there has to be a system [in place] where

they have to have just a number and no name even written on there because once it was in the system, her name just got out and she was very upset about that. And I tried my hardest, but the system is not made to continue the privacy in all areas, if you know what I mean. Although the triage might make it private, the GP name might not be on it, but the computer system is not quite private. So, there's barriers with staff . . . and the thing is she didn't really want to come and see me, and I said to her well you know it might be a good idea and you could tell she was distraught...she didn't know whether it was a good idea or not . . . so yeah, it's a shame. Also, because we're one of the main centres, centres of giving this care, this care is not everywhere, it's not like I could have sent her to the clinic next door (Participant Two, Forensic Nurse).

Excerpt 21: [When] a police officer walks a woman in, everyone looks. They have to talk about it at the front desk. It is not a quiet place, a place where they could share any information without other people hearing. They now have to sit in the waiting room until there's space [available] (Participant Five, Social Worker).

### **lack of support for children.**

According to the participants, racialized immigrant women are sometimes accompanied to hospitals by their children. In this investigation, the researcher sought to suggest whether the caregivers in the ED had mechanisms for dealing with the children as they provided medical care to the mothers, and how this impacted on the care provision to the women experiencing IPV. Four of the HCPs who were interviewed in this study reported that many of the women who visited the ED were accompanied by children, and that they lacked a mechanism of caring for children while their mothers received care. Two of the participants reported that most of the time, women were brought in by police officers and that they did not have the challenge of dealing with children. From this study, it was suggested that the ED had no mechanisms in place to take care of the children of these women, and that HCPs had an additional burden of caring for these children, resulting in poor medical care for these women. Below is a sample of the results:

Excerpt 22: My domestic violence patient is often accompanied [by] children and may or may not have another adult with them to help. So that really impacts delivery of care because now I might call the ED's family support worker [if available]. We got some resources that may be available certain hours. That might be when the S.M.A.R.T. worker is involved, and we have a whole bunch of stuff in our closet for kids to play with, because we see children and to make a fun space for them to wait while mommy

gets her care done. But sometimes I'm trying to do an examination with a toddler on the lap and we're looking at the left side, switching the toddler over, looking at the right side because [the toddler] doesn't want to separate. But then when these children are in the emergency environment, your kind of [wonder] what will happen to them? I mean do they stay with the social workers or they go with their mom all the way through, so they're not separated (Participant Four, Forensic Nurse).

### **language and cultural barriers.**

Participants also mentioned language barriers as a hindrance to provision of quality care to racialized immigrant women in the ED. They highlighted their experiences with Syrian immigrant women, and reported that language barriers, and the cultural barriers, were the main challenges:

Excerpt 23: For example, an unemployed female Syrian refugee will need very different resources than a [Canadian Caucasian] woman who has a job. There has been challenges when working with Syrian refugees . . . definitely the language barrier, [having] Arabic interpreters, many of them have different dialects [and we are] not getting [the] full information from [these] women. [We are] not able to get a full disclosure. Then the resources are tough. There's only one doctor in all of Surrey, not even Surrey, they're in Port Coquitlam that will take in women since they don't speak their language. So, if we're looking for a physician to provide ongoing care or whatnot, there are very few options for them. There's a real struggle. I would say the language barrier, the cultural experiences from ER nurses, not to mention the fact that there is a significant prejudice in our community around Syrian refugees. So, they're really dealing with a lot of big issues, just in terms of that. But then it is also the impact of violence. Unfortunately, because of the limited resources for them, the way the MCFD interact with Syrian refugees in particular is different. And so, we have to tread very carefully in terms of that. So yeah, it is a tough one. You don't want to be the person that adds more stress and chaos, to this kind of environment but you also have to follow the protocols put in place by the hospital and our College in terms of reporting. So sometimes there's a bit of a balancing act (Participant Five, Social Worker).

Having the appropriate translators to effectively communicate with women experiencing IPV represents a systemic barrier for effective IPV care within the ED environment.

Notwithstanding the barriers related to language, one participant made an interesting point, that some racialized immigrant women do not prefer having HCPs of their own ethnicity or cultural

background. One participant believed that racialized immigrant women were not willing to disclose IPV experiences to HCPs that shared their ethnicity or cultural background:

Excerpt 24: I have heard from women that they would sometimes prefer not to have somebody of their own cultural or ethnic background and sometimes they prefer to have them. So, the fact that there are two of us here, sometimes we can give those options. We have male staff, that [can] sometimes [be] a very big challenge for rapport building if we have a male staff [member] go and do this kind of intervention. The language barrier, not being able to speak in their original language is a struggle. We're really lucky; we have a lot of Punjabi [and] Hindi interpreters in the ER so we can at least call somebody quickly. But when you have to add the element of somebody on the phone as an interpreter or if the dialect is so difficult to find, sometimes a family member or a child has to help. It limits the amount of disclosure you can get from a woman. And this [is] generally the first time they're telling this complete story and you want to make sure that every option [is available]. Those are [the] challenges (Participant Five, Social Work).

One participant claimed that a lack of understanding and education about other cultures and backgrounds was a barrier to providing IPV care:

Excerpt 25: I think it will be nice, I'm thinking, to have if someone could give us more cultural orientation in with other cultures, although you know life's experience, I do know some things but it's not enough. I think it would be nice to have cultural orientation where some people from different cultures come and talk to us on how their cultures deal with these things and how [and] what we could do to help them. So, I think more, outreach work from different cultures, and communication with them would be good. We all know about how to deal with our own backgrounds, but I don't know how to deal with say someone from Japan or China, I don't know, there's similarities in a lot of cultures but [there is] a lot of differences as well. And even from the Native population, I try to do readings and do the courses, but I still don't know that much as I know [about] my own [culture] so I think a lot of more homework in that area would be good (Participant One, Forensics Nurse).

#### **Theme 4: Assessment and Care**

The fourth theme that was identified by the assessment of data gathered in this research relates to assessment and care. Through this theme, the researcher sought to suggest how ED HCPs assessed and provided adequate care for racialized immigrant women. The theme was organised into various subthemes including the priority areas for the caregivers when dealing with IPV cases among racialized immigrant women, emotional support for the women, and the

analysis of non-triage symptoms that indicated IPV among patients. This theme was important in this research study since it helped to answer the third research question, which dealt with the assessment and care of the racialized immigrant women with IPV cases in the ED.

**priority areas for care providers.**

One of the concerns in this study was the analysis of the priority areas for the ED HCPs while providing care for the impacted racialized immigrant women. Two of the participants reported that they ensured that the patients' physical injuries were treated first, and the patients were stabilized, two of the participants reported that the conditions of the patients were recorded as they received care to help them in seeking legal services, while one of the participants stated that understanding the nature of the IPV was an important priority area that helped in figuring out the type of medical care needed by the patient. The study indicated that the HCPs prioritized differently when dealing with racialized immigrant women presenting IPV issues in the ED.

Below are some of the data from the respondents:

Excerpt 26: My first priority I would say is first of all make sure there's no injuries, that's our main priority that usually has been taken care of when [racialized immigrant women] come into emergency. So, once [racialized immigrant women] come to us, they shouldn't have any obvious injuries. So, after that, my main priority is to get them to calm down. Sometimes they're able to talk; sometimes they're not able to talk. Their first reaction is usually to blame themselves, even when they walk through the door, they say it's my fault, I shouldn't have done this, I should have known better. And so, my main concern is to let them know that they're not alone, that women do go through this and it's not just them, it's not their fault, and then calm them down enough for them to open up to me to start healing (Participant Two, Forensic Nurse).

Excerpt 27: I get a little bit of a story of what happened, so I know what kind of care to give them, so I can organise my care. If I feel there is a need for a pelvic exam, if it's a sexual assault, they've been penetrated, I do a head to toe [assessment and] do a pelvic exam as well. Then my other concern is what kind of medication they need, medication for sexually transmitted diseases, HIV medication if they've had any kind of body fluid contact. Basically, we go through the process. Then we kind of tweak it to the individual person [especially to racialized immigrant women] (Participant Two, Forensic Nurse).



### **emotional support.**

Providing emotional support to women experiencing IPV is an important step towards guaranteeing their physical and mental health. This study aimed to suggest whether HCPs in the ED provided the racialized immigrant women impacted by IPV with emotional support to improve their physical and mental health. Out of the five participants, three of them reported that they always provided the patients with emotional support and assured them of their safety. Two of the respondents, however, reported that the ED was a busy place with several casualties, and concentrating on the provision of emotional care to the racialized immigrant women impacted by IPV was difficult. The study points to that provision of emotional support to the women experiencing IPV was important, and that it impacted positively on their health outcomes.

Excerpt 28: With our role, the care priorities are to ensure that she is safe, she understands that she's safe, that you build rapport so that there can be [an] open honest discussion, that you're figuring as a social worker that we're determining her narrative, what has, how has this become this way, and how does she see herself in that way. We also want to take in theories, theories of social work that we've used which are the person and the environment theory, which is what is her life like, what is her role within her own environment, how does it play with her, does she have a job, is she beholden to him because of money, are there children that are not only at risk but that could be used as a tool against her. What are all of those pieces and how do you know if it's an addiction or the readiness for change, does she want to leave, is she wanting to press charges, is she wanting to make this secret now something known . . . and to discuss that in terms of how it looks for her and her individually. And then to make sure that there's somebody in the community, who can pick up the pieces of her situation when she leaves here because hospital social work is just in the hospital, so we can only support them for as long as the patient is here, and that's unfortunate (Participant five, Social worker).

Excerpt 29: We try and tag them up with somebody outside of here. We try and discuss with them who they would be comfortable seeing. You know do they have friends, if they have a job, do they have any kinds of benefits, programs that we can have them in, do they want to be involved with a women's centre, do they want a telephone number for this or that, are they older, work with the OMNI Centre because you know women in an older stage of life are very different than women who are of childbearing in terms of what resources are available to them. And so, we want to just make sure there's a thoughtful choice even though it's an acute crisis that perhaps we've at least thought about what the best option for them would be, and always provide them with resources, I guess the information about funding for various things or whatever they might need, [and] it all

depends on the circumstance. So, very individualised focus for every single situation (Participant Three, ED Nurse).

### **IPV assessment.**

Some of the women with cases of IPV do not present physical symptoms, and it is difficult to know of their IPV-related issues. Through this research, the investigator sought to suggest whether the HCPs are able to assess such cases and suggest that such women experienced IPV. Four of the study participants reported that they did regular screening of the female racialized immigrant patients in the ED, and discovered that many of them presented IPV symptoms that were not easily identifiable at first sight. Overall, the study points too that the ED HCPs' patient assessment helped in the identification of patients that had problems related to IPV. Below are some replies from the participants:

Excerpt 30: IPV is not usually not identified in triage cause triage just happens so quickly, that's the quickest part, it's supposed to be 30 seconds to a minute so then you're focused on what brings you in and, and then we do a quick focus assessment and then it's not until they get into the next area that we're identifying. Those are the cases where women come in not saying, not mentioning that this is a result of IPV. It's not until we bring them into the care and treatment zones where we're actually doing a full assessment and listening to the story as to what brought them in. When the story doesn't match the type of injuries, [such as] I fell down the stairs and then they've got a black eye or multiple abrasions or scratches, things like that that aren't consistent with the story that they're telling you, that kind of sets off red alarms for me. I find when I see constant eye contact between spouses back and forth or waiting for the husband to answer or almost a timid presentation, just really quiet, [and] just how family members react. Sometimes there's a bit of hostility that doesn't need to be there and that kind of sets a couple of red flags up for me that maybe there's something else going on. Since the racialized immigrant women chose to suffer in silence due to fear of deportation and community hostility, regular assessment can help in the identification of IPV cases (Participant Three, ED Nurse).

Excerpt 31: There was a mother-in-law to a [racialized immigrant woman] who was, I think, the patient came in under, a hand injury but I started doing a full head-to-toe assessment, just asking [if there is] any other injuries, any headaches, chest pain, anything else going on, any injuries anywhere else, and when you fell did you bump your head, all this. And the mother-in-law [asked] why are you asking about all these other things, focus on the hand, the hand's a problem, that's what we need to fix, we just need to see a specialist. And then I was kind of like well there's no need for that kind of anger

and behaviour . . . I started looking at the daughter-in-law and she was just staring at the ground . . . was being really quiet and wasn't really answering any questions. And then I [thought] oh, maybe I should try and get her alone . . . And then the mother-in-law asked for the bathroom and then when she went to the bathroom then I [asked] is there anything else going on? Are you being hurt at home? Do you feel safe where you are? And then I got a little bit more and [such as] oh, sometimes they're not very nice to me but it's okay, I have to live there. I think it's the feeling of I have no other choice but this. That kind of hurts me at first then you [think] there are other options, there are other places for you to go (Participant Three, ED Nurse).

### **Theme 5: Promoting the Safety of Women**

The last theme that emerged from the data analysis in this study was the promotion of the safety of women. The subtheme that was identified was safety planning for the racialized immigrant women presenting with IPV-related health conditions in the ED. As part of care provision for racialized immigrant women, practitioners should have a comprehensive plan for their care and safety. This theme is critical to this study since it helps to answer the first two research questions.

#### **safety planning.**

The researcher sought to investigate whether HCPs in the ED engaged in safety planning for racialized immigrant women seeking medical care. The study participants unanimously agreed that they engaged in the safety planning for the patients. Overall, the study suggested that the ED HCPs engaged in safety planning to protect IPV patients from harm.

Excerpt 32: We do safety planning if there is some violence disclosed. We want to make sure even if they say they haven't been assaulted physically or sexually, we want to make sure that they're safe when they go home. We want to make sure they have somewhere to go. So, safety planning is a huge one I think for [women experiencing IPV]. And then of course once they're out of our care, we want to make sure that they're followed up, we want to make sure they get the full support. We know [these women] don't get cured or they don't deal with the situation or the problem in their life overnight. It happens over many years and, this is just another avenue for them to get support when they come in through the doors (Participant Two, Forensic Nurse).

Excerpt 33: My job is, to help identify the needs for safety, to talk to the patient, to get them to open up because sometimes they don't tell you everything, so we don't have the

full picture. My job is to make sure that all the information is obtained from the patient as well as the social worker. We work together as a team; I also call in the Surrey Women's Centre, there's an afterhours support worker that usually attends if they can with every case that comes through the door. We both as a team make sure that this person is safe, not only safe physically but also safe mentally so we talk to her, we tell her that you know maybe she needs to re-evaluate what she's doing or does she think this is the last line, whatever it is she's doing out there that putting herself at risk is that maybe she wants to try something a little different, [but] done obviously with a lot of sensitivity (Participant Two, Forensic Nurse).

## **Summary**

The interview process generated interconnected and multi-layered data; themes and related and layered sub-themes were presented: interests, motivation and reasons for working with women experiencing IPV, resources, lack of awareness, collaborating with other disciplines, barriers to care, assessment and safety. The next chapter, chapter five, will discuss the analysis, and provide recommendations, while also noting the limitations of the study.

## **Chapter 5:**

### **Discussion and Recommendations**

#### **Overview**

In this chapter, I discuss how the data and findings described in chapter 4 contributed to existing literature. Specifically, I outline how the themes add, extend, and/or indicate new directions for knowledge development within the context of health care provider (HCP) practice for women seeking IPV care in the ED. Following the discussion of the findings, I will detail recommendations for health care practice, policy, education and research while also outlining the limitations of the study.

The study findings underscore the critical importance of IPV care for women from the perspective of emergency department (ED) health care providers. From the literature, it has been documented that many racialized immigrant women face structural and systemic barriers to accessing health care services; health care providers in this study shared their perspectives about ED care barriers such as the lack of translation services, lack of support, and inconsistent services for women, while also discussing their views that shape current IPV care for women in the ED.

#### **IPV-related Resources for ED Health Care Providers**

Health care providers in this study emphasised how the lack of resources for women experiencing IPV was a significant factor shaping their care for women in the ED. In addition, the participants highlighted that even when resources were present, there was a lack of awareness about those resources among HCPs, and particularly for those that may have relevance for racialized immigrant women. Within the study site, for example, there is a large population of Punjabi-Sikh immigrants, and many may not be able to communicate fluently in English

(Statistics Canada, 2014). The data from this study supports other studies wherein language barriers and the lack of education and awareness about services and resources provided act to impede care for racialized immigrant women (Ahmad et al., 2009; Furniss et al., 2007; Reisenhofer & Seibold, 2007; Yonaka et al., 2007).

In this study HCPs described the lack of awareness of resources, services, training and referral opportunities to resources and services for women. Similarly, Al-Natour et al. (2014) found that HCPs experienced challenges when trying to refer women due to lack of awareness about accessing appropriate resources or navigating the health care system. Enhancing the availability of resources to women impacted by IPV was a key theme in this study, along with the importance of tailoring care to the needs of racialized immigrant women. As one ED participant mentioned, resources are sometimes not available in languages other than English; thus, specific populations of women experiencing IPV may have difficulties understanding and knowing where to go for IPV care and how to obtain more information about IPV. HCPs in this study, as in other studies indicated that they were unaware of resources and where to refer these women (Ahmad et al., 2009; Furniss et al., 2007; Reisenhofer & Seibold, 2007; Yonaka et al., 2007).

In addressing IPV against racialized immigrant women, resources are always a necessary consideration, both at the ED level, and for the women seeking care themselves. Resources include adequate numbers of highly trained HCPs in the ED to deal with issues related to IPV committed against racialized immigrant women, funding, and the availability of resources that can help in recognizing IPV (Efe & Taskin, 2012; Furniss et al., 2007). According to participants three and five, the major discussion within the ED with women impacted by IPV is whether or not they have available resources to seek help and potentially leave their partners. The data align

with the findings from a study by Kaplan and Komurcu (2017) who stated that HCPs felt ill-equipped when dealing with women experiencing IPV due to a lack of resources and knowledge.

### **Barriers to IPV Care for Racialized Immigrant Women in the ED**

Racialized immigrant women face many barriers that exacerbate other health care barriers when living with IPV, such as poverty and lack of education (Agrawal et al., 2014; Bhandari et al., 2008; Eckhardt et al., 2014; Kennedy et al., 2015; Li et al., 2010). The data from Participant One and Participant Three cited inadequate information and education in offering care to women experiencing IPV as a problem on the part of HCPs. The absence of the required resources meant that the HCPs in this study felt that they were unable to provide the required assistance to women in the ED. This resulted in poor care provision to women experiencing IPV.

#### **language as a barrier.**

In this study it was evident that language acts as a major hindrance to accessing health services, especially for racialized immigrant women. The available pamphlets at SMH are only in English. This reduces the effectiveness of using pamphlets and other literary materials to support racialized immigrant women. These findings also point to the difficulty HCPs have in communicating with these women, as they need an interpreter to assist in the conversation. This creates a barrier for both history taking and the comprehensive assessment that is necessary for effective IPV care. This can also influence the necessary privacy and confidentiality that women need in the ED. The findings revealed that language acts as a barrier to care for racialized immigrant populations. The populations described by HCPs in this study were Syrian immigrants and the Indo-Canadian population. Similarly, studies by Ahmad et al. (2009) and Du Mont and Forte (2012) confirmed that language is a primary barrier for racialized immigrant women impacted by IPV when seeking help.

The findings suggests that some HCPs experienced difficulties in speaking to their clients as some of these women were not fluent in English, especially Syrian immigrants who spoke Arabic dialects. Finding appropriate translators was challenging. Even when translation services were available, translators could fail to understand and translate accurately, hence adversely affecting the quality of services provided to the women experiencing IPV, and consequently impacting on the quality of care that HCPs can provide to women impacted by IPV (Lipsky et al., 2006; Setia et al., 2011).

#### **lack of awareness of forensic services.**

Another important aspect of care that was revealed in this study was the lack of awareness of the forensic team at SMH, especially on the part of ED nurses, RCMP officers, and other community members. While the forensic team is located in the ED, many staff are unaware of the type of services provided by the forensic team, and the services that they are able to provide to women impacted by IPV. Research has indicated that many women impacted by IPV do present themselves in the ED; thus this however of awareness acts as a significant barrier to effective and timely care (Lipsky et al., 2006; Sormanti & Shibusawa, 2008). The findings suggests this lack of awareness about available forensic services at SMH is also a considerable barrier to care for women. The findings not only indicated the lack of awareness about services, but also a lack of knowledge about caring for racialized immigrant populations as shared by HCP Participants One, Three and Four. While providing services to women experiencing IPV, awareness about racialized immigrant populations is of great importance. Awareness about racialized immigrant populations would enable health care professionals to offer tailored services to women experiencing IPV. The findings suggested that knowledge about racialized immigrant populations would empower nurses to be more confident when interacting with racialized



immigrant women impacted by IPV, which may facilitate better care for women experiencing IPV by creating the relational space for effective care and safety planning.

### **Cultural Context**

The findings also indicated that women's cultural context is relevant for how women seek care, and the degree to which women may engage in discussions that disclose violence. However, HCPs need to be critical of the tendency to locate violence within "culture" or align violence with ethnicity to explain women's help-seeking behaviours, or their decisions to seek care. Creating safe spaces, contexts and relationships is far more important for providing care for women than HCPs' efforts to better know "culture" as it relates to women's needs. The findings of this study concur with those of Bournsnel and Prosser (2010) and Efe and Taskin, (2012) who emphasized that ED nurses must have knowledge about barriers to care affecting women impacted by IPV; barriers to care that are relational and structural need to be tackled for the creation of safe relationships as the basis for IPV care in the ED.

### **Wait Times, Privacy and Confidentiality, and HCP Bias**

The study further revealed a number of other barriers to care such as long waiting times in the ED, lack of privacy and confidentiality, and biases of HCPs. It was evident that EDs may have long waiting times which, in turn, can make things worse and more difficult for women experiencing IPV, especially for women living with trauma and violence and who lack supportive spaces and relationships while seeking care (Al Natour et al., 2014).

The study suggests that IPV experiences may make patients impatient when waiting in queue in the ED. The findings indicate that some of the women experiencing IPV who seek help at the ED are just in need of someone to talk to. In many cases, this expectation is often unmet as the ED is a busy place with many patients, all requiring medical attention. Moreover, urgent

cases are often prioritized in the ED. This finding is similar to the works of De Boer et al. (2013) and Leppakoski et al. (2010) who established that the longer waiting hours and lack of time to attend to IPV women in the ED hinder them from receiving quality care. The findings suggests that waiting times can be reduced by assigning specific HCPs to the role of attending to women impacted by IPV in a given health care centre.

### **lack of privacy.**

The lack of privacy and confidentiality were also described as challenges to care provision for racialized immigrant women seeking medical help in the ED. The ED is a busy place with different types of patients. This would make it difficult for racialized immigrant women experiencing IPV to open up to the nurses in such an environment. Moreover, there is a lack of confidentiality for the patients as they become the topic of discussion by staff when brought in by police officers. This finding resonates the work of De Boer et al. (2013) who stated that the lack of privacy in the ED makes it difficult for the nurses to ask some personal questions regarding IPV-related health issues, and also for the women experiencing IPV to provide honest answers. This situation reduces the chances of providing quality care for the racialized immigrant women, hence the difficulty in the realization of positive health outcomes.

### **HCP bias.**

This study further suggests that women experiencing IPV are at times met with bias from HCPs. It was evident that women are likely to experience discrimination when seeking help from HCPs. As such, women are not likely to receive care related to IPV, and many fail to receive suitable referrals as well. Similarly, personal biases among HCPs towards women experiencing IPV were also reported by Cherniak et al. (2005), De Boer et al. (2013), and Leppakoski et al. (2010).

### **Presence of Children in the ER**

The findings of this study suggests that offering support to children and young adults accompanying women seeking assistance following IPV creates a challenge to quality services. The delivery of quality services to the patient in the presence of children demands for extra resources for keeping them busy as they wait for their mothers. As a result, EDs often seek help from S.M.A.R.T workers to keep the children busy during consultations. The findings revealed that the main challenge is when the child is unwilling to let go of the mother and the ED nurse has no other option than to offer services in the child's presence. Moreover, the findings indicated that the ER is not that well equipped to accommodate children. Such an environment brings forth privacy concerns, especially if the child is old enough to discern what is going on (Setia et al., 2011).

### **IPV Assessment**

Another important component of ED IPV care provision, as suggested in this study, is assessing racialized immigrant women for IPV. Although this group of women is the most impacted by IPV, they least report these cases to their care providers out of fear of being deported, and/or receiving backlash from the members of the communities in which they live. Health care providers, therefore, have the mandate of assessing these women in ED settings even if they do not show signs of IPV. Furthermore, the emotional, physical, and sexual health consequences of IPV are known to persist long after the act has stopped.

In this study, it was suggested that the health care practitioners in the ED engaged in the assessment of racialized immigrant women who showed no signs of IPV to identify any hidden symptoms of IPV. In cases where the patients were so fearful to disclose their IPV conditions to the health practitioners, IPV assessment helps in the identification of hidden cases related to IPV,

and consequently, the treatment of the impacted racialized immigrant women. This finding echoes the work of Al-Natour et al. (2014) on the importance of IPV assessment. The authors stated that the examination of patients for IPV by the HCPs helps in the identification of the hidden health problems caused by IPV and their subsequent treatment.

Although IPV assessment is an important component of ED practice with regards to mental, physical, and sexual health issues of racialized immigrant women resulting from IPV, recognition of IPV is not an easy task, especially when the HCPs do not have the required resources. According to Faib et al (2014), IPV assessment and identification depends largely on the availability of resources. Therefore, it is important for the management of hospitals to provide the HCPs with the necessary resources for them to effectively identify IPV among the patients.

### **Emotional Support**

While providing care for racialized immigrant women in Canada, it is important for the HCPs in the ED to provide them with emotional support. IPV takes away the dignity of women, at times resulting in emotional imbalances in these women (Campbell et al. 2002; Cherniak et al. 2005). Moreover, IPV is accompanied by a range of physical and sexual health issues, such as sexually transmitted infections, chronic physical injuries, and pain that impacts negatively on the mental well-being of these women. Spence et al (2014) reported that some of them are incapable of accessing medical care due to family norms, further exacerbating their emotional health issues.

As part of responsive care provision, it is important for the ED health care providers to show emotional support to the patients as a way of assuring them of their safety. In this study, it suggested that ED HCPs provided emotional support to the racialized immigrant women in ED

settings. In cases where they could not help, they referred them to social workers. This research finding resonates with the work of Efe and Taskin (2012) who stated that providing a safe health care environment for the IPV female patients allows them to disclose their situations and improve their care provision. This finding also echoes the work of McMahon and Armstrong (2012) who stated that identifying support systems for IPV female victims helped in improving their emotional well-being.

## **Recommendations**

### **practice.**

Having strong and competent translators and supporting them in their roles is important when communicating with women experiencing IPV, especially for racialized immigrant women who disproportionately face barriers to care. Additionally, having translators who speak a wide array of languages available is critical to meet the needs of the immigrants in BC. There should also be a creation of a private area for women impacted by IPV who come to the ED for treatment. This has the potential of benefiting these women and helps to increase privacy. The provision of forensic nursing services in the ED is not only essential but vital for comprehensive care. It is thus important to meet the medical and legal needs of women impacted by IPV as well as to ensure that they receive compassionate and quality care.

Anti-discrimination training and a more critical orientation to the culture of health care as it impacts racialized immigrant women are necessary to address biases, along with the capacity to analyze the structural barriers to accessing IPV care for all women in the ED. Hiring nurses who speak multiple languages, or hiring translators may contribute to solving some issues involving language barriers. In addition, there should be efforts to inform health care professionals who are likely to come into contact with women experiencing IPV about the

services offered in the ER department. This would ensure that health care professionals are able to offer the much-needed support and resources to women impacted by IPV in a timely manner. Furthermore, the presence of adequately trained forensic nurses to handle these cases will greatly help women impacted by IPV. Moreover, any ED ought to have space or resources to accommodate children while their mothers seek care in the ED.

**policy and education.**

HCPs need to be properly trained and educated about resources and services available for women impacted by IPV. Furthermore, it is pertinent to have resources that are specifically tailored to serve racialized immigrant women. This will help the health care practitioners to understand the exact IPV situation of the migrant women, and their cultural requirements in health care provision. Moreover, the resources will also help recognition of IPV issues among the immigrant women that cannot be identified without these resources. The ultimate result will be an improvement in IPV health care service provision for racialized immigrant women.

The results of this study indicated that ED nurses and HCPs were unaware of the types of services that forensic nurses provide, and the RCMP and the women themselves were also unaware that they could come to the ED for support. As such, there needs to be more education, awareness, and support around issues surrounding IPV, such as doing online courses, conducting in-services, and reaching out to the RCMP and the ED HCPs. Education and raising awareness may help emphasize that the ED is a critical point of care for women experiencing IPV. There is a need to educate the nurses about available resources that can be used to offer services to racialized immigrant women experiencing IPV.

Providing IPV care for women requires knowledge and skills that can be tailored to women's life context, particularly for women's experiencing racialization. By providing care that

prioritizes women's safety within the ED and address systemic barriers, health care providers can contribute to improved care provision for immigrant women in Canada.

### **further research.**

The HCPs emphasized the significance of offering relevant resources to women experiencing IPV; however, at the same time, the HCPs in this study emphasized the magnitude of the lack of resources and barriers to accessing information within the ED setting. Future research ought to focus on accessibility of information required for HCP knowledge and skill development. There is a pressing need for evidence-based care to improve the quality and effectiveness of services for racialized immigrant women experiencing IPV.

### **Limitations**

The sample size for this study was small, and included only five participants from the ED; one nurse, three forensic nurses, and a social worker. This small sample size did have an impact on the breadth, depth, and variability of the data. In addition, another limitation of the study was the potential influence that the researcher may have had throughout the data analysis. As a novice researcher, I had to continually examine prior assumptions held about the topic under study; for example, I undertook the study with the assumption that IPV could be understood through the lens of culture for immigrant women. Being aware of this "culturalist" assumption required ongoing scrutiny, and reflexivity to be open to HCPs' perspectives. Finally, the interview and follow-up questions were somewhat limiting and did not foster in-depth discussion, which was another element of the study reflective of the novice level of the researcher. Finally, the researcher is of South Asian and Canadian descent, and this identity may have influenced the study results. Despite reflexive efforts and ongoing attention to prior assumptions, the researcher may still have influenced the analysis; ongoing efforts were made by

the supervisory committee to draw attention to these influences, and to promote critical reflexivity throughout the study. Some of the limitations were addressed by having my supervisor overseeing the analysis of the first interview transcripts and reading over subsequent interview transcripts to ensure that a coherent approach was used and that my analytical processes were transparent. I also attempted to bracket my preconceived thoughts and biases in order to minimize their influencing the data.

### **Summary**

Chapter five presented a discussion of the findings of this study in relation to the perspectives and experiences of health care providers when caring for women experiencing IPV. This chapter also presented recommendations for future research along with the limitations of this study. The discussion of the findings highlighted how HCPs view barriers to IPV care; the lack of translation services and support, and inconsistent services for women. The perspectives and views of the HCPs were shown to shape their care for women in the ED. The discussion revealed that HCPs lack adequate resources to attend to these women. Additionally, HCPs expressed a lack of awareness about available resources in the ED department, especially pertaining to forensic services. Language was also identified as a key challenge faced by HCPs when offering health care services to these women. Offering support to children and young adults accompanying women seeking assistance following IPV was also revealed to be a key challenge to quality services.



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## Appendices

### Appendix A: Poster

#### EMERGENCY HEALTH CARE PROVIDERS PERSPECTIVES ON PROVIDING CARE TO RACIALIZED IMMIGRANT WOMEN EXPERIENCING INTIMATE PARTNER VIOLENCE



Are you an emergency trained RN, forensic nurse, social worker, or emergency physician?

Have you been employed in the emergency setting for at least three years?

Do you have a full-time or part-time permanent position?

Consider joining a study about emergency health care providers' experiences caring for women impacted by intimate partner violence.

Participation involves a 60 to 90-minute interview with a UBC graduate student researcher

All participants will receive a \$25 Starbucks gift card, and snacks and refreshments will be provided.

Please contact the primary contact person for more information

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Helen Brown, RN, PhD,  
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Investigator / Contact Person:  
Beljinder Mattu, RN  
Graduate Student (MSN)  
University of British Columbia  
(xxx) xxx-xxxx



## Appendix B: Study Invitation



University of British  
Columbia  
School of Nursing  
T149-2211, Wesbrook



### Study Invitation

#### **EMERGENCY HEALTH CARE PROVIDERS PERSPECTIVES ON PROVIDING CARE TO RACIALIZED IMMIGRANT WOMEN EXPERIENCING INTIMATE PARTNER VIOLENCE**

Dear Participant,

My name is Beljinder Mattu and I am a Master of Science in Nursing student at the University of British Columbia (UBC). I am doing research for my thesis on the topic of emergency (ER) health care providers' experiences with caring for women living with intimate partner violence (IPV). I have always been interested in this topic and I believe more research needs to be done about IPV at SMH. I am particularly interested in what informs ER care providers care in relation to IPV for women accessing care at SMH. My goal is to contribute knowledge for IPV prevention and access to care in the ED along with the advancement of policy and research to inform ED practice.

## **The Study**

The purpose of this study is to explore and better understand ED HCPs perspectives on providing care for women experiencing IPV who are seeking care in the ED. I wish to answer the following research questions during this study:

What are ED care providers' experiences of:

- (1) Providing care for women living with IPV?
- (2) The ED environment for how it shapes their care for women?
- (3) Assessment and care for racialized immigrant women experiencing IPV?

## **What is Involved?**

You will be asked to participate in this study by completing an interview with myself. The interview date and time will be arranged as according to your availability and will be located on site. The interview is expected to last for 60 to 90 minutes approximately. Refreshments and snacks will be available and you will be given a \$25 Starbucks gift card after the interview for your participation.

## **Privacy and Consent**

You will be advised that you may withdraw from the study during anytime without any penalty. Your confidentiality and privacy will be protected during the interview and all participants will have pseudo-names such as P1, P2, P3 etc. Your participation will be entirely voluntarily and you may withdraw from the study anytime. Consent will be obtained and you will be asked to sign a consent form if you wish to participate. If you are interested in participating, you will be explained about the study either by phone or via email and the consent form will be emailed for yourself to overlook. When you are ready to be interviewed, the study

purpose will be reviewed and the consent form will be explained to you. If you are interested in participating, you will be asked to sign the consent form.

Thank you very much for your interest in this study and I hope to hear from you very soon. Kindly contact myself via telephone or email at (xxx) xxx- xxxx if you are interested or need more information. Again, thank you for your time.

Sincerely,

Beljinder Mattu

## Appendix C: Demographic Information



University of British Columbia

School of Nursing

T149-2211, Wesbrook Mall

Vancouver, B.C. V6T 2B5

1) In what hospital are you currently and primarily employed?

- ☐ Surrey Memorial Hospital
- ☐ Vancouver General Hospital
- ☐ Royal Columbian Hospital
- ☐ Peace Arch Hospital

2) In what role do you practice?

- ☐ Emergency Nurse
- ☐ Physician
- ☐ Forensic Nurse
- ☐ Social Work

3) What is your gender?

- ☐ Female
- ☐ Male

- Other

4) What is your age range?

- 20 to 30 years of age
- 31 to 40 years of age
- 41 to 50 years of age
- 51 to 60 years of age
- 61 to 70 years of age

5) What is your employment status?

- Full-time
- Part-time

6) Overall years of experience as a health care provider:

- 3 years
- 4 to 9 years
- 10 to 15 years
- 16 to 21 years
- Over 22 years

7) Years of experience working in an emergency department:

- 3 to 5 years
- 6 to 10 years
- 11 to 15 years
- 16 to 20 years
- Over 21 years

8) What's your highest level of education?

- High school Diploma
- Undergraduate Diploma
- Undergraduate degree
- Graduate degree

#### Additional Comments

Please feel free to provide any additional comments:

## **Appendix D: Consent**

### **CONSENT FORM**

**Title: EMERGENCY HEALTH CARE PROVIDERS PERSPECTIVES ON PROVIDING CARE TO RACIALIZED IMMIGRANT WOMEN EXPERIENCING INTIMATE PARTNER VIOLENCE**

**Contact Person:**

This research is part of graduate thesis work in my Master of Science in nursing program at the University of British Columbia

**Principle Investigator:**

Dr. Helen Brown, RN, PhD

School of Nursing - University of British Columbia

**Co-investigators:**

Dr. Colleen Varcoe, RN, PhD

School of Nursing - University of British Columbia

Dr. Victoria Bungay, RN, PhD

School of Nursing - University of British Columbia

Beljinder Mattu, BSN

Graduate Student – University of British Columbia

### **INTRODUCTION**

You are being invited to take part in this research study because you are either an emergency (ER) nurse, forensic nurse, social worker, or ER physician who is primarily employed in an ER setting, have a minimum of 3 years of ER experience and in a permanent part-time or full-time position.

**YOUR PARTICIPATION IS VOLUNTARY**

Your participation is entirely voluntary. It is important for you to understand what the research will entail before you decide to participate. This consent form will explain about the purpose of this study, why the research is being ensued, and how the research will be conducted.

However, if you still would like to participate, you will be asked to sign this form. If you decide to take part in this study you are still free to withdraw from the study anytime without any penalty.

If you do not want to participate, you do not need to provide any rationale and your decision will not impact your current or future employment within Fraser Health.

Please read the following information carefully before making your decision.

**WHO IS CONDUCTING THE STUDY?**

This study is being conducted in fulfilment of Beljinder Mattu's Master of Science degree under the supervision of Dr. Helen Brown, RN, PhD, who will be the primary supervisor involved in this study. Dr. Colleen Varcoe, RN, PhD and Dr. Victoria Bungay, RN, PhD will also be part of the thesis committee.

**BACKGROUND**

Violence against women especially intimate partner violence (IPV) is not only a provincial or national health concern but also a global concern. Women are 80% more likely to be victims of IPV and more likely than males to experience physical abuse. IPV has quite wide physical, mental and financial impacts within women's lives, the impact being even greater for racialized immigrant women living in poverty, and women lacking access to social determinants of health. These impacts of IPV extend beyond women's lives, and also impacts society as a whole, more specifically within the health care system; IPV creates a significant burden on the Canadian



health care system and taxpayers in general, as women who seek care for IPV require acute services often sought out in emergency department (ED) settings. One US study estimated that 4% to 20% of IPV victims who are currently being abused visit the ED. A Canadian study estimated that 13.9% of female IPV victims visit the ED. Physicians and nurses from the ED are most likely to be the first to see IPV victims who are seeking care. Thus, the ED is a major location where IPV victims may turn to for care.

### **WHAT IS THE PURPOSE OF THE STUDY?**

The purpose of this study is to explore and better understand your perspectives on providing care for women experiencing IPV in the emergency department, in order to contribute to effective, ethical, and responsive care.

The research questions for this study that I wish to answer are the following:

What are ED care providers' experiences of:

- (1) Providing care for women living with IPV?
- (2) The ED environment for how it shapes their care for women?
- (3) Assessment and care for racialized immigrant women experiencing IPV?

### **WHO CAN PARTICIPATE IN THE STUDY?**

- ☐ Any ER trained RN, forensic nurse, social worker, and ER physician
- ☐ Has been employed in an ER setting for a minimum of three years
- ☐ Employed in a permanent part-time or full-time position

All participants **MUST** meet the above criteria to be eligible for participation in this study

### **WHAT DOES THE STUDY INVOLVE?**

The study will take place at your work site in a private pre-booked room where only the researcher, observer, and yourself, will be present. You will be interviewed for approximately 60

to 90 minutes and the interview will be audio-recorded. You will be asked to participate outside of your work time. The time and date of the interview will be arranged as according to your availability and schedule. You will also be asked to answer a questionnaire pertaining to demographic information. However, if there are any questions you are not comfortable answering you may refuse at any time.

**WHAT ARE MY RESPONSIBILITIES?**

You will be asked about your experiences of caring for women experiencing or living with IPV in the ER setting and will be encouraged to speak candidly about your experiences without judgement.

**WHAT ARE THE POSSIBLE RISKS OF HARM PARTICIPATING?**

There are no anticipated risks of harm involved in this study.

**WHAT ARE THE BENEFITS OF PARTICIPATING IN THIS STUDY?**

There are no anticipated benefits to you from taking part in this study.

**WHAT HAPPENS IF I DECIDE TO WITHDRAW MY CONSENT TO PARTICIPATE?**

Your participation in this study is voluntary and you may withdraw without any penalty and without providing any explanation of any reasons for doing so. All data that has been collected up to this point will only be used if consent is obtained from yourself, the participant.

**WHAT WILL THE STUDY COST ME?**

You will not incur any costs and your parking will be compensated upon proof of receipt. You will also receive a \$25 Starbucks gift card for your participation in this study.

**WILL MY INVOLVEMENT IN THIS STUDY BE KEPT CONFIDENTIAL?**

Your confidentiality will be respected. However, research records identifying you may be inspected in the presence of the Investigator or his or her designate by representatives from UBC

[Dr. Helen Brown, Dr. Colleen Varcoe, Dr. Victoria Bungay], and [University of British Columbia Research Ethics Board and Fraser Health Research Ethics Board] for the purpose of monitoring the research. No information or records that disclose your identity will be published without your consent, nor will any information or records that disclose your identity be removed or released without your consent unless required by law.

You will be assigned a unique study number as a subject in this study. Only this number will be used on any research-related information collected about you during the course of this study, so that your identity [i.e. your name or any other information that could identify you] as a subject in this study will be kept confidential. Information that contains your identity will remain only with the Principal Investigator and/or designate. The list that matches your name to the unique study number that is used on your research-related information will not be removed or released without your consent unless required by law.

### **WHO DO I CONTACT IF I HAVE QUESTIONS ABOUT THE STUDY?**

If you have any questions or need more information about this study before or during participation, you can contact Beljinder Mattu at (xxx) xxx-xxxx

### **WHO DO I CONTACT IF I HAVE ANY QUESTIONS OR CONCERNS ABOUT MY RIGHTS AS A PARTICIPANT DURING THE STUDY?**

Complaints or concerns arising from UBC research participation are handled by the Research Participant Complaint Line.

### **CONSENT TO PARTICIPATE**

My signature on this consent form means:

- I have read and understood the information in this consent form.
- I have had enough time to think about the information provided.

- I have been able to ask for advice if needed.
- I have been able to ask questions and have had satisfactory responses to my questions.
- I understand that all of the information collected will be kept confidential and that the results will only be used for scientific purposes.
- I understand that my participation in this study is voluntary.
- I understand that I am completely free at any time to refuse to participate or to withdraw from this study at any time.
- I understand that I am not waiving any of my legal rights as a result of signing this consent form.

Name of Participant: \_\_\_\_\_

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

Name of Investigator: \_\_\_\_\_

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

## Appendix E: Demographic Table

**Table 1.** Demographic Characteristics

Characteristic	n	%
Gender		
Male		
Female	5	100
Other		
Age		
20-30		
31-40	3	60
41-50	1	20
51-60	1	20
61-70		
Main Source of Employment		
ER Nurse	1	20
Physician		
Forensic Nurse	3	60
Social Work	1	20
Main Hospital of Employment		
Surrey Memorial	5	100
Vancouver General		

Royal Columbian

Peace Arch

### Employment Status

Full-time	2	40
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Part-time	3	60
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Overall years of experience as a

health care provider

3 years

4-9 years	2	40
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10-15 years

16-21 years	2	40
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Over 22 years	1	20
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Years of experience working in an

emergency department

3-5 years	2	40
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6-10 years	2	40
------------	---	----

11-15 years	1	20
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16-20 years

Over 21 years

### Highest Level of Education

Highschool Diploma

Undergraduate Diploma	1	20
Undergraduate Degree	4	80
Graduate Degree		

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## **Appendix F: Semi-Structured Interview Guide**

### **Preamble**

My name is Bel Mattu and I am a University of British Columbia (UBC) Master of Science in Nursing student. Thank you for taking time out of your busy schedule to participate in this study. I am conducting this study due to my interest in intimate partner violence (IPV). This interest was kindled by the news of the senseless death of Maple Batalia who was murdered by her former boyfriend in 2011. Maple was a vibrant and ambitious young woman who was an aspiring model and a student at Simon Fraser University (SFU). I was deeply impacted by Maple's death as I felt this young woman could have been any woman, including myself. Maple was also an Indo-Canadian woman like myself and had her whole life ahead of her and her death due to IPV was heart-breaking and shocking.

### **Questions**

- 1) What are experiences of ED health care providers when providing care for women living with IPV?
  - I am really interested in your thoughts and experiences about providing care to women impacted by IPV.
  - Are there any specific experiences that stand out to you?
  - What resources are available to you when providing care to women experiencing IPV?
- 2) What are the ED health care providers' experiences of the ED environment for how it shapes their care for women experiencing IPV?
  - What are your thoughts about the ED environment and how it impacts care to women impacted by IPV? How does this impact your practice?



- Are you able to provide specific examples?

3). How do ED professionals approach assessment and care for racialized immigrant women experiencing IPV?

- What are some experiences when caring for racialized immigrant women?
- What are some specific experiences when caring for racialized immigrant women experiencing IPV?
- How do you assess women experiencing IPV in the ED?
- Are you able to provide specific examples of what assessment skills/tools you use?