MATERNITY NURSES’ EXPERIENCES OF CARING
FOR PREGNANT WOMEN INVOLVED IN ABUSIVE RELATIONSHIPS

By

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ABSTRACT

The purpose of this study was to examine maternity nurses’ experiences of caring for pregnant women involved in abusive relationships. A conceptual framework composed of the relevant concepts of maternity nursing care and domestic violence was used. The research methodology of phenomenology was chosen as it allows for the development of a special understanding of the phenomenon in question by talking to participants who have firsthand experience. Data were collected using semi-structured, audiotaped interviews that encouraged the participants to describe the phenomenon in their own words. The study sample consisted of eleven maternity nurses employed in an acute care maternity nursing hospital who were interviewed once from one to three times.

Data were simultaneously collected and analyzed over a period of several months. After transcription of the interviews was completed, data was examined for common themes according to Colaizzi’s (1978) structure for qualitative data analysis.

Maternity nurses’ experience was presented in three central, related themes. The first theme, gaining understanding of patients in abusive relationships was comprised of the sub-themes: (a) discovering the abuse, (b) reacting to discovery of abuse, and (c) developing relationships. It was found that many of the patients’ abusive relationships were discovered through nurses’ use of intuition. As a result, nurses experienced feelings of uncertainty which were reflected in the development of nurse-patient relationships and subsequent nursing care.

The second theme, facing the realities: the health care context, emerged from the health care environment in which the nurses provided care. This theme
was composed of the following sub-themes: (a) identifying the gaps, (b) working with others, and (c) providing nursing care. The nurses often felt frustrated at the perceived lack of support for their abused patients, and the lack of support for the nurses’ emotions.

The third theme, struggling within the realities: the subjective context, describes the participants’ personal experiences of caring for abused pregnant women. Many of the nurses based their own understanding of abuse of their past personal experiences. This theme was comprised of the following sub-themes; (a) nurses’ conceptualization of abuse, (b) feeling fear, and (c) connecting with the patients.

This study has several implications for nursing. In clinical nursing practice, all nurses need to become comfortable with caring for abused women. The goal for maternity nurses must be for all childbearing women to be assessed for the presence of abuse. In order to achieve these changes to clinical practice, nursing administrators must support all front-line nurses to provide effective health care to abused patients. This support should be offered through interactive dialogue and the provision of counselling services for those nurses experiencing personal difficulties. Furthermore, nurse educators must strive to educate present and future nurses on the issues of domestic violence. Finally, the need for further research involves examining groups of nurses from other clinical areas in order to determine the transferability of this present study’s findings, and to explore the similarities and differences of nurses’ experiences.
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CHAPTER ONE: Introduction

Background to the Problem

Domestic violence results in physical and psychological health problems for approximately one million women in Canada and as many as six million women annually in the United States (Henderson, 1992; McLeod, 1987). As the profession of nursing is predominated by women, it can be extrapolated from these statistics that many nurses have been battered in abusive relationships. Consequently, health problems resulting from domestic violence require battered women to use the health care system frequently for episodic care in emergency departments and health care clinics (Rounsaville & Weissman, 1978). Battered women are found in every area of the health care system (Moss & Taylor, 1991). Campbell and Humphreys (1984) identified that the nurse is "especially likely to encounter abused women in the emergency room, in prenatal and maternal care settings, in community health, in primary care settings, in occupational health, and in the mental health field" (pg. 247). Because of this contact, nurses are well positioned to play an important role in identification, intervention and prevention of domestic violence (Moss & Taylor, 1991).

The identification of abuse poses problems from both the nurses and the patients’ perspectives. First, many nurses have difficulty addressing the issue of domestic violence with suspected victims (Henderson, 1992). Nurses feel unprepared to delve into issues surrounding domestic violence because addressing the cause of the injury can feel like "trespassing in another’s territory" (Randall, 1991, pg. 1177). Attitudes of nurses towards domestic violence have not been well researched; however, general social attitudes reflect the belief that abuse is a

The second problem associated with identification of abused patients by nurses is that abused women often do not acknowledge the true cause of their injuries (Hadley, 1992). Bohn (1990) contends that women often make up stories to explain their injuries. This contention is supported by the fact that abusers often accompany their partners when treatment is sought to prevent them from revealing the truth. Given these two problems, it is little wonder that abuse is poorly identified and addressed by nurses.

Awareness of pregnancy as a high risk period for abuse has only recently been addressed by researchers (Helton, McFarlane & Anderson, 1987; Henderson, 1992; Stewart & Cecutti, 1993). Findings of studies of battered women indicate that violence often begins or escalates during pregnancy (Bullock & McFarlane, 1989; Campbell & Humphreys, 1984; Helton, 1986; Helton, McFarlane, & Anderson, 1987; Helton & Snodgrass, 1987; McFarlane, 1992; Stewart & Cecutti, 1993; Walker, 1984). Prevalence estimates of abuse in pregnancy have been identified as high as fifty percent (50%) of women who are already involved in abusive relationships (Bohn, 1990). It has been further estimated that seventeen percent (17%) of pregnant women in the general population are involved in abusive relationships (McFarlane, Parker, Soeken, & Bullock, 1992). Given the high prevalence of abuse in pregnancy and the fact that maternity nurses care for pregnant women, it is likely that maternity nurses care for abused pregnant women. The extent to which maternity nursing care practices are affected by caring for abused pregnant women is not well documented in the literature. As no
research was found on the feelings and experiences of maternity nurses who have cared for abused women, the following research project was undertaken to expand the knowledge base of maternity nurses’ experiences of caring for abused pregnant women.

**Statement of the Problem**

Given the documented prevalence of abuse during pregnancy, it is expected that maternity nurses come in contact with women who are experiencing violence. There was insufficient nursing research found which examines the experiences of maternity nurses who deliver care to women experiencing abusive or violent situations. Nurses are still hesitant to intervene in the care of the abuse itself despite being the providers of front-line care to these types of patients. A better understanding of how nurses experience caring for abused women is needed to identify issues and barriers to the provision of appropriate nursing care for abused women.

**Purpose of the Study**

The purpose of this research study is to describe maternity nurses’ experiences of caring for pregnant women involved in abusive relationships. The research question is: "What was the maternity nurses’ experiences of caring for pregnant women involved in abusive relationships?"

The objective of this study is to identify common themes from these experiences through in-depth exploration of nurses’ experiences as care givers of women who have been abused during pregnancy.
Relevance

It is intended that the examination of the experiences of maternity nurses will contribute to further development of nurses’ roles in the care of abused women. Awareness of maternity nurses’ experiences could promote a better understanding of potential barriers to effective care. Furthermore, knowledge of nurses’ experiences could be used in the development of necessary institutional health care guidelines and appropriate educational in-service opportunities for nurses.

Conceptual Framework

Two concepts have been identified in the literature as central to a consideration of nurses’ experiences with this patient population. The two central concepts are maternity nursing care and domestic violence against women.

Maternity Nursing Care

Maternity nursing is defined as the delivery of professional and quality health care while recognizing, focusing on, and adapting to the physical and psychological needs of the childbearing family (Reeder, Martin & Koniak, 1992). Clinical application of this specialized knowledge includes care of the entire childbearing unit - the mother, the father or support person, and the infant (Phillips, 1980). Therefore, maternity nurses assist all family members, not just the new mother and baby, in adjusting to their new roles.

Maternity nurses provide care to childbearing women and their families that focuses on health rather than illness (Neeson & May, 1986). The pregnancy period is viewed as a "normative crisis" that concerns all members of the family (Reeder et al., 1992). The philosophy of family centred care evolved in response to
consumer demands for patient oriented care, instead of medically oriented care (Post, 1981). Family centred care is based on the philosophical belief that women do not experience childbirth in isolation. Friedman (1992) defines the family as consisting of two or more people who are emotionally involved and live, or have lived, together. Melson’s (1980) definition states family is "anything two or more individuals say it is" (p. 3). The birth of a baby represents the birth of a new family. Given today’s many variations in family structure, Friedman (1992) contends that maternity nurses care for pregnant women within the family context, whatever context that may represent.

Maternity nurses’ work includes prenatal teaching, antepartum care, labour care during the birth process, and early postpartum follow-up care and teaching. The positive focus of the birth event and usually healthy patients sets maternity nursing apart from many other areas of nursing where the focus of care lies on disease and illness. This results in satisfaction for its’ practitioners and longevity of work life. Practitioners develop expertise in the field of maternity nursing as an outcome of education, interest in their work, and longevity of work experience.

**Domestic Violence Against Women**

Domestic violence is a widespread and long-standing social problem. The scope of domestic violence against women was not well understood in Canada until McLeod’s (1980) survey which revealed estimates that, conservatively, indicated that one in ten women living with a male partner is abused each year. More recent statistics indicate an increase in the frequency of abuse to one in eight Canadian women (McLeod, 1987; Task Force on Family Violence, 1992). However, this apparent escalation in frequency may be reflective of an increase in
reporting, not an increase in actual numbers of abused women. Under-reporting of the incidence of domestic abuse frustrates research attempts to determine accurate scope of the problem.

Despite startling statistics of the incidence of domestic violence against women, many victims remain undetected (Randall, 1991). Women experiencing domestic violence are often unable to admit they are in abusive situations. Social isolation, fear for personal safety, and feelings of low self-esteem are factors in women's reluctance to identify themselves as abused (Campbell & Humphreys, 1993; Henderson, 1986; Stewart & Cecutti, 1993; Walker, 1984). Economic dependence on male partners is another factor women consider when contemplating changing their abusive situation (Sampselle, 1991). Many battered women perceive they have few options, and the addition of a pregnancy seems to decrease their perceived options even further (Campbell, 1992).

**Maternity Nursing and Domestic Violence**

Maternity nurses are being forced to examine their nursing practice as the disturbing frequency of prevalence of abuse during pregnancy becomes evident (Bohn, 1990). Domestic violence against women challenges maternity nurses to care for childbearing women who are involved in abusive relationships (Bewley & Gibbs, 1991). Nurses are becoming increasingly aware of health problems arising as a result of violence during pregnancy (Moss & Taylor, 1991). An increased incidence of miscarriage, stillbirths, and premature labours and deliveries following abusive behaviour by their partners has been observed (Bullock & McFarlane, 1989). Nurses report seeing injuries resulting from blows to the abdomen, vaginal area, breasts, and from sexual assault (Helton, 1986). Other abuse injuries
identified by nurses include pneumothorax, stab wounds, concussions, fractures, and dental injuries (Stewart & Cecutti, 1993). Research has documented an increased incidence of low birth weight babies born to women who are abused during pregnancy (Bullock & McFarlane, 1989; Newberger, Barker, & Leiberman, 1992). A significant consideration for nurses is that spousal abuse is often associated with child abuse; therefore, the safety of the child after birth must be considered (Dickstein, 1988). The risk associated with maternal injuries and potential fetal danger indicate that domestic violence against women, especially during pregnancy, is a critical issue for maternity nurses.

The concurrent analysis of the concepts of maternity nursing and domestic violence against women provides a framework for understanding maternity nurses' experiences of caring for abused pregnant women.

**Definition of Terms**

1) For the purposes of the study, 'domestic violence', 'wife abuse' and 'battered or abused' will be used interchangeably. The definition for these terms has been adopted from McLeod (1987).

"Wife battering is the loss of dignity, control, and safety as well as the feeling of powerlessness and entrapment experienced by women who are the direct victims of **ongoing or repeated** physical, psychological, economic, sexual and/or verbal violence or who are subjected to **persistent** threats or the witnessing of such violence against their children, other relatives, friends, pets and/or cherished possessions, by their boyfriends, husbands, live-in lovers, ex-husbands or ex-lovers, whether male or female" (pg. 16).
This definition acknowledges the significance of psychological (emotional) abuse. Emotional abuse is viewed as being as detrimental, or possibly more so, than physical abuse.

2) ‘Abusive relationship’ is defined as any intimate, heterosexual relationship where the perpetrator of abuse is male.

3) ‘Pregnancy’ is defined as a uterine conception of gestational age between 20 weeks to 40 weeks. Women who are under 20 weeks gestation have not reached the age of viability and are often not cared for by maternity nurses when complications of pregnancy arise.

4) ‘Caring for’ is defined as any situation in which a maternity nurse gives direct patient care in a hospital maternal-child care setting.

5) ‘Maternity nurse’ is defined as any registered nurse who is currently working in an acute care tertiary maternal-child care setting.

Assumptions

The researcher has made the following assumptions in this study:

1) Domestic violence occurs during pregnancy.

2) Maternity nurses encounter abused women in their nursing practice.

3) Maternity nurses will speak candidly about their experiences of caring for abused women and their families.

4) By virtue of being women, a number of nurses are themselves abused, or have been involved in abusive relationships.

Limitations

The researcher has identified the following limitations of this study:
1) This study was based upon experiences of eleven individual maternity nurses who have cared for abused women. Their realities were unique, personal, and related to their own personal experiences. This, therefore, limits the transferability of the research findings.

2) Findings of this research study are limited to nurses who work in urban, tertiary hospital settings where maternity care is offered. This researcher recognizes that the experiences of maternity nurses in rural settings could be very different due to availability of health care resources.

Summary

The background to the problem that led to the study has been introduced in this chapter. The research problem has been defined, as well as the purpose of the study, and the research question. A description of the conceptual framework that guides the study was provided which illustrates the general contextual fabric of the literature on maternity nursing care, and domestic violence against women. Definitions for terms were presented, and assumptions and limitations outlined.

In the next chapter, the researcher examines the literature related to the problem and the purpose of the study. Literature is presented from both the theoretical and research perspectives in order to fully delineate the existing state of knowledge about maternity nurses and the nursing care of abused pregnant women.
CHAPTER TWO: Literature Review

The following examination of the literature consists of both theoretical and research perspectives pertaining to the major concepts of domestic violence, domestic violence and the nursing profession, maternity nursing care, and maternity nursing care and domestic violence against women.

**Domestic Violence**

Despite the fact that domestic violence has been recognized in the literature as a health care problem for women, health care providers seem to be generally unaware of the issues surrounding violent relationships (Sampselle, Petersen, Murtland, & Oakley, 1992). This review of the literature examines the current state of information available concerning domestic violence. Domestic violence is explored from a historical perspective, and the literature is reviewed for the prevalence of abuse of women in the health care system and for factors contributing to the perpetuation of domestic violence in today’s society.

**Historical Perspective**

Domestic violence is a phenomenon that has long been a characteristic of family life (Gelles & Strauss, 1988). From a historical perspective, violence has been entrenched in social institutions for centuries. Dobash and Dobash (1979) addressed the sanctioning of woman abuse by identifying that, historically, abusive behaviour has existed for centuries as an "acceptable and desirable part of patriarchal family system within a patriarchal society" (pg. 31). Given the intrinsic nature of beliefs about the abuse of women, it is not surprising that attempts to change societal attitudes about abuse are difficult.
The long-standing problem of domestic violence has become better understood through identification of the scope of the problem. McLeod’s (1987) statistics indicated that abuse within families occurs with alarming frequency, with as many as one in eight women involved in intimate relationships abused by her partner. The pervasiveness of domestic violence would lead one to conclude that social actions addressing family crimes were abundant. However, Greany (1984) found that community and professional endeavours to oppose violence were limited because of a reluctance to get involved in family matters. Therefore, violent incidents that were reported were dismissed by the police and the judiciary as just domestic problems (Greany, 1984). Women in abusive relationships were given no assistance or recognition of the devastating effects of their abuse from the institutions from which they sought assistance.

Prevalence of Abused Patients in the Health Care System

It is only recently that domestic violence has become a focus for inquiry and research. In search of a better understanding of the enormity of the problem of domestic violence, many researchers attempted to document the frequency with which domestic violence victims access the health care system (Appleton, 1980; Brendtro & Bowker, 1989; Flitcraft, 1977; McFarlane, Parker, Soeken, & Bullock, 1992; Moss & Taylor, 1991; Rounsaville & Weissman, 1978). One such study was conducted by Flitcraft (1977) who completed a one month review of medical charts of all women who sought emergency room treatment. These findings indicated that approximately twenty percent (20%) of the women were positive or suggestive of battering. Appleton (1980) confirmed these findings in a study in which questionnaires were administered to women who entered the emergency
departments of general hospitals. Findings of this anonymous survey reported that twenty-two (22%) to thirty-five (35%) percent of women indicate they had been struck at some time by their intimate partners. Conclusions drawn from these early studies indicated that large numbers of victims of domestic violence did seek treatment from health care professionals for injuries of abuse. Secondly, it can also be concluded that health care professionals have frequent contact with victims of domestic violence.

Many of the early prevalence studies used small samples in single clinical settings. Rounsaville and Weissman's (1978) original study of prevalence of women seeking medical care for injuries of abuse used only thirty-seven (37) participants over the period of one (1) month. The findings of this study were based only on women who admitted their abuse. It was likely that many more women did not reveal the true origin of their injuries. When drawing conclusions from prevalence studies, health care professionals must acknowledge the limitations of findings of studies using small sample size.

Drake’s (1982) study of emergency department visits of battered women was also a small (n = 12) retrospective study. The sample population consisted of primarily African-American and European-American women. Despite the small sample size, Drake’s study identified clear evidence that many health care professionals lacked the ability to provide sensitive care to abused women. The fact that many health care professionals are reluctant to acknowledge the presence of woman abuse in their practice is a fundamental difficulty identified when examining the obstacles to addressing domestic violence. This difficulty is supported by much of the literature on domestic violence which indicates that
health care professionals do not address issues of abuse when it is suspected (Delgaty, 1985; Greany, 1984; Henderson, 1992; Moss & Taylor, 1991; Randall, 1991).

Despite the testimony of well-documented statistics on domestic violence, many incidents of abuse elude detection by health professionals (Campbell & Fishwick, 1993; Landsberg, 1986). Victims of violence most commonly seek treatment for their injuries from medical facilities (Hadley, 1992). Many battered women who come into contact with health care professionals do not reveal the etiology of their injuries when questioned and may even deny the existence of abuse (Brendtro & Bowker, 1989; Walker, 1984; Campbell, 1993). This reluctance to disclose abuse may be perceived by health care professionals as ambivalence and tolerance of abuse and can result in "victim-blaming" (McLeod, 1987). Hartman (1987) identified that most battered women welcome the opportunity for disclosure of the abusive situation when asked the appropriate questions and given a supportive environment. Understanding the victim’s fear for herself, her children, if any, and her relationship is essential if health care professionals are to treat abused women effectively. Without appropriate intervention, these women have their physical injuries treated and return home, only to return at a later date with similar, or more severe, injuries. Bullock, Sandella and McFarlane (1989) further identify that incidents of abuse do not occur in isolation and often escalate in severity and frequency. One suggestion found in the literature which would begin to address these problems is to educate health care professionals on factors contributing to abusive situations (Sampselle, 1991).
Domestic Violence: Contributing Factors

Many factors have been identified in the literature as contributing to the existence of domestic violence. These factors occur from both personal and societal origins (Brendtro & Bowker, 1989; Sampselle, 1991). Personal factors include family of origin and individual personality characteristics. Social factors include those factors that are known to sustain violence against women such as societal devaluation of women, male-female power inequality, and the male belief in women as property.

Personal Factors

Intergenerational transmission of violent behaviour has been identified as one of the most important factors in the perpetuation of domestic violence. The Ontario Medical Association (1991) identified a high incidence of wife abuse and/or child abuse in families of origin of both batterers and battered women. The underlying premise is that, for both men and women, violence becomes a behaviour acquired in the family of origin. Brendtro & Bowker (1989) supported this premise by hypothesizing that men learn to batter and women are conditioned to expect violence because of early life experiences. The hypothesis that all individuals with such childhood histories would develop similarly violent behaviour patterns as adults was unsupported by their research study of abused women. These researchers found that a high percentage (48%) of male batterers witnessed wife abuse between their fathers and mothers. Of these men, sixty-one percent (61%) admitted to their wives that they had been battered themselves. However, childhood experiences of abuse were not found to predispose women to abusive relationships. Twenty-four percent (24%) of the women in their survey disclosed
experience with childhood abuse. Gage’s (1991) study used the findings of Brendtro & Bowker to corroborate her assertions that women exposed to childhood abuse are not predisposed to engage in violent relationships later in life. Although the issues of childhood effects of violence on later life for both men and women have been well documented in the literature, the findings remain contradictory and inconclusive. Therefore, the presence of violence in the family of origin must be assessed on an individual basis, as it seems it is more likely to influence male partners than female partners.

Issues of needs for control are addressed in the literature. Delgaty (1984) and McLeod (1987) identified that abusers controlled their partners’ social interactions and restricted opportunities for independence. Abusive men may be excessively dependent on their partners and feel threatened by outside interests of these women (Ontario Medical Association, 1991). Agudelo (1992) stated that abuse can only be perpetuated if one partner remains in a non-dominant position. For abusive men, violence becomes a means of controlling their partners.

Domestic violence occurs within a social context. Clearly, the social context of family life is an important factor when determining the presence of domestic violence. However, focusing only on individual circumstances in the lives of battered families ignores the larger social context in which domestic violence exists.

Social Factors

Domestic violence against women has been found in families from all ethnic, economic, religious and educational backgrounds (Torres, 1991; Walker, 1984). The hidden nature of domestic violence permitted it’s existence and perpetuates
the problem. Goldberg and Tomlanovich (1984) identify that one in five people thought that practices of domestic violence were acceptable. Attitudes such as these contribute to society’s tolerance of domestic violence.

Sampselle (1991) identified three key social factors that contribute to sustaining violence against women. These factors include societal devaluation of women, male-female power inequality, and the male perception of women as property.

Social devaluation of women was identified as a contributing factor to a patriarchal viewpoint towards violence. This traditional view fosters negative male attitudes and serves to maintain women’s lower status in the hierarchy of society. Power inequality has contributed to the abuse of women because of male domination in job markets leading to decreased earning power for women. This factor is of particular significance for abused women who, with sole child-rearing responsibility, leave relationships and are faced with returning to a job market where earning power is often less than their estranged spouses. Lowered standard of living for lone parents and children are common examples of power inequality. Historically, women have been viewed as the property of their fathers and then their husbands. Viewing women as property enabled male partners to “maintain authority” over their spouses and therefore contributed to the sustenance of domestic violence (Sampselle, 1991).

The final contributing factor that this researcher explored in the literature was that of the pregnant state. For some women, pregnancy alone may be a contributing factor to violence. When combined with a relationship containing one
or more social and/or personal contributing factors to violence, a high-risk situation for abuse may be established.

**Domestic Violence and Pregnancy**

Research studies on domestic violence and pregnancy have focused upon the prevalence of abuse during pregnancy and on determining characteristics of abused women. King and Ryan (1989) identified that in order to ensure an accurate prevalence rate of abuse, nurses must assess all women for the presence of abuse. Both the determination of accurate prevalence rates of abuse in pregnancy and the recognition of characteristics of abused women assist health care professionals to better understand the scope and the context of the issues of violence in pregnancy.

**Prevalence of Abuse in Pregnancy**

To better understand the scope of domestic violence in pregnancy, research has focused upon determining prevalence rates. Early studies of battered women in transition houses and shelters reported thirty-five to one hundred percent (35-100%) of women in abusive relationships had continued to be abused during pregnancy (Drake, 1982; Gelles & Strauss, 1988; Walker, 1984). A study conducted by Fagen, Stewart, and Hansen (1983) identified that abuse during pregnancy was more likely to occur if there was an existing family history of violent behaviour. These findings suggested the primary indicator of abuse during pregnancy is presence of abuse prior to pregnancy. Later studies corroborated these findings. Helton, McFarlane and Anderson (1987) studied two hundred and ninety (290) women from both public and private clinics. Findings of their study indicated eight percent (8%) of the women interviewed reported battering during
their current pregnancy. Of these, eighty-seven point five percent (87.5%) of these women had been abused prior to the pregnancy. These women had not been identified as being in abusive relationships prior to the study. An alarming finding of the Helton et al. study was that twenty-nine percent (29%) of the women abused during pregnancy reported an increase in violence during the pregnancy. Bullock and McFarlane (1989) supported this finding by postulating that domestic violence within the context of an intimate relationship will continue its cyclical repetitive pattern during pregnancy and possibly worsen. Conclusions drawn from these studies are that the existence of abuse in a relationship prior to pregnancy increases the risk for abuse during pregnancy.

A secondary analysis of survey data from nine hundred and forty (940) pregnant women examined the prevalence of abuse among women by their choice of care giver - nurse-midwife or physician. Sampselle et al. (1992) found that twelve point two percent (12.2%) of women choosing midwifery care had previous experience with abuse, whereas only eight point five percent (8.5%) of women seeking physician care had a history of abuse. Many of the abused women in the study identified that the female gender of the care giver was an important factor in their choice of prenatal care provider. This finding was supported by Holz (1994) who found that most women survivors of abuse sought medical care from female practitioners. As midwives are traditionally female, this may explain the higher percentage of abused women choosing midwifery care (Bewley & Gibbs, 1991). The Sampselle et al. survey concluded there was an overall nine point seven percent (9.7%) rate of women with previous history of abuse, with zero point nine percent (0.9%) of these women currently in abusive relationships. The findings of
this study are comparable with those of Hillard (1985) who identified a ten point nine percent (10.9%) prevalence rate of pregnant women with previous experience with abuse. However, the prevalence is lower than the findings of Helton, McFarlane and Anderson (1987) who found that fifteen percent (15%) of their study sample of pregnant women identified previous experience with abuse. The disparity in findings may reflect the methodological differences in data collection. The participants in the Helton et al. study were asked about their abuse in face to face interviews, as opposed to pen and paper questionnaire. This suggests that the numbers of abused women identified may be greater when women are approached by a sensitive care giver.

To determine prevalence rates of abuse in the healthy, pregnant population, McFarlane et al. (1992) completed a cross-cultural cohort study of prevalence and severity of abuse during pregnancy. Their sample included one thousand two hundred (1200) women of African-American, Hispanic-American and Caucasian-American cultures; four hundred (400) participants from each cultural group. Findings revealed a seventeen (17%) overall frequency of abuse during pregnancy, which is a disturbing prevalence. A significant finding of this study was that abused women were twice as likely to begin prenatal care in the later trimesters of their pregnancies than non-abused women. These findings may indicate that controlling behaviours of abusers result in abused women being denied access to health care. Prenatal care provides opportunities for women to discuss concerns, and abusers may attempt to prevent opportunities for discussion due to the possibility of revealing the abusive situations. The indication for health care professionals who come in contact with pregnant women is that all women,
particularly those who seek prenatal care in the later stages of pregnancy, must be assessed for the presence of abuse.

Caution must be exercised when drawing conclusions about prevalence rates for abuse during pregnancy. Research into accurate rates of abuse has been conducted with healthy, pregnant women and known abused women; women who are socially impoverished and well-educated women; women of differing cultures and Caucasian women (Helton, McFarlane & Anderson, 1987; Bullock & McFarlane, 1989; and McFarlane, Parker, Soeken, & Bullock, 1992). Given this array of multi-faceted social factors, it has been difficult to compile accurate and generalizable prevalence rates of abuse during pregnancy. Campbell and Fishwick (1993) identified that the challenge for nurses as professionals remains to be alert to the possibility of abuse. By taking active roles in identifying individuals in their practice setting, nurses can determine the unique prevalence of abuse in the populations of patients in their care.

Characteristics of Abused Women

Nursing literature has increased the understanding of the nature of domestic violence by describing those who are abused. It is believed that by knowing common characteristics of abused women, nurses can better understand the necessary assessment techniques and intervention strategies.

Bullock, McFarlane, Bateman, and Miller (1989) identified characteristics of battered women which included behavioral indicators such as fear of partner and lack of eye contact with health professionals. Physical injuries that did not correspond to the story of origin were identified by Lyer (1980) as possibly indicative of abuse. Hillard (1985) found a markedly increased prevalence of
emotional problems in abused pregnant women as compared with those who were not abused, ie: forty-three percent (43%) in the battered group versus five percent (5%) in the non-battered group. These findings were supported by Bewley and Gibbs (1991) who found that abused women exhibited an increase in signs of stress and clinical depression. Furthermore, Greene (1991) asserts that women who have been sexually assaulted are more likely to experience nervous breakdowns, more likely to attempt suicide, and more likely to commit suicide or experience death by homicide than women in the general population.

Dobash and Dobash (1979) described the assault experiences of one hundred and nine (109) battered women where offenses included shoving, being slapped, punched, pushed, kicked, urinated on, bitten, choked, burnt, suffocated, stabbed and shot. Physical injuries described were cuts, multiple bruises, disfigurement, broken teeth and bones, and internal injuries. The Ontario Medical Association (1991) described that repeated episodes of violence resulted in battered women possessing lowered self-esteem, feelings of guilt, and acceptance of responsibility for the violence. The discovery of any of these characteristics should alert nurses to the possibility of abuse.

These behavioural characteristics were found to be similar to those of abused pregnant women (Bohn, 1990). Physical features of abuse in pregnancy included blows to the abdomen, breasts and genitals (Helton & Snodgrass, 1987; McFarlane, 1989). Because attacks on these areas could result in miscarriage, placental abruption, premature labour and stillbirth, women who present with any of these complications of pregnancy should be assessed for the possibility of abuse (Bohn, 1990; Kent, 1989).
The use of documented characteristics of abused women is helpful for familiarizing health care professionals with key characteristics that are common among abused women. A relevant viewpoint was offered by Ajzen and Fishbein (1980) who suggested that professionals need to assess individual strengths and abilities rather than just focussing on patient problems. This viewpoint clearly stresses the importance of assessment of patients as individuals. In order to identify abused women consistently, health care professionals need to assess women individually using knowledge of the common characteristics of abuse.

**Domestic Violence and the Nursing Profession**

Researchers have attempted to articulate and clarify nursing’s role when caring for abused women. Moss and Taylor (1991) declare that nurses play a critical role in the identification, assessment, and intervention of abused women in a variety of settings. The maternity ward has been identified as a prime setting in which to assess for the presence of abuse. McFarlane (1992) contends that assessment for presence of battering in pregnant patients, and initiation of education, advocacy, referral, and counselling are all important roles that maternity nurses play with abused women. Nurses’ unique position as front-line providers of care means they have both contact with abused patients and opportunity to be effective patient advocates (Campbell & Fishwick, 1993).

**Nurse-Patient Relationships**

Nurse-patient relationships are an important component of the identification of the domestic violence experience. In the literature, nursing roles in the care of abused women have shifted from passive listening to more active intervention, as illustrated by King and Ryan (1989) who clearly outlined nurses’ roles in caring for
abused patients. According to these authors, active nursing intervention includes active listening, facilitating the formulation of strategies for the future, and assisting women to establish feelings of self-control and power. Acknowledgement or actual identification of abuse is considered as a form of early intervention because violence is revealed before it escalates further. Essential features of effective nurse-patient interactions should include providing a non-threatening environment, encouraging a sharing of experiences and feelings, and maintaining an individual approach to problem-solving. King and Ryan caution against the dangers of supportive nurses taking over the role of controller for abused women. These authors conclude by saying that the success of nurse-patient interactions may be evaluated by outcomes that occur in terms of what the women want to do, and not what nurses feel they should do.

Nurses’ Attitudes

Nurse-patient relationships with abused women have been further explored through examination of nurses’ attitudes towards abuse. Gage (1991) identified that an examination of nurses’ own experiences and attitudes regarding abuse was crucial to performing unbiased assessments. Sampselle (1991) concurred that nurses should examine personal attitudes towards the issues of abuse. The importance of awareness of nurses’ own beliefs about abuse is stressed in the literature as a critical first step to developing effective nurse-patient relationships with those experiencing domestic violence.

Studies of nurses’ attitudes towards the abuse of women have appeared in the literature. Rose and Saunders (1986) reported that nurses were less likely than physicians to believe that wife-beating was justified, and that victims were
responsible for the abuse. They concluded that female practitioners, both nurses and physicians, were more likely to detect abuse and be more empathic when providing care. These findings were supported by Bokunewicz and Copel (1992) who found that emergency nurses who received an educational presentation on abuse demonstrated an enhanced awareness of how to identify battered women. These nurses perceived they had a better understanding of the dynamics of abusive relationships. Moss and Taylor (1991) viewed health care professionals’ adverse attitudes as impediments to effective health care for abused women. The readiness of abused women to disclose their abuse may be dependent upon the receptivity of health care professionals. Therefore, opportunities for abused women to receive help should be offered and not lost due to the insensitivities of health care professionals (Helton et al., 1987).

Nurses must be sensitive to women as they encourage disclosure of abuse. Henderson (1992) confirmed that some nurses may be uncomfortable when faced with discussing issues of abuse with patients, and suggested that such nurses should refer these patients to another care giver rather than disregard the patients’ needs. Brendtro and Bowker (1989) and Campbell and Fishwick (1993) both offered support for this action by identifying that the more closely nurses work with battered women, the greater the probability that women will admit their abuse sometime during the treatment process.

Maternity Nursing

To understand the link between abuse during pregnancy and maternity nursing care, it is helpful to consider the changes in maternity nursing care in the past two decades. Advances in technology and diversity in family structure are
two challenges which necessitated a change in maternity nurses’ work. Prior to
the early 1960’s, maternal and newborn care was provided primarily by nurses and
midwives (Reeder, Martin & Koniak, 1992). Changes to legislation governing
childbirth bestowed the responsibility of perinatal care entirely on the medical
profession. Childbearing couples were shifted from the home into the hospital
setting for childbirth. The birth process became "medicalized" rather than
"naturalized". During the 1970’s and 1980’s, childbirth intervention through
technology became the focus of medical research activities (Cohen & Estner,
1983). Maternity nurses were challenged to keep abreast of the advancing
technology by concentrating on the more technical skills of invasive caring such as
fetal monitoring (Andreoli & Musser, 1986). Nurses responded to the technical
shifts which focused their care away from the patient by developing the philosophy
of family-centred care. In this way, nurses reinstated their focus of care onto the
patient at the bedside (Meierhoffer, 1992).

Many maternity nurses espouse the philosophy of family-centred care
(Reeder et al., 1992). Family centred care converts the focus of care from the
"individual as client" model of many acute care settings to an "individual within a
family context" model (Minister of National Health and Welfare, 1988). In this way,
all members of childbearing families are cared for in the context of the family, in
whatever form that family context exists (Friedman, 1992).

The frequency with which maternity nurses care for families experiencing
violence is well documented by recent nursing research. In addition to frequency,
studies appear which clarify maternity nurses roles when caring for childbearing
families experiencing internal family adversity (Helton, 1986; Helton et al., 1987;
McFarlane et al., 1992). However, a paucity of research studies exist which assess maternity nurses’ responses to caring for childbearing families experiencing abuse. It is hoped that the completion of this study will add to maternity nurses’ knowledge base of caring for abused families from the perspective of those who have had the experience.

**Maternity Nursing and Domestic Violence**

The nursing role in the care of abusive families has received much research attention. Many nursing research studies were found by this researcher to support the exploration of the phenomenon of maternity nursing and domestic violence.

Nurses have established a pioneering role in research on domestic violence (Bullock et al., 1989; Campbell & Humphreys, 1984; Helton & Snodgrass, 1987; Henderson, 1986; McFarlane, 1992). Positive correlations between domestic violence and pregnancy have appeared frequently in nursing literature (Bohn, 1990; Bullock and McFarlane, 1989; Helton, 1986; Hillard, 1985; Kent, 1989; Parker & McFarlane, 1991). Nurses have investigated the complexities of abusive relationships and their influences on the health of both the mother and fetus. Fagen et al. (1983) found that the prevalence and severity of abuse increased during the pregnancy period, often with tragic results to the unborn fetus. Newton and Hunt’s (1984) study of psychosocial stress in pregnancy and low birth weight demonstrated a significant relationship between life events, low birth weight and prematurity. Bullock and McFarlane’s (1989) study of pregnancy outcomes reported that battered women are two to four times more likely to give birth to low-birth weight infants. Other health risks for both mother and fetus include an increased rate of miscarriage and stillbirth and physical injuries such as blows to
the abdomen and genital areas (Bullock & McFarlane, 1989). These researchers identify the nurse’s unique opportunity for assessment of battering during pregnancy. "Pregnancy provides an optimum time to inform all women about the potential for battering and assess the safety status of each client" (Campbell, 1992 pg. 208). Maternity nurses are in prime positions to establish therapeutic relationships with pregnant women. The hospitalization period provides abused patients and maternity nurses with this opportunity.

**Summary**

In this chapter, the researcher has presented a literature review which has illustrated the challenge that domestic violence poses for the nursing profession and the abused patient. Theoretical and research literature were explored to identify trends in nursing knowledge and to illustrate gaps in nursing discourse. One such gap is the exploration of maternity nurses’ experiences of caring for pregnant women involved in abusive relationships. A better understanding of this phenomenon will enhance nurses’ abilities for assessment and intervention with abused women. A qualitative research approach will encourage participants to discuss their experiences from their own perspective and their own experiences.

In the next chapter, the researcher describes the phenomenological approach to qualitative research and explains the design of the study.
CHAPTER THREE: Methodology

In this chapter, the researcher presents an overview of the key underpinnings of the phenomenological research perspective. A discussion of the sampling process, the criteria for selection and ethical considerations are included. The interview process is described and procedures for analysis of data are outlined.

The Phenomenological Perspective

The purpose of qualitative research is to develop a special understanding of a particular phenomenon, event, or interaction (Locke, Spirudos, & Silverman, 1987). This special understanding comes from talking to participants who have firsthand experience with the phenomenon in question. Since the early 1980’s, nurses have utilized the research method of phenomenology (Anderson, 1989). Phenomenology focuses on the study of the meaning ascribed by the person within the context of the situation. It is an attempt to achieve a sense of the interpretation that an individual gives to that situation (Omery, 1983). The intent of the method is to describe the human experience as it is lived (Oiler, 1983). The focus on the meaning of experience in phenomenology is a focus on human involvement in the world (Munhall & Boyd, 1993). People’s perceptions are presented not as they are thought, but as they are lived. Perceptions of participants become the ‘truth’ the researcher seeks.

Absence of empirical data on topics of interest encourages researchers to employ a phenomenological approach. The phenomenological approach is particularly suited to this study of nurses’ experiences as it permits open exploration of the phenomenon of interest. Nursing-based research is needed to generate knowledge that may ultimately stimulate effective interventions for
Qualitative research can provide such knowledge (Kirby & McKenna, 1989). Phenomenology is a relevant methodology for the examination of this phenomenon as it allows for the collection of rich, contextual data from nurses’ personal experiences. Phenomenology is the research method selected for this study as there seems to be an absence of published nursing research describing maternity nurses’ experiences of caring for abused pregnant women. This study seeks to add to the nursing knowledge base of this phenomenon.

Methodological Criteria

Sampling

The approach to sample selection in phenomenology is known as theoretical sampling. This method is used by researchers to deliberately select all informants according to the theoretical needs of the research (Morse, 1987). The researcher continues to add new informants to the sample until no new ideas emerge from the interview data. Therefore, there is no predetermined sample size. Study participants continue to be added until saturation of data is reached. Munhall and Oiler (1986) identified that saturation is reached when major themes or patterns of data are determined and no new information is added.

Reliability and Validity

Sandelowski (1986) suggests that reliability and validity in qualitative research are attained by examining the data in terms of the following criteria:

1. Truth value refers to determining if the findings are faithful descriptions of lived experience. True understanding of lived experience is attained through exploration of the contextual reality of the participants and encourages development of shared meaning between the interviewer and participants (Merriam,
Sandelowski (1993) described truth value as member validation and states that this type of validation is ongoing throughout the life of a qualitative research project. For this reason, significant statements and themes were validated with the participants in this study;

2. Applicability in terms of fittingness of the data refers to examining interview findings to ensure that the participants' perceptions are accurately reflected. Colaizzi's (1978) procedure for data analysis was used to ensure that the criterion of fittingness is met. Inclusion of verbatim comments extracted from the transcripts also allows the reader to gain understanding of the participants' experience and ascertain the fittingness of the data;

3. Consistency in terms of auditability ensures that another can clearly follow the decision trail of the researcher. Members of the Thesis Committee reviewed the decision trail to ensure clarity. Research participants were involved in validating themes as necessary;

4. Neutrality in terms of freedom from bias was met by bracketing personal ideas and opinions. Valle and King (1978) stated that bracketing is an attempt to suspend one's preconceptions and presuppositions. Bracketing is practised in order to adhere to the rigors required of qualitative research and to attempt to represent phenomenological descriptions based on the perspectives given through the experiences of the participants (Munhall & Boyd, 1993). Bracketing was accomplished by encouraging the participant to guide the interview and by the researcher refraining from any judgements about the content of the participant's discussion.
Selection of Participants

Criteria for Selection

The sample for study was selected according to the following criteria:

1. All participants were maternity nurses employed on antenatal, postpartum, or labour/delivery units of a tertiary acute care maternity hospital.

2. Nurses communicated in English.

3. Nurses agreed to participate in one to three taped interviews with this researcher and were willing to discuss their experiences.

4. The nurses cared for patients whom they knew, or suspected, were involved in abusive relationships. Knowledge (or suspicions) of the abuse must have been present at the time the patient was under care.

Selection Procedure

Approval was obtained from the University of British Columbia Behavioral Sciences Screening Committee and from the Research Approval Committee of the acute care facility where the research was conducted. After these approvals were obtained, recruitment of participants began. Potential participants were informed of the research study by posters placed in prominent areas of nursing stations of the acute care maternity hospital (Appendix D). Telephone contact numbers of this researcher and members of the Thesis committee were identified on the posters. Potential participants contacted this researcher on their own initiative, and meetings were arranged for explanation of the purpose of the study and discussion of eligibility criteria. Once eligibility was established, information letters were distributed (Appendix A), consent forms were signed (Appendix B), and all rights of
the participants were explained. At this point, appointments were made for the interviews themselves.

**Ethical Considerations**

The study participants’ rights were protected in the following manner:

1. Written approval was obtained from the University of British Columbia Office of Research Studies.
2. Written consent was obtained from the Research Approval Committee of the acute care facility where the research was conducted.
3. Written and informed consents were obtained from participants. Consent included permission to audio-tape the interviews (Appendix B).
4. Participants were given written information which summarized the nature of the study, the focus of the data collection, and how confidentiality of the data would be protected (Appendix A).
5. Participants were informed that participation in the study was voluntary. Participants were informed that withdrawal from the study was possible at any point without consequence to employment status.
6. Participants were asked to refrain from identifying any patient, health care provider, or other nurses by name. The participants were informed that their identifies were protected through the use of numerical codes. The coding system was shared only with the Thesis committee members.
7. Audio-tapes and transcribed interviews were kept in the possession of the researcher. Transcripts, or portions of, were shared only with members of the Thesis committee. All audio-tapes were completely erased upon completion of the thesis.
**Interview Process**

Eleven maternity nurses participated in this study. Each of these nurses were interviewed initially in discussions lasting from thirty (30) minutes to ninety (90) minutes. Open-ended semi-structured interview questions were used to guide discussion about nurses’ perceptions of caring for abused pregnant women (Appendix C).

During initial interviews, nurses described patient situations of women involved in abusive relationships. Many clinical examples of nurses’ experience with abused women were given. It was found that many of the first interviews concentrated on nurses’ anecdotes of patients’ situations, and little data was received about the meanings that these situations held for the nurses. Data about patients’ experiences in abusive relationships was obtained. Nurses alluded to their own personal experiences with abuse, and/or how they related to situations that their patients had experienced. Significant statements were assembled from first interviews in preparation for clarification in second interviews. Second interviews allowed for further exploration of issues raised in first interviews.

Eight (8) nurses were interviewed for a second time. During second interviews, nurses embellished their experiences of the patient care situations described in first interviews. Data about nurses’ personal experience with past abusive relationships was obtained. Due to the in-depth nature of the data, second interviews lasted from sixty (60) minutes to one hundred twenty (120) minutes. It was found by this researcher that during these interviews, periods of silence occurred. No attempt was made to fill in the
pauses. It was noted that often following these periods of reflection, particularly significant statements were made.

Third interviews, or validation interviews, were completed with two (2) key participants. These interviews were conducted to validate prevalent themes identified in descriptions of nurses’ experiences of caring for abused patients. It was found that during these interviews, nurses were helpful in clarifying their perceptions of the experience and provided guidance in elucidating the appropriate representative themes. Validation interviews lasted from forty (40) minutes to sixty (60) minutes.

Contact was lost with two of the participants after second interviews because of relocation to distant areas. Two of the participants were pregnant during the first interviews. One of these participants continued in the interview process after her baby was born; the other declined to participate further.

Polit and Hungler (1989) identified that the research environment can exert a powerful influence on a participants’ emotions and behaviour. For this reason, all interviews were carried out in the participants’ homes to ensure a natural and comfortable setting. All interviews were taped and then transcribed verbatim by the researcher to ensure confidentiality of the subject material. Transcripts were studied, and a process of qualitative analysis was undertaken.

**Analysis of Data**

Data was analyzed according to Colaizzi’s (1978) criteria. The following steps were taken:

1. The spoken, written and visualised descriptive data were considered in order to develop an overall feeling and to make sense out of the data;
2. The data were examined and coded to identify and capture significant statements;

3. Meanings of the statements were formulated;

4. The formulated meanings were clustered into themes;

5. The clusters of themes were referred back to the original data in order to validate them with any discrepancies noted;

6. An exhaustive description of the results was developed;

7. Meanings of the description were validated by returning (when possible) to the participants and asking them if the findings reflect their experience;

8. New data that emerged from the validation interviews was integrated into the completed research product.

The researcher returned to the participants throughout the data analysis process for clarification of themes and/or statements. Themes were examined for relationships. The meanings of the participants’ experiences began to form a pattern. This pattern formed the results of the study.

Verbatim quotations of participants’ statements were included in the analysis to exemplify the researcher’s decision trail. This strategy served to ensure faithfulness to the data.

An essential aspect of analysis of data in a qualitative study is sharing reflections about the content of the data with others to clarify one’s thinking. Reflections of the central themes were shared with Thesis committee members. This process facilitated naming and refinement of themes. These themes were then validated for consistency and accuracy with study participants, as research
results were dependent upon shared meaning between researcher and participant (Merriam, 1988).

**Summary**

The qualitative research method of phenomenology was chosen for this study as it is appropriate for determining the essence of the phenomenon as experienced by these nurses. The experiences of maternity nurses caring for abused pregnant women was the phenomenon under question.

In this chapter, the researcher has reviewed the study's design. The interview process was explained, and criteria for qualitative analysis of the data was conveyed. In the next chapter, the researcher will describe the findings of the study.
CHAPTER FOUR: Analysis of Data

In this chapter, the findings which resulted from the data analysis of nurses’ verbal descriptions of their experiences caring for abused pregnant women are presented.

Prior to presenting the results of the data analysis, a brief description of the participants in the study is provided. The description includes the nurses’ ages, gender, and numbers of years experience in nursing, as well as their current area of employment and level of nursing education.

The results of the data analysis are presented in relation to three central, related themes which emerged from analysis of the interviews. These themes capture the essence of the nurses’ experiences of caring for abused pregnant women. The first theme, gaining understanding of patients in abusive situations, is comprised of the sub-themes of: (a) discovering the abuse, (b) reacting to discovery of abuse: uncertainty, and (c) developing relationships. Abusive situations were primarily discovered intuitively as the nurses recognized subtle patient "trigger" behaviours. Subsequently, nurses experienced feelings of uncertainty which greatly influenced the development of nurse-patient relationships.

The second theme, facing the realities: the health care context, emerged from the health care environment in which the nurses provided care to abused women. This second theme is composed of the sub-themes of: (a) identifying the gaps, (b) working with others, and (c) providing nursing care. Gaps in resources identified were within the hospital environment. The gaps in resources were identified as institutional constraints and a lack of in-service education for dealing
with issues of abuse. These gaps were a source of frustration for the nurses as they provided care to abused women. Nurses found support from collaborating with other health care professionals when making or validating patient care decisions. The responses of other health care professionals were found to be both a source of support for the nurses and a source of difficulty. In the provision of care to abused patients, the nurses identified the need to give special attention to their maternity care as well as to provide nursing care which addressed the abuse.

The third theme, struggling within the realities: the subjective context, describes the participants’ personal experiences of caring for abused pregnant women. For many of the nurses, the discovery of abuse and subsequent care of abused women resulted in strong feelings and emotional responses. Many of the participants based their own understanding of abuse on their past personal experiences with abusive relationships. It was discovered that previous experiences with abuse, or lack of experience, clearly influenced nurses’ therapeutic relationships with their abused patients. The principle feelings and responses of the nurses were comprised of: (a) nurses’ conceptualization of abuse; (b) feeling fear; and (c) connecting with the patients, which resulted from the nurses’ personal understanding of abuse.

**Description of Participants**

In this study, interviews were conducted with eleven maternity nurses. All participants were female - no male nurses volunteered. The average age of participants was thirty years; the range was from twenty-five years to forty-five years. All participants were Caucasian.
All volunteers were experienced in the field of maternity nursing. Participants had between two and twelve years of work experience in this area. The average span of work employment was five years. All nurses were employed at one acute, tertiary care maternity hospital. Three of the nurses worked on an Antepartum floor, four were from Labour and Delivery, and four worked on Postpartum units. Education levels of the nurses varied. Five nurses were graduates of diploma programs, six nurses had obtained their Baccalaureate degrees, with one nurse in the process of completing her Master’s Degree in Nursing. One nurse held a Midwifery Certificate.

The marital status of the nurses varied. Two of the nurses lived in common-law relationships, five were single and uninvolved in intimate relationships, three were married, and one was divorced.

Several of the nurses interviewed had direct personal experience with abusive relationships in their past histories, although none admitted to being currently involved in an abusive situation. This and other relevant personal data from the nurses’ past histories will be discussed within the text.

**Gaining Understanding of Patients in Abusive Relationships**

The participants in the study described a process through which they gained a better understanding of the individual patients whom they identified as being in abusive situations. The researcher did not prescribe a definition of an abusive relationship for the nurses. The participants, therefore, could define abusive relationships according to their own understanding. Knowing the patients as individuals was important to the nurses as they provided appropriate nursing care. During initial interactions with the patients, the abusive relationships were
discovered through the use of nurses’ feelings of intuition. For many of the nurses, recognizing some of the trigger behaviours of their patients such as lack of eye contact and unusual interaction between that patients and their partners, was the key to discovering the abuse.

**Discovering the Abuse**

Three possible scenarios unfolded in which nurses described their discovery of their patients’ abuse. Abuse was discovered by some of the nurses as they received their daily shift report on their assigned patients. Secondly, some of the situations were discovered by the nurses themselves after the presence of subtle triggers encouraged detailed assessments as they took over the care of the patients. The third scenario of discovering a patients’ abuse occurred as the patient was admitted to the health care situation. Detailed assessments occurred either at the beginning of the nurses’ shift or during admission of a new patient into the nurses’ care. During their assessments, nurses described their intuitive awareness that "something wasn’t right", and that they used their intuition in the discovery of their patient’s abusive situations. Each participant described a minimum of two to three patient situations that they felt were abusive. Given the number of patient situations discussed, it is estimated that two or more discovery scenarios occurred for each nurse.

**Nursing Reports**

The first discovery scenario occurred as maternity nurses received a detailed report from their nursing colleagues at the commencement of their shift. During this time, for some of the nurses, information was shared verbally about patients’ abusive situations. The nurses acknowledged that the awareness of their patient’s
abuse coloured their impressions of the couple before they met them. Nurses’ feelings of being "guarded" and having a "prejudiced attitude" influenced the formation of their initial reactions. One nurse described that she formed her prejudiced attitude because of her previous personal experience with abusive men, and this influenced her initial behaviour with the couples.

It was documented on the chart that she was abused a week prior to coming into labour, so at 39 weeks gestation she was abused by her husband. I guess the man had beat her up quite badly and thrown her down a flight of stairs. So I kind of went in there with a prejudiced attitude against the couple I was going to be meeting.

I had received a report from the night nurse and she identified that they had a few problems with the couple, mostly the husband. He seemed fine when I walked in, but I was guarded already because of what I had heard in the report.

When discovery of abuse resulted from receiving reports, the nurses identified that they had some warning of the nursing care situation that they were facing. For the most part, the abuse situations were discovered without warning.

**Nurses’ Assessments**

The second scenario of discovering patients’ abusive situations occurred as nurses assumed the care of their maternity patients and completed their own assessments. In these situations, knowledge of the patients’ abuse was not known when care was initiated. One nurse described her discovering her patient’s abuse in the following way:
There were no real factors that alerted us to the fact that she was a victim of violence, we had no social history or anything on this person. This was something that I picked up on after working with [the couple] for a few days.

The third scenario describing the discovery of patients’ abuse also resulted from nurses’ assessments. Discovery of abuse occurred when maternity patients were newly admitted to the health care situation. Nurses described that discovery of abuse in this situation also occurred without warning. Discovery occurred as a result of a thorough nursing assessment that was completed by the nurse assuming primary care of that patient for the duration of that nurses’ shift.

It came out very suddenly, that she was just at that bursting point and someone had shown some kind of interest in her life and from that point on, [her story of abuse] just came flowing out.

As described in the narratives, the discovery of abuse was often an unexpected result of the nurses’ assessments of their maternity patients. Feeling unprepared for the discovery of abuse was a common response of the nurses.

I’m not sure that I really was prepared for the flood of emotions that poured out after my simple question. It came as a surprise to me that she opened up such intimate things so easily to a complete stranger.
It is important to note that each of the nurses described at least one scenario in which they used their intuition to discover their patients’ abuse.

**Using Intuition**

Nurses described their use of intuition as the precursor to discovering some of their patients’ abusive relationships. During the initial phase of the nurse-patient relationship, nurses’ index of suspicions about the presence of abuse was aroused by their feelings of intuition. Intuition was defined in terms of "gut feelings" or having a "sixth sense" about the presence of abuse. One nurse described her feelings of intuition:

> I think it initially starts off as an intuitive thing, just little feelers go out. I just have this gut instinct that these women are in a really bad relationship.

In all cases, nurses observed subtle patient behaviours that they felt were indicative of abuse. Nurses consistently described these behaviours as "triggers" or "cues". Triggers were described as lack of eye contact, patients who appeared withdrawn or demonstrated feelings of low self-esteem, patients who were isolated from family and friends, or patients who flinched when sudden movements were made. One participant described her patients’ subtle behaviours as triggers.

> I can think of three women where I just walked into the room, and they didn’t make eye contact, or if they did, they would talk initially and keep their eyes down and they would look up very quickly, and just the tone of their voice, the way they would answer questions, the way they would be when the partner would be in the room, which was much different than when they were by themselves, just more sort of subtle things like that were the triggers for me.
Some participants described the dynamics of the couples’ relationships, such as unusual interactions between patients and their partners, as triggers. These triggers were characterized as "poor" relationship dynamics where the partner was in control, and when patients were "different" when the partners were not present. The couples’ unusual interactions with each other was described by one nurse in the following way:

It was both my gut feeling and observing the client with her partner and little things she did that were triggers. She didn’t look directly at him, but she would say "I don’t want you to be mad at me". It was her needing constant approval for her talking that sort of tipped something in my mind. It hit me that there was something wrong with that. To me, if someone won’t make eye contact then you wonder why it is that they are doing that.

The nurses identified that using their feelings of intuition was an integral part of discovering their patients’ abuse. The presence of triggers precipitated feelings of intuition which, in turn, encouraged the nurses to explore their patients’ personal relationships and home situations more carefully. The identified triggers were important clues to presence of abusive relationships. Two participants summarized the triggers that initiated their feelings of intuition in the following way:

Sometimes when people would come in, you would get a feeling of...I don’t know just how to describe it, like a gut feeling. I would feel it right down in my stomach that there was something wrong between the couple. There is a friction between them and it would trigger some kind of a feeling about it and you can see the relationship between these people is on edge.
I guess it was the vibes you pick up from the client, things they will and won’t tell you, the way they will or won’t look at you when you are talking about a certain topic. ...so I guess the gut feeling comes for the client herself, and from watching the interaction between her and her partner.

One nurse stood out in her approach to the discovery of her patients’ abusive situations and based her assessments of patients’ abuse solely on her use of intuition. She described how she would orchestrate her actions in order to confirm her patient’s abuse.

Sometimes I would have to actually take the patient with me into the circumcision room and lock the door because that was the only way I could get the patient alone. Then I would ask her about the abuse and just let her talk.

This nurse’s recognition of triggers in the patient’s behaviours was based on her use of intuition and her personal understanding of patients’ needs in abusive situations. This nurse identified that she had had many clinical experiences with abused women and felt comfortable in using direct confrontation with the patients whom she suspected were being abused. She stated:

I got to the point where I would know when I walked into the room that there was some problem with the couples’ relationships, and usually it was because of abuse. I was almost never wrong.

This nurse provided many anecdotes of her unique understanding of abuse throughout the interviews. These unique perspectives are included within the more similar experiences of the rest of the participants. For most of the nurses, the discovery of their patients’ abusive situations resulted in strong feelings and
emotions. Uncertainty was one of the strong feelings which emerged as participants discussed their reactions to discovering the abusive relationships of their patients.

Reacting to Discovery of Abuse: Uncertainty

It was discovered that strong feelings of uncertainty influenced the development of nurse-patient relationships. These feelings of uncertainty emerged in relation to discovering the patients’ abuse and the resulting nursing care decisions, as indicated in the following narratives:

I think there is a lot of uncertainty out there, you are not sure if your intuition [about the abuse] is correct, and you don’t know if you are doing the right thing. You don’t know what the consequences are and that is really a concern, especially if you are not sure that what you are doing is going to help the patient.

I felt really uncomfortable talking to her about this because it was stuff that I really didn’t know very much about. Uncomfortable is a blanket word. I guess I felt uncomfortable about the fact that I couldn’t do anything about the situation that she was in. I guess I felt useless and I couldn’t do anything about it, I really wanted to but I didn’t know how to start.

Intermingled with descriptions of discovering the abusive situations were these nurses’ feelings of uncertainty and feeling "uncomfortable". Uncertainty was related to nurses’ feelings of wanting to support their patients in the best ways possible, but feeling somewhat unprepared as to how best to care for their abused patients. One nurse described her feelings:
I felt very alone and uncertain about how best to proceed with this lady. As a result of feelings of uncertainty, some nurses identified that they did not confirm the presence of abuse, or intervene with abused patients. The following excerpts, which exemplify nurses’ feelings of uncertainty, were extracted from narratives in which nurses described their nursing care. These excerpts chronicle the nurses’ lack of confirmation or intervention with abused patients to whom they provided maternity nursing care.

....it was hard on me I wasn’t sure how I felt about [the abuse].

I never talked about the abuse. I was afraid she would break down, and I knew she didn’t want that.

I didn’t raise the issue about abuse. I wasn’t ready to touch on that topic yet.

I felt completely at sea because I didn’t know how to approach caring for someone who was abused.

These excerpts are descriptions of nurses’ feelings as they discussed the discovery of their patients’ abuse. The significance of these feelings lies in the implications for patient care, particularly for abused patients. These excerpts indicate that these nurses did not address the abuse with their patients, although they knew about it, or suspected it. One nurse summarized her feelings about not addressing the abuse:
So in a sense, you feel like you gypped the patient off, but in a sense, you’ve got to realize that you did all that you could based on what you had. It is important to note that not all the participants addressed the abuse with their patients but steadfastly believed that the abusive relationships existed. Many of the nurses chose to discuss their initial experiences with discovery of maternity patients in abusive situations which they described as being new and unfamiliar in the nurses’ repertoire of nursing experiences. Although these nurses had subsequent experiences with caring for abused women, feelings of uncertainty persisted. Feelings of uncertainty resulted from being unsure of how to proceed in the care of abused women. The nurses identified that they felt that expectations of them as health care professionals were different in the care of abused women than with non-abused patients. One nurse recalled feeling her abused patient care situation was "complex".

I realized that this couple weren’t just your "average Joe" obstetrical patients. I could see that they had stresses in their relationship that went beyond having a baby, and that the situation was more complex. She went on to describe her feelings in relation to this couple.

I had a strong feeling that she was probably being abused, but I wasn’t sure she wanted me to bring up the subject.

Taking cues from the patients sometimes added to nurses’ feelings of uncertainty. The narrative indicated that, for this nurse, she felt that the couple needed "more care" in their complex situation that likely involved abuse. This nurse felt unsure that the couple was ready, or if they even wanted any intervention that would address the abuse.
Nurses’ feelings of uncertainty had an impact on the ways in which they developed their nurse-patient relationships, and their subsequent provision of patient care. As the context of feeling uncertain was further explored, the participants clarified that they felt it was important that the patients not know of their personal feelings.

It’s the not knowing what you can do about the [abuse], and feeling like you can’t do anything except listen. But I really didn’t want her to know how uncomfortable I felt, because it was important that she had a chance to tell her story.

For the participants, personal feelings of uncertainty were shared with nursing peers, healthcare colleagues, and significant others, but not the patients themselves. Not sharing their personal feelings with the patients set the nurses into conflict because of the sensitive nature of the information that the patients were sharing with them.

I think the hardest thing was making the patient know that I valued what she had shared with me, although it made me feel threatened because I felt like I had to do something with it, and I couldn’t let her know how I really felt.

Undercurrent feelings of uncertainty and feeling "threatened" were present for many of the nurses. These feelings formed the context in which interpersonal relationships between patients and nurses were based. These feelings led to one nurse’s description of the conflict she experienced.

It’s that whole inner conflict. You so desperately want to help someone because that is why you went into nursing. You want to help make them all
better but you can't. Yes, it is like an ache, an inner conflict and inner turmoil.

Another nurse described that her undercurrent feelings were related to her perceptions of the boundaries of her nursing role.

I think about what this poor woman had been through and what she had to go home to, and it made me feel angry. You struggle to care for people within the boundaries of nursing, and sometimes you want to go further, but you know that you can't.

For some of the nurses, discovering patients' abuse elicited feelings of uncertainty as they realized the unique needs of these individual patients. More and more, maternity nurses are faced with patients who are experiencing this type of psychological distress. The nurses' perceptions of their abilities to intervene effectively with abused patients resulted in their feelings of prejudice, unpreparedness, and uncertainty. While acknowledging these feelings, the nurses fostered their nurse-patient relationships carefully.

Developing Relationships

Regardless of a patient's culture, language, circumstance or illness, nurses establish relationships with their patients that are, by their nature, responsive to patients' needs. Nurses in this study discussed the importance of carefully developing relationships between themselves and their maternity patients following the discovery of their abuse. Understanding the process of how these nurses developed their relationships with their abused patients is extremely important because coping with patients' pain and psychological distress is inherent in professional nursing practice. Although it is acknowledged that maternity nurses
develop unique relationships with their patients who are not abused, the nurses in this study identified that discovery of their patient’s abuse led them to pay particular attention to fostering these relationships by being non-judgemental, building trust to develop a rapport, gently probing into the patients’ background, and sharing like personal experiences.

**Being Non-Judgemental**

The nurses clearly articulated their convictions that the patients deserved to receive non-judgemental care. Some of the nurses found that their prejudiced attitudes towards the abusing couple made it difficult to be non-judgemental. In order to differentiate their feelings, the nurses chose to build relationships with their patients separately from their partners. These reactions were described.

**Reacting to patients.**

The nurses felt strongly that providing non-judgemental nursing care to their abused patients was the basis for developing relationships with these patients. It seemed important to many of the nurses that their own attitudes and feelings, identified as they discovered the patients’ abusive situations, were not to be communicated to either the patients or their partners. These nurses believed that by appearing non-judgemental about their patients’ situations, they could foster the relationships with their patients and gain a better understanding of the abuse from the patients’ perceptions. This better understanding also fostered nurses’ knowledge of their patients as individuals. When asked about how providing non-judgemental care was unique to the care of abused patients, one nurse answered that providing non-judgmental care meant that the patient received her support and not her opinion.
I can honestly say that [the patient] felt that I was trying to work for her and I was not trying to be judgemental. With her, it was really important to me that she feel supported especially after I knew what had happened to her. She trusted that I was not going to give her my opinion about what she should do.

This narrative illustrates that this nurse’s support for her patient was based on her belief that nursing care should be non-judgemental. Providing non-judgemental care was characterized by one nurse as part of her nursing role.

Whether [their relationship] is right or wrong, that is not my place to be deciding that. So when [abused women] come to the hospital, that is my role to support them, and to listen to them, and to respect what they are saying whether I like it or not.

This nurse talked at length about her need to give non-judgemental care to abused women. She reiterated her beliefs in the following narrative:

I just see myself in a supportive role no matter what [the patients] do, but I don’t give my opinion any more. I share my concern more than I used to.

The above narratives illustrate that these nurses felt the need to provide non-judgemental care to patients in abusive situations despite the presence of their own attitudes and feelings about abuse. All nurses, including those who addressed the abuse with their patients and those who did not, concurred with the belief that the patients deserved to be treated in a non-judgemental way. However, reactions to partners known to be abusive posed difficulty for the nurses in their attempts to be non-judgemental.
Reacting to partners.

Nurses identified that prejudiced attitudes against the partners negatively influenced their relationships with these men. They described how they tried being non-judgemental in their reactions to the patients’ partners. Contrary to their personal feelings, many of the nurses went out of their way to include the partners in the developing relationships with the patients.

I really tried to be non-judgemental and I tried to include him, but it was really hard for me to like him because of the way he presented himself. For this nurse, her attempts to be non-judgemental with her patients’ partner prevented her from articulating her true feelings about his presence in the nursing care situation. She identified that her motivation for being non-judgemental was to best support her patient and not cause undue tension and strain in the developing relationship. When asked to explain why it was important that she avoid undue tension with her patient, she answered:

She was the kind of patient you wanted to walk up to and give a hug and say it’s going to be alright. But the best thing I could do was offer unconditional, non-judgemental care and try to include her jerk of a husband because she wanted him there.

The focus of this nurse’s concern was her developing relationship with the patient. Her commitment to providing non-judgemental care outweighed her negative feelings for her patient’s partner. Another nurse was convinced that her patient’s right to non-judgemental care outweighed her right to be judgemental of her patient’s partner.
I was trying my best to be non-judgemental. Perhaps that is why I tried so hard to get him involved. I was really concerned about her, and she needed my help in so many other ways. So I didn’t want to rock the boat with her and she had already been through enough.

As is illustrated by the narratives, the participant’s motivation for being non-judgemental when developing relationships and providing care to abused patients and their partners was based on their perceptions of the patients’ needs for this type of support. Nurses further developed their nurse-patient relationships by fostering trust and rapport with the patients and respecting their patients’ personal boundaries.

**Building Trust**

Many of the participants perceived that timing was important in the development of nurse-patient relationships. The nurses felt they wanted to build a trust with the patients prior to intervening in the sensitive areas of the abuse. The developing nurse-patient relationships were based on nurses’ "sense" of the patients’ needs for trust.

If I sensed [the abuse] then I would really work hard on developing at least a little bit of trust with this woman so at least she would feel a little bit comfortable. And if there was something that would come up, then we have a bit of a base.

Developing trusting relationships with abused patients was recognized by the participants as important for establishing the patients’ priorities for care. The following narrative illustrates one nurse’s efforts to build trust with her patient in order to demonstrate her commitment to establishing a therapeutic relationship.
Although I never actually told her, I wanted to create an openness with her to let her know that if she ever wanted to talk, that I was there. I really wanted to show her that it was a non-judgemental thing, that if she chose to open up to me that it was okay.

Nurses worked on developing trust by getting to know their patients, thus gaining a better understanding of the patients as individuals in difficult situations. Building trust within their relationships assisted the nurses to decrease their feelings of uncertainty because they were able to base nursing care decisions on individualized patients’ needs. The nurses were also better able to help the patients by encouraging them to talk about their situations. Nurses identified they respected the patients’ personal boundaries, as illustrated by the following narratives.

…on one hand, I wanted to respect the wall she had put up, but on the other hand, I felt there was a lot underlying it. I thought she might have needed someone to talk to and I wanted to be there for her.

I find the most important thing is respecting the woman’s boundaries and helping her to feel that she is in control and is making decisions when she is ready.

Developing therapeutic relationships with abused women was strongly associated with building trust and rapport with the patients, as indicated in this narrative:

[Abuse] is such an intimate problem that you need to build up trusting relationships in order for the [patients] to open up to you, and for them to really believe that you care, and are there willing to help.
Respecting the patients’ boundaries was a key factor in developing therapeutic relationships and cultivating a sense of trust with the patients. In the above narratives, the nurses described how they built trust by respecting their patients’ personal boundaries with the intention of helping them to provide the best care and support to their abused patients.

**Gentle Probing**

In furthering their relationships with abused women, nurses explained how they also used gentle probing to ask questions about the patients’ relationships with their partners. Questions asked about the abusive situations often focused on patients’ backgrounds and past histories. Nurses identified that probing into the patient’s past helped them to gain a better understanding of the patient’s abusive situation.

With someone who hasn’t got an identified problem, I probably wouldn’t be trying to find out who is her extended family and what kind of life she led and what kind of childhood she had, but those things were interesting to me because I wanted to see what kind of history she came from and what kind of history he comes from too. It helps me to sort out in my own mind how these things happen.

Gentle probing and questioning the patients about their backgrounds often resulted in the nurses receiving further disclosures about patients’ abuse. One nurse observed that many of her abused patients broke down and talked about the abuse after being asked open ended questions about their home situations.

I said "you look like you are afraid to go home, what is it going to be like for you when you go home?", and she started to cry. Then she opened up and
said she was afraid to go home and she didn’t know what she was going to do.

In addition to asking probing questions, nurses used active listening when patients responded to their questions. The following narrative illustrates this:

I saw listening to her as part of my role as her nurse because I spent lots of time with her and probably had a lot better chance of finding out information in general by letting her talk about her family and friends. She also told me about the physical environment that she was going home to so I got a good perspective on her home life.

Receiving abuse disclosures and further explorations of abusive situations was difficult for many of the nurses. Although nurses expected to receive answers to their probing questions, some responded to their patients’ disclosures with feelings of distress. One participant summarized her response in the following way:

I knew when I asked her the questions that there was more going on, but I really did go through a whole gamut of emotions with them after she told me all about [the abuse]. I had to think about it, and sort out it out in my head how I really felt.

Further knowledge about patients’ abusive situations was acquired by asking probing questions as the nurses developed the trusting relationships with their patients. As a result, nurses’ understanding of the patients in abusive situations increased. For some of these nurses, the developing relationships with their abused patients resulted in the nurses’ sharing their own experiences of abuse.
Sharing

Many of the nurses acknowledged personal experiences with abuse in their own pasts. The developing relationships between nurses and patients were strongly influenced by the presence of nurses’ past experiences with abuse. Although the influences of past experiences are explored more fully later in this text, the sharing of abuse experiences with patients clearly affected the developing relationships. One participant described her experiences of sharing her own abuse with her patients.

After what I’ve been through, I can support them in a much more effective way and I don’t need to share a lot. The less I share and the way that I say it is just as effective than if I go into this big story about my own abuse. I feel I can help them. I enjoy taking care of these women.

Another nurse with personal experience of abuse offered this narrative about sharing her experiences with her patients.

Yes, I have been abused, and yes, I let this person do this to me, but if you are sharing instead of talking at someone, if you are sharing experiences, and you really do understand what they are saying, you can be empathic because you’ve been there and you can really understand.

Sharing experiences with patients was one way in which some of the nurses developed relationships their patients. One nurse shared her own experience of feeling the emotional and psychological pain that comes with being abused. She stated:
I find it easy to identify with these women and the different stages that they are in. I think that going through a lot of emotional pain yourself, you can identify and see that in other people.

By sharing experiences with their patients, the nurses felt they "received some credibility" in the eyes of their patients when asking probing questions about the patients’ abuse. The nurses identified that sharing of experiences led to greater trust in the nurse-patient relationships.

Few of the nurses felt comfortable sharing past experiences of abuse with their patients. Only one nurse described that she regularly shared her experiences of her own abuse with her patients because she found it a useful strategy for building trust and establishing relationships with her patients. Although not all nurses had experiences with abuse to share with their patients, the common theme identified by the nurses was their commitment to carefully developing relationships with their abused patients. Many nurse-patient relationships were developed under the stress of nurses’ feelings of uncertainty. Nevertheless, nurses’ struggled to protect their patients from their uncertainty by being non-judgemental as their relationships evolved. Being non-judgemental with the patients’ partners was found to be more difficult for the nurses, although they confessed that the desired results of their efforts were focused on establishing trust with their abused patients.

Building trust and rapport was achieved by attempting to respect the patients’ personal boundaries and spending time with the patients. Gentle probing questions were also used as a strategy for developing relationships with patients. The questions were intended by the nurses to assist them in gaining understanding of the patients and the extent of their abusive situations. For some of the nurses,
asking about the patients’ abuse led them to share their own abuse experiences. Sharing experiences resulted in stronger, interpersonal relationships with their patients. For the nurses without personal experience with abuse, relationships were developed through the other strategies described in the narratives.

The participants outlined their process of gaining understanding of their patients in abusive relationships through discovering their abuse and developing the relationships. An understanding of the patients obviously influenced the provision of nursing care. The nurses also discussed the difficulties of nursing abused women from within the context of the health care system.

**Facing the Realities: The Health Care Context**

The experiences of the maternity nurses in this study were greatly influenced by the external constraints of the health care system. The health care resources available to assist the nurses as they cared for their abused patients were the cause of much discussion. Three main themes depict the realities of providing care within the existing health care as system described by the participants: identifying the gaps, working with others, and providing nursing care.

**Identifying the Gaps**

As the participants provided nursing care to their abused patients, they attempted to access additional health care resources to assist them in their care. Many nurses identified the existence of institutional constraints as well as gaps in educational resources. These gaps hampered nurses’ attempts to provide comprehensive care to their abused patients. The nurses felt frustration as a result of inadequate supportive resources to assist them in helping the abused women.
Institutional Constraints

As the participants identified the gaps in available resources, they described the limited support to address abuse they felt from the institution. All nurses were employed in the same institution. One nurse described her frustration at not having access to what she identified as "necessary" infrastructure.

As far as the hospital doing anything specific, I think it doesn’t exist. We are out there on our own, and I find it really frustrating when we identify something like abuse and there isn’t any resources that we can access that will help to tell us what to do. It is a big problem and [the hospital] needs to provide us with some necessary resources to help these women.

As illustrated in the narrative, this nurse’s frustration with the lack of resources was evident. Frustration with the lack of resources was a consistent lament of the nurses. One nurse commented:

I really felt that I was on my own with this woman. It was really frustrating knowing that she needed help, and that there wasn’t much that I could offer her in the way of support from the hospital.

Many participants felt that it was the hospital’s responsibility for providing the institutional support to assist them in providing better care for these women in difficulty. None of the nurses felt that they had a role in ensuring that these supportive resources be implemented, nor did they see that they could raise awareness of the need for these type of services. This theme of wanting support was illustrated as nurses expressed their desires for written guidelines or policies to support them in their nursing roles. One participant discussed the need for institutional support for nurses to fulfil their roles more effectively.
There is nowhere in the Policy and Procedure Manual for us to look up under "abused patient" to help us, or to guide us, and tell us what to do when we find out about these patients. Clinical guidelines were desired by nurses to provide direction as they discovered their patients' abuse. Again the nurses did not discuss that they could participate in the development of guidelines. Because no mention of helping to write the guidelines was made, it is unclear to the researcher if the nurses wanted, or were willing to take part in guideline development, if given the opportunity. However, the nurses clearly felt that their roles in caring for abused patients would be made easier by direction from written guidelines.

I've never been one to promote paper pushing but I definitely think that when you are dealing with something like abuse, having written guidelines would help us to pick up more of these ladies, and give us some ideas about what we can do.

Nurses expressed their ideas about other desired resources such as information packets for patients, or resources packages for nurses.

I've been pushing for a long time for Community Awareness Resources package for postpartum nurses. We need to know what resources are out there and we need to know that we can access them, as opposed to relying on the Community Health nurse.

I think we need information packets, something right on the ward, or on our information board. If there is something on abuse written there, the patients will know that they can at least talk about it, or pick up a pamphlet for later.
Another nurse discussed her ideas about the need for information packets to assist nurses in the care of abused patients. She saw that the need for current, available information was a strong indicator of the lack of institutional support for nurses caring for patients with abusive situations.

How do they expect us to try to help these ladies when we don’t even have a pamphlet that we can hand them. Even if there was just a phone number for them to call, it would be better than what we have now, which is nothing. The hospital really needs to get its act together about this issue because its the nurses that are doing all the work, and we need help.

Institutional constraints were a reality faced by the nurses in the provision of care to abused women. However, the health care context of the hospital itself was identified as generally supportive in other areas such as staffing ratios and patient care autonomy. When asked to describe her views of working as a nurse in this acute care institution, one nurse articulated:

I think in general we have a lot of latitude when we care for our patients. I don’t feel that there is someone breathing down my neck, and we are able to develop really strong relationships with our patients because we have good patient ratios. I think it helps us to pick up on the psychosocial stuff because we aren’t run off our feet.

Institutional support comprised an important component of the health care context. The nurses felt there was some support from the institution, but there was also gaps in the resources for abuse care. Nurses identification of these gaps in institutional support led to discussions of gaps in other resources. As participants
discussed desired resources, the lack of in-service education for nurses was identified.

Lack of In-service Education

Nurses’ desire for in-service education or training in the area of domestic violence was identified. Most of the participants identified their frustration at feeling inadequately prepared to deal with the issues of abuse in their patients because of lack of education. One nurse articulated her wish to have in-services on the issues of abuse.

We have in-services on death and dying so I think it would be good to have someone come in to talk about abuse, even the signs and symptoms of abuse to look for. It would be nice to be able to pick [the abuse] up consistently.

The nurses believed it was the responsibility of their institution to provide in-service education. Surprisingly, none of the participants discussed the possibility of attending continuing education programs on domestic violence of their own accord. The nurses externalized the responsibility for formal education on the issues of abuse and there was no evidence that they felt any need to be proactive in meeting their own learning needs. In most situations, they identified feeling unprepared to deal with their abused patients because they lacked education. One nurse expressed her thoughts:

I know I would definitely like to learn a lot more about [abuse]. I feel inadequate and I’ve tried to help them, but I think I could learn a lot more about abuse and the signs that you are to look for. I feel like I get to a
certain level and then I don’t know where to go from there and I want to learn more about how to do that.

Wanting education on the issues of domestic violence stemmed from the identified gaps in resources available to the nurses. As with the development of clinical guidelines, the nurses did not assume any personal responsibility for educating and preparing themselves for dealing with abused patients. The nurses felt that it was the responsibility of the hospital to provide the education necessary to facilitate effective assessments of abused patients. There was no evidence of nurses’ convictions about life-long learning.

A second gap identified by the nurses was their desire for clinical guidelines or policies of care for abused women. These gaps in resources created some of the difficulties nurses experienced when providing care to abused women within the health care context. In spite of these gaps, there were some supportive resources available within the health care context. The nurses used the resources available to them to provide patient care to abused women. They discussed that having supportive resources had a positive impact on their nursing care of abused women.

Working with Others

Supportive resources described by nurses primarily included their nursing peers and health care colleagues. Nurses found that the support of colleagues was helpful when providing nursing care to abused patients and coping with their resulting feelings. Utilizing the support of significant others at home was identified by some nurses as helpful for coping with their feelings after caring for an abused woman. The consistent theme identified by the participants when working with
others in the health care environment was the strategy of talking about their experiences.

Talking About Experiences

The participants discussed the importance of talking about their nurse-patient relationships that involved abusive situations. Talking about experiences occurred either as the nurses were still involved with the patients or after the relationships were terminated. One nurse talked extensively of the benefits that she perceived from being able to talk with her peers about her nursing care of abused women. This nurse identified that discussing her feelings helped her to prepare for dealing with other abused women.

So what makes the difference for me was to be able to talk about [the abuse] with my friends at work and identify my feelings around the issues that came up. This helps me so that next time I find myself in a situation where I am caring for an abused woman, I will feel better prepared for it.

Other participants identified that talking to nursing peers was a source of support and wisdom for their patient care efforts. The benefits of sharing knowledge about peers’ experiences with abused women were identified. Two participants offered their views of the importance of talking about experiences:

…and [your peers] can help you think things through because they have dealt with similar situations. You need support because you may change your ideas, and maybe you can help [the patient], but you don’t act on it because you aren’t sure.

..........................................................
Even though you talk to your work mates, you are still making the decision by yourself; the decision of whether or not you are going to investigate your gut feelings, and talk to your patient about these things. Even if you are, you should go to your work mates and say "this is what I’ve found and this is what I’m going to do" and they say "have you thought about this", and help you to think about what you are going to say. I find that really helpful.

Some of the participants found that timely support for talking about their experiences with patients in abusive situations was not always available when they needed it. Some of the nurses found that not talking about their feelings while at work meant they went home with their feelings unrecognized.

It’s nice to debrief and bounce things off one another to keep your head above water. But I think it would be nice if your co-workers would say "that was a difficult case, you did a good job". But sometimes you just end up going home before anyone says anything because you’ve all had a hard day.

Talking about demanding nursing care experiences occurred at home for some of the participants. Nurses discussed how they utilized the support of their significant others to cope with their feelings experienced in the care of abused women. One nurse identified that she felt lucky to have someone at home with whom she could talk over her experiences.

I am very lucky that I have some one at home who I can talk to about my work. There are many girls that live alone, and I know they find it hard to go home to an empty house after some of the situations that we’ve had to deal with.
The value associated with talking about experiences was reiterated by many of the participants. Nursing peers and significant others were a strong support for personal feelings. Nurses also identified the value of colleagues’ input when making nursing decisions about the care of abused women.

**Collaborating with Colleagues**

Another theme which involved nurses’ working with others was collaborating with colleagues. The nurses described both the benefits and difficulties of collaborating with their health care colleagues as they carried out their nursing duties with abused patients. In this context, health care colleagues included nursing peers, social workers and physicians.

**Relationships with peers.**

The participants described that working with nursing peers helped them to cope with their nurse-patient relationships, and that peers were supportive of their own needs for guidance.

I say, if you decided to do something to help your [abused patient], there is support out there. You have to make the effort to say "I think that we should do this" and your colleagues will make the effort at that point, but you need to direct your support into what you need. All of us can relate to dealing with difficult patients or an uncomfortable situation.

Collaborating with peers in the nursing care of abused patients took on varying forms for the participants. One nurse described how she would coordinate her nursing care with other staff members so that she could spend time with her abused patient.
I ask my co-workers to help with my patient load so that I can spend time with this woman and give her my attention.

While nurses talked with their peers in order to debrief about their personal feelings, they also collaborated to achieve support for their decision-making in regards to patient care. One nurse expressed that the input of other members of the health care team was supportive of her nursing care of the patient.

It really helps when there are others around to share in the care of an abused patient, then it isn’t so trying on one person. It is up to us to pick up on a certain amount of these women’s care, and then someone else helps from there, so its not you doing all the problems on your own.

Another nurse described collaborating with peers as sharing information with those who were directly involved in the patient’s care.

I would share my concerns with other people who were relieving me for breaks and the charge nurse. Also if I was the one to give report to the postpartum floor, definitely I would tell them about what I had observed.

Relationships with social workers.

In addition to sharing information with nursing peers, the participants identified the supportive resources of the social workers. Referrals to social workers were the most common referrals made by the nurses. Given the sensitive nature of the reason for referral, the nurses generally consulted with the patients, and discussed their reasons for referring the patients to the social worker.

I ask the patient if she feels comfortable if I share the information and discuss it with the social worker and I would say something like "this is
really important information about you and your baby, and I really want you to feel supported and have some people helping you to make decisions."

Collaborating with social workers was generally viewed as supportive of meeting the patients’ needs. Nurses identified feeling confident about the support for the patients when they referred to the social workers. The nurses felt good about their intervention of referring the patients due to their confidence in their social work colleagues.

Well we do have some excellent people that we can refer to. I think that social workers are quite excellent with that and I think they are experts in the field of dysfunctional situations.

As well as support from peers and social workers, nurses discussed support for abused patients from physicians.

**Relationships with physicians.**

Many of the nurses felt they had developed a good rapport with the physicians, both with the general practitioners and the obstetricians that have their practice in the acute care maternity hospital. Good working relationships with physicians was an important factor in attaining support for the nurses’ clinical decisions.

I usually find that the better I know the doctor, the easier it is for me to get his or her support for my suggestions about patient care. From their perspective, too, they feel better when they know, and can trust your judgement as a nurse.

As the nurses described their attempts to access the support of the patients’ physicians, either for confirmation of the presence of abuse or for assistance with
referral of the patients to other health care resources, they recounted their surprise at situations where physicians were reluctant to include themselves in patient care planning.

I finally got a hold of the physician so I could tell him of my suspicions of the patients’ abuse. I was really surprised when he just accepted the situation, and asked me what I was going to do about it. He seemed happy to let someone else intervene, and told me to go ahead with what I thought was best for this woman.

Physicians’ reluctance to get involved when consulted about suspicions of their patients’ abuse was a consistent finding. Even the physicians that the nurses felt were "patient advocates" seemed unwilling to get involved. Again, the nurses reiterated their convictions that the success of the nurse-physician interactions depended upon their having developed good working relationships.

In my experience, I find that the doctors who come to [the hospital] a lot are more willing to listen to the nurses when they ask for Doctors’ orders. I think it is because they know the nurses better...especially when it comes to [dealing with] something like abuse.

It was speculated by some of the participants that lack of knowledge on the part of the physicians was the problem. This participant described her experience with one of the physicians whom she considered to be a strong patient advocate.

My experience with this physician is that he is always there for his patients. I was really surprised when I found he wasn’t willing to get involved with any of the abuse stuff. I don’t think that most physicians know what to do, so they don’t want to get involved.
Even when the patients were in the hospital setting, the nurses found that the physicians were reluctant to get involved.

It was never picked up on or acted on in the hospital because the doctors were in and out the room constantly and nobody addressed that. It was like nobody wanted to get involved.

Physicians not wanting to get involved in the care of abused women had implications for the nurses providing care to these patients. Nurses identified their need for knowledge of resources that could be accessed without referral from physicians. One nurse identified a resource that she had learned about through her work in the community.

I just happened to learn of a place called WestCoast Perinatal where, as a staff nurse anywhere, you can phone this group and say "listen, this is what I’ve got, can you follow up on it?", and there is no health care professional. What I mean is that you don’t need a Doctor to do that. We need to know about more places like that.

Although the participants were frustrated with the physicians lack of support, they saw this as outside of their control. They felt they needed to be able to intervene with these women by working with other available resources and providing options outside the realm of physician referral. The gaps in physicians’ knowledge, and their own willingness to get involved in the care of abused women, were acknowledged as beyond the scope of nurses’ practice.

We have to be accountable and responsible for our own nursing care, and if the physicians are not willing to get involved, then we can’t be the ones to
educate them. We can only do our little bit while we have the patients on the ward, but it would be better if we could all work together.

Collaborating with health care colleagues was summarized by one participant as she acknowledged difficulties experienced by nurses who were involved with care of patients in abusive situation. She referred to the needs for multi-disciplinary services given the complex nature of the supports required.

We have to be able to help the nurses while they are dealing with people who are known to have a dysfunctional relationship. We need to realize that they are going to be exhausted, they are going to need to reach out physically to these people, they are going to need to do extra documentation, because there is always the legal aspect on this, and they are going to have to call in other support services that we have, and that includes social work, the physician and even the police.

The legal aspects of care were not generally discussed by the participants, although the possibility of police involvement was considered by some. The need to approach abused patients’ care from a multi-disciplinary perspective was implied, although these exact words were not stated by the nurses. Overall, the nurses viewed supportive collaboration as strongly shared between their nursing peers and the social workers. The physicians were not included in the list of supportive resources, and this was acknowledged as a source of difficulty for the nurses. The nurses expressed their beliefs that good working relationships that were based on mutual respect for clinical judgement were essential for obtaining their requests for Doctors’ orders.
The participants in this study provided nursing care to abused women within the health care context of an acute, tertiary care maternity hospital. This hospital lacked the necessary resources needed by nurses to deliver comprehensive nursing care to abused women. The existence of gaps in institutional and educational resources was frustrating for the participants. Support was obtained for both clinical decisions and personal feelings from significant others, nursing peers, and health care colleagues such as social workers.

Nurses provided care within the context of the health care system. The nursing care and the necessary adaptations to care for abused women are discussed from within the health care context.

**Providing Nursing Care**

One of the central ways in which nurses enact their professional roles is through the provision of nursing care to their patients. As in every nursing care setting, including the maternity setting, the situational demands often necessitate that nurses respond to patients promptly and with knowledge and skill based on clinical experience. As discussed in the literature review, maternity nurses provide care based primarily on frequent observations and assessments of patients’ physical and psychological adaptations to their maternity care situations, whether in the labour and delivery, antepartum, or post-partum units. Unique or unusual patient situations require that nurses adapt their "usual" repertoire of care behaviours to meet the needs of individual patients. As nurses’ knowledge of the clinical abuse situations described for this study became clearer, they applied this understanding in the provision of appropriate nursing care.
The nurses recognized that their patients required maternity nursing care as well as nursing care which addressed the abuse. The nurses had to adapt their maternity nursing care in order to meet the special needs of their abused maternity patients. Adaptations to nursing care were described as special attention to maternity care, abuse care, and holistic care.

**Special Attention to Maternity Care**

Nursing an abused maternity patient required that the nurses adapt their maternity care while acknowledging the unique needs of the abused women. This specialized care was described as maternity care which focused on supporting the patients’ self-esteem and need for self-confidence.

I spent a tremendous amount of time, mostly helping her with breast-feeding and trying to raise her self-esteem, and trying to encourage her and telling her that she could do this by herself.

I tried to reinforce the baby behaviours with her, and the bonding with her baby because these women don’t have much confidence, and that is one thing for us to do is to foster that self-confidence.

Also included in specialized maternity care was the provision of comfort care. One nurse clearly described the changes to her nursing care as she tried to meet the needs of her abused patient.

So I tried to do little things for her. I know we aren’t supposed to do this, but I ran a bit of a bubble bath for her to make her bottom feel better. I also put a flannel sheet on her bed so it was more comfortable and made sure her curtains were open so she didn’t feel isolated in her dark room.
Making the patient physically comfortable was addressed by some of the participants as part of the special attention they provided in the care of abused women. These nurses felt that the abused women had had enough unhappiness and discomfort in their lives. By providing care that made the patients physically comfortable, the nurses felt they were "doing something" to help the patients. The nurses indicated that they overcompensated in their attempts to provide extra attention to these women. Although the nurses provided this comfort care to abused patients, they also acknowledged this was not unique to the care of this patient population.

Don’t get me wrong, I do try my best to make all my patients as comfortable as I can, but I just felt that I wanted to try to do something extra for this woman because she seemed to be hurting in so many different ways.

Their emphasis on the importance of providing specialized maternity care to abused women was based on nurses’ perceptions of the patients’ needs. These needs included supporting the patients’ self-esteem, building confidence in their abilities to provide baby care, and physical comfort care. The role of maternity nurses is to provide specific, individual care to non-abused women. However, as described in the narratives, the participants differentiated the nursing care they provided as trying to specifically meet the needs of their abused patients.

**Abuse Care**

Abuse care was described by the nurses as interventions that directly addressed the patients’ abusive relationships. Abuse care included providing the women with resource options and crisis information, active listening about the
abusive relationships, and assessing the safety of both abused women and their babies. One nurse described her intervention which included an explicit safety plan:

I’ve been really specific and told women that said they honestly couldn’t leave that this is what they need to do. "You need an extra set of keys, you should keep them outside the house, you should have some money in your car or with a friend that you trust, you should have a bag packed somewhere either at a friends’ house or in your car". You do all of these things with these women because you have to be realistic, and you know [the abuse] is going to happen again.

This participant was really clear in her approach to intervention with abused women. Most of the participants were not as able to provide their patients with such explicit instructions as the safety plan. Most of the participants who provided abuse care chose to focus their interventions on active listening and providing women with initial exploration of resource options.

If a woman was openly discussing the abuse, then I saw my role as sitting down and listening to her and identifying her main concerns, and the things that were important to her at that point. Then I might try to get her to say what she thinks she would like to do next.

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I found myself wanting to play a role in addressing the abuse with her because it was me who had started developing the rapport. I wanted her to know that she wasn’t alone, and that if she wanted to find out some of her options, and get some resources, that I was going to be there to help her.
Abuse care included addressing nurses’ concern for the newborn babies and any other children at home that would be affected by the abusive relationship. One nurse focused her abuse care on assessing for the safety of a baby that was going home to the abusive situation.

I felt worried about the baby and asked if she had thought about his safety. She said she knew he would never hit him, but I knew as soon as she left that I was going to phone Community Health to get an early follow-up.

Another participant indicated her concern for the baby in an abusive situation. I worried about the baby, like I was protective of the baby, but I knew that I couldn’t just take this child from him; it was his daughter.

Abuse care included referral to other health care professionals such as community health nurses, physicians, and social workers. Providing care within the health care system was found to be a major theme contributing to the nurses’ experiences of caring for abused women. Referral to health care professionals was addressed within that context.

Nursing care was rendered by both the special attention to care provided to abused women, and through directly related abuse care. The differentiation of these two focuses for nursing care led some of the nurses to consider the need for a holistic type of care.

Holistic Care

The participants discussed the need to integrate maternity care with abuse care when nursing abused women. In order to address the complex needs of these patients, nurses addressed the integration in terms of providing total care, or holistic care. Nurses saw that caring for abused patients provided opportunities to
meet patients’ total needs on both physical and psychological levels. One participant contributed a particularly poignant narrative illustrating this:

It is very rewarding when you have helped somebody fully. You have taken care of their physical needs and their emotional needs, and you go home feeling like "I helped someone today".

Another participant described a similar interpretation of the need to address abused patients’ needs from a holistic perspective:

We need to learn a lot more about abuse and about abusive relationships, and about difficult pasts. All of these things totally affect who we are as people and who our patients are as people. Until we learn to care for people from a holistic perspective, we will always separate their uterus from their minds. We are not meeting our patients’ needs when we do that.

The need to address patient care from a holistic perspective was expressed by this participant as nurses’ responsibility.

Nursing has to take responsibility for helping women to deal with their issues because we have so much interaction with these women. We have to work through our whole feelings about "what do I do with this information" and "I can’t deal with this". We have to recognize women from a holistic perspective and provide responsive care to help them meet their needs and not our own.

One nurse articulated her ambition that the provision of holistic care happen on a comprehensive level, particularly when caring for abused women.

I see that we aren’t those humanistic, holistic people that touch and feel and sense and smell. So I see that if we got back to that type of care, I’m sure
that we would be better able to appreciate [abused women’s] psychological needs as well as their physical needs.

The need for total, or holistic, care for abused women was addressed by many of the nurses in recognition of the complex needs of this patient population. The desire to provide holistic care was seen as the best way to address both the physical and psychological needs of abused women. The nurses also believed that changes to the health care context would need to occur so that supports would be in place to provide the necessary follow up treatment for these abusive families.

For the participants, a major part of their nursing care was spent meeting, or attempting to meet, the special needs of their maternity patients involved in abusive relationships. Addressing the abuse directly and fostering their patients’ self-esteem through baby care were two ways nurses provided nursing care. Nurses in this study recognized the need to integrate maternity care and abuse care in order to holistically meet the physical and emotional needs of abused patients.

For the nurses, understanding their patients in abusive relationships was coupled with the reality of providing nursing care within the health care system. All of the participants provided care within the same health care context as all nurses were employed at the same acute care institution. The realities of providing care within the health care system were explored with the participants.

As nurses explored the circumstances from which nursing care was delivered, another major theme emerged. Nurses provided nursing care from their own subjective contexts, which was derived from their own personal feelings and responses to caring for abused pregnant women.
Struggling Within the Realities: The Subjective Context

The participants in the study held certain beliefs which influenced the ways in which they saw and interpreted the world around them. This included their personal beliefs about abuse and abusive relationships. Due to the variations in nurses’ beliefs about abuse, the ways in which maternity nursing care for abused women was carried out varied.

Throughout the narratives, nurses interjected their personal feelings and emotions within their nursing care descriptions of abused women. As those feelings and emotions were examined, there emerged a subjective context from which nursing care was delivered. The subjective context varied among participants because it was based on personal or individual understanding of abuse and abusive relationships. These varied subjective contexts encompassed the nurses’ innermost, personal values and reflections upon which they provided their nursing care.

Nurses’ Conceptualization of Abuse

Each of the participants had a different conceptualization of abuse which became evident as they each discussed their personal experiences. Of the eleven participants, seven identified personal experiences with abuse. These experiences included physical abuse in the family of origin; date rape as a teenager; spousal abuse, including during pregnancy; sexual abuse as a child; child witness of wife abuse carried out by the participant’s father; and emotional abuse by a significant other. Two of the eleven nurses described their experiences with abuse of a close friend in a physically abusive relationship and that their personal lives were
influenced by the violence. The remaining two of the eleven nurses described a lack of awareness of personal experience with abuse.

The nurses drew on their past experiences with abuse within the context of delivering care to abused patients. Throughout the data, nurses recounted situations where they provided care to their abused patients and outwardly seemed to take these care experiences in their stride. However, the true personal experiences of the participants surfaced during the individual descriptions of nursing care. Nurses’ personal feelings resulted in difficulties when caring for abused patients. These difficulties resulted in personal struggles for the nurses.

The subjective context revealed a new dimension of the nurses’ experiences of caring for abused women. The subjective contexts were based on two principal personal emotional reactions experienced in response to the nursing care of abused women. These two reactions included feeling fear and connecting with the patients.

Feeling Fear

In conjunction with feelings of uncertainty, nurses experienced feeling fear when engaged in the nursing care of abused women. Fear was a multi-faceted feeling comprised of fear of making a mistake about the presence of abuse and fear of upsetting the patients. These feelings were clearly described by two of the participants in the following narratives:

I guess being the one to open up the can of worms is what our biggest fear is. You also fear upsetting them or asking the wrong thing or asking too much that they are not ready to divulge yet.

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I guess the fear is that the patient will get really upset and then we will have to deal with that.

For one of the nurses, the fear of making a mistake about her patients' abuse was such that she identified a need to withdraw from the patient care situation while she dealt with her feelings.

Once you feel you are on guard yourself, because you feel you made a mistake or if you have done something that made you feel uncomfortable, you tend to withdraw. I felt that need a couple of times as I was involved in [the patients' abuse] situation.

Fear of making a mistake about the presence of abuse was explored with the participants. The nurses reiterated that discovering a patients' abusive situation was usually an unexpected result of completing a comprehensive assessment of a maternity patient. The nurses also contended that it was the presence of triggers, and their own feelings of intuition that precipitated the discovery of abuse. When discussing their personal feelings about actually conducting the assessment when abuse was suspected, the nurses clearly identified that the fear of making a mistake was potentially a reflection on their nursing skills. One nurse described her fear of making a mistake in this way:

I saw that as, if I made a mistake, it would be a reflection back on me, so I guess it was my feelings that held me back because I didn’t want to make a mistake. That is an insult to her if it wasn’t true.

Feelings of fear, for some of the nurses, were related to upsetting the patients by addressing the abuse, and being uncertain about the interventions available once the abuse was discovered.
If you have assessed it wrong, [the patients] may wonder what you are trying to tell them. It is really frightening for most women because, even if you are right, any kind of change can be frightening. So I think it is a hard thing to do, and I would be really afraid of making a mistake.

One nurse identified that her fear of making a mistake was enough to prevent her from completing the assessment that would have confirmed her suspicions of abuse. The following narrative illustrates her decision not to intervene due to her own fear and uncertainty about her nursing skills.

I suppose I could have said to her "I’ve noticed that there is a bit of tension between you and your partner, how is that relationship?". I guess I could have but I was scared of opening up Pandora’s box and then I couldn’t do anything about it anyway. So what right did I have to ruin her life?

This nurse’s perception of "ruining her patient’s life" was indicative of her feelings of fear of making a mistake. These feelings had a direct impact upon her ability to provide nursing care which related to the abuse.

Nurses also described that their feelings of fear were related to facing their own feelings about abuse. When asked to identify the most difficult aspect of caring for abused patients, one nurse responded that caring for abused patients was difficult because of her fear of facing her own feelings about abuse. Two nurses, who identified that they lacked clinical experience in the care of abused patients, confirmed this fear of facing their feelings. One of these nurses articulated her feelings:

I think the fear is delving into your own feelings. I think it is easier to read about it than it is to talk about [abuse]. Of course it is easy enough to just
forget about the abuse. You can always say there is nothing that you can do.

Another nurse offered this narrative in relation to fear of facing her own feelings about abuse:

I think what I was really afraid of was facing my own feelings about some of these horrible things and it is just easier to pass them over and make them appear so that they were not as bad.

Feelings of fear, as identified, were expressed as multi-faceted emotions by many of the nurses. Fear was experienced in relation to making a mistake about discovering the presence of patients’ abuse and fear of upsetting the patients by discussing the abuse.

It is important to consider nurses’ feelings of fear from the context of both developing relationships with abused patients and providing nursing care. Feelings of fear represented many of the underlying feelings and responses of the nurses’ experiences of caring for abused maternity patients. Feelings of fear, as with feelings of uncertainty, decreased as maternity nurses got to know their individual patients and worked through facing their own feelings. It was mentioned that nurses focused their learning needs for in-service education on characteristics of abused women. Fear of making a mistake seemed to be a lingering fear as nurses did not feel confident in their abilities to consistently recognize abused women.

Despite the nurses’ underlying feelings of fear as they developed their patient relationships, they identified feeling strongly connected to their abused patients even if the abuse was never addressed. Many of the participants who did
address their patients’ abuse also experienced a feeling of connectedness with their patients.

Connecting with the Patients

One component of the nurses’ subjective experiences resulted from the intimate nature of the relationships with abused patients. Discussions with the researcher about these relationships led to nurses’ discussions of their past personal experiences. Many of the nurses identified past personal experience with abuse in their own lives.

Personalizing

For some of the nurses, connecting with their patients occurred from a personal level in which they felt the actions of the patients were a reflection of themselves. Nurses identified that they felt very involved in the patients’ situations, therefore they found it difficult to separate their personal feelings.

Her going home really upset me because I felt that she was basically blowing her chances to ever be able to take the baby home. I felt very disappointed when she left with her partner and was not going to the rehab centre which is something I felt that she would have done if she was committed to keeping her baby. I guess I felt like I’d failed a bit even though I knew I couldn’t do very much.

As is illustrated by the above narrative, this nurse personalized her patients’ actions by feeling that somehow she had the ability to control her patients’ decisions. Part of the reasons for personalizing her patients actions, for this nurse, was related to her past experience with abuse. She indicated that her personal reactions to her patient care situation were motivated by her desire to help abused women get out
of their abusive relationships. Her disappointment at not being able to help this patient resulted in her identified feelings of failure.

For one of the nurses, personalizing her patients’ situation resulted in her taking a block of time to put the situation in perspective. This nurse discussed her relationship with the patient at length, which she indicated was reflective of her strong connection to the patient.

I can remember what [the situation] did to me, and it bothered me for days afterwards. I remember driving home and rehashing the whole thing in my head, and for days, I thought about this. I think it helped me to deal with her and my own feelings too.

Another nurse, who had no personal experience with abuse, personalized her patients’ reactions by describing her own experience in a difficult relationship:

At first I couldn’t understand it. But then after having gone through a divorce myself, I know it is not the same situation, but then I slowly began to realize, from a security perspective, you can’t leave. She had a house, a roof over her head, and food on the table, and someone who sort of cared for her. I knew exactly what she was feeling.

Personalizing patients’ reactions by identifying with their psychological pain occurred for many of the nurses. The participants asserted that these feelings often resulted from relating to the patients.

Relating to Patients

Many nurses identified that they related to the situations of abuse that the patients described. The patient situations may have induced memories, sometimes painful ones, of past personal experiences. One nurse identified that
she had been abused during pregnancy. Her response to her patient was based on relating emotionally to the similarity of the situation.

My husband was the same when I was in labour too. I knew emotionally what this woman was going through, wanting to have the contact and this man was not being there for her.

One nurse poignantly described her feelings:

You ache. You can relate to her and you feel...I’ve never been in that situation that she has been in, and I never asked her about it, and I can’t imagine being there and feeling like she did, but you have an ache of ...not sympathy, but empathy.

This narrative illustrates the depth of the personal, intimate reactions of the nurses who cared for abused women.

Many of the nurses expressed that relating to their patients from a personal perspective posed difficulties for them. Desire to help the patients was based not on conventional clinical knowledge, but on personal experience.

I knew I was starting to heal when I could see that she was still in real deep. I wanted her to be more aware of how dependant she was on an abusive person and that she didn’t have to be like that, and I was angry she couldn’t see what kind of a situation she was in. I think that was where my frustration was.

One nurse described how her past personal experience with abuse helped her to relate to her patients.

I was in a situation very similar too, so I could relate to her and I really felt for this lady. I was involved in an abusive situation for ten years, and I am
just recently out of it, and am still very aware of the pain and the hurt that I went through.

This nurse went on to describe how her husband "only hit her once", and that she was "not allowed to talk in the relationship". For this nurse, the experience of caring for her abused patient brought back strong memories of her own personal experiences with abuse. It was not surprising that she related to her patients situation.

Having personal experience with abuse was not the only criteria for relating to patients. Nurses without experience with abuse also related to their patients. The presence of patients’ psychological pain was recognized by all the participants. It was not surprising that nurses without personal experience with abuse also connected with their patients, and one of the main reasons was the presence of psychological pain. One of the nurses who did not have experience with abuse described that relating to her abused patients was based on her own desires to help the patient who was experiencing psychological pain.

I related to this women because she was hurting and needed help. I don’t know why I related to her, but I was interested in the Native culture and I felt quite comfortable taking to her. I felt that I could help her.

Relating to patients occurred on many levels for the participants and for many reasons. The nurses felt strongly that relating to the patient from a personal level resulted in feeling closely connected to their abused patients. These strong feelings were the catalyst for many of the nurse’s decisions about their provision of nursing care. One nurse contended that due to her nursing care, her patients felt comfortable enough to disclose their abuse to her. Their disclosures of abuse led
to this nurses’ feelings of being happy to look after them. These feelings are described in the following narrative:

....I was happy that I was the one to be looking after her, and not someone else. Had it been someone brusque and efficient, and looking after the physical needs, that perhaps neither one of those women would have felt that they could have spoken up and said anything [about their abuse].

This nurse also discussed her perception that her patients were glad that it was her looking after them, instead of someone else. This theme was identified by many of the nurses as empathizing with their patients’ feelings.

**Empathizing**

For some of the nurses, providing nursing care to abused women resulted in their empathizing with some of their patients’ feelings. For example, one nurse discussed a patient situation which was similar to her own experience of involvement in an abusive relationship as an adult. She identified that she based her nursing interventions on the type of care she would have appreciated when she was involved in this abusive relationship. An excerpt from the narrative illustrates this:

R (Researcher): It seems you spent a lot of time developing the relationship between you and the patient.

P (Participant): Yes, I did.

R: Why was it so important for you to do that?

P: Because nobody ever did it for me, and I know how hard it is to trust anybody, or to let anyone in, it is a scary thing to do.
This nurse’s understanding of abusive relationships was based on her personal experience. Often, nurses identified that their personal understanding of patients’ feelings influenced decisions they made about nursing care because they wanted to be caring and supportive of the patients. Another one of the nurse’s empathized with her patient’s feelings. Her empathy was based on her personal understanding of her patient’s situation.

I felt frustration because nothing I did or said could convey that I wasn’t going to hurt this woman because she was terrified of everybody, even her physician whom she said she liked very much. I felt her distrust, her fear, and her anger. She was especially angry that we had to do these [obstetrical procedures] things to her.

During further discussion, this nurse clarified that her perception of her patient’s feelings were a reflection of her own fears around abuse. She related to this patient because the patient’s pregnancy had resulted from marital rape. This nurse disclosed that her own rape occurred while she had been pregnant. She identified that her patient’s feelings were similar to ones she herself had experienced during her abusive incident and that her own experience provided her with insight.

I was glad I was aware of the situation because having been raped myself as a teenager, I know the importance of not feeling dirty, and sometimes people don’t physically touch you after.

By empathizing with her patient’s feelings, this nurse based her nursing decisions on her perceptions of the care her patient needed. The subjective context for this nurse strongly influenced her nursing care of this abused woman because of the intense level of connection this nurse felt with the patient.
For the nurses in this study, connecting with patients occurred for many reasons. Past personal experience, sometimes related to abuse, prompted many of the nurses' feelings of connectedness with their patients. For the nurses with personal abuse experience, this resulted from their powerful feelings of relating to their patients. Relating to patients occurred for all nurses, both for those with experience of abuse and for those who did not. The nurses also described how they personalized their patients' actions as reflections of their care. This resulted, for some of the nurses, in their feelings of failure when the patients acted contrary to the nurses' wishes. Finally, the nurses described how they empathized with their patients' feelings. Empathy with the patients' feelings resulted in nurses using their own perceptions to determine patient care priorities. Connecting with the patient occurred within the nurses' subjective contexts of providing patient care. As illustrated by the narratives, the subjective contexts varied for the nurses and depended upon their personal experiences.

Summary

In this chapter, the researcher has presented an analysis of the data extracted from interviews completed for this study. Verbatim examples of participant's comments illustrated the identified themes.

Participants of the study were described. Then, maternity nurses' experiences were summarized from the three central, related themes of gaining understanding of patients in abusive relationships, facing the realities: the health care context, and struggling within the realities: the subjective context. These themes represent maternity nurses' experiences of caring for pregnant women involved in abusive relationships.
In summary, the participants described the threefold process they used to gain understanding of their patients in abusive relationships. The first element of this process was comprised of discovering the patients’ abuse through nursing reports, nurses’ assessments and nurses’ use of intuition. The second element consisted of reacting to the discovery of abuse with uncertainty. The third element included developing the relationships by being non-judgemental, building trust within the relationship, gently probing for information about a patients’ background and sharing personal experiences with abuse.

The second theme, facing the realities: the health care context, described the external constraints of delivering nursing care within a hospital environment. Gaps in institutional resources were identified by the nurses. Feelings of frustration were experienced as the nurses attempted to deliver comprehensive care to their abused patients. Nurses felt that the institution should be largely responsible for providing the supports necessary to provide adequate care. Supports were desired in the form of written policies and/or clinical guidelines, and in-service education which would better prepare nurses to identify abused women. Nurses described providing appropriate nursing care that was delivered in recognition of the special needs of abused women, through abuse care and through recognition of the need for nurses to provide care in a holistic manner.

Supportive resources from within the health care context were identified in the form of nursing peers and social workers. These health care colleagues provided assistance in decision-making about patient care, and the nurses’ resulting feelings. Physicians were identified as generally reluctant to get involved in the
care of abused women, and this was identified as a source of frustration that was not within the nurses’ control.

The third major theme was struggling within the realities: the subjective context. This theme was the derivation of nurses’ personal conceptualizations of abuse resulting from both their personal experiences and their experiences with abused women. Feelings of fear were the basis of the primary personal emotions experienced in response to caring for abused women. These emotions strongly influenced the nurses’ personal outlook as they provided their patient care, and resulted in the nurses’ strong feelings of connectedness with their abused patients.

Nurses’ descriptions of past experience with abuse were woven into discussions of their patients’ care situations. Nurses explained how the intimate nature of the care experiences often resulted in them connecting with their patients. Connecting with the patients occurred through personalizing the reactions of their patients, relating to their patients on a personal level, and by empathizing with the feelings of their patients.

To better understand the findings of the study, the literature must again be explored. In the next chapter, both theoretical and research based literature is examined to elucidate the major themes found in this analysis of data.
CHAPTER FIVE: Discussion of Findings

Major findings related to maternity nurses' experiences of caring for abused pregnant patients are discussed in this chapter. Although many key conclusions emerged from the data, three notable findings are addressed using both theoretical and research-based nursing literature: (a) nurses' needs for personal relationships with others; (b) relationships with physicians; and (c) nurses' subjective responses to caring for abused women.

The first finding addresses the significance of nurses' needs for personal relationships with both their patients and their health care colleagues. Nurses' needs to mollify their feelings of uncertainty were instrumental in establishing personal relationships which in turn helped the nurses to effectively care for abused women. The second finding examines nurses' relationships with physicians in the context of the physicians' reluctance to become involved in the care of abused patients. The third finding presents the individual nurses' subjective responses to abuse and abusive relationships and the impact of these responses on patient care.

Nurses' Needs for Personal Relationships with Others

Participants in this study reflected positively on the personal relationships that developed with both their patients and their nursing colleagues. According to the participants, these relationships were pivotal in the overall nursing care experiences because they influenced both patient care decision-making and the felt personal support received by the nurses when caring for abused patients.
Personal Relationships with Patients

All of the nurses in the study expressed a strong need to establish personal relationships with their abused patients. This expressed need was important for three reasons.

First, nurses described their relationships with abused patients as personal because of the intimate nature of the conversations held between the women and themselves. The nurses felt these conversations were private and personal, and the nurses felt "special" that the patients shared about their abusive situations. The nurses generally lacked confidence in their abilities to assess the needs of abused women, so by "getting to know" their patients on a more personal level, they were able to best determine the unique needs of the individual patients. According to the nurses, getting to know their patients helped them to pacify their feelings of uncertainty and gave them more confidence to provide care and to interact effectively with abused women. By establishing personal bonds, the nurses felt more certain of their abilities to deliver appropriate, competent nursing care, and more strongly about their need to advocate for the patients.

Second, as the intimate nature of the relationships developed between the nurses and their patients, the nurses identified that they felt protective of these patients. They felt even more strongly that they had to be the proponents for relevant and appropriate nursing care decisions. Getting to know the patients by building trust and gentle probing strengthened the nurses’ confidence to provide appropriate nursing care decisions. The nurses found that by including the patients in nursing care planning, they were better able to meet the patients’ needs and this made their experience more positive.
Third, by establishing personal relationships with their patients, the nurses described feelings of being "connected". These connections occurred at varying levels because of nurses’ differing conceptualizations about abuse resulting from their own personal experience with abusive relationships. For some of the nurses, memories of their own past experiences with abuse were stimulated by their patients’ abusive situations. As a result of the intimate nature of the personal relationships, some of the nurses shared their own past personal experiences of abuse with their patients. The nurses who did not have abuse in their backgrounds shared personal anecdotes about themselves. As a result of these feelings of being connected, the nurses generally felt good about having made a difference in their patients’ care.

A review of relevant literature reveals that the finding related to nurses’ strong needs to develop patient relationships is not unique to this study. Several studies support the findings that developing interpersonal relationships with patients was critical to providing appropriate nursing care (Jenks, 1993; Ramos, 1992; Tanner, Benner, Chesla & Gordon, 1993). Jenks contended that nurses placed such importance on development of the relationships with their patients that they felt insecure and uncertain about their abilities to make appropriate clinical decisions when the interpersonal relationships did not exist. Ramos characterized the development of the nurse-patient relationships as being central to professional nursing practice. The centrality of interpersonal bonds was explored through descriptions of critical situations in which nurses experienced a sense of connection with their patients. Perceptions of close relationships were commonly experienced by the nurses in Ramos’ sample. Factors which influenced the amount
of emotional attachment experienced by the nurses included the amount of time spent with the patients, the patient’s level of illness acuity, and the amount of "biological, psychological and social data" (pg. 504) collected on individual patients. Both Jenks’ and Ramos’ findings are congruent with the reactions of nurse participants in this present study.

The work of Tanner et al. (1993) identified that nurses in their study described "knowing the patient" as knowing both the patient’s pattern of responses as well as knowing the patient as a person. The researchers further argued that not understanding the patients’ complete clinical situation decreased nurses’ overall effectiveness and diminished their abilities for being strong patient advocates. Tanner et al. concluded by identifying that knowing the patient required an involved, rather than detached understanding of the patient’s situation and that this knowledge enabled nurses to make skilled clinical judgements. These conclusions are congruent with the findings of this present study and offer insight into nurses’ needs for personal relationships with their patients.

**Personal Relationships with Colleagues**

Nurses in this study also described a strong need to establish personal relationships with their nursing colleagues. In general, these relationships were found to be supportive for two reasons.

First, good working relationships between and among staff members positively influenced the outcomes of many of the described nurse-patient situations. In many cases, colleagues shared information and "stories" about experiences with patients in abusive situations. These "stories" included discussions of successful and unsuccessful nursing interventions. Having personal
relationships among colleagues encouraged the nurses to "bounce ideas off one another", which was seen as helpful for obtaining support or validation for patient interventions. The nurses saw their peers as supportive of assisting them when making clinical decisions about their abused patients.

Secondly, having personal relationships with colleagues was supportive of the nurses’ private feelings which resulted from their interactions with abused women. Personal relationships were characterized as occurring with colleagues who went beyond "professional" fraternity, and encouraged the divulgence of the nurses’ personal feelings. Many of the nurses described feeling fear and uncertainty when delivering nursing care to abused patients, and nurse colleagues provided an emotional outlet for these feelings. Having "friends at work" with whom the nurses could talk about their experiences was generally seen as key to helping the nurses put their experiences into perspective. Personal relationships with nursing colleagues allowed these nurses to share their feelings, both positive and negative, with others who may have had similar experiences, and contributed to the nurses’ satisfaction with their experiences of caring for abused women.

The responses of these participants are elucidated by the findings in the literature. Tanner et al. (1993) identify that personal relationships among nursing colleagues provide nurses with allies when the need for colleague support arises. In this present study, such relationships encouraged the nurses to collaborate with their colleagues in providing the best possible care to abused women. Further support for this finding was offered by Jenks (1993) who identified that personal relationships with fellow staff nurses facilitate nurses’ clinical decision-making. In this present study, valuable observations, experiences and opportunities for nurses
to share and discuss patient care decisions result from strong personal relationships among staff nurses. The nurses perceived that being able to share experiences and personal feelings with their nursing peers was worthwhile.

Personal relationships with nursing colleagues was identified as a key feature in the experience of caring for abused women. The literature clearly recognizes the positive influence of colleague relationships on clinical decision-making. In general, the nurses found their nursing colleagues to be supportive for both clinical decision-making and personal feelings.

**Relationships with Physicians**

Nurses' relationships with physicians during the care of abused patients is a second noteworthy finding of this study. The distinct features of the nurse-physician relationships are described.

As the nurses discovered that their patients were involved in abusive relationships, they sought the input of the patients' physicians for confirmation of their suspicions about abuse and for guidance in the planning of care. The nurses expressed their surprise when the physicians, even the physicians who were considered "patient advocates", were reluctant to engage in collaborative planning for the abuse care of their patients. Because physicians were hesitant in taking an active part in patient care planning, the nurses drew on the information learned from their personal relationships with the patients to suggest what they felt to be appropriate strategies. Because the nurses generally had established good working relationships with physicians, they obtained support easily for their suggestions. Good working relationships were defined as resulting from mutual trust and respect for clinical judgement. The Registered Nurses Association of British Columbia
(1989) corroborated this finding and took it one step further. They studied nurse-physician relationships and found that when nurses and physicians knew each other socially, fewer power struggles in the workplace resulted. In this study, power struggles between nurses and physicians were not the issue. The nurses explained that they truly felt that the physicians had abdicated the responsibility for clinical decision-making to them. Without the cooperation of the physicians, the nurses felt they were put in the awkward position of accepting responsibility for patient care planning when they did not feel confident.

Other pertinent literature on nurse-physician relationships was supportive of these findings. Jenks (1993) found that although nurses desired a collaborative relationship with their physician colleagues, often they approached the physicians with requests for permission for their own clinical decisions rather than to request the physicians’ collaboration in decision-making. In this study, the nurses were quite directive in their requests for supportive interventions for their abused patients. Jenks’ findings help to explain that many nurses adamantly advocate for suitable interventions for their patients without collaborating with physicians. The unique situation in this study is that the nurses did not feel confident in their roles in the care of abused women, and generally felt disappointed in the lack of guidance from the physicians. Several of the participants identified that the physicians seemed "happy to let someone else intervene".

A contrary viewpoint was offered by Henry (1993) who described the nature of nurse-physician relationships as collaborative. The nurses in this study perceived that the physicians made little effort to collaborate in patient care planning for abused women. It was noted by the nurses that, although it was
common practice for the physicians to be collaborative, in situations dealing with abuse, the physicians seemed to be ill at ease when consulted about these patients. As an aside, several of the nurses insinuated that physicians’ unease was the result of a weak knowledge base in the area of domestic violence. With respect to the collaborative nature of nurse-physician relationships, the literature was found to be incongruent with the narratives of the nurses in this study.

**Nurses’ Subjective Responses to Caring For Abused Women**

In this study, while gaining an understanding of the patients in abusive relationships, the nurses experienced subjective responses to both the patients and their situations. Two of these key responses are discussed.

Nurses in this study experienced fear as they provided nursing care to abused women. However, it was found that the nurses’ fears were as individual and subjective as the participants themselves. Some of the nurses felt fear in relation to being wrong or making a mistake about a patients’ abusive situation. They were afraid of upsetting the patients or even losing their trust as a result of their possible misinterpretation of cues and behaviours. Nurses may even have denied the existence of the problem rather than jeopardizing the delicate beginnings of a personal relationship. Denial of the situation may also have resulted from these nurses attempts to control their feelings of fear. Tilden and Shepard (1989) acknowledge that denial may function as a protective measure for nurses who feel vulnerable or overwhelmed.

Other nurses described that their fears were related to fears of facing their own feelings about abuse. These nurses identified that, although they were aware that abusive relationships did occur during pregnancy, they were not prepared for
their first clinical encounters with abused patients. Whitley (1992) defined fear as being caused by an identifiable source, and included such reactions such as apprehension, dread, and tension. This definition does not concur with the subjective descriptions of fear by the nurses in this present study. These nurses’ feelings of fear were related to the fear of the unknown, whether it was the reactions of their abused patients or facing their own feelings. Many nurses had not yet confronted their own feelings regarding abuse and generally found the experience of caring for abused women difficult for this reason. Feelings of "helplessness and frustration" were often described, and the nurses coped with these feelings by developing interpersonal relationships with their patients and trying to meet their physical and/or psychological needs as best they could. The nurses identified that their fears were primarily based on their perceived lack of education on the issues of domestic violence and administrative support for appropriate intervention with abused women.

The most notable point about the subjective responses of fear was its’ effect on patient care. Although the nurses felt hesitant when addressing issues of abuse, they took their cues from their patients and continued to probe gently in order to build a base of trust. In situations where the nurses did not address the abuse, they felt that they "gypped the patient" by not meeting all of her needs. Some of the nurses found that their feelings of fear interfered with their abilities to properly assess the situation. Fear of "opening a can of worms", or "opening Pandora’s box" were common concerns expressed. Henderson (1992) asserted that nurses must learn they don’t have to have all the answers before they ask the questions.
This reaction of the nurses was not unique to this study. Henderson and Ericksen (1994) identify that nurses may be afraid to intervene because they fear that they may do "damage" to a woman if they counsel incorrectly. Some nurses in this study were hesitant to perform complete assessments based on their fear of making a mistake about the abuse. Tilden and Shepard (1989) recognize that nurses may be hesitant to intervene because they feel that domestic violence is outside of the health care domain. Gage (1991) identifies that not all primary health care providers feel they are in a position to provide intervention to abused women.

The second key subjective response of the nurses in this study involved the effect of nurses' past experiences with abuse on patient care. For the participants in this study, the nursing care experience was highly individualistic and involved a continual process of examining personal feelings and reactions to the patients' abusive situations. Based on the subjective nature of their personal conceptualizations of abuse, the nurses experienced some personal difficulties while providing nursing care. Feelings such as personalizing patient actions and personally relating to the abused patients were two examples of the nurses' reactions. Fenton (1988) supported these findings by saying that nurses may be "deeply affected" by the experience of caring for patients facing difficult situations, and consequently may have difficulty coming to terms with such situations.

The principal problem for many of the nurses in this study was that they found it emotionally distressing to care for abused patients. Little help for relief of their distress was found in the nursing literature. The literature contains information on "how to" care for abused women, but does not provide direction on
how to reconcile one’s own personal distress. More recognition in the professional literature of these difficulties is needed in order to begin to assist nurses to overcome them.

Summary

This chapter has explored three key findings of this study of maternity nurses’ experiences of caring for abused pregnant women in the context of current literature. A variety of sources were reviewed from research and theoretical foundations.

In the next chapter, the researcher presents implications for the profession of nursing, as well as conclusions and a summary of the study.
CHAPTER SIX: Implications, Conclusions and Summary

Implications

The findings of this study have implications for clinical practice, nursing education, nursing administration, and nursing research.

Implications for Clinical Practice

A variety of implications for clinical practice have emerged from the findings of this study. The suggestions noted in this section are not new for nursing practitioners but support the urgent need for nurses to address the difficult issues surrounding domestic violence.

The first major implication for clinical practice is that nurses need to become comfortable with assessing and interviewing abused women. A lofty, but attainable goal for nurses is for all women in maternity settings to be assessed for the presence of abuse. Nurses working in maternity settings are uniquely positioned to address issues of violent relationships as they are the front-line caregivers (Moss & Taylor, 1991). As evidenced by the narratives, abused women exist in maternity nurses’ caseloads. Therefore, nurses must become proactive in their search for knowledge on how to best address the needs of abused women. Knowledge of appropriate interventions such as listening, assessing for patient safety, and referring patients to appropriate resources is well within the realm of nursing practice and is essential to providing effective nursing care. Nurses must recognize that they possess the necessary skills to provide care to abused women.

A second implication for nursing practice is supported by Wilkinson (1989) who suggests that nurses should seek appropriate help when coping with the effects of emotional distress in order to maintain their effectiveness as caregivers.
All nurses who are uncomfortable dealing with abuse have a professional obligation to provide competent care to patients (Canadian Nurses Association, 1991). Many nurses in this study identified that they valued the opportunity to debrief and share personal and common experiences with their nursing colleagues. Nurses can enhance this opportunity with regular and ad hoc scheduling of debriefing sessions. Such contact among colleagues can facilitate the sharing of advice and experiences which may offset feelings of isolation and uncertainty. Open sharing of information based on lived experiences needs to be recognized as a valuable component of the learning process.

Further implications for nursing practice were identified in relation to addressing nurses’ attitudes and knowledge about domestic violence. Nurses must develop an awareness of their own attitudes and beliefs that could influence their interactions with abused women (Boychuk, 1994). Further understanding of the dynamics of abusive relationships is needed by all nurses. Finally, increasing knowledge and skills in the area of assessment for abuse must be confronted. These three areas were common challenges experienced by the nurses in this study.

A final implication for nursing practice stems from nurses’ identified desires for clinical guidelines and in-service education. The Registered Nurses Association (1993) identifies that professional personal development is expected in order to comply with professional standards for practice. Nurses must take responsibility for calling staff meetings and setting agendas to discuss issues of clinical concern. Sitting on policy committees and requesting in-service education are well within the realm of nursing responsibilities.
Implications for Nursing Education

A major implication for nursing education is that nursing schools' curricula need to incorporate courses on domestic violence. Ryan and King (1993) suggest that few nurses have received formal education in this area. If nurses are to provide appropriate care to abused patients, nursing students need to understand health problems related to domestic violence. This can only be achieved by addressing the myths and stereotypes associated with domestic violence (King & Ryan, 1989). Nursing school curricula need to incorporate theoretical content which examines the health care effects of domestic violence in the context of the larger social picture. Tanner (1993) challenges schools of nursing to provide opportunities for students to become informed, caring professionals who are able to provide sensitive nursing care to women in abusive relationships. The multifaceted issues surrounding domestic violence must be included in nursing curricula.

Tilden and Shepard (1987) argue that the inclusion of domestic violence content needs to go one step further. They contend that in order to ensure domestic violence course content in nursing schools is integrated, licensure exams should include domestic violence content, and that knowledge about domestic violence be mandatory for licence renewal and certification.

The need for continuing and in-service education programs on domestic violence is a second major implication for nursing education. Many of the nurses in this study had received no formal education in the area of domestic violence. Young & McFarlane (1991) identified that "the educational preparation of health care providers in the area of abuse during pregnancy was severely lacking" (pg.202). The education of nurses in clinical practice is a challenge for nurse
educators as there are, in Canada, no requirements for nurses to update their clinical skills by taking further education. Innovative ways to educate nurses on domestic violence are needed. One suggestion is to offer peer-run in-services where nurses who have encountered abused women share their experiences. Nurses could be invited to learn from the groundwork of colleagues who have lived the experience.

The implications for nurse educators are many. This study emphasizes the importance of understanding the issues of domestic violence. However, the educational needs of caregivers go beyond didactic teaching methods where participants passively receive information about theories of violence and nursing care approaches for dealing with domestic violence. Educators need to be sensitive to the possibilities that students attending these educational programs may find the content difficult due to past personal experiences. Opportunities for interactive dialogue on nurses’ personal meaning of this type of information should be encouraged. In addition, information on appropriate resources for students should be made available by the nurse educator.

The final implication for nursing education is that, given the number of moral and ethical issues involved in the care of abused women, nurses must learn to resolve ethical problems in an effective way. Nurses in this study struggled with many difficult issues as they cared for their abused patients. Content in ethical decision-making must be integrated into nursing curricula and in-service education.

Implications for Nursing Administration

This study has many implications for nurse administrators. The goal of nurse administrators is to facilitate the effective provision of patient care to abused
women. To achieve this end, nurse administrators should seek feedback from nursing staff about the type of supports that would be helpful when caring for abused patients. This type of interaction would afford opportunities for front-line nurses to provide input into appropriate care practices. This could be accomplished through staff meetings and/or solicitation of feedback through verbal or written communication with the nurse administrators.

Nurse administrators need to acknowledge that nurses in acute care settings are presently caring for abused women. Nurse administrators can support nurses in providing excellent care to abused women through the implementation and dissemination of appropriate policies and procedures for assessment and intervention. This would address the concerns for institutional support desired by the nurses in this study. Guidelines for protocol development of domestic violence training programs have been issued by both the federal (Health and Welfare Canada) and provincial (Ministry of Health) health authorities. The Canadian Nurses Association (1992) issued the Family Violence: Clinical Guidelines for Nurses in recognition of the need to support nurses in their roles of caring for abused women. Therefore, it behooves nurse administrators to provide nurses with explicit written guidelines that are necessary to maintain high standards of nursing care.

A third implication for nursing administration involves establishing mechanisms for counselling of staff members who identify personal issues which may be impacting on their abilities to provide nursing care. This was supported by Fenton (1988) who declared that nurse administrators have a responsibility to be aware of, and supportive of, nurses who may be experiencing emotional distress as
a result of participation in a patient care situation which involves abuse. One of the ways that support may be offered is through the provision of access to supportive counselling that is available separate from the work environment.

Another implication for nurse administrators is the need to be supportive of in-service education on domestic violence for staff members. Nurses in this present study clearly identified their desires for in-service education. Staff development and education is a worthwhile priority of nursing administration (Davitz & Davitz, 1980). This implication is supported by the Task Force on Family Violence (1992) which recommended that sufficient high quality training be provided to all those working with family violence victims.

Nurse researchers are at the forefront of the development of nursing knowledge in the area of domestic violence (Campbell & Humphreys, 1993). The final implication for nurse administrators is to provide support for conducting clinical research studies on domestic violence. By sitting on research committees and keeping abreast of current nursing research projects, nurse administrators can foster the development of nursing knowledge in domestic violence.

**Implications for Nursing Research**

This study identified the complex and highly subjective nature of the nursing care experiences of maternity nurses. It is not known if the experiences of nurses from other clinical settings are consistent with the findings of this study. Repeating this study with nurses from other clinical areas, including the community nurses, would contribute to further understanding of the current status of clinical knowledge in this area as well as expand the transferability of the findings of this study.
Another suggestion for further study would be to implement institutional policy and procedure guidelines for assessment and intervention with abused women and then evaluate their impact on nurses' feelings of uncertainty in their nursing roles. Further exploration is needed to determine the effectiveness of written protocols for patient care.

A final suggestion for further study would be to complete a phenomenological study of nurses' attitudes towards patients with differing cultural backgrounds. In this study, nurses discussed searching for an understanding of the influences of a patients' culture on violent relationships. Bohn and Parker (1993) argue that the findings of studies which examined racial differences in abuse during pregnancy have been inconsistent. The need for further study of the influence of culture on nursing care of abused women is clear. DeMarco, Campbell and Wuest (1993) identify that through careful scholarly analysis and critique, the more difficult and hidden attitudes of ethnocentrism which arise out in unintentional insensitivity and ignorance can begin to be understood.

Conclusions

The first conclusion of the findings is that nurses used intuition in the discovery of patients' abuse. Intuition was based upon the nurses' recognition of unusual patient behaviours and interactions between the patients and their partners. The nurses felt uncertain about relying on their intuition, and this resulted in hesitance when addressing the abuse. Nurses need to be encouraged to acknowledge their feelings of intuition and follow up on them. Farrington (1993) supported this conclusion by stating that expert judgements and clinical decision-making result from nurses' acknowledgement of their gut feelings that things are
not quite right. One participant summarized this conclusion by saying, "If you suspect abuse, it is probably there."

The second conclusion is that many of the nurses in this study have experience with abuse in their backgrounds. Holz (1994) reported that as many as forty-five percent (45%) of health care providers are survivors of childhood sexual abuse. Many of the nurses drew on their personal experiences and, as a result, weathered personal difficulties when caring for abused women. Adequate resources to assist these nurses to cope with difficult personal feelings are presently lacking in health care institutions.

The third conclusion is that there is a need for institutional policies and procedures that clearly outline protocols for assessment and intervention with patients who are experiencing abusive relationships. The perceived lack of resources from nursing and hospital administrative offices was clear in nurses’ descriptions of the health care environment in which they provided nursing care to abused women.

The fourth conclusion is that all nurses require formal education on the issues of domestic violence. Theoretical content must be included in basic education programs. Practising nurses require in-service education to address their specific learning needs. As women experiencing abusive relationships are found more frequently in health care institutions, all nurses, including fledgling nurses, must be appropriately educated to effectively assist these patients.

The fifth conclusion is that nurses in this study welcomed the opportunities to talk about their involvement with abused patients. Despite being a caring profession, nurses may not actively support one another when difficult situations
arise (Pick & Leiter, 1991). Time spent debriefing with colleagues about their encounters with abused patients helped the nurses to shape their subjective understanding of their nursing care experiences. Opportunities for supporting one another as nurses become more involved in domestic violence identification, intervention, and prevention efforts must occur frequently.

Summary

This study was undertaken to describe and explore maternity nurses’ experiences of caring for pregnant women involved in abusive relationships. This study addressed the major question: "What are maternity nurses’ experiences of caring for pregnant women involved in abusive relationships?"

The conceptual framework that directed this study was formed from two related concepts. Maternity nursing care and domestic violence in pregnancy were the two concepts which guided exploration of the relevant bodies of literature. This initial review of literature delineated the present state of the knowledge of the abuse experience of domestic violence in pregnancy and of the social and health care context of maternity nursing care.

The research method used to conduct this study was phenomenology. This qualitative approach seeks to facilitate understanding of the meaning of people’s lived experiences. Phenomenology is a useful method of inquiry for developing a foundational knowledge base when little is known about a subject (Taylor, 1993). The perceptions of maternity nurses were explored in relation to caring for abused pregnant patients.

Eleven maternity nurses who had lived the experience of caring for abused pregnant women participated in the study. All of the participants were employed in
the same acute care maternity hospital. Data were collected through the use of semi-structured interviews. A total of twenty-one (21) interviews were conducted in the participants’ homes. Each interview lasted between sixty (60) to one-hundred twenty (120) minutes. All interviews were audio-taped for transcription purposes.

Analysis of the data occurred by examining transcriptions of the interviews. Common themes were identified from raw data and coded to reflect the general intent of the statements. Using Colaizzi’s (1978) method of qualitative data analysis, the coded data was then explored for possible relationships and validated with the study participants. Anecdotal field notes taken during the interviews preserved the context of subjective data. Identified common themes were further explored in subsequent interviews with eight (8) of the nurses. To ensure truth and faithfulness to the data, synthesis and refinement of the general themes of the nurses’ experience were validated with two (2) of the participants.

Nurses’ relationships with others comprised the first of the major findings of this study. In particular, nurses first described their needs to develop personal relationships with their abused patients. These interpersonal relationships served a twofold purpose. The nurses acquired intimate knowledge about the patients and their abusive relationships. This insight into the patients’ situation allowed the nurses to advocate for appropriate interventions. Second, the importance of developing personal relationships with their nursing colleagues was described. The nurses reiterated that they received both personal and professional support from their colleagues for themselves as they cared for abused women.
The second key finding reflects nurses’ relationships with physicians. These relationships comprised an important part of the nurses’ experiences of caring for abused women because the physicians were hesitant to become personally involved in patient care planning. Lent (1992) identified that physicians may be uncomfortable dealing with the situation because they are unaware of available resources or may feel unprepared to handle the complex problems associated with an abusive relationship. The physicians seemed to rely on the nurses’ judgements to coordinate the best plan of care for the individual patients involved. This reliance on nurses’ judgements was interpreted by the nurses as abdication of responsibility on the part of the physicians. The nurses felt disappointed in the reactions of the physicians.

Two key subjective responses to caring for abused women comprised the third noteworthy finding of the study. Feelings of fear constituted the first key response and were related to fear of making a mistake about the presence of abuse and nurses’ fear of facing their own feelings about abuse. These feelings directly influenced the enactment of nursing roles as the nurses felt hesitant to perform complete assessments on their abused patients. Lack of education and institutional support were two stumbling blocks cited as contributing to nurses’ hesitance.

The second key subjective response of the nurses was related to nurses’ past personal experiences with abuse. Personal conceptualizations of abuse had a strong impact on the enactment of nursing roles because of personal difficulties experienced by the nurses. The discussions of nursing roles found in the literature were valuable for direction in "how to" care for abused women. However, it was
noted that further recognition of nurses’ personal difficulties when dealing with the sensitive issues of domestic violence is needed in the literature.

In summary, this study has explored the phenomenon of caring for abused pregnant women from the perspective of those who have lived the experience. It was found that the process of understanding and caring for abused women was highly subjective and individualistic based on nurses’ conceptualizations of abuse. It is hoped that the findings of this study contribute to the evolving understanding of the personal nature of nurses’ experiences of caring for abused women.
REFERENCES


Canadian Nurses Association.


*British Journal of Nursing, 2*(4) 228-233.


APPENDIX A
Information Letter for Potential Participants

My name is Melanie Basso, and I am a Registered Nurse and a Master’s student in the School of Nursing at the University of British Columbia. For my Master’s Thesis, I am studying the experiences of maternity nurses. In particular, I am interested in talking to maternity nurses who have cared for patients whom they knew were involved in an abusive relationship. If you feel that this is a situation that you have encountered, and would be willing to talk about it, please contact myself, either at home or at work. I can tell you more about the study and set up a convenient interview time. All interviews will be conducted in the most convenient location for the study participants.

As a participant in this study, you will be asked to discuss your experiences with patient situations that you have been directly involved in where there was suspected or confirmed abuse of the patient. As a health care professional, I am interested in what resources you used and in what resources you feel would have been helpful. To allow for full recall of the interview, the interviews will be audiotaped. These tapes will be destroyed when the study is complete.

It is expected that one or possibly two interviews will be required. The length of the interviews would be about one hour each. Confidentiality will be strictly maintained; no names will be used in the interview or in the study. Each study participant will be assigned a coded number, and only the researcher will have access to the identities of these numbers. You would be under no obligation to continue participation once we have begun, and if you decided to withdraw, your nursing employment would not be affected in any way.

It is expected that this information will assist maternity nurses to better understand the experience of caring for patients that are abused. A second goal would be to gain understanding of the effects of domestic violence on the delivery of maternity nursing care. I hope you feel this study is worthwhile and will consider becoming a participant.

If you have any question, you may contact me at 879-4778 (H) or 324-5414 (W), or my Thesis Committee who are:
Ms. Angela Henderson: 822-7435 Ms. Janet Ericksen 822-7505

Sincerely

Melanie Basso RN BSN
APPENDIX B

Consent Form

Maternity Nurses Experience of Caring for Pregnant Women Exposed to Domestic Violence

I agree to be a participant in the above named research project.

I understand that the project is being conducted by Melanie Basso (879-4778), and is under the supervision of Angela Henderson (822-7435) and Janet Ericksen (822-7505) from the School of Nursing at the University of British Columbia.

I have read the information sheet that describes a study investigating the experiences of maternity nurses who have cared for women involved in abusive relationships during pregnancy. I understand that my participation would involve talking about my experience of patient care. I also understand that the interviews will be conducted in strictest confidence, by Melanie Basso, and that they will last approximately one hour. I understand that the interviews will be audiotaped, and that the tapes will be destroyed upon completion of the study.

I understand that my identity will be kept confidential and that will not be personally identified in any way during the study. All data will be kept by the principal investigator, and will be destroyed when the study is completed.

I understand that I may contact Melanie Basso, or Angela Henderson or Janet Ericksen at any time if I have questions. I also can receive a summary of the project if I so request.

I understand that I have the right to withdraw from the project at any time and that such withdrawal will in no way jeopardize my nursing employment. I give consent to participate in this study and have been given a copy of the information letter and consent form for future reference.

Participant: Date:

__________________________  __________________________
APPENDIX C

SEMI-STRUCTURED INTERVIEW QUESTIONS

1. Describe your personal experience of caring for a pregnant patient who had been involved in an abusive relationship?

2. What factors alerted you to recognize that your patient was a victim of domestic violence?

3. What, if any, interventions were you involved in, or did you observe from other disciplines?

4. Do you feel your nursing care changed or was altered in any way in the care of this patient and her family?

5. What supports/services do you feel would have been helpful to you in your experience?
APPENDIX D
Masters Thesis Study
Maternity Nurses
Experience
Of Caring For
Pregnant Women Involved in an
Abusive Relationship

Do you:

- Work as a Registered Nurse on an Antepartum, Postpartum, or Labour and Delivery ward;

Have You:

- Cared for a pregnant woman who you know was involved in an abusive relationship where there was abuse during pregnancy;

Are you:

- Willing to talk about your experience;

If you:

- Are willing to donate one to two hours of your time to nursing research that is addressing this important issue;

- Are interested in finding out more details in how you can participate in this research project;

Please contact:

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