

Love that turns into terror: Intimate
partner violence in Åland – nurses' encounters with
battered women in the context of a government-initiated
policy programme

Anette Häggblom

Doctoral dissertation of public health

Nordic School of Public Health

Göteborg, Sweden, 2008

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ABSTRACT

Violence against women is a problem in all countries in the world, including the small autonomy of the Åland Islands. The violence ranges from psychological threats to femicide. In the Åland Islands the issue has been placed on the agenda of politicians and the authorities, while reports about severe violence against women have been brought to the public. In Åland no scientific research on violence against women has been performed. The overall aim of this dissertation is to gain a deeper insight into how battered women in Åland are cared for by nurses, and how the official organizations have responded to the government policy directives. In this thesis, the first study, a descriptive survey, describes how nurses identify and support battered women. In the second and third studies, the method of grounded theory was used to explore the experiences and perceptions of nurses and battered women of violence against women. In the fourth study a case study approach was used to explore government policies for intimate partner violence. The main findings in this thesis are that battered women used health services to receive help. We found that nurses identified and supported abused women, even though services for these women were inadequate. Nurses were willing to help the women, but they often lacked support. Battered women reported that they received ad hoc help. They were often left alone, dependent on a nearby person to escape, survive, and recover. Another finding was that the Government of the Åland Islands demanded that the official organizations should allocate services to battered women, but the organizations' response to the directives had some limitations. From a public health perspective, the phenomenon presents an urgent challenge. Overall, the public health community can and should contribute greatly towards the understanding, prevention, and control of violence by applying and adapting already constructed principles, and by implementing strategies.

Key words: Violence against women, intimate partner violence, battered women, nurses, government policies, official organizations, descriptive survey, grounded theory, case study.

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Kärlek som vänds i terror: våld i parrelationer på Åland - sjukskötare som möter våldsutsatta kvinnor i ett sammanhang av regeringen initierat handlingsprogram

Anette Häggblom

SAMMANFATTNING

Våld mot kvinnor är ett problem som förekommer i alla länder I världen inkluderat det lilla autonoma området Åland. Fenomenet kan jämföras med terror. Våld mot kvinnor utövas i former från hot till mord. På Åland har problemet lyfts fram både genom politikens som tjänstemäns agendor, samtidigt som rapporter om allvarligt förekommande våld mot kvinnor rapporterats till allmänhetens kännedom. Våld mot kvinnor har inte studerats genom vetenskaplig forskning på Åland. Huvudsyftet med denna avhandling är att uppnå fördjupade insikter angående hur våldsutsatta kvinnor bemöts av sjukskötare och hur de offentliga organisationerna agerat utifrån regeringens direktiv. I denna avhandling är den första studien en beskrivande undersökning som beskriver hur sjukskötare identifierar och hjälper våldsutsatta kvinnor. Den andra och tredje studien har använt *grounded theory* för att studera sjukskötare och våldsutsatta kvinnors erfarenheter och uppfattningar angående våld mot kvinnor. Den fjärde studien en *case study* studie har undersökt regeringens riktlinjer angående våld mot kvinnor. Huvudfynden i denna avhandling visar att våldsutsatta kvinnor söker hjälp från hälsovården. Vi fann att sjukskötare identifierar och stöder våldsutsatta kvinnor även då servicen var otillräcklig. Sjukskötare var villiga att hjälpa kvinnorna men de saknade ofta själva stöd. Våldsutsatta kvinnor rapporterade att de erbjöds en hjälp som de uppfattade som ad hoc. De var ofta lämnade ensamma helt beroende av en närstående person för att kunna fly, överleva, och återhämta sig. Ett annat fynd var att Ålands landskapsregering hade uppmanat de offentliga organisationerna att erbjuda service till våldsutsatta kvinnor, men organisationernas respons var begränsade. Fenomenet utgör en akut utmaning sett utifrån ett folkhälsoperspektiv. Slutligen, de ansvariga för folkhälsan i samhället kan och borde bidra med förståelse, prevention, och kontroll av våldet genom att tillämpa och anpassa redan konstruerade principer, och genom en implementering av åtgärder.

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- II. Häggblom, A. M. E., & Möller, A. R. (2006). On a life-saving mission: Nurses' willingness to encounter with intimate partner abuse. *Qualitative Health Research*, 16(8), 1075-1090.*
- III. Häggblom, A. M. E., & Möller, A. R. (2007). Fighting for survival and escape from violence: Interviews with battered women. *International Journal of Qualitative Studies on Health and Well-Being*, 2(3), 169-178.*
- IV. Häggblom, A. M. E., & Möller, A. R. Implementation of a Government Policy Programme on *Operation Kvinnofrid*
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1. INTRODUCTION

Violence against women as a human rights issue is increasingly seen as a major public health problem (Campbell, Raja & Grining, 1989; Davison, 1997; WHO, 1997; Heiskanen, Piispa & Aromaa, 1998; Lundgren, Heimer, Westerstrand & Kalliokoski, 2001; Watts, Heise, Ellsberg & Garcia-Moreno, 2001; Ramsey, Richardson, Carter, Davidson & Feder, 2002; Krug & WHO, 2002; Mair & Mair, 2003). However, domestic violence has only recently been acknowledged as a serious public health problem (Mayer, 2000; Rönnerberg & Hammarström, 2000). Abuse of women often results in injuries and often has other short-term and long-term health consequences, including mental illness and complications of pregnancy such as premature death (Anonymous, 1997; Macdonald, 2002; Walker, Logan, Jordan & Campbell, 2004). Today, violence against women is recognised as the number one health risk for women between the ages of fifteen and forty-four (Anonymous, 1997; Davis & Harsh, 2001). Recent studies have reported that violence against women has a high prevalence in Sweden, Finland and Norway. In Sweden Lundgren et al., reported in 2001 that 46 per cent of women aged between 15 and 64 years had experience of violence. In Finland, 40 per cent was reported in 1998 (Heiskanen et al., 1998) and 51 per cent in Norway in 2005 (Haaland, Clausen, & Schei, 2005). The experiences vary from “at least once” to very often or regularly. Reports from most countries in Europe show that abuse against women is equally prevalent (Davison, 1997) and Watts and Zimmerman (2002) added that violence against women is almost universally under-reported (Flinck, Paavilainen, & Åstedt-Kurki, 2005). Given the estimated prevalence of this problem and the physical and psychological health consequences, it is essential that health providers learn to respond effectively to women who have been abused (Sword, Carpio, Deviney & Schreiber, 1998).

The identification of abused women is frequently reported to be inadequate, and an underestimation of the rate is common (Waltz, 1995; Anonymous, 1997; Davison, 1997; Walker et al., 2004). Early identification of the problem can reduce its consequences and decrease the likelihood of further victimization (Garcia-Moreno, 2002). Nurses play a vital role in addressing the problem, since the nurse is often the first health care provider that victims of abuse encounter (Anonymous, 1997; WHO, 1997; Davis & Harsh, 2001; Schmidt, Woods & Stewart, 2006). The nurse’s care-giving role, her ability to maintain close contact with clients in a relatively informal atmosphere and in the area of interpersonal

communication, can combine to create a dynamic and effective fit between nurses and abused women (Woodtli, 2000). As Campbell (1991) mentioned, nurses are uniquely suited to meet the needs of abused women; yet, the woman often becomes re-victimized by the nurse (Campbell, 1991; Waltz, 1995; Brandt, 1997; Campbell et al., 1989; Corbally, 2001). Nurses respond with anger and frustration towards women who remain in a relationship characterized by repeated beatings (Moulton, 1997). The women's fear of the man, and threats of reprisals against her and her children, have been given as one explanation (Furniss, 1998). Another reason is that the perpetrator promises to mend his ways (Bergman, Larsson, Brismar & Klang, 1988). Consequently, women return to a violent partner after being offered help and support by nurses who do not respect the woman's choice. Therefore a second victimization of the woman can happen (Campbell, 1992). That means that a woman who feels that she is not believed by the nurse is further victimized and traumatized by the attitude of the nurse (Corbally, 2001). Women who are undergoing separation are at risk of continued violence (Walker et al., 2004). They are probably most at risk for homicide after they have left the abuser or when they have made it clear to him that they are leaving for good (Campbell, Soeken, McFarlane, & Parker, 1998a). Of those who experienced violence after separation (39%) in a study made in Canada, 96 % reported psychological abuse, 58 % reported physical violence, and as many as 60 % feared for their lives (Hotton, 2001).

Most children in homes in which intimate partner violence (IPV) occurs, and where they witness the abuse, are at risk as well as the women (Anonymous, 1997). Children's exposure to violence as victims may have numerous negative consequences (Krug & WHO, 2002). For instance, children who witness violence are more likely as adults to form dysfunctional relationships within their own families. Children in violent homes are often victims of severe forms of violence against them (Weinehall, 1997). Moreover, children who witness violence may exhibit a range of symptoms, including behavioural, emotional or social problems and delays in cognitive or physical development. Krantz & Östergren (2000) reported that exposure to violence victimization during childhood increased the risk of a high level of common symptoms like physical problems, psychological problems, misuse of drugs and suicide attempts by about 60 %. Therefore, health care professionals have a key part to play for the children of abused women.

Nurses are often the first health care providers that battered women and their families interact with (Woodtli, 2000). The nurse's caring role, her ability to maintain close contact with

clients in a relatively informal atmosphere, and her skills in the area of interpersonal communication, can combine to create a dynamic and effective fit between herself and abused women (Woodtli, 2000). The nurse as a health care professional is supposed to deliver health services of excellence. However, she is exposed by her response to stress and her personal experience of being healthy, as well as her coping strategies. She is also a member of a hierarchical structure, which health organizations usually are, and she often has demanding work hours and lack of support.

1.1. Definition of intimate partner violence

There are many different definitions used by researchers, health professionals and others to describe violence against women. The phenomenon is complex and uncertain and a lack of knowledge is more the rule than the exception. The pattern of violence against women is different from the pattern of violence against men. Women are more likely to be physically assaulted or murdered by someone they know, often a family member or intimate partner (Jones, 2000; WHO, 2002). Approximately 90 % of the victims are women battered by a man who the woman knows and has a current or former relationship with (Heise Pitanguy, Germain & International bank for reconstruction and development, 1994; Hadely, Short, Lezin & Zook, 1995). In contrast, Eliasson (2003) and Ellsberg & Heise (2005) stated that men are more likely to be killed on the street by a stranger than by someone they know (WHO, 2002). Moreover, researchers have shown that women can also be violent towards men, and violence also occurs in same-sex relationships (Flinck et al., 2005). Intimate partner violence is characterized by a spectrum of behaviours that involve the threatened and/or actual use of physical force and/or power. Risberg (1994) compared violence against women with torture (Heise et al., 1994). This spectrum includes physical and/or sexual assault, damage and/or destruction of property and pets, psychological abuse, deprivation and neglect (Ambuel, Hamberger & Lahti, 1997; Daniels, 2005). Humphreys (1998) underlined that the battering man is the typical child abuser.

The World Health Organisation (Krug & WHO, 2002) defines violence as: “the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation”. The uses of the word “power”, in addition to the phrase “use of physical force”, broadens the understanding of

violence and includes threats and intimidation. Thus, “the use of physical force or power” should be understood to include neglect and all types of physical, sexual and psychological abuse, as well as suicide and other self-abusive acts (Krug & WHO, 2002).

The United Nations General Assembly in 1993, defined violence against women as “any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life” (UN Declaration, 1993, p. 2). Violence against women encompasses, but is not limited to, “physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non spousal violence and violence related to exploitation; physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere; trafficking in women and forced prostitution; and physical, sexual and psychological violence perpetrated or condoned by the state, wherever it occurs” (WHO, 1997). There is increasing international consensus that the abuse of women and girls, regardless of where it occurs, should be considered as “gender-based violence,” as it largely stems from women’s subordinate status in society with regard to men (Ellsberg & Heise, 2005).

In the literature, interpersonal violence is called family and IPV, domestic violence, wife battering, abuse against women, spouse abuse, and sexualised violence (Ellsberg, 2000). Rönnberg and Hammarström (2000) use sexualised violence as an overarching term for this kind of violence, which is regarded as an expression of male power and dominance over women. They relate the definition not only to a partner relationship, but also to a gender order found in society as a whole.

According to Corbally (2001) domestic violence is a vague term, and is not specific to women alone; it is inclusive of both heterosexual and homosexual adult relationships. Both spouse abuse and domestic violence limit the perception and understanding of the concept of violence against women as being a private act behind closed doors (Campbell, 1992). Another term, “family violence”, refers to all forms of abuse within the family, regardless of the age or sex of the victim or the perpetrator. Although, family violence is commonly used, it fails to highlight that violence in the family is mostly perpetrated by men against women and children

(Ellsberg, 2000). The term *victimization* includes four main forms of violence against women: psychological, physical, sexual, and stalking (Walker et al., 2004). In North America physical assault of a woman by her partner or ex-partner is often termed IPV (Campbell, 2002). However, this term does not make it explicit that the victims are generally women. When abuse occurs repeatedly in the same relationship, the phenomenon is often referred to as battering (Krug & WHO, 2002). According to Corbally (2001), the term woman battering is deemed appropriate, as well as IPV. Woman battering is defined specifically as a process whereby an adult woman is the recipient of intended acts causing physical or psychological pain by an adult partner. Abuse against women can include emotional degradation, sexual assault, threats, and violence toward property, as well as physical assault (Campbell, Poland, Waller & Ager, 1992; Moulton, 1997). Additionally, the battering episodes are repetitive in nature. The abuse is continued indefinitely without regard to the woman's rights and with the sole aim of controlling and instilling fear into the victim. The terms that seem to be the most appropriate are "gender-based violence", "battered women", "abuse against women", "violence against women" or "intimate partner violence," (Ellsberg, 2000; Campbell, 2002; Guedes, Bott, Güzemes & Helzner, 2002) and thus, in this thesis these terms are used interchangeably to refer to the range of sexual, psychological and physical coercive acts used against women by a current or former male intimate partner. Femicide is another term recently introduced and used in scientific articles to refer specifically to the killing of women (Campbell et al., 1998a).

1.2. Gender and violence

There is obviously a need to define the feminist perspective when researching gender-based violence. According to Volbrecht (2002), a feminist is a person who rejects the ways in which women and their experiences have been criticised, ignored, and devalued. Further a feminist is also someone who works to bring about the social changes necessary to promote more just relationships between women and men. Yet gender defines the social and cultural construction of femininity and masculinity in any given society, justifying the differential allocation of resources and power (Hirdman, 1992a). Gender is a social category that refers to women's and men's roles and responsibilities that are socially determined. Hirdman (1992a) described this relationship between women and men as women's subordination to men during the 20th centuries (Florin, 1994). Women are and have been subordinated to men both in sexual, economic, and political perspectives. Gender-based violence, seen mainly as a political issue, contributes to viewing violence not mainly as a cultural, private or individual

issue but rather as a political matter that requires states to take action. According to Hirdman (1992b), in Sweden the process has started but has mainly focused on changes of women's issues rather than on men's changed actions towards an equity-based society. The process can be described as being more or less the same in the other Nordic countries. Gender-based violence, however, is a major constraint to women's full participation in society.

Despite the gaps between women's and men's participation in equity based changes in society, the issue of gender and violence has moved forward, and is no longer seen as an issue that only involves marginalized groups in society, such as people with drug problems, poor economy and other related problems (Goldner, Penn, Sheinberg & Walker, 1990). Most members of society agree that violence against women can happen to anyone (Goldner et al., 1990). Corbally (2001) stated that "there are no socio-economic pre-dispositions for women who encounter violence; it is universal." Therefore, there is no special less successful group. However, gender-based violence is more prevalent in settings where violence is normal, and where the effects of poverty and economic inequality are mediated through their effect on levels of conflict over resources (Mullen et al., 1988; Heise et al., 1994; Jewkes, 2002). The causes of gender-based violence are complex. Nonetheless, two factors seem to be necessary in an epidemiological sense: the unequal position of women in a particular relationship (and in society), and the normative use of violence in conflicts (Jewkes, 2002).

Ekström (2002) described the attitudes among attorneys in courtrooms from 1946 to 1950 in Sweden. At that time, "a little" violence was accepted in a rape-case. If the woman had a poor reputation, had an "impure" sexual history, and had a relationship to the perpetrator, the judgment was in the man's favour. Little has changed in the courtrooms since the 1950s. During the last few years, severe group rape cases in Sweden have ended in favour of the perpetrators, who have been released by the prosecution. In today's society, attitudes towards violence remain in a mixed state of myths. Severe violence is seen as fragmented incidents of crime (Lundgren & Westerstrand, 2005). Humiliating behaviour towards women with an absence of physical violence is seen as normal, and not associated with more severe forms of violence. As long as severe violence is seen as individual situations, and less severe violence is not recognised as violence against women, men's dominion continues. Mostly the men set the norms for what is acceptable or not (Lundgren, 2005). Informal rules seem to guide common everyday situations at home and at work, as the earlier common 'rule of thumb' in

England (Corbally, 2001). A 19th century British law stated that a wife could be beaten by her husband with any instrument, as long as it was not thicker than his thumb.

According to some researchers a violent man can be recognised as a 'normal man', as opposed to the normal "truth" that portrays him as a man with psychological problems, who is socially deprived, unemployed, alcoholic, or segregated in society (Lundgren, 2004; Krug & WHO, 2002). According to some researchers a battering man cannot be distinguished from a non-battering man when it comes to alcohol consumption (WHO, 2002), social maladjustment, education, economy, work, and birth place (Stoltenberg, 1989; Goldner et al., 1990; Wood, 2001; Schmidt et al., 2006). In contrast, Flinck et al., (2005) indicated that spouse abusers often also are alcohol and drug abusers, and battering men are more likely to act more brutally when drunk according to Jewkes, 2002. Schmidt et al., (2006) included the domineering of the assisting partner in a clinical appointment as a 'red flag', possibly indicating a home situation of assault and battery. The characteristics that researchers have associated with men who commit violence against women include low assertiveness, low self-esteem, poor social skills, anger and hostility, to be depressed, high spouse-specific dependency, and to score high on certain scales of personality disorder, including antisocial, aggressive and borderline personality disorders (WHO, 2002; Flinck et al., 2005).

Nevertheless, Flinck et al., (2005) stated that spouse abusers are not a homogenous group and no one factor predict the likelihood of spouse violence (Jewkes, 2002). Findings have shown that children who both witness violence and who are abused themselves are at particular risk of being violent against women in adulthood (Caeser, 1998; Heise, 1998; Krug & WHO, 2002). Researchers have reported that sons of women who are beaten are more likely to beat their intimate partners (Ellsberg, Peña, Herrera, Liljestrand & Winkvist, 1999). Jensen (1995) found that the use of pornography by men can be linked to sexual violence, by shaping a male-dominant view of sexuality. Pornography may make it difficult for men to distinguish between sexual fantasy and reality. They may then break down their victim's resistance to sex and end up by committing sexual violence against women. It is noteworthy that most of the men had experienced abuse as children. The men described their own roles as being dominant and as subordinating women. Jensen (1995) concluded that the issue is mainly political, because of the availability of pornographic literature in society, which supports the promotion of sexual violence against women. Flinck et al., (2005) found that most abused women had also suffered some form of mistreatment and violence in their childhood (Jewkes, 2002). Due to adults creating social norms, boys may learn to use violence and girls may learn to tolerate violence, or at least tolerate aggressive behaviour (Wood, 2001; Jewkes, 2002). Nevertheless,

Humphreys (1998) concluded that ‘although a history of violence in the family of origin can seriously affect children, and increases the risk of boys becoming adult batterer, exposure to violence does not automatically result in serious behavioural problems and a certainty of violence in future relationships’ (p. 123).

In the fragmented perspective of men’s violence against women, the focus passes on to the men’s justification of weaknesses, and the violence is thereby explained and accepted (Joelsson, 2005). Thus men’s violent behaviour remains in the shadow, and empathy is constructed towards him according to the woman’s nags, and the man resorts to physical force (Piispa, 2004). In addition, men continue to set the norms. Goldner et al., (1990) describe men’s violence against women as simultaneously an instrumental and an expressive act:

Its instrumentality rests on the fact that it is a powerful method of social control. A man can enforce his will and extend his areas of privilege in a relationship by hitting or merely threatening to hit his wife. Eventually he can get his way merely by a shift in his tone of voice or facial expression. In this sense, violence is a strategy of intimidation in the service of male domination, a strategy that a man consciously *chooses*. At another level, violence can be understood as an impulsive, expressive act. It is often felt by men to be a regressive experience, the feeling of losing *it*. We believe that both are true: that male violence is both wilful and impulse ridden, that it represents a conscious strategy of control, and a frightening, disorienting loss of control. (p.2)

Isdal (2001) describes the violent man as acting out of a mood of powerlessness. Boys and men have a strong need to be in power, and when they feel they are losing their power over the situation, they control their powerlessness with the use of violence. The perpetrator explains his sudden anger because of her stupidity (Isdal, 2001). Jacobson & Gottman (1998) described two main types of batterer, called Pit Bulls and Cobras. Some Cobras are psychopaths and more dangerous than Pit Bulls. They gain control through a ferocious, cold calculating method of abuse. Pit Bulls feel that they are victims, because they fear being abandoned by their partner. They use a method of violence that involves total mind control, to the point where the battered woman begins to doubt her own sanity. Both types of men are capable of killing their women (Jacobson & Gottman, 1998).

Joelsson (2005) described how social welfare personnel found excuses for violent fathers’ obligations towards their children, to the extent that they even found excuses for violence against the children. She reported that “the administrator explained that the father is challenged so hard that he reacts violently even against his children”. Efforts in the

communities to achieve zero tolerance for violence against women must be continued. Focus must not be concentrated mostly on the men. As long as abused women are not offered total support and help from the community, and as long as women are abused, the focus must be kept on their needs and their children's needs. The issue of violence against women has been on the agenda for some years (Wood, 2001), and knowledge has been shared in a constructive way. However, reluctance and unwillingness to accept the need for changed attitudes and behaviour (Jones, 2000) must be understood as a refusal to accept the available knowledge (Lundgren & Westerstrand, 2005).

1.3. Constructs of empowerment, stress, and coping

The concepts of empowerment, stress and coping are important for understanding the situation of the battered women. A battered woman captured to isolation and often daily threats may experience powerlessness and stress. Powerlessness and stress can be recognised as risk factors that adversely affects the quality of life. In a public health perspective, empowerment is a fundamental element, along with stress, and coping (Antonovsky, 1987). As defined by Rappaport (1984), empowerment is viewed as a process: the mechanism by which people, organizations, and communities gain mastery over their lives. In this thesis, as a concept, 'empowerment' is a useful tool in which a positive process is enhanced by the nurse by delegating responsibility and power back to the patient, 'the woman'. The word power comes from 'potere', a Latin word meaning to be able and to have the ability to choose (Kuokkanen & Leino-Kilpi, 2000), according to Rodwell (1996), to empower means to authorize, to license, to impart power, to enable, and to permit. The concept is fundamentally positive, referring to solutions rather than to problems, and is associated with growth and development. Additionally McDougall (1997) argued that "empowerment is not a fundamental way of thinking, and for this reason it cannot be thought of as a technique. Power comes from within, through self-awareness, and self-esteem. Consequently it has been said that nurses cannot empower patients, only patients can empower themselves (p.4)." Trust is a necessary condition in the empowerment process between the nurse and the battered woman, where the nurse needs to delegate and share her power and her help to the patient in order to gain power. Henderson & Ericksen, (1994) stated that the goal of expert caring is empowerment rather than domination and control. Thus, the empowering process involves, for example, patient-nurse intervention. The client outcomes are self-efficacy, power to be, sense of control, sense of mastery, growth, a sense of connectedness, and improved health and well-being (McMurray & Moore, 1994). For a battered woman the outcomes can serve as

lifelines back to a more desired life. To achieve self-care the individuals must use empowerment to be activated to take charge of their own health (Pender, 1996). The base is that the individual should be actively involved in health problem-solving, making rational and informed choices regarding health care, developing competence and skills that foster creativity and adaptation amid changing life circumstances and striving for greater mastery of environmental conditions that have an impact on health and well-being.

In nurses' empowerment approaches, their behaviour towards women can enhance the process of enabling women to increase their self-respect and to gain more control over their lives. On the other hand, a nurse can ruin the woman's possibilities to get control over the violent situation in which she is entrapped, when the nurse is not observant in her role of giving hope, trust and affirmation to the woman. According to Moulton (1997), nurses avoid identifying battered women in emergency departments. Corbally (2001) reported that nurses disliked caring for 'regular users' of the emergency department. Battered women are recognised by nurses as regular users of health care. This approach disempowers patients. As non-compliant patients, they are unpopular (McDougall, 1997).

Lazarus (1993a) recognised two influential qualitative expansions of the stress concept. One of the two concepts was *eustress*, which is the good kind of stress associated with positive feelings and healthy bodily states. The second concept was *distress*, which was explained as the bad kind, associated with negative feelings and disturbed bodily states. A further distinction of distress made by Lazarus (1993a) described three different kinds of stress: harm, threat, and challenge. Presumably these different kinds of psychological stress states are caused by different antecedent conditions, both in the environment and within the person, and have different consequences. Battered women are more than ten times more likely to experience emotional distress than women who have never experienced abuse (Ellsberg, 2000). Threat is a common experience of battered women, and is an unpleasant state of mind that may seriously block mental operations and impair functioning. It is a reason why women suffer difficulties in concentration (Lazarus, 1993a).

Stressful events occur in everyday situations as long as a battered woman stays with her violent partner. Nurses are also at risk of violence in carrying out their work and in their private lives. Lazarus (1993a) stated that some people resist the deleterious effects of stress better than others. He pointed out that some personality traits appear to be associated with

resilience, such as constructive thinking, hardiness, hope, learned resourcefulness, optimism-shades of Horatio, self-efficacy, and sense of coherence. A person affected by a stressful situation reacts in two main ways: problem-focused coping and emotion-focused coping (Lazarus, 1993b). Coping is seen as a process – a person's ongoing efforts in thought and action to manage specific demands that are taxing or overwhelming (Lazarus, 1993a; Thernlund, 1995). By definition, problem-focused coping is goal-directed, it includes strategies for gathering information, decision-making, planning, and resolving conflicts in order to solve or manage problems that impede or block goals and create distress (Folkman, 1997). Emotion-focused coping uses strategies to regulate the distress associated with specific problems (Zink, Jacobson, Pabst, Regan & Fisher, 2006).

Coping depends on an appraisal of whether anything can be done to change the situation. If the appraisal indicates that something can be done, problem-focused coping predominates; if the appraisal indicates that nothing can be done, emotion-focused coping predominates (Lazarus, 1993a). Coping is highly contextual, because psychological stress defines an unfavourable relationship between the person and the environment, and its essence is process and change. Thus, if coping is to be effective, it must change over time and across different stressful conditions (Lazarus, 1993b). Despite this, Folkman (1997) reported that people with high levels of distress also experience positive psychological states during care giving and bereavement. In the coping process associated with positive psychological states was the searching for and finding of positive meaning (Folkman, 1997). Thus, meaning is created by finding redeeming value in loss, finding that new or closer bonds with others have been formed through experiencing or surviving a disaster together, or through pursuing and attaining important goals (Folkman, 1997). Women have reported that they have joined battered women's self-help groups to find out what other abused women are like, to share experiences and to reflect (Rahm, Renck & Ringsberg, 2006).

Denial and distancing are powerful techniques in the control of psychological stress, because they enable a person to appraise an encounter as more benign (Lazarus, 1993a). According to Lazarus (1993b), denial has been regarded as pathogenic. However, denial as a coping strategy can be useful to adopt under certain definable circumstances. In some situations, a battered woman can benefit from coping through denial as well as the opposite. In a life-threatening situation, denial can cause death. A nurse who copes with violence by using the approach of denial is leaving the battered woman without options.

Stress is defined as “a consequence of the individual’s cognitive appraisal of a situation as a threat or a challenge” (Moulton, 1997, p.114). In relation to nurses, they cope with stress according to their individual appraisal of the relationship between environmental demands and individual and social resources. The nurse who experiences a high level of stress in the workplace or in her private life can respond with fight or flight strategies (Moulton, 1997; McEwen, 1998; Ogden, 2000). Two factors largely determine individual responses to potentially stressful situations: the way a person perceives a situation and a person’s general state of physical health, which is determined not only by genetic factors but also by behavioural and lifestyle choices (McEwen, 1998). A nurse who responds with flight might deny that the woman’s problems are related to abuse, or that these problems are her responsibility. The nurse willingly treats the woman’s wounds, but ignores the problem of violence. But hiding behind the acceptance of violence may lay the nurse’s appraisal of the event as harmful and negative. Nurses most commonly express their emotional responses to violence as anger, frustration and sadness (Moulton, 1997). The stress level becomes too high and the nurse responds with resistance to the stressor. Davison (1997) reported that nurses do not respond adequately to battered women because of unresolved feelings about violence against women and the propensity towards victim blaming. Some factors behind this were: inadequate training, supervision and support, which render the problem invisible, lack of clarity about nursing roles and boundaries, and lack of confidence about how to intervene in possible cases of intimate partner abuse. The reactions of the nurses when the woman chose to go back to the abusive situation were frustration and sadness; sometimes even anger (Moulton, 1997). Other stress factors expressed by nurses are “whether they as professionals do what they can, whether they say the right things, and whether they learn by experience and handle new cases better”.

Other nurses may respond with less stress, respond with direct action, or seek information. The event is interpreted as a positive challenge by the nurse, who responds with enthusiasm and curiosity about how to solve the problem. The nurse’s self-efficacy provides her with a feeling of confidence that she can perform the desired action of helping the victim. Further, the nurse may have a high degree of hardiness, which is conceived as a constellation of three dimensions: commitment, control and challenge (Ogden, 2000). Therefore, hardy nurses may suffer fewer health-related consequences when stressed (Moulton, 1997). They may also succeed better in their work performance. Nurses who respond by feeling challenged may not react with stress. Thus, hardiness provides buffering effects that protect health in stressful

situations. Harri (1998) stated that hardiness has a clear link to the salutogenic model (Antonovsky, 1987). The salutogenic model, 'the sense of coherence' (SOC) defined by Antonovsky (1987), explains why some individuals cope successfully with stressors, and includes three core components: comprehensibility, manageability; and meaningfulness. Comprehensibility refers to the extent to which one perceives the stimuli that derive from the internal and/or external environments as making sense (Harri, 1998). The stimuli may not be desirable, but it is possible to make sense of them. Manageability refers to the extent to which one perceives that the resources to meet the demands are at one's disposal (Harri, 1998). Meaningfulness refers to the extent to which life makes sense emotionally, the extent to which the demands are worth investing energy in and are challenges rather than burdens (Harri, 1998). Thus, a person with strong SOC is expected to feel that things will work out as well as can reasonably be expected. Accordingly, sexual-abused women reported extremely low SOC levels in childhood (Renck & Rahm, 2004). The women suffered from severe psychiatric disabilities and high levels of depressive and psychotic symptoms. They were probably unable to mobilise adequate resources. Nurses can be the woman's link to her inner being, through giving her strength, by being present, by listening, by showing affirmation, and probably by giving support to a stronger SOC within the woman.

1.4 Gender-based violence in a public health perspective

Public health aims at responding to criteria related to the frequency of a phenomenon of ill health in society, to its consequences for individuals and society, and to its distribution in society (Leander, 2002; Krug & WHO, 2002). While WHO (1987) defined health "as a complete physical, mental and social state of well-being and not merely the absence of disease" in 1987 (Magzoub, 1994), violence against women was recognised as a crime against human rights during the 1990s (Widding Hedin, 2002). In the past decade, enormous efforts both intellectual and practical have been made to devise strategies to improve the lives of the many millions of disadvantaged people in the world (Oakley, 1989). The concern and emphasis of public health is to prevent and promote health-related problems. The public health approach to any problem is multidisciplinary and science-based. Eskola (1995) stated that violence was one of the major public health problems in Finland. Finnish national health policy has been strongly based on that of WHO (1987) and the Alma-Ata Declaration (Eskola, 1995). The constructed strategies have focused on equity by establishing as a general principle that priority should be given to the needs of the most disadvantaged people, and to ensuring social equity. Thus, seen in a global perspective, violence against women is a public

health issue of great magnitude (Helton, McFarlane & Anderson, 1987; Campbell, 1992; Heise et al., 1994; Hadley et al., 1995; Gazmararian, Lazorick, Spitz, Ballard, Saltzman & Marks, 1996; Gracia-Moreno, 1999; Woodtli, 2000; Davidson, Grisso, Garcia-Moreno, Garcia, King & Marchant, 2001; Edin & Högberg, 2002; Leander, 2002; Nicolaidis, 2002; Widding Hedin, 2002; Daniels, 2005). Battering is reported as being a major cause of injury to women, causing more injury than cancer, automobile accidents, muggings, and rapes combined (Loring & Smith, 1994; Anonymous, 1997). The phenomenon of violence against women is described as a multifaceted and complex problem (Mullen et al., 1988; Ambuel et al., 1997; Heise, 1998; Davis, 2002a; Krug & WHO, 2002; Smith, 2003), and escalating over time (Piispa, 2004). According to Leander (2002), intimate partner violence is the result of interactions between psychosocial, biomedical and social processes (Goldner et al., 1998).

When conceptualizing violence against women in a public health perspective, the ecological model may explain the complex interplay of individual, social, cultural and environmental factors (Heise, 1998; Ellsberg, 2000; Ellsberg, Peña, Herrera, Liljestrand & Winkvist, 2000; Krug & WHO, 2002; Larsson, 2003). The ecological model explores the relationship between individual and contextual factors and considers violence as the product of multiple levels of influence on behaviour.

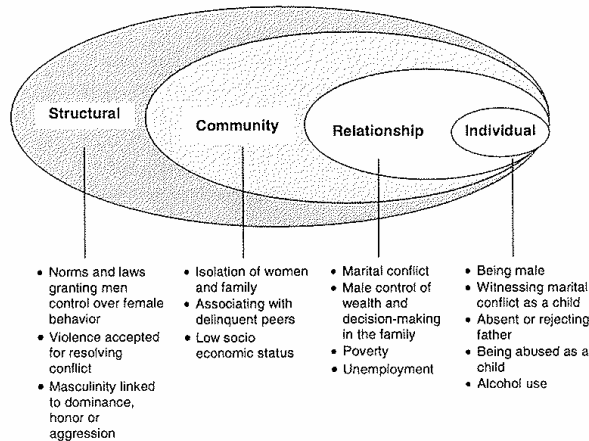


Figure 1. An ecological framework for understanding violence against women (adapted from Ellsberg, 2000).

The model consists of four levels of analysis, best visualised as four concentric circles (see Figure 1). The ecological framework can be described using four circles. The **innermost circle** represents the personal history factors that each individual brings to his or her behaviour and relationships associated with partner violence (Heise, 1998; Ellsberg, 2000; Ellsberg et al., 2000; Krug & WHO, 2002; Larsson, 2003). The **second circle**, 'relationship', represents the immediate context in which abuse takes place – frequently the family or other intimate or acquaintance relationships. Several authors have cited male economic and decision-making authority in the family as strong predictors of partner abuse (Hotton, 2001; Watts & Zimmerman, 2002). Thus, most efforts, including resource allocation, are focused on the relationship level, and aim at modifying individual factors thought to contribute to violent behaviour (Leander, 2002). The **third circle**, the community level of the ecological framework, encompasses the institutions and social structures, both formal and informal, that embody the relationship level – the world of work, neighbourhood, social networks, and identity groups (Heise, 1998; Ellsberg, 2000; Ellsberg et al., 2000; Krug & WHO, 2002; Larsson, 2003). Finally, the **outer circle** of the ecological framework represents the general views and attitudes that permeate the culture at large (Heise, 1998; Ellsberg, 2000; Ellsberg et

al., 2000; Krug & WHO, 2002; Larsson, 2003). It includes laws, social and economic policies and cultural norms. Reluctance is seen on the structural level, whereby social processes contribute to violence, whereas if they were addressed they could have an impact. This model can be applied either at the level of the individual, to develop a profile of the men who are most at risk of abusing, or at the level of the community, to improve our understanding of why rates of abuse vary according to setting, and why women are so consistently the victims (Heise, 1998; Ellsberg et al., 2000). The model provides a way to grapple with the complexity of violence against women, thus to facilitate designs of intervention and prevention programmes (Leander, 2002).

1.5. Women's health problems related to gender-based violence

Research has indicated that battering is the single most common source of injuries to women, surpassing that of car accidents and muggings combined (Loring & Smith, 1994; Caralis & Musialowski, 1997; Mayer, 2000; Ambuel et al., 1997). In general, there are four main kinds of health effects from violence against women: acute physical injury, chronic physical injury, exacerbation of other health problems, and stress-related health problems (Walker et al., 2004). Injuries sustained from physical abuse include contusions, concussion, lacerations, fractures and gunshot wounds (Ellsberg, 2000). Researchers found that among the methods that the perpetrators used, punching, pushing, kicking and slapping women were the most common (Pakieser, Lenaghan, & Muelleman, 1998). Among the objects used for hitting the victim were knives, guns, hammers, nail guns, crow bars, household items and hands.

Tønnesen, Lundh & Heimer (1999) reported that victimized women are perceived as being frequent users of health care services (Risberg, 1994). Indeed, battered women experience more non-trauma related outpatient care, including gynaecological care, more hospitalization for non-trauma related surgical conditions, medical conditions, non-specific conditions, suicide attempts (Chambliss, Curtis Bay & Jones, 1995) and psychiatric treatment (Risberg, 1994), more non-trauma related medical emergencies, and more elective abortions and miscarriages (Ambuel et al., 1997). Women with past histories of family violence continue to use more medical resources. They experience more stress-related illness, including fatigue, headache, gastrointestinal problems and pain, and they experience more depression and anxiety (Ambuel et al., 1997; Ellsberg, 2000). Piispa (2004) reported that older women had experienced physical violence three times more often than younger women. Age was not

associated with having psychological consequences. Both young and older women reported fear, numbness, guilt, and lowered self-esteem. Violence is reported to escalate over time, thus older women reported more severe forms of violence than younger women (Piispa, 2004).

Studies confirm that female psychiatric patients often have a current or past history of abuse (Mullen et al., 1988; Hoff & Rosenbaum, 1994). Abused women seeking help at a mental health facility are commonly diagnosed as having borderline personality disorders, multiple personality disorders, anxiety/panic disorders, and a burgeoning list of diagnoses associated with victimization trauma (Hoff & Rosenbaum, 1994; Tönnesen et al., 1999). Other health care problems that have been recognised by health care professionals are chronic pain, pelvic inflammatory disease and eating disorders. A history of violence is a major risk factor, but is seldom assessed (Campbell, 1992). The most common mental health problems associated with IPV include post-traumatic stress disorder (PTSD) and depression (Mullen et al., 1988; Walker et al., 2004). In addition to these signs and symptoms, patients sometimes present with environmental and behavioural cues, which are often associated with psychological distress, sleeping problems, fragmentary memory, forgetfulness and concentration problems and missed appointments (Heiskanen et al., 1998; Campbell & Soeken, 1999; Campbell, 2002; Flinck et al., 2005). Researchers in Sweden reported that in one study 20 women were interviewed who had sought health care for diffuse back pain, but eleven of them had experienced violence (Tönnesen et al., 1999).

1.6. Violence against pregnant women

A key aspect of violence against women is unintended pregnancy, followed by battering during pregnancy. The extent of this abuse has been found to be considerable (Loring, & Smith, 1994; Pallitto, & O'Campo, 2005). Gazmararian et al., (1996) indicated that violence is a more common problem for pregnant women than pre-eclampsia, gestational diabetes, and placenta previa. Some researchers have found that battering often begins and escalates in pregnancy and results in poor pregnancy outcome (Helton et al., 1987; Chambliss et al., 1995; Iwarsson-Sporrong, 1998; Gracia-Moreno, 1999). Widding Hedin (1999) did not find that pregnancy was a risk factor for violence, but reported that younger women more often experience violence during pregnancy and are therefore at greater risk for abuse during pregnancy. One characteristic of IPV is that threats, intimidation, control, and physical battering escalate over time (Heise et al., 1994; Caralis, & Musialowski, 1997; Feldhaus,

Koziol-McLain, Amsbury, Norton, Lowenstein & Abbott, 1997; Mayer, 2000). Moreover, most of the women do not experience physical violence until after they have married. Studies document that the more severely and frequently a woman is beaten before pregnancy, the more likely she is to be abused while pregnant, thus increasing the risk of pre-term labour, maternal and foetal injuries, low birth weight, and subsequent child abuse (Risberg, 1994; Perrin, Boyett, & McDermott, 2000). One study found that 26 % of 200 pregnant adolescents reported being in a relationship with a male partner who was physically abusive (Perrin et al., 2000). Abused pregnant women have been reported to be alcohol and drug abusers (Campbell et al., 1992; Curry, & Harvey, 1998; Ellsberg, 2000). Campbell, Oliver and Bullock (1998b) assumed that at least some women diagnosed with postpartum depression have experienced abuse from an intimate partner. Battered pregnant women are rarely identified at antenatal clinics (Widding Hedin, 1999; Edin, & Högberg, 2002), although 80 % of the women attending such a clinic in Sweden reported that they were positive about being asked about this (Stenson, Saarinen, Heimer, & Sidenvall, 2001). Walker et al. (2004) indicated that 5 % or less of women with histories of partner violence are identified by health personnel. Further, physicians asked only 10 % to 15 % of their patients about victimization (Friedman, Samet, Roberts, Hudlin & Hans, 1992). Some physicians also believe that they miss many cases, and that up to 30 % of battering incidents go unreported and untreated (Henderson & Ericksen, 1994; Gerbert, Johnston, Caspers, Bleecker, Woods & Rosenbaum, 1996).

1.7. Battered women leaving the abusive relationship

The majority of battered women do not stay in abusive relationships (Campbell, 1991). The complex leave-taking process often takes a long time. Women leave and return several times before finally breaking up (Campbell Ulrich, 1998; Smith, 2003). Risberg (1994) emphasized that the normalization process (the man normalizing the violence) is one reason that women give as an explanation to stay. Some women may not recognise the less severe forms of violence when the violence continues, and therefore they remain in the relationship (Piispa, 2004). In contrast, young women report less severe violence, and talk more openly about problems and violence in relationships (Piispa, 2004). Older women cope with violence because they feel forced to do so until society provides resources to help them to leave their abusive partners (Zink et al., 2006). Some older women stay for the following reasons: they remain committed to their abusive partner, they feel responsible for the abuser, they feel responsible for helping their partner, they fear financial loss, they fear reprisals, and they fear for the physical safety of themselves and their children (Smith, 2003). Some of them feel

fulfilled in their lives, others are simply surviving. A non-supportive environment can be a major barrier in preventing the women from leaving an abusive relationship (Campbell Ulrich, 1998). A woman's decision about whether to stay or leave may be influenced by feelings of forgiveness (Coop Gordon, Burton & Porter, 2004). If a woman believes that her partner is intentionally and maliciously hurting her, she may be much less likely to forgive him, and therefore much less likely to return.

There have been many explanations of why women stay in abusive relationships, but there has been little focus on how women are able to leave such relationships, according to Campbell Ulrich (1998). Smith (2003) described two main triggers that were critical in helping women to leave their abusive partners. First, the women's tolerance of pain, fear, and coercive treatment had finally been exhausted, a line had been crossed. Second, they felt that their children were in severe danger. External factors that help women to leave are economic support, family affirmation, friends who care, shelters and support groups, and professional help (Campbell Ulrich, 1998; Smith, 2003). Another factor is the woman's personal growth (Campbell Ulrich, 1998). For most women, the availability of positive social support is the most important factor (Campbell Ulrich, 1998).

1.8. The nursing context – assessing violence

Research has shown that 47 % of battered women who were killed had been seen in the health care system during the year before they were killed (Campbell, 2004). Zink et al., (2006) investigated how older women cope in long-term abusive intimate relationships. They found that the women remained committed to their abusive partner, so that leaving was not recognised as an option. Nurses need to identify methods to keep older women safe and give them help when they ask for assistance. Risk assessment scales are not fully validated. This makes the woman's perception of risk an important source of information. Health professionals are therefore as important as the woman herself in assessing the level of danger to the woman, and in creating safe options. In general, a selective screening made by the nurses should be carried out as a routine (Lamberg, 2000; Campbell, 2002; Gracia-Moreno, 2002). In particular, all pregnant women should be questioned about violence (Bullock, 1998; Ramsey et al., 2002). Furniss (1998) found that women of college age had a higher risk for dating violent men than women in general, and therefore all young women should be routinely questioned during any health encounter. Nurses are reported to be reluctant to ask women about violence (Henderson & Ericksen, 1994), although women themselves have

responded positively to being asked (Stenson et al., 2001; Socialstyrelsen, 2002; Schmidt et al., 2006). An abused woman is constantly aware of being abused. The woman needs a supportive advocate who will listen, care, and provide information about viable options, offered in an acceptable context when the woman is ready (McFarlane, Christoffel, Bateman, Miller & Bullock, 1991; King & Ryan, 1996).

However, studies report that nurses are insensitive to the problem of violence. Although they treat injuries, they ignore the cause (Hendersen & Ericksen, 1994). A significant number of nurses interviewed by Shipley (1982) reported never having encountered an incidence of abuse. Others were frustrated by their own perceived lack of education, skills and resources. Other nurses had low motivation to assume professional responsibility for treating family violence. Some had prejudicial attitudes (e.g. they viewed partner violence as a problem of the lower classes. They underestimated battered women's ability to take action). Some nurses were frustrated with these clients because of their experiences with family violence. Some health professional who assumed leadership roles were marginalized by others in the health care system (Ambuel et al., 1997). Keeping in mind that 20-30 % of the women seen in any health care setting are battered women, most of them are undetected (Campbell, 1992).

Among the barriers that make nurses fail to assess women for abuse are perceived lack of support from colleagues, physicians, and social workers, and possibly, a narrow definition of their role (Henderson & Ericksen, 1994; King & Ryan, 1996). Moore, Zaccaro & Parsons (1998) mean that inadequate assessment of abuse, and lack of appropriate intervention by nurses and other health care providers, present major barriers to the care of abused women. Furthermore, King & Ryan (1996) stated that nurses believe that the situation is too complicated and hopeless. Some nurses feel general discomfort with the issue of abuse, and some nurses believe in societal myths about abuse (Henderson & Ericksen, 1994). Nurses might also believe that direct questioning would jeopardise the relationship between themselves and their clients, possibly resulting in the client terminating the care. McFarlane et al. (1991) showed that for women seeking help at an emergency unit, the prevalence of abuse was 29.3 % when the women were assessed by nurses, compared with 7.3 % when women were asked to report abuse themselves. The nurse is avoiding her responsibility if she believes that the woman will share sensitive information with her when she is ready. The women are surrounded by factors through their experience of abuse, such as shame, the threat of further violence, fear of judgement, and self blame (Flobecker & Hammarström, 1998). Considering

the risk, not asking a woman about abuse jeopardizes her safety. Also, given the social constraints and personal feelings of guilt and shame, it is extremely unlikely that a woman will voluntarily disclose abuse, even to a nurse (Hoff & Rosenbaum, 1994; King & Ryan, 1996). Perrin et al., (2000) reported that 65 % of abused pregnant adolescents had not talked to anyone about the abuse, and none of them had reported the abuse to law enforcement agencies. At health care facilities it should be routine to ask every woman about abuse, if nurses are to be successful in detecting abuse (Campbell & Sheridan, 1989; King & Ryan, 1996; Ambuel et al., 1997; Richardson, Coid, Petruckevitch, Chung, Moorey, Feder 2002). In contrast, some researchers report that nurses disagree that all women should be asked about abuse, because of the inconvenience (Cole, 2000; Garcia-Moreno, 2002; Ramsey et al., 2002). However, researchers recommend that all women should be asked at the initial history-taking, and that at subsequent health care visits a series of specific questions designed to elicit current or past history of partner abuse should be asked (Campbell, 1992; King & Ryan, 1996; Feldhaus et al., 1997; Humphreys, 1998; Widding Hedin, 2002; Wijma, Heimer & Wijma, 2002; Zink & Jacobson, 2003; Daniels, 2005; Flinck et al., 2005; Hotton, 2001). Routine screening questions should be asked in complete privacy in the nurse's own words (King & Ryan, 1996) and in a non-judgemental and empathic manner. Further, nurses should avoid the use of terms like 'battered or abused women'. Nevertheless, nurses are strategically positioned to detect actual and potential risk of abuse through the scope and variety of their practice in health care environments (Hoff & Rosenbaum, 1994).

A nurse assessing a woman must decide at what level to intervene. Health prevention interventions include specific measures to reduce diseases, and are not often aimed at actively improving health. There are three levels of prevention: primary – which aims to prevent people getting a disease or disorder by using measures such as vaccinating older people against flu; secondary – which aims to detect a condition in its early stages and might, for example, include screening women with known risk factors for violence; and tertiary – which consists of active treatment of a particular condition or illness in order to reduce its effects (Bernard, 2000). In planned nursing intervention, primary prevention includes identifying known or potential stressors and trying to reduce the possibility that the individual will encounter the stressor (Bullock, 1998). Secondary intervention is needed once the stressor has broken through the flexible line of defence, and the goal is to strengthen the basic structure so that the effect of the stressor is minimized (Bullock, 1998; Humphreys, 1998). King and Ryan (1996) suggested that the nurses' roles in primary and secondary prevention of abuse against

women are of great importance. Nurses are often the first non-family contact with whom the women feel comfortable discussing their personal and social concerns or problems. At the tertiary intervention level, the nurses' main goals are the reconstitution of the women to an optimal level of health (Bullock, 1998). The goals for this level of care are to reduce or prevent future occurrences with the stressor, where nurses are in an excellent position to support realistic and needed changes (Bullock, 1998; Humphreys, 1998).

1.9. Gender-based violence on the historical agenda

During the last century the issue of violence against women has undergone a fundamental change. Not many years ago, people questioned a woman leaving her husband. Her place was with her husband. People judged her actions and criticised her decisions, and this still happens. However, now the question is often "why does she not leave?" (Risberg, 1994; Smith, 2003). The focus is still on the woman – though, the batterer is often the one in focus: Why does he batter? Why does he not stop?. The public attitude is purely patriarchal. The woman is the weak link in the chain. The question today – why does she not leave? – has two sides (Jones, 2000). On the one hand it blames the victim – the woman – for the abuse she suffers. On the other hand, it suggests that women now have more options and therefore should leave the abuser.

1998 was the fiftieth anniversary of the Declaration of Human Rights (Corbally, 2001). Article 5 of this Declaration illustrates how wrong abuse is (General Assembly of the United Nations, 1998). In Finland Lucina Hagman (1843-1946) was one of the strongest proponents of the women's movement (Högman, 1990). She strived for human rights for women her whole life. She formed the Union for Women's Issues (Kvinnosaksförbundet) and participated in forming the Women's Organization of the Swedish People's Party in Finland (Finska kvinnoförbundet). In her dissertation, Högman (1990) described the status of women in the Åland Islands from 1700 to 1950. In Åland women generally did the same work as men. They cut hay with scythes, they went behind the plough, and they helped with fishing nets. Seafaring was one of the main sources of income in the Åland Islands, so this meant that women often had the whole responsibility for the home and children, because the husband was away at sea. The women raised their children. At the beginning of the 20th century, the different generations lived in the same house. When bringing up children, girls were expected to be obedient, submissive, good, honest, polite, quiet, hard-working and strong. The church was powerful and had strong discipline over the people. People had to attend church every Sunday, otherwise they were punished. Men and women were exhorted to follow the word of

God: “you men live with your wives wisely”, “you men love your wives as your own bodies and you wives submit to your husbands in everything.” Even the media emphasized the subordination of women. In “Ålandstidningen” (a newspaper) in 1892 the following could be read: “the man will be happy if the wife is good”. The successfulness of a man was related to his wife. During the late 19th Century there were priests who regarded women as sensible beings, and who understood that women’s liberation was needed. However, there were many antagonists, and they were more powerful. The most important role for teachers was to make people respect God and authority. At the beginning of the 20th Century, teachers in Åland started to demand “the same salary for the same work” for teachers, irrespective of gender. According to Jones (2000), fewer efforts were made to prevent IPV, compared to in the 21st Century. Salvage (1993) described the status of women of today as depressing. Women make up half of the world population and they contribute almost two thirds of all hours worked, but they earn only one tenth of the world’s income and are owners of less than one hundredth of the world’s property.

In the USA from 1879 to 1891 Lucy Stone and her husband Henry Blackwell campaigned in Massachusetts for legislation modelled on laws already passed in England in response to Francis Power Cobbe’s revelation about “wife-torture” (Jones, 2000). The new legislation provided legal separation (not divorce) and financial maintenance for wives whose husbands were convicted of assaulting them. But even that modest proposal, seen as an attack upon the family, failed. Jones (2000) stated that the women’s movement started in USA started to be against IPV in 1974. A common attitude to wife beating during the 20th Century in Finland and in other parts of the world was that it was a widely practised means of exercising power, and was an acceptable part of life (Corbally, 2001). And, what happens within the home is the family’s own private business. People saw no reason to interfere, as they did not see any wrong in a man’s actions towards his wife. It is only recently that IPV has become unacceptable on the individual level. In Finland, women were allowed to vote as early as 1906.

The law forbidding house punishment (chastisement/beating) came as late as 1970 in Finland, while in Sweden the law was passed in 1864. In 1971 the law of punishment of the victim of incest was repealed, and rape in marriage has been a criminal offence in Finland since 1994. The Finnish Penal Code of 1 September 1995 brought domestic violence under public prosecution. As a result, the police have a mandate to register and investigate all cases of

domestic violence (Heiskanen et al., 1998). In October 1997, the position of women who are the victims of violence was improved, when the Act 689/97 (The Finnish Government, 1997) allowed for the assignment of support persons and legal advisers for these women at the expense of the state (Heiskanen et al., 1998). The next step in the development of laws in this area was the law on sexual protection and restraining orders the Act 898/98 (The Finnish Government, 1998) which came into force in January 1999, when rape was also brought under public prosecution. This legislation applies in Åland as well as in Finland. Homicide is classified as family violence if the perpetrator is living in the family.

1.10. Options for help in society

So what support is available to help battered women to leave? The most important source of support is a health service with responsibility for identifying and giving care to abused women (Björck & Heimer, 2003; Heimer & Posse, 2005). Support is also provided by social services, which have a duty to provide services to abused women, and by the police (Nylén, 2003; Wallberg, 2003). Other agencies that provide support are the civil and criminal courts, with specialized prosecutors who can intervene in relationships of IPV, based on criminal law services delivered to abused women (Kurts-Swanger & Petcosky, 2003; Wicklund, 2003). Other available options for battered women are hotlines. Hotlines are often run by specially trained volunteers or by paid staff of victim service programmes. Shelter homes provide a refuge where women can temporarily escape from violence, find safety and make decisions about their current and future lives (Dobash & Dobash, 1992; Beausang, 2003). Zink et al. (2006) suggest that older women who do not see leaving the abuser as an option, should be offered help when they ask for assistance, to ensure that they are safe. Such help can be provided by home health agencies that care for shelter clients, assisted-living facilities that provide emergency shelter, and domestic violence advocates who provide services at senior centres or make home visits. Smith (2003) found that other helpful options were going to church or developing spiritually in other ways, counselling, reading educational material and journals, and meeting a non-abusive man. However, there are gaps between the supply of help available for battered women and the utilization of services, since many services are not available to all women (Aldén, 2005; Stenius & Veysey, 2005). Another deficiency is the understanding of the ecology of violence in relationships, and that present paradigms continue to result in interventions that are based on the pathology of individuals (Kurts-Swanger & Petcosky, 2003). This means that instead of concentrating on the positive resources of the person, help is based on the pathological factors of the individuals.

Leaving a violent partner has consequences for the woman and her children. It is of great importance that this is recognised by professionals. The separation affects the woman physically, psychologically and socially (Walker et al., 2004). Physical effects are related to stress reactions. Psychological effects are related to conflicting emotions, mourning the loss of a relationship, re-establishing a new identity and regaining feelings of competence and self-esteem (Walker et al., 2004). Some women seem to be unable to recover (Smith, 2003). Since recovery depends on relating to people who the women can trust, recovery cannot occur in isolation. Some of the social factors the woman has to cope with are a new household, a new job and new friends. Professionals must help women to realise that although the past cannot be changed, they can work towards changing their future (Smith, 2003).

A better name for prevention strategies is intervention programmes, since they mainly intervene with violence after it has occurred (Kurts-Swanger & Petcosky, 2003). One example is the European programme on the tertiary level called “Operation Kvinnofrid International” (International Operation for Peace for Women) funded by the European Commission Medium-Term Programme, Community Action Programme on Equal Opportunities for Men and Women (1996-2000), which targeted men’s violence against women (Danilda, Leander & Operation Kvinnofrid International, 1999). The overall aim of the project was to disseminate information and to increase awareness of violence against women. The programme actively tried to put a stop to violence. The project’s objectives were to spread knowledge about methods of counteracting violence against women and to exchange experiences about this, to develop trans-national methods, to establish a trans-national network of experts on issues related to violence against women, and to increase cooperation and joint action between public authorities (Danilda, Leander & Operation Kvinnofrid International, 1999). Among the countries which joined the programme were the UK, Italy, Sweden, Åland, and Finland.

2. THE STUDY SITE

The study site is the Åland Islands, that consist of more than 6 500 islands located in the Baltic Sea between Finland and Sweden. Åland is an autonomous, demilitarized, Swedish-speaking region of Finland, where the whole public health service comes under an overall organization called Åland’s Health Care (ÅHS), which is governed by a politically-elected board. The population of Åland is approximately 27 000. Åland’s largest municipality is

Mariehamn and the smallest one is the outer island municipality of Sottunga with about 120 inhabitants. Being a small community with an open economy, Åland is dependent on the exchange of goods and services with surrounding regions. The long-standing basic industries in the Åland economy are shipping, agriculture and fishing. Tourism has been an expanding branch since the 1960s, and because of ferry services, tourism has greatly expanded.

3. AIMS OF THE STUDY

Nurses, who are often the first people to encounter battered women, face high demands and expectations. They need to be knowledgeable, to be skilled, and to behave well towards the women. They need to perform successfully, both on a physical and psychological level. Not all the nurses have a background without violence, either as children, or as adults in their relationship with their partner. Battered women seeking help may either disclose or hide their problem, depending on the nurses' responses. In fact, nurses have life and death in their hands. According to the ICN's Code of Ethics for nurses, they are also obliged to respect the patient, irrespective of gender or illness... and to take appropriate action to safeguard individuals who they perceive to be unsafe or in jeopardy (The International Council of Nurses, 2000). If nurses do not follow these recommendations, this can endanger the women's safety.

Battered women seek help and support mainly from health services, social services and the police. Therefore, nurses' understanding of the phenomenon, and the guidelines, act as tools to maintain care. The guidelines regarding the needs of battered women have been developed by professionals who meet battered women. Women in need have expectations of the health service, and legal rights to receive help (Ålands landskapsstyrelse, 1993). Women also need services from other organizations, such as the police and social services. These organizations need to cooperate with each another on a permanent basis. Even if guidelines are well formed and cooperation is well organized, services for battered women can be inadequate if the women's expectations are not met.

There is a lack of scientific studies about how health services provide care to battered women. Some studies have made assumptions, presented reflective comments, and identified some critical aspects indicating unsuccessful and inadequate care. Learning more about the

phenomenon could lead to improved care of battered women in Åland: to promote health, to prevent illness, to restore health and to alleviate suffering.

The overall aim of this thesis was to gain a deeper insight and to describe how battered women in Åland experienced the care, help and support mainly offered by nurses, how nurses understand and respond to battered women, and how intimate partner violence is addressed by the authorities that are important to the women.

The aims of the different studies were:

- To describe nurses' knowledge, practices, and training related to abuse against women (PAPER I).
- To investigate the nurses' motivation and readiness to take care of female victims of abuse in the Åland Islands (PAPER I).
- To explore in depth nurses who are known to be supportive of battered women, nurses' experiences in nursing situations with women who have experienced violence, and nurses' roles as health care providers to these women (PAPER II).
- To explore and describe women's perspectives of the meaning and understanding of the experience of being battered, leading to the act of searching for help, mainly from health services, and to leave-taking from abusive relationships (PAPER III).
- To find out whether the government's policy directives in line with the *Operation Kvinnofrid* (Peace for Women) recommendations have had an impact, and how the directives have been implemented by the official organizations in the Åland Islands. Further, an exploratory strategy was used to investigate whether the government policy programme had been effective (PAPER IV).

Table 1. Overview of the four studies included in the thesis

Study	Authors	Title	Method	Participants	Journal
I	Häggbloom, A.M.E., Hallberg, L. R.-M., & Möller, A. R.	Nurses' attitudes and practices towards abused women.	Descriptive analysis	133 nurses working within the official health service in Åland	Nursing and Health Sciences
II	Häggbloom, A.M.E., & Möller, A.R.	On a life-saving mission: Nurses' willingness to encounter with intimate partner abuse.	Grounded Theory	10 nurses working within the official health service in different units	Qualitative Health Research
III	Häggbloom, A.M.E., & Möller, A.R.	Fighting for survival and escape from violence: Interviews with battered women.	Grounded Theory	9 battered women	International Journal of Qualitative Studies on Health and Well-Being
IV	Häggbloom, A., & Möller, A.	Implementation of a Government Policy Programme on <i>Operation Kvinnofrid</i>	Case study	An equality Government minister, the head of Gender issues officer, the chief commander of the health service, the chief of the social service, a prosecutor officer, the police officer in charge	Submitted

4. METHOD

A major focus in this thesis has been to obtain harmony between the research questions, the data collection and the analyses. In addition, the aim of the methods used has been to drive data collection techniques and analysis out from the research questions (rather than vice versa) (Hallberg, 2002; Larsson, 2005; Hallberg, 2006). Nevertheless, methods are not neutral. Larsson (2005), and Denzin & Lincoln (1994) have argued that science is power, and that there is no value-free science. The methods in this thesis are related to perspectives of the phenomenon intimate partner abuse, from the perspectives of the nurses, the women and the organizations that aim to help the women. In this thesis, both quantitative and qualitative methods are used. Strauss and Corbin (1998) emphasised that qualitative or quantitative studies about the same phenomenon can extend the knowledge about the issues concerned. This combination of approaches enhances truth value through triangulation, and lends insight into processes and meanings that cannot easily be assessed through survey data alone. Quantitative methods, which are driven by a positivistic paradigm, and qualitative methods, which are based on a humanistic paradigm, complement each other in this research (Malterud, 2001). Quantitative research focuses on measuring and statistically working up of variables that have been qualitatively determined and defined (Denzin & Lincoln, 2000), in contrast to qualitative research that aims at characterising, describing and shaping phenomena. Defined by Denzin and Lincoln (1994, p.2), qualitative research is “multimethod in focus, involving an interpretive, naturalistic approach to its subject matter”. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them (Malterud, 2001). Qualitative research involves studying the use and collection of a variety of empirical materials – case study, personal experience, introspection, life study, interview, observation, history, interaction, and visual texts that describe routine and problematic moments and meanings in individuals’ lives. In the descriptive survey of this thesis, data were collected to measure different variables to give an understanding of the nurses’ daily caring for abused women, while the qualitative studies were used to investigate the individuals’ own empirical meaning and understanding of their reality.

This thesis is based on one quantitative study (I) and three qualitative studies, two using grounded theory as the methodology (II, III) and one using a case study approach (IV). *Study I* was a descriptive and cross sectional survey which examined the distribution of a set of

variables at a given point in time (Cowl, 1996). The survey focused on four main areas: 1) conception of domestic violence, 2) caring for women victims of domestic violence, 3) education and knowledge about domestic violence, and 4) networking. *Study II* aimed at exploring in more depth nurses' experiences of women victims of IPV, and used in-depth interviews. *Study III* focused on battered women's experiences of abuse and their need for help, and used in-depth interviews. *Study IV*, a case study, focused on how government recommendations on IPV are implemented by official organizations.

4.1. Triangulation

In the studies described in this thesis, quantitative and qualitative research methods were used to provide a holistic view of the informants' world (Begley, 1996). The aim was to explore the phenomenon violence against women with a focus on treatment provided by nurses, prevention and promotion in a form of triangulation. Triangulation is a way of increasing the validity, strength, and interpretive potential of a study, decreasing investigator bias (the researcher's pre-understanding and prejudices), and providing multiple perspectives (Manderson & Aaby, 1992; Polit & Hungler, 1995; Thurmond, 2001).

Denzin & Lincoln (1994) define triangulation as the combination of two or more data sources, investigators, methodological approaches, theoretical perspectives, or analytical methods in the study of a single phenomenon. These combinations result in four types of triangulation: data triangulation, investigator triangulation, methodological triangulation, and theoretical triangulation (Denzin & Lincoln, 1994; Polit & Hungler, 1995; Thurmond, 2001). Begley (1996) added a fifth category: analytical triangulation and Parahoo (1997) added a sixth category: multiple triangulation. Methodological triangulation and data triangulation have been used in this study. Different methods and different data sources have been combined in order to increase the ability to interpret the findings and to form a more complete picture (Begley, 1996; Bechtel, Davidhizar & Bunting, 2000; Thurmond, 2001). Additionally, by using multiple methods, the researcher strives to reduce deficiencies and bias that stem from any single method, creating the potential for counterbalancing the flaws or weaknesses of one method with the strength of another. Data triangulation is based on data obtained from different sources. According to methodological triangulation, in this study the 'between or across method' is employed. Thus, both quantitative and qualitative approaches were used (Thurmond, 2001). The methods used were: descriptive survey (a quantitative approach,

Study I), grounded theory (a qualitative approach, Studies II and III), and case study (a qualitative approach, Study IV).

According to Foss & Ellefsen (2002), who stated that methods are not uniformly linked to paradigms, methods can be successfully combined. The case study fits on the premises that it lends itself well to both quantitative and qualitative approaches (Parahoo, 1997; Yin, 1994). Another reason for using a combination of both quantitative and qualitative data is that violence against women is a complex and differentiated reality, which requires different types of knowledge. In this thesis, knowledge is understood as plural, and the difference between the two paradigms (quantitative/qualitative) of inquiry should be seen as different positions, which make it possible to gain interesting and complementary knowledge (Foss & Ellefsen, 2002). The complexity of the phenomenon of violence against women means that no single method or combination of several methods, as in this thesis, can capture the whole and complex reality (Foss & Ellefsen, 2002). The combination of methods (triangulation) provides an opportunity to capture three different kinds of knowledge of violence against women: first, the dimension broad general knowledge (nomothetic) and deeper insights (ideographic) (Möller & Nyman, 2005), second, the macro and micro levels in all different areas of interaction between the individual (the women) and society, and third, knowledge about the individual actors' intentions and meanings (mainly nurses and women).

In the descriptive survey (I), the deductive approach-seeking explanation is aimed at generalization, while Studies II, III and IV use a more inductive approach, aiming to seek understanding and interpretations. This means that the quantitative approach gives a broad, general view of the numbers and distribution, and the qualitative approach gives data that provide a deeper and more multifaceted insight. Study III, in which the women's voices are heard, is incorporated by the criteria of ethics and morals. Moral was understood in the sense that the receivers' opinions and perspectives are as important as the providers, that is, nurses and administrators. In Study III, the battered women were given the opportunity to formulate and tell their views through open-ended questions.

The method triangulation can also support the perspective of micro versus macro levels. In this thesis, the qualitative data provide the context for the quantitative findings. The person-environment relationship should be seen as a cornerstone of nursing, and between-methods triangulation has been shown to be a potential way of linking the two. This means that

triangulation combines the perspective of micro versus macro levels. In this thesis, the quantitative survey provides a more contextual picture when combined with the qualitative studies, in which individuals were given the opportunity to use their own words.

4.2. STUDY I

The descriptive survey

The quantitative research method is based on the assumption that experiences of individuals lend themselves to objective measurement (Bechtel et al., 2000). In Study I, a questionnaire was used aiming to investigate nurses' knowledge, practices, and training related to IPV. The questionnaire also addressed the nurses' motivation and readiness to take care of battered women.

Data collection

Study I: The sample was all the nurses working in the government health care organization, ÅHS, in the Åland Islands, a total of 234 nurses. ÅHS consists of a small hospital with 4 wards and one emergency department, one small psychiatric hospital and one mental health care unit, two health centres and about 16 public health posts. The survey included all the nurses working in ÅHS. The overall response rate was 57 % (n = 133) after giving the nurses three reminders within a period of 13 months. Forty-four nurses (33 %) responded after the first reminder, 19 (14 %) after the second reminder, and eight (6 %) after the third reminder. Ninety-six per cent of the respondents were female. One respondent provided only demographic information. The respondents ranged in age from 24–61 years with a mean age of 41 years (SD = 11 years). Forty-five per cent of the respondents worked at the hospital, 22 % in primary health care units, 10 % at the psychiatric department, 9 % at the unit for health care of elderly people, and 14 % did not answer the question about place of work. Of the 133 nurses, 75 % had received their nursing education in Finland, 13 % in Sweden, 8 % in the Åland Islands, and for 4 % of the nurses, the data were missing.

Questionnaire

Study I: A self-administered questionnaire was sent to all 234 nurses working in ÅHS in October 2000. The questionnaire consisted of 60 questions about knowledge, practices, and training related to violence against women. The 60 questions were mainly adopted from a

survey carried out in Sweden (Iwarson-Sporrong, 1998). Additionally, eight questions assessing information related to attitudes and beliefs were adapted from Moore et al., (1998). Five health professionals who are experts on issues such as health service utilization, nursing management and violence against women, including three head nurses, one physician, and one gender and equity inspector, tested the questionnaire before it was distributed to the respondents. Revisions were made to take account of the suggested changes. The format of the questions was as follows: 40 items were in a rating scale format, nine items were checklists, and five items were open-ended questions. The questionnaire also included six questions requesting demographic information (age, gender, duration of employment, place of work, title of employment, and place of education). Nursing practices about abuse were measured using 11 statements with a rating scale of “always”, “often”, “sometimes”, “seldom”, and “never”. For questions using yes/no/don’t know, the answers were scored 1, 2, and 3, respectively. Two examples of the questions and statements used in the questionnaire were: “Abuse occurs only in relationships with financial or addiction problems”, and “Alcohol and drug abuse are the cause of physical violence”. Questions about nursing practices were: “Do you collect information about the circumstances surrounding the incident(s)?”, and “Do you document information concerning violence against women?”. Questions about training were: “In your basic training did you gain knowledge about violence against women?” and “Are you interested in participating in courses on violence against women?”. Missing answers were scored as zero.

Data analyses

In Study I, descriptive statistics in the form of frequency tables and cross tabulations were used to describe the SPSS computed data in terms of number and percentage distributions. The chi-square test was used to test whether differences between groups were statistically significant. The material was analysed for strengths between variables (Norusis, 1998). The qualitative data for open questions were read and transcribed, and the content was categorized according to the question themes.

4.3. STUDIES II and III

The grounded theory research approach

Grounded theory is a qualitative research method (Annells, 1997). The emphasis in qualitative research is on the holistic description of the phenomenon being studied, rather than on measuring variables isolated from their contexts, as in quantitative research (Bechtel et al., 2000). Qualitative research has its focus on quality, meaning and processes (Hallberg, 2002). According to Larsson (2005), the aim of qualitative methodology is to characterize something. The word comes from the Latin “qualitas”, which means quality, characteristic, kind. Qualitative methodology is based on the premise that human behaviour is complex and evolving, and that people cannot be reduced to measurable units that exist independently of their cultural, environmental, and social background. Qualitative methodology is a systematic way of configuring the quality of something. The theoretical root of grounded theory, symbolic interactionism, was developed between 1920 and 1950 at the Chicago School of Sociology (Charmaz, 1995; Dellve, Henning Abrahamsson, Trulsson & Hallberg, 2002). The American social psychologist Mead argued that the human self emerges through the process of social interaction with others, in which social roles and expectations are crucial (Mead, 1934; Blumer, 1997; Vehviläinen-Julkunen, 2000). Blumer went on to expand the concept of symbolic interactionism (Blumer, 1997). Symbolic interactionism is considered as part of the interpretative tradition, and concerns generation, persistence, and transformation of meaning. Meaning is established through interaction with others. Then, with who, with what, and how one interacts becomes a major determinant of how one perceives and refines reality. Thus the researcher needs to determine what kind of symbolic meanings words and artefacts have for people when interacting with each other (Vehviläinen-Julkunen, 2000). As a result of the need for a special methodology for studying human behaviour and the social world, based on the assumptions and theoretical underpinnings of symbolic interactionism, Strauss and Glaser formulated and introduced grounded theory (Glaser & Strauss, 1967; Annells, 1997; Vehviläinen-Julkunen, 2000; Dellve et al., 2002). Grounded theory is aimed at generating a theoretical framework. The power of the method lies in its tools for understanding empirical worlds (Charmaz, 2000). Therefore grounded theory can be used to inductively derive a theory from the study of the phenomenon it represents; the theory is developed and not discovered, and provisionally verified through systematic data collection and analysis of data pertaining to the phenomenon (Mead, 1934; Strauss & Corbin, 1990).

According to Charmaz (2000), who differentiates between objectivist grounded theory, such as for example Glaser and Strauss also named the classical grounded theory (Annells, 1997; Hallberg, 2000; Hallberg, 2002), adhering closely to positivistic canons of traditional research, such as for example Glaser and Strauss (1967) and, less so, Strauss and Corbin (1990; 1998) emphasising a reformulated and “demystified” grounded theory of the classical version (Dellve et al., 2002).

In the classical version of constructivist grounded theory, the emphasis is on interpreting how subjects construct their realities (Annells, 1997). According to Guba and Lincoln (1994), constructivism assumes the relativism of multiple social realities, recognises the mutual creation of knowledge by the viewer and the viewed, and aims towards an interpretive understanding of the subjects’ meaning. Constructivist grounded theory aims at gaining interpretative understanding of subjects’ meanings of their reality, rather than seeking the “truth”. In this perspective, the “discovery of reality” is a product, or construction, of interactions between the researcher and the data (Annells, 1997). Thus, according to Charmaz (2000), the power of grounded theory methodology is that it gives tools for understanding subjects’ empirical worlds, and can be used as flexible, heuristic strategies rather than as static procedures and rigid prescriptions.

The methods used in Studies II and III are embedded in a more constructivist perspective than an objectivistic perspective (Strauss & Corbin, 1998; Annells, 2006; Hallberg, 2006). Constant comparative analysis was used as a central feature in the data collection and analysis, which occurred simultaneously. Each item of data was compared with every other item of data (Cutcliff, 2000). Thus, a search was made to discover the subjects’ (nurses and battered women’s) own meaning and understanding of their empirical world related to the phenomenon of violence against women. The tools (the three categories: open, axial and selective coding) that were first created by Strauss and Corbin (1990; 1998) and further described by Charmaz (2000) fitted the aims and research questions of Studies II and III.

One important objective with this research was to describe the phenomenon from the perspective of the providers and the users of health care. The use of grounded theory was appropriate to generate theories from the participants’ perspective, while not applying theories to what they describe of their told meaning of reality.

Data collection

Study II: The qualitative data collection consisted of interviewing 10 female nurses who worked in the ÅHS. The sample was selectively chosen by colleagues, leaders and the battered women. This way of sampling was considered to be satisfactory with regard to the women.

In-depth interviews were used with the ten nurses. The interviewees worked in different units, such as the emergency unit, an outpatient clinic, a mother and child health clinic, and psychiatric units where battered women seek help (except one nurse, who had recently moved to another place of work). The educational backgrounds of the nurses ranged from basic nursing diplomas to more extensive education (none at the master's level), and six of the interviewees had participated in seminars on IPV. Their ages ranged from 36 to 56 years, with a mean of 46. The length of time the nurses had worked at their current workplace ranged from 2 to 33 years, with a mean of 18 years. The nurses had worked within the health service organization from 13 to 33 years, with a mean of 24 years.

Study III: The sampling was purposive rather than random and aimed to select cases that provided rich data. Thus, 11 women were asked to participate in in-depth interviews. Two of them did not participate for unknown reasons. All the participants had to identify themselves as women who had had abusive experiences in intimate relationships and who were willing to share those experiences. Moreover, all of the women had to have received treatment and care from the government health service. The participants were contacted through word-of-mouth network sampling.

Questions

Study II: Themes were used in the interviews, though not in a leading manner. The interviewees were able to describe their thoughts, feelings and actions in the situations described that were related to the care of female victims of gender-based violence. The interview process was structured by four questions. The first question invited the nurse to describe what aroused her suspicions that the woman was being battered: "*What makes you suspect that a woman has been abused?*" This was followed by a question asking the nurse to describe such a meeting with a battered woman: "*Can you describe a meeting with a woman who you thought had been abused and who was seeking treatment at your workplace?*" The

third question raised the issue about the nursing profession related to intervening with battered women: *“How do you perceive your role as a nurse when meeting battered women?”*

Finally, the nurses were asked if they had ever experienced a traumatic incident of violence in their own lives: *“Nurses are not immune to traumatic events. Have you ever experienced a traumatic event or violence in your life? What were your experiences from that event?”*

Study III: The interviews were conducted by one of the authors (AH) and carried out as open-ended interviews. The interviews began with the following question: *Can you tell me about the contact you have had with the health service due to being battered by your partner?* The interview concluded with the question: *Is there anything else you want to tell me about from your experiences of being battered?*

Data analysis

In Studies II and III, audiotapes and written materials, including transcripts, were coded with numbers and different names. The analysis of the data was done at the same time as the data collection (Hallberg, 1998). The data were analysed in three stages: open coding, axial or theoretical coding, and selective coding (Hallberg, 1998; Strauss & Corbin, 1990; Charmaz, 2000). Open coding involved closely scrutinising the data and breaking the data down into parts. The data were examined sentence by sentence, to identify individual phenomena, and grouped into concepts and then into broader categories. In the following step, axial coding of each category was developed by identifying its properties and dimensions, and subcategories of each category were explored (Thunberg, Carlsson & Hallberg, 2001). The last stage was the selective coding process, where core categories, as few as possible, were identified and labelled. The researcher kept a self-reflective journal and wrote code notes or “memos” throughout the data analysis process, to help her to keep track of the products of coding and make conceptual links (Ritchie, 2001).

The aims were to generate hypotheses, models or preliminary theories about what was revealed in a social situation, rather than verifying existing theory. The researcher kept close contact with the supervisor in analysing the data in the sense of modifying theory derived from data collection (Hallberg, 1998). All the interviews in Studies II and III were analysed sentence by sentence in order to look for new information. The studies were regarded as complete when the data collection reached saturation (Wårdh, Hallberg, Berggren, Andersson

& Sørensen, 2000). Saturation point was reached when additional data would not contribute anything new to the emerging theory.

4.4 STUDY IV

Case study

Case studies are in-depth investigations of an individual, group, institution, or other social units (Polit & Hungler, 1995; Parahoo, 1997). The case study method allows researchers to retain the holistic and meaningful characteristics of real-life events, such as individual life cycles, organizational and managerial processes, neighbourhood change, international relations, and the maturation of industries (Yin, 1994). In general, case studies are the preferred strategy when “how” or “why” questions are being posed, when the researcher has little control over events, and when the focus is on a contemporary phenomenon within some real context (Yin, 1994). The type of data produced is mainly descriptive, although attempts are made to find correlations between variables (Parahoo, 1997). Using the case study approach, data can be collected in the past, present or future. While surveys involve large populations and use samples for the purpose of generalizing their findings, case studies tend to be more specific, in-depth and holistic. The emphasis is on understanding the particular case or group of people, as in Study IV, understanding how policy recommendations from the government were received and implemented by the organizations offering service to battered women. The aim of case studies is to investigate a contemporary phenomenon within its real-life context, especially when the boundaries between the phenomenon and the context are not clearly evident (Yin, 1994). The present single-case study is an investigation of the government policy recommendations about how to deal with IPV, and the organizations’ responses and implementation of the recommendations. The development of case study designs needs to maximize four conditions related to design quality. According to Yin (1994) these conditions are: (a) construct validity, (b) internal validity (for explanatory or causal case studies only), (c) external validity, and (d) reliability. The main approach was qualitative, seeking to explore and understand the rationales for choices. The qualitative data were supported by quantitative data on structured routines and guidelines of the protocol. The method of analysis used in Study IV was pattern replication (Yin, 1994).

Data collection

The triangulation frame included: first: data from the interviews with the leaders of the three organizations: the health service, the social services and the police; second: data from the prosecutor officer; and third: data from an interview with the head of gender issues officer at the Government of Åland, who had initiated the government focus on intimate partner violence, and the chairperson of the kvinnofrid reference group, who was the equality minister in the Government of Åland. Documents such as annual reports and budgets (1999-2005) were also used. In-depth interviews using semi-structured questionnaires were carried out with the manager of the health service (a man), the manager of the social services (a woman), the prosecutor officer (a man), and the chief commander of the police (a man). The key informants represented their organizations in the reference group. The head of gender issues officer acted as secretary. Interviews were also carried out with the head of gender issues officer (a woman), and the equality minister (a woman).

Questions

Topics which were covered were: the leaderships' opinions and attitudes towards violence against women, how the organizations used guidelines and routines, how workers and clients responded towards strategies about routines, and how government policies were understood and used in the organizations. The first perspective compares the official organizations that are the health sector, the social service in Mariehamn, the public prosecutor department and the police department. The organizations had been directed to implement the government recommendations. The services they provide include help to abused women, based on a written policy document.

Data analysis

Each interview session was conducted by the researcher (A.H.). Interviews were taped, transcribed verbatim and coded. The content was analysed and compared with information from the other sources of evidence about the same issues (e.g. annual reports). The final analysis of similarities and differences between cases was based on pattern replication (Yin, 1994).

5. CRITERIA FOR VALIDITY AND RELIABILITY

Researchers propose different kinds of criteria for scientific rigour in quantitative and qualitative research. In qualitative research, Lincoln and Guba (1985) suggest the use of the following criteria: credibility, dependability, confirmability and transferability. They argue that these criteria correspond with quantitative criteria in some ways. They compare credibility with internal validity, confirmability with objectivity and transferability with generalisability. In contrast, Malterud (2001) emphasizes that qualitative research can be assessed with the same broad criteria as quantitative research. Validity and relevance are the essential criteria. To improve validity, it is suggested that procedures and principles such as triangulation, respondent validation, clear detailing of methods of data collection and analysis, reflexivity, attention to negative cases, and fair dealing should be assessed. In addition, relevance can be increased by using detailed reports and sampling techniques (Malterud, 2001). Another equal standard is reflexivity, which should be measured as an equal standard with validity and relevance.

In order to increase reliability and validity in Study I, the questions in the questionnaire were adopted from other published studies (Iwarson-Sporrong, 1998; Moore et al., 1998). Second, all the questions in the questionnaire were tested by key persons who had insight, understanding and knowledge of the phenomenon violence against women, and about the nurses and their environment. In order to improve the reliability of the data in Studies II, III and IV, the interviews were tape-recorded and transcribed verbatim. During the interviews the subjects' statements were frequently summarized and repeated by the researcher. During the data analysis, the researcher regularly discussed the methods and findings with the supervisor in order to improve reliability. The research results were compared with similar studies in the literature. The main data for the study were transcribed interviews, but field notes and observations were also used in the data analysis to ensure reliability.

5.1. Ethical considerations

When carrying out research on violence against women, ethical concepts must be taken into consideration and incorporated. Ellsberg & Heise, (2005) emphasized that respect for persons (nurses and battered women) have to be addressed at all stages of the research process. The principle of respect for persons incorporates two fundamental ethical principles: respect for

autonomy and protection of vulnerable persons, which has been considered throughout this research. The risk of causing a woman physical harm and distress through participating in the research must be minimized (Ellsberg & Heise, 2002). A woman may be in danger of physical harm if her partner finds out that she has been talking to others about their relationship. Therefore, in this research the women chose where and when they wanted to be interviewed. The interviews ended when the focus of the questions were saturated, except once when the woman felt distressed and requested the interview to be stopped. She was informed about how to get support if she needed help. If the respondents became distressed by the sensitive questions, and from having to recall painful or frightening events, the researcher was sensitive to this during the interviews and asked the informants if they wished to stop the interview. Therefore, the primary ethical concern related to researching violence against women was to protect and ensure the safety of the participants, as Ellsberg & Heise (2005) have emphasized. The interviewer may also be at risk from the partner of a woman who is interviewed, although, in this research this was not a problem. The women often responded by expressing calmness at the end of the interviews. Although asking a woman to tell about trauma is generally considered to involve a risk of harm, disclosure can be an important experience for researchers and respondents. However, at the beginning of the interviews they expressed feelings of shame and distress. King & Ryan (1996) mentioned that many women who report violence in surveys have never told anyone else about their situation, and they welcome the opportunity to share their experiences with the researcher. That was not always the case in this research. Some of the women reported that they had told close friends or relatives about their situation. Nevertheless, even if care is taken to minimize distress in the interview, the woman may still feel the need for further help and support. In this research, both nurses and battered women who needed further help were advised to attend the emergency department at the hospital. The nurses had promised to give counselling if an informant requested help. The risks of the research were considered in relation to the benefits. The risks of gender-violence research (both for battered women and suspected battered nurses) are potentially large. The risks (not involving women) of ignorance, silence, and interaction with the phenomenon of violence against women are also large. The risks were weighed up against the benefits for the women who participated in the study. Every possible precaution was taken to minimize harm and to maximize benefits.

The respondents were given full confidentiality. The participants were asked whether they would allow the data to be used for research purposes. All of them gave their consent. They

were informed that their identity was protected. Permission was granted for Studies I and II from the head nurse at ÅHS, according to the practice in Finland. Permission for Study III was obtained from the local ethical board in the Åland Islands. According to the Finnish regulations relating to research, permission was not needed to carry out Study IV. All the collected material was locked in a safe place. As soon as the documents (questionnaires, tapes and transcribed material) had been analysed, the material was stored according to the regulations of the Ministry of Health in Finland.

6. SUMMARY OF THE FINDINGS

The results showed that in Åland the government health services offer help and support to battered women. These women mainly meet a nurse at their first encounter with the health services. Not all the nurses were informed about the recommendations set by their organization, even though they have a duty to offer health services to battered women, according to the guidelines. Only one third of the nurses knew about the health organization's guidelines and of these less than one tenth knew about specific routines about how to care for the women's children. In addition, some of the nurses had a history of violence themselves. Almost none of the nurses had received counselling, and few of them had been given supervision. The nurses decided themselves whether to respond or not to a woman's needs due to IPV. This resulted in an ad hoc health service, where the battered women received help if the right nurse was on duty. However, nurses who encountered battered women were willing and motivated to help. They used the knowledge they had gained from similar areas within health care intervention strategies, though most of them lacked specific knowledge about IPV. They described how they helped their colleagues, because they felt highly responsible to act, despite feelings of distress and anger. They were angry because of the terror they saw the women had been exposed to. They were angry because of the negligence of colleagues and other professionals. And they were angry because they did not get supervision when they continued to support women. This research found that some of the nurses felt that it was difficult to intervene because they knew the persons involved privately.

As a result of this study, IPV is now recognised as a phenomenon in small communities like Åland. The battered women participating in this research willingly shared their experiences (Paper III). They disclosed the threatening, painful and inhumane treatment they received from their spouses. Despite that, they showed their strength by finally leaving their violent partners. They strived and struggled, often with the help of only one person, who was often a close friend. They also sought help from the health services, the social services and the police. The women reported that the helping professionals sometimes gave them excellent support, but others revictimised the woman. The women's construct of being abused varied from understanding that the man was the one who was behaving wrongly, to feelings of being the guilty one who triggered the man to use violence.

The findings also showed a government health service that has a duty to provide health services to battered women in accordance with policy programmes and regulations made by the government. That means that the Government of Åland has raised the issue and decided that the phenomenon has to be dealt with by the health services and other sectors. Further, it showed a local government participating in the European project “Operation Kvinnofrid International”, aiming to deliver services of high quality to battered women and their children in the Åland Islands. The initiative taken by the Government emphasized the need to develop new methods and strategies to reach the objectives. The Government demanded that organizations should follow the policies and regulations. The focus of the directives was that the organizations should implement structured programmes and follow formalized guidelines. The organizations had made attempts to follow the directives given by the Government, though there were shortcomings in implementing the proposals. They had designed guidelines, but the introduction of the manuals, and the support and the follow-up of the manuals, were not given priority. The health organizations had not organized regular training programmes for health professionals about violence against women, even though most of the staff required more in-depth knowledge and skills.

6.1. Nurses’ attitudes and practices towards abused women (Paper I)

Nurses’ practices, knowledge and beliefs were found to be unsystematic and to have some drawbacks. Fifty-three per cent of the nurses reported that they met battered women in their workplace. However, they had difficulties in identifying battered women, even in units where battered women asked for help. Ten per cent of the nurses working in the emergency department reported that they had never met abused women. Most of the nurses asked women about violence, though some nurses did not ask. They expected that women would refuse to tell the truth, or that they would not be willing to talk about abuse. The nurses recalled that the seriousness of injury was a crucial factor for them whether to ask or not. Despite that, the nurses reported that they did not feel ready to ask women about abuse, due to respect for the integrity of the woman, difficulty in formulating the question, and lack of experience.

Most of the nurses who had identified battered women documented the violence. Forty-seven per cent of them always did so. The nurses also took the opportunity to inform about legal implications. However, some nurses chose not to document every contact, although most of the nurses encouraged the women to report to the police.

The majority of the nurses were not familiar with the formal structure provided by the health administration. A manual was produced by the health organization in 2000, containing routines and guidelines for the care of battered women and their children. However, most of the nurses did not know that. Only one third of the nurses reported that they knew about the guidelines, and only one tenth of them reported that they knew about the guidelines on the care of the children of battered women.

The nurses did not focus on follow-up, although a few of them kept close contact with the women for a while. They reported that follow-up activities were the responsibility of the social workers employed by the health organization. Less than one quarter of the nurses cooperated with other organizations in a network. Nurses often had limited knowledge about the phenomenon violence against women. Few had studied the subject in their nursing training. Most of the nurses with some training had only participated in short seminars offered by the Government. Thus, most of the nurses (77 %) welcomed more training about how to deal with patients who had experienced IPV. Many of the nurses reported that alcohol and drugs were a common and single cause of IPV. This misunderstanding caused nurses to believe that if a woman wanted to leave her violent partner, she could do so. Despite that, one quarter of the nurses believed in myths such as that abuse was the result of the woman's helpless personality. Nevertheless, the findings showed that training changed knowledge and practices. There was a significant relationship between in-service training and nurses' attitudes, practices and networking.

To summarize, some of the nurses tried their best to deliver a health service aimed at meeting the women's needs. In contrast, most of the nurses' practices showed serious deficiencies in dealing with battered women and their needs for services. The study showed that nurses require directives, which include structured services with standard objectives to achieve the aims of high quality care for battered women. Most of the nurses required training and support, thus, very few felt equipped to intervene satisfactorily. In order to meet this urgent need, a training programme should be initiated. This programme would help nurses to identify survivors of abuse, and prepare them to intervene more efficiently and effectively in order to provide health care that meets the women's needs. In addition, all the nurses need structured and regular feedback, including supervision and support.

6.2. On a life-saving mission: Nurses' willingness to encounter with intimate partner abuse (Paper II)

The main purpose of this qualitative study was to explore selected expert nurses' experiences of encountering patients from IPV in nursing situations. The findings were included in an emerging theory comprised of the two key themes: nurses' perceptions of IPV, and nurses' opinions about whether they felt equipped to intervene. The core category was understood as being on a life-saving mission: nurses' willingness to encounter battered women. The findings showed that violence against women in a small local community is common, and that there are pitfalls because the nurses know the inhabitants. Furthermore, the findings indicate that the nurses are devoted to help, and that their role in caring for battered women and sharing knowledge is important. The nurses showed that they compensate for a lack of training by having a mature personality and by being secure within a social context. In this study, nurses reported that they were often left alone to meet the woman. In contrast, some of the nurses did not feel obliged to respond to the women's needs. The nurses treated injuries in a professional way. However, some of the nurses asked the women about abuse if they were suspicious about this, while other nurses remained silent. In more practical aspects they responded differently to demands.

Some of the nurses documented the situation, gave advice and followed up, while others did not act at all. Nurses reported that without enough knowledge and training they felt insecure and frustrated. They also mentioned that for a newly-qualified nurse the demands of dealing with battered women can be too difficult. An inexperienced nurse needs the support of an expert nurse. Some of the nurses were afraid to offend the women, and others did not know what to say. Some nurses described how delicate the situation is to ask a woman about violence. They also mentioned that a nurse needs to behave in a certain way, such as keeping eye contact, showing respect, and giving the woman time to respond. A few nurses explained how difficult the task is when the nurse herself has been battered and has no help to overcome or solve her own problems. The nurses mentioned how strongly they needed the support of the leadership. Some of them had such support, others did not.

To summarize, the nurses interviewed in this study showed ambition and enthusiasm to encounter battered women. The overriding theme that emerged from the data was a strong sense of nurses' commitment and concern to respond to women survivors of violence. The nurses were highly motivated to deliver services of high quality. Nurses clearly displayed

their competence and expertise in their role as one of the most important persons providing help to battered women. Nevertheless, these encounters also caused considerable frustration and stress. Nurses' frustration and anger could be due to their own experience of violence, the women's severe injuries, the leaders' weak responses to the nurses' needs for support and counselling, and society's failure to maintain equal opportunities for men and women.

6.3. Fighting for survival and escape from violence: Interviews with battered women (Paper III)

The third article is a qualitative study with the aim of providing meaning and understanding of the women's experiences of being battered. It explored the act of searching for help, mainly from the health service, and ending abusive relationships. The core category in this study was conceptualized as survival and escape. The abused women's lives were closely tied up to the abusive partner, who most often totally controlled them and entrapped them. The battered women had to be careful how they related to their partners, since just a word or a tone could trigger their partners' abusiveness. Three categories emerged from the interviews with the battered women and developed the core category. The categories that were developed from the subcategories were 'personal construct of violence', 'struggling to cope with the violence', and 'feeling of support'. The three categories describe the development of ways of relating to the violence. The women had experienced horrible IPV situations and all had broken up from the abuser. The women with deep inner scars struggled to find meaning and recovery from the violence. In the leave-taking process an important other, often a friend, played a supportive role in creating inner strength within the woman, which enabled her to break up. Supportive professionals found and maintained important solutions, whereas other professionals revictimised the women. The conclusion was that social and health professionals need increased competence to intervene efficiently with battered women.

To summarize, women leave their violent partners, and survive a separation. They described the normalization process whereby they became controlled, isolated, offended and abused. Their self-worth was broken down, and they lost their self-confidence. The women mainly solved their problems on their own, though a friend was an important person during the leave-taking process. Some nurses and other care providers offered adequate help, while others remained silent or, even worse, revictimised the woman. Thus, the help offered to women was sometimes seriously inadequate.

6.4. Implementation of a Government Policy Programme on *Operation Kvinnofrid* (Paper IV)

In this study, the focus was to find out how the government policy directives had been implemented by the official organizations in the Åland Islands. The theoretical proposition was that the Government directives would result in the organization's implementation of strategies to develop a more suitable delivery of service. The investigation through pattern matching showed that the organizations had responded to the Government directives by literal replication to a certain degree. The case study showed that the Government has implemented a policy programme including some directives regarding violence against women. The Government of Åland participated one year in the European project "Operation Kvinnofrid International". The directives for participants in the Operation Kvinnofrid International Programme had been implemented by the Government of Åland. The Government of Åland continued the programme Operation Kvinnofrid after ceasing to participate in the project. The Government continued to administer the reference group and offered some education in issues regarding violence against women to the organizations. The official organizations had received directives from the Government on how to implement services for battered women and their children, and the organizations responded by addressing and implementing the directives. The implementation of the directives by the organizations was deficient in some aspects, such as insufficient allocation of resources, inadequate support to nurses and almost no follow-up of the implementation of the recommendations. The guidelines that were designed and implemented in the organizations were well formulated, and met the needs of battered women and their children. An exception was the prosecutor department, which did not have any guidelines. A response group chosen by the head of gender issues officer did not have regular meetings, and the officer was not satisfied with the contribution of the members.

To summarize, at the government level efforts have been made to implement strategies to offer a well-structured service to battered women and their children. At the level of the organizations, there was a lack of commitment from the leaders to achieve a service that meets the needs of both the providers and users.

7. DISCUSSION

7.1. Content aspects

The overall aim of this thesis was to examine how battered women are cared for mainly by nurses and how gender-based violence is addressed by authorities that are important to the women. The phenomenon violence against women is reported in scientific studies to be a number one public health problem and therefore of importance to be studied in the context of the Åland Islands as elsewhere (Davison, 1997; WHO, 1997; Heiskanen et al., 1998; Cambell at al., 1989; Lundgren et al., 2001; Watts et al., 2001; Howe & Crilly, 2002; Ramsey et al., 2002; Krug & WHO, 2002; Widding Hedin, 2002; Mair & Mair, 2003). In this thesis the problem is defined as a public health problem, because women reported that violence affects them physically, psychologically and socially. Despite that, the problem is also identified as an extremely complex phenomenon, deeply rooted in gender-based relationships (Heise et al., 1994). The women in this thesis reported that violence affected their children, relatives and friends, and official organizations such as the health service, the social service and the police were often involved.

Women in this thesis reported that they had physical injuries and different kind of diseases from the violence, as reported by other researchers (Campbell & Sheridan, 1989; Campbell, 1991; Krantz & Östergren, 2000; Widding Hedin, 2002). They also reported being highly affected by psychological problems such as depression, anxiety, post-traumatic stress disorder, stress, and sleeping problems, in line with the findings of other researchers (Edin & Högberg, 2002; Daniels, 2005). Women emphasized that the psychological problems were the worst (Paper III). The present thesis confirms that it is of utmost importance to screen for psychological maltreatment as well as psychological health problems such as anxiety and depression, as stressed by Widding Hedin (1999). Social problems and economic problems were also a problem for most of the women (Paper III). First, the women face problems in their relationship with the batterer; the women were often not allowed to have their own economy or to keep their own salaries. Second, as separated women, they struggled to get a job or were on sick leave for long periods of time (Paper III). They described difficulties in caring for their children, because of financial problems. Findings from this thesis also confirmed that gender-based violence results in great costs to society in the form of lost

productivity and the use of mental health services, health services and legal services, as reported by Tjaden & Thoennes (2000).

This study also confirms that gender-based violence exists in small communities where people know each other. IPV was also found to be regarded as a social problem. This is shown by the Government's demands for official authorities to address the problem by making guidelines (Paper IV). This is also shown at the health service level, where nurses as frontline workers were the ones mainly involved in addressing this issue (Paper I, II). However, there were deficiencies at the level of delivering health services to the women. Some of the nurses burned for this issue, but some did not encounter battered women at all (Paper I, II). When the nurses recalled the problem, they felt angry and sad, though some of their colleagues did not take part in this work (Paper II). The women confirmed that by telling about episodes like "I was at the maternity ward and my second child was born. As I told, I was worried and scared to go home, and it could have been different if I had got more support. Of course they listened and said, yes, it will be all right, keep in contact" (Paper III). This woman reported that the nurses did not show empathy, did not inform her about what to do or who to contact if she was in need, and did not tell their colleagues at the health clinic to do a home visit. This shows that some nurses damage the relationship and miss a unique opportunity to help, as described by Henderson & Ericksen (1994). Not all women are unwilling to disclose abuse, as reported by King & Ryan (1996). In this thesis some women wanted to discuss the victimization with nurses if they were given the opportunity, as reported by Walker et al., (2004). In contrast, if a woman does not disclose abuse, the nurse should simply ask, using short questions such as: "Have you been hit, kicked, punched, or otherwise hurt by someone within the past year? If so, by whom?" (Ambuel et al., 1997; Feldhaus et al., 1997). Studies indicate, as some of the nurses in this study described, that asking about violence is essential, but it is also important how many times and in what way the questions are asked (Davis & Harsh, 2001; Edin & Högberg, 2002; Garcia-Moreno, 2002; Walker et al., 2004).

The correlation of variables (Paper I) showed that training has an effect on the quality of services, as described by Corbally (2001). The nurses who had participated in short seminars on IPV asked women about abuse, they documented the abuse, and they gave the women useful information (Paper I, II). This finding ought to be seriously considered by those responsible for the health service. Nurses face a difficult task in educating themselves about

detecting victims of violence, as described by Corbally (2001). Nurses in this study used knowledge from similar areas of health care when they lacked specific education about IPV (Paper II). This shows that an expert nurse manages this, but how about inexperienced nurses? (Papers I and II) (Benner, 1984)? The women reported that when they attended the health services, sometimes they met nurses who performed their duty excellently; sometimes they met nurses who did not (Paper III). The majority of the nurses (83 %) welcomed more training, which shows that they are highly motivated to help battered women. This is a unique opportunity for the health service administrators – highly motivated nurses! Nurses reported that they had shortcomings when intervening with battered women, and this could be a problem for them. The main shortcoming appeared to be detecting abused women (Paper I). Nevertheless, it is encouraging to see that the Government of Åland is committed and highly motivated to provide satisfactory care for the victims. This thesis shows that the Government challenges and demands the official organizations to deliver a service of high quality. Meanwhile, some weaknesses were found in implementing the services (Paper IV). If the health departments used a monitoring system for their service, shortcomings could be detected and corrected (Paper I). The police department focused on providing the best possible services to battered women and their children (Paper IV). Other organizations saw this problem as one of many problems that did not need more effort than other problems that they had to deal with. Services were neither fully planned nor well addressed in the implementation strategies. Nevertheless, the health services are perhaps the most important arena for detecting and taking action against violence against women. The issue remains a serious challenge to the health service.

7. 2. General discussion

This research has focused on nurses' understanding, commitment to help, and management of battered women. Further, the research has included the battered women's own experiences and perspectives on the health service that they have been offered. The battered women's expectations and needs for help and support from the health service have been the focus. The exploration has aimed to serve as a baseline survey for a training programme for nurses, and to identify elements that can be used in future work to support battered women and to achieve zero tolerance of IPV in Åland.

The results show that nurses are not adequately trained to meet the demands of an optimal health service for battered women in Åland (Paper I, II). The health service does not often

meet the needs of battered women, and therefore does not meet their expectations (Paper I, II, III). The authorities in the Åland Islands have responded to the Government's policy programme, and have produced guidelines, although their implementation of the guidelines, and follow-up and support of their employees, is not convincing (Paper IV). Could that be mainly due to gender aspects? Norms are often set by men, and statistically some of them could be perpetrators themselves. The health service should be in the front line to prevent violence against women, as emphasized by Leander (2002). Health professionals in a community often have a lot of knowledge about the community members, and they are often appreciated by the people. Therefore, they are in a good position to intervene with women and to place the issue on the community's agenda. In combating violence primary health nurses could coordinate community interventions and bring together policymakers, law enforcement agencies, the justice system, batterer treatment programmes, the church, and other relevant groups, in order to develop a coordinated response to IPV.

This thesis provides no answer to the underlying causes of gender-based violence. This was not an aim of the study. Nonetheless, any systematic effort to root out violence must be multidimensional, drawing on the expertise and resources of many sectors in a multi-sectoral manner to obtain a deeper understanding. The results show that effects on women and their children are serious (Paper II, III), such as psychiatric disorders and poor socio-economic standards. To eliminate violence against women the strategy must be to confront the underlying cultural beliefs and social structures that perpetuate violence. In order to be effective, as suggested by Heise et al., (1994) such a strategy would have to draw on a wide range of expertise and resources, both governmental and non-governmental. In this thesis gender-based violence is understood from a feminist standpoint and as not an inherent part of "maleness" but a function of socially-constructed norms of acceptable behaviour. Consequently, an individual is not responsible alone. Everyone who builds today's society is responsible. Nevertheless, nurses described the problem of violence as being based on a patriarchal model of attitudes and values supporting men's violence against women (Paper II).

The strong emotions of fear, self-destruction and anger that have been expressed by the battered women and the nurses in this thesis act as alarm signals (Paper I, II). They tell us that the women suffer from high levels of stress in their efforts to cope with violence. As Lazarus (1993b) reports, a person reacting with anger is under stress. Both target groups described situations in which they had been challenged by violent events without being able to cope.

According to Lazarus (1993a; Thernlund, 1995) in coping with stress, distancing and denial are common. The women described how they had reacted with distancing and denial during some periods of abuse (Paper III). In coping with anger, two main patterns have been observed. One pattern is anxiety encounter, where efforts are made to reassure the other person and to preserve the relationship. In the other pattern, the encounter involves anger, and more efforts are made to repair self-esteem than in anxiety encounter (Lazarus, 1993a). In anger, efforts of reparation include attacking the other person, defending oneself and posturing. Battered women, nurses and abusers use these encountering strategies (Paper II, III). Helping clients to understand these processes is seen as unquestionably important by nurses (Paper II). Problem-focused efforts are not always the most desirable and therefore not always recommended as a strategy by nurses (Paper II). In situations where a woman can do nothing to change the situation, rational problem-solving efforts can be counterproductive, and can even result in chronic distress when they fail. Emotion-focused efforts would then be the best choice to support the battered women in settings where they attend certain services for help (Lazarus, 1993b). Examining their coping efforts in a larger contextual framework would be beneficial to both nurses and battered women (Lazarus, 1993b). This calls for a more complex and long-term research design, to study coping over time and across diverse sources of stress in the same persons, in a sufficient number of people to address both the process and the trait aspects, with an appreciation of the whole person (Lazarus, 1993b). Nevertheless, the nurses who were working in the emergency departments were at risk of psychological stress (Paper III). One nurse described her psychological stress when encountering a battered woman who decided to return back home: “then I wonder how is she going to survive the night” (Paper II)? The psychological stress that nurses experience can range from juggling conflict, to demands, to managing moment-to-moment encounters with battered women and their children, to dealing with repeated exposure to loss and suffering. Similarly, the battered women also suffer, coping with the psychological stress of severe and repeated threats by the perpetrator, and the negative attitudes of professionals, friends and neighbours (Paper III). Consistently, the nurse who cares for a battered woman may be forced to recognise her own abusive relationship, and this taxes her personal coping resources, and may precipitate a change in her relationship with her partner. Obviously, the need for support through counselling for the nurses as well as for the women is a demanding issue for health administrators to address (Paper II).

The results of this study have identified the difficulties that women face, being battered in a small community. Most people know each other and appreciate being met with respect. The women expressed the shame and guilt they felt from being battered by their partner in their own homes (Paper III). According to the nurses the shame creates barriers to asking for help (Paper III). The women hide behind a silent mask, isolated and controlled, scared and depressed. Consequently, some nurses interpreted this as the battered woman being reluctant to receive help. As long as health workers do not act, the women are entrapped and left on their own (Paper II). The health service remains in the status quo and is far from achieving null tolerance of violence against women. This research shows that battered women expect nurses to ask and to suggest solutions when they attend the health service (Paper III). It also shows that nurses are willing and whole-hearted in their efforts to help (Paper II). An important factor supporting the nurses to engage in this kind of work can be hardiness (Ogden, 2000) (Paper II). The nurses feel commitment and act as gatekeepers, they feel that they have the power to take decisions, and are also challenged to meet the women's needs (Ogden, 2000). Nonetheless, nurses need to be given support to be committed and to maintain their commitment at times of frustration (Paper II). They need to be encouraged and strengthened in their efforts. In order to be able to meet the needs and expectations of battered women, they have to be valued and listened to. They need empowerment strategies in their working situation. Nurses confirmed their readiness to help their less skilled colleagues (Paper III). They were ready to act if their leaders gave them the opportunity. If the leaders responded, health services for battered women and their children would be improved. The women's stories show that gender-based violence is a complex life-threatening situation (Paper III). Further, there are no easy ways to solve the problem or to escape (Paper III). Some of the nurses are aware of this, but not all of them (Paper II). Some of the nurses suggested that health professionals should be willing to offer help without expecting the woman to immediately respond to their suggestions and advice (Paper II).

The aim of the meeting between a nurse and a woman can be understood as one person depending on the other person's help. However, the meeting is influenced by both persons, through their personalities, experiences, perceptions and understanding (Paper II). In the context of a nurse meeting a battered woman, the nurse has responsibility for creating a healing atmosphere. May (1986) states that in a real meeting both persons change. If the nurse does not want to change, the battered woman will not change. The battered woman changes in the sense of accepting her innocence and being enabled to loose her feelings of guilt.

However, a temptation lies close at hand for the nurse, because it is easier to meet the woman on a technical arena (Paper II, III). The woman who is affirmed by the nurse, gains contact with her own presence in time, and a healing process can start (May, 1986). Meaning, then, is a social product constructed by the woman and created through the interaction with another person –the nurse. The woman who is uncertain of her own guilt or innocence can create an understandable meaning of the terror that has happened to her in the nurse’s response (Paper II).

Similarly, the nurse’s empathic understanding opens doors through affirmation and the woman may feel strengthened to trust in her own capabilities, which can enable empowerment. It has been argued that since nurses are disempowered they cannot empower patients until they themselves are empowered. This is entirely accurate and indeed relevant. However, while the professional autonomy of nurses is questionable, they have much more freedom of choice and action than patients have. They have the power to speak out, take risks and change practice if they wish, compared with battered women, who often feel ashamed of being a victim (Paper III). The events of violence even hinder them to tell anybody about the violence (Paper III). Women who can control their own life, who are aware of healthy choices, and who can independently decide what kind of health service and way of life they want, will certainly become healthier. Battered women’s health and well-being is probably also connected to their SOC (Antonovsky, 1987). The women describe how important the factors of comprehensibility and meaningfulness during the leave-taking period had been to them (Paper III). As long as they were battered without understanding why violence was happening to them, they felt manipulated. When the women gained an insight into the violent acts that the men perpetrated against them, they were more able to deal with it. A woman described this as “I didn’t know how to behave according to it (in the beginning)...later on ... I left because I understood that I couldn’t do anything ... to solve things through arguing when you can’t communicate only makes things worse ... I can protect myself through leaving.” As a result the women managed to leave their violent partners; however, their self-worth had been reduced (Paper III). In that situation the supportive other definitely played an important role. The “other” was maybe the person the woman gained insight from to understand the violence.

The results identify the need for more serious efforts to be taken by leaders (Papers I, II, III, and IV). Actions should be in favour of women and their children. Nurses and other health

personnel need continuous support to develop their skills. The battered women and some of the nurses emphasized their need for a women's crisis centre where they could get help any time of the day (Paper II, III). Nevertheless, the women reported that their contacts had often been sporadic. They may have received adequate help from the health service, but may have been offended by a social worker or vice versa (Paper III). Battered women need services from different organizations in an acute situation, and these services should have similar aims and strategies (Paper II). Everybody should be aware of the measures and activities of the other sectors, and appreciate each other's efforts and commitment. Hence, there is a long way to go before the services meet the women's needs in an appropriate way in Åland.

A negligent and passive attitude in society towards gender-based violence will take time to change. The media represent a resource in the community that has the potential to bring about change (Kurst-Swanger & Petcosky, 2003). Their efforts are significant, and they report IPV in line with research findings. If the media raise the issue again and again, this will certainly result in changed attitudes towards gender-based violence. Myths about battered woman still seem to exist in society. Even some nurses believed that battered women asked to be battered (Paper I). The battered women are seen as persons with difficult characteristics, and individuals who deserve punishment. Some nurses believed that the battered woman would leave her abuser if she wanted to (Paper I). Most probably these incorrect beliefs cause women to be blamed, and the women feel offended and misunderstood. In contrast, this research shows that myths about gender-based violence were mentioned by only a few nurses (Paper I). Hopefully this indicates that nurses in Åland have some general knowledge about IPV. Most of the nurses with no training in the subject area did not believe in myths, in contrast to what Henderson and Ericksen (1994) have reported. Nevertheless, further studies on aspects of gender and equity among nurses may detect attitudes that reflect the long tradition of a patriarchal social system in the Nordic countries.

Nurses who are reluctant to help battered women, and who avoid helping them, need to be identified and supported. Inquiry in the local health service is also needed in order to understand nurses' reluctance. A main need seems to be training on violence against women, therefore, a regular training programme should be set up (Paper I, II). The nurses who respond to women's needs could be used as facilitators in such a programme. They could share their knowledge, and give advice and feedback to more inexperienced nurses, as described by Benner (1984). Undoubtedly, one of the most important aspects of training nurses about abuse

of women is developing constructive attitudes towards patients, as mentioned by Campbell (1992) and Waltz (1995). Training nurses to adopt positive, compassionate, non-judgmental, empathic, and supportive attitudes to patients would allow patients to feel safe in the clinical care setting. This would enable health care providers to serve the needs of patients who are victims of violence, or at risk from violence, as Brandt (1997) has emphasized. Safety is a prime concern (Paper II). Anderson (2003) stated that abused women are not safe as long as there are nurses who do not address the issue. Schön (1990) described the link between theory and practice provided by critical reflection. As adult learners, the ability to solve problems is essential. Learners should be performance-centred in their orientation to learning. Thus, the problem of violence against women challenges nurses to be knowledgeable and skilled.

As reported by Piispa & Heiskanen (2001), the economic cost of intimate partner violence is incredibly high. However, the human cost is more serious. Schmidt et al., (2006) indicates that IPV is increasing in scope contrary to Piispa (2004) who reported that surveys in Finland rather indicate a decrease. Jones (2000) stated that the anti-violence against women movement has regressed. As a result of growing gender awareness, women's subordination, and the need to challenge it, is recognised. Awareness of women's equality is accepted by most people. Similarly, violence against women is recognised and condemned. In general, women's participation in all decision-making bodies is seen as important. But why do we not move forward? It seems that the process that recently started in the Nordic countries has slowed down. This thesis gives support to the belief that there are powerful barriers to minimizing and preventing violence against women in Åland. The responses given to the issue by some of the key persons were faltering (Paper IV). More complete implementation of gender equity in society is expected. Obviously, there are some underlying barriers that hinder the process, thus, mainly the patriarchal social system (Paper II). We need to understand and identify the factors that hinder zero tolerance of violence. A suggestion based on this thesis is that further research should be carried out on the factors that hinder the women's rights movement. Strategies can then be formed to strengthen the anti-violence movement.

Research has shown that 50 % of men who have witnessed or experienced violence as children and as adolescents do not use violence as adults (Krug & WHO, 2002) In the book *Asyl*, Marklund & Eriksson (2004) portray a non-violent man who makes a big effort to support his wife who has been battered by an earlier partner in Sweden. Although he is not the perpetrator, he becomes a victim. He becomes a victim, because the former partner continues

to use severe violence against the family, while, the Swedish Government does nothing to protect the family, and stop the man. Their children suffer. How does this happen? In the Nordic countries, violence against women happens as everywhere else. In the Nordic countries some changes have taken place in providing services suitable for battered women. However, most of the efforts to combat violence against women are supported by women. Where are the non-violent men? They could use a language that men understand, hopefully leading to changed attitudes and behaviour among batterers. Hopefully, as Denzin & Lincoln (1994) emphasized, science is power, and research findings have political implications. This research may have an impact. The thesis focuses on a burning social issue that responsible actors cannot easily avoid being touched by.

A researcher doing research with a focus on violence against women exposes herself to different kinds of feelings. The researcher cannot, as no person can, control her own feelings and be totally objective towards the informants and their stories. Meeting women, and listening to them describing episodes of terrible and frightening violence, raises feelings of anger, sorrow and fear of being terrorized by the perpetrator. There is a risk that both the interviewee and the interviewer could be pursued and injured, as Weinehall (1997) described when she did her research in Sweden. When carrying out Studies II and III, feelings of indignation about the terrible experiences that the women told about caused frustration. The positive effect of those feelings was a deeper awareness of being guided by objectivity, and a deeper understanding of the phenomenon.

Importance

In 1998, violence against women and children was put on the agenda in Åland. The awareness and recognition of violence against women includes misconceptions and myths even among professionals. However, some nurses feel deep concern for women and their children, and provide help and support with great responsibility (Paper I, II). Nevertheless, incorrect beliefs among nurses lead to inadequate help to abused women (Paper I). Decision-makers do not give priority to the problem (Paper IV). Professionals have limited possibilities to act and have a shortage of resources (Paper II). Thus, lack of resources leads to inadequate intervention and prevention, resulting in dissatisfied health providers and receivers. This thesis encourages the women victims of violence to come forward, and raises awareness of the problem, its prevalence and its effects. Recognition and awareness of the problem among

nurses and responsible leaders gives hope: hope that the aim of zero tolerance of violence against women in society will be reached (Paper II, IV). Other aims of this research are to raise awareness of the service's commitment to tackling violence against women in all its forms, and to increase public confidence in reporting incidents to the police. This research can give support to health workers, social workers, politicians, and other persons engaged in developing a more gender and equity-based society. The result may be that an organization implements more effective networking to support these women, and allocates more resources. Recognising the needs of women and nurses, and learning from this thesis, may save the lives of women and save public money. Reports show that abused women are more often sick and in need of health services than other women (Krug & WHO, 2002). If the number of unhealthy women decreases, an economic public benefit is achieved. But the greatest advantage is for the woman, her children and the health and happiness of the whole family.

7.3. Methodological considerations

Triangulation

According to Bechtel et al., (2000) some researchers argue that qualitative research is subjective and less rigorous than traditional quantitative research. Other researchers suggest that qualitative studies provide a richer and more meaningful description of the phenomenon under study. Guba & Lincoln (1994) stated that research methods, both quantitative and qualitative, should be seen as equal in scientific research, depending on their appropriate use for any research paradigm, which is the standpoint in this thesis.

Choosing the method of triangulation in this thesis should be recognised as a relevant and useful method to achieve a more holistic picture of violence against women in the Åland Islands (Bechtel et al., 2000). The complexity of the phenomenon violence against women, and an understanding of the phenomenon, called for the use of multiple methods and perspectives. The use of both quantitative and qualitative methods in this thesis is regarded as a strength, providing the potential for improving the quality of research in general, rather than a weakness, according to Strauss & Corbin (1994). There is a link between the complex, intertwined and multidimensional knowledge base of public health and the epistemology of nursing (Foss & Ellefsen, 2002). In this thesis, the aim was to improve the research by exploiting the strengths of each approach, to obtain a more holistic picture of IPV. Using triangulation, the different approaches provided different sets of non-competing knowledge that have equal importance and weight. Both approaches are designed to understand and

explain behaviour and events, their components, antecedents, corollaries, and consequences of IPV in the Åland Islands. Therefore, a blending of both allows the best representation of both world views, as Lincoln & Guba (1985) have described. This has probably provided a richer and more authentic description of the issue of violence against women in this thesis.

The studies showed that the introduction of a policy programme has not mainly affected the patients' needs and expectations (Paper I, II, III). The programme has not facilitated the interaction between the nurses and patients, according to triangulation combined in the perspective of micro versus macro levels. This showed that there is a gap between theoretically-constructed programmes at the macro level, where strategies are developed in a top-down fashion, and at the implementation stage at the micro level (Paper IV). There are difficulties at the micro level that are not dealt with (but should be) at the macro level, for example nurses' coping strategies, supervision of nurses and time constraints that Aldén (2005) and Stenius & Veysey (2005) have also described in their studies. The findings from the different approaches (quantitative vs. qualitative) support each other, which increases the validity (Parahoo, 1997). Thus, the results of the different studies do not give separate or different perceptions of reality. Nurses' problems related to delivering services to battered women are identified in Papers I, II, and III. Data triangulation showed for example that only a few nurses identified battered women (Paper I). The nurses who were interviewed described their frustration about their colleagues' non participation in intervening with battered women (Paper II). The battered women confirmed that some nurses did not raise the issue of violence (Paper III).

In the descriptive survey (Paper I), the results are in agreement with the results of Studies II, III and IV. Generally, attitudes towards the phenomenon violence against women among the different respondents were similar. With regard to practical functions, the results showed both strengths and severe weaknesses. The case study revealed that the leaders are not fully committed to allocating high quality services to battered women (Paper IV). The nurses could close their eyes to the problem, and not to respond to the women's needs (Paper II). The nurses reported that they believed that some of their reluctant colleagues reacted negatively because they felt insecure and uncertain, and because they did not feel equipped to help abused women, thus they felt unable to cope (Paper II). The qualitative Studies II and III provided more in-depth knowledge about the weaknesses found in the descriptive survey. Thus, the multiple methods used in this research provide a holistic view of the phenomenon.

One of the disadvantages of triangulation may be that the investigator may lack expertise or knowledge about one of the methods (Polit & Hungler, 1995). The researcher must be familiar with and able to use both quantitative and qualitative methods.

Reliability

Halldórsdóttir (2000) states that reliability of qualitative data depends to a great extent on the methodological skill, sensitivity, and integrity of the researcher. Thus, in this thesis the researcher has been the main research instrument. The researcher has been concerned with exploring the meaning of social phenomena as experienced by the respondents, and describing the respondents' experiences in their context. The researcher's intention has been to be continuously sensitive to emerging concepts and social processes, without any conscious preconceptions. Vehviläinen-Julkunen (2000) claims that research on nursing practice has often been focused on the client-nurse relationship, and has failed to analyse the phenomenon in a broader context. The researcher aimed to avoid this shortcoming in the present study. With regard to the credibility, dependability and confirmability of the results, the researcher has strived to provide reliable information. In this study, the researcher took steps to improve and evaluate the credibility of the data and conclusions. This was done to ensure confidence in the truth of the data (Polit & Hungler, 1995; Bechtel et al., 2000). The credibility of the data was enhanced by triangulation, using multiple methods. Methodological and data triangulation were also used to improve the reliability of the data (Bechtel et al., 2000). The results from triangulation have confirmed and complemented the findings, giving new insight into the phenomenon IPV in the context of the Åland Islands. Study I showed that few of the nurses provided a service for battered women. In Study II insight was gained about the reasons for the nurse's low participation in service delivery to battered women. The results of Study III provided further confirmation from the battered women themselves, and the results of Study IV provided some explanation of the causes of the deficient service to battered women, due to management factors. Hence, the explanations in Studies II, III and IV gave possible reasons for the findings of the questionnaire. Consequently, the results from the different methods support and complement each other, giving new insight and understanding of the phenomenon of IPV in the Åland Islands.

Transferability refers essentially to the generalizability of the data, that is, the extent to which the results can be transferred to other settings or groups. In this thesis, a description of the data has been given, enabling the reader to decide whether transfer is possible. However,

independent of the methods used, no study can provide findings that are universally transferable, according to Polit & Hungler (1995) and Strandmark & Hallberg (2007). The grounded theory research Studies II and III relied on systematic methodology and constant comparative analysis, and address rigor in the inquiries. The dependability of qualitative data refers to stability over time and under different conditions. The supervisor's continual feedback acted as an audit of both dependability and confirmability. The researcher and the supervisor have made conclusions about the relevance of the data. Confirmability has also been supported, since the published articles have been refereed.

Theoretical sensitivity, reflexivity and relationality

The criteria for rigor in qualitative research grounded theory include theoretical sensitivity, reflexivity and relationality (Hall & Callary, 2001). Strauss & Corbin (1990) focused only on theoretical sensitivity of the data analysis. Theoretical sensitivity is understood as the investigator's ability to use personal and professional experiences and the literature to see the research situation and data in new ways and exploit the potential of data for developing these experiences (Strauss & Corbin, 1990). To minimize subjectivity in the analysis, reflexivity and relationality have been used actively by the author, to increase the validity of the findings. Reflexivity is defined as an attitude of attending systematically to the context of knowledge construction, especially to the effect of the researcher, at every step of the research process (Malterud, 2001). In line with Larsson (2005), the researcher has carefully assessed the results in the light of her own perspectives and role. Reflexivity is understood by Annells (1997) as the influence of investigator-participant interactions on the research process, while relationality addresses power and trust relationships between researcher and participant (Hall & Callary, 2001). Accordingly, the researcher was respectful and sensitive to the participants' wishes to ensure good relationships. According to Kvale (1995), talking to other people is an aspect of communicative validity. With this in mind, the studies have been presented to and discussed with other researchers. Hall & Callary (2001) argued that reflection of the study contributes to the assessment of inquiries and increases validity. Every stage of the data analysis has been carefully considered. Strauss & Corbin (1990) encourage the researcher to write extensive codes and theoretical and operational memos. This method has been used for the presentation of self and in the analytic process. In this way, reflexivity has been used to increase validity.

Response rate

Among the reasons why nurses may not fill out a questionnaire are time constraints, too many questions, lack of motivation, and distress about gender-based violence (Paper I). Gender-based violence may present a strong threat to nurses who have been battered themselves, and that may partly explain why they may not answer questions about violence against women. In this thesis, some of the nurses (n=10) reported that it was difficult to answer the questionnaire because they did not encounter battered women. Moreover, the questions were difficult to understand and not relevant to their specific working units (n=6). Some nurses (n=3) said that they were unsure about anonymity. One nurse remarked that at her unit the nurses had discussed the questionnaire and concluded that it was too difficult to answer the questions and understand the aim of the inquiry. However, an information letter explaining the study was provided with each questionnaire. The remarks made by the nurses who filled in the questionnaire may explain the major reasons for dropout. In two departments of the health organization the response rate was less than 50 %. Only 56 (24 %) of the hospital nurses responded, and of the primary health care nurses 28 (21 %) responded. Of the total of 234 nurses working in the health organization 58 % (n=135) worked at the hospital and 26% (n=61) at the primary health care unit. More than half of the nurses working in the other units responded. The mean age of the responding nurses (n=133) was 41, and this was the same for each department in the organization. Hence, the age of the nurses did not seem to be a factor of importance for non-participation.

In Study II, nurses who were known to be committed and motivated to encounter battered women participated. None of them hesitated to share their experiences. They welcomed the inquiry and thought it could lead to better care for battered women in the future. In Study III, the battered women emphasized how important they thought such a study was, and they said that they wanted to do something for other battered women in the future. In Study IV, all the important leaders responsible for implementation of the government policies participated. Some of the women who were interviewed underlined the importance of scientific studies in the area of IPV. With regard to the low response rate to the questionnaire in Study I, Polite and Hungler (1995) argue that qualitative input (Papers II, III and IV) may help to explain the result of the inquiry of Study I. However, triangulation may compensate for the low response rate (Bechtel et al., 2000). Hence, both nurses and battered women explained more in depth how nurses cared for the women (Papers II and III). That explained the nurses' shortcomings that were found in Study I, for example nurses' uncertainty when encountering a battered

woman, which resulted in battered women not being identified. This was confirmed by the findings of Studies II and III. The result of Studies II and III shows that some women received care that did not meet their expectations. This contributed to the fact that the nurses' colleagues often failed to address the issue. Hence, the response rate was low due to the unsolved problems of the individual nurses (being battered, lack of knowledge etc). The case study showed that implementation of different strategies to deal with gender-based violence was inadequate within the organizations. In Paper III some of the nurses' shortcomings were confirmed, for example their encounters with battered women were often dealt with on an ad hoc basis. The nurses explained that their shortcomings in dealing with battered women were due to negligence, lack of knowledge, their own unsolved problems related to their experience of being battered, etc. (Paper II).

General limitations

The research findings are coloured by the researcher. Another researcher could have emphasized different aspects. In Study I, a larger number of respondents could have changed the results. Nurses who identify and understand the concept of violence against women may have fewer barriers to answering a questionnaire with 60 questions than nurses who do not encounter battered women. The nurses who did not respond could be the nurses who have been battered themselves. If that is the case, it is possible that battered nurses could have changed the results. They represent approximately 20-25 % of all nurses (drawn from Finnish and Swedish statistics). These battered women would possibly remain silent, not wanting to participate in studies of this kind. However, the opposite could also occur that nurses used the opportunity to tell about their experiences, although this seems less likely. Study II showed that battered nurses do not receive any help. This may make them avoid studies like this. In Study I, another pitfall may be that IPV was not explicitly defined, but left to the nurses to define themselves. This could have resulted in the limitation that nurses responded to physical violence only. Hence, the number of battered women identified by nurses could have been higher. Another limitation is that there is always the possibility of bias in self-reported data due to misunderstanding. Another limitation is the small number of informants. A larger number of informants may have provided more information and variation of the answers. Valuable documents could have been missed in Study IV, depending on the source's willingness to share information. A limitation of research is 'not grasping all of it' even though the researcher seriously intended to capture as much of the phenomenon as possible, according to Annells (1997).

7.4. Conclusions and future research questions

The main aim of this thesis was to contribute to the knowledge base about the delivery of services to battered women by official organizations, in which nurses were one of the most important health professionals. These services were proposed by the Government of Åland. The results show that the services battered women receive are sometimes satisfactory and sometimes deficient. The services are based on ad hoc premises, depending on the right nurse being on duty. Probably much violence goes undetected. However, some of the nurses act as gatekeepers. Nurses often suspect a history of violence, interpret the women's explanations, and recognise the signs. The nurses detect a discrepancy between the story and the reality. They are concerned to deliver high quality care. They sometimes fail to identify violence, and they have insufficient knowledge. They lack supervision and commitment from the leadership. Both nurses and battered women are victimized. The women are victimized in the sense that they do not get the help they need, and this can put their life in danger. The nurses are victimized because they have a duty to deliver high quality care, which some of them are not able to do because of unsolved problems. Over the last ten years, the care of battered women has changed, but the changes are happening slowly. Nonetheless, treatment and care are moving in the right direction. IPV has been put on the agenda by the Government of Åland, though much is still to be done before battered women receive adequate services.

During this research an awareness of a need for more research has been obvious. In order to refine our understanding of the consequences of gender violence, and to evaluate the effectiveness of different interventions, we need data about:

- the factors that hinder the women's rights movement to move forward
- how nurses can support women to leave violent partners earlier
- how the health service can help battered women to recover faster
- how 'silent' women can be reached
- why screening is not being carried out in Åland.

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1983

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- 1983:2 Methods and Experience in Planning for Family Health – Report from a seminar. Harald Heijbel & Lennart Köhler (eds).
- 1983:3 Accident Prevention – Report from a seminar. Ragnar Berfenstam & Lennart Köhler (eds).
- 1983:4 Själv mord i Stockholm – en epidemiologisk studie av 686 konsekutiva fall. Thomas Hjortsjö. Avhandling.

1984

- 1984:1 Långvarigt sjuka barn – sjukvårdens effekter på barn och familj. Andersson, Harwe, Hellberg & Syrén. (FoU-rapport/shstf:14). Distribueras av Studentlitteratur, Box 141, SE-221 01 Lund.
- 1984:2 Intersectoral Action for Health – Report from an International Workshop. Lennart Köhler & John Martin (eds).
- 1984:3 Barns hälsotillstånd i Norden. Gunborg Jakobsson & Lennart Köhler. Distribueras av Studentlitteratur, Box 141, SE-221 01 Lund.

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- 1985:1 Hälsa för äldre i Norden år 2000. Mårten Lagergren (red).
- 1985:2 Socialt stöd åt handikappade barn i Norden. Mats Eriksson & Lennart Köhler. Distribueras av Allmänna Barnhuset, Box 26006, SE-100 41 Stockholm.
- 1985:3 Promotion of Mental Health. Per-Olof Brogren.
- 1985:4 Training Health Workers for Primary Health Care. John Martin (ed).
- 1985:5 Inequalities in Health and Health Care. Lennart Köhler & John Martin (eds).

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- 1986:1 Prevention i primärvården. Rapport från konferens. Harald Siem & Hans Wedel (red). Distribueras av Studentlitteratur, Box 141, SE-221 01 Lund.
- 1986:2 Management of Primary Health Care. John Martin (ed).
- 1986:3 Health Implications of Family Breakdown. Lennart Köhler, Bengt Lindström, Keith Barnard & Houda Itani.
- 1986:4 Epidemiologi i tandvården. Dorthe Holst & Jostein Rise (red). Distribueras av Tandläkarförbundet, Box 5843, SE-102 48 Stockholm.
- 1986:5 Training Course in Social Pediatrics. Part I. Lennart Köhler & Nick Spencer (eds).

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1987

- 1987:1 Children's Health and Well-being in the Nordic Countries. Lennart Köhler & Gunborg Jakobsson. Ingår i serien Clinics in Developmental Medicine, No 98 och distribueras av Blackwell Scientific Publications Ltd, Oxford. ISBN (UK) 0 632 01797X.
- 1987:2 Traffic and Children's Health. Lennart Köhler & Hugh Jackson (eds).
- 1987:3 Methods and Experience in Planning for Health. Essential Drugs. Frants Staugård (ed).
- 1987:4 Traditional midwives. Sandra Anderson & Frants Staugård.
- 1987:5 Nordiska hälsovårdshögskolan. En historik inför invigningen av lokalerna på Nya Varvet i Göteborg den 29 augusti 1987. Lennart Köhler (red).
- 1987:6 Equity and Intersectoral Action for Health. Keith Barnard, Anna Ritsatakis & Per-Gunnar Svensson.
- 1987:7 In the Right Direction. Health Promotion Learning Programmes. Keith Barnard (ed).

1988

- 1988:1 Infant Mortality – the Swedish Experience. Lennart Köhler.
- 1988:2 Familjen i välfärdsstaten. En undersökning av levnadsförhållanden och deras fördelning bland barnfamiljer i Finland och övriga nordiska länder. Gunborg Jakobsson. Avhandling.
- 1988:3 Aids i Norden. Birgit Westphal Christensen, Allan Krasnik, Jakob Bjørner & Bo Eriksson.
- 1988:4 Methods and Experience in Planning for Health – the Role of Health Systems Research. Frants Staugård (ed).
- 1988:5 Training Course in Social Pediatrics. Part II. Perinatal and neonatal period. Bengt Lindström & Nick Spencer (eds).
- 1988:6 Äldretandvård. Jostein Rise & Dorthe Holst (red). Distribueras av Tandläkarförlaget, Box 5843, SE-102 48 Stockholm.

1989

- 1989:1 Rights, Roles and Responsibilities. A view on Youth and Health from the Nordic countries. Keith Barnard.
- 1989:2 Folkhälsovetenskap. Ett nordiskt perspektiv. Lennart Köhler (red).
- 1989:3 Training Course in Social Pediatrics. Part III. Pre-School Period. Bengt Lindström & Nick Spencer (eds).

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- 1989:4 Traditional Medicine in Botswana. Traditional Medicinal Plants. Inga Hedberg & Frants Staugård.
- 1989:5 Forsknings- och utvecklingsverksamhet vid Nordiska hälsovårdshögskolan. Rapport till Nordiska Socialpolitiska kommittén.
- 1989:6 Omstridda mödrar. En studie av mödrar som förtecknats som förståndshandikappade. Evy Kollberg. Avhandling.
- 1989:7 Traditional Medicine in a transitional society. Botswana moving towards the year 2000. Frants Staugård.
- 1989:8 Rapport fra Den 2. Nordiske Konferanse om Helseopplysning. Bergen 4–7 juni 1989. Svein Hindal, Kjell Haug, Leif Edvard Aarø & Carl-Gunnar Eriksson.

1990

- 1990:1 Barn och barnfamiljer i Norden. En studie av välfärd, hälsa och livskvalitet. Lennart Köhler (red). Distribueras av Studentlitteratur, Box 141, SE-221 01 Lund.
- 1990:2 Barn och barnfamiljer i Norden. Teknisk del. Lennart Köhler (red).
- 1990:3 Methods and Experience in Planning for Health. The Role of Women in Health Development. Frants Staugård (ed).
- 1990:4 Coffee and Coronary Heart Disease, Special Emphasis on the Coffee – Blood Lipids Relationship. Dag S. Thelle & Gerrit van der Stegen (eds).

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- 1991:1 Barns hälsa i Sverige. Kunskapsunderlag till 1991 års Folkhälsorapport. Gunborg Jakobsson & Lennart Köhler. Distribueras av Fritzes, Box 16356, SE-103 27 Stockholm (Allmänna Förlaget).
- 1991:2 Health Policy Assessment – Proceedings of an International Workshop in Göteborg, Sweden, February 26 – March 1, 1990. Carl-Gunnar Eriksson (ed). Distributed by Almqvist & Wiksell International, Box 638, SE-101 28 Stockholm.
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- 1991:5 Growth and Social Conditions. Height and weight of Stockholm schoolchildren in a public health context. Lars Cernerud. Avhandling.
- 1991:6 Aids in a caring society – practice and policy. Birgit Westphal Victor. Avhandling
- 1991:7 Resultat, kvalitet, valfrihet. Nordisk hälsopolitik på 90-talet. Mats Brommels (red). Distribueras av nomesko, Sejrøgade 11, DK-2100 København.

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1992

- 1992:1 Forskning om psykiatrisk vårdorganisation – ett nordiskt komparativt perspektiv. Mats Brommels, Lars-Olof Ljungberg & Claes-Göran Westin (red). sou 1992:4. Distribueras av Fritzes, Box 16356, SE-103 27 Stockholm (Allmänna förlaget).
- 1992:2 Hepatitis virus and human immunodeficiency virus infection in dental care: occupational risk versus patient care. Flemming Scheutz. Avhandling.
- 1992:3 Att leda vård – utveckling i nordiskt perspektiv. Inga-Maja Rydholm. Distribueras av shstf-material, Box 49023, SE-100 28 Stockholm.
- 1992:4 Aktion mot alkohol och narkotika 1989–1991. Utvärderingsrapport. Athena. Ulla Marklund.
- 1992:5 Abortion from cultural, social and individual aspects. A comparative study, Italy – Sweden. Marianne Bengtsson Agostino. Avhandling.

1993

- 1993:1 Kronisk syke og funksjonshemmede barn. Mot en bedre fremtid? Arvid Heiberg (red). Distribueras av Tano Forlag, Stortorget 10, NO-0155 Oslo.
- 1993:2 3 Nordiske Konference om Sundhedsfremme i Aalborg 13 – 16 september 1992. Carl-Gunnar Eriksson (red).
- 1993:3 Reumatikernas situation i Norden. Kartläggning och rapport från en konferens på Nordiska hälsovårdshögskolan 9 – 10 november 1992. Bjarne Jansson & Dag S. Thelle (red).
- 1993:4 Peace, Health and Development. A Nobel seminar held in Göteborg, Sweden, December 5, 1991. Jointly organized by the Nordic School of Public Health and the University of Göteborg with financial support from SAREC. Lennart Köhler & Lars-Åke Hansson (eds).
- 1993:5 Hälsopolitiska jämlikhetsmål. Diskussionsunderlag utarbetat av WHOs regionkontor för Europa i Köpenhamn. Göran Dahlgren & Margret Whitehead. Distribueras gratis.

1994

- 1994:1 Innovation in Primary Health Care of Elderly People in Denmark. – Two Action Research Projects. Lis Wagner. Avhandling.
- 1994:2 Psychological stress and coping in hospitalized chronically ill elderly. Mary Kalfoss. Avhandling.
- 1994:3 The Essence of Existence. On the Quality of Life of Children in the Nordic countries. Theory and Practice. Bengt Lindström. Avhandling.

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1995

- 1995:1 Psykiatrisk sykepleie i et folkehelseperspektiv. En studie av hvordan en holistisk-eksistensiell psykiatrisk sykepleiemodell bidrar til folkehelsearbeid. Jan Kåre Hummelvoll. Avhandling.
- 1995:2 Child Health in a Swedish City – Mortality and birth weight as indicators of health and social inequality. Håkan Elmén. Avhandling.
- 1995:3 Forebyggende arbeid for eldre – om screening, funn, kostnader og opplevd verdi. Grethe Johansen. Avhandling.
- 1995:4 Clinical Nursing Supervision in Health Care. Elisabeth Severinsson. Avhandling.
- 1995:5 Prioriteringsarbeid inom hälso- och sjukvården i Sverige och i andra länder. Stefan Holmström & Johan Calltorp. Sprit 1995. Distribueras av Spris förlag, Box 70487, SE-107 26 Stockholm.

1996

- 1996:1 Socialt stöd, livskontroll och hälsa. Raili Peltonen. Socialpolitiska institutionen, Åbo Akademi, Åbo, 1996.
- 1996:2 Recurrent Pains – A Public Health Concern in School – Age Children. An Investigation of Headache, Stomach Pain and Back Pain. Guðrún Kristjánsdóttir. Avhandling.
- 1996:3 AIDS and the Grassroots. Frants Staugård, David Pitt & Claudia Cabrera (red).
- 1996:4 Postgraduate public health training in the Nordic countries. Proceedings of seminar held at The Nordic School of Public Health, Göteborg, January 11 – 12, 1996.

1997

- 1997:1 Victims of Crime in a Public Health Perspective – some typologies and tentative explanatory models (Brottsoffer i ett folkhälsoperspektiv – några typologier och förklaringsmodeller). Barbro Renck. Avhandling. (Utges både på engelska och svenska.)
- 1997:2 Kön och ohälsa. Rapport från seminarium på Nordiska hälsovårdshögskolan den 30 januari 1997. Gunilla Krantz (red).
- 1997:3 Edgar Borgenhammar – 65 år. Bengt Rosengren & Hans Wedel (red).

1998

- 1998:1 Protection and Promotion of Children's Health – experiences from the East and the West. Yimin Wang & Lennart Köhler (eds).
- 1998:2 EU and Public Health. Future effects on policy, teaching and research. Lennart Köhler & Keith Barnard (eds) 1998:3 Gender and Tuberculosis. Vinod K. Diwan, Anna Thorson, Anna Winkvist (eds)

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Report from the workshop at the Nordic School of Public Health, May 24-26, 1998.

1999

- 1999:1 Tipping the Balance Towards Primary Healthcare Network. Proceedings of the 10th Anniversary Conference, 13-16 November 1997. Editor: Chris Buttanshaw.
- 1999:2 Health and Human Rights. Report from the European Conference held in Strasbourg 15-16 mars 1999. Editor: Dr. med. Stefan Winter.
- 1999:3 Learning about health: The pupils' and the school health nurses' assessment of the health dialogue. Ina Borup. DrPH-avhandling.
- 1999:4 The value of screening as an approach to cervical cancer control. A study based on the Icelandic and Nordic experience through 1995. Kristjan Sigurdsson. DrPH-avhandling.

2000

- 2000:1 Konsekvenser av urininkontinens sett i et folkehelsevitenskapelig perspektiv. En studie om livskvalitet hos kvinner og helsepersonells holdninger. Anne G Vinsnes. DrPH-avhandling.
- 2000:2 A new public health in an old country. An EU-China conference in Wuhan, China, October 25-29, 1998. Proceedings from the conference. Lennart Köhler (ed)
- 2000:3 Med gemenskap som grund - psykisk hälsa och ohälsa hos äldre människor och psykiatrisjuksköterskans hälsofrämjande arbete. Birgitta Hedelin. DrPH-avhandling.
- 2000:4 ASPHER Peer Review 1999. Review Team: Jacques Bury, ASPHER, Franco Cavallo, Torino and Charles Normand, London.
- 2000:5 Det kan bli bättre. Rapport från en konferens om barns hälsa och välfärd i Norden. 11-12 november 1999. Lennart Köhler. (red)
- 2000:6 Det är bra men kan bli bättre. En studie av barns hälsa och välfärd i de fem nordiska länderna, från 1984 till 1996. Lennart Köhler, (red)
- 2000:7 Den svenska hälso- och sjukvårdens styrning och ledning – en delikat balansakt. Lilian Axelsson. DrPH-avhandling.
- 2000:8 Health and well-being of children in the five Nordic countries in 1984 and 1996. Leeni Berntsson. DrPH-avhandling.
- 2000:9 Health Impact Assessment: from theory to practice. Report on the Leo Kaprio Workshop, Göteborg, 28 - 30 October 1999.

2001

- 2001:1 The Changing Public-Private Mix in Nordic Healthcare - An Analysis John Øvretveit.

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- 2001:2 Hälsokonsekvensbedömningar – från teori till praktik. Rapport från ett internationellt arbetsmöte på Nordiska hälsovårdshögskolan den 28-31 oktober 1999. Björn Olsson, (red)
- 2001:3 Children with asthma and their families. Coping, adjustment and quality of life. Kjell Reichenberg. DrPH-avhandling.
- 2001:4 Studier av bruket av dextropropoxifen ur ett folkhälsoperspektiv. Påverkan av ett regelverk. Ulf Jonasson. DrPH-avhandling.
- 2001:5 Protection – Prevention – Promotion. The development and future of Child Health Services. Proceedings from a conference. Lennart Köhler, Gunnar Norvenius, Jan Johansson, Göran Wennergren (eds).
- 2001:6 Ett pionjärbete för ensamvargar
Enkät- och intervjuundersökning av nordiska folkhälsoodoktorer examinerade vid Nordiska hälsovårdshögskolan under åren 1987 – 2000.
Lillemor Hallberg (red).

2002

- 2002:1 Attitudes to prioritisation in health services. The views of citizens, patients, health care politicians, personnel, and administrators. Per Rosén. DrPH-avhandling.
- 2002:2 Getting to cooperation: Conflict and conflict management in a Norwegian hospital. Morten Skjørshammer. DrPH-avhandling.
- 2002:3 Annual Research Report 2001. Lillemor Hallberg (ed).
- 2002:4 Health sector reforms: What about Hospitals? Pär Eriksson, Ingvar Karlberg, Vinod Diwan (ed).

2003

- 2003:1 Kvalitetsmåling i Sundhedsvæsenet.
Rapport fra Nordisk Ministerråds Arbejdsgruppe.
- 2003:3 NHV 50 år (Festboken)
- 2003:4 Pain, Coping and Well-Being in Children with Chronic Arthritis.
Christina Sällfors. DrPH-avhandling.
- 2003:5 A Grounded Theory of Dental Treatments and Oral Health Related Quality of Life.
Ulrika Trulsson. DrPH-avhandling.

2004

- 2004:1 Brimhealth 1993-2003
- 2004:2 Experienced quality of the intimate relationship in first-time parents – qualitative and quantitative studies. Tone Ahlborg. DrPH-avhandling.

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2005

- 2005:1 Kärlek och Hälsa – Par-behandling i ett folkhälsoperspektiv.
Ann-Marie Lundblad. DrPH-avhandling.
- 2005:2 1990 - 2000:A Decade of Health Sector Reform in Developing Countries
- Why, and What Did we Learn?
Erik Blas. DrPH-avhandling
- 2005:3 Socio-economic Status and Health in Women
Population-based studies with emphasis on lifestyle and cardiovascular disease
Claudia Cabrera. DrPH-avhandling

2006

- 2006:1 "Säker Vård -patientskador, rapportering och prevention"
Synnöve Ödegård. DrPH-avhandling
- 2006:2 Interprofessional Collaboration in Residential Childcare
Elisabeth Willumsen. DrPH-avhandling
- 2006:3 Innkost-CTG: En vurdering av testens prediktive verdier, reliabilitet og
effekt. Betydning for jordmødre i deres daglige arbeide
Ellen Blix. DrPH-avhandling

2007

- 2007:1 Health reforms in Estonia - acceptability, satisfaction and impact
Kaja Põlluste. DrPH-avhandling
- 2007:2 Creating Integrated Health Care
Bengt Åhgren. DrPH-avhandling
- 2007:3 Alkoholbruk i tilknytning til arbeid – Ein kvalitativ studie i eit folkehelsevitskapeleg
perspektiv
Hildegunn Sagvaag. DrPH-avhandling
- 2007:4 Public Health Aspects of Pharmaceutical Prescription Patterns – Exemplified by
Treatments for Prevention of Cardiovascular Disease
Louise Silwer. DrPH-avhandling
- 2007:5 Å fremme den eldre sykehuspasientens helse I lys av et folkehelse og holistisk-
eksistensielt sykepleieperspektiv
Geir V Berg. DrPH-avhandling

2008

- 2008:1 Diabetes in children and adolescents from non-western immigrant families –
health education, support and collaboration
Lene Povlsen. DrPH-avhandling

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- 2008:2 Love that turns into terror: Intimate partner violence in Åland – nurses' encounters with battered women in the context of a government-initiated policy programme
Anette Häggblom. DrPH-avhandling

