TUIJA LEPPÄKOSKI

Women Exposed to Acute Physical Intimate Partner Violence Seeking Care at Emergency Departments
Identification of and Intervention in Violence

ACADEMIC DISSERTATION
To be presented, with the permission of the Faculty of Medicine of the University of Tampere, for public discussion in the small auditorium of Building B, Medical School of the University of Tampere, Medisinarinkatu 3, Tampere, on May 25th, 2007, at 12 o’clock.
ACADEMIC DISSERTATION
University of Tampere, Department of Nursing Science
Pirkanmaa Hospital District
Finland

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University of Oulu
Professor Helena Leino-Kilpi
University of Turku

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I dedicate this work to my late parents with deep gratitude for their wisdom and knowledge of life.
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Hospital took part in. The ANSA project was what first got me interested in studying violence within families. I am indebted to the entire ANSA team at Jorvi and the staff at the emergency department for the numerous stimulating discussions we had. Working for Lyömätön Linja, a cooperation network for prevention of violence within families, helped me gain a number of interesting perspectives into violence within families and proved that helping families exposed to violence required close cooperation with all parties concerned. I am very grateful to you all.

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Abstract

The purpose of this descriptive, cross-sectional multi-center study is to create a preliminary model for identifying women exposed to acute physical intimate partner violence seeking care at emergency departments and for intervening in the violence. The model is based on the results of previous research and the present study.

Research material was collected during 2000-2004 with questionnaires given to women exposed to acute physical intimate partner violence (n = 35) and emergency department professionals (n = 480). Moreover, semi-structured interviews were carried out with seven women and 20 emergency department professionals. The data were analysed using quantitative and qualitative methods. Twenty-eight emergency departments from all over Finland participated in the study.

The results of the present study revealed that among the women seeking care for their acute physical injuries the lifetime prevalence of physical intimate partner violence was 94%. Eighty-six per cent of the women had previously experienced physical violence by their current partner and 97% of past and 56% of acute cases of physical violence were accompanied by psychological violence. Physical violence had resulted in contusions, wounds and fractures. Some of the women’s children had witnessed (seen and/or heard) violence between their parents and some had also been exposed to physical violence.

The women studied described their positive and negative experiences of care as patients at an emergency department in many ways. The important factors in a good relationship between a patient and a health care professional included appropriate medical care of injuries with elements of emotional (desire to be listened to and understood) and practical support (providing information on different help services). The women regarded care principles such as kind and confidential care relationship and secure care environment as important. The women expressed their concern about their children and partners and also wanted them to be helped.

The results of the present study revealed that those emergency department professionals who had common practices and written procedures for handling intimate partner violence reported having helped both women and perpetrators more often than the professionals without procedures. Good co-operation with different help providers and possibilities to consult them facilitated intervention methods. Those professionals who had received more training on intimate partner violence reported better skills in identifying intimate partner violence and intervening in it.
The research results suggest that improvement of practical nursing care requires that training be arranged and co-operation with different help providers be developed, and a jointly agreed model be introduced to address intimate partner violence. This is everyone’s professional, ethical duty and also based on legislation. However, an implementation of the model demands the support of those in positions of nursing administration.

The functionality of the model developed is the next step for further research and will be tested in practice.

Keywords: Intimate partner violence, women/children exposed to intimate partner violence, perpetrator, identification of intimate partner violence, intervention in intimate partner violence, emergency department
Tämän kuvailevan, poikittaisen monike skustutkimuksen tarkoituksena on kehittää alustava malli akuutin fyysisen parisuhdeväkivallan vuoksi ensiapupoliklinikoille hoitoon hakeutuvien naisten tunnistamiseksi ja väkivaltaan puuttumiseksi. Malli perustuu sekä aikaisempien että tämän tutkimuksen tuloksiin.


Tämän tutkimuksen tulokset osoittavat, että akuuttiin fyysisiin vammoihin hoitoa hakeneista naisista 94% oli kokenut fyysistä parushdeväkivaltaa jo aikaisemminkin elämässään. Nykyisen kumppaninsa taholta oli aikaisemmin kokenut väkivaltaa 86% tutkimukseen osallistuneista naisista. Fyysinen ja henkinen väkivalta yhdistyi 97%:ssa tapauksista aikaisemmin koetussa parushdeväkivallassa sekä 56%:ssa tapauksista akuutissa väkivallassa. Fyysisestä väkivallasta oli seurauksena ruuhevammoja, haavoja ja luunmurtumia. Jotkut lapset olivat kuulleet ja nähneet vanhempiensa välistä väkivaltaa, ja jotkut heistä olivat myös itse joutuneet väkivallanteon kohteeksi.

Parishdeväkivaltaa kokeneet naisten kuvasivat hyviä ja huonoja hoitokokemuksiaan monin tavoin. Hyvää hoitosuhdetta ilmensivät tarkoituksenmukainen vammojen kliininen tutkimus ja hoito, mukaan lukien saatu emotionaalinen tuki (halu tulla kuulluksi ja ymmärrettyksi) ja käytännön tukitoimet (tietoa eri auttajatuesta), naisen yksilölliset hoidon tarpeet huomioon ottaen. Tärkeinä pidettiin hoitoperiaatteisiin kuuluivat tutkittujen naisten mielestä myös luottamuksellinen hoitosuhde ja turvallinen hoitoympäristö. Naiset ilmaisivat myös huolenlapsista ja kumppanista ja olisivat halunneet myös myötäilevän hoitopäätteen kohteeeksi.

Tutkimustulokset osoittivat, että ne päivystyspoliklinikoida työskentelevät hoitajat, jotka kertoivat toimipisteissään olevan yhteisesti sovittu kirjallisuus menettelytavan parushdeväkivalltaa kokeneiden naisten auttamiseksi, kertoivat ohjanneensa sekä naisia että pahoinpitelijöitä useammin jakamalla mm. tietoa sekä suullisesti että kirjallisesti eri auttajatahoista ja ohjanneet heitä avun piiriin. Hyvä yhteistyö eri auttajatahoihin ja mahdollisuus pyytää heiltä konsultaatioapua tarvittaessa edesauttoivat käyttämään erilaisia interventiomenetelmiä väkivallan katkaisemiseksi.
Tutkimustulosten mukaan hoitotyön käytännön parantaminen edellyttää koulutuksen järjestämistä, yhteistyön kehittämistä eri auttajatahojen kanssa ja yhteisesti hyväksyttyä mallia hoitaa parisuhdeväkivaltaa kokeneita. Tämä on jokaisen ammatillisen, eettisen ja myös lainsäädäntöön perustuva vastuu, mutta mallin vieminen käytäntöön edellyttää kuitenkin hoitotyön hallinnon tukea. Seuraavana vaiheena tulee olemaan kehitetyn mallin testaaminen käytännössä ja sen edelleen kehittäminen.

Avainsanat: parisuhdeväkivalta, naisiin kohdistuva väkivalta, parisuhdeväkivaltaa kokeneet naiset/lapset, pahoinpitelijä, parisuhdeväkivallan tunnistaminen, parisuhdeväkivaltaan puuttuminen, päivystyspoliklinikka.
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1 Introduction

Intimate partner violence (IPV) – also called domestic violence (DV) – is increasingly seen as a serious public health problem around the world. It is first and foremost viewed as an issue of human rights, but it is also a legal question and a criminal act that exists in all social classes and cultures in all types of intimate relationships, heterosexual and same-sex couples (Mechem et al. 2001; World Report on Violence and Health 2002; Johnson & Gorchynsky 2003). Intimate partner violence refers to ‘any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship’. (World Report on Violence and Health 2002, 89.)

Criminological victimization surveys and some other studies have indicated that also men experience violence from their female partners (Tjaden & Thoennes 2000; Pape 2003; Porcerelli et al. 2003; Suomalaiset väkivallan uhreina 2005). However, women are more commonly victims of repeated violence and it involves their intimate relationship. Men, in general, are much more likely to be attacked by a stranger (Tjaden & Thoennes 2000; World Report on Violence and Health 2002; Hofner et al. 2005; Siren & Honkatukia 2005). One of the most common forms of violence against women is that performed by an intimate male partner. Ninety per cent (mean 1987-2005) of all family violence known by the police is intimate partner violence (according to the statistics of the police, IPV means violence between spouses) (Piispa et al. 2006, 14).

In 48 population-based surveys, between 10 and 69% of women reported having been physically assaulted by an intimate male partner at some time in their lives (World Report on Violence and Health 2002). In Europe, the lifetime prevalence of physical and/or sexual violence by current or former partners ranges between 4 and over 30% according to the report State of European research on the prevalence of interpersonal violence and its impact on health and human rights (2006). According to the latest Finnish survey, 44% of the women had at least once experienced physical or sexual violence inflicted by a man, or the threat of it, after having reached 15 years of age. In the 1997 survey, the corresponding share was 40%. In 1997, 22% of women had experienced violence in a current partnership, and in the 2005 survey the corresponding share was 20%. Eight per cent of the women aged 18-74 had experienced violence by their current partner during the past 12 months. In 1997 the corresponding share was 9% (Heiskanen & Piispa 1998; Piispa et al. 2006). In Sweden the corresponding figures are 28% and 7% (del Castillo et al. 2004). In the USA, nearly 25% of surveyed women reported having been raped and/or physically assaulted by a partner at some time in their lifetime, and 2% of them in the past 12 months.
According to various data sources the prevalence of IPV during pregnancy (meaning that women are maltreated physically and/or sexually by their partners at least once) varies between 1% and 17% (Janssen et al. 2003; Johnson et al. 2003). Statistics on intimate partner violence vary because of differences in how different data sources define the term ‘intimate partner violence’ and collect data (e.g. variations in the selection criteria for the study participants), and differences resulting from the data sources used. This is why most prevalence figures on IPV from different studies cannot be compared directly (World Report on Violence and Health 2002).

In spite of variations in the definitions and figures of IPV, it appears to be unrecognized (Davis et al. 2003; Watts & Zimmerman 2002) and underreported particularly because of hidden criminality (Siren & Honkatukia 2005). For example, in the 2003 Finnish survey, only one out of six victims said that the most serious violent act had been notified to or was otherwise known by the police. According to the report, 44% of men and 26% of women (who had been at least hit by someone) told that the incident was reported to the police. Moreover, violence against men is more commonly recorded as a crime than violence against women (Siren & Honkatukia 2005, 164). According to the latest Finnish survey, only 12% of women ever exposed to IPV had sought help from the police (Piispa et al. 2006). The women mentioned that some of the reasons for not seeking help from the police included regarding an act of violence or its consequences minor, protecting the perpetrator and feelings of shame (Siren & Honkatukia 2005; Piispa et al. 2006).

Not all acts of violence come to light although the consequences for women can be serious. However, intimate partner violence brings along both short- and long-term physical and psychical health consequences for women and their children (e.g. Muelleman, Lenaghan & Pakieser 1996; Wagner & Mongan 1998; Coker et al. 2000b; Plchta & Falik 2001; Anderson 2002; Campbell 2002; Sutherland, Bybee & Sullivan 2002; Hornor 2005). In spite of serious health consequences, women have a high threshold to seek help (Eyler & Cohen 1999; Krishnan, Hilpert & Pase 2001). According to the latest Finnish survey, 31% of those who had sometimes experienced IPV had sought help from somewhere, whereas the percentage was 26 in 1997 (Piispa et al. 2006). According to the Finnish victim surveys, women seek care only for the most serious physical injuries (Heiskanen & Piispa 1998; Siren & Honkatukia 2005; Piispa et al. 2006). Many people still consider IPV a private family matter and this makes it difficult for women to obtain help and for health care professionals to provide assistance, even though Finland – along with many states – has ratified international agreements (CEDAW 1996), published guidelines and recommendations, arranged training and developed care protocols (by Social and Health Board of Finland), as well as passed laws to protect women from violence (see Appendices 1 and 2).

The studies reviewed in the present study revealed that 1-23% of all female patients who visited emergency departments (EDs) did so because of an acute episode of physical IPV and 6-14% of women who sought care for any reason had experienced IPV within the previous year. The cumulative prevalence of
IPV in all women presenting to emergency units has been reported to be as high as 54% (Feldhaus et al. 1997; Glass, Dearwater & Campbell 2001; Appendix 3, Table 1). Even though the studies conducted in different health care settings do not define the term ‘intimate partner violence’ precisely, and some researchers do not determine the acuteness of IPV (current, past, any) in their studies, and the exact numbers of women exposed to IPV vary, it is clear that professionals at EDs do encounter these women and their family members.

Yet health care professionals do not always recognize the signs of IPV. Many women are treated solely for their injuries and they pass through the health care system unnoticed, no one asking: ‘Have you been hit? If so, by whom?’ (Haywood & Haile-Mariam 1999, Yam 2000, Corbally 2001), or the patients are sent home without investigating their safety or referring them to social services (Davis et al. 2003). As obstacles, previous studies mention that women may feel ashamed and feel that they are responsible for the violent incident, fear of their partner’s reaction to disclosure, fear that they will lose their children (Corbally 2001; Peckover 2003), judgmental reactions from the emergency department professionals to whom the matter is disclosed (McCauley et al. 1995; Caralis & Musialowski 1997; Dearwater et al. 1998), or that intervention in women’s violent relationships can be frustrating from the health care professionals perspective (Trevitt & Gallagher 1996; McGrath et al. 1997). Studies have shown that the guidance and advice of health care professionals is not sufficient for women (Hotch et al. 1996a; Perttu 1999a). Some professionals have reported their personal experiences of IPV and this may be an obstacle to helping women who have been exposed to violence by their partners (Shea, Mahoney & Lacey 1997; Janssen, Basso & Costanzo 1998).

The emergency department is often the first and sometimes the only contact that the women exposed to IPV have with health care professionals. The health care professionals in these work communities are in a unique position to holistically assess the situation of the woman exposed to IPV (Corbally 2001). When the woman arrives at the ED with or without her family members, a nurse may be the first person to meet and to talk to the woman after the violent act, and the first who can relate to and care for her. Failure to identify IPV contributes to recidivism and health problems for women and children, as well as frequent visits to the ED. Early, effective intervention in the situation of the women exposed to violence can interrupt the cycle of violence, prevent further injury, prevent abuse of children and initiate the help-seeking process (Muelleman, Lenaghan & Pakieser 1998; Corbally 2001).

In Finland, so far only a few family nursing research has been conducted on intimate partner violence. In order to ensure optimal care for women and their family members, more information is needed. Family nursing research generates knowledge concerning families’ and family members’ wellbeing and their experiences of and expectations for nursing and health care (Åstedt-Kurki, Paavilainen & Lehti 2001). Thus studying the identification of IPV and intervention in it to improve the health and wellbeing of women and their family members is a key study priority.
The aims of this study is to describe what kinds of care experiences the women have had when seeking help for their acute injuries and what kinds of interventions the emergency unit professionals have used for women exposed to IPV. The purpose of this study is to create a preliminary model to identify and intervene in this health problem in the ED setting, based on previous results and the findings of the present study, and thus to improve the emergency department services.

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2 Literature review

A literature review was carried out by searching for previous studies and their results from Cinahl, PsycInfo, Medic, Medline, and Cochrane and certain other databases. The terms ‘domestic violence’, ‘family violence’, ‘intimate partner violence’, ‘violence against women’, ‘identification’, ‘screening’, ‘intervention’, and ‘emergency’ were used in the search. The search process was mainly limited to studies conducted in 1995-2005, because the field of IPV in the context of health services has produced thousands of published research papers. From these most recent ones, those studies were selected which described identification of or intervention in IPV from women’s and ED professionals’ perspective. Moreover, studies determining the incidence and/or prevalence of IPV among ED patients, primary care patients, pediatric department patients or obstetric and gynecology clinics patients are included, as are certain screening and intervention studies.

These studies mainly originate from the USA, but there are also some studies from Australia, Canada, the UK and the Nordic countries. Most of them are surveys, but there are also randomized controlled trial and case-control studies, and before/after studies. A majority were conducted using both quantitative (questionnaires) and qualitative methods (interviews, reviews of medical records) for data collection. The main focus of most IPV research has been on preventing the recurrence of violence against women and children. The problem is that very little academic research of IPV has been conducted in the Finnish health care context, and the results of studies conducted abroad are not directly comparable. Some selected screening, identification and intervention studies and studies determining the incidence and/or prevalence of IPV from the perspective of research questions are presented in Appendices 3 and 4.

2.1 Intimate partner violence against women

The term ‘intimate partner’ refers to a person with whom a woman/a man considers herself/himself having an intimate relationship. A person using violence in an intimate relationship is called a ‘perpetrator’. In intimate relationships the most common perpetrators are partners (current or former), parents or other family members. In studies conducted by various health care organizations, researchers have used the concept of ‘intimate partner’ with variability. In these studies an intimate partner is broadly defined as a boyfriend,
girlfriend, ex-boyfriend, ex-girlfriend, husband, wife, ex-husband, or ex-wife, a member of the family or a close relation (Dansky, Byrne & Brady 1999; Zachary et al. 2001; Lejoyeux et al. 2002). Thus according to these studies violence may occur among all types of intimate relationship, whether heterosexual or same-sex couples. In some studies an intimate partner is defined more accurately; for example, as violence used by a male partner (Abbott et al. 1995; Muelleman, Lenaghan & Pakieser 1998). Researchers have used also the concepts ‘violence’, ‘abuse’, ‘assault’, or ‘battering’ in their descriptions of IPV against women (see Appendix 3, Table 1).

The term ‘violence’ means: 1) the exercise or an instance of physical force, usually effecting or intended to effect injuries, destruction, etc. 2) powerful, untamed, or devastating force 3) great strength of feeling 4) an unjust, unwarranted, or unlawful display of force, and 5) doing violence to someone or something (‘to inflict harm upon’; ‘to distort the sense or intention of’). (Collins Concise Dictionary 1995, 1506.) Thus the term ‘violence’ refers on the one hand to a violent behaviour and on the other hand to a very strong feeling. The term ‘abuse’ as a verb can mean: 1) to use incorrectly or improperly; misuse, 2) to maltreat, esp. physically or sexually, 3) to speak insultingly or cruelly to. As a noun the term can mean improper, incorrect, or excessive use (e.g. verbal abuse, drug abuse) or maltreatment of a person (e.g. child abuse, elder abuse). (Collins Concise Dictionary 1995, 5.) The term ‘assault’ as a verb means not only to rape or attempt to rape or to make an assault upon someone but also to make a violent attack, either physical or verbal. (Collins Concise Dictionary 1995, 72.) The term ‘battering’ can sometimes, but not always, describe serious and repeated violence. According to the Collins Concise Dictionary (1995, 72) the verb ‘batter’ expressly means to hit (someone or something) hard and repeatedly using heavy blows. The term ‘battered’ (adj.) means subjected to persistent physical violence, especially caused by a close relative living in the house (e.g. ‘battered wives’, ‘battered babies’). In criminal law (in the British Commonwealth) the terms ‘assault’ and ‘battery’ as nouns mean a threat of attack to another person followed by the actual act (Collins Concise Dictionary 1995, 72, 106).

‘Intimate partner violence’ (IPV) (used by e.g. Campbell et al. 2002; Bensley, Van Eenwyk, Wynkoop Simmons 2003), is known by a variety of names to describe a violent act committed on a woman by her intimate partner. In the publications below, the following terms have also been used:

- ‘abused women’ (Fanslow, Norton & Robinson 1999; Lutenbacher, Cohen & Mitzel 2003)
- ‘domestic abuse’ (Hadley et al. 1995; Zachary et al. 2001; Hardacre 2005),
- ‘domestic spousal violence’ (Kumar et al. 2005),
- ‘domestic violence’ (Evins & Chescheir 1996; Chambliss 1997; Davidson et al. 2001; Richardson et. al. 2002),
- ‘family violence’ (Buel 1995; Wright, Wright & Isaac 1997; Butler Maher 2002),
- ‘inter-parental violence’ (Heyman & Smith Slep 2002),
• ‘intimate partner abuse/partner abuse’ (Dearwater et al. 1998; Fernández-Esquer & McCloskey 1999; Rodriguez et al. 1999; Hathaway et al. 2000; Diatz-Olavarrrieta et al. 2001; Dienemann et al. 2000),
• ‘male-to-female partner abuse’ (Black, Heyman & Smith Slep 2001; Schumacher et al. 2001a and 2001b)
• ‘marital violence’ (Cano & Vivian 2003; Katz & Low 2004);
• ‘violence in a couple relationship’ (Serra 1993),
• ‘wife abuse’ (Campbell & Fishwick 1993; Yam 1995), and
• ‘wife battering’ (Thurston, Cody & Scott 1998), or ‘battered women’ (Hamberger et al. 1998; McNutt et al. 1999; Campbell et al. 2001; Corbally 2001; Lutenbacher, Cohen & Conner 2004) have also been used.

If there is repeated abuse in a relationship, the phenomenon is often referred to as ‘battering’. (Report on Violence and Health 2002, 89.) Battering generally consists of men’s continuous use of physical, and often sexual, assaults along with verbally and emotionally abusive behaviour that may become more severe and damaging over time (Smith, Tessaro & Earp 1995; Thurston, Cory & Scott 1998; Coker et al. 2000a). Some researchers therefore distinguish the phenomenon of battering from acute acts of physical assault. Battering is a chronic, continuous experience of the process of losing power (Smith, Tessaro & Earp 1995). This may lead to a situation where a physical assault is followed by an increase in general medical symptoms and emotional problems and which is called a ‘battering syndrome’ (Alpert 1995; McCauley et al. 1995; Gremillon & Kanof 1996).

The terms ‘family violence’ and ‘domestic violence’ have been criticized by some researchers, because words ‘domestic’ and ‘family’ lend a tendency for others to believe that IPV is a ‘family affair’ rather than a serious crime (Ronkainen 1998). ‘It also neutralizes this type of violence that is mostly directed against women by men’. (Niemi-Kiesiläinen 2004, 23.) Therefore some researchers have started to use more accurate expressions such as ‘battered wives’ (Dobash & Dobash 1998) (in Finnish: ‘hakatut vaimot’), ‘sexualiserad våld’ (‘sexualized violence’ in Rönberg & Hammarström 2000), (in Finnish: ‘sukupolistunut väkivalta’), ‘den våldsutsatta kvinnan’/’väldet mot kvinnor’ or ‘kvinnomisshandel’ (Hedin 2002; Del Castillo et al. 2004). These expressions are used as comprehensive terms for the kind of violence which, from the feminist perspective of some researchers, is regarded as an expression of male power and dominance over women not only within a relationship but in society as a whole. The United Nations has also noted ‘violence against women’ as a gender-specific phenomenon in its definition according to which it ‘means any act of gender-based violence that results in, or is likely to result, in physical, sexual or psychological harm to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life’. (UN Declaration on the Elimination of Violence against Women, Article 1, December 20, 1993.) Violence against women over time includes pre-birth, infancy, childhood/adolescence, reproductive age and old age, and includes
geographically or culturally specific forms (Fischbach & Herbert 1997; Report on Violence and Health 2002; Watts & Zimmerman 2002).

In national victim surveys women exposed to IPV have also been called ‘victims of violence’ (Tjaden & Thoennes 2002; Piispa et al. 2006; State of European research on the prevalence of interpersonal violence and its impact on health and human rights 2006). From the nursing perspective, according to Campbell & Humphreys (1993), all women exposed to IPV are ‘victims’ because they are ‘subjected to oppression, deprivation or suffering’ within violent families, whether or not they are the actual recipients of the aggressive acts. At the same time these women and their family units have significant strengths which appropriate nursing care can build on. (Nursing care of survivors of family violence, 1993, Preface vii.)

Because of the great variety in the concepts that researchers have used for IPV, each researcher should define the content of concepts according to the purpose of their respective studies, as pointed out by Krishnan, Hilpert & Pase (2001) and Campbell (2002). In the present study the term ‘intimate partner’, or ‘partner’ for short, is defined as a woman’s husband, former husband, current or former cohabitant or partner. The present study only examines violence used against women by their partner in heterosexual relationships and refers to the women as ‘women exposed to IPV’.

2.2 Types of intimate partner violence

There is no single, consistent, common opinion on what constitutes ‘intimate partner violence’. Usually, the diversity of IPV has been approached – with regard to the method – from the physical, sexual or psychological perspective. In different health care settings, however, the scope and content of IPV vary from one study to another. Some definitions of IPV include the dimensions of physical, sexual and psychological/emotional violence (Glass, Dearwater & Campbell 2001; Lejoeux et al. 2002; Wijma et al. 2003), while others focus on physical and/or sexual violence (Dearwater et al. 1998; McNutt et al. 1999; Gielen et al. 2000; Stenson et al. 2001; Bacchus et al. 2004) and others on physical violence alone (Muelleman, Lenaghan & Pakieser 1998; Sethi et al. 2004) (see Appendices 3 and 4). Ellis (1999) has brought up social and financial abuse in addition to previous approaches. According to a handbook for Finnish municipalities, ‘To whom the strikes belong?’ (2005, 3), IPV can be physical, mental, religious or sexual; it can be directed at property or it can manifest itself as financial control or threats of violence. The definition of IPV of The World Report on Violence and Health (2002, 89) includes acts of physical aggression, psychological abuse, forced intercourse and other forms of sexual coercion and various controlling behaviours. In a Finnish survey by Piispa et al. (2006, 43), violence in a partner relationship involved the threat of violence in addition to physical violence, sexual violence or intimidation. Eyler & Cohen (1999, 2571), for their part, have illustrated the many faces of IPV to visualize and assess the
risk caused to a woman by her partner’s violent behaviour as physical abuse (e.g. hitting, kicking, punching, grappling) and as power and control (threats, emotional abuse, using male privilege, isolation, sexual abuse, using the children, economic abuse, intimidation or putting fear into the woman).

2.2.1 Physical violence

Several studies show that women in violent relationships have experienced multiple forms of physical violence. They have been slapped, hit, kicked, beaten, choked, had their hair pulled or been punched. The physical violence may also include throwing them down, twisting their arms and using weapons (Hearn 1996; Muelleman, Lenaghan & Pakieser 1996; Caralis & Musialowski 1997; Chambliss 1997; Dansky, Byrne & Brady 1999; Ellis 1999; Eyler & Cohen 1999; Heiskanen & Piispa 1998; Perttu 1999a; Piispa et al. 2006). For example, in the studies by Perttu (1999a) and Zachary et al. (2001) the perpetrators had used weapons such as knives and handguns. The study by Piispa et al. (2006) on physical assaults committed by present partners also included behaviour such as preventing the woman from moving freely, or grabbing her. Muelleman, Lenaghan & Pakieser (1996) showed that women exposed to IPV had been injured as they had been punched (68%), slapped (52%), pushed (51%), kicked (35%), or hit with an object (30%). More than one form of these methods was used in 64% of these violent acts.

Prevalence studies in Europe show that the lifetime prevalence of physical violence alone ranges from 6% to over 25% by the report of ‘State of European research on the prevalence of interpersonal violence…’ (2006). The instruments used to assess physical violence vary greatly between studies. Descriptions of the severity of physical violence are often based on modified versions of the Conflict Tactics Scale (CTS). The CTS consists of a list, developed by Straus (1979), of actions any of which a family member might take in a conflict with another member, starting with those of low coerciveness and becoming gradually more coercive and aggressive. According to the report of ‘State of European research on the prevalence of interpersonal violence…’, (2006), a modified CTS makes it possible to compare, through reanalysis, the prevalence rates of physical violence obtained in the different studies.

Researchers have categorized the severity of violence in different ways in their studies. According to the Finnish survey by Piispa et al. (2006) the most typical form of violence experienced by the woman committed by her current partner during the last year or during the entire length of the partnership (17%) was mild violence (preventing the woman from moving freely, grabbing her, slapping her or throwing hard objects at her). Six per cent of the surveyed women had experienced severe physical violence (kicking, strangling, attempted strangling, shooting, hitting with sharp-edged objects) committed by a current partner. In a study by Caralis & Musialowski (1997), 52% of women had experienced severe violence (being hit, punched, kicked, or beaten up); 22% had been subjects of life-threatening violence (stabbed or shot at or raped). On the
basis of four Swedish samples (three gynecology patient samples + women in one randomized population sample), Swahnberg et al. (2004b), categorized mild abuse (hitting, smacking the face, holding), moderate abuse (hitting with a fist or a hard object, kicking, pushing), and severe abuse (strangling, showing a weapon or knife). Lifetime physical abuse in any form was reported by 32–38% of the participants. Lifetime mild abuse was reported by 17% of the women, while lifetime severe physical abuse, e.g. death threats, was reported by 7–8%. However, dividing acts of violence into mild, moderate or severe violence, will not present the whole truth. For example, the consequences of pushing (mild abuse) can be quite serious if the person is pushed against a hard object (Piispa et al. 2006).

Physical IPV as an offence under the Finnish legislation

Physical IPV is always a criminal offence. Since the entry into force of the Finnish Penal Code on September 1, 1995, family violence has been subjected to public prosecution (Penal Code 578/1995). This means that the police or the prosecuting authority must carry out a preliminary investigation on grounds of a report of an offence received of an assault. The Penal Code divides assaults into three groups: assault, aggravated assault (e.g. causing a serious injury, using a firearm or blade), and mild assault (Penal Code 578/1995; 21, 5-7§). A mild assault is a complainant offence, while the other types of assault are subject to public prosecution. A complainant offence is one where a woman must demand a perpetrator’s punishment herself. Unlike before, the seriousness of an act of violence is no longer evaluated on the basis of injuries alone. According to the new legislation, an act of violence must be evaluated in its totality, with the circumstances and the method taken into consideration as well, for example (Niemi-Kiesiläinen 2004, 266).

Evaluating the seriousness of an act of violence or the need of reporting an offence to the police is not the health care professionals’ task but the task of the police or the prosecuting authority. The health care professionals’ task is always to support the woman to report the offence to the police, even if her injuries seem minor (Perttu 1999b). Covington et al. (1995) and Eisenstat & Bancroft (1999) suggest history taking and comprehensive documentation (e.g. how and where the woman has been injured, the circumstances, severity and consequences of the injuries) is essential for correct patient management in cases of IPV. The injuries should be photographed and these photographs filed (with the woman’s permission) (Eisenstat & Bancroft 1999, Söderholm 2006). A well documented medical record is valuable from the viewpoint of the woman’s legal safety as the information may be needed later.

2.2.2 Sexual violence

The instruments used to assess sexual violence against women vary widely between studies, which is why making comparisons can be very difficult. Definitions of sexual violence range from very narrow definitions based on criminal law and the use of physical force and threats (e.g. rape, attempted rape) to much broader definitions that include severe forms of sexual harassment, as presented in the report of ‘State of European research on the prevalence of interpersonal violence…’ (2006, 9). Piispa et al. (2006) have defined sexual violence in a relationship as pressuring, forcing or trying to force the woman into sexual intercourse. Zachary et al. (2001) define sexual violence as physically or emotionally forced sexual activity. In a study by El-Bassel et al. (2003) sexual violence is defined as the partner verbally or physically forcing the woman into ‘unwanted or uninvited’ sexual activity. Wijma et al. (2003) have assessed the prevalence of sexual violence in patients visiting gynaecology clinics in five Nordic countries by using an adapted questionnaire to define and quantify sexual violence. In their study, they measured sexual violence on three levels: mild (e.g. sexual humiliation by forcing the woman to watch a pornographic film), moderate (genital contact e.g. by touching), and severe sexual violence (penetration).

According to surveys (World Report on Violence and Health 2002) women’s experiences of lifetime sexual violence range from 6% to 42% globally. The lifetime prevalence of sexual violence by intimate partners ranges from 4% to over 20% in European countries, depending on definition. In the latest Finnish survey Piispa et al. (2006), 4% of women living in couple relationships had experienced sexual violence and threatening behaviour at some point in their lives, 2% of them in the preceding 12 months. However, the figures of the above studies ought to be looked at very carefully as there are cultural differences in the degrees of openness with which women can talk about this matter (World Report on Violence and Health 2002; ‘State of European research on the prevalence of interpersonal violence…’ 2006).

According to studies conducted in emergency departments and within other health care services, women’s experiences of lifetime sexual IPV range from 4% to 55%, depending on the definitions applied and the time spans reviewed. In a cross-sectional study with four Swedish samples (patients at three gynecological clinics and women in one randomized population) any lifetime sexual violence was reported by 16–17% of participants (Wijma et al. 2003; Swahnberg et al. 2004b). According to a Nordic study by Wijma et al. (2003) the lifetime prevalence of sexual violence among Finnish patients was 27% (the rate of severe sexual violence was 5%) (Appendix 3, Table 2). An American study by Zachary et al. (2001) found that 51% of the women interviewed had been sexually assaulted in the preceding 12 months. In a study by El-Bassel et al. (2003), which had also been conducted in an ED setting, the corresponding numerical value was 6%.

Research results suggest that physical IPV is often accompanied by sexual IPV (Johnson et al. 2003; John et al. 2004; Kramer, Lorenzon & Mueller 2004;
McFarlane et al. 2005; Mezey et al. 2004). A British survey by John et al. (2004) conducted at a women and children’s hospital pointed out that 48% of women who had experienced physical violence had also experienced forced sexual activity. The study by Kramer, Lorenzon & Mueller (2004) showed that 44% of women who experienced lifetime (ever) physical abuse reported sexual abuse, and 22% of the women who reported past-year abuse, also reported sexual abuse. An American survey by McFarlane et al. (2005) among women seeking a protection order ascertained that 61% of the physically abused women had reported sexual assault. Because physical IPV is often accompanied by sexual IPV, it should always be asked about in connection with treating patients who have been exposed to IPV by Söderholm (2006). Mezey et al. (2004) observed that physical and sexual abuse commonly co-occurred among women of childbearing age and was very traumatic event.

**Sexual IPV as an offence under the Finnish legislation**

In Finland the reformed legislation on sex offences came into effect on January 1, 1999. In the Act, sexual offences are divided into three groups: *rape* (a person is forced to intercourse through use of violence or under threat of violence or when s/he is incapable to protect herself/himself), *aggravated rape* (a rape that causes a serious injury, illness or a state of mortal danger or is committed by several people, or a rape where the victim is threatened with serious violence and which on the whole must be considered aggravated) and *forcing a person into sexual intercourse* (Act amending the Penal Code 563/1998, chapter 20, sections 1–3). Of these, forcing a person into sexual intercourse is (as a rule) a complainant offence (Honkatukia 2001), while the others may lead to public prosecution. In addition to the above offences, *coercion into sexual act* and *sexual abuse*, are sexual offences (Act amending the Penal Code 563/1998, chapter 20, sections 4–5). Under the reformed legislation on sex offences an act of sexual violence must be considered in its totality, with the circumstances and method taken into consideration as well, for example. Rape within marriage was criminalized in Finland on June 1, 1994 (Act amending the Penal Code 563/1998). The Rape Crisis Centre, where patients can be referred to if necessary, provides free legal consultation for IPV victims as well as other services, such as a free helpline for conversations and information related to sexual violence and abuse.

**2.2.3 Psychological violence**

The literature reviewed in this study shows considerable differences in defining the concept of ‘psychological violence’ and what it may exclude or include. There are also differences in the terminology used: for example, the term *psychological* (Coker et al. 2002; Report on Violence and Health 2002; ‘State of European research on the prevalence of interpersonal violence…’ 2006),
emotional (Ellis 1999; Zachary et al. 2001; Wijma et al. 2003), and mental (Perttu 1999a; ‘To whom the strikes belong?’ 2005) have been used to express and measure non-physical violence. The Report on Violence and Health (2002) defines psychological IPV as intimidation, constant belittling and humiliating. According to Ellis (1999) emotional abuse may include coercion, threats, destroying trust, name calling, and intimidation. In a study by Zachary et al. (2001) emotional abuse is defined as the use of verbal acts (putting down with words, name calling) and use of threats (threatening to hurt). Wijma et al. 2003 have measured emotional violence on the levels in their study as repressing, degrading or humiliating (mild violence), threatening, forcing or controlling systematically e.g. controlling what a person may and may not do (moderate violence), or threatening a woman systematically and for a long period so that she finally lives in fear (severe violence). Coker et al. (2002) have defined psychological violence as abuse of power and control (including frightening, isolation, economic control) and as verbal abuse (e.g. name calling, humiliation in front of others). According to Perttu (1999a) mental violence may include threatening, extortion, verbal abuse, stalking and controlling.

The lifetime prevalence of psychological IPV in European countries ranging between 19–42% depending on whether any one specific act (e.g. threats of violence, verbal insults) is considered or a more comprehensive list of acts, including verbal violence, blackmail/extortion, controlling behaviour etc. by ‘State of European research on the prevalence of interpersonal violence…’ (2006). Research suggests that physical violence in intimate relationships is often accompanied by psychological violence and sometimes also sexual violence. According to a study by Kramer, Lorenzon & Mueller (2004), 89% of women seeking health care services at emergency departments or primary care clinics, had experienced lifetime physical abuse, and also reported emotional abuse. The corresponding past-year prevalence was 84%. The same study showed that 88% of women who had experienced lifetime sexual abuse reported emotional abuse, and 44% of women who had experienced lifetime physical abuse reported sexual abuse as well. The corresponding past-year rates were 76% and 22%. (Kramer, Lorenzon & Mueller 2004).

2.2.4 Other types of violence

Other types of violence mentioned by researchers include financial/economic violence (Ellis 1999; Perttu 1999a), mistreatment (Perttu 1999a), threats and symbolic violence (Krishnan, Hilbert & Pase 2001), various controlling behaviour (Richardson et al. 2002; World Report on Violence and Health 2002; Piispa et al. 2006), and spiritual violence (‘To whom the strikes belong?’ 2005). According to Ellis (1999) financial abuse may include withholding money from the woman, denying employment or educational opportunities from her or sabotaging her present employment. It can also include extortion of money or control of the woman’s spending (Perttu 1999a). The term mistreatment (e.g. neglect of care) may also imply failure to satisfy her basic needs such as food
and hygiene (Perttu 1999a). Spiritual violence is psychological/emotional violence accompanied by a religious dimension. It manifests itself as intimidation, forced conversion, accusations, isolation or control. According to the definition given in the Finnish Evangelical- Lutheran church vocabulary (2007) the purpose of spiritual violence is to break a person’s views or way of life.

Power and control

Using financial violence such as living at another person’s expense and spending or taking her money or making her ask for money or trying to keep her from getting a job are all about using power and control, as described by Eyler & Cohen (1999). Isolating a person from their family and friends, monitoring his/her movements, and restricting his/her access to information or assistance are some of the controlling methods mentioned in the World Report on violence and health (2002). Ellis (1999) has used the term ‘social abuse’ instead of isolation and extended its meaning to jealousy, denial of access to telephone, threatening with deportation, and intense possessiveness. According to Eyler & Cohen (1999) isolation means controlling ‘what partner does, who partner talks to or who partner sees’. They also have used the term ‘using the children’, whereby they refer to forms of controlling behaviour such as making the partner feel guilty about the children, using visitations as a way to harass the partner or using the children to pass on messages. Intimidation, putting the partner in fear by destroying his/her property, or killing, hurting or threatening his/her pets are also mentioned in the literature as ways of using power and control by Eyler & Cohen (1999). According to the Finnish survey by Piispa et al. (2006) calling the woman names and humiliating her, manifesting jealousy, and trying to restrict her opportunities to meet her friends and acquaintances, and insisting on knowing where she moves or who she talks to, were typical of violent men.

Threat

In their study, Krishnan, Hilpert & Pase (2001) found that along with abuse (physical, sexual, verbal, mental) interviewees reported that they had been subjected to threats and symbolic violence. These threats were divided into mild, moderate, or serious threats. ‘Shaking a finger at you’ and ‘acting as bully but not hurting directly’ were considered mild threats while destroying something that belonged to partner or damaging something the partner cared about were considered moderate threats. Threatening to hurt the partner, threatening to kill oneself or threatening the partner with a club, knife or gun were considered as serious threats. Symbolic violence was defined as gestures (hitting, kicking walls or furniture, or breaking objects) meant as strong messages to the partner without direct threats or actual violence against the partner. Some women in the Finnish survey by Piispa et al. (2006) had experienced their partner’s threatening
behaviour as the most serious form of violence although they had earlier experienced other severe violence, e.g. been kicked by the partner. Eight per cent of the women surveyed reported that they had experienced different forms of threats in their current partnerships and 32% in their previous partnerships. Illegal threats, negligent deprivation of liberty, and coercion are offences against personal freedom (Act amending the Penal Code, 563/1998, chapter 25, sections 6–8).

2.3 Factors increasing the risk of IPV

Causes of intimate partner violence are complex and not fully known, although some associated risk factors have been described in the literature. Factors associated with a man’s risk for abusing his partner can be divided into individual factors, relationship factors, community factors and societal factors (World Report on Violence and Health 2002). However, none of the explanations alone can provide a satisfactory answer to the question of why IPV occurs, and each theoretical approach has its strengths and weaknesses (Hanrahan, Campbell & Ulrich 1993; Jewkes 2002). The theoretical frameworks that attempt to elucidate the causative factors of violence can be divided into several categories. The broad categories are biological, psychological, sociological, and anthropological, as described by Hanrahan, Campbell & Ulrich (1993).

From a biological perspective violence is a biologically determined phenomenon, with aggression and violence considered as brain or hormonal imbalances. Psychological theories focus on associations between psychological variables – including personality disorders, psychopathology (depression, alcohol, drug abuse) and low self-esteem and partner aggression (Hanrahan, Campbell & Ulrich 1993; Schumacher et al. 2001a and 2001b). Among personal history factors, violence in the family of origin has emerged as a risk factor for partner aggression by men. According to a social learning theory a history of personal violence, including witnessing or experiencing violence in the family of origin, increases the risk of partner violence. ‘Learning of intimate partner violence’ or ‘descendance’ of violence from one generation to another has been mentioned in many studies. A man who has been exposed to violence in his childhood home is at risk of perpetrating violence on his wife (Clarke et al. 1999; Haapasalo 1999b; Heyman & Smith Slep 2002; Caetano et al. 2005). However, the greatest risk effect for violent acts occurs where the man has seen his mother abused (Heiskanen & Piispa 1998; Abrahams & Jewkes 2005). On the other hand it is known that not all children who have witnessed inter-parental violence or have been exposed to it themselves have perpetrated it on their spouses (Clarke et al. 1999; Haapasalo 1999a).

According to sociological theories demographic variables as individual factors (e.g. age, low socioeconomic status, unemployment) which are related to one’s position in the social structure can cause economic stress and are thus risk
factors for partner aggression. Also so-called relationship factors (marital conflict, marital instability, dominance and control of the relationship by the male) are risk factors that fall in this category (McKenry, Julian & Gavazzi 1995; Hanrahan, Campbell & Ulrich 1993; Black, Heyman & Smith Slep 2001; Jewkes 2002; Cano & Vivian 2003). In recent years narrow psychological or anger management approaches have received criticism and the emphasis has shifted towards approaches based on ‘power and control’ models (Hearn 2001).

According to feminist theory traditional sex role attitudes, relationship power imbalances and other similar variables would be associated with an increased risk of partner aggression. Anthropological theories (cultural explanations) explain that violent behaviours tend to be associated with societal and cultural factors such as beliefs and attitudes about women, according to which, for example, women should stay at home and not enter workforce. The risk of violence is greatest in societies where using violence is a socially accepted norm. Community sanctions, for example, are ineffective against IPV (Hanrahan, Campbell & Ulrich 1993; Jewkes 2002; World Report on Violence and Health 2002).

Many researchers have investigated associations between various risk factors and IPV from different perspectives. According to Fogel & Belyea (2001), Miller, Wilsnack & Cunradi (2000), Rodriguez et al. (2001b), Cunradi, Caetano & Schafer (2002), El-Bassel et al. (2003), Caetano et al. (2005), Weinsheimer et al. (2005), Lipsky et al. (2005), social and psychological risk factors – alcoholism and/or substance abuse external stressors (e.g. poverty or financial difficulties, losses, family disruption, work stress, life cycle changes) – are associated with the risk of violence. Rigid or conflicting family roles or rules, past history of abusive relationships, mental or physical disability in family and social isolation have also been found as risk factors for IPV (Eyler & Cohen (1999); Kyriacou et al.(1999); Muhajarine & D’Arcy (1999); Torres & Han (2003); Walton-Moss et al. (2005).

2.4 Consequences of IPV for family members’ health and for society

Intimate partner violence has significant direct and indirect health and social consequences as well as economic consequences for the women exposed to IPV, for their family members, and for society. Knowing these consequences (markers, indicators and/or behavioural signs) of violence, may help emergency department professionals to identify women exposed to IPV, provide appropriate care for them and their families and offer information on a variety of community services and health providers and refer the women to such services if necessary.
2.4.1 Consequences of IPV for women’s health

Several large-scale studies have shown a correlation between IPV and the health of women exposed to it. Physical consequences of IPV range from minor injuries (e.g. bruises) to permanent disability or death (Muelleman, Lenaghan & Pakieser 1996; Sutherland, Bybee & Sullivan 1998 and 2002; Monahan & O’Leary 1999; Plichta & Falik 2001). Injuries often result from consequences of acute trauma. They can be defined as any intentional or unintentional damage to the body resulting from exposure to thermal, mechanical, or chemical energy or from the absence of such essentials as heat or oxygen. (Muelleman, Lenaghan & Pakieser 1996.)

Physical abuse may result in fractures, contusions, lacerations, burns, internal injury and gunshot wounds. Women exposed to IPV are more likely to be injured in the head, face, neck, thorax, breasts, and abdomen than women injured in other contexts (Hotch et al. 1996b; Muelleman, Lenaghan & Pakieser 1996; Fanslow, Norton & Spinola 1998; Helweg-Larsen & Kruse 2003; Biroscak 2006).

In Finland the statistics on causes of death indicate that 20 women (mean) died as victims of IPV in 1995–1999, whereas the corresponding figure in 2000–2004 was 17. During these periods, IPV homicides accounted for 47% of all causes of death each year. Finland has the highest rate of homicides in European countries. In 1987–2004, 1.6 women per 100,000 cohabitants died each year as a victim of violence (c.f. 0.7 in Sweden and in 0.5 the UK) (Piispa et al. 2006). According to Tjaden & Thoennes (2000) IPV homicides make up 40–50% of all deaths of women in the USA. Prior IPV also increases the risk of homicide by the partner (Bailey et al. 1997). In addition to murder, women’s mortality associated with IPV includes suicide, suicide attempts or suicidal ideation (Abbott et al. 1995; Ernst et al. 1997). For example, Abbott et al. (1995) have revealed that women who have been exposed to acute or prior domestic violence are more likely to attempt suicide than unexposed women.


Women exposed to IPV have a roughly 60% higher rate of all problems than women who have never been battered and have no experience of IPV (Campbell et al. 2002). Kramer, Lorenzon & Mueller (2004) have also pointed out that women exposed to IPV report significantly lower health status ratings than women not exposed to IPV. For example, the prevalence of headaches, chronic pain and sleep problems is higher (Dienemann et al. 2001; Hilden et al. 2004).
Results have also shown that women have significantly more than average self-reported gastrointestinal symptoms (loss of appetite, eating disorders) and diagnosed functional gastrointestinal disorders (chronic irritable bowel syndrome) associated with chronic stress (Diaz-Olavarrieta et al. 1999; Leserman et al. 1998; Campbell et al. 2002), and also more sexually transmitted disease, pelvic pain, urinary tract infections, vaginal bleeding and total health problems (Augenbraun, Wilson & Allister 2001; Campbell et al. 2002; John et al. 2004; Kramer, Lorenzon & Mueller 2004).

Intimate partner violence is also linked to mental health consequences for women, including traumatic and post-traumatic stress disorder (PTSD), depression and anxiety (McCauley et al. 1995; Fiscbach & Herbert 1997; Stein et al. 1997; Diaz-Olavarrieta et al. 1999; Dickinson et al. 1999; Lown & Vega 2001; Coker et al. 2000b; Dienemann et al. 2000; Humphreys et al. 2001; Campbell et al. 2002; Coolidge & Anderson 2002; Kramer, Lorenzon & Mueller 2004; Kumar et al. 2005; Pico-Alfonso 2005). For example, any violence (slapping, hitting, kicking or beating) poses an increased risk of poor mental health (Kumar et al. 2005). Dienemann et al. (2000) claimed that the severity of abuse is significantly correlated with the severity of depression. Women suffering from IPV have a significantly higher rate of the PTSD syndrome. Women in multiple IPV relationships also have significantly more depression, PTSD and personality disorders (Coolidge & Anderson 2002). Some studies claim that the severity of IPV is significantly and positively correlated with the intensity of PTDS symptoms. In particular, the psychological form of IPV (especially denigration, restrictive engulfment, dominance/intimidating behaviours) is the strongest predictor of PTSD (Pico-Alfonso 2005; Taft et al. 2005). PTDS symptoms may persist for an average of nine years after the IPV relationship has ended (Woods 2000).

Studies (Kramer, Lorenzon & Mueller; Nicolaidis et al. 2004; Hou; Wang & Chung 2005) have shown that a majority of women have experienced more than one type of violence. Multiple types of IPV may contribute to the different types of health problems among patients. Treating merely the women’s’ physical needs may fulfil the need for primary care but it will not eliminate the potential risk of future harm. Clinical protocols that only focus on one form of violence may underestimate the complexity of women’s experiences and needs. Thus health care professionals should not only treat the physical injuries of women exposed to IPV but also learn how to assess and adequately attend to their mental health problems (Nicolaidis et al. 2004; Hou, Wang & Chung 2005)

2.4.2 Consequences of IPV for children’s health

In many homes faced with IPV, children become witnesses to violence. Augustyn & McAlister Groves (2005, 272) use the term ‘child witness to violence’ to encompass the range of ways that children see, hear, experience, or are affected by violence in their environments without being direct victims
themselves. Children who live in violent households are also at risk of physical injury both prenatally and postnatally. (Christian et al. 1997).

According to several studies pregnancy does not protect women from the risk of physical violence. The prevalence of battering during pregnancy is similar (1–17%) in many studies, e.g. Heiskanen & Piispa 1998 (6%), Muhajarine & D’Arcy 1999 (6%), Spedding et al. 1999 (7%), Martin et al. 2001 (6%), Richardson et al. 2002 (15%); Johnson et al. 2003 (17%), Janssen et al. 2003 (1%), Bacchus et al. 2004 (3%) and Coker, Sanderson & Dong 2004 (15%). Battering during pregnancy is a threat to health and a risk to the life of the mother, the foetus, or both from trauma (Murphy et al. 2001; Janssen et al. 2003; Coker, Sanderson & Dong 2004; Yost et al. 2005). A systematic review and meta-analysis by Murphy et al. (2001) shows a significant association between abuse during pregnancy and low birthweight. Similar results have later been reported by Janssen et al. (2003), Coker, Sanderson & Dong (2004), and Yost et al. (2005). In addition a study by Yost et al. (2005) reveals that the incidence of a low birthweight is significantly increased among women reporting verbal abuse.

Martin et al. (2001), examined patterns of physical abuse before, during and after pregnancy in 2,648 women. This study showed that abuse during a previous period was strongly predictive of later abuse. The prevalence of abuse before pregnancy was 7% compared with 6% during pregnancy and 3% during a mean post partum period of 3.6 months. Richardson et al. (2002) found that pregnancy within the past 12 months doubled the risk of physical violence. Physical violence often not only begins but also escalates during pregnancy (Alpert 1995). According to a study by Rådestad et al. (2004) at least 2% of Swedish women have been hit during the first year after childbirth.

Control and power regarding sexuality and fertility may also pose a challenge for women. According to a study by Coggins & Bullock (2003) some perpetrators force women to become pregnant but also force them to end their childbearing. One of the most severe consequences of rape is unwanted pregnancy, which may end in abortion. Woo, Feine & Goetzl (2005) found that physical or sexual violence or both was twice as common among those women who concealed abortion (24% compared with 12%). The studies by Evins & Chescheir (1996), Glander et al. (1998) and Whitehead & Fanslow (2005) showed that 31-51% of women seeking abortion services had a history of IPV.

Intimate partner violence is also a great risk factor for child abuse (Wolf & Korsch 1994; Jouriles & Norwood 1995; Christian et al. 1997; Paavilainen 1998; Duffy et al. 1999; Wright, Wright & Isaac 1997; Heiskanen & Piispa 1998; Lemney et al. 2001; Heyman & Smith Slep 2002; Kellogg & Menard 2003; Berger 2005; Hornor 2005). Children’s experiences may be limited to one form or a combination of various forms of abuse. Children who live in violent households are at risk of emotional and physical injury. Christian et al. (1997), reported that the age of children who were injured during IPV ranged from two weeks to 17 years. Forty-eight per cent of them were younger than two years. Fifty-nine per cent of these younger children were injured while being held by a parent. Thirty-nine per cent of the children were injured during their own attempts to intervene in fights. Kellogg & Menard (2003) reported that in 86% of
homes with partner violence, the children were also physically assaulted. Inkeri Eskonen reported in her dissertation (2005) that children (aged 4–9 years) who had seen their mother abused by their father had also been physically assaulted by their fathers and perpetrated violence themselves.

Children from families with IPV tended to have more difficulties than other children. The effects of witnessing violence are serious and generally framed in emotional and behavioural manifestations (e.g. developmental delays, lower levels of social competence ratings, depressive symptoms, mental distress) (Attala et al. 1995; Haapasalo 1999a; Augustyn et al. 2002; Bensley, Lutenbacher, Cohen & Conner 2004; Horner 2005) and even predisposed to victimization (Krantz & Östergren 2000; Bensley, Van Eenwyk & Wynkoop Simmons 2003) or acts of violence in their adulthood (Clarke et al. 1999; Haapasalo 1999b; Haapasalo & Aaltonen 1999; Heyman & Smith Slep 2002; Caetano et al. 2005) or an unintended first pregnancy during adulthood (Dietz et al. 1999). In particular, severe physical abuse during childhood is associated with recurrence of male to female partner violence. Studies have highlighted the linkages between childhood abuse and negative social, psychological and physical outcomes in adult health status, particularly among women. Many women exposed to IPV reported experiences of violence in their childhood either as witnesses to or objects of abuse (Hall 1996; McCauley et al. 1997; Haapasalo & Aaltonen 1999; Krantz & Östergren 2000; Dube et al. 2001; Fogel & Melyea 2001; Krishnan, Hilbert & Pase 2001; El-Bassel et al. 2003; Bensley, Van Eenwyk & Wynkoop Simmons 2003; Lutenbacher, Cohen & Mizel 2003; Lutenbacher, Cohen & Conner 2004).

Those who have been battered during childhood present with more physical and psychical symptoms (depression, anxiety, low self esteem) than women with no experience of violence in childhood (Fogel & Melyea 2001; Bensley, Van Eenwyk & Wynkoop Simmons 2003). Furthermore, they are more prone to drug abuse or suicide attempts (Mc Cauley et al. 1997; Cohen et al. 2000; Brodsky et al. 2001; Fogel & Belyea 2001). In a random sample study of Swedish women between 40 and 50 years of age, 32% reported exposure to violence or abuse during childhood. Exposure to violence during childhood increased the risk of a high level of common symptoms (pain in the joints, tiredness, muscular tension, low back pain, headache and irritability) by about 60% (Krantz & Östergren 2000.)

Earlier results show that children are at risk of violence and psychological trauma after witnessing violence. Therefore, children should be assessed for child maltreatment, and suspected cases reported to the social welfare board. Emergency department professionals’ obligation to observe secrecy is comprehensive (Act on the Status and Rights of Patients, 785/1992; Act on the Openness of Government Activities, 1999/621); however, if the child is in danger the obligation to report takes precedence over the obligation to maintain secrecy (Child Welfare Act, 683/1983, section 40; see also The convention on the Rights of the Child 1989; Lapsen seksuaalisen hyväksikäytön ja pahoinpitelyn selvittäminen 2003; Niemi-Kiesiläinen 2004, 180–190; Tupola & Kallio 2004).
The perpetrators themselves may suffer from their own violent behaviour. Men have reported a variety of psychological symptoms, such as guilt, depression, anxiety or shame (Serra 1993; Gerlock 1999; Hautamäki 2002). Violence may bring unhappiness and self-destructiveness (Hearn 2001). Suffering from stress may lead to misuse of intoxicants, sickness leave, job loss and reduced earnings (Hautamäki 2002). Bernard & Bernard (1984) report that men almost uniformly expressed guilt and deep remorse over their violent behaviour and seem eager to change to get rid of their pain and more than interested in changing their violent behaviour. According to the Finnish survey Heiskanen & Piispa (1998), only 6% of violent men have sought help for their violent behaviour. On the other hand, Nyqvist (2001) has stated that abusive men may also disregard any help offered. A man can voluntarily seek help if he is shocked by his partner’s physical injuries from the serious violent act or the police have visited the home or his partner has gone to a shelter for battered women, for example (Hautamäki 2002). A common feature among abusive men seeking help is their concern for their families or relationships (Jussi-työ 2000).

ED professionals who see violent men in their work have to realize that an act of violence within a family is a crisis situation which demands quick intervention and co-operation with a variety of services such as the social services, crisis prevention centres, the police, and services for abusive men, such as Jussi-työ and Lyömätön Linja. The violence of the perpetrators is, on the whole, a problem which involves many other psychosocial problems, which is why co-operation with different help providers is important. The idea is to get the man to accept his responsibility for the abuse; the perpetrator bears the sole responsibility for his violent behaviour and no action can justify the use of violence (Wolf & Korsch 1994; Sveins 2000; Hautamäki 2002; Leander 2002). On the basis of stories told by violent men, a quick intervention can be a turning point in a man’s life and break the cycle of violence (Hautamäki 2005). It is important that the professionals in emergency departments are aware of the help services available for abusive men, and have leaflets at hand to give to them and that they talk to the men, without, however, blaming them.

**2.4.4 Costs of IPV for health care services and society**

Intimate partner violence has health and social consequences as well as economic costs for the woman exposed to IPV, her family members, and society. Unidentified IPV continues to increase health issues that frequently result in repeated ED visits and ultimately higher hospital costs.

Studies indicate that women perpetrated by their intimate partners are at an increased risk of a number of health problems. These effects may manifest as a poor health status, a poor quality of life and intense use of health care services (McCauley et al. 1995 and 1998; Wagner & Mongan 1998; Gerlock 1999; Wisner et al. 1999; Hathaway et al. 2000; Krishan, Hilbert & Pase 2001;
Helweg-Larsen & Kruse 2003; Boyle & Todd 2003; Ulrich et al. 2003; Hilden et al. 2004; John et al. 2004; Kramer, Lorenzo & Mueller 2004). For example, a case control study based on data in the Danish National Patient Register compared the rate of subsequent hospital contacts among cases and controls. In the follow-up periods in 1996, 1997 and 1998 women exposed to IPV by their partners had significantly more hospital contacts due to any disease (Helweg-Larsen & Kruse 2003).

Women exposed to IPV are known to have made more visits to emergency departments and outpatients’ departments than other women (Wagner & Mongan 1998; Crandall et al. 2004; Hilden et al. 2004). In a randomized study by Ulrich et al. (2003) the visit rates and costs of their medical records related to confirmed cases of domestic violence were compared with women whose records showed no evidence of domestic violence. They found that the visits and costs of domestic violence patients were approximately 1.6 to 2.3 fold across all levels of care. Visit rates and costs related to their mental health care were even higher.

Wisner et al. (1999), compared 126 identified women exposed to IPV with a random sample of 1,007 general female enrollees. Regression analyses showed that women exposed to IPV were significantly younger and had more experience of hospitalization, general clinics, mental health care services, and out-of-plan referrals. The rate of using emergency room services was the same across groups, but the rate of using mental health care services was significantly higher and was a driving factor for the high costs.

Some calculations have been made about the costs of violence. However, estimates of the costs of violence vary widely from one country to another, depending on the definitions used, the types of cost included, and the methodologies used (Waters et al. 2005). The costs of IPV against women in USA in 1995 exceeded an estimated $5.8 billion (roughly 5.8 billion euros). These costs included nearly $4.1 billion in the direct costs of medical and mental health care and nearly $1.8 billion in the indirect costs of lost productivity (The economic dimensions of interpersonal violence 2004).

Intimate partner violence costs in the USA economy were $ 12.6 billion on an annual basis, or 0.1% of the gross domestic product, compared to 1.6% of the gross domestic product in Nicaragua and 2% of the gross domestic product in Chile, for example (Waters et al. 2005; The economic dimensions of interpersonal violence 2004). There are, however, some problems: for example, studies on indirect costs – lost productivity and reduced quality of life – yield higher cost estimates than studies which only focus on the direct costs of violence. Other methodological issues include the economic value assigned to human life and lost productive time.

According to a study by Heiskanen & Piispa (2002), violence against women in Finland costs 91 million euros on an annual basis. The health care sector accounts for one fifth of all costs of IPV against women. Psychiatric care accounts for the greatest share of the costs. These findings concur with Wisner et al. (1999) and Ulrich et al. (2003). Over half the costs (53%) are incurred by the social sector (mostly child welfare services) and over one fifth (27%) by the legal sector (e.g. legal aid). The results of the Finnish studies are based on the
2.5 Identification of and intervention in IPV

The severity of IPV and its impact on millions of people in society have resulted in a rush to launch identification, screening and intervention programmes. In the last 10-15 years advocacy groups and medical organizations, especially in the USA and the United Kingdom but also in Australia and Canada, have called for health care facilities and providers to develop and implement routine screening and interventions. For example the AMA (1992, 1998), the ANA (1991) and the American College of Emergency Physicians (1994) support the screening of all patients in abuse cases as standard practice. A number of tools have been developed (e.g. interview instruments such as the Abuse Assessment Screen [AAS], and the Index of Spouse Abuse [ISA], a validated survey tool, and the Women’s Experience with Battering scale [WEB] for identifying women exposed to IPV) (see Chambliss 1997; Nelson et al. 2004; Higgins & Hawkins 2005; McMillan et al. 2006).

Since 1992 the Joint Commission on Accreditation of Healthcare Organizations has required hospital departments and clinics to provide interventions for identified victims of IPV (McAfee 2001; Chang et al. 2005). In 1989 The British Medical Journal highlighted the need for the medical profession to develop codes of good practice in relation to IPV. In response, the Royal College of General Practitioners issued guidance in relation to the care of women subjected to IPV and presenting to general practitioners and other professionals. This guidance was revised and distributed by the Department of Health, in 1998 and launched for all health care professionals (Heath 2001).

However, these recommendations has not been as effective as hoped, nor have they been routinely or systematically implemented (Fanslow, Norton & Spinola 1998; Harwell et al. 1998). Moreover, there is a lack of evidence concerning the effectiveness of screening, training or intervention (Coben 2002; Ramsay et al. 2002; Ramsden & Bonner 2002; Wathen & MacMillan 2003; Nelson et al. 2004).

2.5.1 Identification of women exposed to IPV in emergency departments and in other health care settings

Women exposed to IPV seek care for their injuries in all health care settings. Figures related to the incidence and prevalence of IPV vary because of differences in how different data sources define IPV (physical, sexual, psychological, and combinations), what time scale is applied (current, past, and some/lifetime) and how the data has been collected (survey, interview) (Appendix 3, Table 1 and 2).
Women living in relationships involving physical IPV seek medical care for their injuries and symptoms either directly or indirectly. According to some studies a significant number of women seek treatment in EDs for reasons not related to acute injuries (Abbott et al. 1995; Roberts et al. 1996; Dearwater et al. 1998; Muelleman, Lenaghan & Pakieser 1998; Glass, Dearwater & Campbell 2001). These studies show that 1–23% of female patients visit emergency departments because of acute trauma caused by their intimate partners. Rates of past-year IPV range from 6% to 14%, while cumulative prevalence rates of IPV range from 22% to 54%, depending on how IPV is defined and what measures are used. Studies conducted in other health care settings have report rates of past-year physical IPV ranging from 10% to 28%, while prevalence over the previous 12 months varies from 41% to 66% (Feldhaus et al. 1997; Glass, Dearwater & Campbell 2001; Appendix 3, Table 1 and 2).

Studies on accident and emergency departments show that most women who have experienced IPV are not identified by nurses and doctors (Abbott et al. 1995; Gremillon & Kanof 1966). Studies on emergency and clinic settings have documented that doctors and nurses detect IPV in only 10% to 50% of the cases (Dickson & Tutty 1996; Gremillon & Kanof 1996). According to a study by Sugg et al. (1999), 50% of clinicians and 70% of nurses/assistants in primary care believed that the prevalence of IPV in their practice is 1% or less. One in 10 clinicians and nearly half of nurses/assistants have never identified a person exposed to IPV, and 45% of clinicians never or seldom ask about IPV when examining injured patients. According to a British study by Richardson et al. (2002) a history of physical violence is documented for about three quarters of women who have experienced it. According to Kerker et al. (2000) physicians have detected IPV in 0.3% of the cases, while the women themselves have reported IPV in 4.2% of the cases.

Screening for and identification of IPV and obstacles reported

The purpose of screening is to learn to recognize the signs of IPV and include related questions it as part of routine anticipatory guidance. Lapidius et al. (2002, 332) define screening as ‘assessing an individual to determine if she has been a victim of domestic violence’. Larkin et al. (1999, 2000) have pointed out that universal screening programmes implemented by ED professionals have increased rates of identification of women experiencing IPV. In one of the first studies after implementation of the protocol, a random sample of ED visits by adult women at risk showed an increase from 1% to 18% in IPV and patients were subsequently offered adequate treatment. According to Larkin et al. (2000) pre-intervention and post-intervention (where verbal and written counselling for nurses was used as an intervention method) the screening rates were 29.5% and 72.8%, respectively.

The results obtained by Australian researchers Ramsden & Bonner (2002) were quite the opposite. Their pilot study revealed that during the three months observed nursing and medical staff screened 10% of all women for IPV although
15% of these had mentioned previous or current IPV. Ramsden and Bonner ascertained that screening for IPV did not work for the ED and proposed that an early identification and intervention model was more applicable to ED practices. This model was developed using clinical (physical and psychological) indicators, and in cases of suspected IPV, patients were interviewed and asked direct questions. If IPV was confirmed, the staff liaised with social workers, provided information on IPV, and contacted support services (Ramsden & Bonner 2002, 31-39)

At the same time, some studies conducted in a variety of health care settings show that women and health care professional respondents do not always find screening acceptable (Appendix 4, Table 1 and 2). These studies also describe attitudes, feelings, beliefs, practices and perceptions (obstacles) related to universal screening for or identification of IPV both from the women’s and from the health care professionals’ perspective (Table 1).

Table 1. Obstacles to screening for or identification of IPV

<table>
<thead>
<tr>
<th>Factors that affect disclosure from women’s perspective</th>
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<tr>
<td>Being asked about IPV in an accusatory manner</td>
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<td>Unawareness of being able to confide in the staff confide</td>
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<tr>
<td>Fear of losing control and personal feelings (e.g. shame)</td>
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<tr>
<td>Atmosphere of interrogation</td>
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<td>Fear of being reported to child welfare services</td>
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<tr>
<td>Being asked routinely about violence but not receiving any actual help</td>
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<tr>
<td>Being treated for the physical injury but not inquired how it had occurred</td>
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<table>
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<tr>
<th>Factors that affect asking for IPV from health care professionals’ perspective</th>
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<tbody>
<tr>
<td>Presence of a partner or family</td>
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<tr>
<td>Concern over upsetting family members</td>
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<tr>
<td>Fear of offending or endangering patients</td>
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<tr>
<td>Frustration from not being able to help</td>
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<tr>
<td>IPV is not a problem in this population</td>
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<tr>
<td>Lack of training in or experience of screening</td>
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<tr>
<td>Lack of effective interventions</td>
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<tr>
<td>Lack of knowledge in how to ask about IPV</td>
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<tr>
<td>Lack of privacy for screening (no safe place where the woman can be asked sensitive personal questions)</td>
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<tr>
<td>Lack of protocol</td>
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<tr>
<td>Lack of support from colleagues or management</td>
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<tr>
<td>No time to ask about IPV, a lack of time to evaluate or counsel</td>
</tr>
<tr>
<td>Patients’ refusal to disclose information or comply with screening</td>
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With regard to the women’s perspective, 43–85% of women find questions about IPV acceptable and feel that health care professionals should not only ask routinely about violence, but also provide information on community resources (Caralis & Musialowski 1997; McNutt et al. 1999; Gielen et al. 2000; Glass,
Dearwater & Campbell 2001; Stenson et al. 2001; Richardson et al. 2002) (Appendix 4, Table 1).

According to a study by Hamberger et al. (1998) women value assessment for violence as part of their complete medical history but ‘without creating an atmosphere of interrogation’. According to Haywood & Haile-Mariam (1999, 608) ‘most patients are willing to disclose intimate partner violence when asked directly and sensitively, non-judgementally’, and screening must be done in private to avoid increasing the risk of harm. Women exposed to IPV also report that one of the most undesirable actions taken by health care professionals is to treat the physical injury without inquiring how it has occurred (Haywood & Haile-Mariam 1999). According to a study by Dowd et al. (2002) women’s unwillingness to mention IPV might be affected by fear being reported to the child welfare services. However, identifying those mothers who have been exposed to IPV may be the best way to protect their children (Wright, Wright & Isaac 1997).

With regard to the health care professionals’ perspective, 54% of physicians and 68% of nurses and social workers interviewed by McGrath et al. (1997) indicated that they never or rarely screened for IPV in the ED. Ellis (1999) reported that 53% of nurses felt that they should routinely screen women in the ED. From the nurses’ perspective there were a range of reasons for not routinely asking women about violence. The three obstacles ranked highest were a lack of privacy for screening, not having enough time to ask about domestic violence, and not knowing how to ask about it. A lack of collegial, administrative or management support were also reported by the emergency nurses as obstacles to identifying women exposed to IPV (Ellis 1999).

In addition to a lack of training for or experience in screening, obstacles mentioned by health care professionals include limited time, a fear of offending or endangering patients, a lack of effective interventions, the refusal of patients to disclose information or comply with screening, concern over upsetting family members, a fear of putting the woman at risk and a belief that IPV is not a problem in the particular population, or the belief that the violence results from the abused person’s personality (Wright, Wright & Isaac 1997; Rodriguez et al. 1999; Sugg et al. 1999; Fein et al. 2000; D’Avolio et al. 2001; Waalen et al. 2000; Dowd et al. 2002; Lapidius et al. 2002; Ramsden & Bonner 2002). Lapidius et al. (2002) have ascertained a lack of training as the greatest obstacle to screening women for IPV (Appendix 4, Table 2).

The benefits of screening and the effectiveness of screening instruments have also been evaluated by Thurston, Cory & Scott (1998), Ramsden & Bonner (2002), Ramsay et al. (2002), Anglin & Sachs (2003), Nelson et al. (2004) and MacMillan et al. (2006). They have found little evidence of the effectiveness of interventions in health care settings with women who were identified under screening programmes. Ramsay et al. (2002) have also found that there is little evidence of changes in important results such as decreased exposure to violence; accordingly, they conclude that implementation of screening programmes in health care settings cannot be justified and that more evidence of the benefit is required. There is also limited information regarding the accuracy, acceptability,
and completeness of different screening methods (e.g., face-to-face approach) and screening instruments (Nelson et al. 2004; MacMillan et al. 2006).

2.5.2 Intervention for women exposed to IPV

Along with screening programmes many health care professionals have focused on developing intervention programmes. Development of these programmes provides an opportunity for early intervention for those women and their family members who are frequently seen in the different health care settings. Through intervention women can receive the support required for protecting them and for reducing or eliminating the violence in their lives and their children’s lives. At both individual and societal levels, early intervention in IPV is prevention in practice (Hadley et al. 1995, 190).

Most of these intervention programmes include training or education for physicians and nurses in primary and some other health care settings, and the results from the programmes have been assessed by reviewing women’s medical records or by self-administered surveys, for example (e.g., Hotch et al. 1996a, and 1996b; Harwell et al. 1998; Fanslow, Norton & Robinson 1999; Parker et al. 1999; Thompson et al. 2000; Campbell et al. 2001; McFarlane et al. 2002 and 2004) (Appendix 4, Table 3).

For example, in an experimental design study by Campbell et al. (2001), the intervention method used was a two-day didactic information and team planning intervention, and there was an evaluation of ‘A System-Change Training Model’ of training to improve the effectiveness of ED response to IPV. Interdisciplinary teams at emergency departments consisted of a physician, a social worker and a nurse. Emergency visits were randomly selected and randomly assigned to experimental and control conditions. The results of the study indicated that a model of staff training that emphasizes system change could be effective in improving the IPV-related ‘culture’ at an emergency department. ‘A system-change model’ of IPV training was effective in improving staff attitudes and knowledge about women exposed to IPV and in protocols and staff training, as well as patient information (brochures, posters) and satisfaction. There was also a difference in the proportion of women identified as exposed to IPV between the experimental emergency departments and the control departments (Campbell et al. 2001).

Moore, Zaccaro & Parsons (1998) also found that nurses’ attitudes, beliefs and behaviour were affected by their education (formal or continuing). Nurses with specific education were more likely to routinely assess patients exposed to IPV, provide educational material, emergency numbers and advice for counselling, and inquire after their children. They also became aware that IPV was a problem in the patient population. On the other hand, studies conducted in various health care settings point out - despite the fact that practice guidelines and protocols have been available for several years – that there can be obstacles. Many women encounter social, institutional and personal obstacles to obtaining
help from the health care system for problems related to IPV. Also many health care professionals have encountered obstacles when trying to help these women (Table 2).

Table 2.  

**Obstacles to intervention in IPV from perspectives of the women and the health care professionals**

<table>
<thead>
<tr>
<th>From the women’s perspective</th>
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<tbody>
<tr>
<td>Economic dependence</td>
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<tr>
<td>Fear of escalating violence, fear of their partner</td>
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<tr>
<td>Concern for children, loneliness</td>
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<tr>
<td>Possible police involvement</td>
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<tr>
<td>Fear of losing custody of their children</td>
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<tr>
<td>Judgemental reactions (e.g. ‘she must have done something to deserve it’)</td>
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<tr>
<td>Lack of knowledge regarding appropriate sources, support or protection</td>
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<tr>
<td>Lack of trust, support or confidence</td>
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<tr>
<td>Long waiting times</td>
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<tr>
<td>No time to listen</td>
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<tr>
<td>Shame and embarrassment, low self-esteem, denying the abuse</td>
</tr>
<tr>
<td>Lack of understanding from the staff for their emotions</td>
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<table>
<thead>
<tr>
<th>From the health care professionals’ perspective</th>
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<tbody>
<tr>
<td>Abused person’s personality leads to the violence</td>
</tr>
<tr>
<td>Feelings of frustration and helplessness</td>
</tr>
<tr>
<td>Concerns about misdiagnosis</td>
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<tr>
<td>Reluctance to intrude into familial privacy</td>
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<tr>
<td>Health care professionals are not aware of the trauma caused by violence</td>
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<tr>
<td>Lack of 24-hour social service support</td>
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<tr>
<td>Lack of training or experience with regard to IPV</td>
</tr>
<tr>
<td>No strategies or protocol to help women</td>
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<tr>
<td>Time constraints</td>
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**Obstacles reported by the women** include negative care experiences (judgmental reactions from those to whom information is disclosed) and structural limitations within the health care system (lack of knowledge regarding appropriate sources of support and protection, long waiting times), fear of retaliation from the violent partner (fear of escalating violence), social (economic dependence) and psychological effects (shame and embarrassment, low self-esteem, denial of the abuse) (Rodriguez, Szkupinski & Bauer 1996; Hamberger et al. 1998; Haywood & Haile-Mariam 1999).

Women exposed to IPV live with feelings of denial, shame and humiliation that are sometimes reinforced by health care professionals and keep women from seeking and receiving optimal care (Rodriguez, Szkupinski & Bauer 1996; McCauley et al. 1998). For example prejudice or frustration expressed by the staff, belittling the woman’s problem or blaming her for the problem can increase her own fear and frustration and prevent her from reporting IPV (Ellis
1999; Cox 2003). Women may fear the consequences to their children (losing custody of their children) and this factor may affect their willingness to mention IPV and seek help (Dowd et al. 2002) (Appendix 4, Table 4).

The women described the importance of a good patient-professional relationship that include elements of trust, support and confidence. They stressed that ED professionals needed to be supportive and non-judgemental, take the time to listen to them, and provide information on community and legal services (Rodriguez, Szkapinski & Bauer 1996; Caralis & Musialowski 1997; Hamberger et al. 1998; McNutt et al. 1999), but they did not want their physicians to take action without their knowledge (Hamberger et al. 1998). The study by Chang et al. (2005) indicated the women wanted legal advice, hotlines, and IPV resource information as well as counselling on safety, relationship issues, and depression/anxiety. The women also stressed the importance of individualized IPV interventions for the specific needs, concerns, and ‘stage of readiness’ of each woman, which would thus protect their safety, privacy and autonomy.

Women also hoped for a better understanding for their emotions with regard to IPV. The process of leaving a violent relationship involves repeated attempts at leaving and returning. Women appear to use more avoidance strategies while they still are in violent relationships and try to cope with ongoing violence. There are a number of factors affecting women’s’ choices in coping with IPV: the frequency and severity of the abuse, the length of the relationship and the woman’s own resources (e.g. social support, friends, financial resources) (Landenburger 1998; Lutenbacher, Cohen & Mitzel 2003; Waldrop & Resick 2004). Many women experience IPV in a three-stage-cycle with wide variations between individual couples: the tension-building stage, the occurrence of actual physical violence and the ‘honeymoon stage’ (‘this will never happen again’). They would like to believe that it really will never happen again (Chambliss 1997).

Buell (1995) has documented that leaving is the most dangerous time for women. In the survey by Piispa et al. (2006), 40% of Finnish perpetrators had actively sought and harassed the women during the past year, although their relationship had ended. Leaving the partnership may not be the ultimate goal for many women, which is why interventions should provide other objectives as well. Women have described factors that inhibit, support or sustain their abilities to leave or stay out of violent relationships. For example, leaving evokes a wide range of emotions for the women (e.g. relief, guilt, shame, fear, anger, loneliness). Financial constraints play a major role in remaining out of a violent relationship, the homes of friends and families making it impossible for some women to remain in their own communities. ‘He is still my husband and father of my children. I know I should not stay, but I love him’. (Lutenbacher, Cohen & Mitzel 2003, 60.) Recovering from a violent relationship can be a lifelong process, and health care providers have unique opportunities to support the woman’s recovery (Landenburger 1998).

The providers of help do not always understand that the families and children of women exposed to IPV have many complex needs. In the studies by Lutenbacher, Cohen & Mitzel (2003) and Lutenbacher, Cohen & Conner (2004)
women exposed to IPV emphasized the notion that domestic violence was much more than a safety issue for themselves, as it was an issue that concerned the entire family. According to the researchers this family-centred perspective highlighted many complex needs that had be considered if the outcome for the individual family members was to be improved. The need to develop more family-oriented services was mentioned by the authors Cody (1996), Lutenbacher, Cohen & Mitzel (2003) and Lutenbacher, Cohen & Conner (2004).

The literature reveals that provision of effective care by health care professionals for women exposed to IPV is hampered by many reasons. Obstacles reported by the health care professionals are a lack of training and skills (personal reservations about discussing IPV), the stereotype of a ‘typical battered woman’ (the women being under the influence of alcohol, or other so-called societal myths and stereotypes), a fear of the offending the woman or the perpetrator, and non-responsibility (personal attitudes and values), a lack of time for dealing with IPV, and a lack of 24-hour social services, or too close identification with the victim or the abuser (McGrath et al. 1997; Wright, Wright & Isaac 1997; Sugg et al. 1999; Rönnberg & Hammarström 2000) (Appendix 4, Table 5).

Health care professionals’ feelings of hopelessness or frustration over the woman’s return to her partner was also mentioned as an obstacle to effective help, according to a study by McGrath et al. (1997). For example trauma caused by IPV is not always recognized by health care professionals (Perttu 1999a). It can affect the woman’s ability to make decisions. The woman’s trauma may also manifest itself as unwillingness to discuss the problem. According to Perttu (1999a), these were considered the biggest obstacles to help by the health care professionals.

However, a woman exposed to IPV is an independent, autonomous adult who is free to make her own decisions. That includes a decision to return home either for the time being or for good (Chambliss 1997; Hadley 2002). IPV is not a ‘quick fix’ problem. If a woman is not ready to leave the relationship, health care professionals have to help her to prepare for the time she may feel it is safe to leave. Being aware of the stages of the woman’s behaviour change may also serve to lessen the health care professionals’ frustration in caring for her and may facilitate an effective response to her situation (Dickson & Tutty 1996; Hadley 2002). Women in crisis are also often unable to focus holistically on their life situation at the time of their visit to the ED (Dienemann et al. 2002).

Health care professionals’ personal history of IPV may also be an obstacle to effective help for women suffering from IPV. Some studies have indicated that 18–43% of ED professionals (nurses, doctors) have experienced physical and/or sexual violence during adulthood themselves, and some of them (42–80%) emotional violence (deLahunta & Tulsky 1996; Shea, Mahoney & Lacey 1997; Janssen et al. 1998; Moore, Zaccaro & Parsons 1998; Diaz-Olavarrieta et al. 2001; Christofides & Silo 2005). Eighty-three per cent of professionals who have experienced physical abuse indicate that they have felt emotionally abused (Janssen, Basso & Costanzo 1998). Many ED professionals have also experienced violence in childhood (Yoshihama & Mills 2003). 31–41% of
professionals have reported violence amongst family and friends (Moore, Zaccaro & Parsons 1998; Christofides & Silo 2005).

A personal history of violence as a victim or witness to domestic violence may raise intense feelings (anger, shame, depression, fear) that can prevent professionals from caring for others (Shea, Mahoney & Lacey 1997). Therefore professional caregivers (doctors, nurses) have an obligation to examine their own feelings about ‘tough cases’, raise their awareness about their own strengths, and be aware of their limitations, to ensure the provision of appropriate care (Shea, Mahoney & Lacey 1997). For example, counselling for battered nursing staff and conversations with colleagues may help them identify themselves as survivors and break the cycle of violence (Janssen, Basso & Costanzo 1998; Diaz-Olavarrieta 2001; Weiss 2005). Acknowledgment by health care professionals that violence in intimate relationships is a potential risk for everyone would be a step toward enhancing the identification of IPV and initiating interventions on behalf of survivors of IPV (deLahunta & Tulsky 1996). However, a study by Christofides & Silo (2005) showed that nurses who had personally experienced IPV had no influence on IPV identification and management. Those nurses with experience of violence among friends and family were more likely to provide better care for patient presenting after IPV.

2.6 Summary of the literature review

Violence against women is a universal problem that crosses national, social, racial, and religious boundaries. Studies conducted throughout the world show that the prevalence of physical violence against women is between 10% and 69%. IPV takes many forms and happens in various contexts. It is a complex pattern of behaviour that may include, in addition to physical acts of violence, sexual and psychological violence.

Published literature on the subject suggests that the following risk factors have an effect on violence against women: the age of the woman and her partner, the socio-economic status of the family, the employment status of the woman and her partner, alcohol or other narcotics used by the woman or her partner, cultural dynamics, criminal history, and violence in the abusive partner’s family. However, it is impossible to create a profile of the women exposed to IPV.

IPV has many negative consequences for the woman and her family members. Physical injuries, mental health problems and complications during pregnancy are some of the health consequences that result from violence inflicted on women by their partners, and may cause frequent visits to emergency departments. The cumulative prevalence of IPV in all women presenting to emergency departments has been reported to be as high as 54%. Studies conducted in EDs include a great deal of bias, depending on the different definitions of IPV and the different study designs and time spans, which is why there are differences in the prevalence rates of IPV. However, it is clear that
health care professionals in EDs see women who are exposed to IPV, although the exact numbers of women vary.

Professionals in emergency departments are in a unique position to holistically assess the situation of the woman and her family members needing help. However, studies on accident and emergency departments have shown that most women who have experienced IPV are not identified by the professionals as victims of IPV, nor are they asked about IPV. Studies conducted abroad in various health care settings describe professional, cultural or other obstacles in the way of effective intervention in violent situations. Problems reported by health care staff include a lack of training and skills, ignorance of ways of asking about IPV, societal myths and stereotypes, personal attitudes and values, lack of time for dealing with IPV, lack of 24-hour social services and the professionals’ own experiences of violence.

Some studies indicate, however, that the women want to be asked about violence without being blamed for it. They describe the importance of a good relationship between the patient and the ED professional that includes elements of trust, support, and confidence. They stress that professionals should take the time to listen to the women and provide information on community and legal services. They also hope for a better understanding of their emotions with regard to IPV. The women also emphasize the importance of individualized IPV interventions for the specific needs and the ‘stage of readiness’ of each woman which would protect their safety, privacy and autonomy. Early, effective intervention for women exposed to IPV can interrupt the cycle of violence, prevent further injury, prevent abuse of children, and initiate the process of seeking help. Studies conducted in many health care settings have increased health care professionals’ knowledge and changed their attitudes to IPV. In order to ensure optimal care for the women and her family members, more information is needed about the complex obstacles preventing women from receiving appropriate care. Developing the related practices provides an opportunity for early identification of and intervention for women exposed to IPV who visit EDs.
3 Aims of the study

The main purpose of the present study was to create a preliminary model to identify and intervene in IPV. The basis of the model was made up by 1) describing the history of IPV and its health consequences for the women seeking care for their acute injuries at EDs, and 2) describing their experiences of the care and support they had received, and 3) describing the interventions carried out by the ED professionals.

The objective of this study was to acquire more information for identification of and intervention in IPV, determining the women’s needs for care and support, and providing appropriate services for them and their families. More specifically, the present study had the following aims and accompanying research questions:

1. To describe past and acute physical violence with health consequences for women exposed to IPV
   a) What kinds of past and acute physical IPV had the women experienced by their partners before seeking care at EDs?
   b) What kinds of acute health consequences had the women sought care for?
2. To describe experiences of women exposed to IPV with regard to care during their acute visits to EDs
   a) What kinds of experiences had the women had with regard to interventions by ED professionals?
   b) What kinds of positive and negative experiences had the women had with regard to care when visiting EDs?
   c) What kinds of principles of care did women regard as important when visiting EDs?
3. To describe identification of acute IPV and interventions for the women from the ED professionals’ perspective
   a) How did the ED professionals identify women when seeking care?
   b) How did the ED professionals act when suspecting IPV?
   c) What support did the ED professionals offer to the women, their children and the perpetrators?
   d) What kinds of abilities did the ED professionals assess to have with regard to supporting the women?
4. To create, on the basis of the results of previous studies and the present study, a preliminary model for identification of women exposed to IPV and intervention in violence and to prevent further violence and thus promote the health and well-being of the women and their family members.
4 Materials and methods

4.1 Triangulation

In order to describe and understand better the factors that have influence on identification of IPV and intervention in it from the women’s and the ED professional’s perspectives, a multiple approach was chosen for the present study. The topic of IPV was examined by using both quantitative and qualitative study methods. A combination of both methods is commonly called triangulation – which has also been called ‘mixed methods’ and ‘the syncretic approach’ by Sandelowski (2000a), Risjord, Dunbar & Moloney (2002) and Happ et al. (2006). In research terminology, triangulation has been quite broadly defined as a combination of two or more theories (theoretical triangulation), data searches (data triangulation), methods (method triangulation), investigations (investigator triangulation) and analysis (analysis triangulation) in a single study (Morse 1991; Leino-Kilpi 1997; Foss & Ellefsen 2002).

There has been ongoing debate about combining qualitative and quantitative approaches in a single study (Morse 1991; Carr 2004; Leino-Kilpi 1997; Coyle 2000; Sandelowski 2000a, 2001; Thurmond 2001; Foss & Ellefsen 2002; Risjord, Dunbar & Moloney 2002; Happ et al. 2006). The theoretical discussion on the epistemological grounds of triangulation has been an object of debate because qualitative and quantitative methods are built on philosophical differences or paradigms (views of reality, views of knowing and the relationship between knower and to-be-known, views of modes of inquiry) in the structure and confirmation of knowledge. To put it more simply, quantitative methodologies, for example, test theory deductively on the basis of existing knowledge, while qualitative research develops theory inductively (Sandelowski 2000a; Risjord, Dunbar & Moloney 2002). A combination of different paradigms is not sound or realistic from the developing of branch of science, but the nature of the matter under investigation requires different study methods at the technique level (Leino-Kilpi 1997; Sandelowski 2000a).

Combinations at the technique level permit innovative uses of a range of techniques for a variety of purposes: triangulation (to achieve or ensure corroboration of data, or convergent validation), complementary (to clarify, explain, or otherwise more fully elaborate the results of analysis), and developmental (to guide the use of additional sampling, and data collection and analysis techniques) (Sandelowski 2000a; Risjord, Dunbar & Moloney 2002). In the present study, method triangulation, data triangulation and analysis triangulation were used. Method triangulation entails the use of different
methods for collecting data. Morse (1991, 122) suggests that methodological triangulation is a method of obtaining complementary findings, strengthening research results, and contributing to the theory and knowledge development. There are two basic ways in which qualitative and quantitative methods are usually combined: a qualitative approach used as a preliminary inquiry in quantitative work, or the opposite where a quantitative approach takes precedence over a qualitative approach. This is called sequential triangulation, where one approach precedes the other (quantitative => qualitative / qualitative => quantitative) (Morse 1991, 120-123; Liehr & Taft Marcus 1994, 279). The present study began with data collection based on a questionnaire for the women exposed to IPV. Once the data provided by questionnaires from the women and ED professionals had been collected, further data was collected by using the qualitative approach (interviews with women and ED professionals). Responses to the questionnaires illustrated the phenomenon under investigation and the interviews with women and ED professionals added new dimensions to the existing knowledge about IPV (by Eskola & Suoranta 2003).

Simultaneous triangulation is the combination of qualitative and quantitative methods in the study at the same time (qualitative + quantitative / quantitative + qualitative). Two self-report questionnaires were developed for this study by the researcher, with open-ended and open questions (free-text comments) and additionally structured questions, to gain complementary information on the participants' feelings and thoughts. For example Foss & Ellefsen (2001) ascertain that researchers tend to formulate questionnaires that reflect their own priorities and concerns, and patient responses may differ from the views of the researcher when expressed in the respondents’ own words. In this study the qualitative data were used not only to augment quantitative results by illustrating participants’ thoughts and experiences, but also to illustrate different points of views by ‘hearing the voices’ of the women and the ED professionals.

Data triangulation involved using multiple data sources, i.e. women exposed to physical IPV and seeking care for their acute injuries at EDs, and ED professionals working in the different EDs. Data triangulation was utilised in the present study by gathering similar data (the same questions were presented to women and professionals) to address the same problems (whose task it is to stop violent behaviour, or what kinds of care principles are regarded the most important). This form of triangulation provides a more holistic view of the phenomenon and is important for development of the different intervention methods to improve the quality of ED services for women and their family members.

The data for the present study were analysed through both statistical analyses (non-parametric tests) and quantitative and qualitative content analyses. Quantitative content analysis (quantitizing) is a process where qualitative data (items) are treated with quantitative techniques to transform them into quantitative data. Quantitative content analysis was based on grouping and calculating the responses of the women and the ED professionals to the open-ended and open questions of the questionnaires. Qualitative content analysis is a dynamic form of verbal data analysis (who, what and where) that is oriented
toward summarizing the informational contents of that data. (Sandelowski 2000b; Sandelowski 2001)

Triangulation refers to the use of multiple references to draw conclusions about what constitutes the ‘truth’, while simultaneously opening new perspectives on the phenomenon under investigation to obtain a richer and more comprehensive picture of the issue (Crossan 2003). Methodological triangulation is thus a means to support the validity of quantitative data by using participants’ statements to explain and complete information providing confirmation of the results. This allows the investigator to view the phenomenon in a variety of ways. The use of methodological triangulation in this study is justified by the fact that the subject of the study is complex, sensitive, and underexamined (Leino-Kilpi 1997; Aronson Fontes 1998; Eskola & Suoranta 1998).

4.2 Design of the study

The present study is a descriptive, cross-sectional multi-centre study with convenience samples. At first, the aim was to examine all hospital districts (21) with 24-hour EDs with a complete sample of a total of about 56 units listed by The Association of Finnish Local and Regional Authorities 2002. The advantage of a complete sample is that it can provide more reliable data for the matter under investigation (Grönroos 2003). However, a complete sample was not possible because not all organizations decided to participate in the study. Opting out of the study was based on a number of reasons (‘no time’, ‘no resources’, ‘many other projects at the same time’, ‘these kinds of patients are rare here’, ‘we did not participate’, etc.). Some organizations never replied to the request to participate. All of the final data for the study were collected from 28 EDs in 13 Finnish hospital districts that had agreed to participate, i.e. 3 university hospitals, 10 central hospitals, 13 district hospitals and 2 large health care centres. The application form with the study design and from the opinion of the Ethics Committee of the University of Tampere Hospital for performing the study was first sent to the nursing director at each organization (Appendix 5).

The research material for this study consisted of self-report questionnaires and interview material submitted by women who sought help for acute injuries at EDs, and self-report questionnaires and interview material submitted by ED professionals (Figure 1). Both questionnaires were distributed by a contact person for each unit (the head nurse, or a selected contact person) between 1999–2002 (pilot) and 2003–2004. The research process began with collection of quantitative data from the women. Semi-structured interviews were conducted by the researcher after the quantitative data collection. The process did not start the same time in all organizations; on the one hand the statement was still being handled, and on the other hand the process was to proceed on the organization’s own terms. Collecting data from the women also took a long time.
Figure 1. Design of the study
For ethical reasons it was not possible to perform a drop-out rate analysis because it was not known how many had failed to respond to the questionnaires.

4.2.1 Development of the questionnaire for women

Data collection from women exposed to physical IPV was accomplished with questionnaires formulated for this study on the basis of the literature (Table 3). The questionnaire, a seven-page blank with 29 items, was based on earlier research results. Most of these items were structured, multiple-choice questions. The questionnaire also contained open questions to which the respondents were asked to answer by providing more detailed information about their experiences and perceptions. The target of the open-ended and open questions in the questionnaire was to obtain spontaneous opinions from the respondents. Such responses are useful whenever there is reason to suspect that not all answers can be anticipated, or if the researcher has only a limited idea of what the respondent will say (Grey 1994; Heikkilä 2004).

The questionnaire consisted of three main parts (Appendices 8 and 9). The first part of the questionnaire for the women asked for background information on their socio-demographic characteristics and family relationships (items 1–7). Some studies (e.g. Walton-Moss et al. 2005) have focused on risk factors (age, education) for IPV, although it is impossible to create a profile of the ‘woman exposed to IPV’. The questionnaire also contained questions about the women’s history with regard to IPV (items 8–11). Part two of the questionnaire concerned the violence experienced by the women before their arrival at the ED and their requests for treatment (items 12–19). Earlier studies have showed that women in IPV relationships have often experienced multiple forms of violence and have a high threshold for seeking care (Heiskanen & Piispa 1998). Part three included questions about the woman’s perceptions of the care and support received from the ED professionals (items 20–26). These questions are important for the development of practices for the women and their family members. The ED professionals must be prepared to carry out the required intervention. Question 20 was formulated by using Likert response options, which were ‘fully agree’, ‘agree’, ‘disagree’, ‘fully disagree’, and ‘I cannot say’. A question on the care principles regarded as important by the women (item 25) was also presented in a Likert-type format. The same question was also asked of the ED professionals (item 24 in the questionnaire for ED professionals). The rest of the items (27–29) were questions on whether the violent partners had sought help after their violent behaviour, whose responsibility it is to stop the violence (item 30 in the questionnaire for ED professionals), and whether the woman was willing to take part in an interview. Only those women who agreed to an interview gave their contact information at the end of the questionnaire and filled in the consent form (Appendix 8). Both the questionnaire and the consent form had also been translated into Swedish (Appendix 9).
Table 3. Parts of the questionnaire and references used for planning the questionnaire for women

<table>
<thead>
<tr>
<th>Part of the questionnaire (see Appendices 8 and 9)</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background information Questions 1–11</td>
<td>Caralis &amp; Musialowski 1997; Dearwater et al. 1998; Ellis 1999; Fernández-Esquer &amp; McCluskey 1999; Perttu 1999b; Glass, Dearwater &amp; Campbell 2001; Campbell et al. 2002;</td>
</tr>
<tr>
<td>The woman’s perceptions of the care and support she received Questions 20–25</td>
<td>Rodriguez et al. 1996; Caralis &amp; Musialowski 1997; Hamberger et al. 1998; McCauley et al. 1998; McNutt et al. 1999; Rodriguez et al. 1999; Yam 2000</td>
</tr>
</tbody>
</table>

4.2.2 Development of the questionnaire for ED professionals

The purpose of the questionnaire for the ED professionals was to explore their ability to identify IPV, and their knowledge, attitudes, procedures and experiences related to caring for and supporting women exposed to IPV and their family members who sought help at the EDs. The questionnaire was based on the results of earlier studies (Table 4).

The questionnaire for the ED professionals consisted of a ten-page blank with 34 questions. The first part of the questionnaire (Appendix 10) dealt with information on the ED professionals’ background (items 1-12). Earlier studies have pointed out that all health care professionals cannot identify or do not ask about IPV in suspicious cases, nor do they provide emotional and practical support for women seeking care for acute or past health consequences of IPV. The second part of the questionnaire consisted of questions concerning the extent of IPV discovered at an ED (items 13–16), and the third part of the blank considered the discovery of IPV and the problems with identifying it (items 17–20). The fourth part of the questionnaire consisted of questions on interventions for the women exposed to IPV (items 21–25), and part five the ability of the professionals to support and help women, as well as the professionals’ training needs (items 26–29). The last four questions of the questionnaire were about the professionals’ own personal experiences of IPV either in their own lives or in the
lives of their relatives or friends, about the professionals’ opinions on whose responsibility it primarily was to stop the violence (as their attitudes might have influenced interventions for the women exposed to IPV), and about support systems available for the professionals. Finally, question 34 was about whether the participant was willing to be interviewed.

Most questions were structured, multiple-choice questions. The Likert response options were ‘Fully agree’, ‘Partly agree’, ‘Partly disagree’, ‘Fully disagree’ and ‘I cannot say’. The professionals’ actions of intervening in IPV were measured by the choices ‘Always’, ‘Often’, ‘Now and then’ and ‘Never’ (this question is similar with question 20 for the women). The questionnaire also contained open questions in which the respondents were asked to provide more detailed information about their experiences and perceptions concerning identification of IPV and the problems with the identification, and about the professionals’ training needs. Both instruments were structured so that the easier questions (demographics) came first.

### Table 4. Parts of the questionnaire for ED professional and references

<table>
<thead>
<tr>
<th>Part of questionnaire (see Appendix 10)</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background information Questions 1–12</td>
<td>McGrath et al. 1997; Sugg et al. 1999; Rönnberg &amp; Hammarström 2000</td>
</tr>
<tr>
<td>Identification of IPV and problems with identifying it Questions 17–20</td>
<td>Gremillon &amp; Kanof 1996; Coeling &amp; Harman 1997; McGrath et al. 1997; Wright, Wright &amp; Isaac 1997; Ellis 1999; Fanslow et al. 1999; Waalen et al. 2000; Rodriguez et al. 1999; Glass et al. 2001</td>
</tr>
<tr>
<td>ED professionals’ ability to support and help Questions 26–29</td>
<td>Harwell et al. 1998; Moore, Zaccaro &amp; Parsons 1998; Fanslow, Norton &amp; Robinson 1999</td>
</tr>
</tbody>
</table>
4.2.3 Collection of data from the questionnaires

The participating organizations gave estimates for the required number of questionnaires for the women. The number of questionnaires sent out was from three to five per ED. The women included in the study had to meet the following criteria:

1. Aged 18 years or older
2. Physically exposed to IPV by her partner
3. Visiting the ED due to injuries from physical violence
4. Able to give a written consent (absence of severe injury or illness, or absence of substantial alcohol or drug intake)
5. Able to understand Finnish or Swedish.

Women from foreign cultures were excluded.

The women were given a brief description of the nature of the study (Appendices 8 and 9). The ED professionals handed them the questionnaires with instructions and also told them orally about the study. The women were pointed out that the study was completely voluntary, that it had nothing to do with the care they were receiving, and that all the information would be kept strictly confidential. The women were given the possibility to fill in the questionnaire and the consent form in a quiet place (unaccompanied by anyone) before leaving the ED or to take it with them and complete it later. A key principle was to ensure the women’s safety. The completed questionnaires were returned to the Department of Nursing Science at the University of Tampere.

The number of questionnaires for the ED professionals (for both permanent and temporary professionals) per organization was determined on the basis of the number of positions in each work community. The questionnaires were sent to the health care organizations by mail, or brought by the researcher in person when she visited the organizations and told them about the study. In the EDs, the questionnaires were distributed by a head nurse or a contact person named by the ED. The completed questionnaires were returned to the Department of Nursing Science at the University of Tampere.

4.2.4 Validity and reliability of the measurement instruments

A questionnaire is an effective, economic and suitable tool for gathering data from a great amount of people, which is why questionnaires were also used to gather data for the present study. However, compared with interviews, for example, it has the disadvantage of superficiality. Unless the validity of the measurement instruments reflect the concepts of the phenomenon under examination, conclusions drawn from the empirical phase of the study will be invalid (in other words the purpose of the study and the measures have to correspond with each other) (LoBiondo-Wood & Haber 1994; Burns & Grove 1997; Vilkka 2005).

The reliability of a study means that casuals study results are not allowed. Weaknesses in the reliability of a study may arise from careless mistakes.
concerning the sampling, coding or analysis of the data, for example, and will manifest themselves as calculation errors. The validity of a study is, however, the most difficult criterion for the quality of a study. Validity refers to whether a measurement instrument accurately measures what it is supposed to measure (LoBiondo-Wood & Haber 1994; Eriksson & Wiedersheim-Paul 1997; Alkula, Pöntinen & Ylöstalo 2002). Validity is made up of external and internal validity. The sum of these two is called total validity. External validity refers to the extent to which the results of a study can be generalized (to what degree the conclusions drawn from a sample or random sample describe the population). Internal validity refers to the rigour with which the study was conducted (the study process was conducted systematically).

The validity of measurement can be assessed in many ways, and the objects of assessment are content validity, criterion-related validity and construct validity. The typical problem of internal validity (content validity) is the operationalization of the used concepts. When an instrument is valid, it truly reflects the concept it is supposed to measure. Construct validity is based on the extent to which a test measures a theoretical construct. Alkula, Pöntinen & Ylöstalo (2002) separate four phases in the process of defining measurable concepts. These phases are: general formation and determination of the concept, determination of the dimensions (divisions) of the concept, transition from theoretical (abstract) language to concrete colloquial language and indicators, and accurate description of operationalization. During the first phase before the construction of instruments the researcher familiarized herself with the concept of IPV and its various dimensions by using different search terms and found out how and in which context it had been used in studies conducted in different health care settings, and then compared the results of the studies. After this phase, the items that reflected the concept and its dimensions were formulated into questions. This formulation process was facilitated by the fact that the researcher had worked for many years in network teams seeking to stop IPV, first on the ANSA project in 1995–1998, and then in the Lyömätön Linja network team in Espoo in 2000–2006. Within these projects for stopping domestic violence, the researcher had had the opportunity to talk to the different help providers in various fields (the police, a shelter and social workers) helping women, men (perpetrators) and children.

Pilot testing of the questionnaires

When the first version of the questionnaire for ED professionals was ready, it was evaluated by two nurses and an expert on IPV. It was then used as a pilot test to assess the validity of the measurements (logicality, activity, understanding). The Ethics Committee of the University of Tampere Hospital granted a permission (no. R00074H) for performing the pilot study. The pilot study was conducted in four EDs.

In this study, the reliability of the measuring instruments was improved in the following ways: The questionnaire for the ED professionals was pilot-tested by
72 ED professionals (purposive sample), and then modified to ensure clarity and readability. There was a separate accompanying blank with the questionnaire, where the professionals were asked about their opinions on the length of the questionnaire and about the way they understood the questions. They were also asked to explain why any specific questions might have been difficult to understand. After the answers had been analysed the measure was modified.

The questionnaire for the women was pilot-tested by 12 women and then modified to ensure clarity and readability. The reliability of the study was also improved by giving clear instructions both orally and in writing. The sample of women was drawn from three of the EDs chosen for the pilot study. The sample of the women was taken for the final sample. The pilot study took two years (2000-2002). An extension for the pilot study was asked of the Ethics Committee and granted.

In addition, the reliability of the Likert-scale format questions was measured by Cronbach’s alpha coefficient, which is the best known test for internal consistency in nursing studies. In other words, it is used to establish whether the items within a scale reflect or measure the same concept (LoBiondo-Wood & Haber 1994). The women’s experiences of interventions used by the ED professionals were measured by a Likert-type format question of (question 20 in the women’s questionnaire with 16 items). Each item was rated on a five-point Likert scale. The Cronbach’s alpha for the scale was 0.77. Question 21 of the questionnaire for ED professionals with 12 items was used to measure staff’s behaviour. Each item was rated on a four-point Likert scale. The Cronbach’s alpha of the scale was 0.81. The reliability coefficient ranges from 0 to 1. The figures could therefore be considered good (LoBiondo-Wood & Haber 1994, 374).

4.2.5 Collection of data from the semi-structured interviews

The interview data for this study consisted of semi-structured interviews, as well as open-ended and open questions in both questionnaires. The interviews were created for specific purposes: they provided an opportunity to explore the reasons behind the person’s answers in the questionnaire, and to verify the reliability of those answers. The results from the qualitative data were used to complete the quantitative results. Semi-structured interviews were used with the women and the ED professionals (Appendix 11). The interview populations of women and ED professionals consisted of those informants who had given their consent to be interviewed (see Figure 2). The consent had been asked for at the end of each questionnaire.

Because it could be too expensive to interview all the ED professionals from all parts of the country who had given their consent (n = 72), a random sample of interviewees was selected by using the random-number generation tool in the Microsoft Excel software. Twenty-four persons (33%) were selected randomly from among all those who had given their consent. Because eight of them did not respond, four persons from the pilot study were included in the sample. As the
ED professionals selected for interviews were from different parts of the country, sixteen of them were interviewed over the telephone. The telephone interviews lasted for 20 to 30 minutes.

Five women out of the twelve informants who had given their consent were contacted by phone and an appointment for the interview was arranged. Seven out of the twelve did not reply, which is why two women from the pilot study were included in the sample. The researcher interviewed all the informants herself. Two of the interviews with women were conducted in the researcher’s car, one at the woman’s workplace and the rest over the telephone. The lengths of the interviews ranged from 30 to 60 minutes. All interviews with the women and the ED professionals were recorded on tape and transcribed verbatim.

4.2.6 Validity and reliability of the interview data

Errors reducing validity and reliability are associated with every phase of an interview. In the interviewing process the question of validity relates to how well the themes of the interviews reflect the theoretical basis (construct validity), and whether the questions sample the field of behaviour adequately (content validity) (Keats 2000). This study emphasized the participants’ experiences, and the questions were focused on that area. The questions were asked in a simple language that was easy to understand, and abstract or foreign terms were avoided as far as possible.

People are the primary source of information in intervention studies, but they enter qualitative studies by virtue of their intimate knowledge of and ability to communicate about the events under study. The quality of all interview data depends on the ability of the study participants to put into language the target events for which they were recruited into a study. This ability to articulate experience depends, in turn, on the participants having had enough time after the target event to process it: that is, to transform the event-as-experienced into the event-as-told. (Sandelowski 1999.) All interviews with the women were conducted approximately six month after they had completed the questionnaire, so that they had had time to process their experiences. On the other hand memory loss is a typical consequence of a stressful situation, such as exposure to IPV (Söderholm 2006).

One of the most demanding aspects was the interviewer-respondent relationship. Having a clear understanding of the respondent’s role will help to create a good relationship (Keats 2000). The first contact was a telephone call. The respondents were told what the interview was going to be about, what was going to be done with the information obtained, and how confidentiality was going to be guaranteed. The respondents were also told how and why they had been selected as participants.

The reliability of the qualitative data improved with the small pilot sample of women (2) and professionals (4). Particular attention was paid to the time spent in each interview, as well as the formulation and design of the questions. In this study, all data was collected by the same interviewer, which ensured consistency
as all questions were asked in the same way. The interviewer had a checklist at her side to ensure that all questions were asked. After the discussion, the interviewer also made notes on the course of the interview process.

4.3 Data analysis

4.3.1 Quantitative analysis

A data analysis system (SPSS version 12.0) was used to produce tables of frequency counts and percentage values for individual variables. First, frequency distributions were formed in order to identify possible coding errors and to examine the normality of the distribution of each variable. Only the variable for the women’s age formed a normal distribution, whereas the other scales of both questionnaires were not normally distributed. As the size of the sample of women was too small, the data were described by means of frequency and percentage distributions and cross-tabulation.

Because the scales of the answers were not normally distributed, a non-parametric test (chi-square) was used for the statistical analyses. The chi-square test was used to test the statistical significance of the data. A p-value of less than 0.05 was considered to indicate statistical significance of each analysis. All analyses were performed by the researcher. The continuous variables (age, occupation time, period of employment in current job) related to the questionnaire for the professionals were determined using medians. Additionally, the frequencies for some of the variables related to the questionnaire for the ED professionals (questions 13 through 16, 21 and 22) were categorized/combined into two or three classes, when it was necessary for improved visualization and understanding, or when the numbers of frequencies in the classes were too small to be analysed. The formation of the classes is presented in more detail in Chapter 5. Distribution of opinions was also illustrated by using a median. Upper and lower quartiles were used as the measures of dispersion. The wider the quartile range (Q3 – Q1) was, the greater the dispersion of opinions was. (Appendix 10, questions 21 and 22).

The present study is based on a descriptive approach and self-reported data. Statistical methods have been used to describe and summarize the sample data, with only the associations between variables presented. The results are illustrated in the Figures and Tables.

4.3.2 Qualitative analysis

The qualitative data consisted of transcripts of the audiotape recordings of the interviews, and written documentation material, i.e. free-text comments (open-ended questions and open questions) from both questionnaires. The qualitative
and quantitative data sets can be linked by preserving the numbers and words in each data set. The numbers were used for analysing, interpreting, and representing qualitative data. The first task was to reduce verbal data into items that were intended to mean only one thing and could therefore be represented numerically (Sandelowski 2000b; Sandelowski 2001).

The answers to the open-ended and open questions were analysed using quantitative content analysis by grouping and calculating the data given by the women and the ED professionals. A unit of analysis was considered to consist of a statement or phrase which was categorized according to the words or phrase that expressed a participant’s thought, opinion, behaviour, practice, knowledge, attitudes, beliefs or feeling. Simple objective measures would include data on how much or how often particular topics appeared in the text, and what categories were mentioned, for example (Dew 2005).

In the present study, the qualitative ‘themes’ were numerically represented as percentages and clusters, and/or through visual display, such as tables or graphs, in order to describe and/or interpret a phenomenon more fully. For example, the most prevalent category (75% of all) was ‘Contusions and bruises’ as consequences of acute physical IPV, while the least prevalent was ‘Concussion’ (6%) (question 19 in the questionnaire for women).

Qualitative content analysis was used in the present study to improve reliability. According to Graneheim & Lundman (2003) this is a matter of producing trustworthiness, including the concepts of credibility, dependability and transferability. The content analysis was based on the open-ended and open questions in both questionnaires. In the present study a meaning unit was considered to consist of words, sentences/statements or paragraphs containing aspects related to each other through their content and context (by Ganeheim & Lundman 2004). A content area was based on theoretical assumptions derived from the literature.

Statements, sentences or phrases that directly addressed the experience were extracted from the descriptions, and clusters of themes were organized into main categories and sub-categories from the formulated meanings. Thus each category referred mainly to a descriptive level of content and could therefore be considered an expression of the manifest content of the text. (Graneheim & Lundman 2004.) (Appendices 14 and 15). Direct citations were also used to describe the women’s experiences of interventions carried out by the ED professionals, and the ED professionals’ behaviour provided needed intervention.

4.4 Ethical perspectives of the study

Ellsberg & Heise (2002) offer a summary of key ethical and safety recommendations especially for IPV research. These ethical and safety principles should guide all research on violence against women. A poorly designed research project could put women in violent relationships at substantial risk. For
women experiencing violence, the mere act of participating in a study may provoke further violence.

The legal and ethical considerations must be addressed before, during, and after the conduct of a study. Selecting the subject for a study is already an ethical decision in itself. Other ethical questions concern adjustment of study problems, the relationship between researcher and organization, the relationship between researcher and participants, collection of data, and publication of the results (Jackson 1994; Malone 1998; Mäkinen 2006).

Intimate partner violence against women – the research topic selected for the present study – is a serious health problem for the woman and her children. It is also a violation of human rights and the protection of law, and a serious crime (Universal Declaration on Human Rights 1948; Convention on the Rights of the Child 1989; Declaration on the Elimination of Violence Against Women 1993; Act amending the Penal Code 563/1998). Therefore, identifying IPV, providing services for women and their family members, and preventing IPV is ED professionals’ professional, ethical and sometimes also legal duty (see Child Welfare Act 683/1983, section 40, ‘Duty of Notification’).

One basic question is also what the researcher will include in or exclude from the study. Therefore, when posing the research question, one has to decide what values will be encouraged. Thus the present study also aimed to bring forth the women’s points of view with regard to their experiences of the care they had received at the ED. The study also examined how the ED professionals had helped the women’s children and the perpetrators. The twofold study design gave an opportunity to find out possible contradictions between the women’s points of view and the ED professionals’ points of view on interventions carried out by the professionals for these women. There are many assumptions, attitudes and beliefs that may prevent effective identification of IPV (Thurston, Cory & Scott 1998; Rönnberg & Hammarström 2000; Hadley 2002).

The relationship between the researcher and the organizations studied was very important in the present study, as the participants were recruited through ED professionals. Each organization was asked for a permission to conduct the study. First, the request, the study design and the opinion (no. R02125H) of the Ethics Committee of the University of Tampere Hospital was sent to the head of the nursing staff at each research organization. Next the study design and the opinion of the Ethics Committee of the University of Tampere Hospital were sent to the ethics committees of those organizations that had decided to participate. Data collection did not begin until an official study permission had been obtained from the ethics committees. The above process took a long time, and obtaining the permission from some of the organizations was very difficult and complicated, despite the fact that the ethical principles were to be the same in all cases. The researcher visited the organizations and informed the professionals about the present study orally.

According to legislation (488/1999; 295/2004 and 986/99) and the ethical regulations issued by the committees, an informed consent was required from the patients. In this study, an informed consent was based on an explanation of the purpose of the study, as well as a description of any benefits to the subject or
other parties, and of the extent to which confidentiality and the anonymity of the subject would be preserved. An accepted consent required that the participant was capable of understanding the content of the consent. In accordance with the ethical principles, the consent included the right to refuse to participate, withdraw from participating, and ask questions at any time. The consent form therefore also included the researcher’s phone number.

The consent form was given to the participant along with the questionnaire and a covering letter (Appendix 8 and 9). Thus the women had the possibility to take it home and take time to consider their choices. The informed consent form was returned with the questionnaire, signed and dated by the participant. The ED professionals also gave a verbal explanation about what measures would be taken to maintain confidentiality. The recruiting took place without the presence of anyone who might have accompanied the women to the ED.

Protecting confidentiality is essential to ensure both women’s safety in IPV cases and data quality (Ellsberg & Heise 2002). The process of obtaining informed consent presents certain ethical dilemmas, and patients may find the information in the informed consent document more confusing than helpful (Steinke 2004). Often, the information is presented at a time when the person has a reduced capacity to process it. In the acute care setting, for example, the patient’s anxiety may contribute to diminished patient recall of informed consent and study procedures (Steinke 2004). Women in crisis visiting the ED are often unable to focus on the larger picture in their life situation (Dieneman et al. 2002). For this reason, it was important that ED professionals made sure that the women understood what participation in the present study meant. The questionnaire was therefore not handed out to women who were intoxicated, confused, or critically ill.

Part of the research material was gathered through interviews. Ethical principles guide the researcher in addressing the initial and ongoing issues arising from qualitative research in order to meet the goals of the research, as well as to maintain the rights of the participants (Orb, Eisenhauer & Wynaden 2001). In the case of violence, the safety of women respondents and interviewers may be at risk (Aronson Fontes 1998; Ellsberg & Heise 2002). The inherent risks entailed in research can only be justified if the interviews are used to provide information on the available services and are a source of immediate referral when necessary, if high-quality data are obtained, and if findings are used to raise awareness of and improve services for women exposed to IPV. (Ellsberg & Heise 2002.) Because researchers must protect people from physical or mental harm or discomfort, a good relationship between the interviewer and the respondent was essential (Jackson 1994; Keats 2000).

All questions were asked in a supportive and empathetic manner. Empathy helps the researcher to understand the reasons why people behave and think as they do, and cope with feelings and reactions to unpleasant pieces of information (Keats 2000). Traumatic events and experiences can also be heavy to recall. The informants may reveal such matters to a researcher that they have never told anyone else before. Emphasizing the protection of confidentiality before the interview is essential for ensuring the women’s safety and the quality of the data.
Participation may pose a risk for the women exposed to IPV both before or after the interview. The interviews should therefore not be conducted in places where privacy cannot be preserved (Ellsberg & Heise 2002). In the present study, therefore, the women were free to decide the time, place and manner (by telephone or face to face) of the interview.

Aronson Fontes (1998) ascertains that research is always some kind of intervention and may have direct benefits for the participants. Research can help participants recognize recourses for themselves, or it may help participants to think about their own lives in new ways, reinforcing their own coping strategies and reminding them that the information they have shared is important and will be used to help other women in a violent situation. In the present study, all interviews ended on a positive note. The researcher had also prepared for the interviews by taking along information on shelters and other support systems recommended for women exposed to IPV (Ellsberg & Heise 2002), and, after the interview, some of the women wanted to know more about the different services for women and perpetrators in their communities. Anonymity and confidentiality were also ensured during reporting (by Jackson 1994; Malone 1998). In addition, all study material, such as tapes, was placed in a locked file (Personal Data Act 523/1999).
5 Results

5.1 Description of the participants

5.1.1 Background information on the women exposed to IPV

Thirty-five women who had experienced acute physical violence filled out the related questionnaire. The response rate among the women was 27%. Two replies were rejected as incomplete. Twelve women from the pilot study were included in the final sample. The final data consisted of data from questionnaires filled out by 35 women and from seven interviews (Figure 2).

Demographic data on the women studied were asked about through questions 1–7 (Appendices 8 and 9). The youngest of the women was 19 years old and the oldest 67 (median age: 39). Sixty-one per cent of the women had a general education that was lower than upper secondary school. Fourteen women (42%) had an at least post-secondary level qualifications. Forty-seven per cent of the women were unemployed, on sick leave, students or retired. Nineteen women out of 35 (54%) were married or cohabiting, and 60% were currently living together with their partners. The time they had lived together with the current partners ranged from 0.1 to 29 years (Table 5). Fifteen women out of 35 (43%) had a total of 33 children between them (1–5 children each). Eleven women out of 35 (31%) had a total of 21 children under 18 years old between them living in the same household. Four women out of 11 with seven children between them were living together with their partners.
Table 5. Demographic data on women exposed to IPV studied (n = 35)

<table>
<thead>
<tr>
<th></th>
<th>Years</th>
<th>% (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td></td>
<td>39</td>
</tr>
<tr>
<td>Range</td>
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<td>19-67</td>
</tr>
<tr>
<td>Age group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19-24</td>
<td></td>
<td>9 (3)</td>
</tr>
<tr>
<td>25-34</td>
<td></td>
<td>17 (6)</td>
</tr>
<tr>
<td>35-44</td>
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<td>43 (15)</td>
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<td>45-54</td>
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<td>20 (7)</td>
</tr>
<tr>
<td>≥55</td>
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<td>11 (4)</td>
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<tr>
<td>Marital status</td>
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<tr>
<td>Married/cohabiting</td>
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</tr>
<tr>
<td>Dating</td>
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<tr>
<td>Divorced/separated</td>
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<td>17 (6)</td>
</tr>
<tr>
<td>Time living with current partner</td>
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<td></td>
</tr>
<tr>
<td>Median</td>
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</tr>
<tr>
<td>Range</td>
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<td>0.1-29</td>
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<tr>
<td>Currently living with partner in the same household</td>
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<td>60 (21)</td>
</tr>
<tr>
<td>Women living with the children under 18 in the same household</td>
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<td>31 (11)</td>
</tr>
<tr>
<td>General education</td>
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<tr>
<td>Elementary school</td>
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<td>Middle school or comprehensive school</td>
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<td>Upper secondary school</td>
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<td>39 (13)</td>
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<tr>
<td>Professional education</td>
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</tr>
<tr>
<td>No professional education</td>
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<td>21 (7)</td>
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<tr>
<td>Vocational upper secondary education</td>
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<td>37 (12)</td>
</tr>
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<td>Post secondary level vocational education</td>
<td></td>
<td>21 (7)</td>
</tr>
<tr>
<td>Polytechnic</td>
<td></td>
<td>9 (3)</td>
</tr>
<tr>
<td>Higher education institution or university</td>
<td></td>
<td>12 (4)</td>
</tr>
<tr>
<td>Employment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full/part-time employed</td>
<td></td>
<td>53 (18)</td>
</tr>
<tr>
<td>Unemployed</td>
<td></td>
<td>29 (10)</td>
</tr>
<tr>
<td>Other (on sick leave, student, retired)</td>
<td></td>
<td>18 (6)</td>
</tr>
</tbody>
</table>

5.1.2 Background information on the ED professionals

The response rate among the ED professionals studied (nurses, practical nurses/emergency medical technicians) was 51% (n = 488). This corresponds closely with studies conducted in different health care settings abroad (self-completed questionnaires) (See appendix 4, Table 2). Eight questionnaires were rejected because of incomplete answers. In total, the material related to ED professionals consisted of 480 replies. Twenty professionals were interviewed (see Figure 2).
Some background information on the professionals is presented in Table 6. The median age of the total sample of professionals was 38 (range: 19–60). Over half of the professionals had an upper secondary school education. Most of them were nurses. Fifty-seven per cent of the sample (two-thirds of the men and a little over half of the women) had received their qualifications after 1990. About fifty per cent of professionals had been practising their profession for 11 years or less. Fifty per cent of the professionals had been in their current jobs for six years or less. Thirty-three per cent of the professionals worked at university hospitals, 36% at central hospitals, and the rest at district hospitals and health centres. Over one quarter of the professionals were in temporary employment, most of them at university and central hospitals.

One third of the ED professionals studied had received training on how to deal with intimate partner violence (IPV) or domestic violence (DV). Over one fifth of the professionals themselves had left an abusive partner or were currently in a violent intimate relationship. Twelve of the professionals (3%) did not answer this question.

### Table 6. Demographic data on ED professionals studied (n = 480)

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>80%</td>
<td>20%</td>
<td>100%</td>
</tr>
<tr>
<td>Age</td>
<td>39 (19-60) years</td>
<td>36 (22-57) years</td>
<td>38 (19-60) years</td>
</tr>
<tr>
<td>Median (range)</td>
<td>49%</td>
<td>57%</td>
<td>51%</td>
</tr>
<tr>
<td>19-38 years</td>
<td>49%</td>
<td>43%</td>
<td>49%</td>
</tr>
<tr>
<td>Over 38 years</td>
<td>51%</td>
<td>43%</td>
<td>49%</td>
</tr>
<tr>
<td>General education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than upper secondary school</td>
<td>42%</td>
<td>54%</td>
<td>44%</td>
</tr>
<tr>
<td>Upper secondary school</td>
<td>58%</td>
<td>46%</td>
<td>56%</td>
</tr>
<tr>
<td>Professional education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than post secondary level</td>
<td>13%</td>
<td>26%</td>
<td>16%</td>
</tr>
<tr>
<td>Post secondary level</td>
<td>57%</td>
<td>53%</td>
<td>56%</td>
</tr>
<tr>
<td>Polytechnic or university degree</td>
<td>30%</td>
<td>21%</td>
<td>28%</td>
</tr>
<tr>
<td>Occupation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>84%</td>
<td>63%</td>
<td>80%</td>
</tr>
<tr>
<td>Practical nurse/Emergency medical technician</td>
<td>16%</td>
<td>37%</td>
<td>20%</td>
</tr>
<tr>
<td>Graduation year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1961-1990</td>
<td>46%</td>
<td>35%</td>
<td>43%</td>
</tr>
<tr>
<td>After 1990</td>
<td>54%</td>
<td>65%</td>
<td>57%</td>
</tr>
<tr>
<td>Occupation time</td>
<td>12 (0.3-40) years</td>
<td>10 (0.5-35) years</td>
<td>11 (0.3-40) years</td>
</tr>
<tr>
<td>Median (range)</td>
<td>49%</td>
<td>58%</td>
<td>51%</td>
</tr>
<tr>
<td>0.25-11 years</td>
<td>51%</td>
<td>42%</td>
<td>49%</td>
</tr>
<tr>
<td>Over 11 years</td>
<td></td>
<td></td>
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</tr>
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</table>

(continued)
Table 6. (continued)

<table>
<thead>
<tr>
<th>Organization</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
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<tr>
<td>University hospital</td>
<td>36%</td>
<td>23%</td>
<td>33%</td>
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<tr>
<td>Central hospital</td>
<td>34%</td>
<td>43%</td>
<td>36%</td>
</tr>
<tr>
<td>District hospital/health centre</td>
<td>30%</td>
<td>34%</td>
<td>31%</td>
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<table>
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<th>Working in current job</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median (range)</td>
<td>6 (0.1-33)</td>
<td>6 (0.3-34)</td>
<td>6 (0.1-34)</td>
</tr>
<tr>
<td>0.1-6 years</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Over 6 years</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
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</table>

<table>
<thead>
<tr>
<th>Size of staff</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>1-60 persons</td>
<td>51%</td>
<td>64%</td>
<td>54%</td>
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<tr>
<td>Over 60 persons</td>
<td>49%</td>
<td>36%</td>
<td>46%</td>
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<table>
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<th>Employment</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
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<tbody>
<tr>
<td>Permanent</td>
<td>74%</td>
<td>66%</td>
<td>73%</td>
</tr>
<tr>
<td>Temporary</td>
<td>26%</td>
<td>34%</td>
<td>27%</td>
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<table>
<thead>
<tr>
<th>Working hours</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
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<tbody>
<tr>
<td>Full-time work</td>
<td>92%</td>
<td>96%</td>
<td>93%</td>
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<tr>
<td>Part-time work</td>
<td>8%</td>
<td>4%</td>
<td>7%</td>
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<table>
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<tr>
<th>Form of working time</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>Three-shift work</td>
<td>87%</td>
<td>77%</td>
<td>85%</td>
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<tr>
<td>Other form of working time</td>
<td>13%</td>
<td>23%</td>
<td>15%</td>
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<table>
<thead>
<tr>
<th>IPV/DV training received</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>34%</td>
<td>32%</td>
<td>33%</td>
</tr>
<tr>
<td>No</td>
<td>66%</td>
<td>68%</td>
<td>67%</td>
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<table>
<thead>
<tr>
<th>Personal experience of IPV</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>25%</td>
<td>11%</td>
<td>22%</td>
</tr>
<tr>
<td>No</td>
<td>75%</td>
<td>89%</td>
<td>78%</td>
</tr>
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<table>
<thead>
<tr>
<th>Experience of IPV of an acquaintance or a relative</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>67%</td>
<td>64%</td>
<td>66%</td>
</tr>
<tr>
<td>No</td>
<td>33%</td>
<td>36%</td>
<td>34%</td>
</tr>
</tbody>
</table>

5.2 Past and acute physical IPV with health consequences for women

5.2.1 Women’s experiences of past physical IPV

Women exposed to IPV who had sought care at EDs were asked about past physical violence (Appendices 8 and 9, questions 8-11). Thirty women out of 35 (86%) had previously experienced physical violence by their current partner. For five women out of 35, the experiences of past physical IPV had been extremely hard: they had previously experienced physical violence inflicted by the current partner, some other person (near relative, workmate, occasional acquaintance or stranger), and a former partner (former husband or former cohabitant or former partner in a relationship) alike (Figure 2).
Among the 35 women studied, there were only two women with no previous history of IPV. Thus lifetime prevalence of physical IPV among the women in this study (those who had been physically injured by a male partner at some point in their lives) was 94%.

![Bar chart showing past physical violence by kind of perpetrator, experienced by the women studied (n = 35).](chart.png)

**Figure 2.** *Past physical violence by kind of perpetrator, experienced by the women studied (n = 35)*

Twenty-two women answered question 9b on whether they had experienced past physical violence 1–15 times by current partner. Fifty per cent of them (n = 11) had been exposed to IPV at least five times by their current partner (Md = 4). The past physical violence had taken many forms. For example, one woman with 15 acts of physical violence reported that her current partner had previously stabbed her with a knife, choked her and tried to kill her with gas. Ten women out of 30 (33%) had previously sought help for physical injuries caused by their current partner. Thirty-six per cent of those (4 women out of 11) who had experienced IPV five times or more in the past, had sought help for their injuries before. Women had sought help at university hospitals, central hospitals, district hospitals, health centres and private clinics and from company doctors (questions 10a and 10b). Twenty-nine women out of 35 (83%) reported experiences of several types of past IPV used by their current partner (question 11a). Physical
and psychological violence had co-occurred in 97% of cases of past IPV (28 women out of 29) (question 11 b).

Past psychological violence by a current partner often manifested itself in various ways, such as forbidding the woman to communicate with her children or threatening her. One interviewee with a history of 25 years of violence said that her husband had used their children as ‘referees’ and protected himself by their fear. Another woman wrote that her partner had threatened her, her children, her relatives and her friends. A 67-year-old participant wrote that her current partner had threatened to beat her so hard that she would never talk again. Defiance, humiliation, bullying, outbursts of rage and breaking things were common forms of psychological violence mentioned by the women.

Five women out of 29 (17%) reported that they had experienced both past physical and sexual IPV by their current partner. Economic violence, which received 11 mentions out of 29 (38%), and spiritual violence, which received 2 mentions out of 29 (7%), were also reported (question 11b). Because of the smallness of the sample, associations between physical IPV and the women’s ages could not be examined. In this study all age groups included women who had experienced both acute and past physical violence by their current partners (Figure 3).

**Figure 3.** Age groups of the women (n = 35) who had been exposed to acute and past physical violence inflicted by their current partners
5.2.2 Women’s experiences of acute IPV before arriving at EDs

The women’s experiences of acute violence which had occurred before they had arrived at the EDs were asked about through a multiple-choice question and an open question. The women reported having experienced both physical and psychological acute IPV by their current partners before arriving at the EDs.

Seventy-four per cent of the women (n = 26) had experienced more than one form of acute physical IPV. The profile of the forms of physical violence experienced by women shows a pattern of serious violence, where beating (e.g. with an object) and punching (with a fist) were most commonly reported. Category ‘Other physical violence’ included twisting/pulling/grabbing arms and legs, pulling her hair, throwing her against the wall, pushing her head down to the floor, and throwing objects at her.

Fifty-six per cent of the women exposed to IPV (n = 19/34) had experienced acute psychological violence in addition to acute physical violence. Psychological violence included symbolic violence, like destruction of property (e.g. breaking dishes and furniture, or tearing wallpaper), verbal abuse (e.g. yelling), and threatening (e.g. threatening to kill) (Figure 4; Appendices 8 and 9, question 12).

![Figure 4. Types of acute IPV reported by women (n = 34)](image-url)
5.2.3 Physical injuries and symptoms of acute IPV reported by women

Acute physical injuries and symptoms were asked from women by an open question (Appendices 8 and 9, question 19). Examination of replies to question 19 simultaneously with those to question 12 ascertained the kinds of physical injuries and symptoms that were consequences of acute trauma. The women had described how they had got their injuries (e.g. ‘My husband punched me’) and what kinds of injuries and symptoms they had got (‘Cut lip’). In addition to these descriptions the data from interviews with seven women was exploited.

The 32 completed questionnaires contained 55 mentions of different physical injuries and symptoms. Eighty-seven per cent of the consequences of acute trauma were clear physical injuries and 13 % were symptoms (Figure 5).

The physical consequences of acute trauma ranged from minor injuries (bruises) to serious ones (fractures). Physical injuries included contusions and bruises all over the body (78% of women), cuts on the corner of the eye, on the forehead and on lips, and fractures of the nasal bone, collarbone or ribs. Other physical injuries were joint dislocations, internal injuries (e.g. internal bleeding), hair loss and loss of hearing. Symptoms comprised earache and headache. In addition two patients mentioned that they were distressed, afraid, and shocked.

Most contusions and bruises had been caused by beating, hitting, kicking, strangling or choking. Cuts were consequences of beating and punching and caused by flying objects. The women had been pushed, punched, and knocked down by their partners and consequently sustained fractures. Concussion, earache and headache had been caused by pushing and beating. Dislocations were consequences of twisting/pulling/grabbing the women’s arms and limbs. Hair loss had been caused by pulling the women’s hair.

Twenty women out of 32 (63%) reported several concurrent injuries and symptoms (Figure 5).
Thirty-five women reported different injuries on different parts of the body (Figure 6). Nine women out of 35 (26%) reported having two or three injuries on the parts of the body mentioned in Figure 6. The most common locations of injuries received as the result of punching, beating and hitting were the face and head (77%). The rest were the extremities (hands, arms, feet or legs), neck, back, chest, and abdomen.
Eighty-six per cent (n = 30) of the women reported that the acute violence had taken place in their homes. The rest of the acts of violence took place in a hotel, in a restaurant, in the partner’s flat or in the street (Appendices 8 and 9, question 13).

Seventy-four per cent of the male partners (n = 25) had been intoxicated at the moment of the act of violence reported by women (n = 34). Three partners had been under the influence of both alcohol and narcotics (Appendices 8 and 9, question 14).

Forty-nine per cent (n = 17) of the women (n = 35) reported that they had been under the influence of alcohol themselves at the moment of the act of violence. None of them had been under the influence of narcotics (Appendices 8 and 9, question 15).

Twenty-seven women out of 35 (77%) had arrived at the ED within three hours after the act of violence. Three women had arrived the following day; two of them had got injuries on the head and face from being punched. One woman who had been pushed, punched, and thrown against the wall, had sustained several rib fractures, and arrived at the ED after three days or later (Appendices 8 and 9, questions 12, 18 and 19).

Eight women had arrived at the EDs with a close friend or a member of the family (daughter or son), five women had arrived on their own, two had been escorted by the police, eight had arrived in an ambulance and two had arrived with their perpetrators (Appendices 8 and 9, question 16).

Four women (11%) sought care at an ED of a university hospital, 10 women (29%) at an ED of a central hospital, 18 women (51%) at an ED of a district hospital, and three women (9%) at an ED of a health centre (Appendices 8 and 9, question 17).
5.2.4 Children as witnesses of past and acute IPV

Questions 4, 5, 9a, 9b and 13 (Appendices 8 and 9) were also related to children witnessing violence (seeing, hearing or being affected by violence between their parents). At the interviews four women told about their children’s experiences of violence. Two of the interviewees also said that their children had been present at the moment of the acute act of physical violence.

Fifteen women out of 35 (43%) had a total of 33 children between them (1–5 children each). Eleven women (31%) out of 35 had a total of 21 children under 18 between them living with them in the same household. Four women out of 11 with seven children between them were married or cohabiting and living together with their current violent partners.

Cross-tabulation of questions 5 and 9a revealed that nine women out of 11 (26%), with a total of 15 children under 18 between them had experienced physical violence by their current partners before. Two of these nine women reported earlier exposure to IPV by their current partners. One of these nine women reported having been assaulted by her current partner 13 times before and another one five times before. Four women had experienced physical violence twice before and one woman once before by the current partner. Two women of nine women did not mention the number of acts of physical violence.

At the interviews of four women it emerged that a total of seven children had been affected by past IPV in a variety of ways. All of these seven children had heard their parents quarrel or their father bawl and yell at their mother at some point in their lives. Two children had also been exposed to past psychological violence and three children to past physical violence.

Four children (< 10 years) had been present and seen their mother get injured by her current partner at the moment of the act of acute violence. One woman had been pushed and knocked down by her partner, the other woman pushed and punched by her partner.

Here are some extracts about children witnessing violence between their parents. It appeared from these stories that the children themselves had been affected by both the physical and the psychological violence. One woman out of the four, who had been in a violent relationship for over 25 years, reported:

‘When my son was only a little baby, I took him with me and ran away to my parents for the first time’. Later, when he was 16, he defended me and tried to hold his father back. My husband never attacked our daughter - at least I have never seen him do that - but he was violent towards our son’.

She continued:

‘Our 13-year-old daughter ran to the neighbour to get help for me. This neighbour called the police. She is now 16 years old, still hears from her father about it now and then’ (Woman no. 27)

Another interviewee reported that her children (aged 5 and 8) came between the parents in an acute violent situation and ran to the neighbour to call for help. Her
partner had also inflicted psychological violence on the children by breaking their toys in his anger.

‘The children could never understand why their father would do that’ (Woman no. 35)

The third interviewee, who had been in a violent relationship for 18 years, reported:

‘She did not know anything about these acts of violence and I could not tell her. Only once did she see my husband elbow and hit me. She was perhaps 16 years old. She had been woken up by my scream. My husband would nearly always rage at night. I do not think that our daughter heard anything. My husband was angry with me – not with her’ (Woman no. 13)

In two families where serious violence had continued for a long time, it appeared that the woman and her partner no longer had their small children living with them (Appendices 8 and 9, question 5). It seems most likely that these children had been taken into care by the child welfare services.

5.3 Experiences of care after acute IPV experienced by women visiting EDs

5.3.1 Women’s experiences of interventions carried out by the ED professionals

The women rated the 16 interventions carried out by the ED professionals on a 5-point Likert scale. A rating of 1 denoted ‘fully agree’, 4 ‘fully disagree’ and 5 ‘I cannot say’. The number of the women answering different statements ranged between 10 and 35 (Appendices 8 and 9, question 20).

For better visualization, the categories ‘fully agree’ and ‘partly agree’ were merged into a new category, ‘agree’. The categories ‘fully disagree’ and ‘partly disagree’ were merged into a new category called ‘disagree’ (Figure 7a and 7b).

As the figures show the category ‘No answer’ is very common in many statements. Nevertheless the dispersion of replies to many statements is certainly wide enough for analysis.

Only one woman agreed with the statement ‘Professionals also discussed in private with the perpetrator’ and two women agreed with the statement ‘Professionals helped the perpetrator to get help for his violent behaviour’. As only two women out of 35 reported that they had arrived for acute care together with a perpetrator (question 16), most of the women had left without answering this question. Only one woman felt that the professionals had not believed her experience of violence.
Further, 23 women out of 35 (66%) put the statements ‘I was asked whether I had been assaulted’ and ‘I was encouraged to report an offence to the police’ under the category ‘agree’. The statement ‘Professionals did not intervene in my violent situation in any way, and only took the necessary care measures’ was agreed with by ten women out of 35 (29%). The statement ‘Professionals discussed with me in private’ was agreed with by 26 women (74%), and ‘A doctor examined me carefully’ by 18 women (51%). Only three women out of 35 (9%) agreed with the statement ‘Professionals belittled my situation and I felt that I did not get enough understanding’. ‘Co-operation was good with those who provided me with care’ was agreed with by 20 women (57%).

Examination of the category ‘disagree’ revealed that 14 women (40%) disagreed with the statement ‘I was told about different help services (e.g. discussion groups with other women, legal aid, shelters etc.)’, and 17 women (49%) disagreed with the statement ‘I was given the opportunity to meet specialized helpers during my visit to the ED (e.g. social and crisis services emergency duty personnel or similar helpers)’. Further, the statement ‘Professionals helped me to plan my safety for future situations (e.g. I received oral advice and/or written information on future violent situations)’ was disagreed with by 21 women (60%), and the statement ‘I was offered the opportunity to stay overnight at the ED’ by 15 women out of 35 (43%).

Thirty-seven per cent of the women (n = 13) agreed that they had been asked about the safety of their children at home. However, none of the women had discussed with the professionals or with a social worker any ways to protect children in a violent situation.

Cross-tabulation of the women (n = 11) who had children under age of 18 living in the same household (n = 21) and the statement ‘I was asked about the safety of my children at home’ showed that four women agreed with this statement, while seven women disagreed. Cross-tabulation of the 11 women and the statement ‘I discussed with the professionals or with a social worker how to protect children in a violent situation’, showed that five women disagreed with the statement (Appendices 8 and 9, questions 5 and 20).

An interviewee who had been exposed to physical IPV by her spouse twice before reported:

‘No one in the emergency room was interested in my children’ (Interviewee no.14).

The children had witnessed violence between their parents and entered the ED with their mother who had come to seek help.
I had a chance to meet other helpers (e.g. social worker).

I was told about different help services (e.g. legal aid and shelters).

I was asked if my children were safe.

A doctor examined me carefully.

Professionals discussed with me in private.

I was encouraged to report an offence to the police.

Professionals did not believe me when I told about my experience of violence.

I was asked if I had been assaulted.

Figure 7a. Experiences of interventions carried out by ED professionals at acute visits (statements 1-8), reported by the women studied (n = 35)
Figure 7b. Experiences of interventions carried out by ED professionals at acute visits (statements 9-16), reported by the women studied (n = 35)
5.3.2 Experiences of care and principles of care regarded as important by women exposed to IPV

Experiences of care during ED visits were asked about through open questions 21 and 22 (Appendices 8 and 9). The answers to the open questions were analysed through quantitative content analysis, where the data given by the women were grouped and calculated. Thus a unit of analysis was formed by a statement or phrase, which was categorized according to the words or phrase that described an experience of care. Appendices 14 and 15 summarize the sub-categories and main categories formed from the women’s descriptions. In addition to categorizing, direct quotes from the women were used to describe their experiences of care during the ED visits.

The women mentioned both positive and negative experiences of care that were grouped into three main categories: appropriate medical care, practical and emotional support, and the structural limitations of the care environment. The women were satisfied with the examinations and treatment of physical injuries and symptoms. They experienced as positive issues emotional support including elements of equality with other accident patients, calmness, empathy, friendliness, and understanding. Another positive issue was a safe and quiet care environment.

Correspondingly the women criticized medical care. A badly injured woman whose treatment was delayed because the doctor had underestimated her injuries and failed to take her story seriously, wrote in the questionnaire:

‘A doctor may disagree with a patient who nevertheless often knows her problem best. My care was delayed and therefore more complicated. The doctor had not believed that my injuries were serious’ (Woman no. 17).

Negative issues mentioned by the women included the restless atmosphere at the EDs and the structural limitations of the care environment. They also reported a lack of privacy. Here are extracts of what some of the interviewees told:

‘In my opinion there should be some other place than a public waiting room. It was really horrible to sit and wait. There were many small children waiting to see a doctor. Certainly they attended to me...I was bleeding. There could perhaps be a screen or a place where one could sit in peace’ (Woman no. 27).

‘Every single patient around the waiting room must have heard the doctor ask if my husband had punched me’ (Woman no. 13)

‘I arrived at the hospital at seven o’clock in the morning. I was asked to come back at ten o’clock when a doctor would be there. They asked if I had any painkillers at home. I said of course I had but I couldn’t go there. They gave me two Buranas and then I went to my parents’ home. It was not a serious situation, because my mother picked me up and I had a chance to talk to my parents. But I
had hoped to get immediate treatment and someone could have talked to me at the ED. Waiting at home was somehow agonizing’ (Woman no. 16).

The lack of practical or emotional support showed in many ways during ED visits. A woman who had been exposed to physical IPV dozens of times but who had not sought help before was dissatisfied with the way the staff had reacted, and she reported:

‘Mental support was completely lacking. Neither the doctors nor the nurses intervened in the act of violence in any way. I was alone with it. I was afraid and I was worried about my children. I was given analgesic. I waited with all the other patients in the same waiting room. I was not advised me on any aftercare. I was not asked if I needed to see a social worker’ (Woman no. 14).

Two women with earlier experiences of violence described their feelings on the following way:

‘I did not really see any nurses except when I arrived in the ED. Now and then they asked me to lie down on a stretcher, and asked how I was feeling. They stayed with me only for short moments at a time, and we did not talk about violence at all. They did not give any guidance on how to get help, not to me or to my husband’ (Woman no. 13).

‘A nurse looked at the cut on my face. How I had got it was not addressed. Later a doctor came to see me, and he was kind and down-to-earth and asked me to explain about the cut. I told him everything that had happened, because I needed the sick leave. The doctor did not say anything. It was...how I should say... rather negative...not negative, but sterile. Thy are not concerned about the matter. They only do their job. My problem was nothing big, only a couple of stitches on the lip. I was quite okay. I got two days’ sick leave and got out’ (Woman no. 9).

Some women criticized the lack of further care for the whole family. They criticized the lack of a support system for women and children. They would have wanted care for the perpetrators as well. One of the seven interviewees described the situation in the following way:

‘I do not know what happened, but I phoned my husband and asked him to come to the hospital, and he did. I would have liked a doctor to ask us both into his room and discuss the matter with us. I wish we had got more information and support. But what would it have helped? When we got out I said we had to seek help or else I would have to leave. My husband said that it had been an accident. I said that it had not. Later he agreed to visit a family counsellor. We went there both together and separately. Then he let the matter rest. He did not want to waste his time there. After that I went there alone’ (Woman no. 13).
Other help which the women might have needed but had not received

The women were also asked through an open question what kind of other help they might have needed but had not received (Appendices 8 and 9, question 23).

One woman with a long history of violence wrote on the questionnaire that she would have needed ‘A holistic view of the whole situation. Distressed and depressed people do not have the energy to go from one place to another for help’ (Woman no. 33).

Another woman wrote that she would have needed to talk to someone during the visit to the ED, because ‘I was very scared and completely alone with this matter’ (Woman no. 35).

In addition the women reported that they would have needed information on how to report the offences to the police and on protection orders and shelters. Some women would have needed crisis therapy and other help through discussions.

The women were worried about their partners’ violent behaviour and they had wanted to help them.

Circumstances that made it more difficult to seek help

The women were also asked through an open question what kinds of circumstances had made it more difficult to seek help this time (Appendices 8 and 9, question 24).

The following mentions were picked up from the questionnaires: Three women mentioned fear of their partner’s revenge and fear of being left all alone. One woman reported that she was not able to leave immediately after the violent act, another that she could not leave her children with the violent partner, and a third mentioned that it had taken a long time for an ambulance to arrive. One woman reported that all the local people knew each other and that stories would spread.

A sense of shame (9 mentions) or guilt (4 mentions), misuse of alcohol, fear of not being taken seriously by anybody, and the lack of any inquiries about the reasons for the act of violence were mentioned. A woman expressed the sense of guilt in the following way and wrote:

‘Often it is the woman who will be blamed – at least on the emotional level; a sense of failure. Why did you not leave in time? Why did you choose someone like him?’ (Woman no. 31).

Another woman wrote: ‘I blame myself for causing a violent situation, although I know that it is not true’ (Woman no. 27).

It emerged from the interviews of the women that downplaying their injuries was one reason why they had not sought help earlier. All these women had been punched in the face by their partners before arriving at the ED. Here are extracts from the interviews:
‘I have never had this kind of shock before, only a little pushing and shoving. I always get bruises then, but you can get bruises anywhere’ (Woman no. 14).

‘Mental injuries were the greatest matter because the situation frightened me’ (Woman no. 8)

‘No... nothing like this had happened before...not really. Perhaps little things...the reason was, of course, that he had been drinking for several days and he was angry’ (Woman no.16)

‘My husband assaulted me so that the injuries were not visible to others...I could cover up my bruises with clothes. No such injuries that would have required hospital treatment’ (Woman no. 35)

**Principles of care regarded as important by the women**

The women rated the principles of care related to the nine statements on a 4-point Likert scale. A rating of 1 denoted ‘Not important’, and 4 ‘Very important’ (Figure 8, Appendices 8 and 9, question 25). The number of the women answering the statements varied between 18 and 31. As the figure shows the category ‘No answer’ was very common for all statements. In addition to that the dispersion of the opinions was small; none of the women rated any statement ‘Not important’ and very few as ‘A little important’. Thus this question is a failure.

However, with regard to the category ‘Very important’, 72% of the women (n = 25/35) put the statement ‘Kind and secure care environment’ under this category, and the statement ‘Confidential care relationship’, 66% of the women (n = 23/35). Only 26% of the women (n = 9/35) put ‘Encouragement in reporting an offence’ to this category. The women also rated the statement ‘Encouragement in getting help for the violent partnership’ less important, as 23% of the women thought that it was ‘A little important’. It is impossible to analyse the women’s opinions related to that question any further.

One woman reported: ‘I have never reported the offences to the police. It would only increase the violence. It is quite useless’ (Woman no. 27).

Another interviewee said:

‘The police asked if I wanted to report the offence. I said of course I did. Much later the police phoned me at home and asked me what should be done about the matter...Did I intend to pursue the matter or not? I said I did not want any further consequences as I was still together with my husband, I did not want any after-effects’ (Woman no. 13).

The women also had the possibility to report what other principles of care that they regarded as important (statement no. 10). Five women had written the
following principles of care: ‘The whole family should get help’ (Woman no. 33), ‘To concentrate on just me’ (Woman no. 10), ‘A doctor should ask why this had happened’ (Woman no. 15), ‘Listening without any rush’ (Woman no. 16), and ‘To get treatment for the spouse’ (Woman no. 8).

**Figure 8.** Principles of care regarded as important by the women (n = 35) studied
Other questions

The women were asked where they had gone after leaving the ED (question 26). Fourteen women out of 25 (56%) reported having gone to their homes. Six women (24%) had gone to the home of a friend or a relative. With regard to the rest of the five women (20%), one woman had gone to a shelter, one to a different care unit at the same hospital, and three had gone to some other, unspecified place.

The women were inquired whether their partners had ever sought outside help for their violent behaviour (question 27). Only nine women (26%) out of 34 reported that their partners had sought help from men’s discussing groups, for example (AA meetings, Lyömätön Linja, the Viola project).

The women were asked a question with a six-point response scale for an opinion about who had the primary responsibility for stopping the violent behaviour. The alternatives were: the women, the perpetrators, ED professionals, both parties (woman and perpetrator), other professionals (e.g. social workers), or others, who had to be specified. The data were collapsed into six responses: ‘The woman’, ‘The perpetrator’, ‘The woman and the perpetrator’, ‘Other professionals’, ‘Others’ and ‘Several alternatives were selected’.

None of the women thought that the responsibility for stopping the violence lay with the woman herself. Nineteen women (54%) out of 35 reported that the perpetrator had the primary responsibility for stopping the violent behaviour. Eleven women (32%) thought that the primary responsibility lay with both parties. Women who answered ‘both parties’ explained their opinions by writing as follows: ‘The woman can end the relationship for herself, but she will need support’, or ‘Both parties need help from society’, or ‘The woman will need help when she decides that she will no longer be assaulted by her partner’. Several alternatives were selected by five women (14%) (Figure 9, Appendices 8 and 9, question 28).
Several alternatives were selected

Others

Other professionals (social worker etc.)

The perpetrator

ED professionals

The woman and the perpetrator

The woman herself

Proportion (%) of women

0 10 20 30 40 50 60

Figure 9. Responsibility for stopping the violent behaviour, as reported by women (n = 35)

5.4 Identification of IPV and interventions carried out by ED professionals

5.4.1 Frequency of visits by women, children and perpetrators as estimated by ED professionals

The ED professionals were asked to assess the frequency of visits by women in IPV relationships, as well as their children and perpetrators, seeking care (Appendix 10, questions 13, 14 and 15; Figure 10). This matter was measured with a six-point response scale: ‘At least once a week’, ‘At least once a month’, ‘Once every two months’, ‘3–4 times a year’, ‘Once a year or less often’, and ‘Never encountered them’. For visualization and better understanding, the data were collapsed into three classes: ‘At least once a month’ (at least once a week, and at least once a month), ‘A few times a year’ (once in two months, and 3–4 times a year), and ‘Once a year or less often’ (once a year or less often or never).
Forty-eight per cent (n = 231) of the ED professionals reported that they encountered women in IPV relationships at least once a month. Sixty-six per cent (n = 314) of the ED professionals encountered children who had witnessed violence only once a year or less often. Eighteen per cent (n = 88) of the ED professionals reported encountering perpetrators at least once a month (Figure 10).

![Graph showing frequency of women, children, and perpetrators, estimated by ED professionals (n = 477-479)](image)

**Figure 10.** Frequency of women, children and perpetrators, estimated by ED professionals (n = 477-479)

The ED professionals were also asked to estimate how often they encountered women exposed to IPV who visit the ED again (question 16). Fifty-six per cent (n = 269) of the ED professionals estimated that they had encountered women exposed to IPV who visited the ED 1–2 times a year or more often. Forty-four per cent (n = 211) of the professionals had encountered repeatedly visiting women less than once a year (Figure 11).
Figure 11. Frequency of repeatedly visiting women, estimated by ED professionals (n = 480)

For the significance ($\chi^2$ test) the data were collapsed into two response categories because of the relatively small numbers in the frequency table: ‘Once a year or more often’ (more than twice a year, and 1–2 times a year), and ‘Less often than once a year’ (less than once a year, and never encountered them).

Male professionals, ED professionals with lower general or professional education, professionals who had received their qualifications earlier, those who had worked longer on their current jobs, practical nurses and professionals in district hospitals and health centres estimated that they encountered frequently visiting women more often. Also those professionals whose work was not three-shift work, who were permanent employed or who had received more IPV training estimated that they had encountered repeatedly visiting women more often.

Those ED professionals who reported encountering perpetrators and children of women exposed to IPV more often, estimated that they encountered repeatedly visiting women exposed to IPV more often (Table 7).
Table 7. *Backgrounds of ED professionals related to incidence of encountering women exposed to IPV who re-visited the EDs*

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Incidence of encountering women who visit the ED again</th>
<th>Significance test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>At least once a year</td>
<td>%</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female (n = 385)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male (n = 95)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General education (n = 478)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than upper secondary school</td>
<td>64</td>
<td>4.088</td>
</tr>
<tr>
<td>Upper secondary school</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional education (n = 480)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than post secondary level</td>
<td>66</td>
<td>8.962</td>
</tr>
<tr>
<td>Post secondary level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polytechnic or university degree</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working on current job (n = 480)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.1-6 years</td>
<td>49</td>
<td>8.725</td>
</tr>
<tr>
<td>Over 6 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupation (n = 480)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>53</td>
<td>7.368</td>
</tr>
<tr>
<td>Practical nurse/emergency medical technician</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Graduation year (n = 480)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1961-1990</td>
<td>62</td>
<td>5.324</td>
</tr>
<tr>
<td>After 1990</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organization (n = 479)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>University hospital</td>
<td>43</td>
<td>22.498</td>
</tr>
<tr>
<td>Central hospital</td>
<td>56</td>
<td></td>
</tr>
<tr>
<td>District hospital/health centre</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>Type of working hours (n = 480)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Three-shift work</td>
<td>54</td>
<td>4.718</td>
</tr>
<tr>
<td>Other type of working hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employment (n = 480)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Permanent</td>
<td>59</td>
<td>5.553</td>
</tr>
<tr>
<td>Temporary</td>
<td>47</td>
<td></td>
</tr>
<tr>
<td>IPV/DV training received (n = 476)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>64</td>
<td>5.584</td>
</tr>
<tr>
<td>No</td>
<td>52</td>
<td></td>
</tr>
<tr>
<td>Incidence of children encountered at ED (n = 477)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>At least once a month</td>
<td>95</td>
<td></td>
</tr>
<tr>
<td>A few times a year</td>
<td>81</td>
<td></td>
</tr>
<tr>
<td>Once a year or less often</td>
<td>42</td>
<td>74.992</td>
</tr>
<tr>
<td>Incidence of perpetrators encountered at ED (n = 478)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>At least once a month</td>
<td>86</td>
<td></td>
</tr>
<tr>
<td>A few times a year</td>
<td>67</td>
<td></td>
</tr>
<tr>
<td>Once a year or less often</td>
<td>33</td>
<td>84.079</td>
</tr>
</tbody>
</table>
5.4.2 Identification of IPV by ED professionals

**Arrivals of the women arrived at EDs as reported by ED professionals**

ED professionals studied were asked to describe the arrivals of women exposed to IPV arrive in the ED (Appendix 10, question 17). This question offered several alternatives of which it was possible to choose one or more. In total, the ED professionals \((n = 471)\) reported 1701 mentions. They reported that the women had mostly arrived (77% of all professionals) with a close friend or with an acquaintance, and almost as often on their own (75%) (Figure 12).

![Figure 12. Descriptions of the women’s arrivals in EDs, reported by ED professionals \((n = 471)\)](image)

These percentages do not equal 100% because it was possible to choose all appropriate alternatives.

**Detection physical IPV in the women as reported by the ED professionals**

Detecting IPV in women who arrived at the ED was asked about through a question which included several alternatives of which to circle one or more. Ninety per cent \((n = 431)\) of all professionals \((n = 477)\) studied assessed that the IPV has been disclosed by the women themselves and very seldom by the perpetrators (Appendix 10, question 18a; Figure 13).
Figure 13. Detection of acts of violence as reported by ED professionals (n = 477).

These percentages do not equal 100% because it was possible to choose all appropriate alternatives.

The ED professionals were asked through an open question how they had identified IPV in cases where the women themselves or their escorts had not mentioned any acts of violence (question 18b). The answers were analysed through quantitative content analysis, where expressions (n = 805) given by the respondents (n = 405) were grouped and calculated. The frequencies of different expressions of IPV reported by the ED professionals participating in the study are presented in Table 8. Sixteen per cent (n = 75) of 480 professionals left the question unanswered.
### Table 8.
*Frequencies of injuries, symptoms and behaviour that may indicate IPV, according to the recorded opinions of the ED professionals (n = 405)*

<table>
<thead>
<tr>
<th>Main category of expression</th>
<th>Subcategory of expression</th>
<th>Frequency of expression</th>
<th>Proportion of professionals %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical injuries</td>
<td>The location/form/type of injury does not correspond to what is told</td>
<td>243</td>
<td>60</td>
</tr>
<tr>
<td></td>
<td>‘Injuries typical for IPV’</td>
<td>211</td>
<td>52</td>
</tr>
<tr>
<td>Diffuse symptoms without any corresponding findings</td>
<td>Chest pain/headache</td>
<td>2</td>
<td>0,5</td>
</tr>
<tr>
<td>Behaviour of the woman</td>
<td>The woman does not explain how she has got her injuries</td>
<td>97</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>Frequent earlier visits to the ED</td>
<td>35</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Alertness/wariness/fear</td>
<td>69</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>Distressed/inhibited/tearful</td>
<td>33</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>The woman first admits, then denies</td>
<td>2</td>
<td>0,5</td>
</tr>
<tr>
<td></td>
<td>Nervous behaviour/ uncertain behaviour/ hostile behaviour</td>
<td>51</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>The woman refuses aftercare/ wants to leave quickly after receiving aftercare</td>
<td>18</td>
<td>4</td>
</tr>
<tr>
<td>ED professional’s intuition</td>
<td>‘Somehow you just sense it’</td>
<td>17</td>
<td>4</td>
</tr>
<tr>
<td>Behaviour of the partner</td>
<td>Perpetrator stays closely with the woman</td>
<td>11</td>
<td>3</td>
</tr>
<tr>
<td>Other mentions</td>
<td>The woman is under the influence of alcohol</td>
<td>16</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>805</td>
<td>100</td>
</tr>
</tbody>
</table>

Most of the expressions belong to main category ‘Physical injuries’ and were mentioned by 243 respondents (60%). ‘The location/form/type of injury does not correspond to what is told’ and ‘The woman’s explanation of the injury is inconsistent with the type and pattern of injury’ were the most typical expressions.

The sub-category ‘Injuries typical for IPV’ comprising 211 ED professionals (52%) consisted of e.g. the following expressions: ‘Bruises all over the body’, ‘Bruises of various age or old bruises’, or ‘Unexplained bruises’, ‘Swollen lips’, ‘Black eyes’, ‘Strangling marks on woman’s neck’ and ‘Facial bone fractures’.
Some professionals expressed the matter on a general level: ‘Signs and locations of injuries’ or ‘The kinds of injuries’.

Only two mentions were placed in the second main category concerning ‘Diffuse symptoms without any corresponding findings’. The answers included the following: ‘Women may have unexplained bruises here and there, but they seek help for just headache and chest pain’.

‘Behaviour of the woman’ as a third main category included symptoms of acute stress disorder (ASD) as consequences of acute trauma describing the behaviour of a woman in an IPV relationship. Ninety-seven ED professionals studied (24%) used expressions which fell under sub-category ‘The woman does not explain how she has got her injuries’. ‘Illogical or indefinite story of how they received their injuries’, or ‘All kinds of explanations about the injuries’, were the most common expressions by the ED professionals. The subcategory ‘Frequent earlier visits to the ED’ comprised mentions such as these: ‘The women make frequent visits because of different bruises or fractures’, and ‘They have made earlier visits similar to the current one’.

The terms ‘alertness’ and ‘wariness’ described the behaviour of the woman as well. According to the ED professionals, ‘The women are afraid of their perpetrators’, or ‘The women’s behaviour changes when their perpetrators enter the room’, or ‘The women don’t go home, or they don’t want to be in contact with their partner’. The professionals also mentioned that ‘They are frightened or fearful’, or ‘They are distressed, inhibited and tearful’.

The expressions ‘Nervous behaviour/uncertain behaviour/hostile behaviour’ described the woman’s behaviour. ‘The women underestimate the seriousness of the committed violence and want to go home’, and ‘The perpetrators don’t leave their partner alone with the ED professional, and they keep their eyes on the partner’.

Seventeen completed questionnaires included expressions to describe the ED professionals’ intuition about identifying an act of violence, for example: ‘Somehow you just sense it’.

Sixteen ED professionals thought that women under the influence of alcohol might indicate IPV.

Interventions carried out by ED professionals suspecting IPV

The ED professionals were asked (question 18c) how they acted if they suspected IPV. A total of 617 statements were gathered. Quantitative content analysis was used. The categories for the statements are presented in Figure 14.

In 283 questionnaires out of 415 (68%) the statements of the ED professionals studied fell under the category ‘I bring the matter up’, which could include expressions like ‘I ask directly’, ‘I ask women about what has happened’, ‘I discuss with women about the act of violence’, or ‘I ask who has battered them’.

Many professionals described their ways of asking the women about possible IPV and the kind of atmosphere and environment where they had inquired about
or discussed the act of violence. Examples of these descriptions were of the following kind: ‘I try to ask’, ‘I try to ask indirectly’, ‘I try to discuss the matter in a discreet or roundabout manner’, ‘I ask about the matter openly’, and ‘I ask about the matter in a suitable situation’. A confidential and safe atmosphere, as well as a calming and empathetic attitude were mentioned: ‘I encourage women to talk’, ‘I listen to the women and support them, or encourage them to talk about it’, ‘I don’t moralize, or provoke or accuse the women’, and ‘I voice my suspicions’. Some professionals emphasized the importance of privacy for the women: ‘I talk to them in private’, and ‘I take the women to a quiet room’.

Fifty-six per cent of the ED professionals studied (n = 234) gave the women at least some guidance and information about social office services, crisis centre services, social workers’ services, police services, and shelters for battered women. The ED professionals had given them leaflets that contained information on different help organizations (including telephone numbers), for example, directed them to social workers, and encouraged them to contact the police to report the offence. The verbs ‘support’, ‘guide’, ‘tell’ and ‘advise’ are descriptive of the professionals’ actions.

Seventeen per cent of the ED professionals (n = 70) had discussed the suspected cases with a doctor. They said, for example: ‘I mention my suspicions to a doctor’ and ‘I discuss with the whole team about what to do’.

Seven per cent (n = 30) of the professionals reported having tried to give the women exposed to IPV concrete support. The professionals had checked the women’s and their children’s safety, offered and arranged shelters for the women, phoned to the police for them (with their permission), and offered help services to the perpetrators (Figure 14).

The following statements, which describe the acts performed for the women by the ED professionals, fell outside the previously mentioned categories: Seventeen ED professionals said that they had spoken clearly against violence when caring for these women, using the following expression, for example: ‘Violence is wrong and not your fault’.

Five professionals reported that any intervention depended on the current situation: ‘If the women don’t want to tell us or don’t want any help, I let the matter rest’, or ‘How to proceed and continue depends on the situation’, or ‘I give them leaflets if they like’, or ‘I discuss the matter if they want’. Two professionals pay primary attention to the physical injuries: ‘Treatment of physical injuries comes first’.

96
Proportion (%) of ED professionals

Figure 14. Interventions carried out for suspected IPV, reported by ED professionals (n = 415)
These percentages do not equal 100% because professionals had mentioned several interventions

Problems in identifying IPV

ED professionals studied were also asked to estimate how often and what kinds of problems they had had in identifying IPV (question 19a) and (open question 19b). Fifty-eight per cent of the professionals studied (n = 271/468) reported that they had had problems in identifying IPV ‘often’ or ‘now and then’. Only six per cent of the professionals (n = 28) reported that they had never had any problems in identifying IPV (Figure 15).
Fifty-three per cent (n = 254) of the ED professionals answered the question 19b concerning the kinds of problems they had met in identifying IPV. All expressions (n = 284) of the professionals were written out word for word. The data were grouped for quantitative content analysis (Table 9).

The largest category consisted of factors connected with the women’s unwillingness to discuss the committed acts of violence. The professionals’ comments were of the following kind: ‘They won’t admit it’, ‘They don’t want any help’ and ‘They hide the whole matter’.

The second category consisted of factors connected with either the professionals’ skills or their lack of knowledge with regard to bringing up the violence in discussion. The ED professionals reported the following, for example:

‘I don’t know how to ask about violence’, ‘It’s not easy to ask’, ‘How can you intervene in IPV without invading the person’s privacy’, and ‘I can never be sure’. Some ED professionals wrote: ‘Contusions and bruises can be hidden, which makes it difficult to notice any signs of violence’ or ‘I have not paid attention to injuries that are not visible’. Some professionals wrote: ‘Certainly a lot of cases remain undetected’, and ‘These situations are always problematic to some degree’.

Figure 15. Frequency of problems in identifying IPV as reported by ED professionals (n = 468)
Some ED professionals studied described their feelings by using the concepts of powerlessness, helplessness and frustration, because they felt that they were unable to intervene in the issue.

The third category consists of factors connected with the inconsistencies between the women’s stories and the physical examination or the unusual mechanisms of the injuries. The professionals reported that ‘The women’s explanations for their injuries are inconsistent with the type and pattern of the injuries, but they have told the matter very believably’ or ‘Many stories are believable even for the injuries they have got’.

The fourth category consists of factors connected with the lack of cooperation due to the women in IPV relationship being under the influence of alcohol. The ED professionals expressed the matter in the following way: ‘The assaulted women are under the influence of alcohol and it is difficult to find out what is true and what is a lie’.

The ED professionals were asked to estimate the number of women exposed to IPV that they have encountered who have been under the influence of intoxicants (alcohol, narcotics, pharmaceuticals). Eighty-six per cent (n = 405) of the ED professionals studied assessed that at least 50% (median 75%) of the women exposed to IPV were under the influence of intoxicants when entering the ED (Appendix 10, question 20).

The fifth category consists of factors connected with the presence of perpetrators or relatives. ‘The perpetrators stay beside the women, listening to everything’. Two professionals said: ‘The perpetrators may seem completely sincere’, or ‘The partners have their own stories and views’.

The sixth category consisted of factors connected with the physical work environment. ‘It’s difficult to concentrate on listening to the women because we are so busy with all our work’, ‘There’s no time to listen to the patients’, ‘There’s no time to become orientated to the matter’, and ‘There is no quiet room where to interview the patients’.

The seventh category consists of factors connected with the protection of the perpetrator. The ED professionals reported that ‘The women fear their perpetrators and give some other reason for their injuries’, and ‘The women say that they were assaulted in the street’.

The eighth category consists of factors connected with other reasons for seeking help. For example, one professional described the matter in the following way: ‘People are seeking care for all kinds of problems at the emergency department, and it’s impossible to know whether their chest pain is caused by their fear of the violent partner’. Another professional reported: ‘It’s impossible to identify IPV when the women arrive without any acute trauma’.

The ninth category covers factors connected with other comments, such as ‘The problems are diverse’, ‘The relationship between husband and wife seems good’, and ‘I have no problems in identifying IPV’. Two ED professionals described the matter in the following way: ‘The same women are victims of violence over and over again’, and ‘With the women with a history of violence doing nothing about the matter, even when they understand the seriousness of their situation, and children have been present... it feels hopeless’.

99
Table 9.  

<table>
<thead>
<tr>
<th>Problems in identifying IPV</th>
<th>Frequency of expression</th>
<th>Proportion of professionals %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women’s unwillingness to discuss</td>
<td>112</td>
<td>44</td>
</tr>
<tr>
<td>Lack of knowledge/professional skills</td>
<td>44</td>
<td>17</td>
</tr>
<tr>
<td>Inconsistency between women’s stories and physical examinations</td>
<td>35</td>
<td>14</td>
</tr>
<tr>
<td>Women under the influence of alcohol</td>
<td>25</td>
<td>10</td>
</tr>
<tr>
<td>Presence of perpetrators or relatives</td>
<td>18</td>
<td>7</td>
</tr>
<tr>
<td>Physical work environment</td>
<td>15</td>
<td>6</td>
</tr>
<tr>
<td>Women protect their perpetrators</td>
<td>13</td>
<td>5</td>
</tr>
<tr>
<td>Other reason than IPV to receive care</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Other comments</td>
<td>15</td>
<td>6</td>
</tr>
</tbody>
</table>

Cross-tabulation of the professionals’ backgrounds (questions 1-12 and questions 26 and 32 and 33) with questions 19a and 19b showed that those professionals who had received IPV training were more specific about the problems in identifying IPV than those who had not received such training (61% versus 49%; \(\chi^2 = 5.498, df = 1; p = 0.019\)). Those professionals who had reported a personal history of IPV mentioned identification problems more often than those who had no such history (65% versus 50%; \(\chi^2 = 7.426; df = 1; p = 0.006\)).

Cross-tabulation of questions 19a and 19b with the professionals’ views on attitudes, beliefs and practices (question 22), significant differences were detected between the problems with identifying IPV and the lack of agreed written procedures (categories ‘Fully agree’ and ‘Agree’). The professionals studied had more often problems if no written procedures had been provided (54% versus 42%;\(\chi^2 = 6.245; df = 1; p = 0.012\)). No other statistically significant associations were found.

5.4.3 Interventions carried out by ED professionals

Interventions carried out by the ED professionals were examined through 12 statements with a four-point response scale of ‘Always’, ‘Often’, ‘Now and then’ and ‘Never’ The number of ED professionals answering different statements ranged between 455 and 480 (Appendix 10, question 21; Figures 16a and 16b).

Distribution of the ED professionals’ views were illustrated by a median. The smaller the value of the median for a statement was, the more often the ED professionals had performed the particular intervention mentioned. Statement no. 5 had been presented in a negative form, which is why its interpretation was reversed: The greater the value of median for a statement was, the more often the ED professionals had performed the intervention. The upper and lower quartile were used as the measures of dispersion. The wider the quartile range (\(Q_3 - Q_1\)),
the greater the dispersion of views. The professionals’ views and the percentages (%) of participants reporting those views are listed in Appendix 12.

The most common interventions were (categories ‘always’ and ‘often’): believing the woman’s story (93%; n = 434/466), documentation of the woman’s story about the act of violence and her injuries (86%; n = 395/460), and encouraging the woman to report the offence to the police (86%; n = 396/462).

Twenty-five per cent of the ED professionals (n = 115/457) reported drawing ‘always’ or ‘often’ a plan of aftercare together with the woman.

Sixty-four per cent of the professionals (n = 297/467) reported having ‘always’ or ‘often’ helped the woman to plan her own safety (e.g. by giving oral advice and/or written information) for similar dangerous situations in the future.

Sixty-seven per cent of the professionals (n = 310/464) reported that the woman had ‘always’ or ‘often’ been given an opportunity to stay overnight at the ED if needed, even if the type of the injuries had not required it (e.g. if the woman had been drunk, she could sleep off before the situation was settled any further).

Seventy-two per cent of the ED professionals (n = 336/464) ticked ‘Always’ or ‘Often’ for the statement ‘I have supported the woman in seeking outside help (e.g. by telling her about shelters and other possible help providers as necessary’).

Forty-five per cent of the ED professionals (n = 210/466) reported that they had always reviewed the women’s family situation (e.g. number and age of underage children at home), but only 12% of them (n = 55/457) had always discussed with the women about how to protect their children in a violent situation.

One nurse described her feelings when facing a child with her mother at the ED:

‘It was a very awkward situation. The woman had a 12-year-old daughter with her. It was she who explained what had happened at home. In a way the daughter took the role of an adult in that situation’ (Nurse no. 14).

Forty-two per cent of the professionals (n = 193/455) reported having ‘always’ talked with the women in private even if these had been brought in by their perpetrators.

Only 12 professionals out of 460 (3%) reported having ‘always’ helped the women’s perpetrators by giving them written/oral information on how to stop violent behaviour (e.g. by referring them to men’s discussion groups). Twenty professionals did not answer this question (4%). On the other hand, 43% of the ED professionals reported having encountered perpetrators on the whole once a year or less often (question 14).

Two interviewees expressed their feelings about helping the perpetrators in the following way:
‘Then I felt terribly bad. Of course, this man regretted what he had done. I advised him to turn to the social and crisis services. The situation was in a way terribly conflicting... both parties needed help... this man received a little more sympathy in this situation.’ (Nurse no. 14)

‘It does not always need to be so that the abused woman leaves home. The man needs help, too... he does have a possibility to seek care. I would give them leaflets. Of course it all depends on the man’s behaviour.’ (Nurse no. 10)
I have ascertained women's family situation, e.g. the number and age of children at home
I have not asked about the act of violence, if women spontaneously have not told about it
I have talked privately with women although their perpetrator has escorted them to care
I have encouraged women to report an offence to the police
I have believed women when talking about their experiences of violence
I have made a plan of aftercare together with women

Figure 16a. Interventions carried out by ED professionals (n = 455-466) caring for women exposed to IPV (statements 1-6)
I have documented women's stories about the act of violence and their injuries to the plan of care. I have discussed with women how to protect their children in a violent situation. Women have had an option to stay overnight at the emergency unit. I have also helped perpetrators by giving them written/oral information to stop their violent behaviour. Women have had an option to stay overnight at the emergency unit. I have discussed with women how to protect their children in a violent situation. I have helped women to plan their own safety e.g. by giving written/oral information and advice. I have supported women in seeking help e.g. by telling them about shelters.

Figure 16b. Interventions carried out by ED professionals (n = 457-467) caring for women exposed to IPV (statements 7-12)
For cross-tabulation the categories of the statements were collapsed into two categories of responses: ‘Always or often’ and ‘Now and then or never’. These two groups were compared to the ED professionals’ backgrounds. The Pearson Chi-Square test (2-sided) was used to test significance. Tables 10 through 20 present only those findings that have produced a significant difference (p < 0.05).

Statement number two, ‘believing the woman when she talks about her experience of violence’, had no association with any of the ED professionals’ backgrounds.

IPV training had an association with many (8 out 12) statements used by the ED professionals studied. The more they had had training, the more often they reported ‘Always’ or ‘Often’ to the statements. However, no association was found with believing the woman’s experience of violence (p = 0.789), asking her about violence (p = 0.331), her opportunity to stay overnight at the ED (p = 0.778) or documentation of the woman’s story of the act of violence and her injuries in the care plan (p = 0.746) (Tables 10 through 20).

Gender or personal history of violence had no association with any of the statements.

---

**Association between ED professionals’ backgrounds and making a plan of aftercare together with women exposed to IPV**

Those ED professionals, who worked in a district hospital or health centre, as well as those who had received IPV/DV training, reported having more often made a plan of aftercare together with the woman (Table 10).

<table>
<thead>
<tr>
<th>Table 10. Association between ED professional’s backgrounds and drawing aftercare plans together with the women exposed to IPV</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have drawn a plan of aftercare together with the woman exposed to IPV</td>
</tr>
<tr>
<td>Background</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>Organization</td>
</tr>
<tr>
<td>University hospital (n = 148)</td>
</tr>
<tr>
<td>Central hospital (n = 166)</td>
</tr>
<tr>
<td>District hospital/health centre (n = 142)</td>
</tr>
<tr>
<td>IPV/DV training received</td>
</tr>
<tr>
<td>Yes (n = 153)</td>
</tr>
<tr>
<td>No (n = 302)</td>
</tr>
</tbody>
</table>
Association between ED professionals’ backgrounds and encouraging women exposed to IPV to report the offences

The nurses had encouraged women exposed to IPV to report the offences to the police more often than practical nurses or emergency medical technicians had. Those ED professionals who had received training on IPV/DV had encouraged the woman more often than those without IPV/DV training (Table 11).

Table 11. Association between ED professionals’ backgrounds and encouraging the women exposed to IPV to report the offences to the police

<table>
<thead>
<tr>
<th>Background</th>
<th>I have encouraged women to report the offence to the police</th>
<th>Significance test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Always or often</td>
<td>Now and then or never</td>
</tr>
<tr>
<td>Occupation</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Nurse (n = 378)</td>
<td>88</td>
<td>12</td>
</tr>
<tr>
<td>Practical nurse/emergency medical technician (n = 89)</td>
<td>78</td>
<td>22</td>
</tr>
<tr>
<td>IPV/DV training received</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes (n = 153)</td>
<td>91</td>
<td>9</td>
</tr>
<tr>
<td>No (n = 307)</td>
<td>83</td>
<td>17</td>
</tr>
</tbody>
</table>

Association between ED professionals’ backgrounds and talking to the women in private

Those ED professionals who had a general education of upper secondary school, or a university-level professional education, or a nurse’s occupation, or had received training on IPV/DV, reported having talked to the women in private more often than those without such backgrounds (Table 12).
### Table 12. **Association between ED professionals’ backgrounds and talking with the women in private**

<table>
<thead>
<tr>
<th>Background</th>
<th>Always or often</th>
<th>Now and then or never</th>
<th>Significance -test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>χ²</td>
</tr>
<tr>
<td><strong>General education</strong></td>
<td></td>
<td></td>
<td>df</td>
</tr>
<tr>
<td>Less than upper secondary school (n = 200)</td>
<td>59</td>
<td>41</td>
<td></td>
</tr>
<tr>
<td>Upper secondary school (n = 253)</td>
<td>71</td>
<td>29</td>
<td>6.752</td>
</tr>
<tr>
<td><strong>Professional education</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than post secondary level (n = 67)</td>
<td>52</td>
<td>48</td>
<td></td>
</tr>
<tr>
<td>Post secondary level (n = 259)</td>
<td>68</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>Polytechnic or university degree (n = 129)</td>
<td>70</td>
<td>30</td>
<td>6.746</td>
</tr>
<tr>
<td><strong>Occupation</strong></td>
<td></td>
<td></td>
<td>df</td>
</tr>
<tr>
<td>Nurse (n = 367)</td>
<td>69</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>Practical nurse/ emergency medical technician (n = 88)</td>
<td>55</td>
<td>46</td>
<td>6.300</td>
</tr>
<tr>
<td><strong>IPV/DV training received</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes (n = 151)</td>
<td>73</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>No (n = 302)</td>
<td>62</td>
<td>38</td>
<td>5.021</td>
</tr>
</tbody>
</table>

**Association between ED professionals’ backgrounds and asking the women exposed to IPV about violence**

ED professionals who had more often not asked the women about the acts of violence if the women had not spontaneously told about it had the following properties: they were over 38 years old, had a general education lower than upper secondary school, had received their qualifications before 1991, had a work experience of over 11 years, had been on the current job for over six years, or had not experienced any IPV against an acquaintance or a relative (Table 13).
### Table 13. Association between ED professionals’ backgrounds and asking women exposed to IPV about the acts of violence

<table>
<thead>
<tr>
<th>Background</th>
<th>I have not asked the woman about the act of violence if she has not spontaneously talked about it</th>
<th>% Always or often</th>
<th>% Now and then or never</th>
<th>Significance test</th>
<th>$\chi^2$</th>
<th>df</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19-38 (n = 234)</td>
<td></td>
<td>2</td>
<td>98</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over 38 years (n = 229)</td>
<td></td>
<td>11</td>
<td>89</td>
<td></td>
<td>15.670</td>
<td>1</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>General education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than upper secondary school (n = 206)</td>
<td></td>
<td>10</td>
<td>90</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upper secondary school (n = 255)</td>
<td></td>
<td>3</td>
<td>97</td>
<td></td>
<td>8.626</td>
<td>1</td>
<td>0.003</td>
</tr>
<tr>
<td>Graduation year</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1961-1990 (n = 202)</td>
<td></td>
<td>9</td>
<td>91</td>
<td></td>
<td>5.171</td>
<td>1</td>
<td>0.023</td>
</tr>
<tr>
<td>After 1990 (n = 261)</td>
<td></td>
<td>4</td>
<td>96</td>
<td></td>
<td>5.171</td>
<td>1</td>
<td>0.023</td>
</tr>
<tr>
<td>Work experience</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.25-11 years (n = 232)</td>
<td></td>
<td>3</td>
<td>97</td>
<td></td>
<td>7.853</td>
<td>1</td>
<td>0.005</td>
</tr>
<tr>
<td>Over 11 years (n = 226)</td>
<td></td>
<td>9</td>
<td>91</td>
<td></td>
<td>7.853</td>
<td>1</td>
<td>0.005</td>
</tr>
<tr>
<td>Working on current job</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.1-6 years (n = 230)</td>
<td></td>
<td>4</td>
<td>96</td>
<td></td>
<td>5.310</td>
<td>1</td>
<td>0.021</td>
</tr>
<tr>
<td>Over 6 years (n = 233)</td>
<td></td>
<td>9</td>
<td>91</td>
<td></td>
<td>5.310</td>
<td>1</td>
<td>0.021</td>
</tr>
<tr>
<td>Experience of personal IPV or against an acquaintance or a relative</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes (n = 300)</td>
<td></td>
<td>5</td>
<td>95</td>
<td></td>
<td>4.126</td>
<td>1</td>
<td>0.042</td>
</tr>
<tr>
<td>No (n = 145)</td>
<td></td>
<td>10</td>
<td>90</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Association between ED professionals’ backgrounds and looking into the family situations of women exposed to IPV**

ED professionals who reported looking into the women’s family situations (e.g. the number and age of underage children at home) more often were nurses, worked at a district hospital or health centre, were in part-time employment, or had received IPV/DV training (Table 14).
Table 14. Association between backgrounds of ED professionals and looking into the family situations of women exposed to IPV

<table>
<thead>
<tr>
<th>Background</th>
<th>I have looked into the family situation of the women exposed to IPV, e.g. the number and age of underage children at home</th>
<th>Significance test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Always or often</td>
<td>Now and then or never</td>
</tr>
<tr>
<td>Occupation</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Nurse (n = 375)</td>
<td>77</td>
<td>23</td>
</tr>
<tr>
<td>Practical nurse/ emergency medical technician (n = 91)</td>
<td>67</td>
<td>33</td>
</tr>
<tr>
<td>Organization</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>University hospital (n = 154)</td>
<td>74</td>
<td>26</td>
</tr>
<tr>
<td>Central hospital (n = 166)</td>
<td>67</td>
<td>33</td>
</tr>
<tr>
<td>District hospital/health centre (n = 145)</td>
<td>85</td>
<td>15</td>
</tr>
<tr>
<td>Working hours</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Full-time work (n = 430)</td>
<td>74</td>
<td>26</td>
</tr>
<tr>
<td>Part-time work (n = 35)</td>
<td>91</td>
<td>9</td>
</tr>
<tr>
<td>IPV/DV training received</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Yes (n = 156)</td>
<td>84</td>
<td>16</td>
</tr>
<tr>
<td>No (n = 308)</td>
<td>70</td>
<td>30</td>
</tr>
</tbody>
</table>

Association between ED professionals' backgrounds and helping women exposed to IPV to plan their own safety

ED professionals who reported more often helping the women to plan for their own safety (e.g. by giving oral advice and/or written information for similar dangerous situations in the future) had a post-secondary level professional education, worked at a district hospital or health centre, were part of an organization with less than 61 employees, were permanently employed, or had received IPV/DV training (Table 15).
### Table 15. Association between ED professionals’ backgrounds and helping women exposed to IPV to plan for their own safety

<table>
<thead>
<tr>
<th>Background</th>
<th>%</th>
<th>%</th>
<th>Significance test</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Professional education</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than post secondary level (n = 71)</td>
<td>59</td>
<td>41</td>
<td></td>
</tr>
<tr>
<td>Post secondary level (n = 263)</td>
<td>70</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Polytechnic or university degree (n = 133)</td>
<td>54</td>
<td>46</td>
<td>9.817</td>
</tr>
<tr>
<td><strong>Organization</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>University hospital (n = 155)</td>
<td>57</td>
<td>43</td>
<td></td>
</tr>
<tr>
<td>Central hospital (n = 166)</td>
<td>61</td>
<td>39</td>
<td></td>
</tr>
<tr>
<td>District hospital/health centre (n = 145)</td>
<td>73</td>
<td>27</td>
<td>8.557</td>
</tr>
<tr>
<td><strong>Size of staff</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-60 persons (n = 249)</td>
<td>68</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>Over 60 persons (n = 213)</td>
<td>58</td>
<td>42</td>
<td></td>
</tr>
<tr>
<td><strong>Employment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Permanent (n = 341)</td>
<td>67</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>Temporary (n = 126)</td>
<td>55</td>
<td>45</td>
<td></td>
</tr>
<tr>
<td><strong>IPV/DV training received</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes (n = 155)</td>
<td>75</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>No (n = 310)</td>
<td>57</td>
<td>43</td>
<td>14.539</td>
</tr>
</tbody>
</table>

I have helped the woman exposed to IPV to plan her own safety, e.g. by giving oral advice and/or written information:

Always or often: %
Now and then or never: %

### Association between ED professionals’ backgrounds and supporting women in seeking outside help

ED professionals studied who reported more often supporting women exposed to IPV in seeking outside help (for example by telling her about shelters and other possible help providers) worked at a district hospital or health centre, were part of an organization with less than 61 persons or had received IPV/DV training (Table 16).
Table 16. Association between ED professionals’ backgrounds and supporting women in seeking outside help

<table>
<thead>
<tr>
<th>Background</th>
<th>% Always or often</th>
<th>% Now and then or never</th>
<th>Significance test</th>
<th>(\chi^2)</th>
<th>df</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organization</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>University hospital (n = 153)</td>
<td>67</td>
<td>33</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central hospital (n = 166)</td>
<td>72</td>
<td>28</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>District hospital/health centre (n = 144)</td>
<td>80</td>
<td>20</td>
<td>6.589</td>
<td>2</td>
<td></td>
<td>0.037</td>
</tr>
<tr>
<td>Size of staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-60 persons (n = 248)</td>
<td>76</td>
<td>24</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over 60 persons (n = 211)</td>
<td>67</td>
<td>33</td>
<td>4.502</td>
<td>1</td>
<td></td>
<td>0.034</td>
</tr>
<tr>
<td>IPV/DV training received</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes (n = 155)</td>
<td>83</td>
<td>17</td>
<td>13.916</td>
<td>1</td>
<td></td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>No (n = 307)</td>
<td>67</td>
<td>33</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Association between ED professionals’ backgrounds and offering help services to perpetrators

ED professionals who reported more often helping the perpetrator by giving him written/oral information to stop violent behaviour (e.g. by referring them to men’s discussion groups) were over 38 years old, had a lower than post-secondary level professional education, had received their qualifications before 1991, had a work experience of over 11 years, whose duration of work in current job was over six years, who was a permanent employee, had received IPV/DV training at some point, or had received training on IPV/DV more than once (Table 17).
<table>
<thead>
<tr>
<th>Background</th>
<th>Always or often</th>
<th>Now and then or never</th>
<th>Significance test</th>
<th>( \chi^2 )</th>
<th>df</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19-38 (n = 237)</td>
<td>4</td>
<td>96</td>
<td></td>
<td>14.773</td>
<td>1</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Over 38 years (n = 223)</td>
<td>14</td>
<td>86</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than post secondary level (n = 69)</td>
<td>13</td>
<td>87</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post secondary level (n = 259)</td>
<td>10</td>
<td>90</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polytechnic or university degree (n = 132)</td>
<td>4</td>
<td>96</td>
<td></td>
<td>6.236</td>
<td>2</td>
<td>0.044</td>
</tr>
<tr>
<td>Graduation year</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1961-1990 (n = 198)</td>
<td>15</td>
<td>85</td>
<td></td>
<td>15.505</td>
<td>1</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>After 1990 (n = 262)</td>
<td>4</td>
<td>96</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work experience</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.25-11 years (n = 235)</td>
<td>4</td>
<td>96</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over 11 years (n = 222)</td>
<td>14</td>
<td>86</td>
<td></td>
<td>14.680</td>
<td>1</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Working on current job</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.1-6 years (n = 231)</td>
<td>5</td>
<td>95</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over 6 years (n = 239)</td>
<td>12</td>
<td>88</td>
<td></td>
<td>7.163</td>
<td>1</td>
<td>0.007</td>
</tr>
<tr>
<td>Employment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Permanent (n = 334)</td>
<td>11</td>
<td>89</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temporary (n = 126)</td>
<td>4</td>
<td>96</td>
<td></td>
<td>4.885</td>
<td>1</td>
<td>0.027</td>
</tr>
<tr>
<td>IPV/DV training received</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes (n = 154)</td>
<td>15</td>
<td>85</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No (n = 304)</td>
<td>6</td>
<td>94</td>
<td></td>
<td>11.194</td>
<td>1</td>
<td>0.001</td>
</tr>
<tr>
<td>Amount of IPV/DV training received</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Once (n = 76)</td>
<td>7</td>
<td>93</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Twice or more often (n = 72)</td>
<td>19</td>
<td>81</td>
<td></td>
<td>5.469</td>
<td>1</td>
<td>0.019</td>
</tr>
</tbody>
</table>
Association between ED professionals’ backgrounds and offering the women an opportunity to stay overnight

ED professionals who worked in an organization with less than 61 employees reported more often offering an opportunity to stay overnight at the ED if necessary, even if it had not been called for by the type of the woman’s injuries (Table 18).

Table 18. Association between ED professionals’ backgrounds and offering women exposed to IPV an opportunity to stay overnight

<table>
<thead>
<tr>
<th>Background</th>
<th>The woman has been given an opportunity to stay overnight at the ED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Always or often</td>
</tr>
<tr>
<td>Size of staff</td>
<td>%</td>
</tr>
<tr>
<td>1-60 people ( (n = 249) )</td>
<td>72</td>
</tr>
<tr>
<td>Over 60 people ( (n = 210) )</td>
<td>60</td>
</tr>
</tbody>
</table>

Association between ED professionals’ backgrounds and discussions with women exposed to IPV on how to protect their children

ED professionals who had more often discussed with the women how to protect their children in a violent situation were over 38 years old, had received their qualifications before 1991, had a work experience of more than 11 years, had been on the current job for over six years, were permanently employed, did other working hours than working hours three-shift work, or had received IPV/DV training (Table 19).
Table 19. Association between ED professionals’ backgrounds and discussions with women exposed to IPV on how to protect her children

<table>
<thead>
<tr>
<th>Background</th>
<th>Always or often</th>
<th>Now and then or never</th>
<th>Significance test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>χ²</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19-38 (n = 235)</td>
<td>29</td>
<td>71</td>
<td></td>
</tr>
<tr>
<td>Over 38 years (n = 222)</td>
<td>41</td>
<td>59</td>
<td>8.413</td>
</tr>
<tr>
<td>Graduation year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1961-1990 (n = 198)</td>
<td>42</td>
<td>58</td>
<td></td>
</tr>
<tr>
<td>After 1990 (n = 259)</td>
<td>29</td>
<td>71</td>
<td>7.822</td>
</tr>
<tr>
<td>Work experience</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.25-11 years (n = 230)</td>
<td>27</td>
<td>73</td>
<td></td>
</tr>
<tr>
<td>Over 11 years (n = 222)</td>
<td>42</td>
<td>58</td>
<td>11.139</td>
</tr>
<tr>
<td>Working on current job</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.1-6 years (n = 227)</td>
<td>26</td>
<td>74</td>
<td></td>
</tr>
<tr>
<td>Over 6 years (n = 230)</td>
<td>44</td>
<td>56</td>
<td>15.399</td>
</tr>
<tr>
<td>Employment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Permanent (n = 334)</td>
<td>40</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>Temporary (n = 123)</td>
<td>21</td>
<td>79</td>
<td>13.380</td>
</tr>
<tr>
<td>Type of working hours</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Three-shift work (n = 386)</td>
<td>32</td>
<td>68</td>
<td></td>
</tr>
<tr>
<td>Other type of working hours (n = 71)</td>
<td>51</td>
<td>49</td>
<td>9.381</td>
</tr>
<tr>
<td>IPV/DV training received</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes (n = 151)</td>
<td>43</td>
<td>57</td>
<td></td>
</tr>
<tr>
<td>No (n = 304)</td>
<td>31</td>
<td>69</td>
<td>6.904</td>
</tr>
</tbody>
</table>

Association between ED professionals’ backgrounds and documentation of violent acts against and injuries of women exposed to IPV

ED professionals who reported more often having documented the women’s stories of the acts of violence and their injuries recorded in the care plan were nurses, worked at a district hospital/health centre, or had been on the current job for less than seven years (Table 20).
Table 20. Association between ED professionals’ backgrounds and documentation of violent acts against and injuries of women exposed to IPV

<table>
<thead>
<tr>
<th>Background</th>
<th>Always or often %</th>
<th>Now and then or never %</th>
<th>Significance test</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Occupation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse (n = 369)</td>
<td>87</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Practical nurse/ emergency medical technician</td>
<td>79</td>
<td>21</td>
<td>4.258</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Organization</td>
<td></td>
<td></td>
<td>0.039</td>
</tr>
<tr>
<td>University hospital (n = 151)</td>
<td>85</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Central hospital (n = 164)</td>
<td>82</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>District hospital/health centre (n = 144)</td>
<td>92</td>
<td>8</td>
<td>6.469</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Working on current job</td>
<td></td>
<td></td>
<td>0.039</td>
</tr>
<tr>
<td>0.1-6 years (n = 228)</td>
<td>89</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Over 6 years (n = 232)</td>
<td>82</td>
<td>18</td>
<td>4.840</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>0.028</td>
</tr>
</tbody>
</table>

5.4.4 ED professionals’ views on attitudes, beliefs and practices related to caring for women exposed to IPV

The ED professionals’ views on attitudes, believes and practices were measured through ten statements with a five-point response scale of ‘Fully agree’, ‘Partly agree’, ‘Partly disagree’, ‘Fully disagree’ and ‘I cannot say’ (Appendix 10, question 22). The distribution of the views of the ED professionals, were illustrated by a median. The smaller the value of the median for a statement was, the more the ED professionals had agreed with that statement. The upper and lower quartiles were used as measures of dispersion. The wider the quartile range (Q3 – Q1), the greater the dispersion of the professionals’ views was. The professionals' views and the percentages (%) of participants reporting those views are listed in Appendix 13.

Each statement represents a potential disadvantage in caring for the women. For example, agreement with the statement ‘IPV is a private matter for the woman and I do not intervene. I only take the necessary measures for care’ can be a disadvantage in effective intervention in the woman’s situation and providing support for her. Figure 17 presents the distribution of the given statements.
The distribution of views concerning attitudes, beliefs and practices related to caring for women exposed to IPV showed that 67% of the ED professionals (n = 318/470) reported having an opportunity to consult other help providers outside office hours in cases of IPV (‘Fully agree’ or ‘Partly agree’).

Almost all ED professionals, or 94% (n = 454/477), fully agreed that IPV was never justified. Forty-nine per cent of the ED professionals (n = 232/474) reported (‘Fully agree’ or ‘Partly agree’) that their work community lacked written, commonly agreed procedures on how to help the women exposed to IPV. Fifty-seven per cent of the professionals (268/470) ‘fully agreed’ or ‘partly agreed’ that co-operation with different help providers was good.

Eight per cent of the ED professionals (n = 39/477) thought (‘Fully agree’ or ‘Partly agree’) that IPV was a private matter for the woman and they would not intervene. They would only take the necessary measures for care (treatment of the physical injuries, e.g. stitching cuts). One interviewee described the matter in the following way:

‘In the ED we primarily treat the physical injuries...I think that there is very little treatment available in the ED for the patient’s mental or social problems. The woman is somewhere here in the ED and a doctor agrees on aftercare with her...a nurse has no contact with the woman. Basically, it’s not important for me who takes care of the patient. To be completely honest, I have never given those brochures to anyone’ (Nurse no.5).

Fifty-three per cent of the professionals (n = 253/476) fully or partly agreed that they did not know enough places for aftercare where they could refer women exposed to IPV. Thirteen per cent of the ED professionals (n = 59/469) felt that the IPV had been due to the woman’s own behaviour (‘Fully agree’ or ‘Partly agree’). Eighty-six per cent of the professionals (n = 404/474) fully or partly agreed with the statement ‘The assaulted woman has a right to return to her perpetrator after receiving first aid, if she wants’.

A majority of the ED professionals, 89% (n = 431/478), fully agreed that an assault within a family was a crime which always had to be taken seriously. Thirty-five per cent of the ED professionals (n = 168/469) reported that the staff had discussed the women who had experienced IPV and they had also discussed possible methods to help them (e.g. within nursing teams and at meetings or at department meetings) (‘Fully agree’ or ‘Partly agree’).
Our work community has discussed the women, who have experienced IPV and considered methods to help them.

A violent act which happens within a family is a crime, which shall always be taken seriously.

Women exposed to IPV have a right to return to their perpetrator if they want, after receiving first aid.

In my opinion IPV is a consequence of the woman's own behaviour.

I know too few places for aftercare where I can refer women.

IPV is a private matter of women and I do not intervene. I give only necessary care.

Co-operation with different help providers is good.

We have lack of agreed, written procedures on how to help the women exposed to IPV.

IPV is never justified.

Outside office hours I have an option to consult other help providers in the case of an IPV.

Our work community has discussed the women, who have experienced IPV and considered methods to help them.

Figure 17. Views on attitudes, beliefs and practices related to caring for women exposed to IPV as reported by ED professionals (n = 469-478)
For cross-tabulation of the statements under question 22 with each other, the categories for these statements were collapsed into two categories of response: ‘agree’ (Fully agree and Partly agree) and ‘disagree’ (Partly disagree, Fully disagree, and I cannot say). The Pearson Chi-Square test (2-sided) was used to test significance. The only finding that produced a significant difference ($p < 0.05$) was the statement ‘Our work community does not have any written, jointly agreed procedures on how to help those who have experienced IPV’ in relation to the statement ‘The staff has discussed the women who have experienced IPV and considered methods to help them (e.g. within nursing teams and at meetings or at department meetings)’: Those professionals who reported a lack of procedures had discussed IPV with the women less than those who did not report such lack (24% versus 47%; $\chi^2 = 25.299; \text{df} = 1; p < 0.001$).

Association between the interventions and the attitudes, beliefs and practices of ED professionals

Association between the interventions and the attitudes, beliefs and practices of the professionals was examined by cross-tabulating the ED professionals’ interventions (question 21) with the statements concerning attitudes, beliefs and practices (question 22). The categories for the statements were collapsed into two categories of responses: ‘Agree’ (from ‘Fully agree’ and ‘Partly agree’) and ‘disagree’ (from ‘Partly disagree’, ‘Fully disagree’ and ‘I cannot say’). These two categories were compared with the two categories of interventions that the professionals reported having carried out; the first category includes ‘Always’ and ‘Often’ and the second category includes ‘Now and then’ and ‘Never’. The Pearson Chi-Square test (2-sided) was used to test significance. Only those findings that produced a significant difference ($p < 0.05$) are presented here.

Interventions related to the statement ‘I have looked into the woman's family situation (e.g. the number and age of underage children at home)’ had association with three different statements about attitudes, beliefs and practices. First, those professionals who agreed that they had an opportunity to consult other help providers outside office hours (e.g. social services or crisis services on emergency duty) in the case of IPV, reported more often that they had done that particular intervention than those who disagreed. Second, those professionals who agreed that co-operation with different help providers was good, reported more often that they had carried out that intervention than those who disagreed. Third, those professionals who disagreed that they did not know enough places for aftercare where they could refer women, reported more often that they had carried out that intervention than those who agreed (Table 21).
Table 21. Association between practices and looking into the family situations of women exposed to IPV

<table>
<thead>
<tr>
<th>Practice</th>
<th>Always or often %</th>
<th>Now and then/never %</th>
<th>Significance test</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have an opportunity to consult other help providers outside office hours in cases of IPV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree (n = 312)</td>
<td>79</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>Disagree (n = 149)</td>
<td>67</td>
<td>33</td>
<td>7.870 1 0.005</td>
</tr>
<tr>
<td>Co-operation with different help providers is good</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree (n = 264)</td>
<td>79</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>Disagree (n = 195)</td>
<td>70</td>
<td>30</td>
<td>4.886 1 0.027</td>
</tr>
<tr>
<td>I do not know enough places for aftercare where I can refer women</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree (n = 248)</td>
<td>71</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td>Disagree (n = 217)</td>
<td>81</td>
<td>19</td>
<td>6.318 1 0.012</td>
</tr>
</tbody>
</table>

Intervention concerning both the statement ‘I have supported the woman in seeking outside help (e.g. by telling her about shelters and other possible help providers as necessary)’ and the statement ‘I have also helped the perpetrator by giving him written/oral information on stopping the violent behaviour (e.g. by referring him to men’s discussion groups)’ had association with three statements of practices. Firstly, those professionals who disagreed that their work community lacked written, commonly agreed procedures on how to help women exposed to IPV, reported more often that they had carried out those interventions than those who agreed. Secondly, those professionals who agreed that co-operation with different help providers worked well, reported more often that they had carried out those interventions than those who disagreed. Thirdly, those professionals who disagreed that they did not know enough places for aftercare where they could refer women exposed to IPV, reported more often that they had carried out those interventions than those who agreed (Tables 22 and 23).
Table 22. *Association between practices and supporting women in seeking outside help*

<table>
<thead>
<tr>
<th>Practice</th>
<th>Always or often</th>
<th>Now and then or never</th>
<th>Significance test</th>
<th>( \chi^2 )</th>
<th>df</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have supported women exposed to IPV in seeking outside help (e.g. told them about shelters and other possible help providers required)</td>
<td></td>
<td></td>
<td>( \chi^2 )</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Our work community lacks written, commonly agreed procedures on how to help the woman exposed to IPV.</td>
<td></td>
<td></td>
<td>( \chi^2 )</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree (n = 225)</td>
<td>68</td>
<td>32</td>
<td>4.704</td>
<td>1</td>
<td>0.030</td>
<td></td>
</tr>
<tr>
<td>Disagree (n = 235)</td>
<td>77</td>
<td>23</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Co-operation with different help providers works well</td>
<td></td>
<td></td>
<td>( \chi^2 )</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree (n = 262)</td>
<td>76</td>
<td>24</td>
<td>4.289</td>
<td>1</td>
<td>0.038</td>
<td></td>
</tr>
<tr>
<td>Disagree (n = 195)</td>
<td>67</td>
<td>33</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I do not know enough places for aftercare where I can refer women</td>
<td></td>
<td></td>
<td>( \chi^2 )</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree (n = 245)</td>
<td>65</td>
<td>35</td>
<td>12.718</td>
<td>1</td>
<td>&lt;0.001</td>
<td></td>
</tr>
<tr>
<td>Disagree (n = 217)</td>
<td>80</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 23. *Association between practices and offering help services to perpetrators*

<table>
<thead>
<tr>
<th>Practice</th>
<th>Always or often</th>
<th>Now and then or never</th>
<th>Significance test</th>
<th>( \chi^2 )</th>
<th>df</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have also helped the perpetrator by giving him written/oral information to stop violent behaviour (e.g. by referring to men’s discussion groups)</td>
<td></td>
<td></td>
<td>( \chi^2 )</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Our work community lacks agreed, written, commonly agreed procedures on how to help the woman exposed to IPV</td>
<td></td>
<td></td>
<td>( \chi^2 )</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree (n = 224)</td>
<td>5</td>
<td>95</td>
<td>10.209</td>
<td>1</td>
<td>0.001</td>
<td></td>
</tr>
<tr>
<td>Disagree (n = 232)</td>
<td>13</td>
<td>87</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Co-operation with different help providers works well</td>
<td></td>
<td></td>
<td>( \chi^2 )</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree (n = 259)</td>
<td>11</td>
<td>89</td>
<td>5.147</td>
<td>1</td>
<td>0.023</td>
<td></td>
</tr>
<tr>
<td>Disagree (n = 194)</td>
<td>5</td>
<td>95</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I do not know enough places for aftercare where I can refer women</td>
<td></td>
<td></td>
<td>( \chi^2 )</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree (n = 244)</td>
<td>5</td>
<td>95</td>
<td>7.511</td>
<td>1</td>
<td>0.006</td>
<td></td>
</tr>
<tr>
<td>Disagree (n = 215)</td>
<td>13</td>
<td>87</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Interventions related to the statement ‘I have drawn aftercare plans together with the women exposed to IPV’ had an association with a statement: those ED professionals who agreed that co-operation with different help providers worked well, reported more often that they had carried out intervention than those professionals who disagreed. The significant difference was 29% versus 20% ($\chi^2 = 5.039; df = 1; p = 0.025$).

Those ED professionals studied, who agreed that they had an opportunity to consult other help providers outside office hours (e.g. social services or crisis services on emergency duty) in the case of IPV, also had more often than those who disagreed talked to the women in private even if they had been brought to the ED by their perpetrators (69% versus 60%; $\chi^2 = 13.580; df = 1; p = 0.039$). Also those professionals who agreed that co-operation with different help providers worked well, had more often than those who disagreed it talked in private to the women exposed to IPV (71% versus 60%; $\chi^2 = 5.195; df = 1; p = 0.023$).

Interventions related to the statement ‘I have helped the woman exposed to IPV to plan her own safety (e.g. by giving oral advice and/or written information for similar dangerous situations in the future)’ had association with two different statements of practices. Firstly, those professionals who disagreed that there was any lack of written, commonly agreed procedures on how to help women exposed to IPV, reported more often that they had carried out intervention than those who agreed (69% versus 58%; $\chi^2 = 5.842; df = 1; p = 0.016$). Secondly, those professionals who disagreed that they did not know enough places for aftercare where they could refer women, reported more often that they had carried out intervention than those who agreed (74% versus 55%; $\chi^2 = 17.396; df = 1; p < 0.001$).

Interventions related to the statement ‘I have discussed with the woman exposed to IPV how to protect her children in a violent situation’ had association with two different statements concerning practices. Firstly, those professionals who agreed that co-operation with different help providers was good, reported more often that they had carried out intervention than those who disagreed (39% versus 30%; $\chi^2 = 4.483; df = 1; p = 0.034$). Secondly, those professionals who disagreed that they did not know enough places for aftercare where they could refer women exposed to IPV, reported more often that they had carried out intervention than those who agreed (42% versus 29%; $\chi^2 = 8.085; df = 1; p = 0.004$).

Association between the backgrounds and the attitudes, beliefs and practices of ED professionals

For cross-tabulation of the ED professionals’ backgrounds with the statements under question 22, the categories for the responses were collapsed into two: ‘agree’ (from ‘Fully agree’ and ‘Partly agree’) and ‘disagree’ (from ‘Partly disagree’, ‘Fully disagree’ and ‘I cannot say’). These two groups were compared to the backgrounds of the ED professionals. The Pearson Chi-Square test (2-
sided) was used to test significance. Only those findings that produced a significant difference (p < 0.05) are presented here. (Tables 22 through 26).

Those ED professionals who worked at university hospitals or had received IPV/DV training more than once, had more often reported having an opportunity to consult other help providers (e.g. social services or crisis services on emergency duty) outside office hours in cases of IPV (Table 22).

ED professionals who reported more often a lack of written, commonly agreed procedures on how to help women exposed to IPV had a post-secondary level professional education, were permanently employed, had not received IPV/DV training, or had received training on IPV/DV only once (Table 23).

Those ED professionals who had received training on IPV/DV, more reported that co-operation with different help providers was good (Table 24).

ED professionals who reported more often that they did not know enough places for aftercare where they could refer women had an upper secondary school education, worked at a university hospital, or had not received IPV/DV training (Table 25).

ED professionals who reported that the staff had discussed women who have experienced IPV and they had discussed methods to help them (e.g. within nursing teams and at meetings or at department meetings) were over 38 years old, had a lower than post-secondary level professional education, worked as a practical nurse or emergency medical technician, had received their diplomas or degrees before 1991, had a work experience of over 11 years, worked at a district hospital or health centre, had been on the current job for over six years, had received IPV/DV training at some point, or had received training on IPV/DV more than once (Table 26).

Table 24. Association between backgrounds of ED professionals and their opportunity to consult other help providers outside office hours

<table>
<thead>
<tr>
<th>Background</th>
<th>I have an opportunity to consult other help providers outside office hours in cases of IPV</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Agree</td>
</tr>
<tr>
<td>Organization</td>
<td></td>
</tr>
<tr>
<td>University hospital (n = 155)</td>
<td>77</td>
</tr>
<tr>
<td>Central hospital (n = 168)</td>
<td>58</td>
</tr>
<tr>
<td>District hospital/health centre (n = 146)</td>
<td>69</td>
</tr>
<tr>
<td>Amount of IPV/DV training received</td>
<td></td>
</tr>
<tr>
<td>Once (n = 74)</td>
<td>58</td>
</tr>
<tr>
<td>Twice or more often (n = 74)</td>
<td>84</td>
</tr>
</tbody>
</table>
Table 25. Association between backgrounds of ED professionals and the lack of written, commonly agreed procedures concerning IPV

<table>
<thead>
<tr>
<th>Background</th>
<th>Agree</th>
<th>Disagree</th>
<th>Significance test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than post secondary level</td>
<td>41</td>
<td>59</td>
<td></td>
</tr>
<tr>
<td>(n = 69)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post secondary level (n = 270)</td>
<td>54</td>
<td>46</td>
<td>8.806 2 0.012</td>
</tr>
<tr>
<td>Polytechnic or university degree (n = 135)</td>
<td>41</td>
<td>59</td>
<td></td>
</tr>
<tr>
<td>Employment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Permanent (n = 343)</td>
<td>52</td>
<td>48</td>
<td>6.668 1 0.010</td>
</tr>
<tr>
<td>Temporary (n = 131)</td>
<td>39</td>
<td>61</td>
<td></td>
</tr>
<tr>
<td>IPV/DV training received</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes (n = 156)</td>
<td>33</td>
<td>67</td>
<td>21.534 1 &lt;0.001</td>
</tr>
<tr>
<td>No (n = 314)</td>
<td>56</td>
<td>44</td>
<td></td>
</tr>
<tr>
<td>Amount of IPV/DV training received</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Once (n = 75)</td>
<td>43</td>
<td>57</td>
<td>5.021 1 0.025</td>
</tr>
<tr>
<td>Twice or more often (n = 75)</td>
<td>25</td>
<td>75</td>
<td></td>
</tr>
</tbody>
</table>

Table 26. Association between backgrounds of ED professionals and co-operation with different help providers

<table>
<thead>
<tr>
<th>Background</th>
<th>Agree</th>
<th>Disagree</th>
<th>Significance test</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPV/DV training received</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes (n = 155)</td>
<td>67</td>
<td>33</td>
<td>9.509 1 0.002</td>
</tr>
<tr>
<td>No (n = 311)</td>
<td>52</td>
<td>48</td>
<td></td>
</tr>
</tbody>
</table>
Table 27. Association between backgrounds of ED professionals studied and knowledge of available aftercare

<table>
<thead>
<tr>
<th>Background</th>
<th>Agree</th>
<th>Disagree</th>
<th>Significance test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>χ²</td>
</tr>
<tr>
<td>General education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than upper secondary school (n = 208)</td>
<td>48</td>
<td>52</td>
<td></td>
</tr>
<tr>
<td>Upper secondary school (n = 266)</td>
<td>57</td>
<td>43</td>
<td>4.270</td>
</tr>
<tr>
<td>Organization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>University hospital (n = 158)</td>
<td>58</td>
<td>42</td>
<td></td>
</tr>
<tr>
<td>Central hospital (n = 169)</td>
<td>57</td>
<td>43</td>
<td></td>
</tr>
<tr>
<td>District hospital/health centre (n = 148)</td>
<td>43</td>
<td>57</td>
<td>8.693</td>
</tr>
<tr>
<td>IPV/DV training received</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes (n = 157)</td>
<td>39</td>
<td>61</td>
<td></td>
</tr>
<tr>
<td>No (n = 315)</td>
<td>60</td>
<td>40</td>
<td>18.808</td>
</tr>
</tbody>
</table>

Table 28. Association between backgrounds of ED professionals and group discussions in the work community on how to help the women who have experienced IPV

<table>
<thead>
<tr>
<th>Background</th>
<th>Agree</th>
<th>Disagree</th>
<th>Significance test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>χ²</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19-38 (n = 242)</td>
<td>29</td>
<td>71</td>
<td></td>
</tr>
<tr>
<td>Over 38 years (n = 227)</td>
<td>44</td>
<td>56</td>
<td>11.617</td>
</tr>
<tr>
<td>Professional education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than post secondary level (n = 70)</td>
<td>49</td>
<td>51</td>
<td></td>
</tr>
<tr>
<td>Post secondary level (n = 265)</td>
<td>37</td>
<td>63</td>
<td>8.949</td>
</tr>
<tr>
<td>Polytechnic or university degree (n = 134)</td>
<td>28</td>
<td>72</td>
<td></td>
</tr>
<tr>
<td>Occupation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse (n = 379)</td>
<td>34</td>
<td>66</td>
<td></td>
</tr>
<tr>
<td>Practical nurse/emergency medical technician (n = 90)</td>
<td>46</td>
<td>54</td>
<td>4.591</td>
</tr>
<tr>
<td>Graduation year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1961-1990 (n = 202)</td>
<td>47</td>
<td>53</td>
<td></td>
</tr>
<tr>
<td>After 1990 (n = 267)</td>
<td>28</td>
<td>72</td>
<td>17.716</td>
</tr>
</tbody>
</table>

(continued)
The staff has discussed women who have experienced IPV and considered methods to help them.

<table>
<thead>
<tr>
<th>Background</th>
<th>Agree</th>
<th>Disagree</th>
<th>Significance test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>χ²   df</td>
</tr>
<tr>
<td><strong>Work experience</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.25-11 years (n = 239)</td>
<td>28</td>
<td>72</td>
<td>13.999</td>
</tr>
<tr>
<td>Over 11 years (n = 226)</td>
<td>44</td>
<td>56</td>
<td></td>
</tr>
<tr>
<td><strong>Organization</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>University hospital (n = 154)</td>
<td>28</td>
<td>72</td>
<td>13.999</td>
</tr>
<tr>
<td>Central hospital (n = 169)</td>
<td>30</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>District hospital/health centre (n = 145)</td>
<td>51</td>
<td>49</td>
<td>21.098</td>
</tr>
<tr>
<td><strong>Working in current job</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.1-6 years (n = 235)</td>
<td>27</td>
<td>73</td>
<td>15.106</td>
</tr>
<tr>
<td>Over 6 years (n = 234)</td>
<td>44</td>
<td>56</td>
<td></td>
</tr>
<tr>
<td><strong>IPV/DV training received</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes (n = 154)</td>
<td>60</td>
<td>40</td>
<td>59.931</td>
</tr>
<tr>
<td>No (n = 311)</td>
<td>24</td>
<td>76</td>
<td></td>
</tr>
<tr>
<td><strong>Amount of IPV/DV training received</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Once (n = 75)</td>
<td>49</td>
<td>51</td>
<td>7.041</td>
</tr>
<tr>
<td>Twice or more often (n = 73)</td>
<td>71</td>
<td>29</td>
<td></td>
</tr>
</tbody>
</table>

**Responsibility to stop the violent behaviour**

The ED professionals were asked a question with a six-point response scale for their views on who had the primary responsibility for stopping the violent behaviour in IPV relationships. The alternatives were: the woman, the perpetrator (male partner), both parties (woman and perpetrator), ED professionals, other professionals (e.g. social workers), or somebody else, who had to be specified. The data were collapsed into seven responses: ‘No answer’, ‘The woman’, ‘The perpetrator’, ‘The woman and the perpetrator’, ‘Other professionals’, ‘Others’ and ‘Several alternatives were selected’.

Fifteen per cent of the ED professionals (n = 71/467) felt that the primary responsibility for stopping the violence lied with the woman alone. Thirty-one per cent of the ED professionals (n = 143/467) felt that it was up to the perpetrators to stop the violence. Forty per cent of the ED professionals studied (n = 188/467) were of the view that the responsibility lied with both the woman and the perpetrator. One per cent of the professionals (n = 6/467) answered ‘Other professionals’. Fifty-nine ED professionals studied (13%) had selected several alternatives (Figure 18, Appendix 10, question 30).

One ED professional who felt that it was up to the woman to stop the IPV said:
‘Of course in the end it’s up to the woman’s to stop the violence. A nurse can only give facts ... and we don’t know the situation at home. But in my opinion it’s the woman who decides... accepts help or does something else’ (Nurse no. 3).

![Graph showing responsibility for stopping violent behaviour as reported by ED professionals](image)

**Figure 18.** Responsibility for stopping the violent behaviour, as reported by ED professionals \( n = 467 \)

**Obstacles to intervention in IPV as reported by the ED professionals**

The ED professionals’ views on obstacles to interventions for IPV were measured through question 23. Each statement represented a potential obstacle to intervention in the women’s situation (Appendix 10).

The ED professionals were asked to arrange the statements in numerical order, so that the biggest obstacle for intervention was number one, the second biggest number two, and so on. Some professionals did not understand the question but had ticked the statements instead of numbering them, or had left part of the question unanswered. Only those answers that had been fully completed were included in this analysis.

For analysis, the statements in the frequency table were ranked as follows: The statement considered the most important by a respondent received eight points, the second seven points, and so on. One point was given to the statement that was considered the least obstacle to intervention. The statement that
received most points corresponded to 100%. For example, ‘I do not know enough about legal protection’, got 43% on the basis of the following calculations:

\[8 \times 9 + 7 \times 9 + 6 \times 13 + 5 \times 12 + 4 \times 42 + 3 \times 55 + 2 \times 87 + 1 \times 131 = 911\] points, which is 43% from 2123 points, which was the maximum value and equalled 100% (Figure 19).

The greatest obstacles according to the ED professionals were reflected by the statements: ‘The woman is unwilling to discuss her situation that involves violence’ (100%), ‘The woman’s drunkenness’ (100%), and ‘The woman will not admit that an act of violence has occurred’ (99%).

Eighty-four per cent of the mentions fell under the category ‘Lack of time to deal due to ‘The constant presence of the woman’s partner during care’. ‘The sensitivity of IPV prevents any discussion on the matter’ comprised 57% of the opinions. One informant reported her feelings in the following manner:

‘The biggest obstacle is getting close to the woman, because it’s not possible in an ED to ascertain exactly what is going on at home. Perhaps it’s also about trying to deal with this matter discreetly… we could listen to what the woman wants when she is seeking help. This would give us more courage to deal with the issue. However, it is a very intimate topic from the woman’s perspective’. (Nurse no. 15)

Another informant reported:

‘The most difficult thing is knowing how to ask about violence along the way without hurting the woman’s feelings and yet confirm my own suspicions. Some colleagues do not want to make the effort if they are not quite sure’. (Nurse no. 17)

Fifty per cent of all statements reflected the lack of a quiet space on the premises where to the professionals could have talked to the women alone and face to face. Forty-three per cent of the views expressed fell under the category ‘I do not have enough knowledge about matters related to the woman’s legal protection’. One informant described:

‘I must say that the entire legislation concerning IPV is quite unclear’. (Nurse no. 4).

In addition to the statements presented in Figure 19, the ED professionals had an opportunity to raise other issues that made it difficult to help women exposed to IPV.

In total, there were twelve mentions of such issues: ‘This is a difficult area to handle’ (2 mentions), ‘At work, co-operation with various help agencies is not good’ (2 mentions), ‘Usually, the women talk to the doctor in private’ (2 mentions), ‘The woman’s state of health is not good (confusion, intoxication)’,” If there is a real threat of physical violence, how should we act... how to protect a woman... how to encourage a woman to report the offence,’ The enormous

127
The number of these women has a numbing effect, ‘Very busy and several unfinished tasks concerning other patients’, and ‘The work community is not committed to the directions and the head nurse does not insist on following them’.

Figure 19. Obstacles to intervention in IPV as reported by ED professionals

Principles of care regarded as important by ED professionals

The ED professionals rated principles of care presented in the 9 statements under question 24 on a 4-point Likert scale. A rating of 1 denoted ‘Not at all important’, 2 denotes ‘A little important’, 3 denotes ‘Fairly important’ and 4 ‘Very important’. Because very few of the ED professionals had chosen ‘Not at all important’, this category was merged with the category ‘A little important’ (Figure 20; Appendix 10, question 24) for analysis.
As the figure shows the categories ‘Very important’ and ‘Fairly important’ add up to around 95% in almost every statement. Because the dispersion was so small, this question was a failure.

However, examining the category ‘Very important’, only 51% of the ED professionals (n = 246/480) put ‘Encouraging the woman to report the offence to the police’ to this category. The corresponding percentage for the statement ‘Confidential care relationship’ was 88% (n = 423/480). It is impossible to derive any other results from analysis of the answers to that question.

The ED professionals also had the possibility to report other principles of care that they regarded as important (statement no. 10). Four professionals felt that the whole family should have received help, and four professionals emphasized the importance of documenting the injuries (recording and photographing them). Three professionals stressed that the women had to be able to leave the hospital safely. Two professionals emphasized the importance of child protection. Listening to the women, giving them time, and respecting their privacy were regarded as important by the ED professionals (five mentions). Strengthening the women’s self-esteem, supporting their decisions, emphasizing professional confidentiality, expressing optimism, and maintaining honesty were attributes that described the professionals’ behaviour as they supported women exposed to IPV.
Figure 20. *Principles of care regarded as important by ED professionals*

**Other questions**

The ED professionals were asked about their assumptions as to where the women exposed to IPV went after leaving the ED. Forty-five per cent of the ED professionals (n = 208/461) believed that most of the women went to their homes and 44% of the ED professionals (n = 203/461) studied thought that most of the women went to the home of a friend or a relative. A third option mentioned was a shelter for battered women. Less frequent suggestions were going to some other health care department or to another care department in the same hospital, or going to a social worker or some other support organization (Appendix 10, question 25).
5.4.5 Abilities to support women exposed to IPV as reported by ED professionals

The ED professionals’ abilities to support women exposed to IPV were measured through questions 26-29 and 31 (Appendix 10).

Training received by ED professionals

Thirty-three per cent of the ED professionals (n = 158/480) had received training related to IPV and/or domestic violence (DV). Seventeen per cent (n = 82/480) of the professionals had received such training only once, while sixteen per cent (n = 76/480) had received IPV training 2-10 times.

The backgrounds of the ED professionals was compared against the training on IPV/DV they had received. The Pearson Chi-Square test (2-sided) was used to test significance. Only those findings that produced a significant difference (p < 0.05) are presented in this study.

ED professionals who had received training more often were those who had received their diplomas or degrees before 1991, had a work experience of over 11 years, worked at a district hospital/health centre, had been on the current job for over 6 years, or did working hours other than three-shift work (‘Other type’) (Table 29; Appendix 10, question 26).

Table 29. Association between backgrounds of ED professionals and the training on IPV or DV received

<table>
<thead>
<tr>
<th>Background</th>
<th>Received training on IPV or DV</th>
<th>Significance test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Graduation year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1961-1990 (n = 85)</td>
<td>41</td>
<td></td>
</tr>
<tr>
<td>After 1990 (n = 73)</td>
<td>27</td>
<td>10.229</td>
</tr>
<tr>
<td>Work experience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.25-11 years (n = 64)</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>Over 11 years (n = 93)</td>
<td>40</td>
<td>8.986</td>
</tr>
<tr>
<td>Organization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>University hospital (n = 44)</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>Central hospital (n = 46)</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>District hospital/health centre (n = 68)</td>
<td>46</td>
<td>16.274</td>
</tr>
<tr>
<td>Working in current job</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.1-6 years (n = 65)</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>Over 6 years (n = 93)</td>
<td>39</td>
<td>7.080</td>
</tr>
<tr>
<td>Type of working time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Three-shift work (n = 115)</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td>Other type of working time (n = 43)</td>
<td>58</td>
<td>24.528</td>
</tr>
</tbody>
</table>

131
There was no significant difference between male and female professionals in the amount of IPV training received (p = 0.709), but the 76 professionals who had received training twice or more often distributed differently: Seventy per cent (n = 21) of male professionals who had received IPV training, had received it twice or more often. Only 45% (n = 55) of those female professionals who had received IPV training, had received it twice or more often (70% versus 45%; \( \chi^2 = 5.980; df = 1; p = 0.014 \)) (Appendix 10, question 26).

Of those ED professionals who had received training, 33% reported that the training had been arranged by their own employer and 31% by other instances. Twenty-four per cent of the trained professionals had participated in both internal and external training. The remaining 13% of the professionals who answered this question had obtained information on violence during their professional education or from books. One participant wrote: ‘The information is available if you want it’ (question 27).

**ED professionals’ need for training on IPV**

When inquired through an open question about their need for training, 53% of the ED professionals (n = 249/480) suggested certain topics for training, which got a total of 278 mentions. The various themes were combined and summarized in the following main categories.

First of all, examination of differences between those who had received training and those who had not, revealed that there was no significant difference between these two groups with regard to the need for training (33% versus 34%; p = 0.789).

What the ED professionals wanted most was information on aftercare for the women. Forty-eight per cent of them (n = 120) did not have enough information on where to direct the women or how to arrange aftercare for them. In particular, social services, shelters, crisis prevention centres and various support groups were mentioned.

Twenty-three per cent of the ED professionals (n = 58) would have liked clear procedures for acting in IPV cases, for example: ‘All information concerning domestic violence is needed’, or more briefly, ‘[Training is needed] In everything’.

Eighteen per cent of the professionals (n = 46) wanted information on legislation and legal protection. Some of them mentioned the need to be informed of their own legal protection in cases of severe violence, for example.

The rest of the mentions were divided into skills in face-to-face interaction with the women, which was mentioned by 10% of ED professionals studied (n = 26), co-operation mentioned by 5% of them (n = 12), and other issues mentioned by 6% (n = 16). The professionals had answered, e.g. ‘How to get the women to tell’, ‘How to bring up the matter’, and ‘How to dare to intervene in the matter’. Some professionals wanted training on co-operation with different help organizations (the police or social workers) on networking with different
authorities. Only two of the ED professionals mentioned the need for training in child protection.

Other comments included mentions such as ‘I cannot say’, ‘I’m not able to answer that’, ‘The whole matter is quite unclear’, ‘The lack of time is the biggest problem’, and ‘I’m going into retirement soon’.

The backgrounds of the ED professionals were compared against the need for training on IPV. Female professionals and professionals with less work experience, or who were graduated after 1990 as well as the youngest professionals, or nurses, reported that they needed more training on IPV. Furthermore, the higher the education (general and professional) the ED professionals had, the more likely they were to express a need for IPV training (Table 30; Appendix 10, question 28).

Table 30. Association between ED professionals’ backgrounds and their need for training

<table>
<thead>
<tr>
<th>Background</th>
<th>Need for training on IPV %</th>
<th>Significance test</th>
<th>( \chi^2 )</th>
<th>df</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female (n = 210)</td>
<td>55</td>
<td></td>
<td>4.431</td>
<td>1</td>
<td>0.035</td>
</tr>
<tr>
<td>Male (n = 39)</td>
<td>43</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19-38 (n = 145)</td>
<td>60</td>
<td></td>
<td>11.502</td>
<td>1</td>
<td>0.001</td>
</tr>
<tr>
<td>Over 38 years (n = 104)</td>
<td>45</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than upper secondary school (n = 98)</td>
<td>47</td>
<td></td>
<td>5.214</td>
<td>1</td>
<td>0.022</td>
</tr>
<tr>
<td>Upper secondary school (n = 150)</td>
<td>58</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than post secondary level (n = 28)</td>
<td>39</td>
<td></td>
<td>6.011</td>
<td>1</td>
<td>0.014</td>
</tr>
<tr>
<td>Post secondary level (n = 136)</td>
<td>52</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polytechnic or university degree (n = 85)</td>
<td>63</td>
<td></td>
<td>10.899</td>
<td>2</td>
<td>0.004</td>
</tr>
<tr>
<td>Occupation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse (n = 211)</td>
<td>56</td>
<td></td>
<td>6.011</td>
<td>1</td>
<td>0.014</td>
</tr>
<tr>
<td>Practical nurse/emergency medical technician (n = 38)</td>
<td>41</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Graduation year</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1961-1990 (n = 94)</td>
<td>46</td>
<td></td>
<td>6.424</td>
<td>1</td>
<td>0.011</td>
</tr>
<tr>
<td>After 1990 (n = 155)</td>
<td>58</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work experience</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.25-11 years (n = 141)</td>
<td>59</td>
<td></td>
<td>7.599</td>
<td>1</td>
<td>0.006</td>
</tr>
<tr>
<td>Over 11 years (n = 107)</td>
<td>47</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working in current job</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.1-6 years (n = 140)</td>
<td>59</td>
<td></td>
<td>7.095</td>
<td>1</td>
<td>0.008</td>
</tr>
<tr>
<td>Over 6 years (n = 109)</td>
<td>47</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Ability to support women exposed to IPV as reported by ED professionals studied

The ED professionals were also asked to assess their ability to support and to help women exposed to IPV. This was measured on a four-point response scale of ‘Good abilities’, ‘Satisfactory abilities’, ‘Poor abilities’, and ‘I cannot say’. Twelve per cent of the professionals studied (n = 56/463) felt that they were well able to support and help these women. Sixty-one per cent of these 56 had received related training.

Seventy-three per cent of the ED professionals studied (n = 337/463) felt that their abilities were satisfactory. More than one third of these 337 had received IPV training. Fifteen per cent of the professionals (n = 70/463) felt that they only had poor abilities to intervene in a woman’s situation, or they could not express their opinion on the matter. Among those 70 only eight professionals had received IPV training (Appendix 10, question 29).

ED professionals studied were asked what kind of support systems their organization could offer to maintain their own wellbeing at work. Forty-four per cent of them reported 2-3 different support systems (collegial support, supervision of work, co-operation with various support organizations), whereas seventeen per cent reported none at all. From some of the questionnaires it was evident that encountering the women and their family members (children and partners) had caused the ED professionals a certain amount of distress, or as one participant expressed the matter: ‘In addition to supervision of work, there should be joint discussions among the staff, where people can deal with their distress together’ (Appendix 10, question 31).

5.5 Similarities and differences of views between care and support received by women exposed to IPV and care and support offered by ED professionals studied

The data for the present study were gathered and analysed by using triangulation. The two self-reported questionnaires were formulated especially for this study by the researcher and contained structured, open-ended and open questions (free-text comments) (simultaneous triangulation). The data triangulation involved the use of multiple data sources (women and ED professionals). The data triangulation was utilized in the present study by gathering similar data (with the same questions presented to both women exposed to IPV and to ED professionals) for each problem. This form of triangulation provides a more holistic view of the matter and is important for development of different kinds of intervention to improve the quality of ED services for the women and their family members.
Principles of care regarded as important by the two groups studied

Women exposed to physical IPV were asked which principles of care they regarded as important (Appendices 8 and 9, question 25). This matter was also asked from the ED professionals studied (Appendix 10, question 24). However, these questions failed because of too small dispersions and because the women studied were not motivated enough to answer the question (see Figures 8 and 20). However, it could be seen that the statement ‘Encouragement in reporting the offence to the police’ was the least important and ‘Kind and secure care environment’ and ‘Confidential care relationship’ were regarded as the most important principles of care. It is impossible to analyse any other data from the answers to those questions.

Both the women exposed to IPV and the ED professionals also had the possibility to report any other principles of care that they regarded as important. Five women (14%) and four professionals (0.8%) said that the whole family should have received help.

Responsibility for stopping the violent behaviour

In the questionnaires for both women exposed to IPV and professionals studied there was a question (Appendix 8 and 9, question 28; Appendix 10, question 30) measuring their views on who had the primary responsibility for stopping the violent behaviour (question 28 for women, question 30 for professionals). Fifteen per cent of the ED professionals (n = 71/467) felt that the responsibility lied with the woman alone. None of the women exposed to IPV thought so. Thirty-one per cent of the ED professionals (n = 143/467) and 54% of the women (n = 19/35) felt that it was up to the perpetrator to stop the violence.

Interventions for women exposed to IPV

Question 20 in the questionnaire for women exposed to IPV (Appendices 8 and 9) was about the experiences of women exposed to IPV of interventions performed by ED professionals. Question 21 was about the interventions performed by the ED professionals. The views of the ED professionals describe the frequency of interventions for their patients.

Unfortunately the sample of the women remained small, which is why making exact comparisons between mean values, for example, would be useless. However, both women and ED professionals were very unanimous (see Figures 7a, 7b, 16a and 16b). The answers concerning planning the women’s safety showed that women received less support than the ED professionals studied had estimated to have given. The same difference also seemed to occur with regard to telling the women about different help services; the women received less support than the ED professionals had estimated to have given. Those two differences were the only exceptions, however; in other respects, this study
showed that ED professionals were quite realistic about their interventions for women exposed to IPV.
6. Discussion

6.1 Overview of the findings

6.1.1 Findings from the perspective of the women exposed to IPV

*Prevalence of past IPV as reported by the women studied*

Eighty-six per cent of the women studied reported having been physically assaulted earlier by their current partner. This figure is approximately fourfold in comparison to the two large female victims surveys (Heiskanen & Piispa 1998; Piispa et al. 2006), concerning the Finnish population and based on randomly chosen women.

The cumulative prevalence of past physical IPV among the women studied (being physically assaulted at any point in their life) was 94%. This figure is quite high compared to the larger studies by Sethi et al. (2004) conducted at an ED (corresponding share was 35%) and on elective gynaecology outpatients by Wijma et al. (2003) (corresponding share among Finnish patients was 66%) (Appendix 3, Table 1 and 2).

Because of a quite different study design used in the present study, the results are not comparable with previous studies. Explanations for the high figures of the present study could be that only the most seriously injured women exposed to IPV had been identified by the ED professionals studied, and/or that the sample of the women studied (n = 35), seeking care at EDs, has become selected by accident. These alternatives, however, would demand a future research with a larger sample of women. The third explanation for the high figures could be that women exposed to IPV only seek help after having experienced several acts of violence by their partners and do not seek care until the injuries become more severe (Heiskanen & Piispa 1998).

*Difficulties in seeking care for IPV as reported by the women studied*

According to the present study, only 33% of the women who had been exposed to past physical IPV by their current partner had previously sought care for their physical injuries. The women studied reported difficulties in seeking help for IPV, such as fears for their own safety (fear of escalating violence or fear of their
partner’s revenge), shame, fear that nobody will take her seriously and low self-esteem. One woman said that she could not leave her children with a violent partner. Downplaying of injuries emerged from the interviews of women as a reason why they did not seek help earlier. These findings are in congruence with earlier results conducted in health care settings by Rodriguetz, Szkupinski & Bauer (1996) and Peckover (2003) (Appendix 3, Table 4), and national female victims surveys (Heiskanen & Piispa 1998; Piispa et al. 2006).

Types and forms of IPV experienced by the women studied

Eighty-three per cent of the women studied reported having experienced several types of IPV. Ninety-seven per cent of the women studied reported having experienced psychological violence in addition to past physical violence. This figure is slightly higher compared to an American survey conducted at emergency departments and primary health care clinics by Kramer, Lorenzon & Mueller (2004) (84%) (Appendix 3, Table 2). Fifty-six per cent of the women studied had also experienced both acute physical and psychological IPV. This figure is considerably higher compared to the French study by Lejoyeux et al. (2002) (22%), conducted at an emergency department of a general hospital (Appendix 3, Table 1).

Seventeen per cent of the women studied had experienced both past physical and sexual IPV by their current partner. This figure is lower compared to studies by Kramer, Lorenzon & Mueller (2004) (Appendix 3, Table 2), in which the corresponding figure was 44%, and a British study by John et al (2004) conducted at a women’s and children’s hospital where the corresponding share was 48%. The figures ought to be considered carefully because of cultural differences, e.g. how openly women have told about their experiences of sexual IPV (World Report on Violence and Health 2002).

Previously mentioned results of the present study suggest that the women studied had experienced multiple types of IPV by their partners. They had experienced different forms of physical violence, committed by the current partner, including behaviour such as hitting, kicking, punching, throwing hard objects and strangling. The results are in line with earlier studies (Johnson et al. 2003; Heiskanen & Piispa 1998; Kramer, Lorenzon & Mueller 2004; Piispa et al. 2006). Common injuries found in this study were lacerations, contusions and fractures, mostly in the face and neck region (77%). Similar results have been obtained by Muelleman, Lenaghan & Pakieser (1996), Helweg-Larsen & Kruse (2003) and Biroleačak et al. (2006).
Women’s experiences of intervention methods used by ED professionals during the ED visit

Beside treatment of acute injuries and symptoms, ED professionals’ interventions for the women exposed to physical IPV concentrated on giving information and referring to aftercare. Twenty-six per cent of the women (9/35) agreed that when they were seeking care for their acute injuries they were asked if they had been assaulted (by whom, and how). Even when they had told about their exposure to IPV, neither the doctors nor the nurses intervened in the women’s situation in any way and ‘they only did their job’ (here meaning clinical treatment of injuries) some interviewees expressed the matter. The women studied had not received information on different help services or been referred to aftercare, and the staff had not had enough time to listen to them. Similar results have been achieved by Caralis & Musialowski (1997), Hamberger et al. (1998) and Mc Nutt et al. (1999) by surveying and interviewing women exposed to IPV in different health care settings (Appendix 4, Table 4).

Forty-five per cent of the women agreed that ED professionals had given them information about different help services, and only 23% of the women studied agreed that professionals had helped to plan their safety by giving written or oral information and advice for future IPV situations. Only 20% of the women (7/35) agreed that they had had an opportunity to discuss e.g. with a social worker during their visits to an ED. Perhaps the majority of the visits to the EDs had taken place outside office hours and there were no social services available or the women had not been offered these services by the ED professionals. In Finland there is also a lack of different local support services.

Sixty-six per cent of the women studied agreed that the ED professionals had encouraged them to report an offence to the police. One quarter of the women did not consider it very important to report an offence to the police. Fear of increasing violence and consequences were mentioned by some women. It could also be a question of downplaying the injuries, self-accusation (manifests as a feeling of shame), or the women’s effort to protect her partner because disclosing the matter to the authorities might mean the end of the relationship (Piispa et al. 2006; Sirén & Honkatukia 2005). In reality, it may also be that the women studied did not know the Finnish criminal law and that is why they perhaps did not regard IPV as a crime.

The women’s children suffered both directly and indirectly when living in households where IPV occurred, and this places children at risk physically, emotionally and developmentally (Augustyn & McAlister Groves 2005; Hornor 2005). Only 37% of the women reported that they had been asked about their children’s safety, but none of these women had talked with the ED professionals about how to protect their children in a violent situation, although the women’s children had been witnessing violence. The findings of the present study also showed that children might have been exposed to violence in families where IPV occurs. The findings are in congruence with earlier studies (Christian et al. 1997; Kellogg & Menard 2003; Eskonen 2005).
Negative and positive experiences of care and care principles regarded as important by the women studied

The women described their positive and negative experiences of care in many ways (Appendices 14 and 15). They were both satisfied and dissatisfied with the care of physical injuries, practical and emotional support and physical care environment. What they experienced as negative were the care of physical injuries and symptoms (inadequate medical care), lack of confidentiality and a hurried attitude (including lack of listening), lack of discussion about different help services, and the physical care environment with restless atmosphere and lack of privacy. As positive experiences of care the women mentioned appropriate medical care with emotional and practical support, including elements of equality, calmness, empathy, objectivity, friendliness and understanding (want to be listened, and believed, not blamed), encouragement and support, as well as provision of information on services and assistance when seeking help. Thus the important factors in a good relationship between a patient and an ED professional included appropriate medical care with elements of emotional and practical support. Care principles such as kind and secure care environment and confidential care relationship were regarded as important by the women studied. The women’s reports on the care they received when visiting an ED are in congruence with earlier studies conducted in different health care settings (Rodriguez, Szkupinski & Bauer 1996, Hamberger et al. 1998, Yam 2000 and Chang et al. 2004) (Appendix 3, Table 4).

6.1.2 Findings from the perspective of the ED professionals studied

Identifying women exposed to IPV as reported by the ED professionals

Studies conducted abroad (McCauley et al. 1995, 1998; Wisner et al. 1999; Coker et al. 2000; Helweg-Larsen & Kruse 2003) have noted that unidentified IPV continues to cause health problems that frequently result in repeated visits to EDs. Over one fifth of the ED professionals studied assessed having encountered same women repeatedly visiting the ED for IPV related injuries more than twice a year, and 57% at least once a year. Although the present study did not examine the medical records of the women studied, and the results are based on approximations of the ED professionals studied, the figures of the present study concerning women seeking help repeatedly at the EDs are high. On the one hand, a finding such as this tells that the intervention methods used by the ED professionals studied had not been supportive or effective because of a lack of available support systems and services. On the other hand, it is known that leaving the partnership entails the most dangerous time for women (because of harassment by their partners), and leaving also arouses many emotions in the women.
The ED professionals studied reported that 90% of the women exposed to physical IPV tell about it themselves. They mentioned many manifestations which direct them to suspect that a woman has been exposed to IPV even when she has not mentioned any act of violence. The ED professionals studied reported that the location/form/type of injury did not correspond to that told, or women’s injuries (swollen lips or black eyes) were typical injuries from IPV. They also mentioned ‘the behaviour of the woman’ as a sign of IPV, including symptoms of acute stress disorder as consequences of acute trauma. Thus, the ED professionals studied knew the signs of IPV only in theory. Unless the ED professionals are alert for the variety of reasons for seeking care, the opportunity to intervene in a woman’s situation may be missed, because every trauma patient entering the ED may be a potential victim of violence. Thus, the ED professionals should ask all patients very thoroughly about the mechanism of the injury when they seek care for their acute traumas. Some of the ED professionals studied also reported that the busy nature of their work interferes with concentrating on patients and, without visible signs (bruises, contusions) of violence, the women may move through the whole system without being identified. The busy nature of the work, including lack of health care staff, can be a problem which hinders concentration on women exposed to IPV. On the other hand, it may be question of a person’s professional skill. Personal discomfort with asking about violence or intervening in a woman’s violent situation was also reported by the ED professionals studied, and this may lead them to hide behind the hectic work. Not enough time to ask about IPV has been mentioned as an attitude by nurses and doctors according to the studies conducted by Ellis (1999), Fein et al. (2000) and Dowd et al. (2002) at EDs (Appendix 4, Table 2).

The study results show that 59% of the ED professionals studied reported having problems ‘often’ or ‘now and then’ when identifying women exposed to IPV. The greatest problems have been assigned to the women’s unwillingness to discuss the whole matter. The problem of identifying is seen as the women’s fault. However, it is known on the basis of earlier studies (Glass, Dearwater & Campbell 2001; Stenson et al. 2001; Dowd 2002) (Appendix 4, Table 1) that women do not object to routine screening for IPV, but it should be done in an empathic way. Disclosure of IPV depends on the professional’s professional skill: how to take up the issue of violence. The ED professionals studied were aware of this matter, and the findings of the present study are in line with previous studies (Ellis 1999; Fein et al. 2000) conducted at EDs (Appendix 4, Table 2).

Some of the professionals studied reported being frustrated and distressed when seeing the same women visiting the ED again. This finding is in line with the earlier study of McGrath et al. (1997). The ED professionals’ role is to guide the women towards available resources. According to Landenburger (1998), interventions should provide plenty of information on several alternative support systems (e.g. written material on help providers) and ‘keep the door open’ and support the woman, in case the woman chooses to come back for help some day.
Sixty-eight per cent of the ED professionals studied reported that they ‘bring the matter up’ by asking directly what has happened when they suspect IPV. On the other hand, 42% of the professionals studied reported having not asked about IPV ‘always, often, or now and then’, if the woman has not voluntarily told about it. Some of the professionals studied were timid or shy when asking about IPV, answering ‘I try to discuss the matter carefully’, and some professionals expressed clearly that they let the matter rest if the women do not want to talk about it or do not want help. Asking too carefully or not asking about IPV does not help women to break from the spiral of violence. This is one challenge for further training; how to ask about IPV.

Only seven per cent of the ED professionals studied reported having given concrete support to the women (e.g. with the woman’s permission phoned to the police on her behalf). Lack of time, lack of effective intervention methods, lack of information about community resources, and unawareness of how to ask about violence were brought up by the ED professionals. The findings of the present study are in congruence with the results of previous studies about screening, identification and intervention, by McGrath et al. (1997), Waalen et al. (2000), Fein et al. (2001), Dowd et al. (2002), and Ramsden and Bonner (2002) (Appendix 4, Table 2). Haywood & Haile-Mariam (1999, 608) ascertained that the most important and most easily provided intervention is the simple message that no-one deserves to be hurt and that the woman will not be blamed for the behaviour of the perpetrator. Only a few professionals in the present study reacted negatively towards violence when discussing with the woman and stated: ‘It is not your fault’, or ‘There is no reason for anyone to harm you’, or ‘The violence is wrong’. According to the study by Hamberger et al. (1998), however, the abused women valued practical support, including telling that IPV is illegal and wrong and reassuring that it is not the woman’s fault.

Interventions for women, children and perpetrators, performed by the ED professionals studied

Forty-nine per cent of the ED professionals studied fully or partly agreed that they have lack of jointly agreed, written procedures on how to help the women exposed to IPV. Specific written protocols for IPV intervention, identification of violence, and the availability of support and referral are important ways in which ED staff can provide help to women and her family members. The results of the present study revealed that in the EDs with joint practices and written procedures for handling IPV, the professionals reported having helped both women (e.g. to plan her own safety) and their perpetrators (e.g. referred them to discussion groups) more often. These findings are in congruence with Fanslow, Norton & Robinson (1999) and Campbell et al. (2001). The results of the present study suggest that jointly agreed, written principles and procedures should be available at every ED.
Those ED professionals studied who had a possibility to consult other help providers outside office hours had talked privately with women although their perpetrator had been present. They had also reviewed the women’s family situation (children at home) more often than others. The professionals studied who reported having good co-operation with different help providers reported having made a further care plan with women, helped women (e.g. told about women’s shelters), helped perpetrators (e.g. by giving them written or oral information about men’s discussion groups), determined whether the children are in danger, and discussed with women how to protect children in a violent situation, more often than others. Information on aftercare provided by different help providers was the largest category of the topics in which training is needed, as mentioned by the ED professionals. When the professionals do not know about various help providers, it is impossible to refer the women, children and perpetrators to help. The results of the present study suggest that there is a need for more intensive exchange of information and co-operation with different help providers about how to act and what roles the different providers have for helping women and their family members.

The structural limitations, such as the restless atmosphere of the care environment and the busy work due to the unpredictable nature of the ED, are problematic. The problem is that interviewing the patients often has to be conducted in an open area within the ED entrance and there is no safe place to ask a woman personal questions when suspecting IPV. For example, the interviews of the women studied revealed that the privacy of some women had been violated by the professionals studied when they asked about the occurred IPV in a public waiting room. Ensuring the woman’s privacy means providing an opportunity for a private discussion with a doctor and a nurse, and for example with a police officer or a social worker when needed. This finding suggests that a separate room(s)/place(s) for private discussions with patients should be provided at EDs.

The autonomy of the patient gives the woman the right to privacy and to self-determination about disclosure of IPV. This may place the staff of EDs in a difficult position, particularly if it is known or suspected that the children are in danger. When suspecting that children are in danger, professionals have to discuss with the woman and find a mutual understanding, tell about the professional’s duty based on legislation, and contact the social services whose task it is to solve the matter (Child Welfare Act 1983, ‘Duty of Notification’, Section 40). The discussion could also provide further information about how the woman can protect her children in the future. Although two thirds of the ED professionals of the present study assessed having encountered children who have witnessed (seen or heard or been exposed to) violence between their parents, 3-4 times a year or more often, only 45% of the ED professionals reported that they had always made sure that the children were safe, and only 12% had always discussed with the woman about how to protect her children in a violent situation. Only four ED professionals studied brought child protection up when listing needs for training, and four professionals mentioned that the whole family needs help. The findings of the present study suggest that the ED
professionals do not know enough about their professional duty, that our legislation affects their responsibility to report their suspicions to child protection authorities.

Personal attitudes and a history of experiencing violence (personal IPV, or IPV involving relatives, friends) may lead to false assumptions and avoidance of personal discomfort when caring for women exposed to IPV. In the total sample of the present study, 22% of the ED professionals (female and male) reported personal experience of violence, and 67% reported violence involving their relatives or friends. The figures are similar in several other studies reported by health care professionals (deLahunta & Tulsky 1996; Shea, Mahoney & Lacey 1997; Janssen et al. 1998; Moore, Zaccaro & Parsons 1998; Diatz-Olavarrieta et al. 2001; Christofides & Silo 2005). Associations between a professional’s personal experience of violence and any interventions were not found. However, those professionals whose acquaintance or relative had experienced IPV failed to ask about the act of violence less often. This finding is in line with the results of Christofides & Silo (2005). They discovered that those professionals with experience of violence among acquaintances or relatives had seldom failed to ask about violence when the woman had not voluntarily told about it.

The results of the present study showed that ED professionals in district hospitals had more often arranged support services for the women than professionals in central and university hospitals. The professionals of these organizations had also received more training on IPV, and arranged support services for women more often. One reason for findings such as these could be that in smaller EDs the work environment is less hectic, less injured patients are usually sent to district hospitals for treatment, and thus professionals maybe have an opportunity to concentrate better on patients exposed to IPV. On the other hand, the sample of organizations may have been selective if only those EDs of district hospitals that had developed their care protocols for IPV had participated in the present study. This alternative is supported by the report of Amnesty International’s Finnish branch, published in 2005, which tells that support services for women exposed to violence are not arranged. University hospitals have, for their part, an obligation to carry out research and they had participated, whether or not their EDs had developed IPV programs. This, however, demands further research.

**ED professionals’ abilities to support women exposed to IPV**

Thirty-four per cent of the ED professionals studied had received training on IPV. This is a small amount compared with an American study by Moore, Zaccaro and Parsons (1998) (the corresponding figure was 54%). The present study shows that the more the professionals have training on IPV, the more often they have used different intervention methods and have drafted procedures for how to help women. This finding supports the result of Moore, Zaccaro and Parsons (1998) and Campbell et al. (2001). However, no association was found between training and asking about the woman’s experience of violence. The
finding of improvement of the ED professionals’ level of knowledge is in line with the results of Harwell et al. (1998) and Thompson et al. (2000), but opposite to their findings that the unpleasantness of asking about violence decreased with training.

According to several researchers (Thurston, Cory & Scott 1998; Rönnberg & Hammarström 2000; Hadley 2002), our own preconceptions and biases may blind us to the signs of IPV. Less than one third of the ED professionals and less than half of the women thought that it is the perpetrator’s matter to stop the violence. Fifteen per cent of the ED professionals thought it is only the woman’s responsibility, but none of the women thought in this way. This attitude may affect the interventions used in caring for these women. For example, professionals do not take the women exposed to IPV and their stories seriously. Only fifty-nine per cent of the professionals thought that IPV is not a private matter (‘fully disagree’) and only 51% thought that it is not a consequence of the woman’s own behaviour (‘fully disagree’). The professionals who thought that it is not a private matter reported using interventions methods (e.g. made a plan of aftercare together with women, encouraged women to report an offence to the police, talked privately with women even when their perpetrator had escorted them to care, determined the safety of the women’s children, supported women in seeking help), more often. False assumptions and beliefs about IPV can lead to wrong courses when caring for women, children and perpetrators – at worst professionals not dealing with the matter at all. In fact human rights and legal protection protect all people also from violence happening in a private sector (Declaration of Human Rights, Article 5 1948; Criminal Law 578 / 1995, chapter 21; Criminal Law 563 / 1998, chapter 20; Child Welfare Act 1983, 40§). Thus, health care professionals have professional, legal and ethical duty to intervene in IPV always when they face women, their children and perpetrators.

Sixty-one per cent of the professionals studied reported that they had encouraged the women to report an offence to the police, and only one fifth of all the training needs mentioned by professionals were related to affairs of legislation. The results of the present study suggest that the professionals caring for women exposed to IPV are not familiar with the Finnish legislation concerning IPV, which regards IPV as a crime.

6.1.3 Weaknesses and limitations of the study

The success of the study depends on the comprehensiveness of the research material from the perspective of the research question, and on the quality of data. The study relied exclusively on self-report data, which are vulnerable to the effects of recall bias, and it depends on the ability of the women studied and their willingness to remember and report violent events from their past. Gathering of data depends on what kind of image the research subject has formed of the issue under investigation (Vilkka 2005).

The major limitation of the present study is the small sample size of the women studied. There are several reasons for the small sample. Commonly not
all acts of violence come to light, although the consequences can be serious, and
the women have a high threshold for seeking help (Fischbach & Herbert 1997;
Heiskanen & Piispa 1998; McLaughlin et al. 1999). It is known, depending on
the definition of IPV, that only 1% to 23% of women exposed to IPV visit EDs
because of acute trauma (e.g. Abbott et al. 1995; Dearwater et al. 1998; Sethi et
al. 2004) (Appendix 3, Table 1), and the ED professionals detect as few as 5% of
the women exposed to IPV who come to the ED. Most likely, one part of the
potential study participants were missed because these women were not
identified by ED professionals. Especially if the woman’s injuries were not
visible and were hidden under clothing, many patients may have passed
unnoticed through EDs during the data sampling. For example, 43% of ED
professionals failed to ask about the occurred violence ‘always, often, or now
and then’ if the woman voluntarily had not told about it, and only 6% never had
problems identifying IPV. On the other hand, the study results of the ED
professionals showed that most of the women themselves reported that they had
been exposed to IPV when they entered the ED.

On the basis of earlier study results (Caralis & Musialowski 1997;
Hamberger et al. 1998; Glass, Dearwater & Campbell 2001; Dowd et al. 2002;
Richardson et al. 2002; Kramer, Lorenzon & Mueller 2004), it is known that
women reported barriers to disclosure and factors that would enhance their
ability to trust health care professionals when discussing the occurred violence.
Most notable was that being asked directly and confidentially in an unhurried
and intentional manner makes it easier for women to disclose the matter. The
woman seeking help at an ED did not talk about the act of IPV because of her
personal barriers, such as being afraid or feeling ashamed, or fear of being
reported to child welfare officers, as well as professionals’ barriers such as lack
of time and ‘uncaring’ attitudes. Perhaps due to the busy, unpredictable nature of
the EDs, they could not provide enough women exposed to IPV for the present
study. Simply, professionals did not remember to give the questionnaire to the
women. Giving the questionnaire to the woman was already an intervention. One
third of ED professionals studied did not ask women directly about what had
happened and were timid about bringing the matter up. Presence of the woman’s
partner, friend or relative (as an escort) was also one cause for not asking the
woman to participate, especially if there was no room available where to discuss
with the woman privately and where she could fill in the questionnaire in peace.

The consent was returned with the questionnaire (guaranteeing the woman’s
safety), and for ethical reason a reminder letter was not sent to non-respondents.
This is one reason why the response rate of the women studied remained low
(25%). The low response rate might be partly explained by the long
questionnaire (8 pages with 29 questions), and the time of data collection. The
data collection took place partly during the summer and there were substitute
workers at the EDs. On the other hand, the low response rate was known already
on the basis of the pilot study. It also was impossible to perform an accurate non-
response analysis: why the women refused, and who they were (e.g. the younger
or the older ones, or the women visiting for the first time). This may reduce the
reliability of the study results.
Due to the partly retrospective nature of the study and the use of the self-report questionnaire, there may also be recall bias, and an underestimation of the IPV the women had experienced. As a matter of fact, their life situation may be harsher than what they have told. Furthermore, when the respondents either have undergone some stressful experience or are in an emotionally stressful situation, their behaviour is often characterized by memory loss (Keats 2000).

Time had passed between the interview and the act of violence. The women were perhaps unable to remember their experiences accurately or give a temporally accurate account of what really happened. This may reduce the reliability of the study results. On the one hand, the women had processed their experiences of the IPV, and had had time ‘to put into words’ the target events for which they were recruited into the present study (by Sandelowski 1999). On the other hand, the women who answered the questions were very motivated although the questionnaire was long, and wanted to tell about their life to other women exposed to IPV and encourage those seeking help for their situation.

The participant organizations with their ED professionals were also, as a whole, probably a fairly selected group. Those organizations that did not participate in the study did so due to various reasons (‘no time’, ‘many other projects’, ‘these kinds of patients are rare here’). Some authorities of the organizations that were asked to participate never answered the request. Perhaps the subject of the study was not regarded important, they did not know all aspects of matter, or the topic of the study was too sensitive.

Organizations of the metropolitan area, with one million inhabitants, may also distort the results of the study. However, the participant organizations around Finland differed from each other with regard to their sphere and area of operation – in other words, they were heterogeneous and the sample included different characteristics and qualities.

The present study included several biases that occurred in different ways. Thus, combining both qualitative and quantitative techniques when gathering and analysing data helped to eliminate biases. It was considered that the use of triangulation can increase the reliability, validity or accuracy of the study, especially when the sample of women was small. The methods are complementary because the questionnaires may not capture what is significant for the women in an IPV relationship seeking care for their acute traumas. This methodology provided a deeper understanding of the women’s perspective. On the other hand, this method was laborious for the researcher.

In the present study, the definition of IPV was defined more narrowly than in many other studies conducted in different health care settings. The present study focused on physical violence with consequences. This design only included women visiting EDs due to injuries from physical violence, not women who visited for other problems related to IPV. The present study was limited to women exposed to IPV by a male partner, excluding violence by other perpetrators. These limitations improved the validity of the study.

In spite of the weaknesses and limitations of the present study, the results are in congruence with earlier studies and this adds to the validity of the findings of the present study. The results have provided information and have been as a base
in planning the preliminary model, and this may be transferable to a large population and tested further.

6.1.4 Suggested preliminary model to illustrate the identification of the woman exposed to acute physical IPV seeking care at emergency department and intervention in violence

The main purpose of the present study was to create a preliminary model to identify intimate partner violence and intervene in it at emergency departments. As a summary of the results of the present study and earlier studies concerning those factors that influence the identification of IPV and intervention in it, a preliminary model was formed (Figure 22). The model is based on the following: 1) the opinions and care experiences of the women exposed to past and acute IPV when seeking care for their acute injuries at EDs, and 2) the opinions of the ED professionals and identification and intervention methods used by them, and 3) previous congruent identification and intervention studies (Caralis & Musialowski 1997; Ellis 1999; Hamberger et al. Glass, Dearwater & Campbell 2001; Dowd et al. 2002; Richardson et al. 2002; Rönnberg & Hammarström 2000; Kramer, Lorenzon & Mueller 2004) from the perspective of both women exposed to IPV and health care professionals. The studies are presented in Appendix 4, Table 1-5.

The preliminary model, from the ED professionals’ perspective, illustrates the factors that promote or hamper identification of IPV and intervention in it when the woman exposed to IPV is seeking care for her acute injuries. On the basis of earlier study results and the present study, it is known that asking about IPV by blaming (IPV is the woman’s fault), women’s fear of escalating violence, lack of trust, support and confidence, as well as health care professionals’ lack of time for listening, are factors that may influence women’s willingness to disclose their IPV experiences. Correspondingly it is known on the basis of the studies from the perspective of the health care professionals that lack of effective interventions, lack of protocol to help women, lack of time to ask questions, feelings of frustration, false assumptions (‘IPV is not a problem in our society’ or ‘women’s personality leads to IPV’), are all factors that may hamper appropriate and individual (‘lack of concentration on just me’) care for women exposed to IPV.

By examining the women’s opinions about the care they had received when visiting the EDs studied, the present study revealed that as positive care experiences the women brought up appropriate medical care (clinical examinations and care of physical injuries and symptoms are well managed) with practical and emotional support. Practical support takes care of the individual needs of women, including all-inclusive care, providing information on e.g. legal services, and assistance in seeking help. Emotional support comprises good relationship between the patient and the ED professional, including elements of equality with other patients, calmness, empathy, objectivity, friendliness, and understanding of women’s emotions. According to the study results, paying...
attention to the specific needs of women by listening to ‘the women’s voices’ is the point that is not understood by all ED professionals and can be an obstacle to optimal care.

The women of the present study also regarded supporting the whole family as important. The ultimate target is ending the violence by knowing and recommending resources that promote the health and wellbeing of the woman, her children and the perpetrator. The woman and her children who have witnessed IPV against their mother need to be identified and referred to appropriate care. This is a great challenge for ED professionals when they are planning aftercare with their patient and choosing appropriate services together. The ED professional’s duty is to ask about children’s safety and consider whether the women’s children are at risk, and to consult a social worker when needed. Informing the perpetrator that violence is a criminal act and results in health problems for his partner and their children is also important.

Good teamwork and co-operation between different help providers (the police, social and crisis services, social workers, women’s shelters, men’s discussion groups) is important when developing work against IPV. Agreed, written procedures have to exist in every unit. When they are jointly agreed the action for all women exposed to IPV is uniform. ED professionals’ attitudes toward IPV may be affected by lack of knowledge. False beliefs about who is responsible for stopping violent behaviour may be an obstacle to appropriate care. Some thought that violent behaviour is the women’s fault and this may cause belittling the woman’s need for care. Some of the ED professionals studied felt that supporting women exposed to IPV can be frustrating and difficult. These are all factors that may hamper effective intervention in IPV. Physical care environment with limited structural factors (no place where to discuss in private, a restless and hurried atmosphere, long waiting times) may hamper identification of and intervention in IPV. The findings of this study emphasize the need for systematic training and support systems for the professionals as resources to promote the identification of women exposed to IPV and intervention in violence.

The usefulness of the suggested preliminary model is first of all in identifying and intervening in IPV as early as possible to stop the violence when promoting the health and wellbeing of women and their family members. This will in the long run result in improved health and quality of life for the woman and her children, as well as for the perpetrator when/if he realizes that he has to stop his violent behaviour and is ready to accept the offered support. Secondly, identified IPV reduces repeated ED visits and ultimately brings down health care costs. The preliminary model also makes practical work clearer through functioning as a ‘checklist’ of factors that affect the quality of care when supporting the women and her family members and referring them to different support services. The preliminary model could also standardise different practices and customs for different organizations. It also directs decision when thinking of appropriate aftercare for the women, children and perpetrators.
Figure 21. A preliminary model to illustrate the identification of the woman exposed to acute physical IPV seeking care at emergency department and the intervention in violence.
6.2 Conclusions

Based on the results obtained from the questionnaires used in this study that were answered by women exposed to IPV (n = 35) and ED professionals (n = 480), and from the interviews (7 women, 20 professionals) conducted, the following conclusions can be drawn:

**From the perspective of women exposed to IPV**

1. Women seeking care for their acute injuries at EDs had experienced multiple forms of lifetime IPV by their partners. One third of the women had earlier sought help for their injuries, and only one quarter of the women regarded encouragement to report an offence to the police as very important.

2. The women’s children had also been exposed to physical and psychological IPV.

3. The women stressed the importance of good relationship between the patient and the health care professional, including appropriate medical care with elements of practical and emotional support.

**From the ED professionals’ perspective**

1. The ED professionals reported problems in identifying women exposed to physical IPV, although at least in theory they identified the marks of IPV.

2. The obstacles to identifying are: lack of time, lack of effective intervention methods, lack of information about community recourses, and lack of knowledge about how to ask about IPV.

3. Approximately one half of the ED professionals studied reported that they did not have common written procedures for handling the IPV, and this was an obstacle to offering effective help to the women exposed to IPV, their children and the perpetrators.

4. Good co-operation with different help providers facilitates the intervention. There is a need for more effective change of information and co-operation with different help providers concerning how to act and what roles the different providers have in the support of the women and their family members.
5. ED professionals do not know enough about their professional duty, e.g. that our legislation affects their responsibility to report their suspicions to the child protection authorities if a child’s health and wellbeing is in danger. The legislation concerning IPV is not known very well, and IPV is not perceived as a serious crime by the ED professionals.

6.3 Implications for nursing research, education, practice and administration

This cross-sectional, descriptive study generated new knowledge of caring for women and their family members in the ED context. The present study was the first one in the Finnish ED system that deals with both points of view, of the women exposed to IPV and of the ED professionals.

The information from the present study can be utilized in nursing research, professional education and further training, practical work, and nursing administration.

Suggestions for further research

Testing the functionality of the preliminary model created would be the first step for further research. In the present study, lack of time, lack of effective intervention methods, lack of information about different help services and lack of knowledge about how to ask about IPV were reported as obstacles to identify women exposed to IPV by the professionals. Jointly agreed written procedures and good co-operation with different help providers facilitated the intervention in the woman’s and her family members’ situation. It would be interesting to evaluate the effectiveness of identification and intervention methods used. In practice, this would be done by choosing two parallel EDs with similar backgrounds. Training on IPV, the support systems for the staff, and good teamwork would be chosen as impacts on the ED chosen. The study design would be an experimental design with outcomes (improved identification of IPV). The experimental unit would be given impacts and the control unit would continue their normal operation. Alternatively, the development of better identification and intervention would be concentrated on one unit with measurements at the beginning and at the end.

The findings from the present study showed that some organizations had drawn up guidelines on how to care for the women exposed to IPV and their family members. However, the present study did not examine what kinds of guidelines, procedures and programs already existed, how they had been established, or what they included in the organizations that participated in the present study. It would be very useful to study what proportion of Finnish EDs has intervention policies and procedures. How to provide services for patients who have been assaulted by their partners? If they have difficulties in
implementing these procedures, what is problematic during the process? And are there differences between those organizations with agreed procedures and those with none? This would help to avoid mistakes and plan aftercare for people exposed to IPV. Perhaps it would give ideas for services and good practices which could be put to wider use in our health care system.

The results of the present study showed that even asking about violence when suspecting it was experienced as difficult by some ED professionals. For example, they did not know how to ask about violence because of the sensitive topic. Training is the first step toward a change in practices. It should be assessed how training is carried out, especially when the results of the present study were contradictory: no association was found between training and asking about the woman’s experience of violence. Evidence of the benefit of training is also needed. The change will probably manifest as systematic improvement of patient care and as stronger motivation and greater commitment of the staff in further developing their procedures and care protocols.

The intervention studies conducted abroad (see Appendix 4) have pointed out that not all doctors, nurses, and women exposed to IPV are in favour of screening programs, and there is little evidence of significant outcomes resulting from systematic screening for IPV, such as decreased exposure to IPV, or potential harm to women from screening (Ramsay et al. 2002). It would be very important to examine the evidence for the benefit of this kind of intervention in a Finnish ED context.

The findings of the present study showed that the documentation of IPV was managed well. Over 80% of the ED professionals reported having documented a woman’s story about the act of violence and her injuries to the plan of care. The present study did not examine what else the professionals studied wrote down in the plan of care and how they did it (scope and content), nor what was written in the medical records of the women exposed to IPV. However, all important aspects concerning the act of violence with consequences should be reported in writing. They may be needed later, e.g., if the woman decides to report an offence to the police. If there are deficiencies in the plan of care, further research in this area would improve documentation practices.

The present study was strictly limited to concern women exposed to acute physical IPV, and the prevalence of IPV has been assessed by the ED professionals studied. Equally important is to examine how often, on the whole, victims of domestic violence, both women and men, including homosexual and lesbian couples, seek care for their acute and past violence at the EDs. The studies conducted abroad show that 1% to 12% of women visit EDs because of acute trauma resulting from violence (Appendix 3, Table 1). A weakness in these studies was that they did not use any measure of the severity of the physical abuse. However, before asking about experiences of violence from every patient entering the ED for any reason, and before viewing medical records, there should be an agreed procedure on how to act, knowledge of available resources, and evidence of the benefit of screening.
Implications for professional education and further training

Two thirds of the ED professionals studied lacked training on IPV. However, the findings show that received training affected the ED professionals’ practices. For example, training had an association with many interventions used by the professionals studied. The ED professionals who had received more training reported more efficient identification and intervention in the women’s situation. Because training would change the practices used (and also beliefs that violent behaviour is the women’s fault), systematic training on IPV should be arranged and it should be included in every ED’s annual training plan. Systematic further training plan for ED staff should be developed in order to enhance professionals’ skills and basic knowledge of all types of violence, of how to identify the women, men and children exposed to IPV and intervene appropriately, of where to refer the patients for aftercare in their local networks, taking into consideration the local circumstances, and above all, of legislation concerning IPV, because this was unclear for the majority of the ED professionals. Furthermore, IPV should be included in every health care professional’s education program. Cooperation between different vocational education institutions and health care organizations would be useful. ED professionals themselves could also search for information about IPV on the Internet. There are many resources available for finding information on different help agencies.

Implications for clinical practice

A number of potential obstacles impede appropriate care of the women and their family members. Lack of time, not knowing how to ask about violence, and lack of knowledge about resources available outside the ED, were mentioned by the professionals studied. Of the women exposed to IPV, some had some negative care experiences when seeking and receiving help: lack of support systems for their family members, been given the runaround, and belittlement of injuries, were among the things mentioned by the women studied. All this will pose many challenges for improving the entire care process of IPV.

The matter of IPV is multidimensional. Above all, the care of the woman and her family members is ultimately teamwork between nursing professionals, social workers, doctors, police officers and children’s protect authorities, etc. This is an enormous challenge, particularly in those organizations where basic care and specialized care emergency services are joined under the same roof, or joined, and the patients enter the ED via the same door. The sample of the present study also included women who were given the runaround, and women who were not given the opportunity to meet a specialist even though they had asked for one and the treatment of injuries would have demanded it.

All the above-mentioned issues demand that all health care professionals act uniformly and the philosophy of care be uniform (common protocol). On the level of the whole organization it is an enormous challenge and needs the support
of the management, working together for the good of the women and their family members.

On the ED level it would be useful if a few ‘clinical nurse specialists’ were orientated to IPV and coordinated the care intervention in IPV. They could provide training for others and consultation when needed. They should update all procedures and protocols (both on paper, intranet and internet) and keep in contact with the other nursing staff also on the level of the whole organization, because patients exposed to IPV are encountered in every department, thus, interventions for IPV should be developed together.

*Implications for administration*

A health care professional’s ability to intervene in IPV must not be limited by the absence of resources. At the hospital level, administrative support is important in developing training programs and procedures, guidelines and protocols of care concerning intervention in IPV. Without the support of nursing directors and head nurses this will not be managed. Above all, those who are ultimately responsible for the actual values of the care culture and the development of care should ensure that the protocols will be put into practice.

Attitudes and beliefs influence the effectiveness of interventions used by the ED professionals. They may be the basis of one’s behaviour. Some ED professionals studied were frustrated and powerless when repeatedly seeing the same women exposed to IPV. Examination of these attitudes and beliefs, as well as open discussion about these feelings e.g. in the nursing meetings, would be valuable. This should strengthen professional skill and therefore improve intervention in IPV.

The present study showed that violence has touched, in one way or another, very many ED professionals’ private life, either through personal experience or through friends’ or relatives’ experiences. Therefore, a support system (e.g. counselling) also for the professionals is definitely needed. In this respect the nursing directors are in the key position to ensure the annual resources for this purpose.

The nursing directors are also in the key position when deciding upon the research programs in their units. Persons who are exposed to IPV in their families are usually silent and do not talk about their situation. More research is necessary to reveal the extent of IPV and to understand this multidimensional matter. Improvement of the practical care of persons exposed to IPV in all types of intimate relationship, both heterosexual and same-sex, demands the efforts of those in positions of leadership. It has to be ensured that the health care professionals have enough time to study and develop nursing practice, when promoting the health and well-being of persons exposed to IPV.


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Appendices

APPENDIX 1

Violence against women in some international and national documents


APPENDIX 2

Most important Finnish laws from the view of IPV when caring the patients

1983  Lastensuojelulaki  
       (1983/683) (LSL 40§)

1992  Laki potilaan asemasta ja oikeuksista  
       (785/1992)

1994  Raiskaus avioliitossa kriminalisoitiin

1994  Laki terveydenhuollon ammattihenkilöistä  
       (559/1994)

1995  Pahoimpitely yksityisella paikalla asetettiin virallisen syytteen alaiseksi  
       (578/1995)

1998  Laki viranomaisten toiminnan julkisuudesta  
       (383/1998)

1999  Raiskaukset luokiteltiin törkeyden mukaan kolmeen luokkaan  
       (563/1998)

1999  Laki lähestymiskiellosta  
       (898/1998)

1999  Henkilötietolaki  
       (523/1999)

2000  Laki sosiaalihuollon asiakkaan asemasta ja oikeuksista  
       (2000/812)

2005  Lähestymiskieltolakia laajennettiin koskemaan myös samassa taloudessa  
       asuvia perheenjäseniä

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APPENDIX 3
Incidence and prevalence of IPV (DV) according to some studies conducted in the ED, in primary care, in pediatric and obstetric and gynecology settings

Table 1. Incidence and prevalence of IPV/DV in the ED setting

<table>
<thead>
<tr>
<th>Author(s), year, country</th>
<th>Objective</th>
<th>Study design</th>
<th>Definition of IPV/DV</th>
<th>Acute / current/ past year IPV/DV</th>
<th>Lifetime IPV/DV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abbott et al. (1995) USA</td>
<td>To determine the incidence (acute DV), and past DV exposure (1-year prevalence and cumulative prevalence) of DV among female ED patients</td>
<td>A descriptive written survey with 648 women of 833 presenting during 30 randomly selected 4-hour time blocks</td>
<td>DV was defined as an assault, threat, or intimidation by a male partner</td>
<td>The incidence of acute DV among the 418 women with a current male partner was 11.7% (95% CI, 9% to 15%) (47 women out of 403) 11 (23%) of these 47 women subjected to acute DV presented for care because of trauma</td>
<td>The cumulative prevalence rate of DV was 54% (CI, 50% to 58%) (351 women out of 648 had been threatened or physically injured by a male partner (at some time in their lives)</td>
</tr>
<tr>
<td>Ernst et al. (1997) USA</td>
<td>To determine the prevalence of DV for male and female ED patients and to determine the demographics of DV</td>
<td>A descriptive written survey of adults by using the Index of Spouse Abuse (ISA)*, a validated survey tool All patients presenting during 31 randomly selected 4-hour shifts during one month (233 men and 283 women)</td>
<td>DV was defined as either physical or non-physical on the basis of ISA scoring The prevalence was determined for present (in the preceding year) and past (more than 1 year ago) Four violence parameters were calculated for patients who had a partner at the time of presentation</td>
<td>Of the 207 of women and 157 men with partners at the time of presentation, 15% of women and 11% of men reported present nonphysical violence, and 19% of women and 20% of men reported present physical violence</td>
<td>On the basis of ISA scoring, 22% of women (283) and 14% of men (233) had experienced past nonphysical violence, and 33% of women and 28% of men had experienced past physical violence</td>
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<tr>
<td>Dearwater et al.</td>
<td>To determine the</td>
<td>An anonymous survey</td>
<td>A battered woman was defined</td>
<td>The prevalence of</td>
<td>The cumulative prevalence</td>
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175
<table>
<thead>
<tr>
<th>Year</th>
<th>Study</th>
<th>Country</th>
<th>Objective</th>
<th>Methodology</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998</td>
<td>Muelleman et al.</td>
<td>USA</td>
<td>To determine which diagnoses in the ED, apart from battering injuries, were more common among women who were living in physically abusive relationship than among women who were not</td>
<td>Cross-sectional survey of 9057 women presented for any reason to the ED of 10 hospitals. The questionnaire was completed by 4051 women (73% of those asked, 59% of those eligible, and 50% of those presenting)</td>
<td>The prevalence of IPV among the participants was 11.8% (468) (5.9% positive, probable, or suggestive for battering and 5.9% without battering injury, but currently in a physically abusive relationship)</td>
</tr>
<tr>
<td>1998</td>
<td>Zachary et al.</td>
<td>USA</td>
<td>To determine whether any clinical or demographic characteristics could identify adult female patients presenting to the ED with a history of DA (Domestic Abuse)</td>
<td>Cross-sectional survey of 611 women conducted in an urban ED. Women were interviewed using a semi-structured questionnaire</td>
<td>Domestic abuse (DA) was defined as emotional, physical, or sexual abuse or threats of physical or sexual abuse inflicted by a current or former spouse, boyfriend, girlfriend, domestic partner, or adult ‘significant other’. (‘Recent DA occurred in the preceding 12 months’</td>
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<td>Muelleman et al.</td>
<td>USA</td>
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<td>Year</td>
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<td>Results</td>
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<td>2002</td>
<td>France</td>
<td>To assess the prevalence of DV among patients examined in the emergency service of a general hospital</td>
<td>126 consecutive patients (men and women) received by the emergency service interviewed using a specific questionnaire</td>
<td>DV was defined as physical, sexual and psychological caused by a partner, a member of the family or a close relation. The prevalence of actual DV (three or more positive answers to the specific questionnaire) was 18% (23) among patients examined by emergency service. Thirty-five percent of the cases were physical violence (8), 22% (5) sexual violence (women 22%), 17% (4) psychological violence (women 17%, men 17%), and 26% (6) of multiple forms of DV (women 22%, men 4%). 74% of the patients have been exposed to DV more than one year.</td>
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<tr>
<td>2003</td>
<td>UK</td>
<td>To identify the incidence and prevalence of DV among patients of both sexes attending a UK emergency department, and to test the hypotheses that reported DV was associated with deliberate self-harm, alcohol misuse, and increased use of medical care</td>
<td>A single centre cross sectional study of 256 completed interviews. Patients were interviewed in randomly allocated time blocks using validated questions from a US study.</td>
<td>DV defined as 'illness or stress or injury resulting from the deliberate actions of an intimate partner' (emotional and physical). The incidence of DV was 1.2% (95% CI, 0.2% to 3.4%). The lifetime prevalence of DV was 22.4% (95% CI, 15% to 31%) among women 22% (95% CI, 16% to 30%) among men (at any point in the past / cumulative prevalence).</td>
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</table>
Sethi et al.  
(2004)  
UK

To identify the prevalence of DV in women attending an inner city accident and emergency department

Questionnaires for 198 women  
DV defined as physical abuse perpetrated by intimate partners  
The prevalence in women attributable to DV was 1% (95% CI, 0.14% to 3.6%) (The present physical injury was the cause of their visit)

The prevalence of lifetime (cumulative prevalence) physical abuse was 35% (95% CI, 28%-42%), of past year physical abuse was 6% (95% CI 3.2 to 10.3), and of lifetime life threatening physical abuse was 11% (95% CI, 6.3%-14.9%)  

*) Index of Spouse Abuse (ISA) The ISA is a 30-item, self-report scale designed to measure the severity or magnitude of physical (ISA-P) and non-physical (ISA-NP) abuse inflicted by a male partner (See Hudson WW & McIntosch SR 1981. The assessment of spouse abuse: two quantitative dimensions. J Mar Family, November, 873-885.)

**) Intimate Partner Abuse (IPA) Questions: 1) ‘Did you come to the ED today because you were hurt by you husband, boyfriend, or partner (or ex-husband, ex-boyfriend, or ex-partner?’ (acute trauma from abuse) 2) ‘Within the last year, have you been pushed, shoved, hit, slapped, kicked, or otherwise physically hurt by your husband...’ (past-year prevalence of physical abuse) 3) ‘Within the past year, has your husband, boyfriend, or partner forced you to have sexual activities (or ex-husband…)?’ (past-year prevalence of sexual abuse) 4) Past-year prevalence of physical or sexual abuse was defined as answering yes to either question 2 or 3 5) Lifetime prevalence of abuse was defined as answering yes to question, ‘Have you ever been emotionally or physically abused by your husband, boyfriend, or partner (or ex-husband…)?’ 6) No history of abuse was defined as any case in which the patient answered no to all the questions on abuse

***) Incident cases were those who gave affirmative answer to the questions ‘Are you here today because of injuries from your current partner?’ and ‘Are you here today because off illness or stress related to threats, violent behaviour or fear from your current partner?’

****) Definitions used were those in response to questions concerning whether women had: a) ever experienced physical abuse in the form of being slapped, punched, kicked, having something thrown at them, burnt, or injured by a knife or weapon by the current or any partner (defined as lifetime experience of physical DV); b) been physically abused (as above) in the past year (defined as physical abuse due to DV in the past year); c) that the present physical injury was the cause of their visit (defined as a acute trauma from DV); d) been choked, burnt, or injured by a knife or weapon by the current or any partner (defined as lifetime experience of life threatening physical violence)
<table>
<thead>
<tr>
<th>Author(s), year, country</th>
<th>Objective</th>
<th>Study design</th>
<th>Definition of IPV/DV</th>
<th>Acute / current / past year IPV/DV</th>
<th>Lifetime DV</th>
</tr>
</thead>
<tbody>
<tr>
<td>McCauley et al. (1995)</td>
<td>To determine the prevalence of DV among female patients and to identify clinical characteristics that are associated with current DV in four community-based, primary care internal medicine practices</td>
<td>Cross-sectional, self-administered, anonymous survey with 1952 female patients</td>
<td>A patient was considered to be a current victim of DV (currently abused) if she answered to either of the following questions: 'Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone'? or 'Within the last year, has anyone forced you to have sexual activities'? and she identified the abuser as a husband, ex-husband, boyfriend, or relative.</td>
<td>108 of the 1952 (5.5%) had experienced DV in the year before presentation</td>
<td>418 of the 1952 (21.4%) had experienced DV sometime in their adult lives, 429 (22%) before age 18, and 639 (32.7%) as either an adult or child</td>
</tr>
<tr>
<td>McGrath, Hogan &amp; Peipert (1998) USA</td>
<td>To determine the prevalence of physical and sexual abuse in pregnant and non-pregnant women in an urgent care obstetrics and gynaecology triage unit and the frequency with which these patients recall being screened by their health care provider</td>
<td>A structured survey of 255 pregnant and 142 non-pregnant women. The survey consisted of 22 questions, seven of which were modified from the AAS</td>
<td>DV was defined as physical or sexual abuse</td>
<td>38 (10%) women out of 397 reported recent physical or sexual abuse</td>
<td>184 (46%) women reported a history of physical or sexual abuse in the past. Only 18% of women recalled being asked about abuse by a health care provider</td>
</tr>
<tr>
<td>Duffy et al. (1999)</td>
<td>To determine the prevalence of DV in a convenience cross-sectional survey</td>
<td>DV was defined as physical or sexual abuse perpetrated by their partner</td>
<td>A total of 10% of women reported histories of adult abuse</td>
<td>A total of 52% of women reported histories of adult abuse</td>
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<tr>
<td>Country</td>
<td>Study Details</td>
<td>Findings</td>
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<tr>
<td>USA</td>
<td>against mothers in a pediatric ED and relationship of their children to the abusers</td>
<td>sample of mothers seeking treatment for their children at an urban pediatric ED intimate partner relationship in the past year physical abuse, and 21% reported adult sexual abuse, and 28% reported childhood sexual abuse. Intimate partners perpetrated 67% of physical abuse and 55% of sexual abuse.</td>
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<tr>
<td>Richardson et al. (2002) UK</td>
<td>To measure the prevalence of (DV) among women attending general practice; test the association between experience of (DV) and demographic factors; evaluate the extent of recording of (DV) in records held by general practice; and assess acceptability to women of screening for (DV) by general practitioners or practice nurse</td>
<td>Self-administered questionnaire survey. Review of medical records. General practices in London 1 207 women (&gt; 15 years) attending general practices Any woman who had ever experienced any type of physical violence, including forced sex from a partner or former partner Current (DV) was defined as physical violence experienced during the past 12 months 160 women out of 949 (17%) (95% CI 14% to 19%) had experienced physical violence within past year 425 women out of 1035 (41%) (95% CI 38% to 44%) had ever experienced physical violence from a partner or former partner</td>
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<tr>
<td>Wijma et al. (2003) Nordic countries</td>
<td>To estimate the prevalence of emotional, physical, and sexual abuse in patients visiting five gynaecology clinics in the Nordic countries, and to assess the frequency with which abused patients were</td>
<td>A cross-sectional, multi-centre study of women attending five departments of gynaecology in Denmark, Finland, Iceland, Norway, and Sweden. 3 641 (77%) included in the study Participants completed a postal questionnaire (NorAQ)* Primary outcome measures were prevalence of emotional, physical, and sexual abuse, and whether abused patients had told their gynaecologist about these experiences The ranges across the five countries of lifetime prevalence were 38-66% for physical abuse (in Finland 66%), 19-37% for emotional abuse (in Finland 37%), and 17-33% for sexual abuse (in Finland 27%)</td>
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<tr>
<td>Study</td>
<td>Objective</td>
<td>Methodology</td>
<td>Findings</td>
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<td>Bacchus et al. (2004) UK</td>
<td>To examine the prevalence of (DV) and its associations with obstetric complications and psychological health in women on antenatal and postnatal wards</td>
<td>A cross-sectional survey conducted in an inner-London teaching hospital. Two hundred English-speaking women aged 16 and over, were interviewed between July 2001 and April 2002. The AAS ** was used to assess for experiences of (DV). Women who reported physical or sexual violence by a current or former partner/husband or family member, were coded as positive for a history of (DV). Six women (3%) reported DV during the current pregnancy.</td>
<td>Forty-seven (23.5%) women reported a lifetime history of DV. The perpetrators were a current partner or husband (11%), an ex-partner or husband (75%), and family member (15%). Eleven (23.4%) of the 47 women reported being forced to have sex, all of whom cited an ex-partner or husband as the perpetrator.</td>
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<tr>
<td>Kramer, Lorenzon &amp; Mueller (2004) USA</td>
<td>To determine prevalence of IPV among women accessing health care, factors that influence rates of abuse, barriers to disclosure, and associated health problems and perceptions of safety</td>
<td>A convenience sample of women seeking health care completed 1268 anonymous surveys at urban, suburban, or rural emergency departments or primary care clinics. IPV was defined as a pattern of assaultive or coercive behaviours that may include inflicted physical injury, psychological abuse, sexual assault, progressive social isolation, stalking, deprivation, intimidation, and threats. In the past year, 28% reported emotional abuse, 12% physical abuse, 6% severe physical abuse, and 4% sexual abuse. Of women 50-57% had experienced physical and / or emotional abuse and 26% reported sexual abuse in their lifetime. 89% of women who experienced lifetime physical abuse also reported emotional; 88% of women who experienced lifetime sexual abuse reported emotional abuse; and 44% of women who experienced lifetime physical abuse reported sexual abuse.</td>
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</table>

*) NorAQ Norvold Abuse Questionnaire  
**) AAS Abuse Assessment Screen
## APPENDIX 4
Identification of IPV (DV) and intervention in it according to some studies conducted in different heath care settings

Table 1. Some screening studies from the women’s perspective

<table>
<thead>
<tr>
<th>Author(s) and country</th>
<th>Setting</th>
<th>Objective</th>
<th>Design</th>
<th>Type of sampling and subjects</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caralis and Musialowski (1997) USA</td>
<td>Ambulatory clinics</td>
<td>To assess the knowledge and attitudes of women toward DV and the prevalence of abuse among female patients in an ambulatory setting. Additionally, to develop appropriate medical interventions. DV was defined as either an injury (from being hit, punched, or slapped or from other trauma) or stress (from threats or violent behavior or from her own fears) to a woman caused by a boyfriend, husband, partner, ex-partner or relative.</td>
<td>Survey Interviewing of female patients by using a standardized questionnaire</td>
<td>All female patients who came daily during the designated 4-hour time blocks of the clinic were asked to participate in a study concerning ‘women’s health issues’. (n=406)</td>
<td>Eighty five percent of women agreed that doctors should routinely screen for abuse in their practices (50% strongly agreed). Only 12% of the total respondents have been asked by doctors or nurses about abuse; 23% of abused women were asked. Even when told of abuse, the doctors did nothing for 20% of the patients. Reasons given for not telling their doctors about abuse included the following: fear, ignorance that they could confide, thought abuse was controllable, and did not go to a doctor. As part of treatment, all women strongly recommended that the doctors provide information on community and legal recourses and assistance in seeking protective services.</td>
</tr>
<tr>
<td>McNutt et al.</td>
<td>Family practice &amp; four urban</td>
<td>To ascertain how women want health care providers to address</td>
<td>Cross sectional survey</td>
<td>Eighty female patients seen at an urban family practice and 91 women</td>
<td>Forty-three percent of all women favored routine inquiry, and 10%</td>
</tr>
<tr>
<td>Year</td>
<td>Country</td>
<td>Study Design</td>
<td>Setting</td>
<td>Women Description</td>
<td>Methodology</td>
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<tr>
<td>1999</td>
<td>USA</td>
<td>Self report survey and individual interviews from four urban DV programs were asked about screening for DV. A total of 161 women with different ethnicity participated in the study, including 38 patients who had never experienced IPV, 40 patients who had ever experienced partner abuse, 58 women using services of DV programs, and 25 shelter residents.</td>
<td>DV during primary care visits. DV was defined as physical and/or sexual violence by a male intimate partner.</td>
<td>75% of abused women (inc. severely abused), had never been asked about DV. Fear of losing control and personal feelings (e.g. shame) inhibited some women from discussing abuse with physicians. Women want to be listened, to be believed and not judged when they speak about their experiences, and to maintain control over decisions about their living arrangements and relationship. They want to be treated respectfully and with sensitivity. Women want information about DV and referrals to community resources to be provided when needed.</td>
<td>favored doctors saying nothing unless woman brought it up.</td>
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<tr>
<td>2000</td>
<td>USA</td>
<td>Cross sectional case-control by using telephone interviews standardized questions</td>
<td>A large metropolitan health maintenance organization</td>
<td>DV was defined as physical or sexual abuse by a current or former husband, boyfriend, or female partner.</td>
<td>A total of 2005 women completed the telephone-screening interview, from which case subjects (202 abused women) and control subjects (240 randomly selected non-abused women) recruited.</td>
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<tr>
<td>Glass, Dearwater &amp; Campbell (2001) USA</td>
<td>Eleven emergency departments of community hospitals</td>
<td>To provide clinical practice recommendations for screening and interventions for IPV, by assessing attitudes of women toward routine screening and mandatory reporting of IPV by ED staff.</td>
<td>An anonymous survey. In addition medical records were abstracted for every woman.</td>
<td>All women (n=4 641) aged 18 years older who came to the ED during 309 selected shifts. The PSSS (an adaptation of the AAS) was used to screen all eligible female ED patients for IPV during the course of their ED visit.</td>
<td>The vast majority of both abused (80%) and non-abused (90%) women supported routine screening for IPV. However, fewer than 25% of women said they were asked about IPV by ED staff.</td>
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<tr>
<td>Stenson et al. (2001) Sweden</td>
<td>All antenatal clinics in a medium-sized Swedish university town</td>
<td>To examine women’s attitudes to being asked about exposure to violence, during and after pregnancy.</td>
<td>An explorative study using content analysis of one open-ended question.</td>
<td>All women registered for antenatal care before 32 weeks of pregnancy, during a period of six months. 879 women were presented with the open-ended question. The AAS was used.</td>
<td>Eighty percent of women found the questioning acceptable, 12% neither acceptable nor unacceptable, 5% both acceptable and unacceptable, and only 3% found it unacceptable. There was no difference between those who reported abuse and those who did not.</td>
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<tr>
<td>Dowd et al. (2002) USA</td>
<td>Pediatric emergency department</td>
<td>To determine attitudes, feelings and beliefs of mothers toward routine IPV screening,</td>
<td>Qualitative study with semi-structured discussion guide.</td>
<td>A total sample of 59 mothers who brought their children to a children’s hospital emergency for care.</td>
<td>Most mothers remarked that routine screening for adult IPV is an appropriate activity for a pediatric emergency department. However many expressed concern that willingness to disclose might be affected by fear of being reported to child protective services. They stressed the importance of addressing the child’s health problem first. Screening should be...</td>
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</table>
Richardson et al. (2002) U.K.

**General practices**

- To assess the woman’s attitude to being questioned about DV by her general practitioner or practice nurse.
- To evaluate the extent of recording of DV in records held by general practices.

DV was defined as physical violence, including forced sex by a partner or former partner.

- Randomised, self-administered questionnaire survey
- Review of medical records

Thirteen randomly selected general practices with surveying 207 women. The medical records of 258 women (given consent) were reviewed.

In total 20% of women reported that they would mind being asked by their general practitioner about abuse or violence if they had come about something else. Forty-two percent of women reported that they would find it easier to discuss these issues with a female doctor. Physical violence was recorded in the medical records of 15/90 (17%) women who reported it on the questionnaire.
<table>
<thead>
<tr>
<th>Author(s) and country</th>
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<th>Design</th>
<th>Type of sampling and subjects</th>
<th>Result</th>
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<tbody>
<tr>
<td>Ellis 1999 USA</td>
<td>Emergency department</td>
<td>To describe attitude to nurses screening all women for current and past DV, where perpetrator is partner.</td>
<td>A qualitative cross sectional survey with self completed questionnaire</td>
<td>One hundred one registered nurses employed in a large emergency department. Forty nurses (40%) completed the survey.</td>
<td>Fifty-three percent of nurses felt that they should routinely screen women. The three highest self-ranked barriers were: a lack of privacy for screening in the health care setting, not enough time to ask about DV, and not knowing how to ask about DV, or to feel uncomfortable asking. Lacking of support from colleagues and nursing management, afraid of offending the patient, not know what to do if the answer is ‘yes’, and not to know enough about DV were also mentioned as barriers by the nurses.</td>
</tr>
<tr>
<td>Rodriguez et al. 1999 USA</td>
<td>Primary care</td>
<td>To describe the practices and perceptions of primarily care physicians regarding intimate partner abuse (IPA) screening and interventions.</td>
<td>Cross-sectional survey with a 24 item questionnaire</td>
<td>Sample of 582 of 900 physicians practicing family medicine (n=149), general internal medicine (n=115), and obstetrics/gynecology (n=136). The response rate was 69%.</td>
<td>Seventy-nine percent of the primary care physicians routinely screen injured patients for IPA. However, routine screening was less common for new patient visits (10%), periodic checkups (9%), and prenatal care (11%). Neither physician sex nor recent IPA training had significant effects on reported new patient screening practices. Commonly cited barriers to identification and referral included the patients’ fear of retaliation (82%), and</td>
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Police involvement (55%), lack of patient disclosure (78%) and follow-up (52%), and cultural differences (56%). Commonly reported routine interventions included relaying concern for safety (91%), referral to shelters (79%) and counseling (88%), and documentation in the medical chart (89%).

<table>
<thead>
<tr>
<th>Study</th>
<th>Methodology</th>
<th>Objective</th>
<th>Data Collection</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waalen et al. (2000) USA</td>
<td>Literature review of published studies containing original research</td>
<td>To describe barriers to screening for IPV from health care professionals’ perspective</td>
<td>The studies were conducted among a variety of health care settings and among practitioners from a variety of specialties (physicians and nurses)</td>
<td>Provider-related barriers were lack of provider education regarding IPV, lack of time, and lack of effective interventions. Patient-related factors (patient nondisclosure, fear of offending the patient) were also frequently mentioned.</td>
</tr>
<tr>
<td>Fein et al. (2000) USA</td>
<td>Anonymous, cross-sectional written questionnaire</td>
<td>To assess emergency departments clinicians’ attitudes and behaviors regarding identification, assessment, and intervention for youth at risk for violence in the ED.</td>
<td>Emergency medicine residents and faculty, pediatric residents, pediatric emergency medicine fellows and faculty, and ED nurses A total of 184 (88%) of 208 potential respondents completed the questionnaire, including 107 physicians and 77 nurses.</td>
<td>Fifteen percent of the clinicians correctly recognized the lack of existing protocols for addressing youth violence. Clinicians reported being most active in identification of at-risk youth (93% asking context of injury and 82% determining relationship of victim and perpetrator), with pediatricians being more active than general ED clinicians. Clinicians less often reported performing assessment or referrals of at-risk youth. Nurses and physicians were no different in their reported identification, assessment, or referral behaviors. Barriers identified included concern over upsetting family members, lack of</td>
</tr>
</tbody>
</table>
Dowd et al. (2002) USA *Pediatric emergency department*  
To describe attitudes, feelings and beliefs of health care providers toward routine IPV screening. Qualitative study with semi-structured discussion guide  
Twenty-one nurses and 17 physicians participated dealing four provider focus groups (2 predominately female nurse focus groups and 2 physician groups)  
Themes identified in the provider groups included concerns about time constraints, fear of offending, and concerns that unless immediate intervention was available, the victim could placed in jeopardy.  

Lapidus et al. 2002 USA *Primary care*  
To assess rates of previous DV training, current screening practices, and barriers to screening for DV. Domestic violence was defined as past or current physical, sexual, emotional or verbal harm to a woman caused by a spouse, partner or family member. A statewide self-administered mail survey  
Pediatricians and pediatric care-providing family practice physicians (n=438). The response rate was 49%  
Twelve percent of the physicians reported routinely screening for DV at all well-child care visits, 61% reported screening only selective patients, and 30% said they did not screen for DV at all. Sixteen percent of the physicians reported having an office protocol for dealing with victims of DV. Lack of training was the greatest barrier to screening. Other major barriers to DV screening included: a lack of time for screening and for evaluating and counseling patients who screen positive, frustration that the physician cannot help, fear of offering, and a belief that DV is not a problem in this population. Prior DV training was the strongest predictor of routine screening.  

Ramsden & Bonner Emergency department  
To screen, for three months, all women sixteen years old and over  
Nursing and medical staff screened all women sixteen years old and over  
During the months, 2,446 over the age of 16
Intervention: staff undertook training and issues were addressed prior to the screening. A screening form was developed for the staff to use during the pilot. Information cards on IPV resources and referral flow chart were developed for their pilot.

regardless of reason for presentation. Taking part in the screening was voluntary and those women whom staff assessed to be physically and mentally unwell and unable to answer the questions were not screened.

presented to the ED, of these 245 women (10%) were screened for DV. Fifteen percent of them disclosed previous or current DV. Why screening did not occur, the main reasons given were that the woman was either physically or mentally unwell, or that a partner or family was present. Participation by staff in the screening project was a challenge and the staff identified the e.g. following reasons: lack of time to ask questions, a lack of privacy and confidentiality for patients, no after-hours social worker for referrals and belief that it was not useful to ask violence history. Elder abuse was not identified and the procedures were unclear when elder abuse is suspected. Also there were concerns that man asking a woman about DV may lead to a staff safety risk.
## Table 3. Some intervention studies in different health care settings

<table>
<thead>
<tr>
<th>Author(s), year and country</th>
<th>Setting</th>
<th>Objective and intervention method</th>
<th>Design</th>
<th>Type of sampling and subjects</th>
<th>Result</th>
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</thead>
<tbody>
<tr>
<td>Harwell et al. (1998) USA</td>
<td>Four community health centers (CHC)</td>
<td>To assess the intervention’s effort to increase screening, identification, and referral for services. <strong>Intervention:</strong> a two-phase evaluation was conducted to assess the Training Project (RADAR) *. Phase 1 included to evaluate professionals knowledge and comfort pre-training, post-training, and at 3 months follow up. Phase 2 included a medical chart review of 4 CHCs to assess the rates of screening, documentation of abuse, assessment of safety, and referrals for help at baseline (6 months pre-training) as compared to intervention period (6 months post-training).</td>
<td>Time series Self-administered surveys Medical records</td>
<td>Phase one: Of the 108 care providers who participated, 38% were physicians, 43% were nurses, nurse practitioners, nurse midwives, or physician assistant, and 20% were social workers or psychologists. Phase two: The medical charts of female clients, who had at least one visit during the baseline or intervention periods were systematically selected and reviewed. Half of the charts were from women seen during the 6 months prior to the RADAR* training (n=251), and half were from the 6 months after the training (n=255).</td>
<td>The health care providers’ perceived level of knowledge and comfort increased significantly post-training and then later decreased at 3 months follow-up. The rate of screening for DV (25% vs. 5%), suspicion of DV (6% vs. 2%), completion of safety assessments (17% vs. 5%), and referrals (4% vs. 0%) increased significantly between the intervention and baseline periods. However, the rates of documentation of abuse did not change.</td>
</tr>
<tr>
<td>Fanslow, Norton &amp; Robinson (1999) New Zealand</td>
<td>Two emergency departments</td>
<td>To evaluate if the positive effects of an initially successful ED protocol of care for victims of partner abuse (PA) were maintained at one year follow up. <strong>Intervention:</strong> involved training staff at one ED in a protocol for</td>
<td>A comparative study of the 2 EDs Before and after and follow up parallel groups</td>
<td>Outcomes were assess by reviewing a random sample of women’s medical records (total n=10 961) Identification of PA was assessed for each record on a yes/no basis. Identified cases were classified as ‘confirmed’ or ‘suspected’ PA.</td>
<td>Significant interactions were found for classification of PA and acute management offered to victims between EDs over the different study phases. However, the increase in identification of confirmed cases and the improved acute management</td>
</tr>
<tr>
<td>Study</td>
<td>Setting</td>
<td>Objective</td>
<td>Design</td>
<td>Protocol</td>
<td>Medical records</td>
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<tr>
<td>Parker et al. (1999)</td>
<td>Two public clinics prenatal setting</td>
<td>To evaluate the effectiveness of an intervention for abused pregnant women to prevent further abuse</td>
<td>Cohort study</td>
<td>The intervention was based on the principles of care outlined by the AMA.</td>
<td>Medical records</td>
</tr>
<tr>
<td>Thompson et al. (2000)</td>
<td>Primary care five primary care clinics of a large health maintenance organization (HMO)</td>
<td>To test the effectiveness of an over a 1-year period to improve asking about DV, case finding, and management in primary care.</td>
<td>A group-randomised controlled trial</td>
<td>The intervention included skill training for providers, environmental orchestration (posters in clinical areas, DV questions on health questionnaires), and measurement and feedback.</td>
<td>Medical records</td>
</tr>
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</table>
heterosexual or homosexual couples were included.

<table>
<thead>
<tr>
<th>Study (Year)</th>
<th>Setting</th>
<th>Intervention Details</th>
<th>Study Design</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Campbell et al. (2001) USA</td>
<td>The EDs of twelve hospitals</td>
<td>To evaluate a system-change model of training for improving the effectiveness of ED response to IPV</td>
<td>Randomized, controlled trial</td>
<td>ED visits were randomly selected and randomly assigned to experimental and control conditions ED teams (physician, nurse, social worker) from each experimental hospital and a local DV advocate participated. The experimental hospitals were significantly higher than the control hospitals on a staff knowledge and attitude measure, on all components of the ‘culture of the ED’ (having protocols regarding IPV, and having IPV information; brochures and relevant posters, regular, routine and mandated IPV training for staff) as well as patient satisfaction after the intervention. However, change in actual clinical practice was more difficult to achieve and may be influenced by institutional policy. There was no significant difference in the identification rates of battered women in the medical records of the experimental and control hospitals.</td>
</tr>
<tr>
<td>McFarlane et al. (2004) USA</td>
<td>A special family violence unit of a large urban district attorney’s office processing civil protection orders for abused women and offers counseling on DV and referrals to each applicant</td>
<td>To test a telephone intervention intended to increase the ‘safety-promoting behavior’ of abused women.</td>
<td>Case-control study</td>
<td>The women in the intervention group practiced significantly more safety-promoting behaviors (e.g. hid money, hid keys, hid extra clothing, social security number, bank account numbers, receipts) than women in the control group at each assessment.</td>
</tr>
</tbody>
</table>

Intervention: Emergency department teams (physician, nurse, social worker) from each experimental hospital and a local DV advocate participated in a two-day didactic information and team planning intervention. Intervention: Women in both groups received follow-up calls to assess safety-promoting behaviors at three, six, 12, and 18 months after intake.
<p>| Protheroe, Green &amp; Spiby (2004) UK | Midwifery services | To evaluate the impact on midwives of a training programme designed to increase their awareness and understanding of violence against women from men they know. <em>Intervention:</em> Midwives attended training. The training programme comprised a 3-hour training session, followed by a 2- to 3-month reflective practice period before attending a further 1-day training session. | A cross-sectional survey using semi-structured interviews. A stratified sample of 55 midwives who attend training were asked to participate. Twenty-six of them agreed. | Participants reported greater awareness and understanding of DV, and an increased likelihood of identifying and supporting women, partly through improved knowledge of other helping agencies. However, some practical difficulties were raised in implementing training including e.g. time and privacy (the presence of the partner, having time to talk to women). |</p>
<table>
<thead>
<tr>
<th>Author(s) and country</th>
<th>Setting</th>
<th>Objective</th>
<th>Design</th>
<th>Type of sampling and subjects</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rodriguez, Szkupinski &amp; Bauer. (1996) USA</td>
<td>Urban and suburban community-based organizations serving women and their families.</td>
<td>To determine the barriers to identification and management of DV from the battered woman’s perspective. The participants were asked to discuss definitions of DV, sources of help for problems related to DV and attitudes, feelings, and behaviors that may predispose battered women to seek, or to avoid seeking, help from health care providers.</td>
<td>Qualitative study method using semi-structured focus groups. Interviews lasted approximately 90 minutes.</td>
<td>Participants were 51 women with histories of DV with different ethnicity.</td>
<td>Participants identified a wide range of psychological (fear of escalating violence, shame and embarrassment, low self-esteem), social (adherence to gender roles; obligation to family / partner, economic dependency), and institutional / health system (cost of health care, long waiting times, possible police involvement) factors that affect their willingness to seek for help. Eighty-six percent of participants described the importance of a good patient-provider relationship including with elements of trust, compassion, support and confidentiality. Most participants said that that providers should take the initiative to ask directly about DV. Participants also emphasized that providers need to be supportive and non-judgmental, and take time to listen to battered women.</td>
</tr>
<tr>
<td>Caralis and Musialowski</td>
<td>Primary care (ambulatory)</td>
<td>To develop appropriate medical intervention methods to stop</td>
<td>Interviewing, using a</td>
<td>Four hundred six female patients</td>
<td>Although 68% of the women could tell their doctors they were abuse</td>
</tr>
<tr>
<td>Year</td>
<td>Location</td>
<td>Study Design</td>
<td>Methodology</td>
<td>Sample</td>
<td>Results/Findings</td>
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<tr>
<td>1997</td>
<td>USA</td>
<td>Clinics</td>
<td>Standardized questionnaire</td>
<td>Abuse by assessing women’s experiences with DV and their expectations of physicians in treating victims.</td>
<td>Only 12% have been asked about abuse. Even when told of abuse, the doctors did nothing for 20% of the patients. As part of treatment, all women strongly recommended that doctors provide information on community and legal resources and assistance in seeking for help.</td>
</tr>
<tr>
<td>1998</td>
<td>USA</td>
<td>Self-reported survey</td>
<td>One hundred fifty women who had been battered by a male partner recruited from support groups and other battered support groups and other battered women’s programs.</td>
<td>The participants valued emotional support in the form of confidentiality. The emotionally supportive physician listens carefully and reassures the woman that the abuse is not her fault, and her feelings of shame, fear, anger, depression are understandable. Valued practical support includes telling that spouse abuse is illegal and wrong. Battered women want to know resources (e.g., shelters, legal services), but do not want their physicians to take actions without their knowledge. The physician should also ask about safety of the children. Almost one third of women reported that their physician examined them roughly, minimized an injury, blamed the patient for the abuse, excused the abusive man, and/or failed to provide resources.</td>
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<tr>
<td>?</td>
<td>USA</td>
<td>Qualitative methodology</td>
<td>Twenty-one women in group therapy for domestic violence.</td>
<td>To explore the attitudes and experiences of abused women to identify barriers to disclosure of abuse.</td>
<td>Many of the barriers to disclosure of abuse could be overcome by a...</td>
</tr>
<tr>
<td>Year</td>
<td>Location</td>
<td>Setting</td>
<td>Methodology</td>
<td>Participants</td>
<td>Findings</td>
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<tr>
<td>1998</td>
<td>USA</td>
<td>centers and one women’s shelter</td>
<td>identify characteristics that helped or hindered abuse disclosure to clinicians and to determine how women viewed potential interventions to improve detection and treatment in a medical settings</td>
<td>physician’s knowledge of the link between abuse and medical illness, an understanding of the women’s emotions about abuse (e.g. women reported intense shame about the abuse and described their self-denial of abuse), and her treatment preferences.</td>
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</tr>
<tr>
<td>Yam M. (2000)</td>
<td>USA</td>
<td>Emergency department</td>
<td>To describe bettered women’s perceptions of their ED experience. A battered woman was defined as a woman who had been subjected to the use of physical force (battering) by her male partner.</td>
<td>A qualitative design with a phenomenological approach. Methods used to collect data were in-depth, individual, audiotaped interviews and demographic data sheets. Five women who had sought help for abuse related injuries at a hospital emergency department within the past 12 months participated in the study.</td>
<td>Several categories emerged as being descriptive of the women’s perceptions of their ED experience. Themes were; fear of their partner, concern of children, and loneliness; the women’s belief that ED staff do not understand abuse; satisfaction with treatment of physical injuries but dissatisfaction with how the issue of abuse is managed; the difficulty of disclosing the abuse because of fear, embarrassment, and lack of resources; and a request that health care professionals display compassion, provide referrals, and offer options.</td>
</tr>
<tr>
<td>Peckover (2003)</td>
<td>U.K.</td>
<td>Health visiting service</td>
<td>To describe women’s accounts of contact experienced DV with the health visiting service.</td>
<td>Qualitative study with interview data. Sixteen women</td>
<td>Women described difficulties in seeking help about DV included practical concerns such as fears for their own safety, lack of knowledge regarding appropriate sources of support and protection, and concerns about losing custody of their children. For those who disclosed the DV to their health visitors, they did not always receive appropriate support or</td>
</tr>
<tr>
<td>Chang et al. (2004) USA</td>
<td>To determine what women want from health care interventions for IPV and understand why they found certain interventions useful or not useful.</td>
<td>Qualitative method using semi-structured personal interviews including a pile sort procedure</td>
<td>Twenty-one participants with past or current IPV history recruited using flyers, posters, and announcements at a local DV shelter, a women’s hospital, and a general internal medicine clinic; and direct recruitment by health care clinicians who identified patients with experiences of IPV.</td>
<td>The women wanted legal, hotline, and IPV resource information as well as counselling on safety, relationship issues, and depression / anxiety. The women emphasized on individualizing IPV interventions to the specific needs, concerns, and stage of readiness of each woman that protected safety, privacy, and autonomy.</td>
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</table>
Table 5. *Factors that influence to intervene in IPV/DV from health care professionals’ perspective*

<table>
<thead>
<tr>
<th>Author(s) and country</th>
<th>Setting</th>
<th>Objective</th>
<th>Design</th>
<th>Type of sampling and subjects</th>
<th>Result</th>
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</thead>
<tbody>
<tr>
<td>McGrath et al. (1997) USA</td>
<td>Adult ED trauma center, An affiliated pediatric ED, Women’s urgent care center</td>
<td>To determine health professionals’ behavior in screening for DV and sexual assault (SA); training in DV and SA; knowledge of available protocols for DV and SA; and perception of barriers to intervention.</td>
<td>Anonymous, structured survey were distributed to staff</td>
<td>Of 207 staff members included physicians, nurses and social workers. The response rate was 59%. Fifty-four percent of doctors and 68% of the others reported that they never / rarely screen for DV or SA. Thirty-five percent had not received DV training and 27% SA training. Providers trained in DV were more likely to screen for DV and SA. Barriers that the majority of staff experienced in the care of DV/SA victims included: frustration that the abused person would return to a partner, concerns about misdiagnosis, lack of time, personal discomfort, reluctance to intrude into familial privacy, and lack of 24-hour social service support.</td>
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<tr>
<td>Wright, Wright &amp; Isaac (1997) USA / CAN</td>
<td>Pediatric emergency in the United States and Canada</td>
<td>To determine pediatric emergency medicine fellows’ level of preparedness to respond to battered mothers, and assess obstacles and attitudinal barriers to their effective response</td>
<td>Self-reported written survey</td>
<td>162 pediatric emergency medicine fellows Items most frequently selected from a list of potential obstacles to responding to battered women included: lack of protocol, lack of formal training in the field, and lack of experience with woman battering case Potential attitudinal barriers confirmed with the greatest frequency included: frustration that nothing could be done and lack of time to respond appropriately</td>
<td></td>
</tr>
<tr>
<td>Author(s)</td>
<td>Country</td>
<td>Study Design</td>
<td>Methodology</td>
<td>Results</td>
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<tr>
<td>Perttu (1999) Finland (The part of the EU Daphne project)</td>
<td>Seven town</td>
<td>The first part of survey concentrated e.g., the extent of DV counted in the work of social welfare and health care professionals and the second part examined the skills, means and collaboration of professionals in encountering violence and their views of prevention of DV</td>
<td>A postal questionnaire</td>
<td>Professionals were uncertain about recognizing and dealing with DV. The professionals were not aware of the trauma caused by violence (biggest obstacles to helping). Pace of work and lack of time obstacles to intervention. The secrecy code and its interpretation obstacles to networking. Great need for training, guidance and advice were also seen important.</td>
<td></td>
</tr>
<tr>
<td>Sugg et al. (1999) USA</td>
<td>Five primarily care clinics with 240 providers at a large urban health maintenance organization</td>
<td>To assess the attitudes and beliefs of the primarily care provider team (physicians, physician assistants, nurses, and medical assistants) toward the identification and management of abused patients and perpetrators of DV</td>
<td>Survey using a confidential questionnaire</td>
<td>Fifty percent of clinicians and 70% of nurses/assistants believed that the prevalence of DV in their practice was 1% or less; 1 in 10 clinicians and nearly half of nurses/assistants had never identified an abused person; 45% of clinicians never or seldom asked about DV when examining injured patients. Twenty-five percent believed the abused person’s personality led to the violence; 28% believed they did not have strategies to help abused persons; and 20% were concerned for their personal safety in discussing DV. Only 10% believed they had management information, but 77% had not attended any educational programs on DV in the past year.</td>
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<tr>
<td>Rönnberg and Hammarström (2000) Sweden</td>
<td>Studies concerning different health care settings.</td>
<td>To review (from feminist perspective) about possible barriers to recognition and intervention regarding women</td>
<td>Literature review</td>
<td>A total of 49 articles published in 1988-1998</td>
<td>The barriers reported by the health care professionals were: lack of education, the stereotype of 'a typical battered woman', too close</td>
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exposed to sexualised violence in their interactions with the health care system.

identification with the victim/abuser, time constraints, fear of offending the victim/abuser, and feelings of hopelessness and non-responsibility

List of abbreviations used in Tables:
DV  Domestic Violence  ED  Emergency department  IPA  Intimate Partner Abuse  SA  Sexual Abuse  CHC  Community Health Centre

*) RADAR
R = Routine screening
A = Ask direct questions
D = Document your findings
A = Assess patient safety

**) The protocol include providing staff training on recognizing signs and symptoms indicative of DV, asking appropriate screening/casefinding questions, assessing immediate risk and providing appropriate intervention (including depression assessment, counseling about police and legal options, and safety planning, in addition to treatment of physical injuries, and referrals to community and social services by American Medical Association, council of scientific affairs. Violence against women: Relevance for medical practitioners (JAMA 1992, 267, 3184-3189).
APPENDIX 5
Application to conduct the study

Arvoisa hallintoylihoitaja, johtava ylihoitaja, ylihoitaja


Tutkimus on kaksivaiheinen. Tutkimusaineistot koostuvat sekä asiakkaille että hoitohenkilöstölle kohdistetuista kysely- ja haastatteluaineistoista. Tutkimuslupa pyydettään kussakin organisaatiossa ja noudatetaan kunkin organisaation tutkimusosaston eettisiä ohjeita lopamaatettuksessa. Lisäksi joka lavassa tutkimusorganisaatiosta on yhteysnimeä, jonka kautta tutkimuksesta liittyvä kirjeenvaihdon tapauksessa ja johon tutkija on tarpeen mukaan yhteydessä.

Tutkimuksella on Pirkannyttä sairaanhoitopäivin eettisen toimikunnan myönteinen lausunto.

Ystävyysterveisin

Tuija Leppäkoski
terveystieteen jatko-opiskelija
09 861 3237 (työ)
050 514 8969

Päivi Åstedt-Kurki
professori
väitöskirjastyrä

Eija Paavilainen
ma. professori
väitöskirjastyrä

Liitteet: Tutkimusuuunnitelma
PUSH:n eettisen toimikunnan lausunto tutkimuksesta

POSTISOITE: HOIOTIETEEN LAITOS 33014 TAMPEREEN YLIOPISTO
MAILING ADDRESS: DEPARTMENT OF NURSING SCIENCE FIN-33014 UNIVERSITY OF TAMPERE FINLAND
PUB/TEL: +358 (0)3 215 8000
TELEFAX: +358 (0)3 215 8665

KATUOSOITE/ VISITING ADDRESS: Medicintie 3 33014 TAMPEREEN YLIOPISTO FINLAND

201
APPENDIX 6
Announcement to the staff

TIEDOTE HENKILÖKUNNALLE KOSKIEN TUTKIMUSHENKILÖIDEN REKRYTOINTIA

"Parishudeväkivaltaa kokonut nainen ensiapupoliklinikan asiakkaana” — tutkimus

Arvoisa ensiapupoliklinikan henkilökunta,


Tassa tutkimuksessa parsiuheväkivaltaa ymmärretaan sekä nykyisen että entisen avio- tai avopuolisen että miesystävän naiskumpaaniassa kohdistamaksi välivallaksi. Tällöin kyseessä on parsiuhe, jossa ensiapupoliklinikalle saapumisen hetkellä a. osapuolet ovat naismisissa ja asuvat yhdessä, b. osapuolet ovat naimisissa eivätkä asu yhdessä (osapuolet ovat asumuserassa t. asumusero on vireillä), c. osapuolet eivät ole naimisissa ja asuvat yhdessä (pahoinpitelijä on nykyinen avomies), d. osapuolet eivät ole naimisissa eivätkä asu yhdessä (osapuolet ovat eronneet ja pahoinpitelijä on entinen avomies tai nykyinen miesystävä). Tutkimus rajataan suomalaisista kulttuurista koskevaksi ja asiakkaan tulee olla täysikäinen (18 vuotta täyttänyt) voidakseen osallistua tutkimukseen. Lisäksi asiakassuhteessa tulee liitetä, että kyseessä on parsiuheväkivalta.


Jokaisessa tutkimusorganisaatiossa on yhteys henkilö, jonka kautta tutkimukseen liittyvää kirjeenvaihto tapahtuu ja johon tutkija on tarpeen mukaan yhteydessä.

Teidän organiseetaissanne yhteys henkilölle on

Yhteysosoitteet:
Tuja Leppäkosken
terveysliiteliöen jatko-opiskelija
tuula.leppakoski@uta.fi
050 514 8969

Päivi Åstedt-Kurki
professori
väitöskirjatyön ohjaaja

Eija Paavilainen
ma. professori
väitöskirjatyön ohjaaja
APPENDIX 7
Accompanying letter for women exposed to acute physical IPV seeking care

TIAMPEREEN YLIOPISTO
HOITOTIETEEN LAITOS

UNIVERSITY OF TAMPERE
DEPARTMENT OF NURSING SCIENCE

ASIAKASTIEDOTE PARISUHDEVÄKIVALLAN VUOKSI HOITOON HAKEUTUNEILLE NAISILLE

Arvoisa asiakas,


Menestän olevan tutkimuksen laskutukseensa on selvitä paheutiperheen vuoksi ensiapupoliikin kliikoille ja -asemille hakeutuvien naisten hoitokokemukset. Tutkimuksen tuottaman tiedon avulla ensiapupoliikin asemi työskentelevät hoitoyön ammattilaiset ja muu sosiaali- ja terveydenhuollon henkilöstö voivat kehittää palvelujärjestelmiämänsä naisen ja hänen läheistensä terveyden ja hyvinvoinnin edistämiseksi.


Mikäli päättäte osallistua tähän tutkimukseen, pyydämme Teitä kohtelaimmin allekirjoittamaan oheisen suostumuksen ja palauttamaan sen yhdessä kyseisellä mukassa. Voitte täyttää kyseisellä mukassa ennen poistumistaan poliklinikalta tai ottaa kyseisellä mukassa mukaanen ja palauttaa se kahden viikon sisällä kirjoituessaan olevaan osoitteeseen.

Kiitos vastauksestanne ja osallistumisestanne tutkimukseen.

Päivi Åstedt-Kurki
professori
väittöskirjatyön ohjaaja

Eija Paavilainen
ma. professori
väittöskirjatyön ohjaaja

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FINLAND

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APPENDIX 8

Permission and instruction with questionnaire (in Finnish and in English) for women exposed to physical IPV

PARISUHDEVÄKIVALTAAN KOKENEEN NAISEN HOITOKOKEMUKSIA SELVITTÄVÄ TUTKIMUS


suostutun osallistumaan tutkimukseen

asiakkaan allekirjoitus

asiakkaan nimen selvennys

asiakkaan syintymänäika

asiakkaan yhteystiedot

paikka ja päiväys

suostumukseen vastaanottaja

suostumukseen vastaanottajan allekirjoitus

paikka ja päiväys

Oikaa ystävällinen ja palauttakaa tämä suostumuslomake yhdessä täytetyn kyselylomakkeen kanssa.

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MAILING ADDRESS:
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PUHELIN/PHONE:

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Arvoisa vastaanottaja


Tämä tutkimus on Tuula Leppäkosken vältös kirjatyön ja käsittelee naisen kokemaa väkivaltaa pariauhteessaan. Tutkimusta ohjaavat professorit Päivi Åstedt-Kurki ja Eija Paavilainen.

Tutkimuslomakkeen on varsin pitkä, koska asiakkaiden hoitokokemuksista ja niihin vaikuttavasta tekijöistä halutaan saada perusteellista ja luotettavaa tietoa. Kyselylomakkeeseen vastaaminen on vapaaehtoista, mutta toivomme kuitenkin, että osallistuisitte. Teidän mielepiteen on tärkeää ja arvokas tutkimuksen onnistumisen kannalta.


Pyydämme Teiltä lomaikkeen täytettyynne sulkumaan on oheiseen kirjelevureen yhdessä suostumuslomakkeen kanssa ja antamaan kirjelevuro ensiapupoliikkinen henkilökunnalle. Jos päätätte täyttää lomaikkeen muualla, pyydämme lähettämään sen postitse kahden viikon kuluessa oheiseen kirjelevurosa. Postimaksu on maksattu.

Yhteistyössä kiitän!

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Päivi Åstedt-Kurki
professori
vältös kirjatyön ohjaaja

Eija Paavilainen
ma. professori
vältös kirjatyön ohjaaja

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Fyysisä parisuhdeväkivaltaa kokeneet naiset

Kyselylomake

Olkaa hyvä ja vastatkaa kysymyksiin rengastamalla katsomanne sopivin vaihtoehto(t) ja/tai kirjoittamalla kysytty tieto sille varattuun tilaan.

A. TAUSTATIETOJA

1. Mikä on syntymävuotenne?
   19 _____

2. Mikä on siviilisääätynne?
   1. Avio- tai avoliitossa
   2. Seurustelusuhteessa
   3. Naimaton
   4. Leski
   5. Eroprosessi on vireillä
   6. Eronnut tai asumuserossa

3. Kuinka kauan olette ollut nykyisessä avio- tai avoliitossa tai seurustelusuhteessa?
   _____ vuotta _____ kuukautta

4. Miten asutte tällä hetkellä?
   1. Asun yksin
   2. Asun avio- tai avopuolisoni kanssa
   3. Asun muun omainen (esim. äidin) tai läheisen (esim. ystävättären) kanssa.

5. Kuinka monta lasta asuu kanssanne kotona?
   _____ lasta, joista alle 18-vuotiaita on _____ lasta

6. Mikä on saamanne koulutus?
   a) Yleissivistävä
1. Kansakoulu
2. Keskikoulu tai peruskoulu
3. Lukio
4. Jokin muu, mikä? ________________________________

b) Ammatillinen

1. Ei ammatillista koulutusta
2. Kouluasteen ammatillinen koulutus
3. Opistoasteen ammatillinen koulutus
4. Ammattikorkeakoulu
5. Korkeakoulu tai yliopisto
6. Jokin muu, mikä? ________________________________

7. Mikä seuraavista vaihtoehdoista kuvaa nykyistä toimintaanne?

1. Työssä
2. Virkavapaalla tai työläsloilla tai vuorotteluvapaalla
3. Sairausloilla
4. Työn tai työnhakija
5. Kotiäiti
6. Opiskelija
7. Eläkkeellä

8. Aikaisempi pahoittely muun henkilön kuin nykyisen kumpannin toimesta

a) Oletteko koskaan aikaisemmin elämissäntä kokenut ruumiillista väkivaltaa muun henkilön kuin nykyisen kumpannin taholta?

1. En
2. Kyllä

b) Jos vastasitte edelliseen kysymykseen myönteisesti, niin voisitteko kertoa kenen tai keiden taholta? (Ympyröikää kaikki sopivat vaihtoehdot)

<table>
<thead>
<tr>
<th></th>
<th>Ei</th>
<th>Kyllä</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Entinen avio- tai avomies</td>
<td>1</td>
</tr>
<tr>
<td>2.</td>
<td>Entinen mies- tai poikaystävä</td>
<td>1</td>
</tr>
<tr>
<td>3.</td>
<td>Lähesukulainen</td>
<td>1</td>
</tr>
<tr>
<td>4.</td>
<td>Työkaveri</td>
<td>1</td>
</tr>
<tr>
<td>5.</td>
<td>Satunnaisuttavuus</td>
<td>1</td>
</tr>
<tr>
<td>6.</td>
<td>Vieras henkilö</td>
<td>1</td>
</tr>
<tr>
<td>7.</td>
<td>Joku muu henkilö, kuka?</td>
<td>1</td>
</tr>
</tbody>
</table>

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9. Nykyisen kumppanin aiheuttama aikaisempi pahoinpitely

a) Onko nykyinen kumppaninne pahoinpidellyt Teitä aikaisemmin?

1. Ei
2. Kyllä

b) Jos vastasitte edelliseen kysymykseen myönteisesti, niin arvioikaa montako kertaa: _______ kertaa

10. Pahoinpitelyyn hakemanne aikaisempi apu

a) Oletteko aikaisemmin hakenut apua nykyisen kumppaninne pahoinpitelyyn seurauksena saamianne ruumiillisiin vammoihin?

1. En
2. Kyllä

b) Jos vastasitte edelliseen kysymykseen kyllä, niin mistä hoitopaikoista olette apua hakenut? (Ympyröikää kaikki sopivat vaihtoehdot)

<table>
<thead>
<tr>
<th>Ei</th>
<th>Kyllä</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.  Yliopistosaaran ensiapupoliklinikalta</td>
<td>1</td>
</tr>
<tr>
<td>2.  Keskussairaalalan ensiapupoliklinikalta</td>
<td>1</td>
</tr>
<tr>
<td>3.  Aluesairaalalan ensiapupoliklinikalta</td>
<td>1</td>
</tr>
<tr>
<td>4.  Terveyskeskuksen ensiapupoliklinikalta</td>
<td>1</td>
</tr>
<tr>
<td>5.  Yksityiseltä lääkäriasemalta</td>
<td>1</td>
</tr>
<tr>
<td>6.  Työterveyslääkäriiltä</td>
<td>1</td>
</tr>
<tr>
<td>7.  Jostakin muualta, mistä?</td>
<td>1</td>
</tr>
</tbody>
</table>

11. Väkivallan esiintymisen muodot

a) Onko nykyisessä parisuhteessanne esiintynyt ruumiillisen väkivallan (mm. lyöminen, potkiminen, töniminen) ohella myös muita väkivallan muotoja?

1. Ei
2. Kyllä

b) Jos vastasitte edelliseen kysymykseen myönteisesti, niin voisitteko kertoa mitä muita väkivallan muotoja parisuhteessanne on esiintynyt? (Ympyröikää kaikki sopivat vaihtoehdot)

<table>
<thead>
<tr>
<th>Ei</th>
<th>Kyllä</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.  Seksuaalista väkivaltaa (esim. raiskaus tai seksiiin pakottaminen)</td>
<td>1</td>
</tr>
<tr>
<td>2.  Henkistä väkivaltaa (esim. toistuvaa syyttelyä, nimittelyä, ihmisuhteista eristämistä, raivokohtauksia, vahtimista ja kontrollointia)</td>
<td>1</td>
</tr>
<tr>
<td>3.  Taloudellista väkivaltaa (esim. oman rahan käytön estämistä, rahan kirstämistä tai omaisuuden luvatonta käyttöä)</td>
<td>1</td>
</tr>
</tbody>
</table>

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4. Uskonnollista väkivaltaa
   (esim. uskonnon harjoittamisen kieltämistä) 1 2
5. Muita väkivallan muotoja, mitä?

_________________________________________________________________________________

1 2

B. TAPAHTUNUT VÄKIVALLANTEKO JA HOITOON HAKEUTUMISENNE

12. Minkälaista ruumiillista tai muuta väkivaltaa koitte tällä kertaa kumppaninne
taholta ennen hakeutumistantanne hoitoon ensiapupoliklinikalle?
   (Ympyröikää kaikki sopivat vaihtoehdot)

   2. Pelottelu, uhkailu 8. Veitsellä tai puukolla iskeminen
   3. Töniminen 9. Ampuminen
   4. Lyöminen 10. Raiskaus
   5. Nyrkillä iskeminen 11. Kuristaminen

13. Missä väkivallanteko tapahtui?

   1. Omassa tai yhteisessä kodissa
   2. Tuttavien, ystävien tai sukulaisten kodissa
   3. Jossakin muualla, missä? ______________________________________

14. Oliko kumppaninne väkivallanteon hetkellä päihteiden vaikutuksen alaisena?
   (Ympyröikää kaikki sopivat vaihtoehdot)

   1. Alkoholi 3. Lääkkeet
   2. Huumeet 4. Kumppanini ei ollut päihtynyt
                  väkivallanteon hetkellä

15. Olitteko itse väkivallanteon hetkellä päihteiden vaikutuksen alaisena?
   (Ympyröikää kaikki sopivat vaihtoehdot)

   1. Alkoholi 3. Lääkkeet
   2. Huumeet 4. En ollut päihtynyt väkivallanteon hetkellä

16. Kuinka tulitte hoitoon ensiapupoliklinikalle?

   1. Väkivallan tekijä saattoi
   2. Tuttava tai ystävä saattoi
   3. Muu lähiomainen (esim. tytär tai poika) saattoi
   4. Tulin itse oman avuin

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5. Poliisi saattoi
6. Tulin muulla tavoin, miten?

________________________________________________________
________________________________________________________

17. Missä terveydenhuoltolaitoksessa Teitä hoidettiin nyt?

1. Yliopistollinen sairaala
2. Keskussairaala
3. Aluesairaala
4. Terveyskeskus
5. Jokin muu hoitolaitos, mikä? ________________________________

18. Arvioikaa kuinka kauan aikaa oli kulunut vähivallanteosta hakeutuessanne hoitoon ensiapupoliklinikalle?

1. alle 1 tunti 4. 8-12 tuntia 7. yli 2 vuorokautta
2. 1-3 tuntia 5. 13-24 tuntia 8. yli 3 vuorokautta
3. 4-7 tuntia 6. yli vuorokausi

19. Minkälaisia saamanne vammat olivat?

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

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C. SAAMAANNE HOITOON JA TUKEEN LIITTYVIÄ MIELIPITEITÄ

20. Seuraavassa esitän hoitokokemukseanne koskevia väitteitä. 
Mitä mieltä olette niiden paikkansapitävyydestä? 
(Ympyröikää numeroista 1-5 se, joka parhaiten vastaa mielipidettänne).

1. Minulta kysyttiin, olinko joutunut pahoinpitelyn kohteeksi  
2. Kertomani väkivaltakokemuksen todenperäisyttä epäiltiin  
3. Minua rohkaistiin tekemään pahoinpitelyystä rikosilmoitus  
4. Hoitohenkilöstö keskusteli kanssani kahden kesken  
5. Lääkäri tutki minut huolellisesti  
6. Minulta kysyttiin kotona olevien lapsieni turvallisuudesta  
7. Minulle kerrottiin eri auttajatahoista (naisten keskusteluryhmät, oikeusapu, turvakodit ym.) ja sain niistä kertovia opaslehteisiä tai tiedotteita  
8. Minulla oli mahdollisuus tavata ensiapupoliklinikalla ollessani erityistyöntekijöitä, esim. sosiaali- ja kriisipäivystyksen tai vastaavan auttajatahon edustajia  
9. Hoitohenkilöstö opasti minua turvasuunnitelman tekemisessä tulevaisuutta varten (mm. sain suullisesti ohjeita ja/tai kirjallista tiedotusta vastaisten vaaratilanteiden varalle)  
10. Hoitohenkilöstö keskusteli erikseen myös pahoinpitelijän (avio- tai avopuolisoni, miesystäväni) kanssa tapahtuneesta (Mikäli tämä oli saattajana ensiapupoliklinikalla)  
11. Hoitohenkilöstö suhtautui vähättelevästi tilanteeseeni enkä tuntenut saavani riittävästi ymmärtämystä  
12. Minulle tarjottiin mahdollisuutta yöpyä ensiapupoliklinikalla  
13. Hoitohenkilöstö ei puuttunut pahoinpitelyysyksestä mitenkään vaan suorittavat hoitotöitä ennen  
14. Keskustelimme hoitohenkilöstön tai sosiaalityöntekijän kanssa yhdessä, miten lapsia voi suojella väkivaltaisesta onnettomuudesta (Mikäli tämä oli saattajana ensiapupoliklinikalla)  
15. Yhteistyö sujuu hyvin minua hoitaneiden henkilöiden kanssa  
16. Hoitohenkilöstö neuvoo väkivallan tekijää hakamaan apua väkivaltaiseen käyttäytymiseensä. (Mikäli tämä oli mukana)
21. Mikä ensiapupoliklinikalla asioidessanne oli hoitonne osalta hyvää?
__________________________________________________________________________

22. Minkä seikat koitte mahdollisesti huonoiksi asioidessanne ensiapupiliklinikalla?
__________________________________________________________________________

23. Minkälaista muuta mahdollista apua olisitte tarvinnut asioidessanne ensiapupoli-
   klinikalla, mutta ette mielestänne saanut?
__________________________________________________________________________

24. Minkä asiat mahdollisesti vaikeuttivat avun hakemistanne?
__________________________________________________________________________
25. Miten tärkeinä pidätte seuraavia hoitoonne liittyviä toimintaperiaatteita? (Ympyröikää numeroista 1–4 se, joka parhaiten vastaa mielipidettänne).

1. Uskominen kertomukseeni tapahtuneesta
   1 2 3 4

2. Jatkohoitomahdollisuksien selvittäminen yhdessä
   1 2 3 4

3. Ystävällinen ja turvallinen ilmapiiri
   1 2 3 4

4. Väkivallasta avoimesti puhuminen
   1 2 3 4

5. Tukeminen rikosilmoituksen tekemisessä
   1 2 3 4

6. Luottamuksellinen hoitosuhde
   1 2 3 4

7. Peloista keskusteleminen
   1 2 3 4

8. Rohkaisemenen hakamaan apua väkivaltaiseen pariisuhteeseen
   1 2 3 4

9. Huolellisesti suoritetu lääkärintutkimus
   1 2 3 4

10. Jokin muu tärkeäksi kokemanne toimintaperiaate, mikä? __________________________________________
    1 2 3 4

26. Mihin poistuitte ensiapupoliklinikalta saamanne avun jälkeen?

1. Omaan tai yhteiseen kotiin
2. Tuttavan tai sukulaisen kotiin
3. Turvakotiin
4. Saman sairaalan toiseen hoitoyksikköön
5. Toiseen hoitolaitokseen, mihin?
6. Johonkin muuhun paikkaan, mihin?______________________________________
27. Onko kumppaninne hakenut ulkopuolista apua väkivaltaiseen käyttäytymiseensä?

1. Kumppanini ei ole hakenut apua väkivaltaiseen käyttäytymiseensä
2. Kyllä on hakenut apua.

Jos vastasitte tähän kysymykseen myöntävästi, niin millaista apua kumppaninne on hakenut?

_________________________________________________________________________
_________________________________________________________________________

28. Kenelle mielestänne vastuu väkivallan lopettamisesta ensisijaisesti kuuluu?

1. Naiselle
2. Väkivallan tekijälle (mieskumppanillenne)
3. Hoitojenkilökunnalle
4. Molemille osapuolille (naiselle ja miehelle)
5. Muille ammattiauttajille (esimerkiksi sosiaalityöntekijöille)
6. Jollekin muulle taholle, kenelle? _______________________________________

29. Oletteko valmis antamaan myöhemmin lisätietoja haastattelun puitteissa?

1. En ole
2. Kyllä olen.

Yhteystietoni:
__________________________________________________________________
__________________________________________________________________

Lomakkeen täyttöpäivämäärä: ____ / ____ 200

Monet kiitokset avustanne!

Jos Teillä tulee mieleen muita hoitoonne liittyviä ajatuksia, voitte kirjoitella niitä kaikin mokomin lomakkeen vapaaseen tilaan.
Women exposed to acute physical intimate partner violence

Questionnaire

Please answer the questions by circling the alternative(s) which You think is the most appropriate and/or by writing down the information in the space given.

A. BACKGROUND INFORMATION

1. In which year were You born?

19 _____

2. What is Your marital status?

1. Married/cohabiting
2. Dating
3. Single
4. Widowed
5. Divorce is pending
6. Divorced/separated

3. How long have You been married to or cohabiting with or dating Your current partner?

______ years ______ months

4. How do You live at present?

1. I live alone
2. I live with my husband or cohabitant
3. I live with some other relative (e.g. mother) or with a close friend (e.g. girlfriend)

5. How many children live with You in the same household?

______ child/children, of which ______ child/children are under the age of 18

PTO!
6. What is Your education?
   a) General
      
      1. Elementary school
      2. Middle school or comprehensive school
      3. Upper secondary school
      4. Other (please specify) __________________________

   b) Professional
      
      1. No professional education
      2. Vocational upper secondary education
      3. Post-secondary level vocational education
      4. Polytechnic
      5. Higher education institution or university
      6. Other (please specify) __________________________

7. Which of the following alternatives describes Your current situation?

   1. Employed
   2. On leave of absence or alternation leave
   3. On sick leave
   4. Unemployed or job applicant
   5. Homemaker
   6. Student
   7. Retired

8. Past violence inflicted by some other person than current partner

   a) Have You ever before in your lifetime experienced physical violence by some other person than your current partner?
      
      1. No
      2. Yes

   b) If You answered ‘yes’ to the previous question could You please tell by whom.
      (Please circle every suitable alternative)
      
      |                          | No | Yes |
      |--------------------------|----|-----|
      | Former husband or cohabitant | 1  | 2   |
      | Former partner in a relationship | 1  | 2   |
      | Near relative             | 1  | 2   |
      | Workmate                  | 1  | 2   |
      | Occasional acquaintance   | 1  | 2   |
      | Stranger                  | 1  | 2   |
      | Some other person (please specify) | 1  | 2   |
9. Past violence inflicted by current partner

a) Have You previously been assaulted by Your current partner?

   1. No
   2. Yes

b) If You answered ‘yes’ to the previous question, please assess how many times:
   _____ times

10. Help previously sought for an assault

a) Have You previously sought care for Your physical injuries caused by Your current partner?

   1. No
   2. Yes

b) If You answered ‘yes’ to the previous question, from what kind of health care services have You sought help?
   (Please circle every suitable alternative)

<table>
<thead>
<tr>
<th>Service</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Emergency department of a university</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Emergency department of central hospital</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3. Emergency department of district hospital</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4. Emergency department of health centre</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5. Private clinic</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6. Company doctor</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>7. From somewhere else (please specify)</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

11. Types of violence

a) In addition to physical violence (e.g. hitting, kicking, pushing), have You experienced other kinds of violence by Your current partner?

   1. No
   2. Yes
b) If You answered ‘yes’ to the previous question could You please tell what kinds of violence You have experienced by Your current partner.
(Please circle every suitable alternative)

1. Sexual violence (e.g. rape or forced sexual intercourse)                   No   Yes
   1
2. Psychological violence (e.g. repeated accusing, name-calling, isolating from human relations, fits of rage, guarding and controlling)   1   2
3. Economic violence (e.g. prevention of using own money, extortion of money, unauthorized use of property)                      1   2
4. Spiritual violence (e.g. forbidding the practice of Your religion)            1   2
5. Other forms of violence (please specify)                                    1   2

B. THE EXPERIENCED ACT OF VIOLENCE AND YOU SEEKING CARE

12. What kind of physical or other violence did Your partner inflict on You this time before You arrived in care at the emergency department.
(Please circle every suitable alternative)

1. Yelling                                                                  7. Beating
2. Intimidation, threatening                                               8. Stabbing with a knife
4. Hitting                                                                  10. Raping
5. Punching                                                                 11. Strangulation
                                                                               ________________________________

13. Where did the act of violence take place?

1. In my/our home
2. In the home of an acquaintance, friend or relative
3. Somewhere else (please specify) _________________________________
14. **Was Your partner under the influence of some intoxicant when the act of violence took place?** (Please circle every suitable alternative)

1. Alcohol
2. Narcotics
3. Pharmaceuticals
4. My partner was not intoxicated when the act of violence took place

15. **Were You under the influence of some intoxicant when the act of violence took place?**

(Please circle every suitable alternative)

1. Alcohol
2. Narcotics
3. Pharmaceuticals
4. I was not intoxicated when the act of violence took place

16. **How did You arrive in care at the emergency department?**

1. The perpetrator escorted me
2. An acquaintance or a friend escorted me
3. Some other near relative (e.g. a daughter or son) escorted me
4. I arrived on my own
5. The police escorted me
6. I arrived in some other way (please specify)

__________________________________________________________________________

17. **At which emergency department were You cared for this time?**

1. University hospital
2. Central hospital
3. District hospital
4. Health centre
5. Some other health care unit (please specify)

__________________________________________________________________________

18. **Assess how much time had passed after the act of violence before You arrived in care at the emergency department?**

1. Less than 1 hour
2. 1-3 hours
3. 4-7 hours
4. 8-12 hours
5. 13-24 hours
6. More than one day
7. More than 2 days
8. More than 3 days

19. **What kinds of injuries did You receive?**

__________________________________________________________________________

__________________________________________________________________________

**PTO!**
C. OPINIONS CONCERNING THE CARE AND SUPPORT YOU RECEIVED

20. In the following, I present statements about the care You received.
What do You think about their accuracy?
(Please circle the alternative that most closely corresponds to Your opinion).

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Fully agree</th>
<th>Partly agree</th>
<th>Partly disagree</th>
<th>Fully disagree</th>
<th>I cannot say</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I was asked whether I had been assaulted</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2.</td>
<td>Professionals did not believe me when I told about my experience of violence</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3.</td>
<td>I was encouraged to report an offence to the police</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4.</td>
<td>Professionals discussed with me in private</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5.</td>
<td>A doctor examined me carefully</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6.</td>
<td>I was asked about the safety of my children at home</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7.</td>
<td>I was told about different help services (e.g. discussion groups with other women, legal aid, shelters etc.) and I received brochures and handouts on them</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8.</td>
<td>I was given the opportunity to meet specialized helpers during my visit to the emergency department (e.g. social and crisis services emergency duty personnel or similar helpers)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9.</td>
<td>Professionals helped me to plan my safety for future situations (e.g. I received oral advice and/or written information on future violent situations)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10.</td>
<td>Professionals also discussed in private with the perpetrator (my husband or cohabitant or partner in a relationship) about the incident (if he was escorting)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11.</td>
<td>Professionals belittled my situation and I felt that I did not get enough understanding</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12.</td>
<td>I was offered the opportunity to stay overnight at the emergency department</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13.</td>
<td>Professionals did not intervene in my violent situation in any way, and only took the necessary care measures</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>14.</td>
<td>I discussed with the professionals or with a social worker how to protect children in a violent situation (if there are children living with me at home)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>15.</td>
<td>Co-operation was good with those who provided me with care</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>16.</td>
<td>Professionals helped the perpetrator to get help for his violent behaviour (if he was escorting)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
21. Which aspects of care did You regard as good during Your visit to the emergency department?
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
22. Which aspects of care did You possibly regard as bad during Your visit to the emergency department?
_______________________________________________________________________________
_______________________________________________________________________________
23. What other kind of help would You have needed when visiting the emergency department, but did not receive in Your opinion?
_______________________________________________________________________________
_______________________________________________________________________________
24. What things possibly made it more difficult for You to seek help?
_______________________________________________________________________________
_______________________________________________________________________________
25. How important do You regard the following care principles concerning Your care?
(Please circle the alternative that most closely corresponds to Your opinion).

<table>
<thead>
<tr>
<th></th>
<th>Not important</th>
<th>A little important</th>
<th>Fairly important</th>
<th>Very important</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Believing my experience of acute violence</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. Deciding on aftercare together with professionals</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. Kind and secure care environment</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. Talking about violence openly</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. Encouragement in reporting an offence</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. Confidential care relationship</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. Talking about fears</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. Encouragement in getting help for the violent partnership</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9. Careful clinical examination</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10. Some other care principle You regard as important (please specify)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

PTO!

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26. Where did You go after leaving the emergency department?

1. To my home
2. To the home of a friend or a relative
3. To a shelter
4. To another care unit in the same hospital
5. To some other health care department (please specify)_______________________
6. To some other place (please specify)_____________________________________

27. Has Your partner sought outside help for his violent behaviour?

1. My partner has not sought help for his violent behaviour
2. Yes, he has sought help
   If You answered this question in the affirmative, please specify what kind of help he has sought:
   ______________________________________________________________________
   ______________________________________________________________________

28. In Your opinion, who has the primary responsibility for stopping the violent behaviour?

1. The woman herself
2. The perpetrator (male partner)
3. Emergency department professionals
4. Both parties (woman and perpetrator)
5. Other professionals (e.g. social workers)
6. Some other (please specify) ________________________________

29. Would You be willing to give further information later in an interview?

1. No
2. Yes.
   My contact information:
   ______________________________________________________________________
   ______________________________________________________________________

Date of responding to the questionnaire: ____ / ____ 200

Grateful thanks for Your help!

If You have some other thoughts concerning Your care, please feel free to write them down in the questionnaire’s blank space.
APPENDIX 9

Accompanying letter, permission and instruction with questionnaire for women exposed to physical IPV in Swedish

PATIENT INFORMATION TILL KVINNOR SOM SÖKT VÅRD PÅ GRUND AV VÄLD I SITT PARFÖRHÅLLANDE

Ärade kund


Meningen med pågående undersökning är att utreda värdefarenheter av de kvinnor som sökt sig till dejourpolikliniker. Med hjälp av den information som undersökningen ger, kan den vårdspecialiserade personalen på dejourpolikliniken samt övrig social- och hälsosvärdspersonal utveckla det servicesystem som befrämjar kvinnan och hennes anhörigas välbehinna.


Såvida ni besluter er att deltaga i undersökningen ber vi er hörvigen underteckna bifogade medtyckande samt returnera det tillsammans med frågeformuläret. Ni kan fylla i frågeformuläret innan ni lämnar polikliniken eller ta frågeformuläret med er och returnera det inom två veckor till adressen på kuvertet.

Tack för ert svar och för ert deltagande i undersökningen!

Tuja Leppäkoski
studerande
09-861 3237 (arb.)
tuja.leppakoski@uta.fi

Päivi Åstedt-Kurki
professor

Elja Paavilainen
professor

(klienten kan behålla denna blanket)
SAMTYCKE

UTREDANDE UNDERSÖKNING OM I PARFÖRHÅLLANDE VÄLDUTSATTA KVINNORS VÄRDERFARENHETER


____________________ / 200

ort och datering

Jag ger mitt samtycke till att delta i undersökningen:

klientens underskrift

emottagare

emottagarens underskrift

förtydlig av namn

förtydlig av namn

kontakts födelseår

adress

telefonnummer
Ärade mottagare


Syftet med undersökningen är att utreda vårdmodeller och erfarenheter på dejourpolikliniker och stationer, både ut kundens samt personalens synvinkel. Med hjälp av den information som undersökningen ger, kan den vårdspecialiserade personalen på dejourpolikliniken samt annan social- och hälsovårdspersonal utveckla det servicesystem som befärdmar kvinnan och hennes anhörigas välbefinnande.


Tack för samarbete!

Tuuja Leppäkoski
terveystieteiden jatko-opiskelija
tuija.leppakoski@uta.fi
050 514 8969

Päivi Åstedt-Kurki
professori
vältösirkjatyön ohjaaja

Elija Paavilainen
ma. professori
vältösirkjatyön ohjaaja
Frågeformulär

Ärade mottagare

Var vänlig och svara genom att inringa svaret ni anser vara lämpligast eller genom att skriva svaret på det reserverade utrymme.

A. BAKGRUNDSINFORMATION

1. Er ålder?
   _____ år

2. Ert civilstånd?
   1. Gift eller sambo
   2. Sällskapsförhållande
   3. Ogift
   4. Änka
   5. Skilsmässoprocess på gång
   6. Skild eller boskillnad

3. Hur länge har ni varit i ert nuvarande äktenskap eller samboende eller sällskapsförhållande?
   _____ år _____ månader

4. Hur bor ni för närvarande?
   1. Jag bor ensam
   2. Jag bor med min make eller sambo
   3. Jag bor med en annan anhörig (t.ex. mor) eller närastående (t.ex. väninna)

5. Hur många barn har ni hemma?
   _____ barn, av vilka _____ barn är under 18 år.

vänd!

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6. Vilken är er skolningsnivå?

a) Allmänbildande

1. Folkskola
2. Mellan- eller grundskola
3. Gymnasie
4. Någon annan form av skolning, vad? ____________________________

b) Yrkesutbildning

1. Ingen yrkesutbildning
2. Yrkesinriktad skoln. på skolnivå
3. Yrkesinriktad skoln. på institutnivå
4. Yrkeshögskola
5. Högskola eller universitet
6. Någon annan form av skolning, vad? ____________________________

7. Vilket av följande alternativ beskriver ert nuvarande arbete eller er sysselsättning?

1. Är i arbetslivet
2. Arbetslös
3. Studerande
4. Hemmafru
5. Pensionär
6. Något annat, vad? ____________________________

8. Har ni tidigare varit utsatt för våld inom ett annat parförhållande än det som ni nu är i?

a) Nej
2. Ja.

b) Om ni svarade jakande på frågan, kan ni då berätta av vem ni blev utsatt för våld? (Ni har möjlighet att inringa flera alternativ).

<table>
<thead>
<tr>
<th>Årsnummer</th>
<th>Nej</th>
<th>Ja</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. F.d. make eller sambo</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2. F.d. manlig vän eller pojkvän</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3. Nära släkting</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4. Arbetskamrat</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5. Tillfällig bekant</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6. Okänd person</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>7. Någon annan, vem?</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

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9. Har er nuvarande kumpan tidigare utsatt er för våld?

a)
1. Nej
2. Ja

b) Om ni svarade jakande på frågan, kan ni då uppskatta hur många gånger:

_____________ gånger

10. Har ni tidigare sökt hjälp för de fysiska skador ni fått genom misshandel?

a)
1. Nej
2. Ja

b) Om ni svarade jakande på föregående fråga, kan ni då berätta på vilka vårdplatser ni sökt hjälp? (Ni har möjlighet att inringa flera alternativ).

<table>
<thead>
<tr>
<th>Nej</th>
<th>Ja</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Universitetsklinikens dejourpoliklinik</td>
<td>l</td>
</tr>
<tr>
<td>2. Centralsjukhusets dejourpoliklinik</td>
<td>l</td>
</tr>
<tr>
<td>3. Kretssjukhusets dejourpoliklinik</td>
<td>l</td>
</tr>
<tr>
<td>4. Hälsocentralens dejourpoliklinik</td>
<td>l</td>
</tr>
<tr>
<td>5. Privat läkarstation</td>
<td>l</td>
</tr>
<tr>
<td>6. Arbetsplatsläkaren</td>
<td>l</td>
</tr>
<tr>
<td>7. Något annat ställe, vilket?</td>
<td>l</td>
</tr>
</tbody>
</table>

11. Har det förekommit, förutom fysiskt våld (s.s. slagning, sparkning, skuffning) någon annan form av våld inom nuvarande parförhållande

a)
1. Nej
2. Ja

b) Om ni svarade jakande på föregående fråga, kan ni då berätta vilka andra former av våld? (Ni har möjlighet att inringa flera alternativ)

<table>
<thead>
<tr>
<th>Nej</th>
<th>Ja</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Seksuell misshandel (tex. våldtäkt eller tvång till samlag)</td>
<td>1</td>
</tr>
<tr>
<td>2. Själslig våld (tex. återkommande beskyllningar, benämningar, isolering av människorelationer, raseriutbrått, vaktande och kontrollerande uppträdande.)</td>
<td>1</td>
</tr>
<tr>
<td>3. Ekonomiskt våld (tex. hindrande att använda sina egna pengar, utpressning eller olovlig användning av egendom.)</td>
<td>1</td>
</tr>
<tr>
<td>4. Kontroll över utövande av religion.</td>
<td>1</td>
</tr>
<tr>
<td>5. Annan form av våld, vad? ________________________________</td>
<td>1</td>
</tr>
</tbody>
</table>

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B. DEN SKEDDA VÅLDSHANDLINGEN SAMT ER EFTERFÖLJANDE VÅRD

12. Hurudant fysiskt eller annan form av våld utsattes ni för denna gång av er kumpan innan ni sökte hjälp? (Ni har möjlighet att inringa flera alternativ).

1. Skrik 7. Slagning
2. Skrämnings, hotelser 8. Knivhuggning
4. Hackande 10. Våldtäckt
5. Slag med knytnäv 11. Strypning
________________________

13. Var skedde våldshandlingen?

1. I eget eller gemensamma hem
2. I bekantas, vänners eller släktingars hem
3. Någon annanstans, var?

14. Var er kumpan drogpåverkad då han utförde våldet? (Ni har möjlighet att inringa flera alternativ).

1. Alkohol 3. Mediciner
2. Narkotika 4. Min kumpan var ej drogpåverkad

15. Var ni själv drogpåverkad under våldshandlingen? (Ni har möjlighet att inringa flera alternativ).

1. Alkohol 3. Mediciner
2. Narkotika 4. Jag var inte drogpåverkad

16. Vem hjälpte er att söka vård?

1. Den som utförde våldshandlingen
2. Bekant eller vän följde mig
3. Annan anhörig (t.ex son eller dotter) följde
4. Jag kom med egen hjälp
5. Polisen följde
6. Kom på annat sätt, hur?
17. På vilken vårdanstalt blev ni nu omskött?

1. Universitetsklinik
2. Centralsjukhus
3. Kretssjukhus
4. Hälsocentral
5. Någon annan vårdanstalt, vilken? ______________________________________

18. Uppskatta hur mycket tid det gått från den stund ni blev utsatt för våldet till det ni sökte hjälp på dejourpolikliniken?

1. under 1 timme
2. 1-3 timmar
3. 4-7 timmar
4. 8-12 timmar
5. 13-24 timmar
6. över 1 dygn
7. över 2 dygn
8. över 3 dygn

19. Hurudana skador fick ni?

_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

vänd!
C. ÅSIKTER ANGÅENDE FRÅGOR SOM BERÖR ER VÅRD

20. Härnäst framför jag påståenden som berör er vård. Anser ni att de håller plats? (Svaren ges genom att ringa in något alternativ mellan 1–5).

1. Man frågade mig, om jag blivit utsatt för våld 1  2  3  4  5
2. Personalen trodde inte på min berättelse 1  2  3  4  5
3. Man uppmuntrade mig att göra brottansmälan 1  2  3  4  5
4. Vårdpersonalen diskuterade med mig på tu man hand 1  2  3  4  5
5. Läkaren undersökte mig noggrant 1  2  3  4  5
6. Man frågade mig om mina barnens trygghet 1  2  3  4  5
7. Man berättade mig om utomstående hjälpinstanser (t.ex. om skyddshem o.d.) och jag fick bl.a skriftlig information 1  2  3  4  5
8. Jag hade möjlighet att träffa även andra specialgrupper (t.ex. social- och krisjouren el. motsvarande hjälpinstans) 1  2  3  4  5
9. Vårdpersonalen rådde mig att göra en skyddsplanering för framtiden (jag fick bl.a skriftlig information) 1  2  3  4  5
10. Vårdpersonalen diskuterade även med den som utförde våldet, om det skedda. (Såvida denne var med) 1  2  3  4  5
11. Vårdpersonalen brydde sig inte i tillräcklig grad om min situation och jag fick inte tillräckligt förståelse 1  2  3  4  5
12. Jag fick övernatta på dejouren 1  2  3  4  5
13. Vårdpersonalen tog inte tillräckligt del av frågorna kring våldshandlingen, utan utförde enbart den nödvändigaste vården. 1  2  3  4  5
14. Vi diskuterade tillsammans med skötaren eller socialarbetaren, hur man kan skydda barnen. (Om jag har barnen hemma) 1  2  3  4  5
15. Samarbete med vårdpersonalen fungerade bra 1  2  3  4  5
16. Vårdpersonalen rådde även den som utfört våldet att söka hjälp för sitt våldsbenägna beteende. (Såvida denne var med) 1  2  3  4  5

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21. Vilka saker angående er vård upplevde ni som bra under ert besök på dejourpolikliniken? ______________________________________________________________________
_______________________________________________________________________________

22. Vilka saker upplevde ni möjligen som dåliga under ert besök på dejourpolikliniken? ______________________________________________________________
_______________________________________________________________________________

23. Hurudan annan hjälp (vid sidan om den hjälp ni fick för era fysiska skador) skulle ni ha behövt men nu tyckte att ni blev utan vid besöket på dejourpolikliniken? ______________________________________________________________
_______________________________________________________________________________

24. Fanns det faktorer som möjligen försvårade sökande av hjälp i fråga om våldshandling? Vilka, enligt er åsikt, var dessa faktorer? ______________________________________________________________
_______________________________________________________________________________

25. Hur viktiga anser ni de följande verksamhetsformer angående er vård? (Ringa in det alternativ mellan 1–4 som närmast motsvarar Er egen åsikt).

1. Personalen trodde på min berättelse 1 2 3 4
2. Klargör tillsammans möjligheter till eftervård 1 2 3 4
3. Vänlig och trygg atmosfär 1 2 3 4
4. Tala öppet om det skedda 1 2 3 4
5. Stöda att göra polisanmälan 1 2 3 4
6. Förtroendeingivande vårdförhållande 1 2 3 4
7. Diskussion om rädsla 1 2 3 4
8. Uppmuntra att söka hjälp till det våldsamma parförhållandet 1 2 3 4
9. Nogran läkarundersökning 1 2 3 4
10. Någon annan form av verksamhet som ni anser viktig, vilken? ________________________________________________________________ 1 2 3 4

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26. Till vilket ställe för ni efter det ni blivit utskriven från de jourpolikliniken?

1. Till eget eller gemensamma hem
2. Till bekantas eller släktingars hem
3. Skyddshem
4. Till en annan vårdanstalt, vilken? ________________________________
5. Samma sjukhus, en annan vårdenhet
6. Något annat ställe, vilket? ________________________________

27. Har er kumpan sökt utomstående hjälp för sitt våldsbenägna beteende?

1. Ja, han har sökt
   Om ni svarade jakande på föregående fråga, kan ni då berätta hurudan hjälp er kumpan sökt? ________________________________
2. Min kumpan har ej sökt hjälp för sitt våldsbenägna beteende.

28. Vem har enligt er åsikt i första hand ansvaret för att sluta våldsbeteende?

1. Kvinnan
2. Den som utför våldet (er manliga kumpan)
3. Vårdpersonalen
4. Båda parterna (kvinnan och mannen)
5. Andra professionella hjälpare (tex. socialvårdare)
6. Någon annan instans, vem? ________________________________

29. Är ni beredd att senare ge tilläggsuppgifter angående intervjun?

1. Nej
2. Ja.
   Era kontaktuppgifter:
   ___________________________________________________________________
   ___________________________________________________________________

Datum: ____ / ____ 200

Många tack för er hjälp!

Om ni har några andra tankar och funderigar om saker som berör er vård kan ni utan vidare skriva ner det på det tommas utrymnet på pappret:
Arvoisa vastaanottaja

Pyydämme kohtelaimmink Sinua vastaamaan oheiseen kyselyyn. Kysely kuuluu tutkimukseen, joka on osa Tampereen yliopiston hoitotieteiden laitoksen perhevääkivaltaa käsittelevää tutkimusprojektia. Projektiin tarkoituksena on selvittää väkivaltaisen perheen perhe-dynamikkaa ja omia kokemuksia toiminnastaan sekä terveydenhuollon henkilöstön kykyä tunnistaa ja hoitaa perhevääkivallan eri osapuolilla. Tavoitteena on tuottaa tietoa perhevääkivallan eri muodoista perheiden hoitamisen kehittämiseksi ja hyvinvoinnin parantamiseksi.

Tämä tutkimus on Tuija Leppäkosken väitöskirjatyö ja käsittelee naisen kokemaa väkivaltaa parisuhteessaan. Tutkimusta ohjaavat professorit Päivi Ästedt-Kurki ja Eija Paavilainen.

Tutkimuslomake on varsin pitkä, koska hoitohenkilökkunnan kokemuksista hoitaa ja tukea perhevääkivallan eri osapuolilla halutaan saada perusteellista ja luotettavaa tietoa. Kyselylomakkeeseen vastaaminen on vapaaehtoista, mutta toivomme kuitenkin, että osallistuisit. Sinun mielipiteesi on tärkeä ja arvokas tutkimuksen onnistumisen kannalta.


Pyydämme Sinua lomakkeen täyttävästä sulkemaan sen oheiseen kirjekuoreen ja lähettämään postitse kahden viikon kuluessa. Postimaksu on maksettu.

Yhteistyöstä kiitän!

Tuija Leppäkoski
terveyskieleiden jatko-opiskelija

Päivi Ästedt-Kurki
professori
vätöskirjatyönhaja

Eija Paavilainen
ma. professori
vätöskirjatyönhaja

050 514 8869

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Päivystysyksöissä työskentelevät terveydenhuoltoalan ammattilaiset

Kyselylomake

Ole hyvä ja vastaa kysymyksiin rengastamalla katsomasi vaihtoehto(t) ja / tai kirjoittamalla kysytty tieto sille varattuun tilaan.

A. TAUSTATIETOJA

1. Mikä on sukupuolesi?
   1. Nainen
   2. Mies

2. Minkä ikäinen olet?
   _______ vuotta

3. Mikä on saamasi koulutus?
   a) Yleissivistävä
      1. Kansakoulu
      2. Keskikoulu tai peruskoulu
      3. Lukio
      4. Jokin muu, mikä? ________________________________
   b) Ammatillinen
      1. Kouluasteen ammatillinen koulutus
      2. Opistoasteen ammatillinen koulutus
      3. Ammattikorkeakoulu
      4. Korkeakoulu tai yliopisto
      5. Jokin muu, mikä? ________________________________

4. Mikä on ammattisi?
   1. Sairaanhoitaja
   2. Perus- tai lähiosoittaja
   3. Lääkintäväntietemiestari
   4. Muu ammatti, mikä? ________________________________
5. Milloin olet suorittanut ammattiasi vastaavan tutkinnon?

vuonna _________

6. Kuinka kauan olet toiminut ammatissasi?

______ vuotta

7. Mikä on toimipaikkasi?

1. Yliopistollinen keskussairaala
2. Keskussairaala
3. Aluesairaala
4. Terveyskeskus
5. Muu, mikä? ________________________________

8. Kuinka kauan olet toiminut nykyisessä työyhteisössäsi (osastollasi)?

______ vuotta _______ kuukautta

9. Kuinka suuri on työyhteisösi (osastosi) henkilökuntamäärä?

1. 1 - 10  
2. 11 - 20  
3. 21 - 30  
4. 31 - 40  
5. 41 - 50  
6. 51 - 60  
7. 61 - 70  
8. 71 tai enemmän

10. Millainen on työ- tai virkasuhteesi?

1. Vakinainen
2. Määräaikainen

11. Millaista työtä teet?

1. Kokopäivätyötä
2. Osa-aikatyötä

12. Mikä on työaikamuutosi?

1. Päivätyö
2. Kaksivuorotyö
3. Kolmivuorotyö
4. Jatkuva yötyö
5. Muu, mikä? ________________________________
B. PARISUHDEVÄKIVALLAN KOHTAAMISEN YLEISYYS

13. Arvioi kuinka usein kohtaat työssäsi parisuhdeväkivallan kohteeksi joutuneita naisia?

1. Viikoittain vähintään kerran
2. Kuukausittain vähintään kerran
3. Kerran kahdessa kuukaudessa
4. 3 – 4 kertaa vuodessa
5. Kerran vuodessa tai harvemmin
6. En ole koskaan kohdannut heitä

14. Arvioi kuinka usein kohtaat työssäsi parisuhdeväkivallantekijöitä?
(tässä tarkoitetaan miehiä, jotka toimivat kumppaninsa saattajina)

1. Viikoittain vähintään kerran
2. Kuukausittain vähintään kerran
3. Kerran kahdessa kuukaudessa
4. 3 – 4 kertaa vuodessa
5. Kerran vuodessa tai harvemmin
6. En ole koskaan kohdannut heitä

15. Arvioi kuinka usein kohtaat työssäsi parisuhdeväkivallan kohteeksi tai näkijöiksi joutuneita lapsia?

1. Viikoittain vähintään kerran
2. Kuukausittain vähintään kerran
3. Kerran kahdessa kuukaudessa
4. 3 – 4 kertaa vuodessa
5. Kerran vuodessa tai harvemmin
6. En ole koskaan kohdannut heitä

16. Arvioi kuinka usein kohtaat työssäsi toistamiseen pariisuhdeväkivallan vuoksi hoitoon hakeutuneen saman naisen?

1. Enemmän kuin kaksi kertaa vuodessa
2. 1 - 2 kertaa vuodessa
3. Harvemmin kuin kerran vuodessa
4. Tähän mennessä en kertaakaan
C. PARISUHDEVÄKIVALLAN ILMITULO

17. Miten kohtaamasi parisuhdeväkivaltaa kokenut nainen on saapunut hoitoon ensiapupoliklinikalle? (Ympyröi kaikki sopivat vaihtoehdot).

1. Väkivallantekijä on saattanut
2. Muu omainen (esim. lapsi, sisar, äiti) on saattanut
3. Tuttava / ystävä on saattanut
4. Asiakas on tullut yksin
5. Poliisi on saattanut
6. Muulla tavalla, miten? ______________________________________
7. En ole kohdannut työssäni näitä asiakkaita

18. Väkivallan ilmitulo naisen saavuttua ensiapupoliklinikalle

a) Miten tapahtunut väkivallanteko on käynyt ilmi? (Ympyröi kaikki sopivat vaihtoehdot).

1. Asiakas on itse kertonut joutuneensa kumppaninsa väkivallan kohteeksi
2. Väkivallantekijä on kertonut naiskumppaninsa pahoittelystä
3. Muu läheinen / lähiomainen on kertonut naisen väkivaltakokemuksesta
4. Lääkäri on havainnut väkivallan tutkiessaan asiakasta
5. Minulla on herännyt epäilys väkivallasta keskustellessani asiakkaani kanssa
6. En ole kohdannut työssäni näitä asiakkaita

b) Mistä päättelet, että nainen on saattanut joutua parisuhdeväkivallan kohteeksi vaikkei nainen itse tai hänen saattajansa siitä kertoisikaan?
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

19. Ongelmat parisuhdeväkivallan tunnistamisessa

a) Miten usein Sinulla on ollut ongelmia parisuhdeväkivallan tunnistamisessa?

1. Usein
2. Silloin tallöin
3. Harvoin
4. Ei koskaan
5. En ole kohdannut työssäni näitä asiakkaita
b) Jos olet kohdannut ongelmia, niin minkälaisia?

20. Arvioi kuinka moni tapaamasi parisuhdeväkivaltaa kokenut nainen on ollut hoitoon tullessaan päihteiden (alkoholi, huumeet, lääkkeet) vaikutuksen alaisena?

1. Jokainen (100%)
2. Melkein jokainen (noin 75%)
3. Joka toinen (noin 50%)
4. Joka kolmas tai harvempi (noin 0 - 33%)
5. En ole kohdannut parisuhdeväkivaltaa kokeneita naisia
### D. PARISUHDEVÄKIVALTAAN KOKENEESEEN NAISEEN HOITAMINEN JA TUKEMINEN

21. Kun olet hoitanut parisuhdeväkivaltaa kokenutta naista, miten usein olet tehnyt seuraavia toimenpiteitä? 

Ympyröi se numero (1-4), joka parhaiten vastaa mielipidettäsi.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Olen tehnyt jatkohoitosuunnitelman yhdessä asiakkaani kanssa</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>Olen uskonut naista hänen puhuessaan väkivaltakokemuksestaan</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>Fyysisessä pahoinpitelyssä olen rohkaissut asiakastani tekemään rikosilmoituksen polisille</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>Olen keskustellut asiakkaani kanssa kahden kesken vaikka väkivallan tekijä olisi ollut saattajana</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5</td>
<td>Olen jättänyt kysymättä asiakkaaltani väkivallasta, vaikka epäilisinkin sen mahdollisuutta, jos hän ei ole oman aloitteisesti siitä kertonut</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6</td>
<td>Olen kartoittanut asiakkaani perhetilanteen (mm. kotona olevat alaikäiset lapset; ikä ja lukumäärä)</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7</td>
<td>Olen auttanut asiakastani suunnittelemaan omaa turvallisuuttaan (mm. antanut suullisia ohjeita ja/tai jakanut kirjallista tietoa vastaisten vaaratilanteiden varalle)</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8</td>
<td>Olen tukenut asiakastani ulkopuolisen avun hakemisessa esimerkiksi kertonut turvakodista ja muista mahdollisista auttajahistoria tarpeen mukaan</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9</td>
<td>Olen auttanut myös pahoinpitelijää antamalla hänelle tietoa kirjallisesti tai suullisesti väkivaltaisen käyttäytymisen lopettamiseksi (esim. ohjaus miesten keskusteluryhmiin)</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10</td>
<td>Asiakkaallani on ollut mahdollisuus yöpyä päivystyksessä tarvittaessa vaikka vammojen laatu ei siitä edellyttäisikään (esim. nukkunut pois humalatilansa ennen asioiden jatkoselvittelyä)</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11</td>
<td>Olen pohtinut asiakkaani kanssa yhdessä, miten lapsia voi suojella väkivaltatilanteessa (Mikäli naisella on ollut lapsia kotona)</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12</td>
<td>Olen kirjannut asiakkaani kertomuksen väkivallanteosta ja hänen saamansa vammat hoitosuunnitelmaan.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
22. Seuraavassa esitän parisuhdeväkivaltaa kokeneen naisen hoitamista ja tukemista koskevia väitteitä.

Ympyröi se numero (1-5), joka parhaiten vastaa mielipidettäsi.

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Virka-ajan ulkopuolella minulla on perheväkivaltatilanteissa mahdollisuus konsultoida tarvittaessa myös muita auttajahoeja (esim. sosiaali- ja kriisipäivystystä)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. Parisuhdeväkivalta ei ole milloinkaan oikeutettua</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. Työyhteisööämme puuttuvat kirjalliset, yhteisesti sovitut toimintaohjeet perheväkivaltaa kokeneiden auttamiseksi</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. Yhteistyö eri auttajahojen kanssa toimii hyvin</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. Parisuhdeväkivalta on asiakkaan henkilökohtainen asia enkä puutu siihen, vaan teen vain tarvittavat hoitotoimenpiteet</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. Tiedän liian vähän jatkohoitomahdollisuksista, joihin ohjata asiakkaita</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. Uskon, että väkivalta on seurausta naisen omasta käyttäytymisestä</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. Asiakkaallani on oikeus poistua saamansa ensiavun jälkeen väkivallan tekijän luo, jos hän niin haluaa</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9. Perheessä tapahtuva pahoinpitely on rikos, johon tulee suhtautua aina vakavasti</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10. Olemme keskustelleet väkivaltaa kokeneista naisista ja miettineet auttamiskeinoja esim. hoitotimeissä, hoitotyön kokouksissa tai osastotunneilla.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

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23. Mitkä seuraavat alla esityt seikat vaikeuttavat parisuhdeväkivaltaa kokeneen naisen auttamistyössä?
Kerro mielipiteesi asettamalla asiat järjestykseen numeroin 1 – 8, jolloin 1 on eniten auttamista vaikeuttava asia ja 8 vähiten vaikeuttava asia.

_____ Ajanpuute käsitellä väkivaltaongelmaa
_____ Työyhteisössämme ei ole rauhallista paikkaa kahdenkeskiseen keskusteluun
_____ Naisen humalatila
_____ Nainen on haluton keskustelemaan väkivaltatilanteestaan
_____ Parisuhdeväkivallan arkaluonteisuus estää asian esille ottamisen
_____ Nainen ei myönnä tapahtunutta väkivallantekoa
_____ Naised kumppanin tiivis mukanaolo hoitotilanteessa
_____ Minulla ei ole riittävää tietoa asiakkaan oikeusturvaan liittyvistä asioista
_____ Jokin muu mieleesi tuleva edellä mainitsematon asia, mikä? ____________________
____________________________________________________________________
____________________________________________________________________

24. Miten tärkeinä pidät seuraavia toimintaperiaatteita pahoinpidellyn naisen hoitamiseen liittyvissä kysymyksissä.
Ympyröi se numero (1-4), joka parhaiten vastaa mielipidettäsi.

1. Naisen kertonaan väkivaltaodemukseen uskominen 1 2 3 4
2. Jatkoohitomahdollisuksien selvittäminen yhdessä asiakkaan kanssa 1 2 3 4
3. Ystävällinen ja turvallinen ilmapiiri 1 2 3 4
4. Väkivallasta avoimesti puhuminen asiakkaan kanssa 1 2 3 4
5. Tukeminen rikosilmoituksen tekemisessä 1 2 3 4
6. Luottamuksellinen hoitosuhde 1 2 3 4
7. Asiakkaan peloista keskusteleminen 1 2 3 4
8. Asiakkaan rohkaiseminen hakemaan apua väkivaltaiseen parisuhhteeseensa 1 2 3 4
9. Huolellisesti suoritettu lääkärintutkimus 1 2 3 4
10. Jokin muu tärkeäksi havaitsema toimintaperiaate, mikä? 1 2 3 4
25. Mihin mielestäsi parisuhdeväkivaltaa kokenut asiakasi tavallisesti poistuu
hoitotoimenpiteiden jälkeen?
    Merkitse yleisimmän vaihtoehdon eteen numero 1, toiseksi yleisimmän eteen numero 2 ja
    kolmanneksi yleisimmän eteen numero 3.

    1. Omaan kotiin
    2. Tuttavan tai sukulaisen kotiin
    3. Turvakotiin
    4. Toiseen hoitolaitokseen
    5. Saman sairaalan toiseen hoitoysikköön
    6. Sisäaityöntekijän tms. viranomaisen luokse
    7. Johonkin muuhun paikkaan, mihin? __________________________

E. TYÖNTEKIJÄN VALMIUDET TUKEA JA AUTTAA PARISUHDEVÄKIVALTAAN
KOKENUTTA NAISTA

26. Kuinka monta kertaa olet ollut perhe- ja/tai parisuhdeväkivaltaa käsittelevässä
    koulutuksessa?

    ______ kertaa

27. Mikäli olet osallistunut koulutukseen, mikä on ollut koulutusmuoto?

    1. Ulkoinen koulutus (yhteisön tai järjestön tai toisen organisaation järjestämä)
    2. Sisäinen koulutus (oman työpaikan järjestämä)
    3. Sekä ulkoinen että sisäinen koulutus
    4. Jokin muu tapa hankkia tietoa, mikä? __________________________

28. Missä parisuhdeväkivaltaa kokeneen naisen tukemiseen ja auttamiseen
    liittyvässä asiassa kaipaat lisätietoja?

________________________________________________________________________

29. Millaiset valmiudet katsot itselläsi olevan parisuhdeväkivallan kohteeksi joutuneen naisen
    tukemiseen ja auttamiseen?

    1. Hyvät valmiudet
    2. Tyydyttävät valmiudet
    3. Ei juuri valmiuksia
    4. En osaa sanoa

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30. Kenelle mielestäsi vastuu väkivallan lopettamisesta ensisijaisesti kuuluu?

1. Naiselle
2. Väkivallan tekijälle (mieskumpanille)
3. Hoitohenkilökunnalle
4. Molemille osapuolille (naiselle ja miehelle)
5. Muille ammattiauttajille (esimerkiksi sosiaalityöntekijöille)
6. Jollekin muulle taholle, kenelle? ________________________

31. Millaisia tukimuotoja työyhteisössäsi on tarjolla oman jaksamisen ylläpitämiseksi? (useampi vaihtoehto mahdollinen)

1. Vertaistuki
2. Yhteistyö eri viranomaisten kanssa
3. Konsultaatio
4. Työnhjaut
5. Muita keinoja, mitä? ________________________

32. Oletko itse joutunut joskus parisuhdeväkivallan kohteeksi?

1. Kyllä
2. Ei

33. Onko joku tuttavistasi tai sukulaisistasi joutunut joskus parisuhdeväkivallan kohteeksi?

1. Kyllä
2. Ei

34. Oletko valmis antamaan myöhemmin lisätietoja haastattelun puitteissa?

1. En ole
2. Kyllä olen

Yhteystietonne:
________________________________________
________________________________________
________________________________________

Lomakkeen täyttöpäivämäärä: ____ / ____ 200

KIITOKSET VAIVANNÄÖSTÄSI!
Jos Sinulla on muita parisuhdeväkivaltaa kokeneen naisen tai hänen läheistensä kohtaamiseen, tutkimiseen ja auttamiseen liittyviä mietteitä, voit kaikin mokomin kirjoitella niitä lomakkeen vapaaaseen tilaan.

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Emergency department professionals

Questionnaire

Please answer the questions by circling the alternative(s) which You think is the most appropriate and/or by writing down the information in the space given.

A. BACKGROUND INFORMATION

1. What is Your gender?
   1. Female
   2. Male

2. What is Your age?
   ______ years

3. What is Your education?
   a) General
      1. Elementary school
      2. Middle school or comprehensive school
      3. Upper secondary school
      4. Other (please specify) __________________________
   b) Professional
      1. Vocational upper secondary education
      2. Post-secondary level vocational education
      3. Polytechnic
      4. Higher education institution or university
      5. Other (please specify) __________________________

4. What is Your profession?
   1. Nurse
   2. Practical nurse
   3. Emergency medical technician
   4. Other (please specify) __________________________

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5. When did You obtain a degree in Your profession?

   year _________

6. How long have You practised Your profession?

   _______ years

7. What is Your place of work?

   1. University hospital
   2. Central hospital
   3. District hospital
   4. Health centre
   5. Other (please specify) ____________________

8. How long have You worked in Your current work community (department)?

   _______ years _______ months

9. How many staff members are there in Your work community (department)?

   1. 1-10  4. 31-40  7. 61-70
   2. 11-20  5. 41-50  8. 71 or more
   3. 21-30  6. 51-60

10. What is the type of Your employment?

    1. Permanent
    2. Temporary

11. What kind of work are You doing?

    1. Full-time work
    2. Part-time work

12. What is the type of Your working time?

    1. Daywork
    2. Two-shift work
    3. Three-shift work
    4. Continuous night work
    5. Other (please specify) ____________________
B. FREQUENCY OF ENCOUNTERING INTIMATE PARTNER VIOLENCE

13. Assess how often in Your work You encounter women exposed to intimate partner violence.

1. At least once a week
2. At least once a month
3. Once every two months
4. 3-4 times a year
5. Once a year or less often
6. Have never encountered them

   (this refers to men who are escorting their partners)

1. At least once a week
2. At least once a month
3. Once every two months
4. 3-4 times a year
5. Once a year or less often
6. Have never encountered them

15. Assess how often You encounter children who have been exposed to intimate partner violence or have witnessed it.

1. At least once a week
2. At least once a month
3. Once every two months
4. 3-4 times a year
5. Once a year or less often
6. Have never encountered them

16. Assess how often You encounter women exposed to intimate partner violence who visit the emergency department again.

1. More than twice a year
2. Once or twice a year
3. Less than once a year
4. Have never encountered them
C. DISCOVERY OF INTIMATE PARTNER VIOLENCE

17. How have the women exposed to intimate partner violence arrived in care at the emergency department?
(Please circle every suitable alternative).

1. The perpetrator has escorted the woman
2. Some other relative (e.g. child, sister, mother) has escorted
3. An acquaintance/a friend has escorted
4. The woman has arrived on her own
5. The police has escorted
6. Some other way (please specify) _________________________________
7. I have not encountered these women in my work

18. Discovery of violence when the woman had arrived at the emergency department

a) How has the act of violence been disclosed?
(Please circle every suitable alternative)

1. The woman herself has told about being exposed to intimate partner violence
2. The perpetrator has told about assaulting his female partner
3. Some other close relative/friend has told about the woman’s experience of violence
4. A physician has observed the signs of violence when examining the woman
5. My own suspicion about violence have risen when talking with the woman
6. I have not encountered these women in my work

b) How do You determine that the woman may have been exposed to intimate partner violence even if the woman herself or her escort does not tell about it?

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b) How do You determine that the woman may have been exposed to intimate partner violence even if the woman herself or her escort does not tell about it?

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b) How do You determine that the woman may have been exposed to intimate partner violence even if the woman herself or her escort does not tell about it?

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b) How do You determine that the woman may have been exposed to intimate partner violence even if the woman herself or her escort does not tell about it?

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b) How do You determine that the woman may have been exposed to intimate partner violence even if the woman herself or her escort does not tell about it?

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b) How do You determine that the woman may have been exposed to intimate partner violence even if the woman herself or her escort does not tell about it?

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b) How do You determine that the woman may have been exposed to intimate partner violence even if the woman herself or her escort does not tell about it?

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b) How do You determine that the woman may have been exposed to intimate partner violence even if the woman herself or her escort does not tell about it?

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b) How do You determine that the woman may have been exposed to intimate partner violence even if the woman herself or her escort does not tell about it?

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b) How do You determine that the woman may have been exposed to intimate partner violence even if the woman herself or her escort does not tell about it?

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b) How do You determine that the woman may have been exposed to intimate partner violence even if the woman herself or her escort does not tell about it?

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b) How do You determine that the woman may have been exposed to intimate partner violence even if the woman herself or her escort does not tell about it?

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b) How do You determine that the woman may have been exposed to intimate partner violence even if the woman herself or her escort does not tell about it?

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b) How do You determine that the woman may have been exposed to intimate partner violence even if the woman herself or her escort does not tell about it?

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b) How do You determine that the woman may have been exposed to intimate partner violence even if the woman herself or her escort does not tell about it?

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b) How do You determine that the woman may have been exposed to intimate partner violence even if the woman herself or her escort does not tell about it?

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b) How do You determine that the woman may have been exposed to intimate partner violence even if the woman herself or her escort does not tell about it?

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b) How do You determine that the woman may have been exposed to intimate partner violence even if the woman herself or her escort does not tell about it?

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b) How do You determine that the woman may have been exposed to intimate partner violence even if the woman herself or her escort does not tell about it?

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b) How do You determine that the woman may have been exposed to intimate partner violence even if the woman herself or her escort does not tell about it?

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b) How do You determine that the woman may have been exposed to intimate partner violence even if the woman herself or her escort does not tell about it?

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

b) How do You determine that the woman may have been exposed to intimate partner violence even if the woman herself or her escort does not tell about it?
19. Problems in identifying intimate partner violence

a) How often have You had problems identifying intimate partner violence?

1. Often
2. Now and then
3. Seldom
4. Never
5. I have not encountered these women in my work

b) If You have had problems, what kind?

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

20. Assess how many of the women exposed to intimate partner violence that You have encountered have been under the influence of intoxicants (alcohol, narcotics, pharmaceuticals).

1. Everyone (100%)
2. Almost everyone (c. 75%)
3. Every other (c. 50%)
4. Every third or less (c. 0-33%)
5. I have not encountered women exposed to violence

PTO!
21. When You have cared for a woman exposed to intimate partner violence, how often have You taken the following actions?

Please circle the alternative (1-4) that most closely corresponds to Your opinion.

<table>
<thead>
<tr>
<th>Number</th>
<th>Action</th>
<th>Always</th>
<th>Often</th>
<th>Now and then</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I have made a plan of aftercare together with the woman</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2.</td>
<td>I have believed the woman when talking about her experience of violence</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3.</td>
<td>I have encouraged the woman to report an offence to the police</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4.</td>
<td>I have talked privately with the woman even when her perpetrator has escorted her to care</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5.</td>
<td>I have left without asking about the act of violence, even when I have suspected it, if the woman spontaneously has not told about it</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6.</td>
<td>I have reviewed the woman's family situation (e.g. the number and age of underage children at home)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7.</td>
<td>I have helped the woman to plan her own safety (e.g. by giving oral advice and/or written information for similar dangerous situations in the future)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8.</td>
<td>I have supported the woman in seeking outside help (e.g. by telling her about shelters and other possible help providers as necessary)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9.</td>
<td>I have also helped the perpetrator by giving him written/oral information to stop violent behaviour (e.g. by referring to men’s discussion groups)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10.</td>
<td>The woman has been given an opportunity to stay overnight at the emergency department if needed, even when the type of injuries has not required it (e.g. if drunk, has slept it off before further settling of the situation)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11.</td>
<td>I have discussed with the woman how to protect her children in a violent situation (if she has had children at home)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12.</td>
<td>I have documented the woman's story about the act of violence and her injuries to the plan of care</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
22. In the following, I present statements about caring for and supporting women exposed to violence.
Please circle the alternative (1-5) that most closely corresponds to Your opinion.

<table>
<thead>
<tr>
<th></th>
<th>Fully agree</th>
<th>Partly agree</th>
<th>Partly disagree</th>
<th>Fully disagree</th>
<th>I cannot say</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Outside office hours I have an opportunity to consult other help providers (e.g. social and crisis services emergency duty) in the case of domestic violence</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Intimate partner violence is never justified</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. Our work community has lack of written, jointly agreed procedures on how to help those who have experienced domestic violence</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Co-operation with different help providers works well</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. Intimate partner violence is the woman’s private matter and I do not intervene. I only take necessary care measures.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. I do not know enough places for aftercare where I can refer women</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. I believe that violence is a consequence of the woman's own behaviour</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. The assaulted woman has a right to return to her perpetrator after receiving first aid, if she wants</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. An assault which happens within a family is a crime, which should always be taken seriously</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. Our work community has discussed the women who have experienced IPV and considered methods to help them (e.g. in nursing teams and meetings or department meetings.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

PTO!

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23. **Which of the following circumstances make it more difficult to help women exposed to intimate partner violence?**

State Your opinion by arranging the circumstances in numerical order 1-8, so that number 1 stands for the most difficult matter and number 8 for the least difficult matter.

- Lack of time to deal with the problem of violence
- Our work community does not have a peaceful place where to talk with women face to face
- The woman’s drunkenness
- The woman is unwilling to discuss her situation that involves violence
- The sensitiveness of intimate partner violence prevents discussion on the matter
- The woman does not admit that the act of violence occurred
- The constant presence of the woman’s partner during care
- I do not have enough knowledge about matters related to the woman’s legal protection
- Some other circumstance not mentioned above (please specify)

23. **In Your opinion, how important are the following care principles in matters related to the care of an assaulted woman?**

Please circle the alternative (1-4) that most closely corresponds to Your opinion.

<table>
<thead>
<tr>
<th>Not important</th>
<th>A little important</th>
<th>Fairly important</th>
<th>Very important</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Believing the woman’s experience of violence</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Deciding on aftercare together with the woman</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Kind and secure care environment</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Talking about violence openly with the woman</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Encouraging the woman to report an offence to the police</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Confidential care relationship</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Talking about the woman’s fears</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Encouraging the woman to get help for the violent partnership</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Careful clinical examination</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Some other care principle You regard as important (please specify)</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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25. Where do You think a woman exposed to intimate partner violence goes after leaving the emergency department?

Please choose the three most common alternatives by marking 1 in front of the most common alternative, 2 for the second most common and 3 for the third most common.

1. To her home
2. To the home of a friend or a relative
3. To a shelter
4. To some other health care department
5. To another care unit in the same hospital
6. To a social worker or other similar authority
7. To some other place (please specify)

E. EMERGENCY DEPARTMENT PROFESSIONALS' ABILITIES TO SUPPORT WOMEN EXPOSED TO INTIMATE PARTNER VIOLENCE

26. How many times have You received training on domestic and/or intimate partner violence?

______ times

27. If You have received training, what type of training has it been?

1. External training (arranged by a society, organization or some other institution)
2. Internal training (arranged by Your own employer)
3. Both external and internal training
4. Some other method of getting information (please specify)

28. On which topics related to helping and supporting women exposed to intimate partner violence do You need more information?

29. In Your opinion, how good are Your abilities to support and help women exposed to intimate partner violence?

1. Good abilities
2. Satisfactory abilities
3. Poor abilities
4. I cannot say
30. In Your opinion, who has the primary responsibility for stopping the violent behaviour?

1. The woman
2. The perpetrator (male partner)
3. Emergency department professionals
4. Both parties (woman and man)
5. Other professionals (e.g. social workers)
6. Some other (please specify) _________________________________

31. What kind of support systems does Your organization offer to maintain Your own wellbeing at work?  
(You may choose several alternatives)

1. Collegial support
2. Co-operation with various support organizations
3. Consultation
4. Supervision of work
5. Other systems (please specify) _________________________________

32. Have You personally ever been exposed to intimate partner violence?

1. Yes
2. No

33. Have any of Your acquaintance or relatives ever been exposed to intimate partner violence?

1. Yes
2. No

34. Would You be willing to give further information later in an interview?

1. No
2. Yes
   My contact information:
   ______________________________________________________
   ______________________________________________________

Date of responding to the questionnaire: ____ / ____ 200

GRATEFUL THANKS FOR YOUR HELP!
If You have some other thoughts about encountering, supporting and helping women exposed to intimate partner violence, or their close relatives/friends, please feel free to write them down in the questionnaire’s blank space.
APPENDIX 11

Puolistrukturoidun haastattelun teemat
Themes of the semi-structured interview

Haastatteluteemat akuuttiä fyysistä parissuhdeväkivaltaa kokeneelle naiselle
The themes of the interview for women exposed to acute physical intimate partner violence
1. Taustatietoja haastateltavista naisista? (perhesuhteet)
   Background information about the interviewees (family relations)
2. Tapahtunut väkivalta ja hoitoon hakeutuminen
   The experienced act of violence and seeking care
3. Hoitokokemukset ensiapuklinikalla
   Opinions concerning the care and support received at the ED
   - hoiotenhilöstön toiminta
   - työtyvääsyn saattuun hoiottoon
   - muu perheen saama apu
   - other help received by the family
4. Poistuminen päivystysklinikalta
   Leaving the emergency department

Haastatteluteemat päivystysyksiköissä työskentelevälle terveydenhuoltoalan ammattilaiselle
The themes of the interview for health care professionals working at EDs
1. Taustatietoja haastateltavista (työkokemus ja työskentelyaika nykyisessä työyhteisössä ja ammatissa toimiminen)
   Background information about the interviewees (work experience and duration of work in current work community and occupation time)
2. Parissuhdeväkivaltaan kohtaaminen työssä ja ilmitulo
   Encountering and discovering intimate partner violence at work
   - parissuhdeväkivaltaa kokeneen naisen ja hänen perheenjäsentensä kohtaamisen yleisyy
   - frecuency of encountering women exposed to intimate partner violence or their family members
   - väkivallan paljastuminen hoitosuhteessa
   - discovery of violence when caring for women
3. Parissuhdeväkivaltaa kokeneen naisen hoitaminen
   Caring for a woman exposed to intimate partner violence
   - keinot ja välineet naisen ja hänen perheensä auttamiseksi ja tukemiseksi
   - resources and means for helping and supportign the women and their family
   - mahdolliset koetut esteet auttamistyössä
   - possible barriers encountered during care
   - yhteistyö muihin auttajatahoihin (virka / päivystysaika)
   - co-operation with other helth services (during office hours/emergency duty)
4. Työntekijän valmiudet hoitaa parissuhdeväkivaltaa kokeneita naisia
   ED professionals’ abilities to support women exposed to intimate partner violence
   - saatu koulutus ja koulutuksen tarve
   - received training and need for training
## APPENDIX 12

**Distribution of interventions used by ED professionals when caring women exposed to IPV** (See Appendix 10 question 21)

<table>
<thead>
<tr>
<th>Statement (no. of respondents/size of the whole sample)</th>
<th>1 Always</th>
<th>2 Often</th>
<th>3 Now and then</th>
<th>4 Never</th>
<th>Median</th>
<th>Lower quartile</th>
<th>Upper quartile</th>
<th>No answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I have made a plan of aftercare together with the woman (n = 457/480)</td>
<td>5</td>
<td>20</td>
<td>43</td>
<td>32</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. I have believed the woman when talking about her experiences of violence (n = 466/480)</td>
<td>37</td>
<td>56</td>
<td>6</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. I have encouraged the woman to report an offence to the police (n = 462/480)</td>
<td>61</td>
<td>25</td>
<td>10</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>4. I have talked privately with the woman even when her perpetrator has escorted her to care (n = 455/480)</td>
<td>42</td>
<td>24</td>
<td>17</td>
<td>17</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>5. I have left without asking about the act of violence, even when I have suspected it, if the woman spontaneously has not told about it (n = 463/480)</td>
<td>1</td>
<td>5</td>
<td>37</td>
<td>57</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>6. I have reviewed the woman’s family situation (e.g. the number and age of underage children at home) (n = 466/480)</td>
<td>45</td>
<td>30</td>
<td>18</td>
<td>7</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. I have helped the woman to plan her own safety (e.g. by giving oral advice and/or written information for similar dangerous situations in the future (n = 467/480)</td>
<td>27</td>
<td>37</td>
<td>26</td>
<td>10</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>8. I have supported the woman in seeking outside help (e.g. by telling her about shelters and other possible help providers as necessary (n = 464/480)</td>
<td>36</td>
<td>36</td>
<td>21</td>
<td>7</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>9. I have also helped the perpetrator by giving him written/oral information to stop violent behaviour (e.g. by referring to men’s discussion groups ) (n = 460/480)</td>
<td>3</td>
<td>6</td>
<td>24</td>
<td>67</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>10. The woman has been given an opportunity to stay overnight at the emergency department if needed, even when the type of injuries has not required it (e.g. if drunk, has slept it off before further settling of the situation) (n = 464/480)</td>
<td>28</td>
<td>39</td>
<td>30</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>11. I have discussed with the woman how to protect her children in a violent situation (if she has had children at home) (n = 457/480)</td>
<td>12</td>
<td>23</td>
<td>37</td>
<td>28</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. I have documented the woman’s story about the act of violence and her injuries to the plan of care (n = 460/480)</td>
<td>62</td>
<td>24</td>
<td>9</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>
APPENDIX 13
Distribution of opinions concerning attitudes, beliefs and practices in caring for women reported by ED professionals
(See Appendix 10 question 22)

<table>
<thead>
<tr>
<th>Statement (no. of respondents/size of the whole sample)</th>
<th>1 Fully agree</th>
<th>2 Partly agree</th>
<th>3 Partly disagree</th>
<th>4 Fully disagree</th>
<th>5 I cannot say</th>
<th>Median Md</th>
<th>Lower quartile Q1</th>
<th>Upper quartile Q3</th>
<th>No answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Outside office hours I have an option to consult other help providers (e.g. social and crisis services emergency duty) in the case of domestic violence (n = 470/480)</td>
<td>43</td>
<td>24</td>
<td>16</td>
<td>11</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>2. Intimate partner violence is never justified (n = 477/480)</td>
<td>94</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>3. Our work community has lack of written, jointly agreed procedures on how to help those who have experienced domestic violence (n = 474/480)</td>
<td>15</td>
<td>34</td>
<td>22</td>
<td>24</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>4. Co-operation with different help providers works well (n = 470/480)</td>
<td>12</td>
<td>45</td>
<td>30</td>
<td>5</td>
<td>8</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>5. Intimate partner violence is the woman’s private matter and I do not intervene. I only take necessary care measures (n = 477/480)</td>
<td>2</td>
<td>6</td>
<td>30</td>
<td>60</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>6. I do not know enough places for aftercare where I can refer women (n = 476/480)</td>
<td>8</td>
<td>45</td>
<td>24</td>
<td>21</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>7. I believe that violence is a consequence of the woman’s own behaviour (n = 469/480)</td>
<td>1</td>
<td>12</td>
<td>32</td>
<td>51</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>8. The assaulted woman has a right to return to her perpetrator after receiving first aid, if she wants (n = 474/480)</td>
<td>56</td>
<td>30</td>
<td>9</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>9. An assault which happens within a family is a crime, which should always be taken seriously (n = 478/480)</td>
<td>89</td>
<td>8</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>10. Our work community has discussed the women, who have experienced intimate partner violence and considered methods to help them (e.g. in nursing teams and meetings or department meetings) (n = 469/480)</td>
<td>12</td>
<td>23</td>
<td>24</td>
<td>32</td>
<td>9</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>2</td>
</tr>
</tbody>
</table>
**APPENDIX 14**

Statements of categorizing positive experiences of care reported by women (n = 29) visiting at ED

(See Appendix 8 and 9, Question 21)

<table>
<thead>
<tr>
<th>Statements reported by women (no.)</th>
<th>Subcategories</th>
<th>Main categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>I received care very quickly (3, 8)</td>
<td>Receiving care quickly</td>
<td>Physical care environment</td>
</tr>
<tr>
<td>The doctor examined me at once after caring for the patient before me (16)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I was given a peaceful room where to be alone (6)</td>
<td>Safe and peaceful care environment</td>
<td></td>
</tr>
<tr>
<td>I was given an opportunity to rest in a safe environment (19)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A good doctor and good nurses (14)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I was given analgesic for my pains (16)</td>
<td>Satisfaction with the clinical examination</td>
<td>Appropriate medical care</td>
</tr>
<tr>
<td>All possible examinations were made (18)</td>
<td>of physical injures and symptoms</td>
<td></td>
</tr>
<tr>
<td>Thoroughness, bruises were examined carefully (35)</td>
<td>Satisfaction with the care of physical injures and symptoms</td>
<td></td>
</tr>
<tr>
<td>Examinations were well managed (24)</td>
<td>Good care/maintenance</td>
<td></td>
</tr>
<tr>
<td>First aid (physically) (33)</td>
<td>Solicitude</td>
<td></td>
</tr>
<tr>
<td>Good care (13, 22)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care/maintenance (21)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The staff was kindly (21)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt as important as other accident patients (26)</td>
<td>Equality with other accident patients</td>
<td>Emotional support including elements</td>
</tr>
<tr>
<td>The staff was calm (4)</td>
<td>Calmness</td>
<td>of equality, calmness, empathy,</td>
</tr>
<tr>
<td>Seemly behaviour/seemly treatment of the matter (13, 15)</td>
<td>Seemly treatment</td>
<td>objectivity, friendliness, and</td>
</tr>
<tr>
<td>The nurses had an unhurried and earnest attitude (10)</td>
<td>Empathy</td>
<td>understanding</td>
</tr>
<tr>
<td>The nurses had an empathetic attitude (32)</td>
<td>Objectivity</td>
<td></td>
</tr>
<tr>
<td>The staff treated me objectively (31)</td>
<td>Friendliness</td>
<td></td>
</tr>
<tr>
<td>All the nurses were sympathetic, friendly, unprejudiced (17)</td>
<td>Understanding</td>
<td></td>
</tr>
<tr>
<td>I felt that they understood me (32)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friendly nurses (9, 23, 29, 30, 34)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The staff took my requests into consideration (3)</td>
<td>Encouragement and support</td>
<td>Practical support, taking care of</td>
</tr>
<tr>
<td>The staff did not demand anything but because the battering was obvious,</td>
<td>Taking individuality and autonomy into</td>
<td>individual needs of women, including</td>
</tr>
<tr>
<td>the nurse encouraged me and supported me in telling about the act of violence (7)</td>
<td>consideration</td>
<td>all-inclusive care</td>
</tr>
<tr>
<td>In an accident room, I got the whole thing off my chest (27)</td>
<td>Providing information on services and</td>
<td></td>
</tr>
<tr>
<td>Conversations with a nurse and crisis worker were well managed (24)</td>
<td>assistance in seeking help</td>
<td></td>
</tr>
<tr>
<td>I was guided to a crisis centre (25)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 15

Statements of categorizing negative experiences of care reported by women (n = 20) visiting at ED (See Appendix 8 and 9, Question 22)

<table>
<thead>
<tr>
<th>Statements reported by women (no.)</th>
<th>Subcategories</th>
<th>Main categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>A long waiting time (&gt; 2 h), alone (9)</td>
<td>Long waiting time</td>
<td>Physical care environment</td>
</tr>
<tr>
<td>A long waiting time (&gt;12h) in a draughty corridor (35)</td>
<td>Lack of privacy</td>
<td>with limited structural factors</td>
</tr>
<tr>
<td>I was not pleased with the waiting time (&gt;2.5h) (30)</td>
<td>Restless atmosphere</td>
<td></td>
</tr>
<tr>
<td>Running from one place to another (16)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I had to wait for a doctor for several hours (23)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Common restless atmosphere (10)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sitting and waiting in a public waiting room (27)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perhaps the lack of privacy in the situation (18)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would have wanted to have a peaceful room where to wait for a doctor (shame?) (31)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of staff (doctors). E.g. medical statement on X-ray film took a long time (26)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I did not like the growl of drunks (14)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unskilled doctor, my care became difficult and prolonged, s/he did not believe that my injuries were serious (17)</td>
<td>Dissatisfaction with the care of physical injuries and symptoms</td>
<td>Inadequate medical care</td>
</tr>
<tr>
<td>Without analgesic with terrible pains (23)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of necessary analgesic (24)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overmuch interrogation (11)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I perhaps would have wanted more emotional support (in private) (31)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nobody asked me about being battered (9)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A doctor who walked past me spoke with a loud voice with the nurse about my case, although he did not participate in my care (7)</td>
<td>Dissatisfaction with way of inquiring about IPV</td>
<td>Lack of emotional support</td>
</tr>
<tr>
<td>The staff hurried, doctors were perhaps a little bit stressed and irritated (29)</td>
<td>Talking loudly about the woman’s affair</td>
<td>including elements of</td>
</tr>
<tr>
<td>I felt that I suffered injustice, when drunks came in after me but received care before me (14)</td>
<td>Feeling of inequality</td>
<td>inequality and distrust</td>
</tr>
<tr>
<td>They only asked me if I wanted to report an offence (15)</td>
<td>Lack of confidentiality and a hurried attitude</td>
<td></td>
</tr>
<tr>
<td>Complete lack of discussion about help (5)</td>
<td>Lack of support system for women and children</td>
<td></td>
</tr>
<tr>
<td>Nobody informed me about agencies that could provide help for me and my children (14)</td>
<td>Leading perpetrator to care</td>
<td></td>
</tr>
<tr>
<td>I would have wanted to talk with my husband (13)</td>
<td>Lack of discussion about help</td>
<td></td>
</tr>
<tr>
<td>I wanted my husband to receive care (13)</td>
<td>Lack of further care of the woman, children and perpetrator</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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