INTIMATE PARTNER VIOLENCE AND RURAL PUBLIC HEALTH NURSING PRACTICE: CHALLENGES AND OPPORTUNITIES

Tracy A. Evanson, PhD, APRN, BC[1]

[1] Assistant Professor, College of Nursing, University of North Dakota, tracyevanson@mail.und.nodak.edu

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ABSTRACT

Health care providers of all disciplines encounter victims of intimate partner violence (IPV) in all practice settings. However, few studies have examined the role of public health nurses (PHNs) who visit the homes of families where IPV is occurring, and none have focused on the unique aspects of rural PHN practice with these families. This research, derived from a larger descriptive phenomenology study, describes the unique challenges and opportunities experienced by rural home-visiting PHNs when working with families where IPV was occurring. The rural PHNs described unique opportunities in their abilities to establish and maintain relationships with families, to assess for IPV, to advocate for victims with other community providers, and to keep perspective about their work. However, living and practicing in rural areas also created unique challenges related to barriers to disclosure of IPV, maintaining confidentiality, helping victims access resources, getting support for themselves, and establishing and maintaining professional-personal boundaries.

INTRODUCTION

Intimate partner violence (IPV) is a serious public health issue, resulting in approximately $4.1 billion in direct health care costs each year in the U.S. (National Center for Injury Prevention and Control, 2003). At least 1.3 million women are physically assaulted by an intimate partner annually in the U.S and at least 22% of women in the general population have been physically assaulted by a former or current intimate partner sometime during their lifetimes (Tjaden & Thoennes, 2000). Population-based studies, which provide evidence of IPV prevalence among rural women, do not exist (Johnson, 2000), but results of several convenience sample studies (Johnson & Elliott, 1997; Kershner, Long & Anderson, 1999; Persily & Abdulla, 2000; Van Hightower & Gorton, 1998; Wagner, Mongan, Hamrick & Hendrick, 1995) suggest that the prevalence of IPV experienced by rural women is at least as high if not higher than rates in the general population. In the largest study to date, Kershner et al. (1999) found that among 1,693 rural women seeking care in rural medical clinics and Women, Infants, Children (WIC) clinics, 21.4% reported current abuse, and 37% had experienced abuse as an adult at some point in their lifetimes.

Health care providers of all disciplines encounter victims of IPV in all practice settings. However, few studies have examined the role of public health nurses (PHNs) who visit the homes of families where IPV is occurring, and none have focused on the unique aspects of rural PHN practice with these families. Public health nurses, who work

with families through home visiting, may serve a pivotal role in IPV prevention and intervention. They have a unique advantage of being in a position to recognize a potential for violence in the home before it begins or worsens (Bekemeier, 1995) and they are able to gain unique insights into family health that do not present when these same people are seen in hospitals or clinic examining rooms (Shephard, Elliot, Falk & Regal, 1999; Zerwekh, 1991). The role of PHNs in IPV prevention and intervention is likely to be especially significant in rural areas, where PHNs may be one of the few HCPs available in communities, and where an IPV victim may be hesitant to disclose abuse to her primary care provider because that same person is likely to also be the abuser's primary care provider (Leipert, 1999).

While minimal research exists regarding the realities of rural battered women's lives, various rural factors have been anecdotally described (Adler, 1996; Fishwick, 1993; Goeckermann, Hamberger & Barber, 1994) as uniquely contributing to IPV and complicating victims' lives. Isolation, a major means of control among abusers, is easier to achieve in rural areas. A rural woman may be less likely to contact law enforcement because she may know the officers, and even if she does contact them, response times are often lengthy because of driving distance. The seasonal nature of agricultural work creates long periods in which men may be at home, creating more opportunities for abuse to occur. Other rural factors that have been described are a lack of IPV prevention programs and other social services, less availability of transportation and telephones, increased risk of lethality because of the availability of guns in the home, and lack of privacy and anonymity. Kershner et al. (1999) found the greatest barriers for a rural abused woman to disclose the abuse to a nurse or physician were: shame; fear of being seen by someone; fear that clinic staff would talk about them or wouldn't understand; and a high reliance on self, friends/family, and/or God to solve their problems.

Public health nurses, living and working in rural areas, may play a key role in IPV prevention and intervention efforts in their home communities. However, research to date has not described or evaluated the role of rural home-visiting PHNs in IPV prevention. The purpose of this research article is to describe the unique challenges and opportunities experienced by rural home-visiting PHNs when working with families where IPV was occurring. Identification of the challenges and opportunities of rural nursing practice has been named a top research need in the area of rural nursing (Bushy, 2000), and this study contributes to that research priority. Policies and practices that are developed in urban settings are not always readily transferable to the rural setting (Ulrich, Fulton & MacLeod, 2004), and therefore a thorough understanding of the issues that rural PHNs face is essential in order to effectively address the issue of IPV in rural areas.

RESEARCH METHODS

Design

The findings presented here are part of a larger study (Evanson, 2003), which sought to describe the practice of home-visiting PHNs (both rural and non-rural) when working with childbearing/childrearing families experiencing IPV. The research approach utilized in the study was descriptive phenomenology (Dahlberg, Drew & Nystrom, 2001). In the design of the larger study, it was purposefully planned to recruit

approximately half the sample of PHNs from health departments serving rural areas and half from non-rural areas. This was done in an attempt to describe the phenomenon as fully and richly as possible, and also to ascertain if there were any major differences in practice related to rural vs. non-rural PHNs. This article describes the practice challenges and opportunities unique to the rural PHNs in their work with families where IPV was occurring. In this study, rural was defined as places of 2,500 or less persons either inside or outside of incorporated areas (U. S. Census Bureau, 1995).

Participants

Participants were recruited from county health departments from throughout a Midwestern state in the U.S. Purposive sampling was utilized, and participants were chosen based upon specific inclusion criteria that insured they were experienced and knowledgeable in relation to the phenomenon of interest (Morse, 1989; Streubert & Carpenter, 1999). Inclusion criteria were PHNs who a) were currently certified as a PHN in the state in which they were practicing, b) were currently providing home visits to childbearing/child-rearing families at least half-time c) had a minimum of five years of experience as a PHN, d) felt they had experiences of working with families where IPV had occurred and were able to describe those experiences.

In the larger study, participants included thirteen PHNs, six practicing in non-rural areas and seven practicing in rural areas. The findings presented here pertain to the seven rural PHNs, who were recruited from four different rural health departments. The seven rural PHNs had an average age of 41.9 years (range 28 – 51 years). All were Caucasian and all were female. They had an average of 15.2 years of experience as a registered nurse (range 6 – 26 years) and an average of 13.4 years as a public health nurse (range 5 – 22 years). All of the rural PHNs had a baccalaureate degree in nursing. Only two of the seven participants reported they had received any education about IPV in their baccalaureate programs, but all had received continuing education (CE) on the subject since entering practice and most (five) had attended more than one CE session. All of the PHNs lived in the rural areas in which they practiced.

Protection of Human Subjects

The study received Institutional Review Board approval from the Human Subjects Committee at the University of Minnesota before research commenced. Each PHN received verbal and written descriptions of the study purpose and methods. Written consent was obtained from each participant, and they were provided with a copy of the signed consent. To assure anonymity and confidentiality, participants were assigned codes used to mark the audiotapes and the transcripts of the interviews. All names and identifying information were removed from the transcripts. Participant codes, audiotapes and transcripts of the interviews were all kept in separate files accessible only to the researcher.

Data Collection and Analysis

Each participant completed a demographic questionnaire, which was developed for the study, in order to describe the sample characteristics. Two semi-structured interviews were conducted with each participant. The interviews were audio recorded and transcribed verbatim for analysis. The purpose of the first interview was to elicit specific descriptions of PHNs' experiences working with families where IPV was occurring. Lines of inquiry focused on how the PHN identified that IPV was occurring, and how assistance was or was not able to be provided to the family. The purpose of the second interview was to identify the factors in the PHNs' practice that were perceived to influence their ability to identify and provide assistance in cases of IPV. The second interview was also a time for the researcher to follow-up on questions that had arisen from analysis of the first interviews, and to gain more depth on data gathered on the first interview. The interval between the first and second interview was three to four weeks. The interviews ranged from 60 to 95 minutes in length, averaging 74 minutes. The interviews were at a location of the participants' choosing. All but one of the interviews were conducted at the participants' places of employment and during their regular work hours (with permission from each of the participating agencies). One interview, at the request of the participant, was conducted in the participant's home, during non-work hours. The researcher personally conducted all of the interviews.

Initial analysis began with the first interview and continued with all subsequent interviews. Dahlberg's approach to descriptive phenomenology analysis was used as the framework (Dahlberg et al, 2001). This analysis structure involves a fluid movement between whole – parts – whole. In the first phase, the researcher read all of the data repeatedly to get a sense of the whole. The focus then shifted to examining parts of the text, which were identified by shifts in meaning, and the text was organized into meaning units. As the meaning units were identified, the researcher named the meaning, using the words of the participants whenever possible. Once meaning units were named, a process of organizing the units into clusters of meaning was utilized. The next phase of analysis was to return to the whole and give it expanded meaning. The clusters of meaning were synthesized into a structure that bound them together, and a model of the phenomenon was formed, with constituents, themes, and subthemes.

In order to determine if there were differences between the rural and the non-rural nurses' practices, a process of constant comparison between the rural and non-rural PHNs' transcripts was employed (K. Dahlberg, personal communication, June 11, 2002). As differing aspects of practice were identified, analysis focused on whether the meaning of the particular aspect was a separate constituent, theme, or subtheme of the phenomenon, or if it was simply a variation within those components.

FINDINGS

In the larger study, it was discovered that there were no major differences between rural and non-rural PHNs in the constitutents, themes or subthemes of their practices when working with families where IPV was occurring. However, the rural PHNs described variant aspects within those practice themes that were due to the rural nature of the communities in which they worked and lived. The rural PHNs described

unique opportunities in their abilities to establish and maintain relationships with families, to assess for IPV, to advocate for victims with other community providers, and to keep perspective about their work. However, living and practicing in rural areas also created unique challenges related to barriers to disclosure of IPV, maintaining confidentiality, helping victims access resources, getting support for themselves, and establishing and maintaining professional-personal boundaries.

Establishing and Maintaining a Relationship with Families

The rural PHNs had an advantage over the non-rural PHNs in relation to establishing and maintaining a relationship with families, because they had more opportunities to have contact with their clients both in work and non-work settings. The non-rural PHNs typically reported that home visiting with families was the primary or sole responsibility of their job. However, because of the smaller size of their health departments, rural PHNs were not only doing home visiting, but were also working in other settings in the health department, such as WIC clinics, immunization clinics, communicable disease work, etc. In addition, it was not unusual for rural PHNs to see their clients in various settings in the community, such as at church, the grocery store, school or community functions, etc. In the words of one rural PHN:

> The women who I visit in the home, I will see them in a different setting as well. . . I see them in the grocery store. I see them out in the parking lot with their boyfriend and their kids . . .Where in a metro area, you wouldn't have that opportunity. I suppose we are just a closer-knit community and you see people outside of the home setting.

Their generalist roles and their encounters with families through rural living provided the PHNs with increased opportunities for repeated contact with families in multiple settings, resulting in more opportunities for building relationships.

Identification of IPV

The multiple settings in which the rural PHNs encountered their clients also afforded them increased opportunities to observe and listen for risk factors and indicators of IPV. As one rural PHN described:

> There have been times where I have been able to see women in different settings other than their home, and noticed relationship issues between them and their significant others. In a metro area you would probably never run into them like that. I think back to a few years ago, when in a grocery store, when I heard some verbal abuse going on between a boyfriend and one of my clients. I just found it interesting that I was able to pick up on that *in a grocery store*.

It was not unusual for rural PHNs to have separate cases of families related to each other. In these cases, knowledge of extended family history or current issues in one

family helped inform the assessment of the other family and provide clues to potential IPV. It was also not uncommon for rural nurses to have personal knowledge of a family's history and issues because the PHN may have known them through some aspect of the PHN's personal life. As one rural PHN noted,

> Some of these women, I went to high school with. Some of them, their parents were my teachers. . . The public health nurses, they pretty much know—well they grew up here, so they know everybody in the families, or somebody in the office knows the family, unless it is somebody that just moved in. It is much easier to do that in a smaller community, to know the support systems and to know what their relationships were like, when you were growing up with them too in the same town.

At the same time, rural PHNs faced a unique disadvantage in relation to identification of IPV. The rural PHNs reported they frequently knew their clients personally, or they had mutual friends or acquaintances. In these circumstances, the rural PHNs perceived that victims of IPV might be reluctant to disclose the abuse to the PHNs, because of their personal ties. As one rural PHN stated:

> Like one gal I had, I had taught her in Sunday school. And she found out I was her nurse, and she thought, 'Oh, no.'. . I'm sure she thought she couldn't possibly share her sexual history with her Sunday school teacher, now could she?

Confidentiality

All of the PHNs, rural and non-rural alike, described that maintaining confidentiality was integral to their abilities to build trusting relationships with families. If it was learned they breeched confidentiality with a family, they not only risked losing the trust of the family, but also their reputation as a professional in the community.

Situations sometimes occurred where a PHN was contacted by extended family members (such as the client's mother, siblings, etc.), particularly when working with teenage parents. In those cases, the PHN still respected the confidentiality of the client and informed the family member they could not disclose any information without a written release of information from the client. As mentioned, it was not unusual for rural PHNs to be visiting more than one extended family member, or to be visiting two or more clients who could be friends. This, coupled with their high visibility in communities, created special challenges for rural PHNs to maintain confidentiality, as one nurse noted:

> In [a very small town], it turns that out of the three [pregnant mothers] that I was visiting in [that town], they all delivered in a span of three or four months—and they all knew each other. . . They would say, 'Weren't you just over at so-and-so's?'. . . But whatever they tell me is private and I hope they know that I won't disclose anything. 'Didn't you just see so-and-so?' And I'll say, 'Well, you know I can't say.' So it puts you in a spot with a small community that they *know* where you are going, who you're seeing.

Rural PHNs faced other unique challenges when maintaining confidentiality. For example, the PHN and family may have had mutual personal contacts, or may have even known each other personally outside of the professional relationship. Rural PHNs described attending the same church with their clients, having children who were friends, having children on the same sports teams, frequently seeing clients when out in the community on non-work hours, etc. Additionally, the car that the PHN drove was easily identifiable and recognized in small communities, thereby indicating which house she was visiting. The lack of privacy and anonymity required the rural PHNs to be constantly vigilant at maintaining confidentiality, and at times, required that they withhold the truth from others, as one PHN described:

> If I see them in the grocery store, I just say 'Hi,' and they say 'Hi.' If they want to talk more, they will. They'll come up and say something, and then I'll keep going with the conversation. But if they don't want to talk to me, then I just keep on going. My kids are bigger now, and they've gotten to the point of, 'How do you know them? How do you know them?' And I, 'Oh, I just know them. They work over by me.' I'll make up something like that.

Community Resources

The rural PHNs in this study generally felt there were adequate resources within their communities to assist victims of IPV. The one exception to this was the availability of accessible and acceptable shelters. In the rural areas, many communities did not have shelters available, but instead had safe houses. However, these were not always easily accessible because options for transportation were lacking. Even if women accessed the safe houses, the PHNs perceived there were still other unique challenges to staying safe in a rural community. This was explained by one rural PHN, when she said,

> One of the things in a rural community that is difficult . . . is having a place for the women to go to that is safe. It doesn't take long for the men to figure out in a rural area where the safe houses are at, and they can harass the women and stalk the women going there. It is really hard to keep women safe in a rural area. . . because a lot of areas are really accessible. It's not that far to drive. Many women have specific cars that might stick out, and if they go anywhere in the county, men can find them. The big shelters, if they wanted to go to [a shelter in another county], they are usually very full. So what they get in [our] county is just a private home that has been opened up to a family for a short time to use as a shelter. Things can be seen. If you're in town and somebody sees your car outside of the house, it's not very difficult to figure out that the woman is in that house, and that is the temporary shelter where she is staying. So that is real scary for women. The other thing is that they know that they can't go to those places for very long. They are real temporary things. . . And if they want to leave, they don't want to go somewhere for just a few

> days. They want to go somewhere for a while. So they don't very often use [the shelters].

The lack of accessible and acceptable emergency shelter care put an extra burden of care on the rural PHNs. They had fewer options for safety to provide to victims, requiring that they utilize more creative strategies when assisting victims with planning for their safety. For example, one rural nurse described how, when safety planning with a woman, "we found a safe place in the barn where she could hide if she needed to."

The rural PHNs also perceived they had a unique advantage in relation to community resources. Unlike most of their non-rural counterparts, the rural PHNs typically knew other providers in the community on a personal level, or had multiple professional contacts with them, given the small community size. One rural PHN explained how this could work to their advantage when advocating for victims.

> The positive of the rural area is that you know everybody and know who to contact. Like in the police department, you know who has perhaps handled a case and done a good job, or you know who you are not going to call on because you know from past experience that he does not handle the situation very well. You know somebody at social services that can help handle the needs of the children—some time away, or whatever. . . So it's more personal contacts. You know the people that you are working with, and sometimes that saves a lot of time. You can say, 'You need to call so-and-so,' and you can direct them to the right person. That sometimes saves a lot of time and stress, not only for you, but for the client.

Personal-Professional Boundaries

In order to work effectively with families where IPV was occurring, the PHNs needed to use strategies that helped them keep perspective about their role, the purpose of their work, and their abilities to create change in the families. One of the strategies used by all of the PHNs to keep perspective, was by setting boundaries between their personal and professional lives. The PHNs, rural and non-rural alike, described how, in working with families where IPV was occurring, they needed to be able to develop a close relationship and empathize with the victims; but at the same time, they needed to be able to maintain a professional distance so they were not becoming enmeshed in the family and it's issues.

While all of the PHNs described that setting boundaries was an important strategy for preserving themselves in the difficult work of IPV, the rural PHNs needed to have somewhat looser boundaries than the non-rural PHNs. The rural PHNs related that because they had more personal ties with clients in their communities, the boundaries between their personal lives and their professional lives were not black and white. Instead, their boundaries were grayed at times, and more permeable than those of the non-rural nurses. However, the rural PHNs described that they simply accepted this as part of being a rural nurse, and with experience, had found ways to be comfortable with less distinct boundaries. They had also learned to be flexible with their boundaries, depending on the

individual situation. The permeability and flexibility of the personal-professional boundary is illustrated in the following quote by a rural PHN.

> It's just a given in a small town that you are going to see some of these people [in your personal life]. . .That's an important part of being a public health nurse in a small town. You've started with them, and maybe that means that you can never totally forget them or give them up because you might be seeing them in the community. . . I don't have people calling me at home. It's when I go out in the community and I see them that I visit with them. I just think that's fair game. If they see me out in the community, so be it. . . I don't allow people to call me at home and talk to me. That would be extremely rare that anybody did that—well, unless they had a really pressing problem and they maybe needed to find a resource out in the community that I could help them with. That has actually happened several times through the years, where people will call me at home and say, 'I know you're not seeing me anymore, but I just need you to tell me where I can locate another resource.' And I do that. It's just a given that you are going to see your clients out in the community, and I don't mind that. Sometimes it's really fun.

Having a Balanced Workload to Keep Perspective

Another strategy for keeping perspective in their work with families where IPV was occurring, was to try to maintain a balanced workload. One way in which all of the PHNs tried maintain a balanced workload was to not have all high-risk or multi-problem families, such as those experiencing IPV, in their home-visiting caseloads. They tried to balance these more difficult and demanding cases with some cases that were considered lower risk.

The rural PHNs had the opportunity to achieve a balanced workload in a way that most of the non-rural PHNs did not. As mentioned, for most of the rural PHNs, their role in the health department required them to be generalists. These nurses expressed that having a variety of roles was an additional way they were able to have a balanced workload and keep perspective about their work. Many described that the other roles offered them more obvious rewards than home-visiting with multi-problem families. One rural PHN described this when she talked about her role with the WIC clinics within the health department.

> WIC, I think can be more rewarding sometimes than doing the home visits, because you are able to give them a product. You do a lot of nutritional education too, but you give them a voucher, and they say, 'Oh, this is really going to help.' So I get a lot more positives that way. I think the combination of both helps balance things out. . . You need to have some rewards sometimes where a person says, 'Gosh, this really helped my baby,' or 'You really helped us get through the month.'

Getting Support

An important component of all of the PHNs' practice with families experiencing IPV was to get support for themselves. This strategy involved using external sources to help find validation for the significance of one's work as well as easing the emotional labor involved when working with families where IPV was occurring. The PHNs perceived that it was important for them to be able to receive support from others so they were able to have the emotional reserves to, in turn, support the victims and work effectively with them.

Getting support from coworkers was unanimously described as the most significant strategy that all of the PHNs used for preserving themselves and coping with the stress of working with families where IPV was occurring, as well as other high-risk families. Home-visiting required that they work very independently, spending much of their day alone, without interactions from peers. Therefore, the PHNs perceived it was very important to have others that they could turn to in order to verbalize what was going on in their caseloads, to receive personal validation and encouragement for their work, and to obtain feedback about their role.

Every participant in the larger study identified support from coworkers as a strategy that they routinely used. Most of the PHNs reported they did not routinely share their stresses about their caseloads with their family or friends. Family and friends were not able to understand, relate, and give feedback in the same effective way that their PHN coworkers could. For the rural PHNs, sharing anything about their clients with family or friends was not even viewed as an option because of unique issues of confidentiality. While non-rural nurses could share their stresses by leaving out names and still maintain the confidentiality of their clients, rural PHNs were not able to do this. Even if they did not use names, rural PHNs felt their family or friends might still be able to identify the family they were talking about because they knew the family and their situation. In the words of one rural PHN, "Our husbands can very easily figure out who we are talking about." So, for the rural PHNs, being allowed and taking the time in the workplace to be able to talk with and receive support from their coworkers was even more important for effective practice.

DISCUSSION

The findings from this study suggest that, when working with families where IPV is occurring, rural PHNs encounter unique challenges and opportunities not encountered by their non-rural peers. The issues related to a generalist orientation, increased contacts with client through close interactions with the community, challenges to confidentiality, and a high degree of visibility and lack of anonymity, described by the rural PHNs in this study, are supported by others who have described unique aspects of rural nursing (Bigbee, 1993; Bushy, 2000; Crooks, 2004; Davis & Droes, 1993; Ide, 2000; Mahaffy, 2004; Shellian, 2002; Weinert & Long, 1991).

The PHNs typically spoke positively about their generalist role and perceived that it resulted in multiple benefits in their home-visiting work with families experiencing IPV. First, the variety of roles and settings offered increased opportunities for contact with families. Second, by having the opportunity to observe families in settings additional to

the home, the rural PHNs had more frequent opportunities to pick-up cues that IPV might be occurring. The contact rural PHNs frequently had with families in the community when on non-work hours also provided these same opportunities in their practice. It is possible that these additional contacts could potentially be further opportunities to provide victims of IPV with assistance. This would be particularly true if the abuser is usually in the home when the PHN visits, but is not present when the victim, for example, comes to WIC or an immunization clinic. A final benefit related to the multiplicity of roles was that it helped PHNs keep perspective about their work. Some of their other, more immediately rewarding work helped to provide a balance to the emotionally demanding work of home-visiting with high-risk families. This may be an important strategy for prevention of staff burn-out.

Another opportunity in their work with IPV was that the PHNs often had valuable interpersonal knowledge about families, which contributed to their ability to identify that IPV was occurring. The rural PHNs were also likely to have more personal relationships with providers in other agencies, and this made it easier to advocate for victims when helping them connect with community resources.

While the rural PHNs described many opportunities in their practice, they also faced challenges that the non-rural nurses did not. First, the rural PHNs faced greater challenges in relation to confidentiality. This required that the rural PHNs be hypervigilant in maintaining the confidentiality of the families with which they worked. Second, their level of personal contact and interpersonal knowledge was also perceived to be a potential barrier to disclosure of IPV. Women they had some personal contact with might feel embarrassed, or might fear that the PHN would share what was disclosed with their mutual contacts. Davis & Droes (1993) reported that rural PHNs in their study described an additional disadvantage of interpersonal knowledge, in that knowing clients well may cause one to make assumptions that could lead to inadequately assessing the client. While not described as an issue by the PHNs in this study, this could be a particular problem in IPV assessment if the PHN made assumptions about who is/isn't an abuser or victim, based upon interpersonal knowledge about the family.

A third challenge was that the rural PHNs were less likely to be able to share the stresses of their work with friends and family and still maintain confidentiality; and so were highly dependent upon their peer to provide them with the support they needed to cope with the emotional labor of their work. This may help explain the greater cohesiveness and camaraderie that is a unique characteristic of rural nursing practice (Bigbee, 1993).

A lack of available, accessible, and acceptable emergency shelter for victims created an extra burden of care on the PHNs to creatively strategize how to keep victims safe. Emergency shelters were often located long distances away and transportation was not readily available. This perception is supported by the work of Goeckerman et al. (1994), who found that among rural Wisconsin women who had accessed DV programs, 56% had no transportation of their own, and had traveled an average of 59 miles to access service.

Finally, because of their high visibility and lack of anonymity in communities, rural PHNs had less obvious boundaries between their personal and professional lives. Among the few studies that have examined rural PHN practice, there have been varied findings in how this challenge has been perceived. The rural PHNs in this study never

described feeling uncomfortable or resentful of their visibility and lack of anonymity, whereas Davis & Droes (1993) reported that lack of anonymity and intrusions into off-work hours were perceived to be a distinct disadvantage of rural public health nurses. Oberle & Tenove (2000) reported that the rural PHNs in their study "had to make a deliberate attempt to keep their personal and professional lives separate in the interests of confidentiality for the client and self-preservation for themselves" (p. 433). Leipert (1999), in her qualitative study of rural PHNs' practice in women's health in Canada, also found that rural PHNs faced the challenge of frequently encountering clients in their off-duty hours. She reported that some of the PHNs found this contact to be intrusive into their personal life. However, other PHNs, like the rural PHNs in this study, "welcomed the contact with the public these experiences afforded, and saw them as ways to further build relationships and promote health" (p. 287). The difference in PHN perceptions between these studies may be related to the fact that the PHNs in this study were expert practitioners who may have learned to cope with looser boundaries and, through years of experience, found positive benefits in a high level of visibility and lack of anonymity.

The PHNs in this study generally spoke quite passionately and positively about their work with families where IPV was occurring and expressed concern about the social and health implications of IPV. When participants were recruited for the study, all PHNs who met the inclusion criteria were invited to participate. However, in some of the agencies, some PHNs who were eligible did not participate. The characteristics of non-participants are unknown and therefore cannot be compared to those of the participants. It is possible that PHNs who were less concerned about the issue of IPV, or who felt less confident and competent in addressing it did not come forward to participate and would describe very different perceptions of challenges and opportunities in their practices. This is a limitation of this study and a direction for future research. Further studies with PHNs from other parts of the U.S. are also recommended.

This study contributes to the small, but emerging bodies of research on rural public health nursing, and on the role of PHNs in IPV work. The findings are significant in that they provide unique insight into rural PHN practice when working with families experiencing IPV. Nurses who are new to rural public health nursing, or rural PHNs who are not comfortable with IPV work, may gain a better understanding of how to maximize the opportunities and cope with the challenges that come with working with IPV in their practice. The findings can contribute positively to nursing education courses that address concepts of rural nursing, community health, or intimate partner violence. The findings may also be useful in helping rural public health supervisors, administrators, and policy makers understand some of the unique issues that rural PHNs must deal with, so that appropriate policies can be put in place to support the nurses in their work.

An important implication of the findings is that all rural agencies should create opportunities for nurses to support each other in their work with IPV and other multi-problem families. Peer support should be encouraged to occur informally among nurses, and ideally, formal mechanisms for support should also be instituted through routine staff meetings or case conferences.

Public health nurses are a key link in the chain of prevention for IPV in rural communities. While the work of PHNs in IPV prevention and intervention is not new, the potentially important role that PHNs play and the practice issues that they face are just beginning to be examined and elucidated. This is the first study in the U.S. to examine

rural PHN practice related to IPV, and further knowledge needs to be developed in this area. If we are to end the violence that occurs in people's homes, then the health care providers who go into those homes should be one of our primary modes of prevention and intervention, and we should strive to learn from them and support them in their work.

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