

**PUTTING THE PIECES TOGETHER: HOW PUBLIC HEALTH  
NURSES IN RURAL AND REMOTE CANADIAN  
COMMUNITIES RESPOND TO INTIMATE PARTNER VIOLENCE**

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**ABSTRACT**

Intimate partner violence (IPV) is a recognized public health problem with direct physical and longer-term psychological health effects. Because of these recognized health impacts, women who have experienced IPV are likely to use health care services. Research suggests that women want to and will disclose that they have experienced IPV to health care providers. Given this, the ability to identify and respond appropriately to women's disclosures and then support and connect them with needed community services becomes a key responsibility for health care providers. However, much research reports that few health care providers routinely screen their patients for IPV or provide appropriate follow up and referral. Through in-depth interviews with six public health nurses (PHNs) practicing in rural and remote communities, this study documents how these nurses identify female clients who have experienced IPV, how they intervene in these situations, and the challenges of responding in isolated rural practice contexts. The findings demonstrate that although these PHNs did not have an articulated mandate to screen and intervene in situation where IPV is occurring, they are engaged in this work. Recommendations for training and improved practices are included.

**INTRODUCTION**

Intimate partner violence is a recognized public health problem with direct impacts, including cuts, bruises, and broken bones as well as longer-term effects, including headaches, insomnia, depression, anxiety, substance abuse, and a greater likelihood of developing Post-Traumatic Stress Disorder (PTSD) (Dutton, et al., 2006; Loxton, Scholfield, Hussain, & Mishra, 2006; Plichta, 2004; Romito, Molzan Turan, & Muarchi, 2005). As a result, women who experience IPV use a variety of health care services, including emergency departments, primary care physicians, and public health nurses (Campbell, 2002; Plichta, 2004; Van Hook, 2000). Although rates of IPV identification vary by practice setting, the results suggest that utilization of these services by victims of IPV is common. For example, 13 percent of 1,526 women at 31 outpatient clinics were identified as victims of abuse (Wasson et al., 2000), as were 14 per cent of 2,465 women using a variety of obstetrician/gynecologist offices, emergency departments, primary care offices, pediatrics, and addiction recovery (McCloskey, et al., 2005), and 44.3 percent of 399 women at one family medicine clinic (Peralta & Fleming, 2003). Given the prevalence of IPV in these settings, health care providers have a central role in dealing with immediate injuries and other health impacts of IPV. However, it is also crucial for these providers to appropriately identify and refer women to much needed community resources which may prevent further injury and support women in working toward reducing and eliminating violence in their lives. For victims of IPV who live in remote and rural communities, support offered by health care providers is more crucial, as there is often few other resources and services.

The purpose of this qualitative pilot study is to explore and describe the experiences of public health nurses located in rural communities when assessing and intervening on behalf of women experiencing IPV. The project focuses on PHNs and their nursing practices as the public health mandate, which includes prenatal and postpartum screening, sexual health clinics and education, and home visits brings them into contact with many female clients. This practice area has also been identified as a primary health area where identification and response to IPV can occur (Grafton, Wright, Gutmanis, & Ralyea, 2006; Webster, Sangster Bouck, Wright, & Dietrich, 2006). In addition, PHNs are recognized as important health resources within rural and remote communities (Leipert & Reutter, 2005), especially for women who have experienced IPV (Cox, Cash, Hanna, D'Arcy-Tehan, & Adams, 2001; Everson, 2006). The research describes the interactions between PHNs and their female clients during the moments when clients reveal they are victims of IPV.

### **RELEVANT LITERATURE**

Universal or routine screening of all women for IPV is controversial. Both the Canadian and U.S. Task Forces on Preventative Health Care recommend against the use of routine protocols, as there is currently a lack of empirical evidence linking the use of these screening procedures to positive outcomes, including decreased incidence of physical and psychological abuse and injury (Berg, 2004; Nelson, Nygren, McInerney, & Klein, 2004; Wathen & MacMillan, 2003). Many Canadian and American professional organizations recommend screening as a routine part of medical examinations (Campbell, 2002; McCloskey, et al., 2005). Others, like Worster (2004), citing the potentially harmful effects of false positives and false negatives, advocate a case-finding approach in which clinicians are alert for possible signs or symptoms of IPV and then screen or question if clinically relevant. A final approach suggests that health care providers assess for IPV, so that doctors and nurses can open communication channels and provide ongoing support to abused women patients (Griffin & Koss, 2002; Janssen, Dascal-Weichhendler, & McGregor, 2006; Smith, 2002; Wagman Borowsky & Ireland, 2002; Walton-Moss & Campbell, 2002).

In the absence of clear recommendations and guidelines however, health care providers are unsure of when and how they should screen or assess. Survey research documents differential rates of routine screening, with 11 percent to 50 percent of nurses and physicians across diverse practice settings reporting that they routinely screen patients (Ellis, 1999; Glowa, Frasier, Wang, Eaker, & Osterling, 2003; Gutmanis, Beynon, Tutty, Wathen, & MacMillan, 2004; Lapidus, et al., 2005). Although higher rates of IPV identification have been documented after introduction of a routine screening question (Gerber, Leiter, Hermann, & Bor, 2005; Scholle, et al., 2003; Paschall Richter, Surprenant, Schmelzle, & Mayo, 2003), two studies (Gerber et al., 2005; Paschall et al., 2003) noted there was little evidence of additional follow up or referral.

As the majority of research on IPV screening outlined above focuses on institutional or private practice settings, there has been little investigation of the role of PHNs in providing services to families where IPV is occurring (Dickson & Tutty, 1996; Evanson, 2006; Leipert, 1999). A survey of 125 PHNs in an urban setting revealed that the majority (86 percent) believe that IPV screening is within their public health role and mandate, even if women do not raise the issue, and 71 percent of participants stated that if IPV indicators were present, they would ask screening questions (Dickson & Tutty, 1996). However, 55 percent of these PHNs also reported that they were unsure of what to say to women about IPV. Through in-depth qualitative interviews, one group of eleven PHNs (Webster, et al., 2006) and another group of six PHNs

(Jack, Jamieson, Wathen, & MacMillan, 2008) similarly reported that they believed home visits are appropriate settings for screening and responding to IPV; yet, these two groups of PHNs also reported that they struggle in knowing how to ask about IPV and then intervene.

Two qualitative studies, Evanson (2006), who interviewed seven PHNs in rural, mid-western U.S., and Cox et al. (2001), who interviewed 24 PHNs in rural Victoria, Australia, specifically sought to examine how the rural context influences practice with families in which IPV is occurring. Both participant groups of nurses reported that their rural locations create multiple opportunities for them in establishing and maintaining relationships with families, especially with women experiencing IPV. The variety of work roles performed by PHNs, including home visits, immunization clinics, and community health education, as well as their non-work activities in and around the community, provide them with repeated contact through which they become aware of potential risk factors and be witness to incidents of IPV. In these studies, the PHNs reported that, at times, identification of IPV is easy. Other times, however, the participants noted that identification requires intuition. In Cox et al.'s (2001) study, one PHN described this as “picking up cues” and how she became alerted to the possibility of IPV because of the reaction one of her clients had when asked if she wanted to have her partner in the room.

### **PURPOSE**

The purpose of this qualitative pilot study is to provide descriptive data about the assessment and intervention practices of PHNs when working with families experiencing IPV in the context of rural and remote northern Canadian communities. We recruited PHNs located in the communities of Prince Rupert, Terrace, Dease Lake, and Kitimat in northwestern British Columbia, Canada. These communities are considered isolated because each is located at a distance from neighboring communities—about 150–700 kilometers apart from each other, between 700–1,000 kilometers to the comparatively large, urban center of Prince George, and between 1,500–1,700 kilometers from even-larger Vancouver. The distances between these rural communities, combined with the winter climate and rugged geography of northern British Columbia, uniformly create difficulties for daily living and for the provision of social and health care services (Leipert & Reutter, 2005). There are differences, however, among these communities in the availability of services. The larger communities of Prince Rupert and Terrace, each with populations of about 15,000, have community networks and resources. Dease Lake, the smallest community at about 70 families, has more limited services and is also located the farthest from neighboring communities and larger urban centers (600 kilometers to the nearest community of Terrace, BC, and 1,000 and 1,700 kilometers to the larger centers of Prince George and Vancouver, BC, respectively). Within these communities, PHNs may be one of only a few professional and confidential supports available to women experiencing IPV (Leipert, 1999). The research objectives were to: 1) understand how women disclose to PHNs and how these nurses come to know that IPV is occurring within families; 2) document screening practices used by PHNs; and 3) identify the responses of PHNs to women experiencing IPV and how these are influenced by the rural practice context.

### **METHOD**

A qualitative method was used to study the everyday nursing practices and the interactions PHNs have had with women who have experienced IPV. A semi-structured question format was used, as it allows the research interview to cover information that is useful for the

inquiry, and this format also provides opportunities for participants to add to the depth of the information that is collected (Fontana & Frey, 2003). Questions focused first on if and then how participant PHNs identify abused women among their clients or how women identify to them (Do you have a process or protocol for identifying or screening for woman abuse? Can you describe this process or protocol?), their responses to IPV (When you have a woman in front of you as a client who discloses that she has experienced intimate/domestic violence, what do you do first?), and the community supports or resources available and what services are lacking (What services, resources, or programs are available for abused women in your community? Are these helpful to women? What services or programs are necessary but unavailable?).

### ***Data Collection***

Participants were recruited through the Northern Health Authority in British Columbia with the cooperation of the manager of PHNs who had circulated a research poster describing the study within each of the identified communities. Nurses were interviewed as they contacted us and agreed to participate. Prior to each interview, participants read an information sheet detailing the purpose of the research and signed an informed consent sheet. Honorariums were provided at the beginning of each interview. Interviews varied from 45 to 60 minutes in length and were digitally recorded. Ethical review for the study was provided by The University of Northern British Columbia.

Recruitment was difficult, as PHNs have many time constraints, and in some of these Northern communities there are staff shortages. In the end, six PHNs with an average of 13.8 years of experience (range between 2.5 to 35 years of experience) were interviewed. These years of experience include public health, as well as practice in emergency/acute care departments and mental health and addiction/detox services. All interviews were conducted by the first author.

### ***Data Analysis***

Each completed interview was transcribed verbatim by the second author. All identifying information was removed, including the names of the interviewees', which were replaced with a non-identifying number (for example, Nurse 01). Each transcript was read several times by both authors to fully capture the meaning. Analysis began with the first two interviews, which were uploaded as transcripts into the NVivo qualitative software program for coding. The second author began this process by generating a list of codes that served as a framework for analyzing the remaining transcripts. Where possible, we employed in vivo coding, which uses the participants' words to name the emerging codes. This technique maintains closeness between the data and the developing and final analyses. Reports for each code were generated and links between these more specific codes were made where the data contained within them overlapped and connected. For example, specific codes, such as "women's disclosures," "remain supportive," and "routine screening," were connected together because data contained with each of these codes described how conversations about IPV occurred between PHNs and women clients. Through this process, four broader themes were identified. Next, compelling quotations from the interviews that illustrate the processes described or provided context for our analyses were selected. Once the analysis was complete, the first author reread the interview transcripts again and compared these to the developed analysis. The dependability of the analysis is established by these multiple processes of coding and the final comparison of the completed

analysis against the raw data in each interview. As a final step, all of the study's participants were sent a description of the processes by which the PHNs heard women's experiences and responded to disclosures of IPV. They were asked to review the account and provide comments about the accuracy of the description. Two out of the six nurses responded and confirmed that the account matched their experiences. These procedures were recorded in a methodological journal (Guba & Lincoln, 2004; Morrow, 2005).

## FINDINGS

Three broad themes were identified in the analysis process: 1) the way in which nurses described how women disclosed experiences of abuse to them, 2) how the PHNs respond, and 3) the challenges of intervening in the rural and northern practice context. Each of these themes is described below. A final section outlines the recommendations provided by the PHNs to improve their own practices. Quotations are used to demonstrate the connection between the derived analysis and the raw data and to reveal both the agreement and variability within the PHNs descriptions of the ways women disclose and how they respond.

### *Indirect and Direct Disclosures: Becoming Alert to Intimate Partner Violence*

All interviewed PHNs described past practice experiences in which women either disclosed IPV to them or they were alerted to the possibility. Salient within their descriptions of these various situations is that disclosure occurs in what are the everyday and routine health care services these PHNs provide, including prenatal and postpartum screening, the well child program and immunization clinics for babies and children, sexual health clinics, and sexual health education provided for youth. A complex pattern emerged of the ways in which PHNs ask and come to know about IPV and about how women clients directly and indirectly reveal this to them.

Although all of these PHNs stated that some women directly stated that their partner abused them, these instances were noted as rare and tended to occur only when injuries were obvious. Indirect disclosures were the norm, and all but one of these PHNs provided examples. Disclosures were indirect in that women were not coming to PHNs directly because of abuse by their partners or immediately after a violent incident. Rather, female clients sought advice or inquired about child development, parenting difficulties, sexual health, or the effects of conflict on children and through these questions the PHNs became alerted to the possibility that IPV may be occurring: “I go in thinking what we are really going to talk about is related to the baby or your birth control and what happens is that’s not the issue for the family or the person at all” (Nurse 01); “They don’t come to us directly. If we see them they are usually presenting here worried about other aspects of their health” (Nurse 03); and “Somehow it comes up through other things so most often when I’ve dealt with this issue they’ve been coming in seeking help for something else and then you sort of delve into it and that’s when you discover those underlying issues” (Nurse 04).

Questions contained within assessment instruments, such as the Parkyn postpartum screening instrument and sexual health questionnaires, provided an opportunity for four of the six PHNs to ask and initiate discussions about IPV. However, it was not necessarily the questions that signaled to these PHNs that IPV may be occurring. Rather, it was the discussion that ensued in response to the questions—collecting information about a woman’s health history or details about past parenting difficulties, for example—that alerted PHNs to the possibility of IPV:

Storytelling. So for example a woman talking about years of becoming pregnant because last time she became pregnant her partner got so angry and hit her in the belly and forced her to have a termination. During their personal social history, storytelling like that would come out when I'm trying to get myself into the context of the clients' life (Nurse 06).

It will come up in terms of what has parenting been like in the last couple of months and it comes up that there is violence or it was experienced in the household and it's affecting the kids. It's initially brought up less about them themselves then it is sort of the family or the kids that they're concerned about and that's how we get into the topic and then you know over time we can sort of bring it back to their experience (Nurse 01).

Another practice example provided by four of the six PHNs involves sexual health education in high-school settings. The nurses described how adolescent girls approach them and ask questions about birth control and sexual health and behaviors. Then, through these interactions, the PHNs explained how they become concerned that these girls may be in abusive relationships:

Girls who'll come in for birth control and then come in a number of times for emergency contraceptives and who are quite anxious about their birth control method and quite insecure that they might be pregnant, and sometimes you get that feeling of maybe this person isn't ready for the sexual life that their involved in (Nurse 06).

Once the connection was made, these PHNs then stated that they would initiate frank discussions about healthy relationships:

I can have a conversation with this person about whether or not she's ready to be having sex and what kind of power dynamics exist in the relationship; is she able to talk about that with her partner? (Nurse 06).

In presenting these practice examples, each of the PHNs was clear in saying that it is she and not the girl who makes the connection between certain types of questions about sexuality and IPV:

Those questions aren't ones that they are identifying at all with violence or with controlling behaviors or unhealthy relationships. In their minds those are questions specifically about sex (Nurse 01).

Four of the six PHNs clearly stated that revelations about IPV did not necessarily occur as the result of a one-time contact in which screening questions were asked. Rather, women revealed experiences to them because of the relationships that are established between them as PHNs follow women through pregnancy, postpartum screening, and then infant and child immunizations, and follow-up home visits with some families. The importance of this relationship is illustrated in the following:

The women with whom I am doing home visits, they definitely want the relationship first and sometimes it's three, six months, a year, two years before they're willing to disclose anything about what's happening between them and their partner" (Nurse 01)

It depends on the relationship I think and the rapport that's built with the practitioner before they trust (Nurse 03); and

Slowly [with] a lot of relationship-building, things like that come up after you see them a few times, they trust you" (Nurse 04).

The next section describes the responses and the variety of strategies engaged by these PHNs after IPV is revealed.

### ***Supporting Women and Providing Referrals***

Although there was consistency in the participants descriptions of how women disclose and how they come to know about the presence of IPV, there was more variability in what they described as their own responses, including: providing information and referrals, assessing immediate risk, safety planning, and offering short- and long-term support. Providing information about community services, access to resources, and referrals to these was the most-identified task performed by these PHNs. Three of the six PHNs reported that after disclosure they engage in assessment of immediate safety concerns, including asking about the presence of guns in the home and if the partner has previously threatened to harm the woman and/or her children. Two of these PHNs said that they extended these discussions to help women develop long-term safety plans, which included strategies such as having a safe place in the home to hide, memorizing telephone numbers of emergency shelters, and asking a family member or neighbor for transportation to community services that could help them.

Five of the six PHNs interviewed stated that offering women initial and ongoing support was also a key response after disclosure of IPV. One of these PHNs said that she keeps women connected either to the public health service she worked for or to other clinics or services in the local community. She said that these connections were crucial in lessening isolation and creating multiples opportunities for women to ask for and receive help. Another PHN described how keeping women connected to public health services is safe, as women can tell their abusive partners that the appointments are for children's health:

Here's how to reach me, commit this phone number to memory, it's the health unit's phone number so you can call me any time and ask for an appointment for your child" (Nurse 05).

In addition, for two of these five PHNs, remaining supportive of women meant allowing them to take the lead in decisions about if, when, and how to accept help:

I think it's just trying to remain supportive of where they are at. Asking what can I do to assist you, is there anything that would help you to feel better about your

situation—and I guess what I try to dance around is maintaining my rapport and connection and nonjudgmental approach with them by not assuming that they want to get out of their relationship (Nurse 8).

### ***The Northern and Rural Practice Context***

All six of the PHNs spoke of the difficulties of living within rural and northern areas, especially for women. They described this reality, including details on the lack of employment opportunities for women, the high cost of housing, wage disparities between men and women, and lack of childcare spaces. They also noted how all of these factors combined create greater inequality between women and men in heterosexual relationships and how they can become significant barriers to leaving abusive partners. Access to community resources was also identified in all interviews as a significant barrier, for a variety of reasons, for example, the number of resources is limited in smaller communities, some are not culturally appropriate for Aboriginal and Southeast Asian women, and there is no anonymity in the use of some services that are located in well-known areas of some communities. Transportation to services was also described as a challenge because local, public buses may not reach all the areas where some services are located, or transit is not available on nights and weekends. For women living in more isolated areas outside these small centers or on reserve communities, farms, or islands, transportation on buses, ferries, and float planes can be difficult to obtain and expensive.

The difficulties that these various factors create for women in living with and leaving abusive partners, which are specific to the rural context, add weight to the supportive role that these PHNs take on. Despite this, four of the six nurses noted that in rural areas there is little support offered to them in this role, as there are few opportunities for professional development or clinical supervision.

### ***Recommendations***

At the end of each interview, we asked all PHNs for recommendations on how to improve their own practices with women who experience IPV. One PHN suggested that a clear mandate and consistent practice guidelines need to be developed so nurses would have a protocol to work with when they suspect IPV or when women disclose IPV to them:

The contact we have with these families and women is all through other channels and back channels, and in public health we could have some more clear mandates and guidelines around trying to access these populations (Nurse 04).

Three of the PHNs noted the contradiction between the practice reality wherein women disclose experiencing IPV during the course of standard nursing activities and the lack of a clear mandate and guidelines to intervene. The following two quotations illustrate these concerns:

[We are not] getting to the root or the cause of a lot of that stuff even a lot of the sexual health education that we do in the schools. We spend so much time on sexual health around how to use a condom and are you on birth control and testing for STIs and that kind of thing but such a small segment is healthy relationships and how to decide what is acceptable and what is not. We become

really task focused but we forget that really important piece around the emotional health and relationships (Nurse 04).

A lot of the intake is focusing, like, on your physical health: do you smoke, do you have a history of cancer in your family, how long are your periods, how many people have you had sex with, and then there's one question that says do you have any pain during intercourse. Which I've always thought was an interesting question because the way that I think it was intended on the form was to look at any physical issues that are causing pain during intercourse but certainly there are psychological and emotional variables that can affect the answer to that question (Nurse 06).

These PHNs are asking for direct mandates on if, how, and when to ask and respond to IPV. Moreover, they seek clear guidelines on how to practice competently to effectively support and intervene with women after they disclose; to do so, they need more training and professional development:

I don't think that we're trained sort of adequately to address the why and blanket more of the opportunities that we have when we're interacting with clients, to learn to pick up cues, to have questions, and to know what to do with the answers. I would say that one of the biggest gaps is that we need more professional development and actual hands on practice (Nurse 8).

### ***Limitations***

Although this in-depth account provides insight of the ways in which the PHNs ask about and hear women's experiences of IPV, the findings are limited as they only reflect six unique experiences and perspectives. Further interviews with nurses in these remote communities are needed to increase the depth and credibility of the findings.

## **DISCUSSION**

This study reveals the complex and multiple ways women disclose and how PHNs come to know about IPV, the responses that PHNs offer, and how the northern and rural practice context influences women's ability to seek help. Although identifying and supporting women are a part of the work the PHNs are doing, it is not a part of their mandate. The findings here demonstrate that they are nevertheless engaged in these practices, as direct and indirect disclosures of IPV emerge from the patient-practitioner discussions about the patient's physical and sexual health – all of which are mandated public health services.

Although not consistent across all of these interviews, all of these PHNs stated that they did respond to women's disclosures, including offering support, safety assessment and planning, and referral to needed services. Five of the six interviewed PHNs not only emphasized detecting IPV but also building relationships with and supporting women. The strategies these PHNs engaged in reflect best practice recommendations, particularly strategies identified from research conducted with women who have experienced violence in which women suggest that they want health care providers to ask in a nonjudgmental manner, provide validation of their disclosures,

referral to community services, and respect their decisions about when to seek other help and leave abusive partners (Bates, Hancock, & Peterkin, 2001; Dienemann, Glass, & Hyman, 2005; Dowd, Kennedy, Knapp, & Stallbaumer-Rouyer 2002; Hamberger, Ambuel, Marbella, & Donze, 1998; Van Hook, 2000; Wendt Mayer, 2000; Zink, Elder, Jacobson, & Klostermann, 2004). Yet, only two of the PHNs expressed confidence in their ability to respond effectively, and all them stated that they needed enhanced training and professional development. Other qualitative research with PHNs has found similar results, which shows that although these health care providers believe that identifying and responding to IPV is an important aspect of their practice, they are not confident in their abilities (Cox et al, 2001; Dickson & Tutty, 1996; Evanson, 2006; Grafton, et al., 2006; Webster, et al., 2006).

Consistent with other qualitative research about the practice of PHNs in rural areas (Cox et al., 2001; Evanson, 2006), and as described in all of the interviews, the absence or the inaccessibility of other services in the context of rural communities, creates a crucial role for PHNs in identifying and supporting women who have experienced violence. Although only one of the PHNs in this sample acknowledged it, the services offered by PHNs can be a safe place in which women can disclose and seek support, as visits to a PHN can be disguised as child health appointments. A similar finding was reported by the Cox et al. (2001) study of 24 PHNs in rural Australia.

### ***Future Research***

As one of the identified limitations of this research and others (Cox et al., 2001; Evanson, 2006) is small sample sizes, further research with larger numbers of PHNs is necessary to extend the depth and credibility of the findings. Future research must also consider the differences in urban and rural practice contexts, including the different relationships and boundaries between PHNs and their clients and variations in the availability and accessibility of other health and social services supports for both PHNs and clients (Cox et al., 2001; Evanson, 2006). Given the close connection between the health care interventions routinely provided by PHNs and disclosures of IPV, future research also needs to focus on these moments of interaction and be sensitive to specific practice settings and the initial reason for which health care is being sought or a service being performed (Rittmayer & Roux, 1999; Spangaro, Zwi, & Poulos, 2009).

### ***Implications for Practice***

The finding that disclosure of IPV is embedded in standard nursing practices is significant. It is clear from the multiple practice descriptions supplied by five of the PHNs in this study that awareness of IPV is triggered by specific aspects of prenatal and postpartum screening or when concerns about parenting or sexual health are raised. Three of the PHNs in this study noted the need for this form of specific knowledge, which would build their skills in making connections between the pieces of information revealed through questions about women's physical and sexual health or parenting difficulties and the presence of IPV in women's lives. Specific knowledge about these interactions is crucial to the development of effective training and professional development programs.

The variability in interventions offered by this small group of PHNs suggests the need for a clearly defined mandate and practice guidelines. However, engaging in this work of detecting and responding to IPV is risky as PHNs are aware of and at times witness to the prevalence of

IPV in their communities. Specific safety protocols in addressing IPV need to be developed, especially when PHNs are conducting home visits and when these occur in remote communities or isolated private properties (Cox et al, 2001). Further, support and confidential supervision from other professionals is crucial so that PHNs can continue to be effective in providing support to women in their communities (Cox et al., 2001; Evanson, 2006).

### CONCLUSION

The findings identified through this study extend the small but emerging body of research about the practices of PHNs among families where IPV is occurring (Cox et al., 2001; Dickson & Tutty, 1996; Evanson, 2006; Grafton, et al., 2006; Webster, et al., 2006). The findings are significant in providing needed and specific knowledge about the health care concerns and questions that abused women bring to PHNs and the ways in which they are alerted to the presence of IPV through their standard nursing practices. IPV is a complex social problem that requires a variety of social and legal remedies that are beyond the ability of any one health care provider or health care setting to effectively address (Smith, 2002; Rittmayer & Roux, 1999; Spangaro, et al., 2009). Given the significant health impacts of IPV, however, all health care providers are responsible for identifying and supporting women who have experienced IPV. Because there may be few other community supports and services available, and because of the multiple public health roles that PHNs have with women in their communities, PHNs can be an important resource within rural and northern communities in providing a safe, confidential space for women to disclose and to receive support, as they make difficult decisions to keep themselves and their children safe.

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