

EMANCIPATING EMERGENCY NURSES TOWARDS TAKING CARE OF SURVIVORS OF INTIMATE PARTNER VIOLENCE

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SUBMITTED IN FULFILLMENT OF THE REQUIREMENTS FOR THE
DEGREE

Philosophiae Doctor

in

Nursing Sciences

In the

FACULTY OF HEALTH SCIENCES

At the

UNIVERSITY OF PRETORIA

APRIL 2013

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I declare that the thesis

**EMANCIPATING EMERGENCY NURSES TOWARDS TAKING CARE OF
SURVIVORS OF INTIMATE PARTNER VIOLENCE**

Is my original work and that it has not been submitted before for any degree or examination at any other institution. All the sources that have been used or quoted have been acknowledged by means of complete references in the text and bibliography.

ANNA ELIZABETH VAN DER WATH

DATE

My religion is based on truth and non-violence. Truth is my God. Non-violence is the means of realising Him.

Mohandas Gandhi

DEDICATION

The study is dedicated to:

- My late father, Jonathan Minnaar Bruwer, who taught me that whatever I want to know, is written somewhere. It is for me to search for it and read until I understand.
- My late mother, Johanna Jacomina Elizabeth Bruwer, who taught me to be responsible for my actions.

To them I owe my life philosophy:

You must be the change you want to see in the world - Gandhi

- The emergency nurses who care for others while they suffer inside:

...but isn't it you won't let others see, you just cry internally?

ACKNOWLEDGEMENTS

I would like to extend my sincere gratitude to the following people and institutions who contributed to the success of this study:

- My husband, Salomon van der Wath, for believing in me and for the many sacrifices he made to allow me this opportunity.
- My daughter, Elana van der Wath, who never fails to inspire me with her dedication and positive outlook on life.
- My son, Johan van der Wath, who encouraged me in his very pragmatic way: "Mamma moet nou net sit en dit klaarmaak!"
- My supervisor, Prof NC van Wyk, for her consistent support and guidance. I have great admiration for her insights as a researcher.
- My co-supervisor, Dr ES Janse van Rensburg, for her thorough and detailed feedback and her consistent support and encouragement.
- Barbara English, who edited the thesis and provided me with valuable critique.
- Prof Mavis Mulaudzi, a dedicated and strong leader, who reminded me of my responsibility to finish what I have started.
- My colleagues at the Nursing Department, who are a source of inspiration to me.
- My friends, Neltjie, Ronell and Elsie, for their care, humour and refreshing presence.
- My sisters, Retha, Hanlie and Ester, for their interest in my progress. *I am because you are.*
- Maria Soele, for maintaining order in the household in her quiet and patient way.
- The emergency nurses, who openly and spontaneously allowed me into their professional and personal lifeworlds.
- The panel of experts who participated in the Delphi rounds, who gave their precious time to validate the guidelines.
- The Department of Health, who granted me permission to conduct the interviews in two hospitals.
- The UNEDSA project grant, for funding the study through the Community-Oriented Nursing Education for Women and Child Health Programme: A joint collaborative initiative of the University of Pretoria and the University of Limpopo (Medunsa Campus).

ABSTRACT

EMANCIPATING EMERGENCY NURSES TOWARDS TAKING CARE OF SURVIVORS OF INTIMATE PARTNER VIOLENCE

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Emergency nurses have the opportunity to intervene when survivors of intimate partner violence (IPV) are most receptive for interventions following exposure. However, exposure to IPV is often not detected, and the majority of women still experience significant challenges to find help. The provision of care to survivors of IPV within the violence-prone South African landscape poses unique challenges to emergency nurses. The challenges seemed to be situated within emergency nurses' own vulnerability to personal exposure to violence related to gender inequality, and their on-going professional exposure to survivors of IPV. The encounter with IPV can trigger overwhelming emotions in nurses that they are expected to suppress while on duty. These emotional experiences can lead to internal conflict, emotional detachment and vicarious traumatisation, which can in turn affect emergency nurses and the care they provide to survivors. When taking care of a survivor of IPV, emergency nurses need to facilitate a critical awareness in the survivor of the disadvantage she suffers. For nurses to make an impact, they need to reflect on their own personal and professional position in relation to power and need to deal with their own experiences of oppression through emancipation.

The aim of this research was to explore and describe emergency nurses' experiences of taking care of survivors of IPV; and develop and validate guidelines to facilitate the actualisation of emancipatory knowing in emergency nurses with regard to taking care of survivors of IPV.

The research was conducted in two phases. Phase 1 of the research was conducted within a constructivist paradigm. A descriptive phenomenological inquiry, grounded within the philosophical foundations of Husserlian phenomenology, was used. The phenomenological reductions were applied throughout data collection and analysis. Concrete descriptions were obtained from interviewing nine nurses working in

emergency units of two public hospitals in an urban setting in South Africa. In order to arrive at a description of the essence, the data were analysed by searching for the meaning given to the experience of caring for survivors of IPV.

The findings were described in terms of the essence that was illuminated by the constituents that reflected the following meanings emergency nurses attached to the experience of taking care of survivors of IPV: the emotional and cognitive impact related to being witnesses to survivors' experiences of IPV, identification with IPV survivors' experiences, the interrelation between IPV related personal and professional domain experiences, attempts to cope with professional domain experiences related to IPV, attempts to make meaning out of IPV, formation of gender perceptions and assumptions related to IPV and provision of care to survivors of IPV.

A literature review was conducted after data collection and analysis to ensure an open and unbiased approach towards participants' lifeworld experiences. The literature review helped to clarify the meanings and deepened the researcher's perspectives on the research phenomenon. Injustices and oppression uncovered in emergency nurses' experiences of taking care of survivors of IPV guided the researcher to formulate nine guidelines in terms of emancipatory knowing processes in nursing.

The draft guidelines based on the findings of the phenomenological inquiry and emancipatory knowing processes in nursing were validated through a Delphi technique. The guidelines were refined according to the suggestions of a panel of experts who rated the guidelines using the criteria of reliability, validity, applicability, clarity and flexibility. Recommendations were made in terms of organisational and supportive structures to enable emergency nurses to provide quality care to survivors of IPV, support structures to provide care for the carer, and realisation of emancipatory knowing with regard to taking care of survivors of IPV.

Keywords: Emergency nursing, descriptive phenomenology, emancipatory knowing, clinical practice guidelines, intimate partner violence.

TABLE OF CONTENTS

DECLARATION.....	II
DEDICATION.....	IV
ACKNOWLEDGEMENTS	V
ABSTRACT	VI
TABLE OF CONTENTS	VIII
LIST OF ADDENDUMS	XIV
LIST OF TABLES	XV
LIST OF FIGURES	XVI
CHAPTER 1: ORIENTATION OF THE STUDY	1
1.1 INTRODUCTION.....	1
1.2 BACKGROUND AND RATIONALE.....	3
1.2.1 History of social responses to IPV	3
1.2.2 International prevalence of IPV.....	4
1.2.3 South African prevalence	5
1.2.4 Causal and risk factors for IPV.....	6
1.2.4.1 Individual level.....	6
1.2.4.2 Family (relationship) level.....	6
1.2.4.3 Socio-cultural level	7
1.2.5 Impact and consequences of IPV	7
1.2.5.1 Physical health implications of IPV	8
1.2.5.2 Mental health implications of IPV	9
1.2.5.3 Social implications of IPV	10
1.2.5.4 Economic implications of IPV	10
1.2.6 The role of the healthcare system in IPV.....	11
1.2.6.1 Healthcare utilisation by survivors of IPV	11
1.2.6.2 Healthcare system response to IPV	12
1.2.6.3 The role of emergency nurses in IPV	15
1.3 PROBLEM STATEMENT	17
1.4 RESEARCH QUESTION	20
1.5 RESEARCH AIM AND OBJECTIVES	20
1.6 PARADIGMATIC PERSPECTIVE	21
1.6.1 Ontological assumptions	22
1.6.2 Epistemological assumptions	22
1.6.3 Axiological assumptions.....	22
1.6.4 Methodological assumptions.....	22

1.7	PHILOSOPHICAL FRAMEWORK.....	23
1.8	CLARIFICATION OF KEY CONCEPTS	23
1.8.1	Emancipation	23
1.8.2	Emergency nurse.....	24
1.8.3	Experience.....	24
1.8.4	Intimate partner violence.....	24
1.8.5	Survivor	25
1.8.6	"Taking care of"	25
1.9	SIGNIFICANCE OF THE STUDY	26
1.10	RESEARCH METHODOLOGY	26
1.11	PHASE 1: PHENOMENOLOGICAL INQUIRY TO EXPLORE AND DESCRIBE EMERGENCY NURSES' EXPERIENCES OF TAKING CARE OF SURVIVORS OF IPV	27
1.11.1	Research design	27
1.11.2	Research method.....	27
1.11.3	Trustworthiness of the findings.....	28
1.12	PHASE 2: DEVELOPMENT AND VALIDATION OF GUIDELINES TO FACILITATE THE ACTUALISATION OF EMANCIPATORY KNOWING	30
1.12.1	Development of guidelines	30
1.12.2	Validation of guidelines.....	31
1.12.3	Validity of the guidelines.....	33
1.13	ETHICAL CONSIDERATIONS.....	33
1.13.1	The principle of respect for human dignity.....	33
1.13.2	The principle of beneficence	35
1.13.3	The principle of justice.....	36
1.14	SUMMARY	36
1.15	ORGANISATION OF THE STUDY	37
	CHAPTER 2: PARADIGMATIC PERSPECTIVE, PHILOSOPHICAL FRAMEWORK AND RESEARCH METHODOLOGY	38
2.1	INTRODUCTION.....	38
2.2	PARADIGMATIC PERSPECTIVE	39
2.2.1	Research paradigm	39
2.2.2	Meta-theoretical assumptions: constructivist paradigm	41
2.2.2.1	Constructivist paradigm: ontological assumptions	41
2.2.2.2	Constructivist paradigm: epistemological assumptions.....	42
2.2.2.3	Constructivist paradigm: methodological assumptions.....	42
2.3	PHILOSOPHICAL FRAMEWORK.....	43
2.3.1	What is phenomenology?	43
2.3.2	Origin and historical development of phenomenology	44
2.3.3	Phenomenological philosophical foundations.....	46
2.3.3.1	Epistemological and ontological assumptions.....	47

2.3.3.2	Methodological assumptions.....	50
a)	Assuming the phenomenological reduction	50
b)	Descriptions from others	51
c)	Search for the invariant meaning	51
2.4	RESEARCH METHODOLOGY	52
2.5	PHASE 1: PHENOMENOLOGICAL INQUIRY TO EXPLORE AND DESCRIBE EMERGENCY NURSES' EXPERIENCES OF TAKING CARE OF SURVIVORS OF IPV	52
2.5.1	Research design	52
2.5.2	Research method.....	54
2.5.2.1	Assuming the phenomenological attitude	55
a)	An open life-world approach	56
b)	Bracketing.....	57
2.5.2.2	Researcher's role	60
2.5.2.3	Research setting	61
2.5.2.4	Selection of participants	61
2.5.2.5	Inclusion criteria	62
2.5.2.6	Data collection	63
a)	Unstructured phenomenological interviews	63
b)	Field notes	67
2.5.2.7	Data analysis	69
a)	Eidetic reduction	70
b)	Essences.....	70
c)	Descriptive analysis	70
2.5.2.8	Description of findings	73
2.5.2.9	Literature review	74
2.5.3	Trustworthiness of the findings.....	74
2.5.3.1	Bracketing	74
a)	Abstract formulation	75
b)	Research praxis	75
2.5.3.2	Reflexivity.....	76
2.5.3.3	Eidetic reduction.....	77
2.6	PHASE 2: DEVELOPMENT AND VALIDATION OF GUIDELINES TO FACILITATE THE ACTUALISATION OF EMANCIPATORY KNOWING IN EMERGENCY NURSES WITH REGARD TO TAKING CARE OF SURVIVORS OF IPV	78
2.6.1	Development of guidelines	78
2.6.1.1	Methodology of guideline development	79
a)	Guiding attributes in the guideline-development process	79
b)	Guideline development in terms of dimensions of emancipatory knowing in nursing	80
2.6.2	Validation of guidelines.....	81
2.6.2.1	Selection of participants	82
2.6.2.2	Inclusion criteria.....	82
2.6.2.3	Delphi Round 1.....	83
a)	Data-collection method and instrument.....	83
b)	Data analysis.....	83
2.6.2.4	Delphi Round 2.....	83
a)	Data collection method and instrument.....	83
b)	Data analysis.....	84
2.6.3	Validity of the guidelines.....	84
2.7	SUMMARY	85

CHAPTER 3: DESCRIPTION OF FINDINGS	86
3.1 INTRODUCTION	86
3.2 FINDINGS	87
3.2.1 Emotional impact related to being a witness to survivors' experiences of IPV	89
3.2.2 Cognitive impact related to being exposed to survivors' experiences of IPV	93
3.2.3 Identification with IPV survivors' experiences	95
3.2.4 Interrelation between IPV-related personal and professional domain experiences.....	99
3.2.5 Attempts to cope with professional domain experiences related to IPV	103
3.2.6 Attempts to make meaning out of IPV/understand IPV	106
3.2.7 Formation of gender perceptions and assumptions related to IPV	110
3.2.8 Provision of care to survivors of IPV	116
3.3 CONCLUSION	129
CHAPTER 4: DISCUSSION OF RESEARCH FINDINGS AND LITERATURE REVIEW.....	130
4.1 INTRODUCTION	130
4.2 EMERGENCY NURSES' EXPERIENCES OF PROVIDING CARE TO SURVIVORS OF IPV	130
4.2.1 Exposure to the survivors' experiences of IPV.....	135
4.2.1.1 Emotional impact related to being a witness to survivors' experiences of IPV	135
4.2.1.2 Cognitive impact related to being exposed to survivors' experiences of IPV	140
4.2.2 Identification with survivors' experiences	143
4.2.3 Interrelation between IPV related personal and professional domain experiences.....	148
4.2.4 Attempts to cope with experiences involving survivors of IPV	152
4.2.5 Attempts to make meaning out of IPV/ understand IPV	156
4.2.6 Formation of gender perceptions and assumptions regarding IPV	158
4.2.7 Provision of care to survivors of IPV	162
4.2.7.1 Emotional care provided to survivors of IPV	163
a) External barriers to disclosure	164
b) Factors affecting disclosure of IPV – survivor's perspective	165
c) Factors affecting disclosure of IPV – emergency nurse's perspective	166
d) Emergency nurses' frame of reference in relation to provision of care to survivors of IPV	170
4.2.7.2 Referral of survivors of IPV	178
4.3 CONCLUSION	179
CHAPTER 5: DEVELOPMENT AND VALIDATION OF GUIDELINES TO FACILITATE THE ACTUALISATION OF EMANCIPATORY KNOWING IN EMERGENCY NURSES WITH REGARD TO TAKING CARE OF SURVIVORS OF INTIMATE PARTNER VIOLENCE	180
5.1 INTRODUCTION	180

5.2	GUIDELINE DEVELOPMENT	180
	Injustice and oppression uncovered in emergency nurses' experiences of taking care of survivors of IPV	182
	DIMENSION 4: INTEGRATED EXPRESSION IN PRACTICE - <i>Guideline 8: Praxis</i>	182
5.2.1	Guiding attributes in the guideline development process	183
5.2.2	Summary of findings	184
5.2.3	Reflection on knowledge development in nursing	186
5.2.4	Injustice and oppression uncovered in emergency nurses' experience of taking care of survivors of IPV	186
5.2.5	Guideline development in terms of dimensions of emancipatory knowing in nursing	190
5.3	VALIDATION OF THE DRAFT GUIDELINES	193
5.3.1	Selection of participants	193
5.3.2	Delphi Round 1	196
5.3.2.1	Data-collection method and instrument	196
5.3.2.2	Data analysis	197
5.3.3	Delphi Round 2	197
5.3.3.1	Data collection method and instrument	197
5.3.3.2	Data analysis	198
5.4	DRAFT GUIDELINES WITH SUGGESTED CHANGES	198
5.5	VALIDITY OF THE GUIDELINES	218
5.6	SUMMARY	218
	CHAPTER 6: VALIDATION AND DESCRIPTION OF GUIDELINES, CONCLUSIONS AND RECOMMENDATIONS	219
6.1	INTRODUCTION	219
6.2	SUMMARY OF MAIN FINDINGS	219
6.2.1	Emotional impact related to being a witness to survivors' experiences of IPV	220
6.2.2	Cognitive impact related to being exposed to survivors' experiences of IPV	221
6.2.3	Identification with IPV survivors' experiences	221
6.2.4	Interrelation between IPV-related personal- and professional-domain experiences	222
6.2.5	Attempts to cope with professional-domain experiences related to IPV	222
6.2.6	Attempts to make meaning out of IPV/understand IPV	223
6.2.7	Formation of gender perceptions and assumptions related to IPV	223
6.2.8	Provision of care to survivors of IPV	224
6.3	DEVELOPMENT OF THE GUIDELINES	225
6.4	VALIDATION OF THE GUIDELINES	226
6.5	DESCRIPTION OF THE FINAL GUIDELINES	227
6.5.1	Name of the guidelines	227
6.5.2	Purpose and objectives	227
6.5.3	The scope of the guidelines	228

6.5.4	Development of the guidelines.....	228
6.5.4.1	Background.....	228
6.5.4.2	Guideline development in terms of dimensions of emancipatory knowing in nursing.....	228
6.5.4.3	Methodology	228
6.5.4.4	Literature review	229
6.5.5	Validation of the guidelines	229
6.5.6	Guidelines.....	229
6.5.7	Review and updating of the guidelines.....	229
6.6	RECOMMENDATIONS FOR PRACTICE.....	229
6.6.1	Organisational and supportive structures to enable emergency nurses to provide quality care to survivors of IPV.....	230
6.6.2	Support structures to provide care for the carer.....	230
6.6.3	Realisation of emancipatory knowing with regard to taking care of survivors of IPV	231
6.7	RECOMMENDATIONS FOR RESEARCH.....	231
6.8	LIMITATIONS OF THE STUDY	232
6.9	CONCLUSION	233
	LIST OF REFERENCES	234

LIST OF ADDENDUMS

ADDENDUM A: APPROVAL FROM THE FACULTY OF HEALTH SCIENCES RESEARCH ETHICS COMMITTEE OF THE UNIVERSITY OF PRETORIA (125/2010).....	265
ADDENDUM B: INFORMATION LEAFLET AND INFORMED CONSENT - PHASE 1	267
ADDENDUM C: INFORMATION LEAFLET AND INFORMED CONSENT - PHASE 2	270
ADDENDUM D: LETTER TO REQUEST PERMISSION FROM THE DEPARTMENT OF HEALTH AND SOCIAL DEVELOPMENT - TSHWANE METSWEDING REGION	273
ADDENDUM E: CLEARANCE CERTIFICATE FROM THE DEPARTMENT OF HEALTH AND SOCIAL DEVELOPMENT - TSHWANE METSWEDING REGION (TMREC 2010/51)	275
ADDENDUM F: EXAMPLE OF A TRANSCRIBED UNSTRUCTURED PHENOMENOLOGICAL INTERVIEW	277
ADDENDUM G: EXAMPLE OF ANALYSED TRANSCRIBED INTERVIEW	283
ADDENDUM H: DELPHI - LETTERS TO EXPERT MEMBERS OF PANEL	290
ADDENDUM I: DELPHI INSTRUMENT	294

LIST OF TABLES

Table 1 Strategies to ensure trustworthiness.....	29
Table 2 Descriptive information of the Delphi technique participants	194
Table 3 Criteria and rating scale for validation of draft guidelines.....	197
Table 4 Rating of guidelines - Delphi Round 1	226
Table 5 Summary of themes - Delphi Round 1.....	227

LIST OF FIGURES

Figure 1: Framework of findings	88
Figure 2: Guideline development and validation.....	182

CHAPTER 1: ORIENTATION OF THE STUDY

1.1 INTRODUCTION

Women are not safe in this world; least of all in an intimate relationship - "at least one out of every three women around the world has been beaten, coerced into sex, or otherwise abused in her lifetime – with the abuser usually someone known to her" (United Nations Development Fund for Women (UNIFEM) 2007: 1). Intimate partner violence (IPV) in this research refers to a pattern of sexually, psychologically and physically coercive acts against a female adult or adolescent woman by a current or former male intimate partner (Ellsberg & Heise 2005: 12; Watt, Bobrow & Moracco 2008: 715; Wu, Huff & Bhandari 2010: 71). This human rights violation persists globally with an estimated lifetime prevalence of between 15% and 71% (Garcia-Moreno *et al.* 2006: 1260; UNIFEM 2007: 1-2). The South African situation is reflected in the shocking findings that a woman is killed by her intimate partner every eight hours in this country (Abrahams *et al.* 2012: 2).

In this study, the term "survivor" is used and refers to a female healthcare user at the emergency unit who is seeking help for health problems directly or indirectly related to exposure to IPV. By choosing the term "survivor" the researcher acknowledges a woman's potential to move beyond the oppression of IPV (see 1.8.1.5). The researcher acknowledges that men are also exposed to IPV, but considering the high prevalence of women in South Africa exposed to IPV (see 1.2.3), the focus in this study is on female survivors of IPV.

IPV has a significant impact on women's physical and mental health (Gerber *et al.* 2008: 64; Moran 2008: 194-195; Gass *et al.* 2010: 582; Norman *et al.* 2010: 6). IPV increases the likelihood of non-primary and emergency healthcare utilisation. Seeing that the emergency unit is often the first and most common source of contact for IPV survivors, it is critical for emergency nurses to identify survivors and intervene appropriately (Reisenhofer & Seibold 2007: 7; Wu *et al.* 2010: 80; Watt *et al.* 2010: 716). Failure to do so may result in ongoing exposure to violence with subsequent morbidity and mortality (Anglin & Sachs 2003: 1122; Leppäkoski, Paavilainen & Åstedt Kurki 2011: 27-28).

The minimum response any healthcare system should provide towards management of IPV is described by the World Health Organization (WHO) (2010: 9-10) in terms of: the desired attitude healthcare professionals should display; provision of medical care,

information and support; and appropriate referral and documentation. Survivors of IPV expect sensitive and respectful support from emergency nurses and view building of trust and rapport as important (Watt *et al.* 2008: 724).

In spite of organisations' and survivors' expectations, and the overwhelming evidence of the negative health consequences associated with IPV (Cherniak 2005: 369-370; WHO & London School of Hygiene and Tropical Medicine (LSHTM) 2010:16-17), the healthcare system's response is often inadequate; and the majority of women still experience significant challenges in seeking and finding help while few are identified as abused (Jansen van Rensburg & van Staden 2005: 48-49; Bostock Plumpton & Pratt 2009: 106-108; Goldblatt 2009: 1652).

Reasons for the healthcare system's ineffective response to IPV include myths and stereotypes held by healthcare professionals, frustration, fear and discomfort with IPV, personal history of IPV and a feeling of inadequacy to deal with IPV (Minsky-Kelly *et al.* 2005: 1293; Häggblom & Möller 2006: 1087-1088; Furniss *et al.* 2007: 241; Robinson 2010: 575). Healthcare professionals' personal and professional experiences with IPV seem to have a significant effect on the provision of care to survivors of IPV (Gutmanis *et al.* 2007: 9); even more so in South Africa where exposure to IPV is a common occurrence (Kim & Motsei 2002: 1245-1251; Christofides & Silo 2005: 10 & 13). The emotional impact associated with providing care to survivors of IPV was also found to play a role in the provision of care, especially in an emergency unit where stress levels are high and nurses are confronted with often seriously injured survivors (Reisenhofer & Seibold 2007: 9; Goldblatt 2009: 1645).

The findings of the studies mentioned in the previous paragraph represent a fragmented view of the different factors that might affect emergency nurses' response to survivors of IPV. The factors mentioned include knowledge, skills, attitudes, personal perceptions, values and emotions. The in-depth experience of taking care of survivors of IPV from the perspective of emergency nurses is not reflected in the literature reviewed by the researcher.

The aim of this research was to illuminate and understand the whole of the complex experience of taking care of survivors of IPV from the perspective of emergency nurses within the South African context.

In this chapter the background and rationale for the study are outlined as they led to the problem statement. The research question, aim and objectives are stated. The

conceptual framework is set out. A broad overview of the paradigmatic perspective, philosophical framework, research methodology according to the two research phases and measures to ensure trustworthiness are provided. These factors are discussed in more detail in Chapter 2. The ethical considerations are discussed in detail.

1.2 BACKGROUND AND RATIONALE

Although violence against women is acknowledged as the most pervasive human rights violation in the world (Ellsberg & Heise 2005: 9), the United Nations Secretary-General Ban Ki-Moon stated:

“Violence against women and girls continues unabated in every continent, country and culture. It takes a devastating toll on women’s lives, on their families, and on society as a whole. Most societies prohibit such violence — yet the reality is that too often, it is covered up or tacitly condoned.” (UNIFEM 2007: 1)

The background provides an overview of: the history of social responses to IPV; the prevalence of IPV; causal and risk factors for IPV and the impact and consequences of IPV. The focus then moves to IPV as a public health issue that has certain implications for the healthcare system and emergency nurses.

1.2.1 History of social responses to IPV

In a historical perspective on family violence, Bala (2008: 271) described how family violence was treated as a private matter before the 1960s. The unfavourable situations of many victims were largely ignored by the justice system, health providers and social science researchers. It was only in the late 20th century that social attitudes changed under the influence of the feminist movement. As social awareness and understanding improved, support for victims grew and reporting of family violence happened more often. During the 1980s to 1990s, law reforms in most industrialised countries resulted in a more sensitive approach from the justice system towards the needs of women and children (Bala 2008: 271-274). Nelson *et al.* (2005: 28) ascribed the changes that have occurred over the last few decades in the legal and healthcare management of IPV in the USA to the determination of victims, healthcare professionals and lawyers. From disbelieving and blaming women for IPV as a personal problem occurring in a few problematic relationships, it is now recognised as a legitimate human rights issue (Ellsberg & Heise 2005: 5; Muhlbauer

2006: 301; McHugh & Frieze 2006: 121). It is clearly stated in international human rights law as the duty of all governments to prevent, prosecute and punish violence against women (WHO 2005: vii).

According to the WHO (2005: vii), violence against women started to be recognised as a human rights concern after the World Conference on Human Rights and the Declaration on the Elimination of Violence against Women in 1993. Gender-based violence was accepted as a threat to women's health and human rights when 189 governments signed the Platform for Action of the 1995 United Nations Beijing World Conference on Women. This Platform of Action clearly acknowledged violence against women as an obstacle to the achievement of the objectives of equality, development and peace (Kishor 2005: 2). During the five-year review of the Beijing Platform for Action in 2000, governments were requested to implement measures to eliminate discrimination and violence against women and to treat all forms of violence against women and girls as criminal offences (United Nations (UN) 2006: 17).

Violence against women is closely related to the social status of women. States who accept treaties that seek to end discrimination against women and foster gender equality commit themselves to women's rights that seek to end violence against women. The Convention on the Elimination of all Forms of Discrimination against Women (UN 1979) defines discrimination against women and sets up an agenda for national action to end such discrimination. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Union 2003) guarantees comprehensive rights to women in Africa; and the Member States of the South African Development Community (SADC) signed the Protocol on Gender and Development (SADC 2008) to foster gender equality in Southern Africa.

1.2.2 International prevalence of IPV

IPV is not confined to a specific race, ethnicity, social class or education level, but affects women of all racial, economic, religious and cultural backgrounds (Muhlbauer 2006: 301; UN 2006: 27; The Advocates for Human Rights 2006; Moran 2008: 194). The WHO multi-country study (2005: vii) confirmed that IPV is still a common worldwide phenomenon. IPV prevalence rates of between 15% and 71% were reported across all study sites while prevalence rates of as high as between 30% and 60% were reported in most sites. In all the study settings except one, women were more at risk of violence by an intimate partner than from any other perpetrator (WHO 2005: vii).

More than 1 in 3 women are victims of rape, physical violence, or stalking by an intimate partner in the United States, based on a survey conducted in 2010 (Black *et al.* 2011: 2). Globally about one-third of all women have been abused by intimate partners, while 40% to 70% of all female murder victims are killed by an intimate partner (The Advocates for Human Rights 2006).

1.2.3 South African prevalence

In the South African community violence is often tolerated as an acceptable way of dealing with conflict (Abrahams & Jewkes 2005: 1811). Themistocleous (2008: 4 & 51) comments that South African society has become so naturally desensitised to violence that it has become a normal part of reality. In spite of laws criminalising IPV (Domestic Violence Act no. 116 of 1998), South African studies on prevalence rates paint a dark picture:

- One in four women in the general population has experienced physical violence at some time in their lives (Abrahams & Jewkes 2005: 1811).
- The estimated 12-month prevalence of IPV among South African women 15 years and older is 18.4%. IPV was the second leading cause of healthy years of life lost in 2000 (Norman *et al.* 2010: 4 & 7).
- About 26.6% of women had experienced more than one episode of physical or sexual IPV in a study conducted by Jewkes *et al.* (2006: 1463) in a rural South African area.
- A woman is killed by her intimate partner every eight hours in South Africa (5.6 per 100 000 female population 14 years and older). This is more than double the rate of intimate femicide (homicide of women by an intimate partner) in the USA (Abrahams *et al.* 2012: 2-3).
- A study by Dunkle *et al.* (2004b: 238) indicating that 21.8% of women attending an ante-natal care clinic in Soweto were exposed to multiple assaults by a male partner in the previous 12 months confirmed that IPV constitutes a significant health risk factor during pregnancy.
- In a study examining the prevalence of and risk factors for intimate partner physical violence against women conducted in Cape Town, an average of 42.3% men reported physical violence against a partner in the previous 10 years and 8.8% reported physical violence in the previous year (Abrahams *et al.* 2006: 247-264).

1.2.4 Causal and risk factors for IPV

As explained by Ellsberg and Heise (2005: 24-25), researchers use an ecological framework to explain the interrelated individual, family (relationship) and socio-cultural factors contributing to IPV. Each of the components is briefly discussed in the paragraphs that follow.

1.2.4.1 Individual level

Factors that increase the likelihood that a woman will be abused by her partner include being under 25 years of age, being abused or having witnessed marital violence as a child, having an absent or rejecting father, low income, low educational and economic status and harmful use of alcohol (Abrahams & Jewkes 2005: 1814-1815; Ellsberg & Heise 2005: 24; UN 2006: 35; WHO & LSHTM 2010: 20-23). Hien and Ruglass (2009: 49) reviewed research findings indicating that women who were physically or sexually abused as children are two to three times more likely to be exposed to IPV compared to other women. A South African study conducted in Soweto confirmed that women with a childhood history of sexual abuse were at increased risk of both physical and sexual IPV (Dunkle *et al.* 2004b: 237).

Alcohol or drug abuse on the part of the woman's partner increases the risk for the occurrence, recurrence and severity of IPV (Jeyaseelan *et al.* 2004: 123; Nelson *et al.* 2005: 29; Hien & Ruglass 2009: 49).

1.2.4.2 Family (relationship) level

According to women participating in a study by Bostock *et al.* (2009: 99), their partners' lack of domestic and family involvement and financial irresponsibility contributed to IPV. Interpersonal inequalities in economic, educational or employment status and male control of the economic resources and decision making in the family are recognised as risk factors for IPV (Ellsberg & Heise 2005: 24; UN 2006: 35). Ineffective ways of dealing with conflict and high levels of marital discord can lead to disagreements that escalate into IPV (UN 2006: 33; WHO & LSHTM 2010: 28). Multiple partners and infidelity in the relationship also contribute to the occurrence of IPV (WHO & LSHTM 2010: 24).

1.2.4.3 Socio-cultural level

Communities where women are more at risk for IPV are characterised by: social isolation of women, tolerance and legitimisation of men's violence as a means of conflict resolution, and high levels of social and economic disempowerment, which includes poverty (Ellsberg & Heise 2005: 24; UN 2006: 35). Although many explanations have been proposed, the exact mechanism why poverty increases the risk for IPV is not clear (Jeyaseelan *et al.* 2004: 123; Goodman *et al.* 2009: 307; Hien & Ruglass 2009: 49; WHO & LSHTM 2010: 25).

Violence against women in society can be explained in terms of gender-based subordination or patriarchy. Patriarchy refers to male dominance and female subordination as socially constructed gender roles that are embedded in a society where men are viewed as superior to women. Male dominance manifests itself in different ways and contexts, such as women's reduced involvement in decision making at different levels and reduced access to resources like healthcare, employment and political participation (UN 2006: 29-30; WHO & LSHTM 2010: 25-26). In societies where the prevailing culture supports the ideas of gender inequality, the use of violence against women for transgressions of traditional female gender roles might be tolerated and regarded as legitimate (Ellsberg & Heise 2005: 24; Abrahams *et al.* 2006: 247-264; UN 2006: 29-30).

Governments play an important role in the construction and maintenance of gender roles and power relations – for example, not changing discriminatory laws and practices that oppress women (UN 2006: 34). Denying women equal access to education, employment, income and political roles reduces women's ability to take independent decisions and increases their vulnerability to violence (UN 2006: 33; True 2012: 17-18). A criminal justice system that fails to act appropriately – for example, not sanctioning IPV and male control and providing effective protection to women exposed to IPV – reinforces further abuse (UN 2006: 34-35; Bostock *et al.* 2009: 101-102; WHO & LSHTM 2010: 24).

1.2.5 Impact and consequences of IPV

IPV, acknowledged as a major public health problem with consequences for women's physical and mental health, also has significant social and economic implications (Ellsberg & Heise 2005: 18; UN 2006: 48; Gutmanis *et al.* 2007: 2). In this section

the impact of IPV is discussed according to its physical health, mental health, social and economic implications.

1.2.5.1 Physical health implications of IPV

An Australian study found that IPV has a greater impact on the health of women under the age of 45 than any other risk factor and contributes to 7% of the overall burden of disease (VicHealth 2004: 25; WHO & LSHTM 2010: 5).

Richter (2007: 348) asserts that gender-based violence inclusive of IPV is a leading cause of injuries to women and children in many countries, and victims often require specialised care and psychosocial support. Women might present with superficial injuries such as bruises to more severe injuries such as lacerations, abdominal/thoracic injuries, fractures, gunshot wounds, concussions and burns (Ellsberg & Heise 2005: 18). A systematic review by Wu *et al.* (2010: 81) found that head, neck or facial injuries are often associated with IPV. An analysis of injury patterns of 42 participants in a South African study (Jansen van Rensburg & van Staden 2005) revealed that most injuries were sustained in the head and neck area, most frequently in the face, with the eyes and mouth injured most often. Injuries sustained during the worst incidents were mostly located to the head and skull area (Jansen van Rensburg & van Staden 2005: 49-50).

The indirect physical effects of IPV occur as chronic somatic complaints such as pain syndromes and fatigue, exacerbation of chronic medical conditions such as diabetes and asthma, and chronic somatic disorders including irritable bowel syndrome (Cherniak 2005: 268; Ellsberg & Heise 2005: 21; Gerber *et al.* 2008: 64-65). A Spanish study (Vives-Cases *et al.* 2011: 17-18) indicated that violence against women with the inclusion of IPV is strongly associated with poor physical health (coronary heart disease, chronic back pain, chronic neck pain and chronic headache).

IPV is associated with an increase in disorders of the reproductive organs such as unintended pregnancies, HIV and other sexually transmitted infections, pelvic inflammatory disease and sexually transmitted infections. Violence during pregnancy has serious health consequences for both mother and child. It leads to high-risk pregnancies and puts women at risk for miscarriage, premature labour and birth, foetal distress, bleeding during pregnancy, stillbirth and low birth weight (Ellsberg & Heise 2005: 9 & 22; Jansen van Rensburg & van Staden 2005: 47; United Kingdom (UK) Department of Health 2005: 17; UN 2006: 48).

HIV and sexually transmitted infections contributed to 51% of the total disease burden associated with IPV in South Africa in 2000 (Norman *et al.* 2010: 6-7). South African studies indicated that gender power inequity in relationships increases women's vulnerability to IPV and HIV (Dunkle *et al.* 2004a: 1419; Jewkes & Morrell 2010: 9). Male control for example, can prevent a woman from accessing services for HIV prevention, treatment and counselling (UN 2006: 48; Richter 2007: 357).

Several authors have acknowledged the fatal consequences of IPV as a cause of maternal mortality, suicide and femicide (Jansen van Rensburg & van Staden 2005: 47; Ellsberg 2006: 2; Chowdhary & Patel 2008: 308; Abrahams *et al.* 2009: 546; Abrahams *et al.* 2012: 1).

1.2.5.2 Mental health implications of IPV

The effects of IPV stretch much further than the physical harm caused (WHO 2005: vii) and are strongly associated with poor mental health (Jeyaseelan *et al.* 2004: 123; UN 2006: 48). According to Humphreys (2007: 122), all studies examining the impact of violence against women indicated increased rates of depression, post-traumatic stress disorder (PTSD), attempted suicide and suicide. Major depression, anxiety, and self-inflicted injuries together contributed to 16% of the total disease burden associated with IPV in South Africa in 2000 (Norman *et al.* 2010: 7).

Depression is more prevalent among women with IPV exposure compared to women who have never been abused (Bonomi *et al.* 2007: 993; Hien & Ruglass 2009: 50). A longitudinal study conducted in India by Chowdhary and Patel (2008: 311) indicated a strong association between IPV and attempted suicide.

Several studies have found a significantly higher prevalence of PTSD (ranging from 33% to 84%) among female survivors of IPV compared to non-exposed women (DeJonghe *et al.* 2008: 295; Hien & Ruglass 2009: 49). Anxiety as a trauma-related symptom plays a significant role in IPV, as illustrated in a qualitative study conducted in the UK on women's understanding of domestic abuse (Crawford, Liebling-Kalifani & Hill 2009: 72-74). The women expressed fear – fear of their partners and fear of the consequences of talking.

In an attempt to cope with the fear and helplessness women may use various coping strategies such as "cutting-off" from emotions (dissociation) (Crawford *et al.* 2009: 75

& 77) and defence mechanisms such as minimising, denial, dissociation and splitting (McCue 2008: 19). IPV survivors often turn to self-destructive ways of coping such as substance abuse (UK Department of Health 2005: 18). Substance abuse accounted for 13% of the burden of disease associated with IPV in South Africa in 2000 (Norman *et al.* 2010: 7).

1.2.5.3 Social implications of IPV

Women subjected to IPV become isolated from their support system and lose their independence. They avoid taking initiative and decisions and refrain from fully participating in their communities, often for fear they might provoke the abuser. Women might also experience stigmatisation, as families, friends and communities might appear unwilling or unable to confront the situation and offer appropriate help and support (UK Department of Health 2005: 17-18; UN 2006: 49; Crawford *et al.* 2009: 72-74).

1.2.5.4 Economic implications of IPV

IPV places a financial burden on individuals, families and societies and holds implications for economic growth (International Center for Research on Women & United Nations Population Fund 2009: 12). The UN Secretary-General's study on violence against women (2006: 49-52) stresses that violence against women reduces the economic development of each nation with regard to three categories: direct costs, indirect costs and the cost of pain and suffering.

“Direct costs” refers to the economic implications IPV holds for justice, social welfare and healthcare services. These services include primary healthcare, hospitalisation and emergency care, shelters, housing, crisis counselling, legal costs, court proceedings and care of children (UN 2006: 49-52).

Indirect costs are incurred by IPV reducing the ability of women to reach their full productive potential (WHO & LSHTM 2010: 6). Women exposed to IPV may present with high absenteeism and reduced work performance, which may eventually lead to loss of employment. The employer has to incur the additional costs for recruiting and training replacements (UN 2006: 49-52).

The impact of IPV might be underestimated because of its “hidden” nature, but prevalence rates have confirmed it as a widespread human rights issue and public

health problem that contributes significantly to the burden of disease with subsequent economic implications (WHO & LSHTM 2010: 3 & 5).

1.2.6 The role of the healthcare system in IPV

Public health practitioners have a role in identifying and documenting the determinants and extent of especially hidden or “private” forms of violence, including IPV, and intervene with the focus on preventative interventions (Rutherford *et al.* 2007: 769-770). IPV is indeed viewed as a prevalent public health problem in the light of the negative effects it has on especially individuals in the younger age group, families, communities and societies (Nelson *et al.* 2005: 31). Approaching IPV as a public health problem allows management from an interdisciplinary and multi-sectoral approach, involving the social, medical, and healthcare sciences (Hien & Ruglass 2009: 48; WHO & LSHTM 2010: 6).

Public healthcare provision in terms of IPV implies: (1) defining and describing IPV as a public healthcare problem; (2) determination of risk factors for both victims and perpetrators; (3) development, implementation and evaluation of interventions to prevent the problem; and (4) dissemination of the outcomes of interventions (Nelson *et al.* 2005: 32; WHO & LSHTM 2010: 7-8). For the purpose of this study the role of the healthcare system is discussed in terms of healthcare utilisation by survivors of IPV, the healthcare system’s response to IPV and the role of emergency nurses in IPV.

1.2.6.1 Healthcare utilisation by survivors of IPV

The healthcare system is often the first point of contact for many women who have been exposed to IPV (Christofides & Silo 2005: 10; WHO 2005: vii). These women either seek help for health problems primary related to the IPV such as injuries, or problems secondary related to IPV (Reisenhofer & Seibold 2007: 7) such as chronic physical illnesses and complaints and mental health problems (Gass *et al.* 2010: 583).

Women exposed to physical IPV show higher utilisation of healthcare services compared with women never exposed. The high utilisation is especially evident in the use of emergency, hospital outpatient, primary care, pharmacy, and specialty services (Bonomi *et al.* 2009: 1060-1062). Especially when IPV stays undetected in women, it can lead to inefficient use of health services in terms of unmet needs for care and increased healthcare costs (Plichta 2007: 227-229).

A study conducted in Baltimore, USA showed that two-fifths of femicide victims sought healthcare in the year before they were killed, which presented an opportunity to intervene and prevent a fatal outcome (Sharps *et al.* 2001: 376-377).

1.2.6.2 Healthcare system response to IPV

Increased awareness of the health consequences accounted for by IPV, and the realisation that women exposed to IPV frequently use healthcare settings, prompts a response from the healthcare system. All healthcare professionals have a responsibility to identify IPV survivors, intervene to address the cycle of violence, and initiate interventions (Jansen van Rensburg & van Staden 2005: 48; UK Department of Health 2005: 5 & 30; Joyner *et al.* 2007: 15d).

The UN (2006: 91) states that the healthcare system should provide survivors of IPV with supportive interventions and take measures to prevent additional exposure to victimisation in the healthcare system. The WHO and LSHTM (2010: 9-10) describe the minimum response that the healthcare system should provide towards survivors of IPV as listening, validation and thorough documentation of what the woman verbalises; collection of forensic evidence in the case of sexual violence; emergency and medical interventions and; provision of information on support systems. Support should be provided in a non-judgmental way and be based on the woman's needs. The next level involves safety assessment, planning and referral (Zolotor, Denham & Weil 2009: 854-855). Interventions should be based on early identification, comprehensive management, providing of information and psychosocial support, thorough documentation, and effective referral to reduce morbidity and mortality (Nelson *et al.* 2005: 32; Joyner *et al.* 2007: 15d).

According to Meerkotter (2009: 1-5), South Africa's health sector's response to domestic violence is under-developed. The management of IPV is not clearly outlined in a single policy, but is fragmented within different policies such as the National Implementation Plan Service Charter for Victims of Crime (Department of Justice and Constitutional Development: Gender directorate 2007) and the Primary Health Care Package for South Africa (Department of Health 2000). The National Strategic Plan on HIV STIs and TB, 2012-2016 (South African National AIDS Council 2011) emphasises that a comprehensive approach needs to be developed for primary and secondary prevention of gender-based violence in South Africa.

The 5-year National Implementation Plan Service Charter for Victims of Crime (Department of Justice and Constitutional Development: Gender directorate 2007) requires health providers to document physical abuse, open files for all victims of violence and inform them of their right to request prosecution. The Implementation Plan has, however, not been disseminated effectively at provincial level so that timeframes for implementation were not adequately met (Meerkotter 2009: 5). The Primary Health Care Package for South Africa (Department of Health 2000) has set norms and standards for primary healthcare of victims of sexual abuse, domestic violence and gender violence and stated that the service requires co-operation between the health sector, the police and the Department of Justice. The services to be provided include counselling and referral of victims, STD prophylaxis and HIV testing, care of injuries, medico-legal advice and documentation of evidence.

A woman's health records can be vital in bringing perpetrators to justice (UK Department of Health 2005: 30). Duma and Ogunbanjo (2004: 37) indicated the important role healthcare professionals in South Africa can play in emergency units and primary healthcare clinics to clearly document their observations when caring for survivors of IPV.

A systematic review of the literature (Todahl & Walters 2011: 361) found that introducing inquiry about IPV in healthcare settings (screening) encouraged women to talk about their experiences and led to an increase in the numbers of women disclosing IPV. Women find it appropriate to be asked about IPV by healthcare professionals (Plichta 2007: 227; Koziol-McLain et al. 2008: 504; Spangaro et al. 2010: 134).

Universal screening in order to identify IPV and intervene at an early stage has been endorsed by several health professional organizations in the USA; for example the American Medical Association (1992), the American College of Obstetrics and Gynecology (1995) and the American Emergency Nursing Association (2006) (Chuang & Liebschutz 2002: 565-566; Elliot et al. 2002: 112; Hien & Ruglass 2009: 52-53). However, in 2004 the U.S. Preventive Services Task Force (2004) concluded that insufficient evidence exists to support routine screening for IPV. This decision was based on methodological problems with many studies and a lack of randomized controlled studies to prove the efficacy of screening and potential interventions in terms of reducing harm to survivors and improving health outcomes (Nelson et al. 2004: 393; Plichta 2007: 233; Zolotor et al. 2009: 852). In 2013 the U.S. Preventive

Services Task Force guidelines were updated and recommend that clinicians screen women of childbearing age for IPV and intervene appropriately.

The debate on screening continues in the literature with inconclusive recommendations regarding effectiveness and improved outcomes (Brauser 2009; MacMillan *et al.* 2009; Rabin *et al.* 2009). A systematic review on screening efficacy (Nelson, Bougatsos & Blazina 2012: 9) concluded as follows:

“Screening instruments designed for healthcare settings can accurately identify women experiencing IPV. Screening women for IPV could reduce IPV and improve health outcomes depending on the population screened and outcome measured, although effectiveness trials have important limitations. Screening has minimal adverse effects, but some women experience discomfort, loss of privacy, emotional distress, and concerns about further abuse.”

Liebschutz *et al.* (2008: 1 & 7) suggest a focus away from screening to building a therapeutic relationship with IPV survivors without demanding from them to disclose IPV. This therapeutic relationship seems to be exactly what IPV survivors need according to a study comparing the perspectives of IPV survivors and emergency nurses on supporting IPV survivors (Watt *et al.* 2008). In the Watt *et al.* study (2008: 724) IPV survivors regarded sensitivity, the provision of emotional support, and the building of trust and rapport as essential. Survivors emphasised that they needed to feel respected and in control, not overwhelmed by the process. A review of research by Hamberger and Phelan (2006: 89-90) similarly indicated that IPV survivors appreciate a supportive approach, respect for their autonomy and validation of their experiences. IPV survivors need healthcare professionals to assess the situation, consider survivors’ children’s safety and document their findings and interventions.

The reality is, however, that the healthcare system’s response towards detection of and intervening in cases of IPV is still inadequate and a considerable number of survivors remain unidentified, while others experience challenges to seek and find help (Colombini, Mayhew & Watts 2008: 639; Leppäkoski *et al.* 2010: 33-34; Sims *et al.* 2011: 868-869). A study done by Bostock *et al.* (2009: 107) found that the legal, health and social services failed to support women sufficiently in certain aspects of the process and often leave them to deal with the problem of IPV on their own.

In the South African context Jansen van Rensburg and van Staden (2005: 48) point out that healthcare professionals often struggle to identify and manage IPV. Joyner *et*

al. (2007: 15c) highlight the phenomenon of survivors “being victimised twice” - not only in the intimate partner relationship, but also in the healthcare setting where they present for help. Joyner *et al.*'s. (2007: 15c) study revealed that survivors experienced a lack of being “cared for” in the emergency unit where they received treatment. Meerkotter (2009: 5) states that healthcare professionals in South Africa inadequately respond to IPV and follow a bio-medical approach. They seldom inquire about the abuse, record the presence of IPV, or refer the patient to support services.

In the next section the focus is on the role of emergency nurses in the management of IPV survivors.

1.2.6.3 The role of emergency nurses in IPV

It is estimated that in the USA 28% of women who suffer injuries as a consequence of IPV will receive medical care and in more than 50% of the cases this care will be given at the emergency unit of a hospital (National Center for Injury Prevention and Control 2003: 14-15; Lipsky & Caetano 2007: 2246). A Canadian study (MacMillan *et al.* 2006: 531) reported 11.3% to 17.7% 12-month prevalence rates of IPV among patients pre-screened in two emergency units, while a similar study in Switzerland (Hofner *et al.* 2005: 481) reported a 11.4% prevalence rate. A more recent study in Australia (Webster, Pedrosa & Lopez 2012: 149-150) indicated an IPV prevalence rate of 14.6% among women who presented to the emergency unit for care.

Considering these prevalence rates, the emergency unit seems to be a common source of contact for IPV survivors and a crucial site for identifying and managing survivors of IPV (Reisenhofer & Seibold 2007: 7; Watt *et al.* 2010: 716; Wu *et al.* 2010: 80). Joyner *et al.* (2007: 15a & 15d) stressed that healthcare professionals should at least be able to identify IPV and respond within the period immediately after the acute violent episode when the woman is most likely to present for treatment at the emergency unit. During this time, conceptualized by Curnow (1997: 130) as the “open window phase”, the woman is faced with the reality of the situation and is most receptive to interventions. Emergency nurses have a responsibility to identify IPV and intervene appropriately to prevent IPV-related mortality and morbidity (Emergency Nurses Association 2006; Lau *et al.* 2008: 456; Leppäkoski *et al.* 2011: 27-28).

Unfortunately, as discussed in the previous section healthcare professionals often do not respond effectively to IPV. The next few paragraphs provide a summary of reasons contributing to healthcare professionals’ and, more specifically, emergency

nurses' ineffective response to survivors of IPV as evident from research findings. As some of these studies were conducted from a screening perspective, the findings were expressed as "barriers to screening".

According to a research review by Plichta (2007: 230), the barriers experienced by healthcare professionals to responding adequately towards survivors of IPV can broadly be divided into three categories: (1) healthcare professionals' abilities (lack of confidence and training), (2) resources (lack of time, effective interventions and resources), and (3) factors related to IPV survivors (presence of the partner, healthcare professionals' concern with offending the survivor, perceived survivor nonresponse/noncompliance and victim-blaming attitudes). Colombini *et al.* (2008: 639) added organisational barriers, which include lack of clear policies on IPV, lack of coordination among professionals and departments involved in service provision and absence of violence-related issues in curricula.

Joyner *et al.* (2007: 15a) consider that South African healthcare professionals' lack of skills to deal with IPV and subsequent avoidance of it might be related to the fact that gender-based violence was historically not part of the curriculum. A South African study by Peltzer, Mashego and Mabeba (2003: 156) reported that only 9.7% of medical practitioners had undergone training in the management of IPV. According to Duma and Ogunbanjo (2004: 37), healthcare professionals lack knowledge related to the dynamics of IPV, safety planning, health effects of violence and appropriate screening and documentation – a limitation that might lead to the non-recognition of signs and symptoms of IPV.

A qualitative study, conducted in the USA on the myths and stereotypes emergency nurses attached to IPV (Robinson 2010: 575), illustrated how emergency nurses' frustration related to being unable to successfully intervene in IPV can affect their decision to screen for and respond to IPV. Similarly Hägglom and Möller (2006: 1087-1088) explain that nurses might avoid dealing with the problem of IPV as they feel overwhelmed, helpless and frustrated.

Emergency nurses' previous experience with IPV seems to play a significant role in the way they respond to the sensitive issue of IPV (Reisenhofer & Seibold 2007: 9). A qualitative study in Finland illustrated that care to survivors of IPV is provided on an *ad hoc* basis, as it depends on the commitment and the experience of the nurse on duty (Hägglom & Möller 2006: 1087-1088). Gutmanis *et al.* (2007: 9) identified professional experience as a key factor in healthcare professionals' preparedness to

respond to IPV. Experience with a relative or friend exposed to IPV also contributes to preparedness, but to a lesser extent. A South African study by Christofides and Silo (2005: 13) found that nearly 40% of the nurses in their study had experienced either physical or emotional abuse or both in their lifetime. The nurses who had a relative or friend exposed to IPV, provided a higher quality of care to survivors of IPV compared to nurses who had no prior experience of IPV. Kim and Motsei (2002) conducted an in-depth exploration of South African primary healthcare nurses' attitudes, beliefs and experiences of IPV and recommended interventions to deal with nurses' personal attitudes and experiences in relation to IPV through self-awareness before introducing training to help nurses manage IPV.

One of the few studies exploring the impact of taking care of survivors of IPV on nurses was conducted in Israel (Goldblatt 2009: 1652). The study described how the encounter with IPV can trigger overwhelming emotions in nurses. Nurses are expected to stay non-judgmental and suppress emotional responses while on duty, which can lead to internal conflict, emotional detachment and vicarious traumatising. The researcher concluded that the encounter with IPV blurs the boundaries between the personal and professional domains of nurses' lives (Goldblatt 2009: 1650-1651). An older study by Henderson (2001: 1303) found that nurses struggled to cope with the emotional demands of working with survivors of IPV. They used their personal explanatory models to make sense of IPV and direct their responses towards survivors. The gender-related beliefs and values they based their responses on might be influenced by families of origin and professional experiences.

1.3 PROBLEM STATEMENT

The background paints a clear picture of the extent of IPV, with its origins often deeply embedded in cultural and community practices (UN 2006: 35; WHO & LSHTM 2010: 24). The high prevalence rate of IPV in South Africa (Gass *et al.* 2010: 583) is to a great extent still ascribed to issues of gender inequality; for example, the association between masculinity and male control, with violence being used against women in some instances to exercise male control (Jewkes & Morrell 2010: 3 & 5).

IPV is acknowledged as a human rights issue that affects individuals, families and communities (WHO 2012) and also as a public health problem (Nelson *et al.* 2005: 31). The devastating health consequences of IPV and the fact that many women are in contact with the health system seeking help for IPV in a direct or indirect manner places a legal and ethical responsibility on healthcare professionals to identify IPV and

intervene appropriately in order to stop the cycle of violence that can have fatal outcomes (UK Department of Health 2005: 5 & 30; Joyner *et al.* 2007: 15d; Colombini, Mayhew & Watts 2008: 635; Liebschutz & Rothman 2012: 2071).

Guidelines for comprehensive management of IPV survivors exist and their focus is on early identification, assessment, safety needs of the survivor, provision of psychosocial support, referral and healthcare information (United Nations Population Fund (UNFPA) 2010: 9; WHO 2010: 9-10). Survivors prefer care provided in a sensitive, empathetic and non-judgmental way that respects their autonomy and is conducive to disclosure (Rhodes *et al.* 2007: 625-626; Moran 2008: 196; Watt *et al.* 2008: 724). The provision of holistic care to survivors of IPV is an important part of nursing practice (Moran 2008: 195-196; Mick 2006: 513).

The healthcare system's response to survivors of IPV is, however, still inadequate and effective and appropriate care is often not reflected in the nursing care women receive (Moran 2008: 195). Exposure to IPV is often not detected, and the majority of women still experience significant challenges to find help (Colombini *et al.* 2008: 639; Bostock *et al.* 2009: 107; Leppäkoski *et al.* 2010: 33-34; Sims *et al.* 2011: 868-869). If healthcare professionals cannot find a way to identify survivors of IPV and respond effectively, survivors will leave the healthcare system with the problem not identified and/or addressed. The devastating physical, psychological, and social consequences of IPV will persist (Montalvo-Liendo 2009: 31).

As reflected in the background, studies exploring the ineffective healthcare-system response to IPV and barriers to screening have highlighted many different factors that contribute to the lack of effective care provision to survivors of IPV (Minsky-Kelly *et al.* 2005: 1293; Häggblom & Möller 2006: 1087-1088; Furniss *et al.* 2007: 241; Robinson 2010: 575). In addition, the exposure to seriously injured survivors and the emotional demands of caring for survivors of IPV have an emotional effect on nurses and can play a role in the way in which they respond to survivors. They might respond with anger or criticism towards survivors (Henderson 2001; Goldblatt 2009). Personal and professional experiences of IPV were also identified as factors contributing to the provision of care (Christofides & Silo 2005: 10 & 13; Gutmanis *et al.* 2007: 9).

Kim and Motsei (2002: 1252) suggest that in the light of the high prevalence of IPV in South Africa, which includes nurses as well, the deeper experiences of nurses regarding, for example, oppression, gender-based violence, and the relation between

personal and professional experiences of IPV must first be explored in depth before training programmes for nurses to manage IPV can be implemented.

In the light of the abovementioned summary of the literature and informal feedback from emergency units and crisis centres in the Tshwane region in South Africa, the research problem was identified: the provision of care to survivors of IPV within the violence-prone South African landscape poses unique challenges to emergency nurses. The challenges seemed to be situated within emergency nurses' own vulnerability to personal exposure to violence related to gender inequality, and their ongoing professional exposure to survivors of IPV.

The researcher considered it necessary to explore the problem in depth from the perspectives of emergency nurses, with the focus not only on the care (or lack of care) provided to survivors of IPV but on the experience as a whole. The "whole" experience could, for example, include but is not limited to the following issues: How does the experience of taking care of survivors of IPV affect emergency nurses as well as the care they provide? What other factors play a role? On which basis is care provided?

When taking care of a survivor of IPV, emergency nurses need to facilitate a critical awareness in the survivor of the disadvantage she suffers. Also to be considered is the effects oppression has on the survivor's decision-making abilities – the ability to choose the best alternative for her personally. Oppression in this context not only exists in the survivor's intimate relationship, but also potentially in her relationship with healthcare professionals. For nurses to make an impact, they need to reflect on their own personal and professional position in relation to power and need to deal with their own experiences of oppression through emancipation (Wittmann-Price 2004: 442-444; Kelly 2011: E47).

According to McCabe and Holmes (2009: 1520-1522), emancipation from the perspective of the French philosopher Michel Foucault involves an awareness of the set of dominant truths by which a person judge his/her and others' conduct and a negotiation towards new ways of being and acting. "The outcome of emancipation is to equalize power between dominant and deprived groups, enabling free choice and promoting true humanistic paradigms in society and health care." (Wittmann-Price 2004: 440)

Chinn and Kramer (2011: 69-73) indicate how emancipatory perspectives, grounded in critical theory, liberation theory and poststructuralist philosophy, gave way to the birth of “emancipatory knowing” in nursing. Emancipatory knowing is seen as a “critical lens” through which to examine nursing practice and knowledge development in nursing. Emancipatory knowing is actualised when nurses recognize injustices or inequities embedded in nursing practice, realise that things do not have to be like that, and take action to bring about freedom from the social contexts and structures that sustain injustices (Chinn & Kramer 2011: 64-65).

The aim of this research was to illuminate and understand the complex experience of taking care of survivors of IPV from the perspective of emergency nurses in the South African context. The understanding generated from their first-hand experiences was utilized to develop guidelines for emergency nurses to actualise emancipatory knowing with regard to taking care of survivors of IPV.

1.4 RESEARCH QUESTION

In light of the background and problem statement the following research questions were formulated:

- What are the experiences of emergency nurses regarding taking care of survivors of IPV?
- What guidelines could be developed to facilitate emancipatory knowing in emergency nurses with regard to taking care of survivors of IPV?

1.5 RESEARCH AIM AND OBJECTIVES

The aim of this study was firstly, to explore emergency nurses’ experiences of taking care of survivors of IPV and secondly, to develop guidelines to facilitate the actualisation of emancipatory knowing grounded in emergency nurses experiences of taking care of survivors of IPV.

Specific objectives were addressed in order to reach the aim of the study. The objectives were to:

- Explore emergency nurses’ experiences of taking care of survivors of IPV;
- Provide an in-depth description of emergency nurses’ experiences of taking care of survivors of IPV;
- Develop guidelines to facilitate the actualisation of emancipatory knowing in emergency nurses with regard to taking care of survivors of IPV; and

- Validate guidelines to facilitate the actualisation of emancipatory knowing in emergency nurses with regard to taking care of survivors of IPV.

1.6 PARADIGMATIC PERSPECTIVE

In this section the research paradigm with the focus on a constructivist paradigm with its underlying meta-theoretical assumptions is discussed briefly. A detailed discussion will follow in Chapter 2.

The research was conducted within a constructivist paradigm. Kuhn's conceptualization of the term "paradigm" as interpreted by Dahnke (2011: 105) refers to a "set of preconceived beliefs about the world" – a given understanding of science at a given time. A paradigm underlies a methodology for gathering and analyzing data. Dahlberg, Dahlberg and Nyström (2008: 153) define a paradigm as a model that shapes the researcher's understanding of the world, subsequently guiding the epistemological and methodological research decisions and the research activities.

Polit and Beck (2012: 12) distinguish two broad research paradigms; namely positivism and constructivism. Within a *positivist paradigm* the source of knowledge is obtained from empirical research, which is based on universal laws that can be observed and measured. Positivists test theories and hypotheses and collect evidence that is transformed into statistical data (Holloway & Wheeler 2010: 22 & 23; Topping 2010: 130, 131 & 134).

In the *constructivist paradigm* (also known as the "naturalistic" or "interpretivist paradigm") reality is seen as a construction of the research participants; reality exists within a context; and many constructions are possible. This paradigm reflects the concept of relativism, which is based on the assumption that multiple interpretations of reality exist in people's minds (Polit & Beck 2012: 12). Assuming that knowledge is socially constructed by people, the naturalistic researcher attempts to understand lived experiences from the participant's point of view (Mertens 2010: 12).

In this study the experiences emergency nurses have while taking care of survivors of IPV were explored as these experiences evolved during in-depth interactions with the researcher. The aim was to understand this complex reality from emergency nurses' point of view – as an experience constructed within a specific context.

The constructivist paradigmatic perspective guiding the research is further explained in terms of the assumptions or basic beliefs answering four philosophical questions

that define a paradigm. These questions are ontological, epistemological, axiological and methodological (Mertens 2010: 10; Polit & Beck 2012: 11).

1.6.1 Ontological assumptions

What is the nature of reality? (Denzin & Lincoln 2005: 183). Within the ontological assumptions underlying a constructivist paradigm reality is seen as multiple and subjective and mentally constructed by individuals (Mertens 2010: 18; Polit & Beck 2012: 13). Applied to this study the reality of taking care of survivors of IPV within the context of the emergency unit is a subjective experience, existing within the minds of emergency nurses as a human complexity.

1.6.2 Epistemological assumptions

What is the nature of knowledge and the relationship between the researcher and the known? (Denzin & Lincoln 2005: 183). In line with the epistemological assumptions of a constructivist paradigm, the findings of this research are the product of the researcher's interaction with the participants (Mertens 2010: 18; Polit & Beck 2012: 13). Emergency nurses' experiences of taking care of survivors of IPV are crucial to understanding this phenomenon in its entirety and in depth.

1.6.3 Axiological assumptions

What is the researcher's ethical stance? (Denzin & Lincoln 2005: 183-184). Guided by the axiological assumptions of a constructivist paradigm, the researcher views the values of the participants pertaining to the phenomenon under study as an inevitable part of their experiences (Polit & Beck 2012: 13). In this study the participants' values were reflected in the findings as an essential part of their experiences.

1.6.4 Methodological assumptions

How can the researcher go about acquiring knowledge? (Denzin & Lincoln 2005: 183). True to the methodological assumptions of a constructivist paradigm, the researcher believes the best way to obtain evidence is to be part of a flexible, emergent and inductive process that seeks a holistic in-depth understanding of the phenomenon as grounded in the participants' experience within their specific context (Mertens 2010: 19-20; Polit & Beck 2012: 14-15). The findings of this study in a narrative format are

the result of a qualitative analysis of the in-depth knowledge of and insight into emergency nurses' experiences of taking care of survivors of IPV.

1.7 PHILOSOPHICAL FRAMEWORK

Adhering to a phenomenological approach, the researcher held in abeyance her personal beliefs and assumptions about the phenomenon being studied and maintained an open attitude towards the phenomenon as it revealed itself (Dahlberg *et al.* 2008:129-130). The study was guided by a phenomenological philosophical framework according to which the meaning of an experience is to be understood through a description of the experience as it is lived (LoBiondo-Wood & Haber 2010: 583).

Flood (2010: 8-10) describes two phenomenological approaches, which are descriptive (eidetic) and interpretive (hermeneutic). In phenomenological research meanings can be interpreted or meanings can be described (Dahlberg *et al.* 2008: 92-93). A descriptive approach was followed in this study as the researcher attempted to describe the findings in such a way that the meanings emergency nurses attach to the experience of taking care of survivors of IPV became evident.

Descriptive phenomenological research is grounded in phenomenological philosophy as founded by Husserl (1859 to 1938) (Giorgi 2009: 77-78; Flood: 2010: 8-9; Holloway & Wheeler 2010: 219). The meaning, historical origins and philosophical foundations of phenomenology as developed by Husserl are discussed comprehensively in Chapter 2.

1.8 CLARIFICATION OF KEY CONCEPTS

The key concepts of the research are clarified in terms of the literature and applied to the study.

1.8.1 Emancipation

Habermas (1994: 103) describes "emancipation" as the liberation from a confinement. Emancipation is based in self-understanding that brings with it an increase in autonomy (Habermas 1994: 103). The outcome of emancipation is the equalisation of power and free choice (Wittmann-Price 2004: 440).

In this study emancipation is seen in terms of “emancipatory knowing” as described by Chinn and Kramer (2011: 64-65). It is actualised when emergency nurses recognize injustices or inequities embedded in the provision of care to survivors of IPV, realise that things do not have to be like that, and put together their experience and resources to bring about freedom from the social contexts and structures that sustain injustices.

Chinn (2011: 158) describe emancipatory leadership as facilitative rather than descriptive and supportive rather than demanding. In this study the actualisation of emancipatory knowing is seen as a facilitative process where a skilled facilitator will work *with* emergency nurses to actualise emancipatory knowing with regard to taking care of survivors of IPV.

1.8.2 Emergency nurse

For the purpose of this study an emergency nurse is a nurse registered with the South African Nursing Council who takes care of survivors of IPV within an emergency unit of two selected public hospitals in an urban area in South Africa.

1.8.3 Experience

Experience in a phenomenological context refers to a person’s lived viewpoint of body, health, knowledge and existence (Dahlberg *et al.* 2008: 42-48). As explained by Merleau-Ponty: experience reflects the way “through which other people and things are given to us” (1945: 66); experience is “a whole already pregnant with an irreducible meaning” and “the layout of a landscape or world” (1945: 25).

In this study “experience” refers to an emergency nurse’s lived viewpoint of providing care to survivors of IPV; it reflects the way through which the act of taking care of a survivor of IPV was “given” to the emergency nurse. Experience in the study context lays bare the meaning of providing care to survivors of IPV in the world of an emergency nurse.

1.8.4 Intimate partner violence

“IPV” refers to the range of sexually, psychologically and physically coercive acts against adult and adolescent women by current or former male intimate partners (Ellsberg & Heise 2005: 12). In the literature the terms “wife/spouse abuse”,

“domestic violence”, are generally used interchangeably. According to the Domestic Violence Act (Act no 116 of 1998), domestic violence includes: any “controlling or abusive behaviour, where such conduct harms, or may cause harm to the safety, health or well-being of the complainant”; and physical, sexual, emotional and economic abuse, as well as stalking and intimidation.

For the purpose of this study IPV is seen as any controlling or abusive behaviour by a partner which harms, or may cause imminent harm to the safety, health or wellbeing of a woman with whom the abuser is in an intimate relationship (derived from the Domestic Violence Act, Act no 116 of 1998).

1.8.5 Survivor

In the literature women exposed to IPV are often referred to as “survivors” rather than victims. This reflects a focus on women’s strengths and potential to move beyond the IPV. Not all women exposed to IPV see themselves as survivors and some of them are trapped by circumstances that constrain their ability to make choices (Dunn & Powell-Williams 2007: 977; Ford-Gilboe *et al.* 2011: 122). The UN report (2006: 12) also acknowledges this debate by indicating that some people feel that the term “victim” implies passivity, weakness and vulnerability and fails to recognise women’s resilience and agency. Others find the term “survivor” problematic because it denies the victimisation experienced by women exposed to IPV.

In this study, the term “survivor” is used and refers to a female healthcare user at an emergency unit who is seeking help for health problems directly or indirectly related to exposure to IPV and is regarded as having the potential to move beyond the oppression of IPV. By choosing the term “survivor” the researcher by no means negates the victimization and constraints experienced by women exposed to IPV. The term “victim” is used in the study in instances where IPV resulted in the death of a woman.

1.8.6 “Taking care of”

In this study “taking care of” is seen as defined by Covington (2003: 321). The definition, which includes elements of “intentionality” and “intersubjectivity” (seen to be in line with a phenomenological perspective), merges the concepts of “presence” and “caring”:

"Caring presence is an interpersonal, intersubjective human experience of connection within a nurse-patient relationship that makes it safe for sharing oneself with another. The nurse brings conscious awareness (intentionality) and is available and attentive in the moment to provide opportunity for deep connection between the nurse and patient in the relationship. Deep connection within the relationship provides an important bond between participants that gives them a sense of safety as both nurse and patient attempt to discover meaning in the human experience of health and illness."

1.9 SIGNIFICANCE OF THE STUDY

The study findings explicated the meaning of "taking care of survivors of IPV" as experienced by emergency nurses. The findings of the phenomenological inquiry and literature review were utilised to develop guidelines to facilitate emancipatory knowing in emergency nurses with regard to taking care of survivors of IPV. The guidelines will open the possibility for emergency nurses to reflect upon and talk about their personal and professional experiences with IPV and to acknowledge their vulnerability to secondary traumatic stress and vicarious traumatisation. Implementation of the guidelines has the potential to create an environment for emergency nurses to take steps to correct the injustices inherent in the provision of care to survivors of IPV. In accordance with the guidelines, realisation of emancipatory knowing in praxis will reflect emergency nurses' engagement in undoing social inequities and injustices with regard to taking care of survivors of IPV.

1.10 RESEARCH METHODOLOGY

The research was conducted in two phases: a phenomenological inquiry to explore and describe emergency nurses' experiences of taking care of survivors of IPV; and development and validation of guidelines to facilitate the actualisation of emancipatory knowing in emergency nurses with regard to taking care of survivors of IPV. As a detailed discussion of the research methodology is provided in Chapter 2, only a brief overview of the two research phases is given here.

1.11 PHASE 1: PHENOMENOLOGICAL INQUIRY TO EXPLORE AND DESCRIBE EMERGENCY NURSES' EXPERIENCES OF TAKING CARE OF SURVIVORS OF IPV

1.11.1 Research design

Qualitative research sheds light on the way people understand their experiences and the world they live in (Holloway & Wheeler 2010: 3). In qualitative research the design is emergent, a holistic account of the problem or issue under study is provided, it occurs in a natural setting, the researcher collects data him/herself and multiple forms of data are used. The data are analysed in an inductive way, focusing on the participants' meaning (Creswell 2012: 47-48). This study design is qualitative in nature, as the experience of nurses taking care of survivors of IPV was explored in the context of the emergency unit. The findings provided a holistic account of the meaning attached to the experience, and how the experience of providing care to survivors affects emergency nurses' lives.

1.11.2 Research method

An approach area in which phenomenology has a contribution to make to nursing inquiry is described as "grounding". Grounding refers to the lifeworld, the everyday world with its complexities and inherent tensions (Holloway & Wheeler 2010: 219). The everyday experiences of emergency nurses with survivors of IPV in the emergency care unit seemed to contain an inherent tension as an area of concern and the need to inquire and explore these experiences was identified by the researcher.

Phenomenological research is based on phenomenological philosophy, which is aimed at understanding and describing the meaning of a lived experience (LoBiondo-Wood & Haber 2010: 583). Descriptive phenomenological research aims to generate an understanding of the essential structures of a phenomenon of everyday experience (Holloway & Wheeler 2010: 213). The first phase of this study was conducted in accordance with the descriptive phenomenological method set out by Giorgi (2009) and reflective life-world research described by Dahlberg *et al.* (2008). The research method is briefly described in terms of the research setting, selection of participants, data collection and data analysis. A comprehensive discussion follows in Chapter 2.

The study was conducted in two emergency units in the Tshwane region (an urban area in Gauteng, one of the nine provinces of South Africa), one in a Level 1 (District) and one in a Level 3 (Academic) public hospital. The target population of this study

was all the emergency nurses providing care to survivors of IPV in the two emergency units that constituted the research setting. As indicated by Holloway and Wheeler (2010: 135), sampling in qualitative research is based on principles of obtaining in-depth and rich data. Purposive sampling was used in this study to select participants from the target population based on their willingness to participate as well as their ability to share rich information on their experiences of taking care of survivors of IPV. Inclusion criteria as well as sample size are discussed in detail in Chapter 2.

Data were collected through the holding of unstructured interviews with participants (Polit & Beck 2012: 535-536). The central research question asked during the nine interviews to obtain in-depth information was:

"What do you experience while/when taking care of survivors of IPV?"

The researcher used interviewing skills such as minimal verbal responses and clarification to validate the meaning of respondent's expressions. The researcher made field notes during the interview session. Field notes include descriptive and reflective notes regarding the researcher's feelings, impressions and ideas (Creswell 2012: 167). A reflexive journal was used to record both the field notes and the researcher's personal notes to enhance reflexive bracketing according to the tips as recommended by Ahern (1999: 408-410).

Descriptive phenomenological analysis (Dahlberg *et al.* 2008: 232-256; Giorgi: 2009: 125-137) was applied to the in-depth interviews and the field notes. The descriptive findings substantiated by participants' quotations (Chapter 3) were followed by a discussion of the research findings supported by a review of relevant literature (Chapter 4).

1.11.3 Trustworthiness of the findings

In phenomenological research the trustworthiness of the findings is reflected in the researcher's honesty about his/her own perspective, pre-existing thoughts and beliefs (Starks & Trinidad 2007:1376). In this study trustworthiness was established according to the strategies as summarised in Table 1 and discussed in detail in Chapter 2. *Reflexive practices, bracketing* and the *eidetic reduction* were employed by the researcher to ensure trustworthiness of the findings.

Table 1 Strategies to ensure trustworthiness

Strategy	Phases	Application
Bracketing (Gearing 2004)	Abstract formulation	Detailed discussion of the research orientation and phenomenological philosophical framework in Chapter 2.
	Research praxis	<i>Foundational focus</i> • Bracketing of knowledge and experiences with regard to IPV and provision of care to survivors of IPV. • A clear reflection of the essence of participants' experiences in the findings. <i>Internal (researcher) and external (phenomenon) suppositions</i> • Interview with a psychiatric nursing specialist to help the researcher acknowledge and bracket her personal history and experiences related to provision of care to survivors of IPV. • Bracketing of therapeutic models known and utilised by the researcher in her capacity as a psychiatric nursing specialist. <i>Temporal structure</i> Bracketing that started before data collection with the bracketing interview and was phased out as the findings were explicated in terms of related theories and research findings in Chapter 4. <i>Parenthesis (boundary) composition</i> Rigid maintenance of bracketing boundaries to ensure unbiased findings.
	Reintegration	Reintegration of study findings in terms of current theories in Chapter 4.
Reflexivity (Finlay 2002b)	Pre-research stage	The researcher's reflections on her own assumptions regarding the research problem in relation to existing literature in order to clarify the research question.
	Data collection stage	The researcher's reflections on her own feelings while writing field notes after each interview.
	Data analysis stage	The researcher's reflections that helped her to place herself in the participant's position and search for the meaning of the experience in terms of the participant's lifeworld.
Eidetic reduction (Giorgi 2006; 2009; 2012)	Validity	The use of imaginative variation led to the essence - the essential meaning that remains throughout the multiplicity of variations - the invariant that sets the boundaries of the meaning of emergency nurses' experiences of taking care of survivors of IPV.
	Reliability	Reliability is evidenced through the essence that precisely and consistently fulfils the meaning of all the participants' experiences of taking care of survivors of IPV.

1.12 PHASE 2: DEVELOPMENT AND VALIDATION OF GUIDELINES TO FACILITATE THE ACTUALISATION OF EMANCIPATORY KNOWING

Guidelines were developed for emergency nurses in order to facilitate the actualisation of emancipatory knowing with regard to taking care of survivors of IPV. The *development, validation and validity of the guidelines* will be discussed briefly as the detail is provided in Chapter 2.

1.12.1 Development of guidelines

Guidelines are advisory statements developed in a systematic way to assist both the practitioner and patient with regard to clinical decision making with the aim of improving quality of care (WHO 2003: 1; Graham & Harrison 2005: 68; Bowker *et al.* 2008: 1; Krahn & Naglie 2008: 436). The guidelines in this study were developed as a guide to facilitate emancipatory knowing in praxis – a nursing practice that will reflect emergency nurses' engagement in undoing social inequities and injustices in the provision of care to survivors of IPV (Chinn & Kramer 2011: 2). The guidelines are linked to a body of evidence through the literature review reflected in Chapter 4. Although the focus is on facilitating emancipatory knowing in emergency nurses, the end goal is to promote care to survivors of IPV based on independent clinical decision making.

The draft guidelines were developed by the researcher in accordance with and guided by the following: findings of the study (Chapter 3), discussion of the findings and the literature review (Chapter 4), guiding attributes in the guideline development process (2.6.2.1), and dimensions of emancipatory knowing in nursing (2.6.2.2).

The guiding attributes guided the researcher throughout the development process to ensure that the guidelines met the requirements of validity, reliability, clarity, flexibility, representativeness and applicability. In light of the injustice and oppression uncovered in emergency nurses' experiences of providing care to survivors of IPV (5.2.4), guidelines were formulated in terms of the dimensions of emancipatory knowing in nursing (Chinn & Kramer 2011).

With emancipatory knowing comes an awareness of how unjust situations are maintained through certain social constructs; an awareness that is effected in praxis (Chinn & Kramer 2011: 64-65). Nursing praxis refers to nursing practice that reflects nurses' engagement in undoing social inequities in the healthcare environment (Chinn

& Kramer 2011: 2). In the context of the study the guidelines guide the process emergency nurses should follow that will enable them to ask the critical questions to initiate the emancipatory process: (1) define and clarify how the provision of care to survivors of IPV and their own experiences of male oppression put emergency nurses' in a disadvantaged position (in both a professional and personal capacity); and (2) open ways to challenge this position and take corrective action.

Chinn and Kramer (2011) describe methods to develop knowledge in the different patterns of knowing. Each pattern of knowing is characterised by processes located within five dimensions:

- Critical questions that initiate and generate knowing and knowledge;
- Creative processes that initiate and generate knowing and knowledge;
- Formal practice expressions of knowledge and knowing;
- Integrated practice expressions of knowledge and knowing; and
- Authentication processes used to examine and improve knowledge (Chinn & Kramer 2011: 3).

The draft guidelines were presented in terms of the abovementioned dimensions of knowledge development. Each dimension was briefly described, followed by the applicable guideline(s), rationale and actions (Chapter 5).

1.12.2 Validation of guidelines

A consensus method, the Delphi technique, was used in this study to validate the draft guidelines developed for emergency nurses to actualise emancipatory knowing with regard to taking care of survivors of IPV. The Delphi technique is used in areas where empirical evidence is lacking (Powell 2003: 381). Expert opinions, predictions and/or judgments are requested using a series of questionnaires on a particular subject. Subsequent questionnaires are developed based on the results of the previous questionnaire. The process stops when consensus is reached that the research question is answered (Cuhls 2003: 96; Skulmoski, Hartman & Krahn 2007: 2).

In this study an e-Delphi ("similar process to the classical Delphi but administered by email") (Keeney 2010: 232; Keeney, Hasson & McKenna 2011: 6) was used to obtain input from experts in the field of gender-based violence (including IPV), emancipation and emergency nursing in the draft guidelines. The guidelines cover aspects of diverse fields namely, emancipatory knowing in nursing, emergency nursing and IPV. The researcher wished to obtain the input of USA, UK and South African experts to ensure

validity and reliability of the guidelines and to refine the guidelines in terms of clarity, flexibility and applicability.

Purposive sampling was used (Keeney 2010: 229), as the researcher wanted a sample of experts in the Delphi technique. Experts were chosen for their work and credibility in the appropriate area (Powell 2003: 379). The researcher selected participants from experts in the field of gender-based violence, emergency nursing and emancipation from academic institutions, the public and private health sector and social services. The representativeness of the sample depends on the qualities of the expert panel (Powell 2003: 378) and the variety of perspectives they represent (Keeney *et al.* 2011: 8). In this study the researcher selected 17 participants in accordance with the inclusion criteria (Chapter 2, 2.6.2.2). Of the 17 selected, 13 participants responded and participated in the Delphi.

Two Delphi rounds were conducted and selected participants were contacted by e-mail through a cover letter explaining the objectives of the Delphi and the conditions of participation. Participants were given a deadline to indicate their willingness to respond where-after the instrument to validate the guidelines, a cover letter including instructions, deadlines, study objectives and summary of the findings and an informed consent leaflet were e-mailed to them.

The nine draft guidelines, based on the findings of the first phase of the study, and the actions for each guideline were e-mailed to participants. Participants were requested to rate each guideline with regard to the criteria of reliability, validity, applicability, clarity and flexibility. The response choices were based on a four-point Likert-type scale to measure levels of agreement (Stitt-Gohdes & Crews 2004: 63; Jones & Rattray 2010: 376). Participants were asked for comments/suggestions at the end of each guideline.

Responses from participants were analysed and collated (Stitt-Gohdes & Crews 2004: 62) in a table format according to the levels of agreement using the Likert scale (Chapter 6, Table 4). Qualitative analysis of the recommendations/suggestions was carried out and themes were summarised (Chapter 6, Table 4). The feedback provided the basis on which the guidelines for the second Delphi round were adapted.

During the second Delphi round participants from Round 1 were contacted again by e-mail with a cover letter to explain the objectives of Round 2 and conditions of participation. The adapted guidelines with a cover letter including instructions and

deadlines were e-mailed to them. A summary of findings from Round 1 was presented according to identified themes. Participants were requested to indicate their agreement or disagreement with the findings and re-rank their responses according to the Likert scale if they preferred (Okoli & Pawlowski 2004: 19).

Data were analysed and collated in the same way as for Round 1. The findings were utilised to finalise the guidelines. As consensus was obtained after Round 2 it was not necessary to resolve disagreements with the participants as suggested by Keeney *et al.* (2011: 14).

1.12.3 Validity of the guidelines

Participants were chosen from different settings and geographical areas in order to enhance the credibility and acceptability of the policy guidelines. Two participants were from the USA, three from the UK, one from Canada and seven from South Africa.

The guidelines were based on the findings of the first phase of the study, the research objectives and the feedback of the expert panel who participated in the Delphi. The expert panel reviewed the guidelines for validity, reliability, clarity and flexibility.

1.13 ETHICAL CONSIDERATIONS

In this research the ethical principles of the Declaration of Helsinki as developed by the World Medical Association (2008: 1-5) as well as the Belmont Report (Polit & Beck 2012: 151-155) were adhered to, namely: beneficence, respect for human dignity, and justice. The application of the principles in the study is discussed in this section.

1.13.1 The principle of respect for human dignity

As stated in the World Medical Association (2008: 3), "each potential subject must be adequately informed of the aims, methods, sources of funding, any possible conflicts of interest, institutional affiliations of the researcher, the anticipated benefits and potential risks of the study and the discomfort it may entail. The potential subject should be informed of the right to refuse to participate at any time without reprisal".

The researcher acknowledged the right to self-determination of participants (Burns & Grove 2011: 110; Moule & Goodman 2009: 39). Self-determination refers to the autonomy of participants that stems from their right to make a voluntary decision free

from coercion regarding participation or withdrawal from the study (Macnee & McCabe 2008: 148). In order to do so the participants must have a “reasonable awareness of the nature of what they are intending to do and its likely consequences.” (Newell & Burnard 2011: 50) Participants should also be allowed the freedom to decide what they want to share (Macnee & McCabe 2008: 152).

Approval for the study was obtained from the Faculty of Health Sciences Research Ethics Committee of the University of Pretoria (125/2010) (Addendum A). Permission to conduct the study was obtained from the Department of Health as well as the public hospital managers (Addendum B). The principle of informed consent indicating that a person can only make a decision about participating in a study after being given all the relevant information was adhered to (Macnee & McCabe 2008: 148). In phase 1 of the study activities of the study were explained to participants; they were provided with a participant information leaflet and informed consent was signed before participation in the study (Addendum C[1]). Participants were given freedom to choose to either participate or discontinue at any given time without the risk of incurring adverse consequences. Through the process of bracketing the researcher attempted not to be biased and refrained from indirectly leading participants to give answers and opinions she wanted to hear.

In phase 2 a participation information leaflet and informed consent form were e-mailed to participants (Addendum C[2]). Activities of the Delphi technique were explained to participants in a cover letter (Addendum D). Participants who wished to participate in the Delphi returned the signed informed consent per e-mail or fax.

“Every precaution must be taken to protect the privacy of research subjects, and the confidentiality of their personal information and to minimize the impact of the study on their physical, mental and social integrity.” (World Medical Association 2008: 3) The right to confidentiality honours a participant’s right to determine the extent to which private information will be disclosed or withheld (Moule & Goodman 2009: 65). Anonymity is ensured when interviews and findings are recorded in such a way that no one else can connect a participant to individual data (Macnee & McCabe 2008: 148, 150; Burns & Grove 2010: 117; LoBiondo-Wood & Haber 2010: 574).

Anonymity and confidentiality in phase 1 of the study were ensured through the following measures:

- Each participant was provided with a code number.

- Code numbers were used on the transcribed interviews and when data were analysed and discussed.
- The master list with participants' names and matching codes and transcribed and analysed data will be kept in a safe place for 15 years.

In phase 1 the researcher protected privacy by showing sensitivity and respect towards the extent to which participants were willing to share personal emotions and perceptions, and refrained from asking leading questions or probing when a participant expressed a wish not to discuss a specific issue.

During phase 2 the anonymity of participants was ensured, as it is one of the characteristics of a Delphi technique (Stitt-Gohdes & Crews 2004: 61; Keeney *et al.* 2011: 9). Participants were individually informed about the study through e-mail and feedback from the first round was collated before feedback was given to participants in subsequent rounds. Addresses and names on the e-mails were deleted before printing and electronic storage.

1.13.2 The principle of beneficence

This principle imposes a duty on the researcher to minimise potential harm and maximise the potential benefits of the study (Macnee & McCabe 2008: 148; LoBiondo-Wood & Haber 2010: 574; Newell & Burnard 2011: 51). The participants have the right to be protected from harm, exploitation and discomfort (Macnee & McCabe 2008: 148). Holloway and Wheeler (2010: 97) indicated that participants might benefit from interviews that provide them with the opportunity to disclose feelings and thoughts; on the other hand the exploration of sensitive issues might lead to emotional discomfort (Johnson & Long 2010: 33).

The findings of this research were used to develop guidelines to actualise emancipatory knowing with regard to taking care of survivors of IPV and were communicated to relevant health care providers as well as the participants in the study.

The researcher acknowledged that in-depth interviews regarding IPV could cause emotional discomfort. She was empathetic and sensitive to any signs of distress in participants. Emotional support and/or debriefing sessions were provided by the researcher when a need for this was identified. This was provided for two participants who became emotional while the interview was being conducted. The two participants

previously received psychological interventions for the trauma they were exposed to and indicated that they did not require additional interventions. No participants required intensive intervention.

1.13.3 The principle of justice

Justice is the principle focusing on the equal distribution of things or activities amongst people. Accordingly the researcher needs to ensure that all individuals have an equal chance to be included in the study and benefit from the results (Newell & Burnard 2011: 53). The participants have the right to be fairly treated, which implies non-judgmental treatment that honours the agreements set out in the informed consent (Macnee & McCabe 2008: 148; Burns & Grove 2011: 540; LoBiondo-Wood & Haber 2010: 580).

Emergency nurses who indicated willingness to participate in the study were included according to the inclusion criteria. Participants were provided with a summary of the study findings. Participants were allowed to withdraw from the study at any time without any prejudice or negative consequences. No participant withdrew from the study. One potential participant indicated during the introduction to the study that she had been previously exposed to IPV and felt uncomfortable to participate in the research. The researcher provided the potential participant with emotional support and referral options, for example, a social worker or a psychologist. She was not coerced to participate in the research at all. The researcher honoured time schedules arranged for interviews.

1.14 SUMMARY

The background and rationale for the study were discussed and the research problem, question, aim and objectives were formulated. The paradigmatic perspective was explained and key concepts defined. The significance of the proposed study and ethical considerations were described. An overview of the research methodology according to the two research phases was provided. In Chapter 2 the paradigmatic perspective, philosophical framework and research methodology are comprehensively discussed.

1.15 ORGANISATION OF THE STUDY

The chapter organisation is summarized below:

CHAPTER 1: Orientation of the study.

CHAPTER 2: Paradigmatic perspective, philosophical framework and research methodology.

CHAPTER 3: Description of findings.

CHAPTER 4: Discussion of research findings and literature review.

CHAPTER 5: Development of guidelines for emergency nurses to actualise emancipatory knowing with regard to taking care of survivors of intimate partner violence.

CHAPTER 6: Validation and description of guidelines, conclusions and recommendations.

CHAPTER 2: PARADIGMATIC PERSPECTIVE, PHILOSOPHICAL FRAMEWORK AND RESEARCH METHODOLOGY

2.1 INTRODUCTION

Research attempts to expand, refine and develop a body of knowledge. Nursing research improves the understanding of concepts central to nursing care and informs nursing practice through exploring the effectiveness of current practices and developing new or improved nursing interventions. Although the research process is interpreted in different ways depending on the specific paradigm and theories underpinning the approach, a scientific method implies a systematic and rigorous approach towards inquiry (Bowling 2009: 137 & 380; Topping 2010: 130; Holloway & Wheeler 2010: 22-26; Polit & Beck 2012: 3). Two broad paradigms of research are distinguished – positivist, which is associated with a quantitative design; and constructivist (also known as naturalistic or interpretivist), which is associated with a qualitative design (Gerrish & Lacey 2010: 8; Polit & Beck 2012: 12). The researcher needs to decide which research design will answer the question of interest as meaningfully and accurately as possible (Macnee & McCabe 2008: 195).

In order to understand the phenomenon of interest as a whole, a qualitative design was utilised in this study. The researcher decided on this design as she was interested in understanding the reality of taking care of survivors of IPV from emergency nurses' perspective. A qualitative design enabled the researcher to explore the phenomenon under study through in-depth personal interaction that produced descriptive data of emergency nurses' accounts of meaning in a narrative format (Polit & Beck 2012: 12-13).

Certain approaches (Holloway & Wheeler 2010), also called methodologies (Macnee & McCabe 2008; Topping 2010), are associated with a qualitative design. Qualitative approaches used in nursing research have been strongly influenced by research approaches from the human sciences such as anthropology, psychology and sociology. Phenomenology, the research approach chosen for this study, is, for example, rooted in philosophy but has also benefited from the disciplines of psychology and sociology. The focus in phenomenology is on understanding the meaning of lived human experiences in a given context (Macnee & McCabe 2008: 205; Todres & Holloway 2010: 177; Holloway & Wheeler 2010: 25-26; LoBiondo-Wood & Haber 2010: 583).

As the aim of this research was to understand a complex human issue, namely the experiences of emergency nurses while taking care of survivors of IPV, the researcher chose a phenomenological approach (phase 1). In order to understand and describe the essence of emergency nurses' experiences in a specific context, the researcher had to enter their lifeworld – their working environment – where they are at times required to take care of survivors of IPV. The findings of the phenomenological inquiry were used to develop guidelines to facilitate the actualisation of emancipatory knowing in emergency nurses with regard to taking care of survivors of IPV (phase 2).

This chapter provides a critical overview of the paradigmatic perspective and philosophical framework underlying the research process. This overview is followed by a description of the research methodology in accordance with the two research phases.

2.2 PARADIGMATIC PERSPECTIVE

In this section the constructivist research paradigm with its underlying meta-theoretical assumptions is discussed.

2.2.1 Research paradigm

A paradigm is an overarching philosophical worldview composed of a system of beliefs or philosophical assumptions about the world (Broom & Willis 2007: 17; Holloway & Wheeler 2010: 24; Mertens 2010: 8; Polit & Beck 2012: 11). The paradigmatic perspective the researcher chooses is associated with certain scientific assumptions for the development of knowledge, which are rooted within a particular worldview and determine the methods for structuring reality (Bowling 2009: 129; Dahlberg *et al.* 2008: 154-157).

A worldview answers *ontological* questions about the nature of reality and existence (Delius *et al.* 2007: 115; Dahlberg *et al.* 2008: 15; Holloway & Wheeler 2010: 21; Polit & Beck 2012: 11). Dahlberg *et al.* (2008: 156) distinguished between atomism and holism as the two basic classical worldviews:

- *Atomism* holds that the complexity of the world can be understood in terms of its smallest components. The best way to understand a phenomenon is through analysing and describing the rule-based composition/combination of its smallest parts (Mudersbach 2007: 5).

- *Holism* assumes that the world is structured in patterns of internal interacting parts. A phenomenon is best understood as a complete whole with its necessary parts. The significance of human behaviour can only be fully understood in relation to the larger whole (Mudersbach 2007: 7; Dahlberg *et al.* 2008: 156).

The scientific view the researcher adopts is related to the worldview and concerns *epistemological* questions such as what counts as valid knowledge, and *methodological* questions regarding the methods chosen to obtain that knowledge. (Denzin & Lincoln 2005: 183; Dahlberg *et al.* 2008: 154-157; Holloway & Wheeler 2010: 21-24; Mertens 2010: 10).

Denzin and Lincoln (2011: 13) distinguish between positivist and post-positivist, constructivist-interpretive, critical and feminist-poststructural paradigms of inquiry. Polit and Beck (2012: 12) describe positivist and constructivist paradigms as being mainly utilised for human inquiry in nursing research. The terms “naturalistic”, “interpretivist” and “constructivist” are used interchangeably in the literature to refer to a paradigm seeking understanding of subjective meanings from data collected in everyday life settings using qualitative methods (Broom & Willis 2007: 25; Topping 2010: 130).

Within a *positivist paradigm* the world is seen as a stable and predictable reality driven by natural causes. According to the philosophical positivistic movement, founded by Comte (1798-1857), the source of knowledge is based on empirical research, which is based on the laws that can be discovered from sensory perception and observation of concrete observable facts and the relations between them (Delius *et al.* 2007: 93-94, 115; Bowling 2009: 137; Holloway & Wheeler 2010: 22-23). In quantitative research reality is objectively measured and broken down into components or variables (atomism/reductionism) (Fossey *et al.* 2002: 718; Krauss 2005: 759-760).

The positivistic scientific method for production of knowledge is based on a quantitative process: (1) observation and experiment in the empirical world leads to tentative explanations expressed as hypotheses; (2) hypotheses are tested and results interpreted; (3) results are often expressed as theories (theories are again testable through experimentation that can either provide the evidence for, or invalidate, the theory); and (4) the researcher uses deductive logic to predict causal relationships and generalisations (Fossey *et al.* 2002: 718; Topping 2010: 132).

Denzin & Lincoln (2011: 1) describe how qualitative research has flourished during the last two decades since the “postpositivist-constructivist war against positivism” between 1970 and 1990. The *constructivist paradigm* originated as a countermovement to positivism and represents alternative approaches for conducting research (Polit & Beck 2012: 12), especially in cases where the researcher seeks to understand subjective experiences, meanings of human behaviour and inter-subjective interaction, which experimental research is ill-equipped to provide (Fossey *et al.* 2002: 717).

A constructivist paradigm provided the perspective from which the researcher wished to explore the subjective reality of emergency nurses’ lived experiences of taking care of survivors of IPV. The decisions taken on the research approach and method were informed by a constructivist paradigm.

2.2.2 Meta-theoretical assumptions: constructivist paradigm

Although the constructivist paradigm was (and still is) shaped by different philosophical movements, scientific theories, social disciplines and methodologies (Holloway & Wheeler 2010: 24), it is characterised by certain fundamental *ontological*, *epistemological* and *methodological assumptions*, which are discussed below.

2.2.2.1 Constructivist paradigm: ontological assumptions

Naturalistic researchers operate under certain ontological assumptions about the world. They view the world not as an objective reality but rather as subjective mental constructions, selected, built and enhanced by individuals based on their experiences. Reality exists within a context and humans experience and perceive reality in different ways; each from his or her point of view, leaving qualitative researchers with multiple realities to consider (Krauss 2005: 760; Mertens 2010: 18; Lincoln, Lynham & Guba 2011: 98; Polit & Beck 2012: 12).

Within this perspective the emergency nurse is seen to construct meaning while perceiving the phenomenon of taking care of survivors of IPV. Meaning is constructed as a subjective mental reality within the emergency nurse’s specific personal, professional, social and spiritual context. The multiple realities of taking care of survivors of IPV as perceived by different emergency nurses were explored.

2.2.2.2 Constructivist paradigm: epistemological assumptions

Within the epistemological assumptions underlying a constructivist paradigm, knowledge about a phenomenon is believed to be best acquired within the interactive relationship between the researcher and the participant. Knowledge is subjective and context bound (Krauss 2005: 759-761, Mertens 2010: 19; Polit & Beck 2012: 13).

Within the chosen paradigm the researcher believed emergency nurses' experiences of taking care of survivors of IPV could only be explored through in-depth interaction. The knowledge obtained is contextual – situated within the life-world of emergency nurses.

2.2.2.3 Constructivist paradigm: methodological assumptions

Certain methodological assumptions are generic to the different methodologies and approaches used within a constructivist paradigm. The research usually follows a subjective, holistic, inductive, dialectic, and qualitative method. The researcher becomes immersed in the culture of the group under study and uses listening, talking and observation to explore meaning and gather data. The findings are presented in a narrative format (Krauss 2005: 759-760; Topping 2010: 130; Polit & Beck 2012: 13).

In this study a qualitative, inductive, flexible and holistic process was followed that focused on understanding the meaning as it emerged during emergency nurses sharing of their experiences of taking care of survivors of IPV. The findings derived from an in-depth analysis, presented in the form of a narrative description served as the basis from which the guidelines to actualize emancipatory knowing were developed.

Phenomenology, described as a research approach within the constructivist paradigm (Topping 2010: 135; Holloway & Wheeler 2010: 213; Denzin & Lincoln 2011: 14), converges with qualitative strategies (Carter & Little 2007: 1318; Giorgi 2009: 5). Hermeneutic phenomenology emphasises interpretation while descriptive phenomenology focuses on the value of describing an everyday experience to achieve an understanding of its essential structures (Holloway & Wheeler 2010: 213). Descriptive phenomenology was considered the most appropriate framework within

which to explore and describe the meaning of taking care of survivors of IPV as embedded in the experiences of emergency nurses.

The philosophical framework associated with a descriptive phenomenological inquiry is explained in the next section.

2.3 PHILOSOPHICAL FRAMEWORK

A descriptive phenomenological approach requires the researcher to hold preconceived views of the phenomenon in abeyance (Todres & Holloway 2010: 181). As such, the researcher in this study decided to take an a-theoretical stance. No theoretical assumptions were formulated and the research was guided by the philosophical framework associated with a phenomenological inquiry.

Holloway and Wheeler (2010: 213) emphasise that phenomenological researchers need to understand and focus on the philosophical basis from which the method originated. Seeing that descriptive phenomenological research is grounded in the philosophy as founded by Husserl (1859-1938) (Giorgi 2009: 77-78; Flood: 2010: 8-9; Holloway & Wheeler 2010: 219), the meaning, historical origins and philosophical foundations of phenomenology as developed by Husserl are discussed in the next section.

2.3.1 What is phenomenology?

Phenomenology is described as a philosophy, a science and a research approach. The word phenomenon comes from the Greek, meaning “appearance” or “that which shows itself” (Cogswell 2008: 84; Crane 2009:31). Phenomenology as defined by Husserl is the scientific study of the *essential structures* of consciousness; or the *content of consciousness*. The content of consciousness describes the nature of the *intentional acts of consciousness* and asks how *objects of consciousness* present themselves (Solomon & Higgins 1996: 251; Delius *et al.* 2007: 114). Through suspension of judgment and bracketing the natural standpoint (Moran 2005: 8; Higgs & Smith 2006: 56; Smith 2007: 29), the phenomenologist gains insight into the common features of lived experiences and uncovers the general truths that underlie phenomena (Brauner 2005: 2-4; Kumar 2012: 793).

2.3.2 Origin and historical development of phenomenology

In opposition to the dominance of natural sciences, a number of approaches in philosophy that emerged in the 19th century emphasized that the way towards understanding existence and human life is through subjective experience. When applied to the study of human life, the positivist paradigm failed to capture essential features of human existence, and even to a greater extent human emotions and will (West 1996: 79–83)

The phenomenological movement as founded by Husserl in the beginning of the 20th century played a significant role in a tradition of thought inspired by humanistic concerns known as *continental philosophy* (West 1996: 1; Smith 2007: 2; Crane 2009:31). Continental philosophy is seen in contrast to analytic philosophy, which regards science as the most important source of knowledge and focuses more on theory building and formal logic. Continental philosophy views the possibility of philosophical theories with skepticism and place greater emphasis on the role of philosophy within the historical context and intellectual culture. There is no “single homogeneous continental tradition”, rather a “variety of more or less closely related currents of thought” (Crane 2009: 31).

Phenomenology originated from the views of Brentano (1838-1917) who was Husserl’s teacher. Brentano, a philosopher and psychologist, proposed a “descriptive or phenomenal psychology”. He wanted to differentiate between mental and physical phenomena, and he based this distinction on the intentionality of mental phenomena, referring to the fact that mental phenomena are always directed at something (Moran 2005: 3 & 18; Crane 2009: 31).

Husserl wished to constitute a single and complete foundational method for philosophy as a rigorous science (West 1996: 88; Moran 2005: 35; Crane 2009: 31). He saw phenomenology as the basis of all scientific thinking, taking the everyday human world as it is experienced as the foundation of science. This is opposed to positivism and objectivism, which separate the researcher and the object of research (Dahlberg *et al.* 2008: 30-31).

Husserl resisted the narrow models of positivism and 19th century empiricism (Moran 2000: 13; Moran 2008), which voided the “world of all meaning and value” and reduced the “human mind to a mere object” (Cooper 2003: 438). He believed that positivism would result in “dehumanisation of society” as it lost touch with the

everyday lifeworld (Moran 2005: 4; Dahlberg *et al.* 2008: 30-31). According to Husserl, philosophy “needs an entirely new point of departure” as it cannot begin with the natural standpoint that views the world as the “given” existence or reality “out there” and reduce all necessary truths to empirical generalisations (Solomon 1972: 158-163).

The tradition that Husserl belonged to was *rationalism* (Tieszen: 2005: 38; Cogswell 2008: 85). According to rationalism, knowledge is derived from rational thought that is based within a universal, comprehensive and ordered system of concepts, judgments and conclusions (Delius *et al.* 2007: 41-42, 115).

Like for Descartes and Kant, the starting point of epistemology for Husserl was the contents of consciousness, which represent the only certain knowledge; this implies that all knowledge comes through experience (Solomon & Higgins 1996: 249; West 1996: 89). Although Husserl was not satisfied with their philosophical answers to knowledge, he pursued the approaches of Descartes and Kant in an attempt to answer the question: How does consciousness contribute to the constitution of objective knowledge and necessary truths? (Solomon 1972: 144; Moran 2000: 61; Luft 2004: 204). Husserl explored Kant’s (1724-1804) *transcendental idealism* as a potential approach towards developing a phenomenological method and Descartes’s (1596-1650) *methodical doubt* as a basis for a rigorous science (West 1996: 89).

Descartes saw knowledge as based on complete certainty or absence of doubt (Newman 2010). Knowledge is established through methodical doubt, a method setting aside for the time being all preconceived opinions based on alleged facts perceived by the senses (Delius *et al.* 2007: 44; Crane 2009: 31; Newman 2010). When certainty has been established beyond a point of doubt, doubt can be reversed (Smith 2003: 24; Newman 2010).

Husserl was not interested in doubt *per se*, but rather in refraining from judgment (Moran 2005: 9). The basis of Husserl’s phenomenology is as drastic as Descartes’s philosophy in the sense that it is entirely pre-suppositionless (Schacht 1972: 296), but for Husserl there can be no reversal or return to the natural attitude: the *époché* (bracketing) provides the transcendental perspective from which a philosophical inquiry takes place (Smith 2003: 24-25).

The term transcendent as used by Kant refers to anything beyond sensory experience that can be rationally known through reason (Delius *et al.* 2007: 116). For Kant

empirical objects are the only possible objects of knowledge for human beings and “the limits of such knowledge matches up with the limits of possible experience” (Tonner 2007: 8). Husserl attempted to overcome the limitations of empirical knowledge related to objects that present themselves as something transcendent. Within a rigorous philosophy free of all presuppositions, reliable transcendental knowledge is possible through the phenomenological reduction that directs attention to the contents of consciousness as given. For Husserl the transcendental is something concrete of which the essential characteristics and laws governing its various structures can be identified (West 1996: 89; Nenon 2008: 427-428, 434-438).

The concepts of intentionality, essences and phenomenological reduction highlight Husserl’s major contribution to what transpired as descriptive phenomenology (Holloway & Wheeler 2010: 216-219). Although phenomenology as founded by Husserl was criticised by his followers (for example, Heidegger, Merleau-Ponty and Gadamer) his critique on the natural sciences and philosophical thoughts resulted in a new way of understanding the world. Husserl’s followers and students applied his phenomenological method, resulting in a diverse and rich phenomenological tradition that still exists in France. His philosophy defined the basis for Sartre, Scheler, Merleau-Ponty and Heidegger’s interpretive phenomenology (Solomon 1972: 143 & 153; Moran 2000: 20-22; Delius *et al* 2007: 98; Smith 2007: 4).

2.3.3 Phenomenological philosophical foundations

Philosophy attempts to answer ontological questions regarding existence, epistemological questions about the nature of knowledge and truth, as well as ethical questions referring to social values and morals (Velasquez 2011: 10; Burns & Grove 2011: 229).

Husserl attempted to develop a systematic philosophy in which phenomenology, ontology, epistemology and logic are independent parts (Smith 2007: 12). Knowing and being in phenomenological terms are closely related, indeed the knowing activity has an inter-subjective communal grounding, also referred to as the lifeworld, which is seen as the context of human experience (Moran 2000: 61). In *Crisis* Husserl delineates the central focus of his philosophy – the relation between being and reason – with the question: “Can reason and that-which-is be separated, where reason, as knowing, determines what is?” (Husserl 1970: 11).

The first part of the following section focuses on explaining philosophical phenomenological concepts within a Husserlian perspective as it pertains to epistemology without ignoring the ontological aspects of being in the world. The second part explains the methodological assumptions according to the philosophical phenomenological method as developed by Husserl.

2.3.3.1 Epistemological and ontological assumptions

Consciousness as the “medium of access for any knowledge” is seen as the condition of all experience (Moran 2000: 61; Giorgi 2009: 4-5, 76). Reality is grounded within a “perceptible, thinking and remembering consciousness” (Delius *et al.* 2007: 112). Phenomenology seeks to understand anything that can be experienced through consciousness, which can refer to an object, person or complex state of affairs. It requires a person to be present to the “given”, exactly as it presents itself (Giorgi 2009: 4, 68, 93).

A **phenomenon** is described as the “direct evidence of what appears in consciousness” (Delius *et al.* 2007: 98); as anything that shows itself to consciousness (Dahlberg *et al.* 2008: 32; Giorgi 2009: 9-10). A phenomenon is not seen as the contents of the mind or as an object as it is in itself but is rather understood as a concrete or abstract part of the world experienced by a conscious subject (Dahlberg *et al.* 2008: 47; Giorgi 2009: 4, 93).

Intentionality refers to the directed character of consciousness (Cooper 2003: 440; Giorgi 2010: 76). Phenomenology emphasises the essential interrelatedness between subjects and objects. Subjects are seen as conscious, embodied human beings situated in the world of objects (Howarth 1998). Embodiment implies that as human beings we are connected and rooted through our bodies to the world (Dahlberg *et al.* 2008: 41). Objects present themselves as “objects of our gaze” and “compel, invite or resist our actions”. Humans perceive the world through acting in and on it - acts of consciousness directed towards objects having significant, indefinite and ambiguous meanings (Howarth 1998). When a person experiences something, it is experienced as something that has meaning (Dahlberg *et al.* 2008: 47).

Meaning evolves within the context of intentionality. Directedness towards the object has a specific or particular quality that is the meaning - the particular way in which the object is experienced (Giorgi 2009: 80). Van Manen (2007) distinguished two types of meaning: cognitive and non-cognitive. Cognitive meaning refers to the

"conceptual, objective, measurable features of something" (van Manen 2007: 21), while the non-cognitive meaning (described as "pathic") is concerned with the "relational, situational, corporeal, temporal, actional" and "refers to the general mood, sensibility, sensuality, and felt sense of being." (van Manen 2007: 21-22) The simultaneous recognition and understanding of both these sources of meaning is described as a transformative experience; an intuitive grasp of meaning that creates a rich understanding of everyday life experiences (Flood 2010: 7-8).

Experience is described in a broader way in that we do not only experience concrete and particular objects, but also abstract and universal ones (Zahavi 2003: 14 & 37). Experiences include bodily awareness, embodied action, perception, cognition (for example memory and imagination), emotion and volition (Spiegelberg 1964: 327; Husserl 1973: 42 & 50; Moran 2005: 3 & 21; Smith 2011). Husserl focused specifically on experiences that possess intentionality (Zahavi 2003: 14 & 37) – "consciousness-of-objects which constitutes experiences" (Solomon 1972: 152).

For Husserl the term "lived experience" "signifies givenness of internal consciousness, inward perceivedness" (Husserl 1964: 177). "Lived experience is simply experience-as-we-live-through-it in our actions, relations and situations." (van Manen: 2007: 16)

Essences represent the required features that necessarily must belong to the phenomenon if it is to appear as a phenomenon of a given type (Cooper 2003: 440; Giorgi 2009: 84). Essences resemble the invariant characteristic(s), the meaning and structure (Wertz 2005: 168), the non-empirical entities and laws (Brauner 2005: 2), the being of the phenomenon (Dahlberg 2006: 18). The method of intuition is used to uncover the essence (West 1996: 93; Wertz 2005: 168).

Intuition is described as "givenness", when something is "experienced as the thing itself in immediate presence" (Moran & Mooney 2002: 167). While physical objects are intuited through the act of perception (Føllesdal 2006: 109), essences reveal themselves, not through sensory intuition, but through eidetic intuition (Husserl 2001: 292-294). Intuition enables the phenomenologist to investigate mental phenomena that have no physical qualities (West 1996: 93). "Intuition" means the ability to immediately grasp the essence of the object: the meanings as presented but also the potential meanings not directly presented (Solomon 1972: 171).

The meaning given in an act of consciousness is called the "noema". Each act has a "noesis" – the experience that gives meaning to the act. The "hyle" are sense

experiences. These three elements remain hidden – transcendental (Føllesdal 2006: 107-109). An object is experienced within its “horizon” – the horizon is the full consciousness a subject has of the characteristics of an object even though all the potential meanings are not directly presented (Moran & Mooney 2002: 599; Dahlberg *et al.* 2008: 49-50). The horizon refers to the presentation of the experience that transcends the immediate given. Seen this way, meaning is infinite – never complete and always contextual (Dahlberg *et al.* 2008: 50-53).

The “lifeworld” is the context of all possible human experiences, the often unnoticed and disregarded existence in the world (Moran 2000:181; Dahlberg *et al.* 2008: 35-38). Merleau-Ponty (1964: 127) philosophised: “the presence of the world is the presence of its flesh to my flesh”. This quotation speaks of “the idea that everything that is, is so because of everything else that exists” (Dahlberg *et al.* 2008: 39). Science emerges from the life-world – it provides the tacit ground for science within and through which scientists work (Moran 2005: 10; Dahlberg *et al.* 2008: 35-38; Giorgi 2009: 10-11). The life-world “precedes knowledge” and “knowledge speaks” of the life-world (Merleau-Ponty 1945: x). Phenomenological research involves understanding and describing the life-world as humans experience it, relate to it and ascribe meaning to it: “the implicit and tacit becomes explicit and can be heard”. (Dahlberg *et al.* 2008: 35-38).

In his later works Husserl focused more on inter-subjectivity and described life as living in a world of shared objects, environment, language, and meanings. He also explored the problem of “how does the other enter into my consciousness”; being different from the way objects are given to consciousness (Moran 2000: 176). The ground for understanding the mental experiences of others lies in one’s own self-understanding and empathy for others that enables access to the inter-subjective world (Moran 2000: 175-179; Holloway & Wheeler 2010: 216).

In this study the researcher wanted to describe the reality of taking care of survivors of IPV, a reality that exists within the life-world of emergency nurses. This reality exists because violence against women inflicted by their intimate partners is still a common problem worldwide. There is shared meaning between the emergency nurse and the survivor of IPV when the survivor enters the emergency unit to seek care. The intentional act of providing care is a phenomenon grounded within emergency nurses’ consciousness and is experienced as something that has meaning, both cognitive and non-cognitive. The essential meaning of the experience was uncovered through the research as an intuitive process. The otherwise unnoticed experiences of emergency

nurses were brought into awareness as the researcher entered their life-world and their consciousness, asking them to reflect upon their experiences.

The researcher attempted to grasp meaning through questioning, empathy and sensory attentiveness. During the description of the findings the researcher focused on relaying the conceptual as well as more expressive elements related to the phenomenon. The guidelines for emergency nurses to actualise emancipatory knowing were developed from the essential insights the researcher developed.

2.3.3.2 Methodological assumptions

Methodology refers to a theory of producing knowledge through research and provides a rationale for the way research proceeds. It refers to more than data collection and analysis methods; rather, it provides the justification based on theoretical principles for choosing such methods in relation to the kind of understanding the researcher is seeking (Gough 2002: 4-5; Carter & Little 2007: 1317). Giorgi (2009: 11) pointed out that a definite delineation of phenomenology as a scientific theory does not yet exist (Giorgi 2009: 11).

This research process was guided by reflective life-world research as described by Dahlberg *et al.* (2008) and the scientific descriptive phenomenological method developed by Giorgi (2009). Reflective life-world research is rooted in the philosophy of Husserl, Heidegger, Merleau-Ponty and Gadamer; and the scientific descriptive phenomenological method is grounded in the original philosophical phenomenological method developed by Husserl. The criteria for sound scientific descriptive phenomenological research synthesised by Giorgi (2009) entail *assuming the phenomenological reduction, descriptions from others* and *search for the invariant meaning*. These criteria are discussed below and are followed by an application to the study to indicate how the chosen method relates to the understanding the researcher sought.

a) Assuming the phenomenological reduction

The philosophical phenomenological method requires the philosopher to apply transcendental phenomenological reduction; a reflective attitude aiming to eliminate the natural attitude and the empirical content of consciousness. The phenomenologist assumes a pure, transcendental consciousness – a special realm of meaning in order to describe the world as it appears – as pure phenomena (Moran 2000: 78; Luft 2004:

207 & 224; Føllesdal 2006: 111; Giorgi 2009: 87-88). For scientific research Giorgi (2009: 90-91) recommends the assumption of phenomenological reduction, which is not as radical as the transcendental reduction. Two levels of reduction are emphasised (Giorgi 2009: 90-91):

- The research phenomenon is understood as something that is present to consciousness exactly as it is experienced by the participants. The researcher does not assume the existence of the object but considers it as a presence to be explored (Giorgi 2009: 90-91).
- The researcher brackets prior personal knowledge and assumptions about the phenomenon and adopts a standpoint of openness in order to prevent personal judgments and preconceptions from biasing the study (Giorgi 2009: 99-100; Flood 2010: 8-9).

b) Descriptions from others

Husserl was interested in understanding and describing the essential nature of consciousness from a first-person perspective (Zahavi 2003: 15). Such an approach is of particular importance for the phenomenological researcher seeking to understand what humans perceive to be real within their subjective experiences (Flood 2010: 8-9) – “their lived viewpoint of body, health, knowledge and existence” (Dahlberg *et al.* 2008: 42). The concrete descriptions regarding the phenomenon as experienced in real life in everyday language are the starting point of the inquiry (Finlay 2009: 10; Flood 2010: 10-11; Todres & Holloway 2010: 180). These descriptions given within the natural attitude, as it is lived, are referred to as the “raw data” (Giorgi 2009: 96).

c) Search for the invariant meaning

Through applying the eidetic reduction, the philosopher searches for and reduces the particular object to its essence (Giorgi 2009: 88) which is described without presuppositions. Giorgi (2009: 100) recommends that the researcher search for the eidetic invariant meanings when analyzing participants’ concrete experiences. This involves describing what is present as accurately as possible, including co-present absences which refer to horizontal aspects of the given that are not present but determinative of the essence as given (Giorgi 2009: 89).

In this study the researcher chose to hold in abeyance prior substantive theories (existing knowledge and conceptualization regarding IPV, the challenges it poses to nurses and the way nursing care should or should not be provided to survivors) that

might have biased the data collection and analysis. The researcher obtained concrete descriptions from emergency nurses regarding their lived experiences of taking care of survivors of IPV. The eidetic invariant meanings that belonged to the experience were determined through analyzing the concrete experiences. The researcher distinguished between the act and the object in the participants' descriptions in order to accurately identify the meaning of their experiences. The guidelines for emancipatory knowing were developed from the knowledge and insight gained on the phenomenon as a whole, as well as through the research process.

2.4 RESEARCH METHODOLOGY

The research was conducted in two phases:

- **Phase 1:** A phenomenological inquiry to explore and describe emergency nurses' experiences of taking care of survivors of IPV
- **Phase 2:** Development and validation of guidelines to facilitate the actualisation of emancipatory knowing in emergency nurses with regard to taking care of survivors of IPV.

The research methodology will be discussed according to these two research phases as followed in the study.

2.5 PHASE 1: PHENOMENOLOGICAL INQUIRY TO EXPLORE AND DESCRIBE EMERGENCY NURSES' EXPERIENCES OF TAKING CARE OF SURVIVORS OF IPV

In this section phase 1 is discussed according to the *research design, research method* and *trustworthiness of the findings*.

2.5.1 Research design

The term "research design" is used in different ways and some textbooks use the terms "research strategy", "traditions of inquiry" and "approaches" to refer to the same concept. In this study "research design" refers to the overall plan utilised to study the phenomenon of interest according to a systematic approach deemed suitable to address the research goal and question (Macnee & McCabe 2008: 195; Bowling 2009: 158; Holloway & Wheeler 2010: 42; Denzin & Lincoln 2011: 14).

Lacey (2010: 19-20) distinguishes clearly between qualitative and quantitative designs, indicating that the two designs are based on different philosophical assumptions and historical traditions. The assumptions underlying a qualitative research design as chosen for this study has already been discussed (2.2.2).

Within a qualitative research design the focus is on exploring the full nature of a phenomenon and on shedding light on the various ways in which the phenomenon manifests itself within the context of people's lives (Macnee & McCabe 2008: 28; Polit & Beck 2012: 18). The design is emergent, data is collected in a natural setting, data analysis establishes themes, and the report includes the voices of participants and reflexivity of the researcher (Creswell 2012: 44). Newell and Burnard (2011: 37) consider issues to be addressed best within a qualitative research design – for example, patients' and carers' experience of illness and care where the researcher is more interested in the participants' detailed stories. The area of interest in this study lies within emergency nurses' detailed representation of their lived experiences of taking care of survivors of IPV.

The characteristics of a qualitative research design according to Creswell (2012: 47-48) are discussed and applied to this study:

- **Emergent design:** The initial plan for the research can change or shift during the process; for example, the questions, individuals studied and sites. In this study emergency nurses from two different emergency units were selected and interviewed. The guidelines to actualise emancipatory knowing with regard to taking care of survivors of IPV were developed based on the meaning of their experiences as they emerged from the data analysis process.
- **Holistic account:** Qualitative research tends to report multiple perspectives or facets of the problem under study in order to develop an understanding of the complex whole. The researcher strove to create a holistic understanding of the phenomenon of providing care to survivors of IPV as experienced and perceived by emergency nurses.
- **Researcher as the research instrument:** Qualitative researchers collect and analyse data themselves. The data in this study was obtained through the use of in-depth interviews with emergency nurses conducted by the researcher.
- **Multiple methods:** Qualitative data is gathered through using more than one strategy such as interviews, observations and documents. As described by MacNee and McCabe (2008: 167): "the more we can know, feel, or understand about a variable of interest, the closer we will come to a full and complete meaning."

Interviews with participants and field notes were used in this study to ensure triangulation of data collection.

- **Complex reasoning through inductive and deductive logic:** In order to establish a comprehensive set of themes, the qualitative researcher uses an inductive process to analyse and categorise data into abstract units of information. The concrete descriptions of their experiences of taking care of survivors of IPV as obtained from emergency nurses were transformed into meanings that revealed the situation as it is for emergency nurses. From these meanings essential descriptions were compiled.
- **Participants' meaning:** In qualitative research the focus is on reflecting the meaning participants attach to the research phenomenon from their viewpoint in their own words and grounded in real life. The interviews and data analysis in this study were conducted in such a way that the findings reflect the meaning emergency nurses attribute to caring for survivors of IPV.

As summarised by Giorgi (2005: 80), "if you ask a qualitative question, which relates basically to the question: *what is it like to experience a particular phenomenon?* then you use a qualitative method."

2.5.2 Research method

As mentioned by Creswell (2012: 44 & 53), apart from choosing a qualitative design, the researcher needs to decide on a specific research approach towards inquiry that guides the data collection and analysis procedures. The research method is defined as the practices and techniques used to gather and analyse data in a systematic way (Carter & Little 2007: 1317 & 1325; Bowling 2009: 158; Holloway & Wheeler 2010: 340). Gough (2002: 5) explains that the word "method" comes from the Greek *hódos*, which means "the way", so a research method can be described as a "way of conducting a research inquiry".

Rapport and Wainwright (2006: 234) suggest that a phenomenological method is appropriate for nursing research seen in the light of nursing as an inter-subjective, interpersonal activity. This is even more so when concepts such as suffering are studied in relation to the nurse-patient relationship. In this study a phenomenological inquiry guided by a descriptive phenomenological method (Giorgi 2009) and reflective life-world research (Dahlberg *et al.* 2008) was regarded as the best way to explore the study phenomenon, which is interpersonal in its very nature. Applicable

suggestions from other research textbooks and scientific articles in line with descriptive phenomenological research were incorporated in the research method.

In general this research followed a process as outlined by Flood (2010: 10). From a position of pre-reflexive thought, the researcher obtained a description of a phenomenon of interest from emergency nurses as experienced in daily life. The researcher maintained an open attitude by bracketing her own pre-understanding of taking care of survivors of IPV in order to "see" the phenomenon as it appeared to the consciousness of the nurses (Dahlberg *et al.* 2008: 95-120). In order to understand how meaning is given to the experience of taking care of survivors of IPV (Flood 2010:10), the researcher employed the eidetic reduction and looked for the invariant structures - the unchangeable characteristics that are typical of the phenomenon (Giorgi 2009: 84-85). The findings reflect the essential characteristics of emergency nurses' experiences (Dahlberg *et al.* 2008: 242; Giorgi 2008: 3).

The discussion on how the phenomenological inquiry proceeded will focus on *assuming the phenomenological attitude*, the *researcher's role*, the *research setting*, the *selection of participants*, the *inclusion criteria*, *data collection*, *data analysis*, the *description of findings* and the *literature review*.

2.5.2.1 Assuming the phenomenological attitude

Assuming and maintaining a phenomenological attitude throughout a phenomenological inquiry is critical in order for the findings to be a true mirror image of the participants' experiences (Wall *et al.* 2004: 21; Hamill & Sinclair 2010: 20). The phenomenological attitude entails the application of a series of phenomenological reductions, which include the *époche*, and the eidetic reduction (Finlay 2011: 82). The eidetic reduction is a transition from the natural attitude (directed towards physical objects) to eidetic intuition (directed towards the essential characteristics of phenomena) (Føllesdal 2006: 109). The eidetic reduction is discussed in detail as part of data analysis (2.5.2.7a).

The *époche* emphasises two aspects of the reduction: the researcher goes beyond the natural scientific theories through bracketing all prior knowledge and withholds the positing of the reality of the state of affairs, rather focusing on the lifeworld as it presents itself (Wertz 2005: 168; Giorgi 2008: 3). Dahlberg *et al.* (2008: 129-130) use the term "bridling" to cover the concepts "bracketing" and "slowing of understanding" to see the object or event as something presenting itself.

In order to capture the essence of the meaning of taking care of survivors of IPV as experienced by emergency nurses, the researcher in this study attempted throughout the research process to assume a phenomenological attitude through bracketing and maintaining an open life-world approach, thus allowing the phenomenon of taking care of survivors of IPV to unfold itself.

Bracketing and *an open life-world approach* will be discussed as applied during the research process. An open life-world approach is discussed as part of the phenomenological attitude by Dahlberg *et al.* (2008: 96), but is also viewed as a result of bracketing (Todres & Holloway 2010: 181).

a) An open life-world approach

Dahlberg *et al.* (2008: 97) describe openness as a “way of being”, a discovering attitude marked by a “true willingness to listen, see and understand”. It requires respect, sensitivity and humility, thus allowing the phenomenon to reveal itself. The researcher needs to become immersed in the phenomenon and be present in the here and now. A researcher becoming too closely involved, though, runs the risk of losing openness and objectivity. The challenge is to simultaneously move between contradictory attitudes of scientific distance and openness (Dahlberg *et al.* 2008: 104-108, Finlay 2009: 13).

In this study the researcher maintained openness on the following levels:

- **Intersubjective openness** requires the researcher to keep in mind that the sharing in the research situation is not equal, as the focus is on participants’ experiences (Cope 2005: 179; Dahlberg *et al.* 2008: 114; Findlay 2009: 13). The researcher aimed to establish trust and communicate a level of nearness to participants in order to facilitate self-disclosure by participants.
- **Openness to the research question** requires the researcher to conduct the research process and the literature review in such a way that the research question is answered in full (Maso 1995, cited in Dahlberg *et al.* 2008: 100). The researcher answered the research question through exploring and describing emergency nurses’ experiences and used the literature to further illuminate the research question.
- **Openness to meaning** requires the researcher to describe the findings using words that will enhance understanding of the meaning of the phenomenon as a unique but also universal experience (Dahlberg *et al.* 2008: 115-119). The

researcher used participants' words to reflect the meaning of their lived experiences and tried to illuminate meanings that seemed to be universal as well as unique.

b) Bracketing

"Bracketing" refers to suspending all judgments and questions of truth or reality and past knowledge assumptions about the world's existence and nature. It is seen as a technique for assuring that phenomenological description of consciousness is not contaminated with prejudices (Higgs & Smith 2006: 56-57; Holloway & Wheeler 2010: 215; Todres & Holloway 2010: 181; Streubert & Carpenter 2011: 452).

In this study the researcher bracketed her personal past experiences, assumptions and knowledge regarding taking care of survivors of IPV in order for the lived experiences of emergency nurses to reveal itself (Giorgi 2009: 99-100; Holloway & Wheeler 2010: 220-1). As phenomenological reduction has an effect throughout all phases of the research process (Finlay 2009: 12; Hamill & Sinclair 2010: 20), the researcher implemented phenomenological reduction "*pre-action*", "*in action*" and "*on action*" (Dahlberg *et al.* 2008: 134-166; Wall *et al.* 2004: 24-28).

• Pre-action

Firstly, the researcher took time to adopt a scientific approach by bringing to mind her pre-understanding of taking care of survivors of IPV. Pre-understanding is described as pre-theoretical, non-critical, taken-for-granted knowledge in the form of personal beliefs, theories and assumptions that the researcher needs to keep in check and reflect on. Understanding how she is rooted in scientific paradigms – for example, psychological and medical models related to IPV – enabled the researcher to focus more critically on the phenomenon of interest (Dahlberg *et al.* 2008: 139-140, 159).

Secondly a debriefing interview (Onwuegbuzie, Leech & Collins 2008: 5-8) was conducted with the researcher. The researcher was interviewed by a psychiatric nursing specialist experienced in research interviews and qualitative research. The interview was audiotaped. The interviewer asked the researcher questions pertaining to possible areas of bias regarding for example the researcher's knowledge and perceptions of and experiences with IPV, the researcher's expectations with regard to possible study findings and the researcher's interviewing skills.

Thirdly the researcher used pre-reflection, which entails the making of notes prior to data collection (Ahern 1999: 408-409). The researcher made notes in a reflective journal regarding the cognitive, social and emotional aspects of her pre-understanding of taking care of survivors of IPV, as embedded in her own history as a psychiatric nurse and a woman. Pre-reflection bring these assumptions, presuppositions, preconceived meanings, prejudices, biases, experiences and beliefs into consciousness (Wall *et al.* 2004: 22 & 23; Dahlberg *et al.* 2008: 134, 144-145; Hamill & Sinclair 2010: 19-20). The researcher noted specific aspects of pre-understanding that required bracketing; for example, her knowledge of post-traumatic stress disorder and trauma counselling. She used visual imagery to visualise her theoretical knowledge and practical experience as being put aside, on hold or suspended (Wall *et al.* 2004: 24-25).

- **In action**

In action, self-awareness is essential for the researcher to stay aware of the significance of his/her own actions, behaviours and decisions and maintain contact with the phenomenon under investigation. In this study the researcher attempted to maintain a critical attitude by being conscious of her own meanings, experiences and perceptions related to taking care of survivors of IPV. During the interviews and data analysis the researcher turned consciousness towards herself in order to consider how her pre-understanding interfered or could interfere with the emerging phenomenon and consciously distanced herself by bracketing there and then (Dahlberg *et al.* 2008: 158-160, 164-165).

"Reflexivity" is defined as a conscious attempt by the researcher to acknowledge and analyse his/her role in and influence on the study. It includes critical self-reflection and an awareness of the effects of the interaction between the researcher and the participants and how the researcher's interpretations affect the findings (Moule & Goodman 2009: 174; Holloway & Wheeler 2010: 8, Topping 2010: 136). The following types of reflexivity were applied in this research, as recommended by Finlay (2002a: 213-224):

- **Introspection** – the researcher continuously did self-examination and set aside personal biases, assumptions and presuppositions about taking care of survivors of IPV in an effort to keep her own experiences as a psychiatric nurse separate from the lived experience as described by the participants.
- **Intersubjective reflection** – the researcher analysed the effects of her relationship with participants; for example, she felt empathy towards a specific

participant who had experienced IPV herself and also a sense of satisfaction with the way in which the participant had overcome her experiences.

- **Social critique** – the researcher remained aware of her social position as a lecturer and the positions of some participants; for example, one participant held a management position.
- **Discursive deconstruction** – the researcher wrote the findings in full awareness of the way her use of language could affect the findings; for example, at times she became aware of portraying participants in an empathetic or appreciative way.

Bracketing is often compared to empathetic awareness of “what it may be like” (Todres & Holloway 2010: 181). To obtain the phenomenological position it may be helpful to place oneself in the shoes of the participant and view the world as he/she does (Newell & Burnard 2011:114). Hamill and Sinclair (2010: 21-23) suggest the use of empathy to assist researchers with bracketing. Empathy is a therapeutic process of laying aside biases and judgments in order to focus on the experiences and perceptions of the client. Both bracketing and empathy aim to access internal (lived) experiences, require the interviewer to lay aside his/her own frame of reference and enter and reflect on the (life)world of the participant. The difference lies in the fact that empathy benefits the client, while bracketing benefits the researcher in reaching an understanding of the participant’s reality. In contrast with the therapist, the Husserlian researcher remains detached in order to enhance the rigour of the study.

The researcher maintained an empathetic approach during interviews by temporarily suspending what she thought she already knew about the experience of taking care of survivors of IPV. She empathetically entered into and reflected on the life-world of the participants (Finlay 2009: 13; Hamill & Sinclair 2010: 17). She utilised communication skills required for an empathetic attitude – such as reflection, open questioning and observation of non-verbal behaviour (2.5.2.6a) to enhance bracketing, but also to obtain data and understand the lifeworld of the participant.

- **On action**

The researcher reviewed methodological progression throughout the study phases and after each interview by reading through the transcripts and reflecting on the interview process to increase self-awareness. This also enabled the researcher to make methodological adjustments to enhance bracketing as she became aware of potential problems. For example, she asked a few leading questions during the first interview (Ahern 1999: 409; Wall *et al.* 26-27).

In addition to self-reflection, professional and scientific reflection, which took place during dialogue with peers, advisers and colleagues, also contributed to self-awareness (Dahlberg *et al.* 2008: 165-166). In this study supervisor review was obtained during frequent discussions after and throughout each study phase and in between interviews to review transcripts and provide feedback on the progress of the data collection and the meanings that already emerged from some of the interviews (Hamill & Sinclair 2010: 21).

A literature review was conducted after the data analysis to contribute to the depth of the findings and further illuminate the meanings of the constituents (Dahlberg *et al.* 2008: 272-273; Hamill & Sinclair 2010: 21).

2.5.2.2 Researcher's role

The phenomenological researcher's responsibilities are described as transformations, which are summarised below as applied to the study (Reinharz 1984: 78-79; Streubert & Carpenter 2011: 88):

- The researcher as the instrument for data collection must possess certain qualities, such as communication skills that will facilitate expression and sharing of experiences. The researcher as an advanced psychiatric nurse experienced in interviewing techniques, utilised verbal and non-verbal skills (see point 2.5.2.6a) to facilitate the expression of experiences during the interviews.
- The data is transformed into a description that lends understanding to the original experience. The description of the findings as reflected in Chapter 3 aims to reflect a clear understanding of participants' experiences.
- This understanding is then transformed into conceptual categories that capture the essences of the experience. Chapter 4 provides a literature review and a conceptualisation of each constituent derived from participants' descriptions.
- The written document should reflect the meaning as well as the richness of the experience. The richness of participants' experiences is reflected through direct quotations. The meaning of the experience is illuminated through the essence (Chapter 3.)

2.5.2.3 Research setting

The research setting is the location in which the study is conducted and can be natural, partially controlled or highly controlled (Burns & Grove 2011: 40). In qualitative research the research usually takes place in a natural setting (LoBiondo-Wood & Haber 2010: 91). The setting is selected according to its appropriateness to the research topic and where the phenomenon under study manifests itself strongly. "The message is: choose a location in which you can learn most about your topic." (Boeije 2010: 34)

In order to obtain access to emergency nurses in practice, emergency units of two public hospitals were selected as the setting for this study. The study was conducted among nurses providing care to survivors of IPV in emergency units in a Level 1 (district) and a Level 3 (academic) public hospital in the Tshwane region in Gauteng (one of the nine provinces of South Africa). These emergency nurses are frequently in contact with survivors of IPV as a result of referrals from police, social or legal services, or women who seek help themselves for injuries or health concerns related to IPV. The unit at the district public hospital deals with general medical emergencies while the other unit, at the academic public hospital, manages complicated emergencies and deals with seriously injured survivors requiring specialised medical care.

The setting was selected for the following reasons:

- Public hospitals deal with survivors of IPV through referrals from the social, legal and police services.
- Women exposed to IPV often end up in the emergency care unit to seek help for their injuries after exposure to IPV.
- Emergency nurses are at the frontline, having to provide emergency care for the acute medical problem, but also having the responsibility to provide holistic care in order to identify and address the not-so-obvious consequences and cause of the problem.

2.5.2.4 Selection of participants

In this study the target population referred to the entire group of persons from which the sample was taken (Macnee & McCabe 2008: 116; Procter, Allan & Lacey 2010: 143). The population consisted of all the emergency nurses providing care to survivors

of IPV in two emergency units in an academic and district public hospital in the Tshwane region (an urban area in Gauteng, one of the nine provinces of South Africa).

Purposive sampling is most commonly used in a phenomenological inquiry as it selects participants that will best help the researcher understand the problem based on their lived experiences of the phenomenon (Moule & Goodman 2009: 34; LoBiondo-Wood & Haber 2010: 105; Todres & Holloway 2010: 183). A purposive sample consists of study participants intentionally selected according to certain characteristics related to the purpose of the study or for the information they can provide about the specific phenomenon (Macnee & McCabe 2008: 121; Holloway & Wheeler 2010: 138; Procter, Allan & Lacey 2010: 149). In this study purposive sampling was used and study participants were selected from emergency nurses working in two emergency units, one in an academic and one in a district public hospital in the Tshwane region. In these units where emergency care is provided to survivors of IPV, emergency nurses were believed to have knowledge on the specific phenomenon. To ensure adequate exposure to the qualities of the phenomenon, participants who were willing to participate and indicated that they had been exposed to taking care of survivors of IPV, were selected.

As indicated by Holloway and Wheeler (2010: 145), there are no rigid rules in qualitative sampling but six to eight data units are seen as sufficient when the sample consists of a homogeneous group. Completion of data collection is signified by repetition of data on the applicable phenomenon (LoBiondo-Wood & Haber 2010: 92; Streubert & Carpenter 2011: 455). Nine female participants were interviewed to ensure sufficient insight was obtained at an in-depth level. Data repetition occurred after the seventh interview. Too large a sample can lead to sacrificing depth and thoughtfulness in the analysis, as the idea is to generate an in-depth understanding rather than to capturing a quantitative incidence of themes (Todres & Holloway 2010: 183)

2.5.2.5 Inclusion criteria

The inclusion criteria provide the boundaries for inclusion based on certain characteristics specified by the researcher and according to the aim of the study (Macnee & McCabe 2008: 134; Moule & Goodman 2009: 265; Holloway & Wheeler 2010: 138 & 144). Participants were selected based on the following inclusion criteria:

- Willingness to give informed consent and to disclose information regarding their lived experiences of caring for survivors of IPV;

- Emergency nurses working in emergency care units in an academic and a district hospital in the Tshwane region;
- Participants needing to have worked with survivors of IPV for at least one year before the commencement of this study to ensure that participants provided information on their experiences within a similar timeframe and context;
- Female gender seeing that the study focused on the experience of taking care of female survivors of IPV.

2.5.2.6 Data collection

Data collection was carried out using *unstructured phenomenological interviews* and *field notes*.

a) Unstructured phenomenological interviews

As the researcher seeks “as complete a description as possible of the experience a participant has lived through” (Giorgi 2009: 122), the interview is the main method of data collection in phenomenological research (Flood 2010: 11). Unstructured interviews are used to explore the experiences of participants in-depth through open-ended questions (Macnee & McCabe 2008: 168; Burns & Grove 2011: 85; Streubert & Carpenter 2011: 36) while the researcher’s focus is on understanding meaning (Tod 2010: 349). Expression of meanings opens the life-world of participants and leads to a deeper understanding of the phenomenon. The researcher’s task is to listen to the “voice of the life-world” and facilitate the telling of stories and the articulation of lived experiences (Dahlberg *et al.* 2008: 184-186).

Data in this study were collected using unstructured phenomenological interviews to allow emergency nurses to elaborate on their views, perceptions and opinions as relevant to them; as opposed to what the researcher assumed as relevant about the phenomenon under study (Holloway & Wheeler 2010: 89). Data collection will be discussed in terms of *preparing for the interviews* and *conducting the interviews*.

- **Preparing for the interviews**

The researcher needed to define the information required and to decide on the wording for questions so that it would make sense to the participants (Bowling 2009: 413, Polit & Beck 2012: 541). In a bracketed interview an initial broad open-ended question is asked to facilitate the expression of lived experiences without leading the

discussion (Tod 2010: 350; Newell & Burnard 2011: 78). The question the researcher decided to ask during the interviews in this study was:

What do you experience while/when taking care of survivors of IPV?

The researcher needed to arrange for a venue in a quiet and comfortable environment that provided for privacy and was easily accessible to participants (Tod 2010: 352; Polit & Beck 2012: 542). In this study the researcher arranged with the unit managers for her to carry out the interviews in a private room in the emergency units as it was not possible for participants to leave the unit while on duty.

The researcher introduced the study to potential participants at the two hospitals during their staff meetings. She did a short presentation on the study procedures and objectives and left a copy of the research proposal for potential participants to read. The researcher visited the hospitals again at times arranged with the respective unit managers. Emergency nurses who indicated willingness to be interviewed were seen by the researcher prior to the interview to prepare them, answer any questions they had about the study, and obtain informed consent.

Informed consent included an explanation of the purpose and procedures of the study; for example, that interviews would be recorded, assurance that data would be treated confidentially; and that participants had a choice to withdraw at any time. Potential participants who indicated at this stage that the topic was too sensitive, as one participant did, were not coerced in any way to participate but were instead provided with emotional support by the researcher. The researcher also made her aware of referral options if she would require further counselling.

Trust and rapport are prerequisites for a successful in-depth interview (Tod 2010: 353; Polit & Beck 2012: 542-543). Rapport in this study was established through showing real interest in the participants' views and being responsive to participants' emotions and body language. The researcher displayed confidence and had planned well for the interviews (Tod 2010: 353). The researcher not only maintained an attitude of openness as already discussed in point 2.5.2.1a , but also an empathetic and sensitive approach that offered a way to understand others.

- **Conducting the interview**

After the initial question was asked the researcher allowed participants to tell their stories: “.....how did it occur for you and what was it like for you?” (Todres & Holloway 2010: 183). As described by Cope (2005: 180), the researcher has to relinquish control to the participant during the interview in order to be open to the phenomenon. However, it is important to direct the participants towards their experience of the phenomenon of interest and not to lead them to say specific things the researcher thinks should belong in the data (Giorgi 2009: 123). During the interviews the main question was followed up by probing and follow-up questions, referring back to certain aspects of the interview requiring clarification and more detail (Bowling 2009: 414-415).

The researcher used the following suggestions provided by van Manen (1990: 64-65) to formulate follow-up questions focusing on the experience of taking care of survivors of IPV:

- Description of the experience from the inside, as it was, the feelings, the mood.
- Description of a particular example, incident or event related to the object of experience.
- Description of an example of the experience that stands out for its vividness.
- Description of sensory perceptions related to the experience – for example, sounds, smells, “how the body felt”.

The researcher attempted to understand the life-world of the participants. Although the researcher cannot directly experience what the participants experience and has no direct access to their emotions, the possibility to understand others and their experiences does exist because we belong to the same world (Dahlberg *et al.* 2008: 58-59). Finlay (2005) illuminated the concept of “reflexive embodied empathy” as a way for the researcher to understand research participants’ experiences and improve self-understanding. Finlay (2005) described Husserl’s views on empathy as a way of understanding the world; through experiencing another’s experience of the world through empathy, the world can be seen as objective and real. By placing oneself in another’s situation and sharing in that situation, one not only gains understanding of the experience of the other but also of the self.

The researcher used communication skills such as open questioning, reflection of feelings, eye contact, open posture and touch during the interviews to indicate a real interest in and understanding of the participants’ situation and experiences, which

were often of a sensitive and emotional nature. The following communication skills also ensured that participants expressed and explained their experiences in a clear and comprehensive way and provided rich descriptions of the research phenomenon:

- **Minimal verbal responses** to indicate that the researcher was listening (Newell & Burnard 2011: 78).
- **Clarification** to validate understanding of the meaning of participants' expressions (Guion, Diehl & McDonald 2011:1). Examples of clarification include: "I wonder about...?" "I don't understand...?"
- **Paraphrasing** cognitive statements or themes verbalised to confirm the meaning of the received message (Guion *et al.* 2011: 2), for example: "You mentioned that you often encounter seriously injured patients."
- **Reflection** of feelings inherent in the message to gain a greater understanding of the message and its meaning (Guion *et al.* 2011: 2), for example: "You feel sad about what happened to you..."
- **Probing** using open-ended questions to gradually explore certain issues, feelings and sensitive topics in order to reach a deeper understanding and explicate meaning (LoBiondo-Wood & Haber 2010: 582). Examples of open-ended questions the researcher used: "What is it like...?" "Tell me more about...?" "Can you give me an example...?"
- **Summarising** the last statements of the participant to encourage more talk and clarify understanding (Holloway & Wheeler 2010: 92).
- **Encouraging, contradicting and challenging** statements were also used to clarify meaning and obtain richer descriptions (Hamill & Sinclair 2010: 21-22)
- **Non-verbal prompts** such as eye contact, leaning forward and listening skills (Holloway & Wheeler 2010: 93).

The interviews lasted between 45 and 60 minutes per participant; interviews were terminated when participants indicated that they had exhausted their descriptions. The interviews were audiotaped with the permission of the participants.

As described in Bowling (2009: 411-412), it is important to thank participants for their valuable input and bring them back to a positive frame of mind at the end of the interview. The researcher allowed enough time for participants to work through the emotional content during the middle phase of the interviews. Two participants who started crying during the interviews were provided with emotional support by the researcher. Both indicated that they did not require referral as they had already undergone psychotherapy.

b) Field notes

The researcher made field notes during the interview sessions. Usually the researcher makes field notes on observations about people, places and things that are part of the study (LoBiondo-Wood & Haber 2010: 272; Streubert & Carpenter 2011: 453). Field notes are broad, analytical and interpretative and illustrate how the researcher recorded, synthesised and understood the data (Polit & Beck 2012: 548).

The next section consists of a discussion of *observational, methodological, theoretical*, (Polit & Beck 2012: 548-550) and *reflective notes* (Polit & Beck 2012: 495) as used in the study. Examples of the researcher's field notes are included in text boxes.

- **Observational notes**

Observational notes are made on the research context, actions and events (Polit & Beck 2012: 548). Non-verbal behaviour such as eye contact, posture, tone of voice, gestures and crying were recorded during the phenomenological interviews (Macnee & McCabe 2008: 168).

Interview 1: Participant appeared calm, self-assured, made eye-contact and talked spontaneously. She used gestures to indicate emotional experiences like covering her eyes with her hands. She seemed to have a need to talk and share.

Interview 4: The participant was friendly, soft-spoken and calm, appeared unsure, then shared spontaneously. I could see the pain and tears in her eyes when she shared a personal experience. She courageously overcame the trauma she was exposed to.

Interview 7: A dedicated, caring and compassionate nurse. Freely provided information, comfortable, relaxed and open. Very much in contact with herself and her emotions.

- **Methodological notes**

Methodological notes reflect the researcher's thoughts about strategies and methods used in the research that were effective and others that were less effective and needed to be changed or revised (Polit & Beck 2012: 549). The researcher made notes on the techniques used during the interviews to reflect on the skills used; for example, questions that were more or less effective. She reflected on methodological

problems that occurred during the research, as well as on the process of data analysis and the literature review.

Interview 1: I listened at first, then summarised and reflected on her experiences. At times she deflected from the topic, but I didn't stop her as I sensed her need to talk. I must not be afraid of deeper experiences, but stay with the feeling, the perception. I must refrain from asking too many questions and stay with the theme – I will get enough data – have trust in the process!

Interview 8: I had to give her time to talk about her personal experiences. I showed empathy and reflected on her pain. I might have focused more on her personal experiences than on the research question – keep the focus on the experience, ask about the experiences – the feelings, the sensations.

- **Theoretical notes**

Theoretical notes contain meanings attached to certain observations made during the interviews. These notes serve as a starting point for data analysis (Polit & Beck 2012: 549). The researcher made notes on, for example, experiences that more than one participant mentioned and professional experiences that seemed to be related to the participants' personal experiences.

Interview 1: Personal experiences lie just under the surface and get triggered by certain professional experiences that have a deeper meaning for the nurse – in this case the senselessness of the violence. Also when the woman seems to be powerless and helpless. Put herself in the shoes of the woman and think that it might have been her daughter in a similar situation.

Interview 9: She felt shocked by the violence she witnessed. A young person, never exposed to IPV in her family and community, she compared her personal experiences with what she witnessed in the unit. She expressed her disappointment in relationships turning out so destructive.

- **Reflective notes**

Reflective notes are often used in phenomenological research to facilitate phenomenological reduction (Kumar 2012: 797; Polit & Beck 2012: 495). Personal notes are usually kept separate from other field notes and recorded as a journal (Polit & Beck 2012: 549). In this journal the qualitative researcher records personal

reflections, ideas, feelings or responses that emerge during data collection (Watson, Booth & Whyte 2010: 387).

A reflective journal was used in this study as recommended by Ahern (1999). The researcher clarified any personal values and identified areas in which she might have been biased or experienced possible role conflict. At times the researcher found herself engaging in a therapeutic way with participants. When she realised this, she changed the questioning to focus on the research phenomenon, and discussed therapeutic referral options at the end of the interview with the participants. The researcher also identified any feelings that might have indicated a lack of neutrality (for example, sadness about certain participants' experiences).

Interview 1: I felt anxious as it was the first interview. Stressed that I will not get sufficient data. Had to wait long in the unit before the staff were ready to accommodate me. I attended the morning-prayer with them. The counsellor read from the Bible and prayed with them. I was touched by the way he encouraged them for the day's work.

Interview 7: I found it difficult to get through to her and her experiences. I felt a bit lost at times. She had this "trust thing". I even tried to help her with her personal experiences of not being able to talk to her family about sensitive issues. I think I sensed her feelings of helplessness.

2.5.2.7 Data analysis

Data analysis reduces, structures, organises and gives meaning to data (Burns & Grove 2011: 52; Polit & Beck 2012: 556). Qualitative data analysis requires the researcher to understand, synthesise, conceptualise and reconceptualise descriptions of feelings, experiences, behaviours and ideas (Macnee & McCabe 2008: 70).

The analysis in a phenomenological study differs from the procedures used in other qualitative research. A descriptive phenomenological analysis requires the researcher to focus on the meaning of the phenomenon. The researcher needs to dwell with the data for as long as necessary in order to reach a clear understanding and accurate description of the essential structure of the phenomenon that illuminate both the commonalities and uniqueness of participants' lived experiences (Dahlberg *et al.* 2008: 231; Holloway & Wheeler 2010: 223; Todres & Holloway 2010: 184).

In this discussion the *eidetic reduction* and the concept of *essences* will be clarified; followed by a detailed description of *descriptive analysis* as followed in the study.

a) Eidetic reduction

The eidetic reduction represents the transition from the natural attitude, directed towards empirical investigation of particular concrete objects to the eidetic attitude, directed towards discovering the essential characteristics (Føllesdal 2006: 110 & 112). The researcher has to intuit ("be present to") all the concrete manifestations of the phenomenon in order to "see" and describe the essential characteristics (Giorgi 2009: 77). Intuition is realised through critical reflection about universal experiences shared by participants and an effort to understand "what it must be like" in such a way that the researcher feels as if "he or she had personally lived the participants' experience" (Kumar 2012: 798).

b) Essences

An essence is a structure of essential meanings that explicates a phenomenon of interest as that very phenomenon. Essences already belong to the everyday world (lifeworld) and are uncovered in the intentional relationship between the researcher and the phenomenon. Phenomena, concretely experienced or imagined, can take various forms. The essence represents the unity that remains throughout the multiplicity of free variations – the invariant that sets the boundaries. If the essential meaning changes in a certain way, the phenomenon is a different phenomenon. Essences are open, infinite and expandable and never completely explored and described as meaning changes in relation to events of the life-world (Dahlberg *et al.* 2008: 245-252).

c) Descriptive analysis

Descriptive analysis (Dahlberg *et al.* 2008: 232-256; Giorgi 2009: 125-137) works with lifeworld descriptions obtained from participants. The experience of taking care of survivors of IPV in the context of the emergency unit is like other lifeworld phenomena, "complex, relational and embedded in the flesh of the world". In order to understand such a complex phenomenon it has to be broken down at some stage into parts whose meanings are clarified and ordered. The process, however, entails not only analysis but also synthesis: the parts are always understood within the context of the whole (the lifeworld) and the whole in terms of its parts (Dahlberg *et al.* 2008:

233). This process represents a spiral of thought, open at the beginning and end to allow for new horizons of meaning to evolve (Dahlberg *et al.* 2008: 236- 237).

The descriptive analysis will be described under the following headings: *Preparation of data; the initial whole; phenomenological parts; and searching for an essence of the phenomenon – a new whole.*

- **Preparation of data**

All data including audiotaped interviews and field notes were organised and prepared. Interviews were transcribed by the researcher, including all verbal and non-verbal information. Field notes were typed. An empty column was left at the side of each page, as well as an open segment at the bottom (Dahlberg *et al.* 2008: 234-235).

- **The initial whole**

The researcher made herself familiar with the research data by reading through the entire description a number of times to obtain a general sense of the whole of the participants' experiences (Giorgi 2009: 128). This reading was done within the phenomenological reduction (Dahlberg *et al.* 2008: 238-239; Giorgi 2009: 128). (See point 2.5.2.1.)

- **Phenomenological parts**

The researcher's attention during this step was focused towards the parts of the data that began to emerge (Dahlberg *et al.* 2008: 243) and entailed two steps.

First the researcher divided the data into smaller segments, described as meaning units. As recommended by Giorgi (2009: 130), the units were divided by making an appropriate note in the margin every time the researcher experienced a significant shift in the meaning. These meaning units highlighted different participants' experiences but together formed the whole of the experience of emergency nurses taking care of survivors of IPV. The researcher maintained openness in order not to impose a meaning other than the meanings expressed by the participants (Dahlberg *et al.* 2008: 243; Flood 2010: 13).

Second the meaning units that seemed to belong together were clustered together. These clusters of meaning were not discussed as part of the study findings, as this

intermediate step is done in phenomenological analysis to help the researcher grasp the essential meanings and structures (Dahlberg *et al.* 2008: 244). (See Addendum G for an example of how the meaning units were clustered together.)

- **Searching for an essence of the phenomenon – a new whole**

The data were again treated as a whole, but with a broader understanding than before. The phenomenon was now understood in terms of its essence – the features that are essential for that phenomenon to present itself to consciousness as that very phenomenon. In order to reach an understanding of the essential meaning of providing care to survivors of IPV, and the structure of these meanings, the researcher followed a process called “free imaginative variation”, which was aided by “interrogating” the data (Dahlberg *et al.* 2008: 245).

In order to explore and illuminate the hidden meanings, their patterns and eventually the essence of the phenomenon, the researcher needs to interrogate the data. Questions central to the research question and/or objectives of the study are asked (Dahlberg *et al.* 2008: 252-253; Giorgi 2009: 131).

The researcher interrogated the data and meaning units in relation to the phenomenon of taking care of survivors of IPV in an emergency unit. The following are examples of questions that led the researcher towards discovering the essence: What is said about the experience of providing care to survivors of IPV? How is it said? What is the content of the experience? What is the meaning of the experience?

By using free imaginative variation, the researcher followed the concrete experiences obtained from emergency nurses and reflected about the different possibilities of the meaning of their experiences of taking care of survivors of IPV. To determine the essential aspects, the researcher mentally removed an aspect of the phenomenon in order to see if the removal transformed what was presented in an essential way. The removal of an essential aspect changed the phenomenon in a radical way, while a feature that hardly changed what was presented when varied was considered not essential (Giorgi 2007: 64; 2009: 69-70, 84).

Free imaginative variation helped the researcher to distinguish between partial and total fulfilment of meaning. Consciousness seeks total fulfilment of meaning – that is the most invariant sense that the meaning unit offers in contributing to the total structure of the phenomenon being researched. The invariant sense reflects all the

critical aspects (constituents) of the meaning unit (Giorgi 2009: 132-137). The researcher determined the most invariant constituents of the experience; the constituents that are truly essential for the phenomenon to present itself to consciousness. If the structure would collapse if a potential constituent were removed, the constituent was identified as essential (Giorgi 2009: 166, 199-200).

2.5.2.8 Description of findings

This step incorporated the synthesis and integration of the meaning units of all the data into a final consistent description of the structure under study (De Castro 2003: 55).

The structure consists of a description of the essentials of the phenomenon and its constituents – “the meanings that constitute the actual essence”. In this study the essence was described at a more abstract level, followed by an in-depth description of the constituents in relation to the essence, reflecting all its nuances to the most concrete level as quoted in participants’ words. This was done in the present tense, as the phenomenon *is* (Dahlberg *et al.* 2008: 255-256). The structure reflects the lived experiences of emergency nurses – it depicts *how* the provision of care to survivors of IPV is lived, so it includes “experiential and conscious moments” (Giorgi 2009: 166 & 200).

The lived meanings are described eidetically – as a general structure and in principle applicable to more individuals than the participant(s) on which they were based (Giorgi 2009: 166). The general structure goes beyond the concrete experiences. Generalisation of results is thus a possibility in phenomenological research, to be considered for each phenomenon and each study. The results are always contextual but the meanings are infinite (Dahlberg *et al.* 2008: 255-256).

To summarise: The researcher searched for the essence, the most invariant structure of the meaning of taking care of survivors of IPV as presented in the concrete life-world descriptions of emergency nurses. Meanings emerged to form a pattern made up of differences and similarities. Meanings were described in relation to other meanings as they simultaneously form a background for each other. The whole structure was explicated – essential parts and concrete events. In this way the reader can judge how far and in what way research results can be generalised (Dahlberg *et al.* 2008: 251-252).

2.5.2.9 Literature review

The applicable literature was incorporated in the findings to create an improved understanding of the essence and its constituents. The inclusion of literature was conducted in accordance with a descriptive phenomenological approach (Dahlberg *et al.* 2008: 272-273): meanings present in the data were more clearly revealed to consciousness through explicating them in terms of related theories and research findings.

2.5.3 Trustworthiness of the findings

In phenomenological research the trustworthiness of the findings is reflected in the way “the researcher engages with the analysis as a faithful witness to the accounts in the data”. The researcher needs to be honest about his/her own perspective, pre-existing thoughts and beliefs. The acknowledgement and setting aside of prior knowledge and assumptions, known as “bracketing”, enables the researcher to focus on the participants’ experiences with an open attitude (Starks & Trinidad 2007: 1376).

Reflexive practices employed in ensuring trustworthiness include consulting with colleagues and mentors and writing notes throughout the research process. The researcher’s reflexive notes on research decisions and data analysis also help to establish an audit trail. The reader of the research report can judge trustworthiness of the findings with the researcher’s perspective in mind (Starks & Trinidad 2007: 1376).

Another way of establishing credibility of the findings is to judge the way in which the researcher supported findings with evidence from the interviews and a convincing explanation (Starks & Trinidad 2007: 1376).

Trustworthiness of the study findings was ensured through *bracketing*, *reflexivity* and the *eidetic reduction*.

2.5.3.1 Bracketing

Three phases of bracketing are distinguished. The researcher’s theoretical orientation and research question help to determine the application of these phases and the type of bracketing. The three phases of bracketing include *abstract formulation*, *research praxis*, and *reintegration* (Gearing 2004: 1432).

a) Abstract formulation

The first phase of bracketing entails a clear statement of the research orientation and theoretical framework (Gearing 2004: 1432). In this research the bracketing was guided by a phenomenological philosophical framework.

b) Research praxis

Research praxis includes five fundamental elements: *foundational focus*, *internal and external suppositions*, *temporal structure*, and *parenthesis (boundary) composition* (Gearing 2004: 1433).

- The **foundational focus** of bracketing refers to setting aside presuppositions about a phenomenon and focussing on the essence of the phenomenon (Gearing, 2004: 1433). In this research the implementation of bracketing has been described in point 2.5.2.1b. The researcher bracketed her knowledge and experiences with regard to IPV and provision of care to survivors of IPV in order to ensure that the findings clearly reflect the essence of the participants' experiences of the research phenomenon.
- **Internal and external suppositions** refer to what should be bracketed out: internal supposition refers to personal knowledge and history and external supposition to research literature available on the phenomenon (Gearing, 2004: 1434). The researcher was interviewed by a psychiatric nursing specialist to help her acknowledge and bracket her personal history and knowledge related to provision of care to survivors of IPV. The researcher as a psychiatric nursing specialist had to put aside the therapeutic models she knows and utilises to assist clients who have been exposed to trauma. She needed to view the care provided to survivors of IPV from emergency nurses' perspectives.
- **Temporal structure** refers to the starting point, duration and end point of bracketing (Gearing, 2004: 1434). Bracketing in this research started before data collection with the bracketing interview and was phased out as the findings were explicated in terms of related theories and research findings in Chapter 4.
- **Parenthesis** describes the nature of the boundaries: How rigid, porous or specific are the bracketing boundaries? (Gearing 2004: 1434). In line with phenomenological philosophy the researcher attempted to maintain the bracketing

boundaries in a rigid way to ensure that the research findings were presented free of bias and her own assumptions. She noted her own feelings and engaged in discussions with the study supervisors to distinguish between her own feelings, perceptions and beliefs and those of the participants.

- **Reintegration**, the final phase of bracketing, entails “un-bracketing” and reintegration of the findings into the study context (Gearing 2004: 1434). The findings of this study were reintegrated in the study context and discussed in terms of current theories in Chapter 4.

2.5.3.2 Reflexivity

Before bracketing can be performed, the researcher needs to become aware of what needs to be bracketed by engaging in reflexive analysis (Finlay 2002b: 536). “Reflexivity can be defined as thoughtful, conscious self-awareness. Reflexive analysis in research encompasses continual evaluation of subjective responses, inter-subjective dynamics, and the research process itself.” (Finlay 2002b: 532) Reflexivity requires “immediate, continuing, dynamic, and subjective self-awareness” (Finlay 2002b: 533).

The researcher stays aware of “experiencing a world and moves back and forth in a kind of dialectic between experience and awareness” (Finlay 2002b: 533). The phenomenological researcher reflexively interrogates his/her subjectivity.

Reflexivity can be limited to the researcher’s acknowledgment of the existence of research bias, but can also involve the researcher’s consistent engagement in analysing and reflecting on his/her self-awareness during the research process: *pre-research stage*, *data collection stage* and *data analysis stage* (Finlay 2002b: 536-539). The reflective notes at the end of this section summarises the researcher’s own experiences and thoughts aimed at obtaining trustworthy unbiased findings.

- In the **pre-research stage** the reflection and reflexive analysis should start with the researcher reflecting on the study topic and his/her relationship to that topic. The researcher already approaches the research phenomenon “with openness and wonder” (Finlay 2002b: 536). In this study the researcher examined her motivations, assumptions, and interests in the research while examining both the existing literature and the problem itself in order to clarify the research question.

- During the **data collection stage** the researcher applied reflexive analysis by writing field notes after each interview. She noted her own feelings of sadness as she felt touched by some participants' experiences. Her experience as a psychiatric nurse helped her to empathise with participants but to distinguish between her own feelings and participants' experiences. The researcher also admired some participants for their caring abilities but had to refrain from expecting the same qualities and abilities in all participants.
- During the **data analysis stage** the researcher felt overwhelmed by the data and struggled to make sense of all the different experiences. She felt tempted to apply her psychiatric nursing knowledge and interpret the experiences in terms of psychological theories. Through reflecting on her own frustration she realised that she had to place herself in the participant's position, asking herself what the experience *meant for the participant*. As the meanings evolved and took shape, the researcher realised the importance of reflexivity.

Reflective notes: The study made me aware of the suffering some women have to endure. All women are at risk for IPV. Women in therapeutic and healing professions not only suffer through their own experiences of IPV, but are also exposed to vicarious traumatisation as they have to deal with survivors' experiences. Without support they are vulnerable to emotional distress. Their own experiences play a role in the provision of care to survivors of IPV.

I needed to constantly remind myself to allow the participants' experiences to evolve. What helped me was to treat the interviews as a therapeutic conversation – the participant's frame of reference was of the utmost importance, my own frame of reference was not relevant when analysing data – I listened to, reflected on and summarised the transcribed conversation as if the participant was present.

2.5.3.3 Eidetic reduction

Validity in phenomenological research is described by Giorgi (2009: 133; 2012: n.p) in terms of "fulfillment of meaning". The researcher searches for the "object" (that can be real or "irreal" for example ideas, images and memories (Giorgi 2009: 67)) that will satisfy the meaning of the experience which is empty. When the researcher finds an "object" it may or may not fulfill what started the search for the meaning. If the "object" fulfills the meaning completely it is called identification. Identification equals

validity because the fulfillment satisfies precisely the meaning that started off the search. If the identifying acts could be performed consistently, *reliability* is achieved. At first the search for meaning is a signifying act, then a possibly fulfilling act, then an act of identification.

- **Validity** of this study's findings was achieved through applying the eidetic reduction to search for the essential characteristics of participants' experiences. The researcher used imaginative variation to discover the essence of emergency nurses' experiences. The essence reflects the essential meaning that remains throughout the multiplicity of variations – the invariant that sets the boundaries of the meaning of the experience.
- **Reliability** is reflected in the essence that precisely and consistently fulfils the meaning of all the participants' experiences of taking care of survivors of IPV.

Giorgi (2008: 5-6) states it clearly that participants should not be used for verification purposes in phenomenological research. Participants describe experiences from the perspective of the natural attitude, whereas phenomenological data analysis is conducted from the perspective of the phenomenological attitude. The findings should reflect the disciplinary perspective from which the study was conducted. The focus is on the meaning of the experience, something the participant might not have considered.

In this study the researcher utilised her experience and knowledge as an advanced psychiatric nurse and therapist to conceptualise the findings in terms of applicable psychological theories.

2.6 PHASE 2: DEVELOPMENT AND VALIDATION OF GUIDELINES TO FACILITATE THE ACTUALISATION OF EMANCIPATORY KNOWING IN EMERGENCY NURSES WITH REGARD TO TAKING CARE OF SURVIVORS OF IPV

The process of guideline development will be discussed in terms of *development of guidelines*, *validation of guidelines*, and *validity of the guidelines*.

2.6.1 Development of guidelines

Guidelines are advisory statements developed in a systematic way to assist practitioner and patient decisions with the aim of improving quality of care (WHO 2003: 1; Graham & Harrison 2005: 68; Bowker *et al.* 2008: 1; Krahn & Naglie 2008: 436). Guidelines can improve both the process and outcomes of care (Graham & Harrison 2005: 68). The guidelines described in the literature consist mostly of evidence-based guidelines that are developed from systematic reviews to link healthcare to the best evidence available (Atkinson 2008: 8; Browman 2010: 1-2; Lum, Rapuano & Coleman 2011: 1015; Rosenfeld, Shiffman & Robertson 2013: S3-S4). Clinical guidelines are recommendations to support the practitioner with clinical decision making (Bowker *et al.* 2008: 8).

The guidelines in this study were developed as a guide to facilitate the actualisation of emancipatory knowing in praxis (Chinn & Kramer 2011: 2) – a nursing practice that will reflect emergency nurses’ engagement in undoing social inequities and injustices in the provision of care to survivors of IPV. The guidelines are linked to a body of evidence through the literature review reflected in Chapter 4. Although the focus is on facilitating emancipatory knowing in emergency nurses, the end goal is to improve the quality of care to survivors of IPV based on independent clinical decision making.

2.6.1.1 Methodology of guideline development

The guidelines were developed in accordance with the following process:

The draft guidelines were developed by the researcher in accordance with and guided by the following: findings of the study (Chapter 3), discussion of findings and literature review (Chapter 4), guiding attributes in the guideline-development process (2.6.1.1a), and dimensions of emancipatory knowing in nursing (2.6.1.1b).

a) Guiding attributes in the guideline-development process

Guiding attributes set for ideal guidelines (Institute of Medicine 1990: 59; Tan 2006: 197-199; Institute of Medicine 2011: 214-228) guided the researcher throughout the development process to ensure that the guidelines meet these requirements. The attributes of validity, reproducibility, reliability, applicability, flexibility, clarity, were applied during guideline development. See Chapter 5, 5.2.1 for a detailed discussion and application of the guiding attributes. A representative process was followed through the inclusion of the target group’s (emergency nurses’) experiences in the guidelines. It is recommended that the guidelines be reviewed after implementation in

practice. The process of developing the guidelines, the evidence used, assumptions made and participants involved in guideline validation were documented in Chapters 5 and 6.

b) Guideline development in terms of dimensions of emancipatory knowing in nursing

In the light of the findings that revealed the tacit injustices inherent in emergency nurses' experiences of providing care to survivors of IPV (Chapter 5, 5.2.4), guidelines were formulated in terms of the dimensions of emancipatory knowing in nursing (Chinn & Kramer 2011).

Fundamental patterns of knowing in nursing were developed by Carper (1978) to include empirical, personal, ethical and aesthetic knowing (Carper 1999:12). Chinn and Kramer (2008: 78) developed a fifth pattern of knowing – emancipatory knowing – defined as “the capacity not only to notice injustices in a social order, but also to critically examine why injustices seem to go unnoticed or remain invisible, and to identify social and structural changes that are required to right social and institutional wrongs.”

With emancipatory knowing comes an awareness of how unjust situations are maintained through certain social constructs; an awareness that is effected in praxis (Chinn & Kramer 2011: 64-65). Nursing praxis refers to nursing practice that reflects nurses' engagement in undoing social inequities in the healthcare environment (Chinn & Kramer 2011: 2). In the context of this study emancipatory knowing focuses on guidelines to facilitate the actualisation of emancipatory knowing in emergency nurses: (1) define and clarify how the interrelation between IPV-related experiences in the professional domain and personal domain can put emergency nurses' in a disadvantaged position; and (2) open ways to challenge this position and take corrective action (Chinn & Kramer 2011: 66-7).

The draft guidelines were presented in terms of the dimensions of knowledge development according to different patterns of knowing described by Chinn and Kramer (2011). Each pattern of knowing is characterised by processes located within five dimensions that include: (1) critical questions that initiate and generate knowing and knowledge; (2) creative processes that initiate and generate knowing and knowledge; (3) formal practice expressions of knowledge and knowing; (4) integrated practice expressions of knowledge and knowing; and (5) authentication processes

used to examine and improve knowledge (Chinn & Kramer 2011: 3). In Chapter 5 each dimension is discussed briefly, followed by the applicable guideline(s), rationale and actions.

2.6.2 Validation of guidelines

Consensus methods seek expert opinion and aim to establish an area of common agreement. Consensus methods are mostly utilised when the evidence base in a specific area is insufficient. Three consensus methods are used in research. These are the Delphi technique, the nominal group technique and the consensus technique (Moule & Goodman 2009: 230).

In consensus methods the expectation is that participants freely and independently propose their views on the key issues or practices regarding the phenomenon under investigation. Through discussion and debate, understanding of the phenomenon is broadened. Processes such as prioritising and consolidation are used to establish areas of the greatest consensus (Ager, Boothby & Wessells 2007: 124-125).

The Delphi technique was used in this study to validate the draft guidelines. The Delphi technique is a systematic procedure used to achieve consensus among a panel of experts (Keeney 2010: 228) in an area where there is lack of empirical evidence (Powell 2003: 381). As it does not require the experts to meet physically, international experts (Okoli & Pawlowski 2004: 18) representing diverse groups can be used (Powell 2003: 381). Expert opinions, predictions and/or judgments are requested by the use of a series of questionnaires on a particular subject. Subsequent questionnaires are developed based on the results of the previous questionnaire. The process stops when consensus is reached that the research question has been (Skulmoski, Hartman & Krahn 2007: 2; Cuhls 2009: 96).

In this study an e-Delphi (Keeney 2010: 232) was utilised to obtain input per e-mail from experts in the field of gender-based violence, emancipation and emergency nursing on the guidelines. The guidelines cover aspects of diverse fields, namely emancipatory knowing in nursing, emergency nursing and IPV; and is unique in a sense that it cannot be compared with similar guidelines in the literature. The researcher obtained the input of experts from the USA, UK, Canada and South Africa to ensure validity and reliability of the guidelines and to refine the guidelines in terms of clarity, flexibility and applicability.

The Delphi technique is discussed in accordance with the method followed: *selection of participants; inclusion criteria, Delphi Round 1 and Delphi Round 2 (including data collection and analysis)*. The ethical considerations are covered in Chapter 1.

2.6.2.1 Selection of participants

According to Keeney (2010: 229), purposive sampling is used when the researcher wants a sample of experts in a Delphi survey. Delphi studies recruit individuals who are perceived to have expertise in and knowledge of the subject under investigation (Keeney, Hasson & McKenna 2011: 7), which McKenna (1994: 1221) defines as “a panel of informed individuals”. Experts should be chosen for their work and credibility in the appropriate area. In the clinical field they may include expert clinicians, researchers and patients/lay people who have experienced the effects of the phenomenon under investigation (Powell 2003: 379).

In this study the researcher selected participants from experts in the field of gender-based violence, emergency nursing and emancipation from academic institutions and the public and private health sectors. A list of potential participants was developed and participants were purposively selected.

The size of the sample depends on the purpose of the research, design and time frame. Keeney (2010: 229) cited different authors recommending sample sizes that ranged from a minimum of seven to several hundred. The representativeness of the sample depends on the qualities of the expert panel rather than on the numbers (Powell 2003: 378). In general the literature suggests 10 to 18 experts on the panel (Okoli & Pawlowski 2004: 19). In this study the researcher selected and invited 17 potential participants in accordance with the inclusion criteria. Thirteen of these potential participants responded and participated in the Delphi.

2.6.2.2 Inclusion criteria

Participants were selected based on the following inclusion criteria:

- Participants interested and knowledgeable about the topic; and
- Participants involved in the identified fields.

Participants’ interest and involvement were determined through either conducting research (must have published work on the topic), teaching or being actively employed in the study field at the time of the study.

2.6.2.3 Delphi Round 1

a) Data-collection method and instrument

The participants, selected according to the inclusion criteria, were contacted by e-mail. A cover letter explaining the objectives of the Delphi and the conditions of participation was attached. Participants were given a deadline to indicate their willingness to respond; whereafter the instrument to validate the guidelines, a cover letter including instructions, deadlines, study objectives, summary of the findings and informed consent leaflets were e-mailed to them.

The instrument consisted of nine guidelines based on the findings of the first phase of the study as well as the actions for each guideline. Participants were requested to rate each guideline and its actions with regard to the criteria of reliability, validity, applicability, clarity and flexibility. The response choices were based on a four-point Likert-type scale to measure levels of agreement (Stitt-Gohdes & Crews 2004: 63; Jones & Rattray 2010: 376). Keeney (2010: 230) indicates that the first round questionnaire usually consists of unstructured, open-ended questions, but as the guidelines in this study were already developed based on the research findings, participants were asked for comments/suggestions at the end of each guideline.

b) Data analysis

The researcher screened, analysed and collated participants' responses as described by Stitt-Gohdes and Crews (2004: 62) in a table format according to the levels of agreement using the Likert scale (Chapter 6, Table 4). Qualitative analysis of the recommendations/suggestions was done and these themes were summarised (Chapter 6, Table 5). The feedback provided the basis on which the guidelines for the second round were adapted.

2.6.2.4 Delphi Round 2

a) Data collection method and instrument

Participants from Round 1 were contacted again by e-mail with a cover letter to explain the objectives of Round 2 and the conditions of participation. Participants were given a deadline to indicate their willingness to respond; whereafter the adapted

guidelines with a cover letter including instructions and deadlines were e-mailed to them.

In the first section of the instrument a summary of findings from Round 1 was presented according to identified themes. Participants were requested to indicate their agreement or disagreement with the findings and re-rank their responses according to the Likert scale if they preferred (Okoli & Pawlowski 2004: 19).

b) Data analysis

Data were analysed and collated in the same way as for Round 1. Consensus (Keeney, Hasson & McKenna 2011: 3-5) was reached on the final guidelines. The findings of Round 2 were utilised to finalise the guidelines.

2.6.3 Validity of the guidelines

Participants were chosen from different settings and geographical areas in order to enhance the credibility and acceptability of the policy guidelines. Two participants were from the USA, three from the UK, one from Canada and seven from South Africa.

The guidelines were based on the findings of the first phase of the study, the research objectives and the feedback of the expert panel who participated in the Delphi. The expert panel reviewed the guidelines for validity, reliability, clarity and flexibility.

The response choices in a Delphi are often rated on a 4-point Likert-type scale (Rayens & Hahn 2000: 309). Keeney (2010: 230) indicates that the first round questionnaire is usually unstructured, open-ended questions to increase the richness of data collected on the topic under investigation. In this study the instrument used to evaluate the guidelines allowed for both recommendations/suggestions and level of agreement responses (Addendum I).

To ensure credibility of the Delphi itself, a clear decision trail should be evident in the research report as suggested by Powell (2003: 380). In this study the decision trail to defend the appropriateness of the method is described in point 2.6.2. The way in which the expert panel was selected is described in points 2.6.2.1 and 2.6.2.2 and the data collection method in 2.6.2.3a and 2.6.2.4a. The consensus levels are set out in Chapter 6, Table 4.

2.7 SUMMARY

The paradigmatic perspective, philosophical framework in accordance with a phenomenological approach and research methodology were discussed in the chapter. The research methodology reflected the two research phases followed in this study. Chapter 3 addresses the findings of the phenomenological inquiry in a descriptive format

CHAPTER 3: DESCRIPTION OF FINDINGS

3.1 INTRODUCTION

In the previous chapter the paradigmatic perspective, philosophical framework and research methodology were discussed in detail. The findings of the phenomenological analysis of the in-depth interviews will be described in this chapter.

The aim of the first phase of the study was to provide a phenomenological description of the essence of emergency nurses' experiences of taking care of survivors of IPV. Interviews were conducted in December 2010 with nine female emergency nurses from two public hospitals in the Tshwane region. They were all willing to share their experiences and had worked with survivors of IPV for at least one year before the commencement of this study. The nurses interviewed were all in full-time employment at the emergency units of the two public hospitals. Their ages varied between 25 and 50 years.

Before the interviews the researcher met with the participants to inform them about the aim of the study and to obtain informed consent. The participants were asked the central question: "What do you experience while/when taking care of survivors of intimate partner violence?" The interviews lasted between 45 to 90 minutes and were conducted over a period of one month. The interviews were audiotaped and transcribed by the researcher. The field notes recorded during the interviews were typed out.

The data were analysed according to a phenomenological descriptive analysis method described by Dahlberg *et al.* (2008: 231-276) and Giorgi (2009: 125-137). The analysis method is summarised briefly to ensure clarity: The first step entailed reading through the data to become familiar with the whole. The data were divided into meaning units, which were underlined and noted in the margin. The meaning units were clustered together and highlighted with different colours, as they seemed to belong together. The researcher used free imaginative variation to grasp the essential meaning of the research phenomenon (emergency nurses' experiences of providing care to survivors of IPV). It involved mentally removing an aspect of the phenomenon in order to see if the removal transforms what was presented in an essential way. If the phenomenon was changed in a radical way by mentally removing an aspect of the phenomenon, the aspect was regarded as essential. A feature that hardly changed what was presented was regarded as not essential. By questioning the data, the

constituents or particulars that constitute the essence emerged. The findings represent the whole structure of emergency nurses' experiences of taking care of survivors of IPV. The structure consists of a presentation of the essence on an abstract level followed by an in-depth description of the constituents – the meanings that constitute the essence. The range of nuances of meanings attached to the phenomenon are reflected in the description of the constituents and illustrated with quotes from the interviews – expressed in the voices of the participants.

The **essence** of emergency nurses' experiences of taking care of survivors of IPV will be presented followed by a description of the **constituents** of the essence. The terms "participant" and "emergency nurse" will be used interchangeably in the chapter. Direct quotations from the interviews are indicated in italics. Words in bold indicate the researcher's own emphasis.

3.2 FINDINGS

In **essence** the care that is provided to a survivor of IPV is guided by the emergency nurse's frame of reference, which is informed by personal assumptions related to IPV and the nurses' professional and caring qualities. The nurse's frame of reference is shaped through an interrelation between professional and personal domain experiences (mostly with, but not limited to IPV) and emergency nurses' attempts to cope with and make meaning of these experiences.

Professional domain experiences refer to a mutual process where the emergency nurse provides care to the survivor of IPV, but is at the same time exposed to the survivor's experience with IPV. This exposure has an emotional and cognitive impact on emergency nurses. The emotional impact is felt in response to being a witness to the survivor's emotional and physical suffering in relation to the phenomenon of IPV. The cognitive impact is experienced as certain thoughts, mostly with regard to the survivor, emerge. These thoughts are of a troubling and lingering nature and include concerns for the survivor; longstanding, recurrent and intrusive memories; and disturbing mental images.

Emergency nurses' professional domain experiences interrelate with their personal domain experiences. Personal domain experiences include emergency nurses' experiences with IPV and other gender-based violence at a personal, family, social and community level. Identification with the survivor's experience reveals itself when certain elements in the survivor's experience reflect with a similar situation that

occurred, or has the potential to occur, in the emergency nurse's personal domain. Professional and personal domain experiences and the emergency nurse's attempts to cope with the exposure to survivors' experiences and make meaning out of IPV shape the emergency nurse's frame of reference. The shaping manifests itself in the formation of gender perceptions and assumptions related to IPV.

The provision of care to survivors of IPV focuses on three interventions: physical care, mostly in relation to the injuries sustained; emotional care, which reflects different ways of approaching and supporting the survivor; and referral to other multi-professional team members. The implementation of the last two interventions relies to a great extent on two factors: firstly the emergency nurse's ability to identify and overcome barriers to disclosure of IPV, and secondly the frame of reference from which the emergency nurse operates. This frame of reference is based on the emergency nurse's gender perceptions and assumptions related to IPV and the provision of care to survivors of IPV. It is shaped by experiences with IPV in the personal and professional domain, the interrelation between these two experiences and the emergency nurse's professional and caring qualities. Altruism that originates from professional or personal considerations provides the driving force behind the provision of care to survivors of IPV.

Figure 1 provides a framework of the essence of the findings and the different constituents based on the researcher's own conceptualisation.

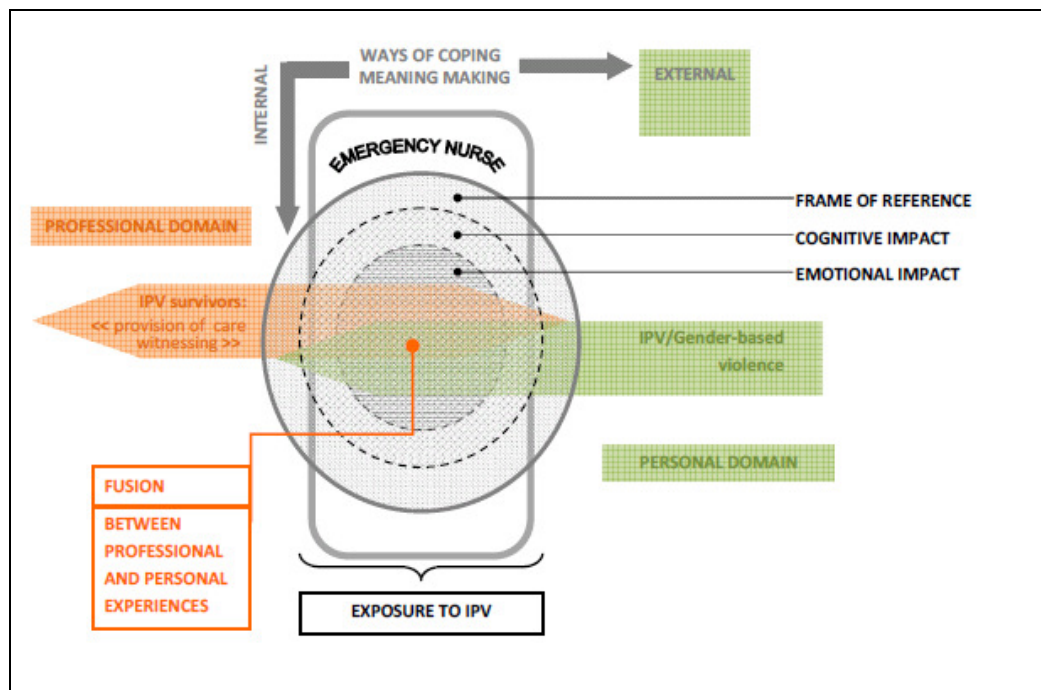


Figure 1: Framework of findings

3.2.1 Emotional impact related to being a witness to survivors' experiences of IPV

Emergency nurses are witnesses to the effects of IPV; they are not only observers to the injuries and the consequences of these, but also the emotional effects survivors experience – for example: fear, sadness and helplessness. They often have to listen to survivors narrating the events surrounding IPV; and sometimes they see the dynamics of an intimate relationship characterised by violence playing out before their eyes. Witnessing is reflected in one participant's summary at the end of the interview: *Those are the things we see and hear and experience.*

Emergency nurses cannot look away; they have to face the effects of IPV, no matter how bad it is to see the injuries: the bruises or a fracture of the arm. Some participants spontaneously described the serious injuries they witnessed: *...she was terribly injured. The mouth was torn from this part up until here* (points to her face), *even from the nose. And when we asked her what did the boyfriend use she just said he used his arms like this* (shows the action), *and it was very, very bad.* To be a witness to the physical scars left by IPV is a terrible experience: *...she was assaulted, her body ... you know could just see that she was tormented...; ...he assaulted her, badly...; ...it was terrible.* While describing the injuries, the emergency nurses expressed the associated emotions they experienced, for example: *...sometimes I used to cry, even when I looked at them ... it's very sad....* Contrary to the previous statement, the reference to the serious injuries in the next quotation is devoid of all emotion: *I do talk to them but then sometimes, others, you find that the person is unconscious, then you will find she had been chopped with an axe, ya then it would be difficult.*

It is emotionally painful to encounter the often devastating consequences of IPV such as a survivor left with a disability: *...she was injured on the right eye, and the eye... they've said the eye's going to be totally blind. It was very painful for me to see....* Witnessing disabling and disfiguring injuries inflicted by IPV and hearing about the preceding traumatic events (even in an indirect way from colleagues) leave a feeling of horror, emotional pain and concern for the victim. These experiences sometimes affect all the staff in the unit: *...she was burned by her boyfriend ... it was so horrible.... Everybody was talking about it, you could see their faces ... and it was so painful. I didn't even go to the ward to see the patient because that lady she changed over the face, was burnt over the face ... the whole day it was that girl ... we kept on*

asking ... *how is she doing...?* This quotation also illustrates how the participant avoided the witnessing of the disfiguring injuries she anticipated.

IPV ending fatally seems to be especially disturbing: *...the thing that affects me mostly is when the woman came abused being beaten almost every day; and that poor lady is bleeding inside ... when the patient came in here she dies, she dies ... it affects me very badly. I can even take a week or two weeks not being myself when I think of that poor lady ... she's gone in a terrible way....*

Emergency nurses find it difficult to reconcile the terrible injuries they witness with love and being humane: *I mean a normal living person can't do this to his partner especially if he loves the partner... they come with terrible injuries....* The encounter with the betrayal inherent in IPV, loving and causing harm at the same time, is something emergency nurses reflect upon: *...but the fact that the person who assaults you is the one who said: I love you...; ...you think that person has been injured by somebody that she trusted....* Sometimes emergency nurses are witnesses to the dynamics of an intimate relationship characterised by ambivalence – for example, when the perpetrator accompanies the woman to the emergency unit and acts in a caring and concerned way: *...her husband cut her face you could see into the sinuses and he was hovering around the bed, and he looked like he was a really caring partner and he just wanted to know if she was OK....* This ambivalence exposes itself to emergency nurses when the perpetrator responds in a caring way to the person he has just injured: *...the only way we could calm her down was when we called him in to talk to her....; After X-ray then they come together holding hands ... now we are confused; ...that was very shocking. I mean we would never have thought that he would be the one that did this to her face. And then the police came and took him away and we were very shocked....* Unable to comprehend the discrepancies they are confronted with, participants described it as a metamorphosis: *(the person) that she loved ... now that person turned to be a monster. Now he changed, now he is abusing her, physically or emotionally....* and: *...all of a sudden he has changed his mind and decided to do the bad things....* Participants expressed the feelings accompanying these confusing experiences as *so sad, touching and very painful.*

It is just as painful to listen to a survivor telling the story of the IPV: *...after that patient told me about the story it affected me a lot.* Sometimes the survivor reveals the IPV for the first time in the emergency unit. This is an emotional experience with revelations that can shock the listener: *...the one that touches the most is ... a deep victim ... who has travelled for some years.... If she talks about it, it's very emotional*

... when she's telling you what's happening ... some things really, you don't expect them, but they do happen. When you hear it for the first time it's like a shock

Emergency nurses are also witnesses to the emotional suffering such as the fear observed by this participant: *...you just see through their faces they have got that fear of explaining and for me as a woman, as a nurse, it is painful anyway to see that kind of a person, she is scared to talk....* To observe another human being's emotional pain, requires sensitivity and understanding and elicits an emotional response. In this quote the emergency nurse conveys her understanding of the unfairness of the survivor's situation: *...she was **crying** hysterically because that she just couldn't understand that she does everything that a wife has to do, everything by the book, but she still gets abused;* and the emergency nurses experienced the sadness herself: *It **saddened** me....* The phenomenon of feeling the survivor's feelings and the emotional burden associated with that is evident in the next excerpt from an interview: *You feel like crying as well ... you can feel this is too much really... people are experiencing serious feelings.... You feel, you feel what she is feeling, it's very hurtful ... sometimes you can even cry....* Sometimes emergency nurses *go home with that feeling and will be so emotional* about what they witnessed and what the survivor endures: *...after she has left it will just kill me alone....*

Witnessing the survivor's suffering elicited emotional responses described as (emotional) pain, hurt or being touched (at an emotional level) and were further elaborated on as sadness (crying), depression, fear (it's so scary), stress, horror, shock, sympathy for the survivor and anger towards the perpetrator: *...it affects me very deeply because sometimes I used to cry alone...; ...most of the time I feel sad, I feel sad ... it's very painful; it's very stressing, very depressing ... So when I see things like that sometimes I feel that its heavy for me....* The witnessing can also have a traumatising effect as summarised by this participant: *Some abuse ... honestly, whether you have been a nurse for some time, they are very traumatic....* The emotions can linger long after witnessing the incident and even have an effect on the participant's family: *...because they are not going to get my full attention I used to give them, because I will be sad most of the time and my kids expect me to be with them, my husband expects me to chat with him and whatever we used to do he expect those things to continue....*

An emotional response that stood out was sympathy for the survivor on the one hand and anger towards the perpetrator on the other.

To see the physical and emotional suffering and to hear what the woman went through triggers a feeling of sympathy: *You feel for the person ... it's very, very emotional ... they will be crying ... the lady we had, she was from another country. She had no one to talk to – only her husband who brought her to South Africa to come and abuse her here; ...and then the poor woman, you feel sorry for the poor woman...; ... there are no relatives and what you see ... it was terrible. I felt bad for that woman....* The previous quotations depict the woman as a victim characterised by vulnerability, helplessness and powerlessness: *And I see her as vulnerable now, she can't even talk the language you see ... and for a woman who's helpless, who can't even talk for herself...* The vulnerability of the survivor is more evident in some scenarios for example, a woman with a baby: *...especially if you see somebody with a baby, you feel for them. Its not like you feel the pain that she's having when she was beaten or something, but you just feel sorry for them, it just hurts you somewhere; ... looking at the baby like that – she is four months – the mother is crying, holding the baby like this, and bruises on the face – that's painful.*

Related to the feeling of sympathy for the woman is the anger towards the perpetrator – the one *who has done this to his wife or his girlfriend* and the one *who is victimising the person*. As expressed by one participant: *...when I look at the man ... that hatred and that anger towards that person....* The anger energises (empowers) this participant to act on behalf of the survivor and ensure that she receives help (as will also be illustrated in 3.2.7): *...then I become very wild ... Just don't be in my way... the husband really shouldn't come into my way... I really had to advocate.* The anger (and frustration in this case) also relates to the perpetrator's lack of compassion: *...frustrated and anger also, why is this man ... can't he see that this woman is going through hell....* Contrary to the abovementioned quotations is the absence of anger in one participant's responses. It is as if the shock numbed this participant's emotional response: *I don't think I have ever been angry at the other person, I think shock more takes over, mm... I think maybe there is this moment of being cross with – why? And that is kind of where it stops* (laughs).

In addition to the emotional impact emergency nurses experience in relation to witnessing survivors' experiences with IPV, the exposure to survivors' experiences with IPV also has a cognitive impact. The nature of the cognitive impact is illuminated in the next constituent.

3.2.2 Cognitive impact related to being exposed to survivors' experiences of IPV

The cognitive impact is characterised by thoughts of a troubling and lingering nature and includes concerns for the survivor; longstanding, recurrent and intrusive memories; and disturbing mental images.

Some of the participants related how they are left with troubling and lingering thoughts about the survivor. These thoughts can linger after the emergency nurse has gone off duty; for example: *...when I arrive at home ... I used to remember it especially for that day when I worked with that patient, even when I am at home, I can still remember I got that patient....* The troubling nature of the thoughts reflects a concern for the survivor, lingering with the emergency nurse like *something that's pressing on my chest* and when coming on duty the next day *the first thing that I want to know, I will check where my patient ended up*. The concern doesn't end there as the survivor's stay in the emergency unit is short lived, leaving the emergency nurse with endless unresolved questions: *...is she coping, how did she sleep, how is the situation at home...? I kept asking myself what's going to happen when she gets there, what is she going to do, pack her bags and leave? The boyfriend is he going to say: 'I'm sorry?'* The concern for the woman's well-being is also voiced in this participant's thoughts: *...she might commit suicide ... you don't know what's in her mind. When she goes out she might think it's over*. An attempt to resolve the concerns is expressed: *I wish I could do follow ups...* and: *...sometimes I wish I could call that person to check how is she doing....*

Certain scenarios tend to raise emergency nurses' concerns more than others. From the interviews three examples can be mentioned. The first is the idea that the survivor is exposed to the IPV repeatedly: *And you think maybe it wasn't the first time, it wasn't the second or third time, it's a thing that is happening almost every time....* The second is the thought of young women being exposed to IPV: *...it was not the first time that her husband assaulted her... she was a young girl ... I mean she was 22 years old, she still has a long way to go, so it was very painful ... She even had a child of six months old – a little girl*. The third concern is about survivors with babies: *What about the little baby that she had?* and: *You don't know what will happen tomorrow, is she going to grow up with both parents...?*

The emergency nurses' concerns sometimes interrelate with their own experiences, for example, a participant who remembers her exposure to gender-based violence (a

near-rape experience during which she was assaulted) when she is exposed to survivors' experiences with IPV. She struggled to reveal the experience to her family as she felt *responsible for what happened*. Later in the interview she described how she worries when she suspects that the survivor is going through a similar experience: *Is she getting that support from the family? Or is the family blaming the person ... sometimes people say: 'If you listened to us' ... sometimes I think maybe everybody is blaming her, so maybe she's getting the support from the family, maybe, maybe....* The following example illustrates how an emergency nurse worries about and even puts herself (**am I**) in the position of the survivor: *Is she scared to go back home to face whatever? What's going to happen tonight? ... **Am I** going to be chased away to the street...?*

The experience with survivors of IPV can become a lingering memory that stays with the emergency nurse, such as the aforementioned case that is still recalled in detail after four years: *It was early morning like this ... She even said to me: 'This is every time when it happens, I always say I am going to pack my bags and leave but this time I seriously mean what I am saying.'... She is one of the patients I cannot forget.* The next quotation illustrates how an unresolved case can lead to ongoing concerns: *Cause when they leave the hospital they say they are going to the police: 'I am going to pack my bags.', but you don't know if they are going to do that. So some of them you keep asking yourself....* Why some cases are experienced as more significant and remembered is difficult to explain: *Not all cases get stuck in your head ... but there are some cases, you know you keep on recalling them: that woman, that patient, what is happening with her?* Participants' narratives of some of these lasting impressions reflected the powerlessness felt by the participant: *...I couldn't even examine her. I tried to speak to her like at least 'wait here until in the morning; we will take care of you', but she couldn't, she was crying like she needs to go home, to be with her family. I do understand but for that night going back to that house what is going to happen when she gets there?... I don't know....* The next quotation shed some light on why some cases are *lingering a bit* as it reflects the nurse's struggle to understand the ambivalence inherent in IPV: *I couldn't understand why she still continues to care so much....*

Participants' memories are sometimes triggered by other similar cases: *When somebody comes beaten up like that I always remember her: 'this time I had enough';* or just surface, especially when you are alone it keeps on coming ... *that vision, it comes back.* What has been experienced during the day: *...the injuries that I have seen ... the moments that I did see the patient... sometimes surface again: that*

vision, it comes back when everything is quiet and the emergency nurse is alone with her thoughts: *The moment you are alone it comes back....*

Some experiences lead to the construction of vivid mental images of the IPV as it happened: *...I just visualise that moment when the man was beating her up and begging him to stop....* These images are sometimes constructed from survivors' narratives as *they explain to you: 'This is what happened';* or triggered *especially when you see the bruises, the injuries.* One of the participants related how she visualized the act of a young woman being set on fire by her partner after being told by her colleagues about the case: *...you can imagine that and see that girl running around ... what happened to this young girl ... you know what came to my mind: It was like I can just see that girl, somebody pouring the petrol on her like that, and she was screaming and he even had a nerve ... like when she was screaming, rolling maybe on the ground, burning like that ... up to 90% ... it is so bad ... so bad....* Just how upsetting and disturbing these mental images can be is illustrated in this quotation: *Just imagine abusing someone who's powerless, who doesn't do anything. If it is a beating up you keep on beating her up and she's also begging you to stop, I mean ... it's so painful, it's so sad.*

Some cases are easier to *put aside* and *don't get stuck in your mind, the minor cases, especially.* These "minor cases" were described as survivors *...having their own stuff - domestic. So at least when you see them they will be telling jokes and screaming.* Seemingly not taken seriously by the survivors, happening repeatedly, and related to alcohol misuse, these instances of IPV don't have such a lasting effect on emergency nurses: *...now we are used to that because they are happening over and over: 'I'm from the shebeen, when I was on my way to the flat blah blah ... then they attack me'.*

While thinking about survivors' experiences, emergency nurses may identify with some of these experiences, as will be described in the next constituent.

3.2.3 Identification with IPV survivors' experiences

Emergency nurses described different ways in which they identify with the experiences of survivors of IPV. Identification reveals itself in descriptions suggesting that certain elements in the survivor's experience reflect with a similar situation that occurred, or has the potential to occur, in the emergency nurse's personal domain.

Identification with the survivor's situation is evident in, for example, the way in which this participant explained the *unacceptable* reason why a survivor *got beaten up*, as if

it had happened to her: *...this is just condoms that ended up in **my** handbag because they got issued at work ... It saddened me.* The same participant expressed strong feelings against IPV in the beginning of the interview: *Oh I feel strongly about it; its one thing I cannot take...* Reference to the survivor's experiences as if experienced in the first person revealed itself in more than one interview, for example: *So you really ask yourself: what's in the mind of the very same person, the man **you** tell **yourself**: this is the man that **I** am supposed to be intimate with, but if a man can afford to beat **you** to a pulp, **you** ask **yourself** why? ...the abuse starts as a simple thing ... when you see that this is becoming intense, that's where a person should make a serious decision: **this is not what I want**.* Identification is also illustrated in this quotation where a participant tells the following to a survivor: *You must think about people who love **me**, who understand **me**, even when **I** did something wrong, who will say to **me** it's OK, it's not the end of the world.* The quotation points to the participant's past experiences when she feared that people would blame her after she was exposed to a near-rape experience.

Identification manifests itself firstly as empathetic feelings – feeling with the survivor – and secondly as an awareness that the survivor's experiences reflect with one's own past and potential future experiences.

Empathy expressed by participants as being *emotionally in their shoes for that time* originated for some participants from a realisation that as women, they, or their daughters, are vulnerable to IPV and can find themselves in a situation similar to that of the survivors: *...when I see this patient I also see myself like this patient one day ... and you think of yourself one day looking like that. As a woman it is painful and you keep asking yourself some questions.* In these questions emergency nurses reflect on how they would feel and act, would they be in a similar situation as the survivor: *What if I was in the same situation ... what if it is was me, and I was experiencing something like that ... **how will I feel**...; ...what if it was my daughter how was I going to feel? ...how was **I going to handle** the situation...; ...If I get beaten to this extent, seriously, will I still continue with this person? I was thinking: Would I stay? Would I be willing to still mm... devote myself to this man who has ruined my life?* Considering the likelihood of being in a similar position as the survivor is suggestive of an empathetic process but does not necessarily include all the levels of empathy: *Mm, I don't think that I want to put myself in their shoes to see it from their perspective ... the only reason why I think about putting me in that position ... just think what it would be to experience such kind of violence ... what if this was me...?*

Identification with the situation sometimes includes the survivor's family: *...you ask yourself: Where are the relatives; what are they feeling?* The following excerpts illustrate the way the participant identified with the relatives: (1) seeing the relatives' pain: *...you can just see their faces...;* (2) imagining what it feels like based on the premise that it could have been the participant's experience: *If it was me, I mean; I can just feel for this girl. I didn't even know this girl, what if I knew her, or it was my own daughter?;* (3) feeling the emotion: *...you put yourself in the family's shoes and feel the pain ... We do experience those emotional hurts that you even wipe your tears – this is so painful.* The stronger the participant's identification with the situation, the more intense the feelings: *Sometimes if you go deeper in these things, you picture it was your daughter ... you could even cry.*

The way in which identification with the survivor interrelates with the care provided is illustrated in the following quote: *...when I nurse this patient – sometimes I used to put myself in this patient's shoes and try to give her all the care that she needs, and thinking that, even myself, I am a woman....*

For participants who were exposed to IPV and gender-based violence in their personal domains, the survivor's experience is close to home. One participant explained: *...some of the situations reflect what I experienced when I was a child...;* and *...every time I saw a patient being assaulted by men ... it comes again.* Also called "flashbacks", the recollection of one's own traumatic experiences that occur while caring for a survivor can cause considerable discomfort: *...now after some years it's still not easy ... that day will be very long for me....* Flashbacks are accompanied by mental images: *...you see the picture of what happened to you then...;* unpleasant feelings: *Sometimes I feel like crying ... I become angry* and disruptive thoughts: *...so when I think about that situation ah... it kills me....* Related to the work environment, this emergency nurse is often confronted with potential triggers: *Most of the time we receive people that have been violated in one way or another. We receive them day in and day out. It does affect me but when I arrive at home, you see that everything comes back ... she (the survivor) is just going the same road that I went...* The last quotation illustrates how the memories often recur after the day's work, as also described in 3.2.2.

The emergency nurse's own experiences can provide a basis for understanding and responding to the survivor's feelings: *...with the anger I normally see I was also like this. I was very angry after the situation ... then I said to myself: 'That's why this person is so angry, I understand.', then I will leave the patient, give her maybe space*

to rest a little bit. Sometimes I understand it's not because she is angry with me, she is angry about the situation. When the emergency nurse's and the survivor's experiences become intertwined, it can, however, become confusing and bring unresolved/repressed issues/doubts into the fore: ...I said to her: 'You know what, it's not your fault what happened.'; at the same time when I explained to her... it comes back ... the words I say hit me back: 'Who am I? What about me...?'

The exposure to survivors' experiences contributed to participants *feeling scared of getting into the same situation: You are afraid it's gonna happen to you, even if it's not gonna happen to you it could happen to your sisters or... somebody close to you ... you are worried about that really ... this thing could happen....* One participant rationalised the fear: *...that's probably fear of the unknown....* For other participants the fear (and concern) pertains to their daughters: *...one day they will be women and then they will have partners - that's what I am thinking about, what kind of partners will they get when they grow up...? and: I even fear for my daughters....*

The realisation that the potential for IPV exists in all intimate relationships is expressed in this quotation: *...realising this is why it's so important when you make decisions when it comes to choosing a life partner....* Moreover seeing that *there's so many cases where you hear about a nurse that got shot by her husband or abused by her husband*, one participant gives serious consideration not to *make the wrong choice* when choosing a life partner. The participant proceeds to explain how a person (and indirectly herself) can protect yourself (herself) against future IPV: *...even if you don't want to listen to other people's opinion about the person you are involved with ... even though it hurts ... you should regard their warnings and as hard and as difficult as it can be you should distance yourself then from the feelings you have towards this person mm... that's blinding you. Try to see what these other people are seeing in this person that they would feel like they need to warn you, and mm... not only follow your heart like you do in a situation of falling in love (laugh) with the wrong person.* Observing survivors' situations leads to emergency nurses becoming more aware of potential triggers to IPV: *...most of the cases were where the other partner was under the influence of alcohol ... so maybe being a bit more ... I won't say scared ... careful when it comes to people using alcohol or the possibility of alcohol abuse....*

The next two quotations illustrate how her professional experiences with IPV made a participant more suspicious in her own relationship:

...you start to be too observant and sometimes only to find that the partner is not in that mind. But you also suspect each and everything; some other things he did, did it unintentionally but because of that thing in your mind ... you start to be suspicious of each and everything he is doing....

...we learn through these things, if they can happen to other people they can also happen to me – you start to observe him for each and every little thing that he is doing ... the behaviour, the way that he is talking ... the attitude, each and everything....

Identification with survivors' experiences is not the only way in which emergency nurses' personal domain experiences interrelate with survivors' experiences, as will be described under the next constituent.

3.2.4 Interrelation between IPV-related personal and professional domain experiences

Caring for survivors of IPV inevitably interrelates with emergency nurses' experiences with IPV and other gender-based violence on a personal, family, social and community level (personal domain experiences). Personal domain experiences (or the lack of them) do not concretely belong to the process of providing care to survivors of IPV. However, personal domain experiences, together with professional experiences, shape emergency nurses' gender perceptions and frame of reference, which guides the way care is provided to survivors of IPV.

During the interviews participants spontaneously revealed their own experiences with IPV and gender-based violence as it relates to and informs the provision of care to survivors of IPV. Participants who were exposed to physical IPV in their personal lives described it as an experience with an emotional impact as illustrated in this quotation: *I have experienced being beaten once ... It's not a nice experience; it's bad, an emotional thing....* Another participant described it as going *through hell: ...when we start it was OK but then as time goes on hell broke loose ... so that husband started to be, abusive or jealous, I don't know ... so I have been through hell, but then I am up on my feet.*

One of the emergency nurses related a very significant childhood experience of exposure to gender-based violence: *He pointed the gun at me and said: 'you know what, you go' then I tried to scream but people were passing, nobody was*

interested.... He grabbed my arm ... at the gate I refused to go in and he took a brick and hit me on my legs ... he took the gun and said we must walk inside. She was saved when someone heard her screaming: ...they were fighting with him; that's when I managed to go.... The thought that she was nearly raped (...though he hit me but he didn't rape me ... going to his home, that's what he wanted...) left her with a burden of self-blame, fear and anger: It was a heavy burden on my shoulder... I was so scared. How would I tell my parents ... I feel like responsible for what happened ... every time I looked in my wardrobe and saw those clothes (clothes that she wore on that day), the anger started again.

Related to the emotional impact personal domain experiences are remembered (*I will never forget*) and cognitively and emotionally relived: *...but the pain, even now, it just keeps on coming ... you keep on reminding yourself what happened.* Experiencing flashbacks was narrated by participants as a long-term consequence of exposure to violence. Years after the incident, one participant still experiences flashbacks: *...I am still not relieved, because this year in June that thing came again and plays like a videotape in my head ... He (the perpetrator) was dark he had a scar here (points to her face). When I see people with the scars huh! I become angry....* Flashbacks (*...it's like a flash, it just comes back...*) are triggered by witnessing IPV or the effects of it in the professional or personal domain: *...I see other people being affected here, I just remember ... even here or wherever or maybe at home there's violence or maybe a friend is telling about the violence, I just remember of it ... it does come back, most of the time....*

Interrelation between personal and professional domain experiences occurs as care is provided to a survivor of IPV. For example, while thinking about the survivor's response to IPV: *I am just asking myself if that person will be able to deal with this crisis, with her crisis...*, the participant considers in relation to her personal frame of reference whether the survivor will: *commit suicide like my husband* or show the ability to *stand on her own, take care of this life and for the kids also*, which was exactly what she herself did. The following excerpts further illustrate how this participant attempts to understand survivors' entrapment in IPV based on her own experiences: *I am also a victim ... you can find that they (some survivors) are unemployed. I was lucky because I was employed ... I did have money ... but some of them you will find they are from a rural area they don't even understand what you are talking about and they depend on these men. and: ...once you are in it's not easy to be out ... even if kids are there ... when you want to get divorced there's no money... I can afford it but that one can't afford it because of the circumstances, so she has to*

stay and there is no back up. The relatives when things are bad, the friends, they just walk away from you. It's up to you.

Talking about caring for survivors of IPV during the interviews related for some participants to their own exposure to emotional abuse in intimate relationships. Emotional abuse was described by participants in terms of a partner's threatening remarks: *...he is abusing you ... you are always reminded: 'If you carry on like that I will be leaving you.'*, dishonesty: *...the relationship I am in now is just fine, but previously, oh, emotionally, people who lie to you, dishonesty...* and controlling behaviour: *When I find myself in a situation where I am coerced into something just because you want me to do I ... I don't want to be controlled.*

Feelings such as inferiority (*as if you are desperate*) and resentment (*I don't take kindly to such things*), which are instilled by emotional abuse (*like a person make you feel*), can lead to reconsidering the meaning of a relationship: *...so what makes you stay in a relationship like that...?* or terminating the relationship: *Its either he understands me, or he just leaves me; life has to go on because I can't spend the rest of my life in that situation.* An encounter with emotional abuse leaves its mark. For example, at an emotional level, unresolved anger: *I have anger ... Sometimes I feel eh the heart will pump like this and I will feel the chest pains....* On a cognitive level changed perceptions can affect future relationships: *That thing has made me more observant about the relationship I am in ... the problem is sometimes you compare the recent one with the previous one....*

During the interviews emergency nurses also shared their experiences with friends'; and community and family members' exposure to IPV. As the different experiences unfolded the story of IPV was told through the voices of participants:

A participant's friend told her how her partner changed from a loving person into a monster: *When we were courting there was no problem. I was never beaten, but you know two months after the marriage then the beating starts; the verbal abuse starts....* Another participant witnessed as a child her pregnant mother being beaten and nearly killed by her stepfather: *...when you see a pregnant woman being ... assaulted or being stabbed ... I have seen my mother ... my stepfather, he was beating her while she was 7 or 8 months pregnant. I could hear my mother screaming and I opened the door. I saw the knife and that he was keeping my mother inside there....*

During the interview one participant linked IPV to the gender-based violence inflicted on her sister and described how difficult it was to talk about such a sensitive subject to someone close to you: *In fact she's my sister. I was hurt (on an emotional level), so it was not easy for me to ask her... 'Did they rape you?'; but I knew that they did that ... when its someone that's close to you ... and she's not talking about this ... sometimes life is so difficult ... I am afraid that maybe I'm going to hurt her if I start....* Later during the interview she reveals the same difficulty to talk to a survivor who is in emotional pain: *Sometimes I don't ask them too much because they are in pain, they are crying, so I feel I am going to make the situation worse.*

Some of the participants related how women exposed to IPV in their communities sometimes consult them: *... a neighbour that was abused by the husband ... it was very traumatic ... I will usually advise her: 'Call the uncles, call your parents...'; with us Africans ... both sides, parents have to be involved ... and another lady in our church ... she didn't get any support from both families.... That's when I involved our pastor....* Experiences in the community can be incorporated in the emergency nurse's frame of reference as a gender perception: *...what I have seen as a woman, really you have to be productive. You have to work, don't depend on them (men), because what I have seen, most of them (men) if you are not working, and you are busy making babies, then its like you depend on them (men), and they are in full control....*

A participant who had no experiences with IPV in the personal domain explained how, during her childhood years, it was *funny* for her to hear other children talking about their parents fighting. The words she uses to describe IPV such as *weird, funny, quite silly* and *shocking* point to her lack of acquaintance with the phenomenon: *Well, mostly it shocks me ... the background I am from its just not seen ... IPV it's really. I don't know. It's weird. I can say mm... I have not been exposed to it....* This participant cannot get herself to fully empathise with the survivor's situation: *Mm I don't think that I want to put myself in their shoes to see it from their perspective. It's just that: 'But what if this was me?' and then that's where it ends....* Even if IPV is not evident in their current relationships, some participants expressed the awareness that the possibility cannot be excluded from their personal domain as illustrated in the next quotation: *...even myself; I am a woman, and then my partner, I cannot say that I know my partner to the fullest. Even though life is just fine but you don't know what is going to happen tomorrow ... because you can be in a relationship for many years knowing your partner is not doing things like that, but sometimes he can change within a second. You wouldn't know what make him change....*

The constituents discussed so far illustrate how experiences with survivors of IPV in the professional domain affect emergency nurses on a cognitive and emotional level and interrelate with personal domain experiences. The next two constituents focus on emergency nurses' attempts to cope with and make meaning out of personal- and professional-domain experiences involving IPV.

3.2.5 Attempts to cope with professional domain experiences related to IPV

Emergency nurses find ways of coping with their experiences with survivors of IPV: *It does affect me but then I am having a way ... I don't know how, it does affect me but then I can treat them* (the survivors).... Different ways of coping emerged from the interviews: to talk to someone about the experiences and feelings; using spiritual resources; and expressing the emotions through crying, suppression, avoidance, distraction, altruism and acceptance.

One way to cope with the experiences involving IPV is to talk to someone for advice: *...that person will give me a lot of advice a lot of things that I can do so that my spirit can be lifted up again so even then the next patient who can come with the very same thing I will feel the courage to do that....* Talking brings relief: *...it feels much more relieved than this thing you were holding by yourself.*

That "someone" can be colleagues: *...most of the time when it happens at work, we speak about it at work.* After voicing a concern to a colleague *...it feels better as talking provides a way of ventilating feelings: ...I can come here and say to Sister X: 'You know what? Sister X. We have got this patient. This is what happened to this patient; this is so sad'. We will talk about it. At least, ventilate to somebody else....*

It is also helpful to talk to someone for spiritual support – for example, the pastoral counsellors in the hospital who are easily accessible and available: *"...moruti (Sesotho word for a "pastor") – our pastor – he is here for us. He is here for those things; he is not only here for patients; it is also for staff ... this is what the hospital is offering to us...; ...they have offices and you just go there and talk to them...; ...if you feel you need emotional support from somebody....* Those consulting the pastoral counsellors experience the service as helpful: *It's good for us...; I just go to ... the spiritual counsellors ... and then after that I'm back to normal.* One participant explained how she consulted her own pastor after struggling to cope with a particularly disturbing incident: *I go to my pastor and she prays with me like that and then it goes away ... but not at the same time – little by little....*

The use of internal spiritual resources to cope is evident in this quote: *...when I see that patient came in ... there's no other way ... it's for me, the first thing that I do before I can go to the patient, I am just taking a two minutes break to ask God for strength, and for power and suddenly ... I have started to stand for that woman, to try to make her feel at home ... and I think God also sees that my child is in trouble, let me give her the strength to do what she is suppose to do ... then I have just wiped away my tears and continue with my nursing to the patient and at the end of the day I can see what a difference I have made to the patient.* The same emergency nurse derives strength from her belief system: *...for us to be here is because of the purpose from God. He knows that there will be some other people outside who need our help so He will give us the strength almost every day so that we can help those people because they are not able to help themselves.*

Another way of coping is to seek distraction in the form of time-out after being emotionally upset by a specific case: *You don't see the next patient immediately, you just want to cool down a little bit after talking to them...; ...you just need a little time, maybe you can just go to the kitchen and grab something and come back ... continue with your work.* and: *...listen to the music – whatever you can do to just relieve yourself. Or you can just go outside and get fresh air. Usually what I do I go outside. There are porters, so I just sit with them and they always make a noise, and I listen to whatever they are saying, and talk to them and come back to my work.* A similar principle applies in the next example where the *talking* with colleagues serves to distract the participant from her memories: *...we are chatting about something different, they (the images) can't come back....* At home family members can play a similar role: *...when I am playing with my daughters I am trying to forget what happened... and: ...my daughter – the small one – sometimes she makes me forget for a moment because she's two years now, so we just play and for that moment I am just forgetting about what I was thinking of.*

Sometimes emergency nurses cry when they are emotionally touched by a case: *I will go to the bathroom, I cry then I come back and feel a little bit relieved afterwards.* But crying is not so much seen as a way of coping as something happening when one is not able to control one's emotions: *...there are experiences that you get to the extent where you cannot hold yourself – you will end up crying....* Crying is not something participants want others to see: *You will just like wipe your tears ... and say: '...people must not see that I am crying'; ...going somewhere to hide yourself from people not seeing you are hurt; and: ...but isn't it you wont let others see; you just cry internally?*

Most of the time emergency nurses just suppress their emotions: *I became angry, but I didn't show it to the family...; ...you know you have to take your feelings aside... and: ...keep it inside of me; ya you just let it go.* The suppressed emotions can stay unresolved: *...what will you do about it? ... you do nothing about it...* and can escalate into strong feelings: *What will you do? You will just hate....* Suppressing emotions can have far-reaching consequences: *...so keeping it to myself it will cause me a lot of harm; for me and my family and those who know me, my friends....*

To suppress personal emotions and keep them out of the equation is perceived by emergency nurses as a clear expectation from different sources:

- The work environment requires emergency nurses to be in control: *This is what I **have to** do, that's it...; ...you have to pull yourself together... and: ... regain your strength to do your work.* There is no time to spend on one's own experiences, just to attend to the ever-present demand to *assist the patient first* and: *You have to see other patients; there are lots of patients waiting for you....*
- The healthcare users and their relatives are *coming and hoping to get something from you; I didn't show (my feelings) to the family and relatives because **I must** comfort the patient. I must not be emotional in front of the patient. I must give hope to the patient, be supportive, though it was hurting to me. But I tried to be strong for the sake of the patient....*
- The emergency nurse's own sense of duty: *I have to carry on even though it is difficult for me ... It's my responsibility... and: **I should** provide help first for there's no way that I cannot help a patient because of my emotions ... I must just help out no matter how bad it can be....*
- The demands from society: *...that's what is happening nowadays, so we have to deal with it whether we like it or not, and we have to get some positive results from that... and: ...ah, what can you do ... **Life must just go on....***

Another way of coping is to avoid situations that are too threatening and close to home. A participant who was exposed to gender-based violence explained how she will avoid an area in the unit if she becomes aware that one of the patients is a survivor of IPV: *...sometimes I am not working in that area and I come to fetch something and I hear the patient explaining the situation that occurred to the sister ... the small talk that I will hear; it makes me stay away from that unit until that patient leaves.* A similar way of coping is not to avoid the situation in person, but to distance oneself emotionally: *...in order to work with this person or to help this person I distance myself mm... I think that's in order not to experience anger, mm....*

The realisation that a survivor has been helped brings relief and helps emergency nurses to cope with the emotional pain. Even if the survivor has just talked about the IPV (*she has exhaled*), it is already a relief: *...now at least that heavy load also comes away from you ... you feel there's this progress or maybe she's attending this counselling – its helping. It automatically goes away....* One participant even follows up some of the patients after discharge or visits them in the wards if they are admitted. The relief of stress and sadness she experiences when the patient is recovering is illustrated in the next quotation: *...(the patient is) awake and smiling ... she's improving and she's fine she can communicate ... that lady has survived some of the things that's she's going through ... it makes a lot of difference for me ... I can see that at least what I have done made a change ... makes me more happy and relieved. Then my stress level is gone. It erased that sadness that was on me....*

For one participant the death of a survivor of IPV was a particularly difficult situation to cope with; the description indicates how meaningful elements in her life like religion helped her to accept the inevitable: *...at the end I just told myself let me accept what has happened; it's just happened but it's difficult to accept it ... I just told myself I have got a family I have to look after. I have got a job and I have patients that want my help ... what is left is just to pray to God to let it not happen again. I have to do that. Sometimes it's very hard to accept – you are in denial about what happened – but in the end you have to accept. It's done, she's gone; she's gone and she can't come back. I can't walk around with it forever.*

There is a need for debriefing and support for emergency nurses as expressed in this quotation: *I think we nurses we need debriefing. We experience many emotional things, you know, and need some counselling so that you don't look at it that way....*

This constituent reflected emergency nurses' attempts to cope with their professional experiences with IPV. Related to this constituent is the next, which illustrates emergency nurses' attempts to make meaning out of IPV.

3.2.6 Attempts to make meaning out of IPV/understand IPV

Emergency nurses struggle to understand and make meaning out of IPV. Some participants attempt to understand the reasons behind IPV, while others try to figure out why a woman would stay in a relationship that involves being exposed to violence.

Participants' displeasure with the senselessness of IPV is revealed this narration of a survivor's experience of being falsely accused and beaten by her husband: *She was sad ... she has never since she got married had an affair... never even looked twice at other men ... she just couldn't take it ... and you got beaten up and with no explanation. I mean it's unacceptable.* Similarly the next quotation illustrates the participant's disappointment with IPV destroying a young life: *...this girl – she is still young and she still has a long life ahead of herself and this is what is happening.*

The question arises: *Who is that person who can do these horrible things...?* This is a question many of the participants reflected on without finding a clear answer. An issue arising is, for example, the possibility of identifying a potential perpetrator before engaging in a relationship: *I have asked quite a few patients after they have been stitched up or when they have calmed down: did you know beforehand of this possibility of violence? And a few cases they would say their mother told them this man is not good for them or some other family members told them or friends told them to watch out for this man....* Another participant indicates that in the initial phases of a relationship *you don't think like that because you trust that somebody, you love him. I mean if you love somebody you are expecting positive things; you don't think about the negative things. The negative things are there but not the one that can destroy you, maybe harm you, assault you....* She continues deliberating that: *...you can't fall in love with someone you'd think one day this one is going to kill me or is going to destroy me.* She ascribes IPV to a partner changing for some or the other reason. *You developed trust in him, but all of a sudden he changes his mind.*

In the following excerpts from interviews participants also reflect on the changing and contradictory behaviour displayed by the perpetrator by using examples from experiences with IPV in their personal or professional domains: *...(the perpetrator was) so kind when it comes to other people ... but he just changed...; ...very loving ... he changed into this monster... and: ...portrays a good person ... becomes something else....* The same phenomenon is explicated in the next quotations: *At the same time they tell the world that they love this other person and then this is definitely not the way to show that they love this person. Mm... it's just so contradicting....* and: *They are sharing more than just a normal relationship, it's supposed to be a building relationship, not one that's breaking each other up or down or mm... abusing.*

When witnessing the serious injuries inflicted by IPV, emergency nurses wonder about the driving force behind the perpetrator's violent and inhumane behaviour: *How can another person cause this pain ... or what drove them to inflict this pain on this other*

person? An explanation offered is that *family history or a history of violence mm... also contributes to that. Sometimes the person was raised in a home where there was constant physical abuse and to them it's the norm; it's the way how you deal with anger or mm... or to turn to violence for solving a problem.* The internal conflict that arises from trying to explain or even justify the perpetrator's behaviour is illustrated in this quote: *...but maybe ... no! but maybe ... no! How can I even think this?*

Emergency nurses provide care to seriously injured survivors knowing that *the very same women who are abused in those relationships, they still stay....* Thinking the woman who just received emergency treatment is *going to go back to that person* who inflicted the injuries is viewed as *unfortunate* and difficult to explain: *...you ask yourself: why is the person still in this relationship?* Participants attempt to explain the survivor's motives to persevere in spite of the IPV. Maybe the survivor still cares: *...there's much more feelings going on because if you care about this person there's still that hope.* Maybe there is an excuse for the violent behaviour: *...that they have got this hope; that maybe it was just because he was drinking or because he was having too much stress and that's why he did this....*

A lack of economic independence might play a role in the survivor's decision to stay in the relationship as one participant speculates: *...sometimes people are looking at material things: If I do this then I lose the man that I love... and: ... sometimes I told myself its because she's not working, the reason why she keeps on staying in that relationship....* The power the perpetrator has over the survivor is strengthened by his economic and social position: *...this man was in serious power because of the occupation he was doing and the poor woman had nothing ... he was so wild, he was so wild.* Social or cultural sanctioning of gender inequalities can contribute to IPV and a woman staying in the relationship: *...men they have got this belief – especially in our culture – they will tell you: these things a woman is not supposed to do, and then they take advantage of this thing because they have got powers. So if you talk they will say: no you don't respect the men.*

Having children to take care of can make the decision to end a violent relationship even more difficult: *They have kids and sometimes they have four or five kids. They depend on these men so there's nothing they can do.* and: *...she's afraid to leave that relationship and go back home. At home there's nobody working and she'll go home with those kids and it's going to be a burden on her parents....* Apart from staying in the violent relationship to financially support the children, some women worry about ending the relationship because: *the children are going to suffer, and then it's going*

to affect the children's lives. I guess most of the time most women stay in the relationship especially where there's kids, um; they know they have got this thing; the children are going to suffer.... But another quotation illustrates how children exposed to IPV become powerless witnesses: But the only thing that people don't realise is that if that abuse is happening ... the kids can see the abuse, although there's nothing they can do. In order to indicate that when ...the woman leaves the relationship, you know children cope better...; one participant quotes her sister's daughter who told her: 'You now auntie now it so nice now we are staying with my mum, and mum is not crying anymore.'

The extended family's response might also contribute to a survivor's decision to stay in a violent relationship: *...some of the families, especially we blacks, we have this tendency of not accepting other situations when somebody has failed (divorce)... Fearing or anticipating a judgmental attitude from family members can cause the survivor not to have the confidence to acknowledge the IPV: She doesn't even tell the family what she's going through.... When the family shows a non-judgmental and caring approach they are in a better position to help the survivor: I have seen the cases that where the family came in and then mm... they didn't go back on: 'Your husband did this, or your boyfriend did this, and you still went back to him...'; they were just showing support and trying to get them through this without reminding them constantly of what happened, where it had a better effect on them.*

One participant states that she does *understand if they (women) go back to them (the perpetrators)* but keeps asking herself: *...if I get beaten to this extent, seriously, will I still continue with this person?* In an attempt to understand, the participant compares the survivor's situation with her own experience, but acknowledges that people are different: *But if he gave me a 'klap' (Afrikaans word for 'slap') like that and I am still with him right now, maybe ... we are not the same people; maybe that's why they go back to the person..."* Similarly another participant alludes to the fact that the decision to leave the relationship is an individual decision that will happen in its own time: *...it takes long for people to react because they keep on staying in that relationship... until the woman one day decides that this is it. But if it hasn't sunk in that this is the time to move, the woman will always stay in that relationship ... until something happens, but it's something that's not easy....* On the contrary, to another participant it is very funny and very shocking and very disturbing to see survivors' indecisiveness. *We asked them: 'So are you going to leave this man?' and they say 'yes', but I don't see that assurance that they are definitely going to leave the man;*

it's not a decision that they make. They are still wondering whether they should or should not do this....

Often confronted with IPV, emergency nurses reflect on IPV as a social problem and ask themselves why it still seems to be such a common occurrence: *...you realise there's been lots of people coming through, lots of organisations like POWA (People Opposing Women Abuse – a women's rights organisation), but men are still abusive. And you ask yourself: these campaigns have existed for years but men still continue to abuse women in different ways.* These thoughts give way to a vital question: *...why is it happening to us women, what went wrong...?*

Professional- and personal-domain experiences and the emergency nurse's attempts to cope with the exposure to survivors' experiences and make meaning out of IPV give way to the formation of gender perceptions and assumptions related to IPV.

3.2.7 Formation of gender perceptions and assumptions related to IPV

During the interviews emergency nurses verbalised gender perceptions and shared their own personal assumptions related to IPV. Some of these perceptions and assumptions seemed to be influenced by professional- and personal-domain experiences. Gender perceptions and personal assumptions in turn have an effect on the way care is provided to the survivor, as will be illustrated in 3.2.7.

The gender perceptions will be discussed according to two themes that emerged from the interviews. The first theme is men as perpetrators and the second is women as victims. The gender perceptions will be followed by a description of participants' personal assumptions with reference to the following themes: Intimate relationships; children in IPV relationships; IPV; dealing with IPV and; the survivor's autonomy.

The quotations used to illustrate the gender perceptions related to men as perpetrators of IPV reflect strong personal convictions, which should be seen against the background of what the participants have been and are exposed to in terms of IPV in their personal and professional domains.

A perception held by some participants generalises the majority of men as perpetrators of IPV, as illustrated in this quotation: *...men behave the same – others can do it physically, others emotionally. And you just realise, agh they are all the same, although there are a few good men. But most of the time if you have to put it*

on a scale of 100% I would say 99% of them are abusers. This perception is somewhat substantiated by a participant explaining that exposure to IPV in the personal domain and/or constant confrontation with survivors of IPV can sometimes lead to a person being *afraid of men thinking that they are all the same*. She nevertheless continues to say: *...but those who are good ... What can I say ... small amount, little ... but the rest ... eish* (a term used in South Africa to express exasperation or disbelief).... The perception is expressed that all men are to be regarded as having the potential for violence, even if it is not overtly visible: *...sometimes you cannot trust a man ... maybe one day, you will never know because people are subject to change ... but you will never know ... if it is to change....* The mistrust in men is further explicated in this quotation pointing to emotional abuse: *The husband, when she (his wife) has to find a job, will say: 'No, why are you going there, sit down and work for me.'* And then he will cheat her. The last excerpt illustrates the perception that, in order to maintain the power and control he exerts, the perpetrator needs to keep the woman dependent, in this case financially. This powerful position, as expressed by one participant, is a situation the perpetrator favours: *...especially the males, they are enjoying what they are doing....* Staying in the violent-prone intimate relationship might end fatally, or rather, **will** end fatally according to the next quotations that illustrate the extent to which the perpetrator will exert his control: *One day your partner is going to beat you up to death...* and: *It is either he will kill both of you, him and me, or he will kill himself, or he will kill the wife only, or maybe he will kill the whole family....*

Gender perceptions can be accompanied by strong feelings as, in this case, a participant who developed a hate towards men: *I started to hate men with all my heart ... I hate them because in my mind it was like all men - they don't care about women*. This perception stems from a childhood experience where the participant escaped from a situation that she thought could have ended in rape. Gender perceptions with emotional connotations can also be informed by caring for survivors of IPV; for example, a participant witnessing the effects of two cases of IPV perpetrated by *men of a particular race*. Witnessing the survivors' injuries in her professional capacity led to the following perception: *...now eish if I look at the millions of other races, I think these men are terrible....* The emergency nurse ended up *hating a particular group of men* (of a particular race) *because of what I have seen them doing*.

Women are seen as susceptible to becoming the victims of male violence: *...especially for us women, we experience those ... being beaten up by males a lot....* The risk to

become a victim applies to all women regardless of *wherever you are staying; or how old you are*. Seen to be contributing to IPV is women's perceived lack of power: *It's just that they are powerless in the face of their partner;, that's why its happening.;* vulnerability: *...those who are involved in women abuse or domestic violence they are so vulnerable to the situation that they become victims...;* and resignation: *... it doesn't mean they want to be in that situation – they are being forced by circumstances to stay in the relationship*. A similar perception is shared by another participant, who suggests that certain characteristics associated with femininity might cause women to be more prone to IPV: *...especially females ... we are suckers for punishment mm... and we're not really ready to walk away if we need to; we continue to care even though there are so many signs and warnings and symptoms of abuse....* After realising that a survivor of IPV she took care of *is actually a nurse* and hearing *people saying that we (nurses) as a group, we make wrong choices when it comes to choosing a life partner*, one participant holds the perception that nurses are more prone to IPV as substantiated in this quotation: *I think its our nature that we want to fix somebody ... we see the situation of this person ... needs caring ... so we want to nurture them and we want to try and fix them (laugh) and then we end up getting abused ourselves*.

Based on her experiences in the community one participant verbalised the perception that economic independence empowers a woman against IPV: *...what I have seen as a woman ... if you are not working, and you are busy making babies, then its like you depend on them (men) and they are in full control. You won't even talk because you can't work ... if you are weak they 'sommer' (Afrikaans word translated as 'just') take advantage of you ... now you have to tolerate all the nonsense because you are relying 100% on the person ... if you're working it gives you confidence ... it's like they (men) get threatened, like this one she's got power ... if you want to leave, you can leave....* The participant emphasised the previous perception by expressing a strong personal standpoint: *Ya, it's about time really. Women should really work; nobody should be a baby maker at home. No matter if you are educated or you are a domestic worker its fine, but everybody should work*.

Social contact and a good social support system are viewed as protective factors against IPV: *...if they can socialise but with good company. You cannot be by yourself alone at home. You need to socialise with other women, hear what they are saying*.

Exposure to IPV, either in the personal- or professional domain, has an effect on the way intimate relationships are perceived. Engaging in an intimate relationship is seen as a rather risky undertaking: *...love has no guarantee or marriage doesn't have any*

guarantee; anything can happen to you. Even if someone can tell you that I'll marry you, I'll love you or be your husband, it doesn't have any guarantee. The next quotation from the same participant illustrates her perception that the potential for violence and deception exists in any intimate relationship: Love is just a time-bomb.... It can become violent at any time ... at any time it can explode... it's just like a trap ... but when you start you don't realize that. Ya, you realise that when you are in ... I am in a trap here.... The next quotation reflects a participant's disillusionment and negative view of intimate relationships, a perception that is generalised to all intimate relationships: *...we are all trapped in that ... from the beginning actually – we shouldn't have a relationship or something that has been called 'love'. It doesn't help. You start being two together and when time goes on I don't know what is going on in somebody's mind. Everything falls apart and even if you can try to... to understand ... you won't even understand. That's the feeling I have and most of the people irrespective of gender or colour or anything ... we are all trapped in that.*

Another participant's statement: *I have come to the point ... I'm a single woman and I think I want to remain single because I don't want to be abused.* This statement is grounded in the perception that, as all intimate relationships are susceptible to become abusive, the only way to protect oneself is to stay single. She continues to say: *Although you realise in the end you will end up with nobody, but sometimes it's better. You have got peace of mind more than anything.* Similarly another single participant shares the perception that *...you really need to think and rather stay single! (laughing) than make the wrong choice....* Although in a stable relationship, this emergency nurse's remark indicates her understanding of how some of her colleagues feel: *...if really, I was single, somehow I would be scared to get married you see, because you think really that's how men are ... that they are all like that....*

Participants shared their perceptions pertaining to children in an intimate relationship characterised by violence. A boy who witnesses his father who he views as a role model (*when we are parents we are the role models of our kids*) *beating mother like that*, may perceive it as the norm: *...they will see it as it's a normal or right thing.* Such a child may become a perpetrator himself: *...he will grow up beating everyone and if he's got a girlfriend he will do the same thing....* This vicious cycle contributes to IPV statistics escalating: *And that's how the percentage is going up and up.*

On the basis of experiences within her personal domain, one participant holds the perception that it is actually better for the children if the woman leaves the abusive relationship: *But the only thing that people don't realise ... the kids can see the abuse,*

although there's nothing they can do. But in a situation where the woman leaves the relationship, children cope better. They actually do well at school, unlike when they are in that abusive relationship. Notwithstanding this expressed opinion, most of the time most women stay in the relationship especially where there's kids, um, they know they have got this thing; the children are going to suffer; and then it's going to affect the children's lives.

A different perception was mentioned by another participant who views a child as providing meaning to a survivor's life, giving her a reason to carry on with her life: *Hope ... I mean the child gives happiness to everyone ... as long as the child is with you ... somebody who gives you a reason to wake up in the morning, the reason to smile ... even if you don't have food on the table but the child, the smile that she's giving you ... it brings this joy.*

Most participants expressed the conviction that IPV is wrong. One participant clearly stated her disapproval: *Oh I feel strongly about it, its one thing I cannot take....* Another sees it as *very sad, it's not good, it's not how we should live.* IPV is unconditionally wrong according to this quotation: *No! there's no justification for this at all! No matter what happened, nothing should cause a person to inflict this kind of pain and harm on somebody else.*

Witnessing the consequences of IPV, emergency nurses ask the question: *...what are you going to do? Are you still going to live with him?* Most participants hold the opinion that the survivor should *make a serious decision: 'This is not what I want!'* and leave the relationship when the *IPV is becoming intense; especially when it is not for the first time, maybe it is more than five times he beat me like this....* For one participant it is clear: *I feel strongly in a relationship people have to be equals and once we are not getting to that, one must take his and I take mine....*

In spite of the opinions expressed in the previous paragraph, something most participants are adamant about is that a survivor of IPV has a choice whether to stay in the relationship or not, and the right to exercise that choice independently: *...it's up to you whether you stay in that relationship or if you want to stop it. Nobody must force you to do that....* One participant is convinced that autonomy is a universal right, a conviction she grounds in her personal belief system and shares with survivors of IPV: *...a person have a choice. I tell a person you have got a choice in being in this relationship because my religious belief is that everybody has got a choice. God has given us this power, the power of choice, and I think I am using it the way it's*

supposed to be used. Similarly, another participant believes that survivors of IPV are the ones that have the solution. She states: I think if they (survivors of IPV) make the choice, rather than (other people) asking them: 'Are you going to leave this man?' mm... in the end have them saying: 'I think maybe I should leave this man.' ... if they make the decision they would follow through rather than following through on someone's advice. Why survivors must take their decisions for themselves is explained in the next two quotations: ...so that when they fail along the way they must not blame anybody. You give them the options. Here are the options. You decide which one you take. and: ...certain people when you give them the shock therapy: 'This is going to happen again and stay away'. It will only draw them closer or push them into this person's arms....

Most participants held the assumption that it is necessary for the survivor to talk about the IPV: *If you are in an abusive relationship, don't keep quiet ... seek help. and: ...go out, talk about it.* It is also important, as added by one participant, to *talk to the right people so that they could develop you.* She mentioned: *If you talk to the wrong people ah...ah, they can make matters even worse. They'll even tell your husband, you see. You check first ... then you know who you can trust.* The assumption that survivors should talk is substantiated: *...keeping quiet doesn't solve it...; ...they mustn't suffer in silence... and: Then you can hear the good advice; if you open up you heal. Don't just always keep everything to yourself; you will bottle up and you will die.*

Another perception shared during the interviews was that younger people displaying a *casual* and open attitude about the violence *cope with it and they can handle it because they talk about it; they heal quickly, the young ones.* However, many survivors *don't talk straight about it, commonly they don't say it, especially the bigger ladies (married/older women)....* The most obvious explanation for this lack of openness seems to be fear. Firstly, there is fear of the perpetrator, who is sometimes present in the emergency unit: *...because the partner will be there, usually even the partners they bring them here. It's not easy to communicate; it's like they are afraid of them... and: ...sometimes when the woman comes with the abuser ... they are afraid to talk – they are too secretive....* Secondly, survivors fear to acknowledge the IPV: *...some of them they are scared to say it – like – 'I've been beaten by my husband or my boyfriend'.* Some of the previous explanations are grounded in perceptions regarding IPV; for example, that survivors *will always lie for their partner.* Another participant suspects the *lie*: *You see the woman coming in and she's been assaulted*

then she says: 'No I bumped into a wall'. This type of statement is usually the survivor's way of indicating that she doesn't want to talk about the assault.

The last constituent illustrates how all the above mentioned constituents play a role in the care that is provided to the survivor of IPV.

3.2.8 Provision of care to survivors of IPV

Care provided to survivors of IPV focus on three interventions: physical care, mostly in relation to the injuries sustained; emotional care, which reflects different ways of approaching and supporting the survivor; and referral to other multi-disciplinary health care providers.

Although emergency nurses' focus is to *deal with the physical scars*, most are aware of their responsibility to *help the patients with their need: physically, emotionally and spiritually also*. However, it sometimes happens that the care is limited to the medical management of the survivor: *You stitch or clean the wounds, send them to X-ray to see if there are any fractures, then we discharge with pain killers*.

Emotional care relies on the emergency nurse's ability to detect IPV and get a disclosure from the survivor, which *gives you a platform to actually talk with your patient*. The quotations that follow indicate the same point of view: *I think it's always better to charge in (manage the problem of IPV) when a person is actually voicing it out...; ...the more you (the survivor) cough it out, the more you can get help from others*. and: *there's nothing you can do until the victim talks or screams for help or shows some signs of seeking help*. However, this opportunity to intervene does not necessarily present itself, as it is unlikely that the survivor will spontaneously ask for help, as the following quotation illustrates: *I never had a patient who said: 'Sister now this is enough. I need your help. I need your intervention. What I can do?'* The history of the patient to be taken relies to a great extent on the emergency nurse's own discretion. Some of the emergency nurses will try to get the survivor to talk about the IPV, others even view it as essential for emergency nurses to detect IPV and get a disclosure, while others feel it is up to the survivor to reveal the IPV. These different approaches as well as the many barriers that can impede disclosure are reflected in the next discussion.

When a patient is admitted the emergency nurse attempts to establish the presenting problem by asking: *What is wrong?* This question already poses a problem as the

emergency unit's layout is not secretive. There will be another patient here and I'm here, maybe that's why they don't talk easily. It is not easy to talk and we are most of the time overcrowded.... One participant puts herself in the survivor's position: ...because really if people are here and they are all looking at me I won't talk.

Some participants, however, find ways to overcome the privacy barrier; for example, if this participant suspects *there's something* she will ensure *as much privacy as possible so that they can talk*. She recommends to other emergency nurses: *...make sure that you maintain serious privacy. You can even take her to the office; I am using this office next door for counselling*. Another participant explains how she will talk to the survivor when an opportunity to see her in private presents itself; for example: *...every patient comes in with pain; when we give the injections; that's when we have privacy. Then you talk to the patients: 'Tell me exactly what happened'*. This is when the survivor might feel free to disclose the IPV: *'I was beaten by my husband or my boyfriend...'*.

Some survivors feel they can tell you what happened: *'This is what happened, sister – we had a fight...'* – while others clearly give you the message that *they don't want to talk about it*, a right that all participants acknowledge and respect: *...you just treat what you see and they go*. Anger is seen as a clear sign that a disclosure is not likely to come: *You can say: 'really, really?', but if she says: 'yes, yes!' and even screams at you, you will not get far*. One participant explains: *...then I will leave the patient, give her maybe space to rest a little bit. Sometimes I understand it's not because she is angry to me, she is angry to the situation*. The understanding reflected in the last remark stems from the participant's experience with her own anger after exposure to gender-based violence: *Because with the anger I normally see I was also like this. I was very angry after the situation ... then I said to myself: 'That's why this person is so angry; I understand'*.

Some participants' narrations explicated their ability to sense the barriers behind the survivor's reluctance to talk. The sensitivity surrounding IPV is a barrier: *But sometimes we know that others won't talk honestly as it's not easy to talk about it...* and; *...you will find that she's not free to tell you ... exactly what happened*. Distrust was identified as another barrier: *Because it's the first time that you see each other. She doesn't trust you to tell the whole thing, she thought after maybe telling you, you will tell everyone....* The emotional state of the survivor may also play a role: *...so she looks a little bit sad, withdrawn, stuff like that and you can see that this poor woman is being depressed and she's afraid to talk....*

Realising that survivors won't *open up* immediately, emergency nurses are aware that the *physical something* a survivor sometimes presents with (for example: *I have abdominal pain*) might just be the tip of the iceberg. One participant narrates how she sometimes suspects *there's more; it's not only this and here's something wrong*. She describes this intuition as: *feel the mood; feel there's something more than this; and something she senses: you should hear, sometimes they (the patients) groan...; ...the tone of the voice...; ...you should look, you can see some others are assaulted, you can see on the face, the eyes... and: ...she can't even look you in the face... Emergency nurses also look for discrepancies in the survivor's narration of the problem: ...whenever you take a history, even if she's saying this, you should look, you should hear... and: so she's trying to tell you this and that ... but at the end of the story ... when you combine, then you can see, no, this is not the real thing ... the story doesn't connect....*

Sensing that something is wrong, some questioning is required: *...then you really have to dig, you can say: 'Ah ah are you ok? When did the abdomen start ... are you pregnant?' and: '...you can't bring abdominal pain of two weeks today, at night? Exactly what is wrong?' Even if you question them and they are impatient sometimes with all the probing, the emergency nurse should persist, an approach one participant substantiates by explaining: ...but if she doesn't want to talk... and emergency nurses don't talk either and we miss it here ... then she's going to go out... - leave the emergency unit – and miss the opportunity to get help. Similarly another emergency nurse views it as her responsibility to try by all means to get the whole story from that woman.*

Realising that more than just questioning is needed to get the survivor to open up, one participant asks herself: *...to get a clear story from that woman what must I do?* She concludes: *...you first have to gain her trust and make her feel at home....* The next excerpts shed some light on how the same emergency nurse overcomes the interpersonal barriers: *...so that she can trust you, so that she can talk ... cough out all the problems ... even the problems that she was hiding... it will depend on the way you are treating her.... First thing that you have to do, you must make sure that this woman feel free when she's with you ... ask her if she wants to say something, even if it's a secret thing, she must be free to talk.... If you can approach her nicely and make her understand that you understand the situation so that she can be open to you. And then she can say anything, but you mustn't put pressure on her to say things. You can*

take it slowly by slowly; you mustn't be short-tempered so that you can understand what is she going through....

It requires sensitivity to determine what are the barriers preventing the survivor from disclosure and what can be done to overcome those barriers; for example: *...if it's a big (older) woman you know she won't talk to me you rather get a bigger (older) sister. As soon as I see that the problem might be too big for me, I see if I can get somebody I feel will be relevant and that the patient really can relate with.*

Probing towards disclosure can cause the survivor to cry: *...there are times where you see: I've pressed the wrong button so you get a response: she will start crying.* Crying, a sign that defences are dissolving and *there's something here* is seen by this participant as an opportunity to get through to the survivor and to probe even more: *...then you know aha* (the nurse is thinking by herself): *'No, you can't cry. What is wrong? Now you need to tell me....'* So she asks the patient: *'Why did you cry when I asked you: when did the abdomen start...mm? ...you need to talk....'* In another participant's experience a survivor who *comes crying, crying* usually responds to being comforted by disclosing the IPV: *...she will even explain: this and this happened.*

Emergency nurses respond differently to emotional expression. Crying is seen by one participant as a sign to leave the survivor: *...and then you give them a chance to relax... and not ask them too much.* The emergency nurse's perception that her probing can make the crying and the emotional pain (*they are in pain, they are crying*) worse can constitute a barrier to disclosure: *It's better for me to just ask them a few questions because so I feel I am going to make the situation worse.*

To get the survivor to talk (and disclose) is something *not everybody can do*. As one of the emergency nurses points out: *...and it goes with passion as well...* She acknowledges that not all emergency nurses have a natural instinct to sense something is wrong and probe the issue: *...maybe we are not all mothers....* In spite of this she still feels: *...but if really, if you can see ... I don't know ... we can be like mothers, you see. I am not going to leave her; something is wrong....*

Some emergency nurses clearly feel different about probing the survivor towards disclosure: *...but if you suspect and you don't have concrete information you cannot force a person to say she has been abused....* As such, some participants rather approach the survivor in a discreet, non-invasive way: *...maybe if the patient is not willing to continue talking to me I just keep quiet... and: ...sometimes, I do talk*

especially if the patient is open ... but other patients, they are reserved, they don't talk ... we just leave them. Another participant sees a non-invasive approach as a way of showing care and respect for the survivor. She feels survivors *shouldn't get pressure* and emergency nurses *as people who are taking care must respect their thoughts and the need to give them space.*

To get the survivor to talk one needs time, something emergency nurses don't always have. As indicated in the next discussion, a lack of time, staff shortages and emergency nurses being overworked make it difficult to reach out to the survivor: *...unfortunately we don't stay with them for a long time; It's only for a short period, so it's not easy for us to keep on asking more ... We don't have enough time. If the unit is hectic... and ...you are really overworked somewhere, somehow you might end up missing serious points ... staff shortages, they (the patients) are waiting for you to help; you see if this woman doesn't want to talk. I would rather leave her, that's it...*

Two participants mentioned language as a barrier. With many patients speaking African languages, a participant who is English speaking indicated that *in most of the cases there has been like language barrier making it a bit difficult to talk to them*. Another participant indicated: *...now in Pretoria there are many different languages like you'll find somebody crying but you don't hear what she's saying ... we don't have interpreters. I remember there was a lady who was brought in. The son at least knew English, then the son – because he was using work transport – had to take the transport back and it took him hours to come back. We did nothing for this woman until the son came back.*

The survivor's partner can pose a significant barrier towards disclosure and even towards providing care: *...when the woman came with the abuser, partner ... they are afraid to talk, they are too secretive.* Sometimes the partner insists to stay with the survivor in spite of the fact that visitors are not allowed in the emergency unit: *they don't want to leave, they want to be with the patient: 'I just want to be here, I want to be here.'* Even if the emergency nurses suspect something and *ask them to wait because we need to talk* some partners will still *be very, very uncooperative and just want to be here ... by the bedside. Others will even go to the extent: 'She's my wife, I married her, I married her'.* The emergency nurse has to be very assertive sometimes: *'You can be whoever you are, if something is wrong, its wrong sir – yes you are married. I respect that but there is something wrong.'* One participant described how difficult it is to get the partner *to just give us a space so that we can talk and respect the patient's rights.* The same participant elaborated on a serious

case of IPV (*she was assaulted – her body. You know, we could just see that she was tormented*) where they had significant challenges with the partner: *Because he was insistent, he didn't want the patient to be admitted ... He was always interfering and he was always here. We just couldn't have our time with the patient ... the husband was complaining that we don't want to give him the wife ... I really had to advocate ... we went as far as the CEO (Chief Executive Officer of the hospital).*

The abovementioned incident also highlights the professional values that form part of an emergency nurse's frame of reference that guides her to overcome barriers to care: She sees herself as an **advocate** for the survivor: *I'm an advocate now. I must take over now ... it comes naturally ... and for a woman who's helpless, who can't even talk for herself....* She feels a strong **sense of responsibility**: *I've seen it ... I can't keep quiet, you can't tell me: 'I married her we need her.' Now she's here ... you just have to abide. You can go wherever but we really have to do what we need to do. And lastly she is **accountable** for her actions: *...she's in my care. Why did she come here in the first place? You know if they do it (IPV) in their place, I don't care, but now I have seen it. Now I have to do something about it.**

Some emergency nurses also provide emotional support, even counselling to the survivor: *...so I just care of that patient in totality and sometimes by talking to her, giving her support....* The provision of emotional support is guided by the emergency nurse's personal and professional frame of reference, as will be illustrated in the next discussion.

In the next three examples the assumptions that underlie the provision of care to survivors are based on participants' personal experiences with IPV and gender-based violence respectively.

In the first example the participant explains that she will sometimes *...do a small interview* with survivors if she gets *...a chance to speak to them*. When she was exposed to IPV, she found relief in talking about the incident to her partner: *...you will feel relieved. Because I talked about these things to him, I spoke about this incident every now and then, just to take it out of my system ... He knows that I didn't like it and it was so way, way out of the way.* She now holds the assumption that talking helps, even if it is not talking to the perpetrator: *...men are not the same – some, if you talk about that, will become angry again....* She tries to create the opportunity for survivors to talk: *...but even it is not to him, to anyone. That's why when they come to hospital I try to speak to them: explain what happened, what is your plan, then at*

least they can say something. Accordingly, the interview she conducts with the survivor will take the following turn: 'Then what are you going to do – did you go the police?' 'They said I must come here.' ... 'Are you still going to stay with him? What is your plan with him? I mean if somebody can do this, don't you get afraid that one day he's going to kill you?' Then they tell you how things are going. Sometimes they will say: 'No he doesn't do it usually.' Some of them they say: 'It's always like this, especially when he is drunk.' 'But then are you going to be like a punching bag to him, when he is drunk he feels like doing something to you, are you going to be there for him to punch you every time, now and then? What did you do to deserve something like this?' and she will say: 'Seriously sister, I don't know this man. He just got angry.'

The second example illustrates how the participant feels obliged to help when she sees a survivor going through IPV (She was also exposed to IPV): *I must help others wherever I can ... she's just going the same road that I went....* Her decision to help is driven by gratitude: *...because I was also helped by someone, people who did counselling, they did come to me, to my house, others, telling me what to do....* Although not sure of the effectiveness of her interventions: *I don't know if they are taking it positive...; it brings consolation to her that ...I have tried to help... and ... as long as I have told them what to do, what not to do, it's up to them.* The participant considers herself fortunate that she had access to social and financial resources to get help and get her up on her feet: *I was lucky because I was employed. My friends tell me to go there (referred her for counselling). I did have money and I did know the road....* Realising that many survivors don't have the resources to gain their independence, she expresses the wish to provide them with shelter and care: *...sometimes I do listen to their problems and I have had that feelings that maybe if I was somebody who had money ... I would take all the people, those who are assaulted or abused, do something, put them inside one house like the orphans and take care of them....* Although giving them advice, for example: *She mustn't just keep quiet with such an abusive relationship; she makes it clear that she is ...not telling them to leave or divorce... as it's up to her (the survivor). It's her life, it's her marriage....* The participant is talking from her own frame of reference when she explains how important it is for the survivor to be self-reliant: *...you have to stand on your own even its difficult for you or not. You have to face it on your own and be strong for everybody....* This assumption is based on personal experience: *I have to carry on even though it's difficult for me. I went to church everything, crying, being moody to other people. It doesn't help. They don't know, they don't know what I am going through. It's my responsibility to keep it cool and then it's tough....* She proceeds to

explain how she relates to survivors: *...you talk to them and then she will tell you: 'You know what? I don't have any options I have to stay in that relationship' I say: 'Ok you can stay in that relationship, but here are the options when you are healed, it is up to you to consult these people.'*

The third participant felt *responsible for what happened* after exposure to gender-based violence (assault and near-rape by a male perpetrator). The assumption that the survivor might feel responsible underlies her interventions: *...I said to her: 'You know what, it's not your fault what happened.'* She also verbalises her understanding of the survivor's emotional pain: *So I will tell the patient: 'I understand the pain you are going through, it's not very nice, it's hurting....'* The participant managed to find hope after surviving the incident: *So I used to say to myself I am fortunate cause some they don't even survive. That's what gives me hope.* She experienced that hope brought her some relief: *I became calm with the situation ... just like that"* She feels the urge to bring hope to the survivor (assuming it might bring comfort as it did to her): *I must comfort the patient ... I must give hope to the patient, be supportive ... if I comfort her, if I became strong she will see that there is a light at the end of the tunnel.* She narrated how she made one survivor (who had a baby) aware that she needs to think about her baby who will give her hope as seen in the following excerpts: *...just look at your little one, look at her with love, then you will see that somebody can keep you going. This little girl she can give hope to you ... Every time whenever you feel hurt just look at her, just talk to her. ...that smile gives you hope. It gives you happiness; she's the reason why you live in this world. You must never think about killing yourself, doing things that will cause pain to this little one. I mean if you kill yourself then this baby when she grows up will ask what happened to her mother.... So the first thing you must think about is the little one first before you think about that man....*

The way the emergency nurse supports survivors as described in the previous paragraph has its origin in a desire to help: *You need to help this person whatever happened to you ... but now this person at this moment needs help.* But it requires effort: *...sometimes I tried very hard...*, as her own exposure to violence interrelates with the provision of care and leads to feelings of powerlessness, self-doubt and guilt: *Sometimes one wants to advise the person. At the same time you see the picture of what happened to you then. I don't know what to say like: 'Who am I to tell this person whereas I got my own (emotional pain)... I feel bad, I feel like there's more I was supposed to do. There's more I was supposed to say to that person.*

The way emotional support is provided to survivors of IPV is not only guided by personal experiences with IPV and gender-based violence, but also the emergency nurse's professional frame of reference, which includes certain professional and caring qualities.

The caring qualities include interpersonal skills such as empathy, open communication, sympathy, listening, patient-centred care and sensitivity. **Empathy** is illustrated in the way in which emotional support is provided by one participant who said: *...sometimes I used to put myself in the patient's shoes and try to give her all the care that she needs...* She describes some skills that she uses when providing emotional care to a survivor of IPV: *...if you **communicate with her openly** and show some **sympathy** ... then you just relay (acknowledge) the anxiety that she's got. Whatever she wants to say she can say it. You will **listen**; you will be a good listener; you give the support all the way...* She also attempts to provide **patient-centred care**: *...you can keep on asking her how does she want you to nurse her according to her feelings. So you must listen to her feelings, you must listen to her, what does she want, what doesn't she want...* **Sensitivity** is illustrated through her observations of the survivor: *...so she feels very scared and most of the time you will see that even when she's lying on the bed in the hospital she doesn't face where people are walking. She faces where there's no one walking on that side, and she also puts the blanket on top of her head so that no one can see her, because her mind has told her that maybe everyone knows about her situation. There are some other things you don't want some other people to know...*

Another example of the use of interpersonal skills portrays one participant's use of open questions to give the survivor the opportunity to express her feelings: *What happened and has this happened before? And mm... how do you feel about this? How do you feel about this person now?* She conveys her understanding of the importance of *allowing them to admit their own feeling as it helps survivors to deal with the situation if they realise their own feelings rather than being told you have been hurt now and this is how you feel*. Although trying to feel the person's pain like putting yourself in their position, she is not sure how to use empathy without getting too involved: *...but then you also don't want to do that because then you might get too attached to then try to fix this person's problems whereas you are probably just going to make it worse if you try and tell them in a way what to do mm...*

Emotional support consists of the use of certain skills on the one hand and the avoidance of certain behaviour on the other hand. Behaviour to be avoided is the

provision of advice. It is something one participant refrains from giving, based on putting herself in the survivor's position: *...because I will not respond well to advice in a situation like that. I don't give advice because if I was in that situation and somebody gave me advice I would see that as mm... they would put me on a guilt trip: If you would have done this and this, this would not have happened. You are putting them down if you try and give them advice.* The inappropriateness of advice is confirmed by the same participant who said: *...it's very easy for us to come with better solutions and everything....* She feels survivors of IPV *more than anything ... come for support. Sometimes they don't really want our advice; they want support. And I guess what's important is to give them that support.*

The question that arises is: What drives some emergency nurses to go the extra mile and provide emotional support to the survivor? One participant described it as an urge and a desire to care: *What comes into my mind is just to help ... when I see a patient I just seek to help. That takes everything. I must just help out no matter how bad it can be....* She attributes it to her professional training as a nurse, which brings with it a responsibility to care: *I think it's the way we are trained. We know these people come here for help.* Similarly, another participant also feels this sense of responsibility: *I need to be there for them because they can't come here if they don't want my help – they are really desperate, need my help and I have to help them.* These last quotations and the next one point towards the altruistic nature of nursing that drives the provision of care on a physical as well as emotional level: *That's my main reason to be here. I have to help those who can't help themselves and I have to help them in totality in everything that I could help them.*

Another factor that motivates emergency nurses to provide emotional support is the feeling of emotional fulfilment experienced afterwards. This feeling can fulfil a personal or professional need as illustrated in the next two examples.

In the first example the emotional fulfilment reflects a professional experience: *...the patients that I have helped that have been abused by a partner – you know I feel glad ... I have nursed her....* The participant even visits survivors who have been admitted in the wards: *I do the follow ups. During my tea-time or my lunchtime, I go straight to the ward.* She finds consolation when seeing for herself that *...she's fine now at the end of the day. I can see that that poor woman she's fine now.*

The second example refers to a participant who has been exposed to gender-based violence herself. She says: *I feel better. I feel good that I have done something for*

somebody today. This feeling is confirmed when the survivor shows gratitude: ...after I speak to the patient then I see the person maybe say: 'Thank you for talking to me.' ...because most will tell you: 'Really sister what you said to me it makes me strong. What you said to me makes me think how important my family is to me than this person. What you have said to me gives me hope that it's not the end of the world.' It feels good to help, a feeling that prompts this participant to do even more for the survivor: *I'll feel good if the person is getting helped and if she doesn't I'll go the extra mile to do something....* To be able to provide emotional support to the survivor serves in a way as compensation for another participant: *...at least I have somebody who I can help to deal with the situation....* She provides emotional support to bring about relief for the survivor: *I think if something happens to you it feels good when somebody cares. If I call that person she will realise that there are people outside who care.* Her identification with the situation is indicated by the use of the personal pronoun when referring to the survivor's situation: *Even if there are those who blame **me** but somebody believes in **me**.... I think that's the difference it can make to the person.*

The final part of the care the emergency nurse provides is to refer survivors to the appropriate services. Most participants are aware that survivors of IPV *...need to be counselled;* and of the different referral options: *...we having the trauma counsellor, psychiatrists, psychologists, social workers ... you can even go to the police station;* and: *...we also have counsellors, church organisations like (mentioned the name of the organisation)....*

The organisation mentioned by emergency nurses in the context under study, is a hospital-based organisation offering pastoral counselling to patients and their families. Most participants are easily referred to these counsellors as they are either available in the units or will quickly respond when called: *...we will even call moruti (Sesotho word for pastor) to counsel; We use them as well for counselling because at least with them they are always here. You see the man next-door; he's a counsellor and what I will like about him is that you can phone him any time and he comes.* and: *...there's those people around from (the name of the organisation) ... its always better to involve them. They help a lot. They have got the skills to help these people.* One participant indicated that she would specifically make the survivor aware of this referral option: *...if she wants a spiritual counsellor or something like that she mustn't be afraid. She must tell me so that maybe I can tell our unit manager about this problem so that she can organise the (name of the organisation) counsellors to come and see her.*

Some survivors though *...don't want pastoral counselling, that's the thing. If we tell them about the priest they say uh hu...* Other referral options are indicated in the following quotations: *...the social worker that can come and speak to her and try and assist her in a way... and: if it's something for a psychological problem ... they organise consultation to the psychologist.... With the psychologist he's got an office and you know they are trained; they do one-on-one.... If the patient is able to walk she can go there or sometimes the social worker or psychologist come in here; then they talk with the patient.* But these professionals are not necessarily always available: *...the social workers have lots of work as well... and ... psychologists are not here. They work office hours....* This poses certain challenges, as survivors do not necessarily come back for appointments: *...sometimes you see you discharge her today, you say 'come back tomorrow' and sometimes they will never pitch ... because when they go home she can try to console herself....* This explicates the phenomenon that survivors are more susceptible to interventions immediately after the abusive episode: *When she comes when she's at the peak I think that's the best time, then she gets counselling that time.* That is why *...we should be able to get counsellors whenever they need them* to ensure that the survivor *...get everything, all the care, all the service* while she is in the emergency unit and *...it's still raw, still raw.* Some survivors don't even have the physical or psychological means to execute the advice to consult a professional person: *...even if you tell them to go to the social worker, the nearest social worker, they don't even know where the social worker is. But some of them are from a rural area and they don't even understand what you are talking about.*

Not all emergency nurses are that attentive about referring survivors. One participant verbalises that she *...never had the opportunity where I could refer them to counselling.* Another one relies on *...pamphlets and phone numbers to give them;* leaving the responsibility with the survivor: *I think you will give them that info and then they can take it up from there.*

One participant explains that *...in a busy unit like this* the nurses don't necessarily do referrals. As explained by this participant, referral is not a priority in the emergency unit: *But straight from here, no, because they have to treat the trauma first, the condition, the injuries before they can refer the patient, and here they don't stay long so that's the reason.* She adds though: *I think after maybe they have been stabilised ... they need to be referred either to the psychologist or ... I think to the psychologist for counselling,* but sees it as someone else's responsibility: *...maybe after when she's in the wards maybe its then that the doctor can refer a patient to a social worker....*

Seeing referral to the social worker or psychologist as the medical practitioner's responsibility might be a logical deduction to make as that is the way the system works: *The doctor who saw the patient will arrange with the psychologist to come to casualty and talk to the person and give them some appointment to come back.* The doctor may also request the emergency nurse to arrange the referral: *...sometimes the doctor maybe can just say: refer to social worker ... because when they discharge the doctor writes: refer to social worker and you refer them, depending on what they said to the doctor inside.*

Although emergency nurses *authority is limited*, they can still advocate for the survivor when they suspect something is wrong and see a need for referral. This recommendation seems to be done in quite a diplomatic way as evident from the next quotation: *...we've seen you are able to advise the doctor ... as soon as the doctor wants to see her you quickly speak to the doctor ... 'There's something wrong there doctor'... 'You know what this lady ... I'm suspecting 1, 2, 3, (a few essential points) because when I was asking she started to cry, I don't know ... I also discovered 1, 2, 3. And doctor what do you plan?' They (the doctors) will even say: 'Did she say something?', then we recommend counselling to the psychologist.* Feedback is received from the psychologist through the doctor: *...then usually the doctor will get a report from the psychologist that um, no, there's 1, 2, 3: 'I will be seeing her, I will be counselling her....'* Feedback from and access to a referral system brings relief: *I know there are things I can do up to here, but then at least whoever takes over, I'm relieved. At least somebody, a psychologist or doctor takes over but at least I did something.*

One participant mentioned that she also makes survivors aware of other resources such as *...support groups, stuff like that or maybe advise her about the telephonic lines for people who have been abused. They have got a number; just advise her where she can get help and stuff like that....* The police are seen as the last option by this participant: *...you can even go to the police station if maybe you find that you don't have anywhere to go. You don't know what to do with that person (the perpetrator) you can go to the police station. They will deal with him.*

Admission to hospital might be considered as a temporary place of safety and to allow time to start the counselling: *You can see there's something wrong at home we suspect serious violence so we end up saying aha this woman can't go home like this. Just to try to take her away from the area you know until she gets the counselling.* Another participant feels that all survivors should be admitted for at least two nights'

observation: *I think maybe we can keep the person for two nights in hospital; that's when we can review the person....* This might also reflect the participant's own need to relieve the concerns she often feels after the survivor has left: *...we can compare the person. How is she compared to yesterday? How is the response? How is that anger? You can check the patient, the fact that she's sleeping and even tried to eat....* Even the participant's concern that the survivor will commit suicide will be addressed: *When somebody is amongst people it's better than going back home where the situation happened. While the situation is still fresh it's difficult. Maybe it's better after some few days....* During admission the survivor will *get time to think, cry if she wants to cry, sleep on the bed alone. Sometimes you don't want to talk to anyone and you just want to sleep, to cry and cry. Some people if they cry they feel better.*

Not to be able to follow up and know what has happened to the survivor is a part of providing care that emergency nurses are deprived of: *But unfortunately I couldn't follow it up ... I was just there for her to ventilate ... They go home, but what is going on at home or afterwards? We don't know ... we don't keep track of them.*

3.3 CONCLUSION

In this chapter the findings of phase 1 of the study were discussed. The essence of emergency nurses' experiences of taking care of survivors of IPV was presented followed by an in-depth description of the constituents – the meanings that constitute the essence. The meanings were illustrated with quotations from the interviews expressed in the voices of the participants. Chapter 4 provides a discussion of the findings and refers to the literature review carried out.

CHAPTER 4: DISCUSSION OF RESEARCH FINDINGS AND LITERATURE REVIEW

4.1 INTRODUCTION

Chapter 3 provided a description of the findings of the phenomenological inquiry. The essence was discussed at an abstract level and was followed by a description of the constituents that illuminate the essence. Chapter 4 consists of a discussion of the findings with the incorporation of the applicable literature in order to create an improved understanding of the essence and its constituents. The inclusion of the literature in the findings was conducted in accordance with a descriptive phenomenological approach (Dahlberg *et al.* 2008: 272-3). Meanings present in the data were more clearly revealed to the consciousness through their being explicated in terms of related theories and research findings.

4.2 EMERGENCY NURSES' EXPERIENCES OF PROVIDING CARE TO SURVIVORS OF IPV

Considered superficially, the provision of emergency nursing care to a survivor of IPV appears to be certain clinical interventions implemented by an emergency nurse in her professional domain – in the context of this study, to a woman injured by her intimate partner. An in-depth phenomenological inquiry, however, revealed this phenomenon to be an experience that does not leave emergency nurses untouched. Exposure to survivors' experiences with IPV has a certain emotional and cognitive impact on emergency nurses who attempt to cope with and make meaning out of these experiences. Moreover, as women living in South Africa, the possibility is strong that emergency nurses might have been personally exposed to IPV, or to friends', family and/or community members' experiences of IPV. These experiences leave a memory that interrelates with experiences of IPV in the professional domain. It turned out that not only experiences with IPV, but also with other gender-based violence, interrelates with professional experiences of IPV. Identification with the survivor's experience reveals itself when certain elements in the survivor's experience interrelate with a similar situation that has occurred, or has the potential to occur, in the emergency nurse's personal domain.

Professional and personal domain experiences and the emergency nurse's attempts to cope with the exposure to survivors' experiences and make meaning out of IPV give

way to the formation of gender perceptions and assumptions regarding IPV and intimate relationships. These assumptions, as well as certain professional and caring qualities, shape the frame of reference from which the emergency nurse provides care to survivors of IPV.

The term “internal frame of reference” was described by Rogers (1959: 210), the founder of client-centred therapy, as follows: “All of the realm of experience which is available to the awareness of the individual at a given moment. It includes the full range of sensations, perceptions, meanings and memories available to consciousness.”

The emergency nurse’s frame of reference that guides the provision of care to a survivor of IPV is based on certain personal- and professional domain experiences. In the context of phenomenology an experience is realised when intentional acts directed towards the same object of experience merge; in other words: “a full experience is a synthesis of several intentional acts” (Spiegelberg 1964: 327). Within the context of the study two questions emerge so far: What is the nature of the *intentional acts of consciousness* and what constitutes the *object of the experience* as related to emergency nurses’ experiences of providing care to survivors of IPV?

The *intentional acts of consciousness* (noeses) direct experiences towards objects and include cognitive (for example, judging, knowing, believing and questioning), linguistic, affective, volitional and perceptive acts, awareness of personal experiences, and awareness of others (Solomon 1972: 172-174; Smith 2011: n.p.). A perceptive act is described as an intentional act with sensory qualities. It brings the object of perception directly to intuition and refers to the “givenness” of an object, it constitutes the now (Solomon 1972: 172-174; Husserl 2001: 296). It can be concluded that experience includes both spontaneous activities (doing) and receptive processes (undergoing) – for example, seeing and hearing (Spiegelberg 1964: 328; Smith 2011: n.p.).

The *object of the experience* refers to the event or state of affairs that the act represents and how it is represented. Not all intentional acts are directed towards concrete objects; for example, mental states. This problem was resolved by Husserl (according to McIntyre & Smith 1989: 157-158) with the concept of the noema. The noema forms part of the phenomenological content of the act. It relates to the quality of an act, the intentional character of the act, what the act represents. In other words, the noema relates to the meaning of the act (McIntyre & Smith 1989: 158-159; Solomon 1972: 170-3). When an object is perceived, it is perceived in terms of the

noema – that is, the appearance of the object from the person's particular perspective. The object of perception has many noemata that cannot be perceived in totality from all different perspectives. Perceptual coherence of an object can be obtained if perceived from all different perspectives and all expectations are fulfilled (the "internal horizon" of an object) (Solomon 1972: 170-4; Yoshimi 2009: 124). The "external horizon" refers to the object's possible relations to other things in the world (Solomon 1972: 170-4; McIntyre & Smith 1989: 174).

In phenomenological terms it can be said that the emergency nurses' personal and professional domain experiences are "first person" experiences synthesised from among others: perceptive acts (witnessing – seeing and hearing); cognitive noeses (concerns, memories and visualisations); affective noeses (feelings); linguistic activity (meaning making), awareness of personal experiences; and embodied action and awareness of others (provision of care). These intentional acts are directed towards the survivor of IPV and in an indirect way towards the phenomenon of IPV. The essence reflects the internal horizon of the experience of providing care to survivors of IPV. The "external horizon" refers, for example, to experiences with gender-based violence in the emergency nurse's personal domain that relate to the process of providing care to survivors of IPV.

Emergency nurses live through professional and personal domain experiences with IPV as they think about, visualise and feel the impact of these experiences. They are conscious and aware of these experiences and attach a certain meaning to them. "This feature is both a phenomenological and an ontological feature of each experience: it is part of what it is for the experience to be experienced (phenomenological) and part of what it is for the experience to be (ontological)" (Smith 2011: n.p.).

The intentional acts of experiential phenomena are dependent on each other and form part of an experiential stream (Giorgi 2009:81). A current intentional act and its object occupy the temporal foreground, but take place against the backdrop of the temporal background: "the acts and objects which are past and future with respect to the intuitive present" (Brough 1975: 57). Similarly "experiences integrate themselves into one stream of consciousness" and are connected as they relate to each other (Fasching 2009: 134). Experiences are not sharply delineated, as they refer beyond themselves and have a temporal pattern that is open towards existing data (past phases) and potential data (future phases) (Spiegelberg 1964: 327). Past phases of an experience do not "vanish into phenomenal nothingness" (Fasching 2009: 135), but are submerged by more recent intentional acts and subside toward deeper levels of consciousness (Spiegelberg 1964: 327).

What has been perceived (including witnessed), thought and felt by emergency nurses over time in terms of gender-based- and intimate partner violence constitute their professional and personal domain experiences. These past experience(s) subside into deeper levels of consciousness. When exposed to a survivor's experience in relation to IPV, whatever the emergency nurse does, feels and thinks (intentional acts) takes place against the temporal background of past and potential future experiences that are related to the current intentional act. This process is termed in the research findings as the interrelation between emergency nurses' and survivors' experiences with IPV and emergency nurses' identification with survivors' experiences. In phenomenological terms the interrelation can be described as an open-ended experiential stream: what is experienced now – the current intentional act of providing care to the survivor of IPV – is experienced in terms of past and potential experiences with gender-based- and IPV in the emergency nurse's personal and professional domain.

Past experiences, or the intentional acts that constitute the experience, continue to be accessible "from the inside" (Fasching 2009: 135) and can be recaptured in terms of the way they were perceived in the past, as well as in terms of the "elapsed inner consciousness through which they were originally experienced" (Brough 1975: 55 & 60). In the research findings emergency nurses recaptured their experiences with survivors of IPV – not only what they heard and saw, but also what they felt and thought at the time of the experience.

So far the essence of emergency nurses' experiences of providing care to survivors of IPV has revealed the following in phenomenological terms: emergency nurses have certain experiences in relation to IPV and these experiences are synthesised from a variety of intentional acts. Past experiences subside into deeper levels of consciousness where they interrelate with each other and with current experiences of IPV and these experiences are cognitively recollected at times. The last part of this discussion relates to the subject or agent of the experience – the emergency nurse.

In the paper "The mineness of experience" Fasching (2009: 132) reasons "that there is something irreducibly subjective about conscious experience." He points out that "experiences exist by being subjectively experienced", and asks the question: "But who or what is this 'experiencer' to whom the experience is exclusively given in this way?" Fasching (2009: 132) points out that experiences are given in a unique way to the experiencer by quoting Husserl (1956: 166) who wrote: "experiences are not in a

nowhere-land”, but “in me”. The subject who performs intentional acts is described in Husserl’s earlier writings as the pure Ego or Transcendental Ego, which is empty of essential components (Solomon 1972: 174-5). However, as Moran (2005: 267) indicates it would be phenomenologically inaccurate to deny that experience is first-personal in its core nature. In later writings Husserl describes the ego as “the center of all affections and actions” with, for example, convictions, values, an outlook and a history (Moran 2005: 275-276), and the notion is introduced that objects are constituted by consciousness and by the ego (Solomon 1972: 177).

A system of beliefs, values and convictions about the world has its origin in a complex process (series) of intentional acts, starting from the basic acts of perception and feeling (that helps to “constitute” the object) and moving to more complex linguistic and cognitive acts, such as judgment, introspection and reflection (Spiegelberg 1964: 327; Yoshimi 2009: 127-138; Spear 2012: n.p.). The process is described in detail by Yoshimi (2012: 127-138) from a phenomenological perspective. When one perceives an object and appearances unfold in a certain stable way, it is assumed that things are the way they seem to be. Sometimes these perceptions of objects are focused on, spoken about, and investigated. Through a process of synthesis the characteristics or structure of objects are explicated and sometimes (theoretically) articulated in language (linguistic acts). These thoughts; and understanding about objects are “sedimented” into consciousness and change the way the object is experienced in the future. In the future the same object is approached in terms of an expanding horizon of tacit meanings, an explicit awareness of the object’s nature and ultimately with linguistic statements about the nature of the object. McIntyre and Smith (1989: 177-179) also describe how a person’s background beliefs and presuppositions help define the boundaries of the horizon of the object. These expectations held by a person are motivated by prior experiences and subsequent conclusions are drawn from experiences.

The previous discussion sheds some light from a phenomenological perspective on how the way emergency nurses’ perceive, think and feel about their experiences with survivors of IPV and the phenomenon of IPV can lead to the formation of expectations, beliefs and presuppositions that will ultimately affect the way survivors of IPV are approached and cared for. However, as Husserl’s focus was more on epistemology and obtaining knowledge from a transcendental realm (Barua 2007: 2), other theoretical explanations are needed to explicate how a person’s assumptions and frame of reference guide behaviour.

For Rogers (1951: 494), the founder of non-directive therapy, “the best vantage point for understanding behavior is from the internal frame of reference of the individual himself”. Rogers’ person-centred approach reflects a phenomenological approach to personality. Personality is unique, as each person perceives the world in his own unique way. The self is made up of ideas, perceptions, concepts and values that characterise the person (Sibaya & Nicholas 2008: 226). How reality is thought about, understood, or felt to be constitutes a person’s internal frame of reference, or subjective world. A person’s response towards an event is guided by experiences and perceptions in relation to that event (Carducci 2009: 207).

The constituents that serve to illuminate the essence as explicated above are discussed in terms of the applicable literature in the next sections.

4.2.1 Exposure to the survivors’ experiences of IPV

Emergency nurses provide care to the survivor of IPV, but are at the same time exposed to the survivor’s experience with IPV. This exposure has an emotional and cognitive impact on emergency nurses. The *emotional impact related to being a witness to survivors’ experiences of IPV* and the *cognitive impact related to being exposed to survivors’ experiences of IPV* are discussed in the next two points.

4.2.1.1 Emotional impact related to being a witness to survivors’ experiences of IPV

Emergency nurses feel the emotional impact in response to being a witness to the survivor’s emotional and physical suffering in relation to the phenomenon of IPV.

According to Weingarten (2004a: 46), there are many experiences that constitute witnessing and definitions differ on types of witnessed events referred to – for example, seeing or hearing a direct event of violence taking place or obtaining knowledge of another person’s traumatic experiences (Buka *et al.* 2001: 298-299). Apart from witnessing the violence and violation all human beings are confronted with, health care professionals have no choice but to expose themselves to trauma survivors’ stories of violation, horror and pain. They are “people who can bear to hear what others fear is unspeakable” (Weingarten 2004b: 70). Ferrell and Coyle (2008: 246) explicate how the close interpersonal involvement implicated in the provision of care puts nurses in a position where they are witnesses to others’ responses to illness and injury. It is part of their daily work to care for those who suffer. To witness and

relieve suffering is an integral part of the nursing profession. "Nurses are the confidants for patients who experience the personal threat of injury or serious illness." (Ferrell & Coyle 2008: 246).

While taking care of survivors of IPV, emergency nurses become witnesses to their suffering: they often have to listen to survivors narrating their experiences with IPV; they see the emotional suffering survivors experience; they see the injuries inflicted by IPV and the consequences of such injuries and; sometimes they see the dynamics of the intimate relationship characterised by violence played out in the emergency unit.

Emergency nurses in the study described the injuries they witnessed. They narrated how painful and disturbing it is to encounter the often devastating consequences of IPV such as disabilities, disfiguring injuries and death. Being confronted with patients badly injured or even dying were reported by doctors and nurses as some of the most distressing experiences (Chan & Huak 2004: 210).

Emergency nurses find it difficult to comprehend that the terrible injuries they witness have been inflicted by a loving partner. At times they are witnesses to and shocked by the ambivalence inherent in IPV – loving someone and causing harm to that person at the same time. Describing predictors of IPV, Finkel *et al.* (2009: 484) also commented on IPV as a shocking and confusing phenomenon by asking the question: "Why would individuals deliberately inflict physical pain on a partner with whom they have chosen to merge their lives?"

Emergency nurses are witnesses to the physical and emotional suffering of survivors of IPV. Kellehear (2009: 388) points out that suffering is characterised by an event and a response. The response can have a physical and/or emotional component of pain and is associated with psychological and/or spiritual distress brought about by an actual or perceived threat to the integrity or meaningful existence of the whole person (Cassell 1991: 24; Wilkinson 2005: 16-18; Ferrell & Coyle 2008: 246). Edelglass (2006: 45-47) illuminates suffering through the eyes of Levinas (a constructivist philosopher who proposed a phenomenological hermeneutic description of lived experience in the world (Bergo 2011)) by explaining how suffering changes the very existence of a person into an "overwhelming weight" that "entangles and suffocates" and disrupts a person's ability to find meaning in existence.

Witnessing the physical and emotional suffering of survivors of IPV has an emotional impact on emergency nurses. They feel it as emotional pain and distress – sadness, depression, fear, horror, trauma, sympathy, anger and shock. People in helping professions working with trauma survivors have reported many psychological experiences. Among others are emotions of sadness, grief, depression, anxiety, horror, fear, anger, hopelessness and a sense of being overwhelmed (Valent 2002: 18; Hernandez *et al.* 2007: 237). Emotional distress can be related to the healthcare professional feeling the survivor's suffering which can lead to powerlessness (Taft, Broom & Legge 2004: 2).

Personal emotional distress is described by Eisenberg and Eggum (2009: 72) as a self-oriented response, on the basis of the work of Batson (Batson 1991: 86; Batson & Shaw 1991: 112-113), who envisaged "personal distress" as anxious, upset and disturbed feelings. Personal distress results in a desire to relieve one's own distress or suffering, as opposed to empathy, which is described as other-directed concern (Eisenberg & Eggum 2009: 72; Eisenberg 2010: 129-130). Empathy triggers altruism which has as its ultimate goal the enhancement of another's well being (Batson 1991: 4 & 6). (For a discussion on empathy refers to point 4.2.2.)

Compassion, an emotional response "that arises in witnessing another's suffering" (Goetz, Keltner & Simon-Thomas 2010: 351-352), also involves a desire to help and motivates altruistic behaviour (Goetz *et al.* 2010: 351 & 362). Nilsson (2011: 125-126 & 139) argues that the person feeling compassion inevitably experiences suffering, as compassion entails (1) the awareness and belief that someone else is suffering, (2) suffering over the other person's suffering for the other person's sake, and (3) wishing for the other person's sake that he or she were not suffering. Compassion results in an "inclination to relieve the suffering" (Gelhaus 2012a: 399).

The emotional impact emergency nurses described reveals something of the witnessing position some of them found themselves in. Weingarten (2000: 395-396; 2004a: 47-48) has developed a witnessing schema consisting of four witnessing positions based on whether the person is aware or unaware of the significance and meaning of the witnessing, and whether one feels empowered in relation to the witnessing or not.

An empowered position would include activities allowing a person to express his or her anger and fear (Weingarten 2004a: 54). The anger emergency nurses feel towards

the perpetrator empowers them in some cases to act on behalf of the survivor. For example, one of the participants felt so strong about a case of serious IPV where the partner tried to prevent the emergency nurses from intervening, that she requested help from the hospital manager. Research illustrating the association between anger and approach motivation and positive activation (Carver & Harmon-Jones 2009: 198) highlights the role of anger as a motivator towards constructive social interaction (Potegal & Stemmler 2010: 4). Anger motivates active attempts to stop or defend an offensive act (Hutcherson & Gross 2011: 732-733), which may refer to, among other things, a sense of injustice (Potegal & Stemmer 2010: 3).

Emergency nurses' feelings of disempowerment in relation to witnessing manifest itself in feelings of sympathy towards the survivor. Sympathy is defined as an emotional response based on the capacity to recognize another's emotional state and is characterised by feelings of concern and sorrow for the other person (Eisenberg *et al.* 1991: 459; Black 2004: 580-581; Eisenberg & Eggum 2009: 71-72; Tompkins 2009: 66). The feelings associated with sympathy are painful, as the word "sympathy" is often associated with "sadness", as highlighted by Goetz (2010: 353). In sympathy feelings *for* another occur, so sympathy is more of a supportive feeling that can be interpreted as feeling *pity* for another's pain (Keen 2006: 208-209).

In the study findings emergency nurses described how they felt sympathy when they sensed the vulnerability and powerlessness of a woman exposed to IPV. In these descriptions the woman was referred to as a "victim" rather than a "survivor". Feelings of sympathy may indeed arise from situations where a person is perceived to be a victim of forces that are beyond his or her control and of undeserved negative events (Feather, McKee & Bekker 2011: 5 & 12). As Clark (2010: 97) explains: in contrast to empathy, that involves a sharing of the experience, sympathy reflects a person's response to another's distress based on his/her judgment of the other's emotional needs. A healthcare professional's expressions of feelings of sorrow based on sympathy (Clark 2010: 97), or implicit agreement that a traumatised person should feel bad, angry, or hopeless can contribute to a survivor assuming the role of a victim (Knapp 2007: 91). A sympathetic connection with the "victim" can lead to over-identification and feelings of disempowerment in professionals (McCann & Pearlman 1990: 137; Pearlman & Saakvitne 1995: 152-153). Over-identification is illustrated in a study by Goldblatt (2009: 1649) where the nurse's strong sense of responsibility and pity for the survivor leads to frustration and anger and a failure to understand the survivor's choice to stay in the relationship. As such, sympathy not only reflects the

“victim’s” unfavourable position, but also puts the emergency nurse in the position of a powerless witness.

Weingarten (2004a: 72) points out that a professional who finds himself or herself in a position of being painfully aware of the significance of the survivor’s situation, but feels helpless, ineffective, or lacks resources to do something about it, is at risk of developing burnout, secondary traumatic stress and vicarious traumatisation. Professionals who feel helpless to change what they are witnesses to can respond with defensive behavior, such as devaluating survivors’ experiences (Pearlman & Saakvitne 1995: 155).

From the abovementioned discussion certain questions arise: Do emergency nurses feel compassion; that is, do they suffer for the sake of survivors of IPV? Do they feel a desire to relieve the suffering of survivors? Do they feel sympathy, personal distress or empathy? The research findings do not provide incontestable answers to these questions. These experiences can also not be seen in isolation; just as compassion, empathy and sympathy are interrelated and are often labelled in similar ways (Batson 2009: 8; Goetz *et al.* 2010: 352-353). Emergency nurses can experience these compassion-related states in different degrees in different situations.

What is, however, clear from the findings is that emergency nurses sometimes do experience suffering for the survivor’s sake. The findings (Chapter 3, 3.2.1) illustrate how participants sometimes feel emotionally touched and affected when witnessing the survivor’s suffering. This emotional pain is sometimes felt long after the witnessing as a “heavy” and depressing feeling. Some of the participants experienced elements of empathy (for example, feeling what the survivor is feeling). The experience of sympathy is elicited in sensing the vulnerability and powerlessness of a woman seen as a victim rather than a survivor. Sympathy is also evident in concern for the survivor, as will be illustrated in the next constituent.

The findings of the study indicate that most emergency nurses are acutely aware of the survivor’s suffering and, although during the interviews some explicated the effects of the witnessing on their own lives, their own experiences are something they normally move to the background as will be seen in Chapter 3, 3.2.4. Gates and Gillespie (2008: 243) indicate that many nurses caring for women exposed to IPV are at risk for secondary traumatic stress, but may lack awareness of the possibility and potential impact on their lives. Secondary traumatic stress will be discussed in the next constituent dealing with the cognitive impact.

4.2.1.2 Cognitive impact related to being exposed to survivors' experiences of IPV

The cognitive impact is characterised by thoughts of a troubling and lingering nature and includes concerns for the survivor; longstanding, recurrent and intrusive memories; and disturbing mental images.

The thoughts of concern emergency nurses experience seem to be associated with the feelings of sympathy they sometimes feel for survivors. The term "empathic concern" as described in the literature illuminates the close relation between thoughts of concern that cannot be seen separate from the associated emotional experiences. Empathic concern, also described as "compassionate concern" is elicited when witnessing someone in need (Niezink *et al.* 2012: 545). Batson, Fultz and Schoenrade (1987: 28) identified six adjectives indicative of empathic concern – "sympathy", "compassion", "being moved", "tenderness", "warmth" and "soft-heartedness". Later research by Niezink *et al.* (2012: 547) distinguished two components of empathic concern – sympathy and tenderness. Sympathy ("sadness" category) was found to be associated with three of the six adjectives identified by Batson *et al.* (1987: 28), while the other three relate to tenderness ("love" category). Sympathy, compassion and being moved are evoked by witnessing someone in need that is experiencing suffering or hurt. Tenderness, warmth and soft-heartedness become evident when a person is perceived to be vulnerable. Compassionate concern has at its goal the desire to relieve suffering; that is, to give "a caregiving response" (Goetz *et al.* 2010:368).

Emergency nurses' concerning thoughts mostly surface after they have left the unit or after the survivor has left the unit and emerge in the form of questions reflecting their worries and concerns for the survivor. They ponder about the fate of the survivor: What happened after she left the unit – more violence? Blaming? Is she coping, or not – perhaps ending in suicide? Is the IPV persisting or not – did she leave the relationship? The thoughts reflect emergency nurses' awareness that the survivor is suffering and a hope for the IPV to end and for the survivor to be relieved. In some cases emergency nurses' concerns also reflect tenderness when the survivor is perceived to be vulnerable; for example, a mother with a baby, a young person, and repetitive exposure to IPV.

Some of the concerning thoughts or mental images constructed from survivors' experiences become entrenched in emergency nurses' memories. The memories sometimes surface spontaneously or are triggered by similar experiences. While

narrating these memories, the emergency nurses in the current study spontaneously expressed the accompanying emotions as were discussed in the previous constituent. These experiences seem to resemble the intrusive symptoms of post-traumatic stress disorder, which are described as recollections of traumatic events in the form of a re-enactment of the event accompanied by strong emotions (Horowitz 2003: 2). The recurrent, intrusive recollections are triggered by internal or external stimuli and can take the form of thoughts, perceptions, images or dreams (Ursano & Norwood 2003: 5). Characteristic of intrusive recollections are unwanted images of the trauma that may include sensory experiences such as smells, tastes or sounds and may be accompanied by the emotions experienced at the time of the traumatic experience (Taylor 2009: 12).

The cognitive and emotional experiences discussed so far echo what Weingarten (2004a: 70) wrote about people in the helping professions: "our choice to witness is not without biological, psychological, and interpersonal consequences for us." Among others the different terms used to describe the negative effects resulting from working with traumatised patients include "compassion fatigue", "secondary traumatic stress" (STS) and "vicarious traumatization" (Way *et al.* 2004: 50). Although these concepts overlap and are sometimes used interchangeably, clear conceptual differences can be identified (Jenkins & Baird 2002: 431; Beck 2011: 2; Tabor 2011: 203-204), which will be discussed immediately below.

Figley (1993: 1) defines STS as a natural consequence of "wanting to help a traumatized or suffering person". People in helping professions may feel the emotional pain and suffering their clients experience - "absorbing" the suffering of others is related to the professional's empathetic capacity (Figley 1995: 1-2). The symptoms of STS are almost identical to post-traumatic stress disorder, the only difference being the trauma is experienced by a significant other. As STS is associated with caring and compassion "in the line of duty", Figley (1995: 14-15) suggests that the terms "compassion fatigue" and "STS" be used interchangeably as some people may find the term "STS" derogatory.

Compassion fatigue depletes a person's ability to feel and care for others (McHolm 2006: 14) and to bear their suffering (Figley 2002: 1434). Coetzee and Klopper (2010: 235) point out that compassion fatigue was originally described by Joinson (1992), who identified the phenomenon in emergency nurses. In nursing practice, compassion fatigue is defined as "a state where the compassionate energy that is expended by nurses has surpassed their restorative processes, with recovery power

being lost.” (Coetzee & Klopper 2010: 237) The exhaustion is described by McHolm (2006: 14) and Showalter (2010: 240) in terms of emotional, physical, social and spiritual exhaustion. Coetzee and Klopper (2010: 239 & 241) elaborated on these; for example, physical effects include symptoms of burnout and a lack of energy; emotional exhaustion presents itself as desensitisation and a feeling of being overwhelmed, social effects include unresponsiveness and indifference towards patients; and spiritual effects are characterised by a lack of spiritual awareness.

The way compassion fatigue is described by Figley (2002: 1435) as a pre-occupation with others’ accounts of traumatisation by re-experiencing the events, avoiding or numbing of reminders of the event and persistent arousal echoes with what McHolm (2006: 14-5) describes as compassion fatigue level 2. The nurse re-experiences the patient’s traumatic experiences as flashbacks coupled with symptoms of avoidance in an attempt to shield the re-experiencing, and/or persistent arousal.

Factors associated with a vulnerability to develop compassion fatigue include a tendency to closely identify with and absorb the trauma witnessed in patients (McHolm 2006: 14, Showalter 2010: 239) and a high turnover of patients and changing shifts, as occurs in emergency units (McHolm 2006: 14). The risk further increases for emergency nurses who are frequently exposed to violently traumatised patients (Gates & Gillespie 2008: 244). Yoder (2010: 195) adds to this those situations where nurses experience an inability to rescue the patient – for example, caring for young dying patients and patients victimised by a significant other. A study conducted in California (Dominguez-Gomez & Rutledge 2009: 201) found that 33% of emergency nurses met the criteria for STS, with symptoms such as avoidance of clients, intrusive thoughts, emotional numbing and reliving clients’ trauma

“‘Vicarious traumatisation’ refers to a transformation in the therapist’s (or other trauma worker’s) inner experience resulting from empathic engagement with client’s traumatic material.” (Pearlman & Saakvitne 1995: 151) Vicarious traumatisation specifies the way in which exposure to the client’s trauma disrupts the professional’s cognitive schemas and memory system (Pearlman & Saakvitne 1995: 153-164). Disruptions in the cognitive schemas will be described under point 4.2.6. Changes in the memory system are described as imagery and take the form of intrusions of the client’s traumatic imagery (Pearlman & Saakvitne 1995: 151). These internalised accounts can lead to disruptions in memory and can be re-experienced as flashbacks, dreams or intrusive thoughts, often associated with uncomfortable emotional reactions (McCann & Pearlman 1990: 142-143).

It is beyond the scope of this study to give a decisive answer as to whether emergency nurses in the study context present with compassion fatigue, STS or vicarious traumatisation. As Hayes and Frederickson (2008: 98) outlined, the degree to which exposure to secondary trauma has an impact on a professional person differs. Other studies (Wastell 2002; Bell 2003; Linley & Joseph 2007; Aycok & Boyle 2009; Von Rueden *et al.* 2010) indicate the role the coping mechanisms employed by a professional play in the development of STS, compassion fatigue and vicarious traumatisation or not.

What is evident from this research is that some of the emergency nurses described experiences of intrusive thoughts and mental images of scenarios witnessed in the emergency unit and reconstructions of how the IPV happened. The re-experience of these traumatic events was accompanied by strong emotional reactions, as already discussed. One of the emergency nurse's narrations of a seriously injured woman was devoid of emotion, and another described avoiding an area of the unit when becoming aware that a survivor of IPV was being treated there (Chapter 3, 3.2.1 and 3.2.4). These experiences can be indicative of avoidance or numbing, which can be ascribed to exposure to traumatic material that is too overwhelming to integrate (Figley 2000: 1435, McCann & Pearlman 1990: 134). Some participants related how the lingering nature of the thoughts and feelings were sensed by their families – something that can have a significant effect on their relationships and lives.

The lingering thoughts about survivors' experiences inevitably interrelate with emergency nurses' own lifeworld experiences: What is familiar? Is there potential for this to occur in my life...? These processes will be reflected in the next two constituents.

4.2.2 Identification with survivors' experiences

Emergency nurses describe different ways in which they identify with the experiences of survivors of IPV. Identification reveals itself in descriptions suggesting that certain elements in the survivor's experience reflect a similar situation that occurred, or has the potential to occur, in the emergency nurse's personal domain.

Identification manifests itself firstly as empathic feelings – feeling with the survivor – and secondly as an awareness that the survivor's experiences reflect with one's own past and potential future experiences.

The phenomenon of identification is explained in the literature in two ways; firstly in psychoanalytical terms as a defence mechanism; and secondly as a component of empathy. The research and literature on empathy illuminate identification from a phenomenological, humanistic and neuroscientific perspective, which seem to be relevant to the way in which this phenomenon manifests itself as part of emergency nurses' experiences of providing care to survivors of IPV.

Cohen (2001: 521), who described identification with media characters defined identification "not as an attitude, an emotion, or perception but, rather, as a process that consists of increasing loss of self-awareness and its temporary replacement with heightened emotional and cognitive connections with a character." Identification, in psychoanalytical terms, plays a major part in the development of the ego and the establishment of moral values (the superego) (Olds 2006: 18). In this sense identification refers to a largely unconscious mental process, first described by Freud in 1896, by which someone "is taking in" a desired object, identifying with and imitating the object, continually being transformed by the object. Identification in a psychoanalytical sense refers to internalisation of attributes belonging to others (Rustin 2012: 498) and has been referred to as "secondary identification" by Sandler and Perlow (1987: 9-10).

Primary identification, on the other hand, refers to a "fleeting" normal phenomenon of feeling oneself to be closely associated with a person (or group) in terms of certain attributes (Sandler & Perlow 1987: 9-10). This phenomenon has been regarded as a basis for empathy in psychoanalytic literature (Sandler & Perlow 1987: 9-10). To understand how identification and empathy are entwined (Olds 2006: 4), one needs to explore the phenomenon of projective identification as originally defined by Melanie Klein (1955: 310-311) as an unconscious fantasy and as a defence mechanism that is a normal part of infant development, but underlies psychotic illness in adult life. Destructive impulses that provoke intense anxiety are projected into and directed towards the mother (Black 2004: 584; Richmond 2004: 246-247). The boundaries between mother and infant merge so that the mother becomes an extension of the self (Richmond 2004: 246-247). Hinshelwood (1989: 296; 2004: 73) described empathy as a "non-omnipotent" form of projective identification into someone else's situation without confusing one's own identity. One maintains a sense of one's own feelings and experiences. This description implicates that empathy requires one to identify – feel closely associated – with another's situation, but at the same time distinguish between one's own and others' experiences.

Identification is central to empathy (Slote 2010: 305), and is viewed by some authors as a precondition to empathy (Decety & Chaminade 2003: 590; de Waal 2009: 80; van Loon 2010: 25-27). In phenomenological terms empathy entails a unique mode of consciousness through which a person can directly experience another's thoughts, emotions and desires. Husserl (1989) and Stein (1989) described empathy in terms of intersubjectivity, and Stein (1989: 60 & 116) indicated that empathy not only helps one to understand others, but also oneself through others' experiences (Coplan & Goldie 2011: xiii-iv).

Empathy is integral in the humanistic psychology and forms the core of the client-centred approach as developed by Carl Rogers (Coplan 2011: xviii). In this sense empathy entails among other things sensing the client's internal world as if it were one's own (Rogers 1957: 95). The therapist identifies with (takes up the other's first-person perspective), has warmth, respect, and unconditional positive regard toward the client (Rogers 1957: 95-96; Håkansson 2003: 34-35 & 37). This directing of attention to another and allowing oneself to become absorbed in the experience of that person was described by Reik (1949, cited in Decety & Jackson 2004: 74) as identification, which he saw as one of the phases of empathy.

Empathy has been conceptualised in many different ways; from the literature the following three different interrelated components, phases or layers were identified: (1) emotional contagion – sharing and being affected by the other person's emotional state; (2) empathic concern – appraisal of the other's situation, valuing the other's welfare and attempts to respond compassionately to the other's distress; (3) perspective-taking – a cognitive capacity to take the perspective of the other person; and imagine and understand how the other is affected by his or her situation. (Batson *et al.* 2007: 72-73; de Waal 2008: 282-283; Hatfield, Rapson & Le 2009: 19; Krause 2010: 140). As these components illustrate, empathy refers to two related human abilities: mental perspective taking (cognitive empathy) and the vicarious sharing of emotion (emotional empathy) (Smith 2006: 3). It is in fact only when perspective taking is combined with emotional engagement, that there can be mention of empathy (de Waal 2008: 285).

The results of the study illustrate how some of the participants experienced empathy through perceiving the survivors' or relatives' emotional pain. The participants took the inflicted person's perspective by imagining what it feels like based on the premise

that it could have been their own or their daughters' experiences. They feel the inflicted person's emotions.

What enables human beings to identify closely with another's situation and to therefore empathetically understand others can today be explained in neuroscientific terms thanks to the discovery of mirror neurons (Gallese *et al.* 1996: 593-609). Neural mechanisms in the human brain make it possible to directly grasp, constitute, experience and understand another's actions, intentions and emotions (Gallese, Eagle & Migone 2007: 149; Iacoboni 2011: 49-57). Observing another's emotional experience produces a similar somatic, sensory and motor state in the observer – neural circuits similar to those of experiencing the observed emotion first-hand are activated in the observer (Wicker *et al.* 2003: 661; Gallese, Eagle & Migone 2007: 144-9; Gallese 2009: 523). The neural representation of a similar state relies on automatic and unconscious activation (Preston & de Waal 2002: 5 & 57) of mirror neurons in the observer's brain (Gallese 2003: 171). Emotional empathy results in more vigorous mirroring of the perceived psychological and somatic state than cognitive empathy (Nummenmaa *et al.* 2008: 571). In this sense, "one does not simply perceive, one *becomes*. One replicates or simulates the external world internally, and only in this way can one understand." (Olds 2006: 30-1)

Although there is a shared psychological mechanism involved in one's own experiences and in perceiving the experiences of another (Decety & Chaminade 2003: 585), the person empathising needs to attribute his or her emotional arousal to the source of the arousal instead of to the self (de Waal 2008: 285). In fact two pre-requisites to empathy are evident from the literature; emotional regulation and self-awareness. Emotional regulation is the ability to control one's own emotions to prevent emotional overwhelm and burnout (Moriguchi *et al.* 2007: 2232, Gerdes, Segal & Lietz 2010: 2332). Self-awareness is the ability to differentiate between one's own and the other person's feelings and allows a person to reflect his or her understanding of the other while maintaining separateness (Decety & Jackson 2004: 73-75; Krause 2010: 140).

Sharing emotion without a sense of self-awareness will result in emotional contagion – total identification without distinguishing between one's own feelings and those of the other. A person will become bound up in the distress of others and will not be able to identify the experiences of others, or feel empathy for them (Decety & Chaminade 2003: 585; Decety & Jackson 2006: 56). Rogers (1957: 95) warns that empathy should take place "without ever losing the 'as if' quality, without your own anger, fear,

or confusion getting bound up in it.” This potential “loss of the self” is addressed in phenomenological terms by describing empathy as “feeling into” and not “feeling one with” (Coplan & Goldie 2011: xiv).

A breakdown in boundaries between the self and the other can lead to a person experiencing the other’s emotions and thoughts as one’s own. This phenomenon is described as “fusion” or “enmeshment” and can lead to over-involvement or over-identification with the other (Coplan 2011: 15-16; Coplan & Goldie 2011: xix).

In this study some of the participants’ referring to the survivor’s experiences in the first person points to a fusion of boundaries. It manifests itself as a reflection of strong feelings regarding, for example, the unfairness and unacceptability of IPV and experiences with survivors that hold a significance in relation to one’s own experiences.

The unconscious significance others’ situations hold is determined by one’s own attitude towards such a situation would it occur in relation to the self (Richmond 2004: 247). The more familiar or similar others’ experiences are to one’s own experiences, the more similar the representation and stronger the relation, which refers to both one’s own emotional contagion and the identification with the other. Familiarity and similarity therefore enhance empathy and perspective taking (Preston & de Waal 2002: 16-17; de Waal 2008: 291). In the findings of this study perspective taking originated for some participants from a realisation that as women, they, or their daughters, are vulnerable to IPV and can find themselves in a situation similar to that of the survivor. They reflected on how they would feel and respond in such a situation.

Although the own experiences of participants in the study in some instances provided a basis for understanding and responding to the survivor’s feelings, the findings also illustrate that when the emergency nurse’s and the survivor’s experiences become intertwined it can become confusing and bring unresolved or repressed issues and doubts to the fore. This leads to strong emotions such as anger, sadness, self-doubt and recollections of own past experiences. Similarly, Goldblatt *et al.* (2009: 370) and Goldblatt (2009: 1648) described in two studies how the close association with issues significant to the healthcare professional leads to a fusion of boundaries between the professional and the survivor and shifts the focus to the professional’s experiences. Hoffman (2008: 442) explicated this phenomenon by explaining that another’s experience similar to one’s own past experiences can lead to self-focused perspective taking and the arousal of intense empathic distress. The association with painful

events in one's own life can lead to imagining that the stimuli affecting the other are affecting oneself. Goldblatt *et al.* (2009: 370) described how a social worker's narration reflects a sense of being affected by her work with IPV survivors: "she is on constant alert" and the "sense of security" in her intimate relationship is under threat as she "need to defend the self" from becoming a victim. In this study's findings emergency nurses' imaginations of what it would feel like to be caught up in IPV, and the thoughts about ways in which to avoid such a situation in the personal domain, in some instances also interfered with the empathic process. This cannot be better explained as in the words of one of the participants: *Mm I don't think that I want to put myself in their shoes to see it from their perspective ... the only reason why I think about putting me in that position ... just think what it would be to experience such kind of violence ... what if this was me...?*

Ahlzén's (2007: 389) recommendation to physicians to move between emotional engagement and personal reflections can perhaps be implemented by emergency nurses as a regulatory mechanism to prevent empathic distress and fusion of boundaries. When approaching a person suffering from illness the physician needs to take "some steps towards a shared life world" – empathic openness and involvement, while at the same time keep a "critical eye on his engagement with the patient", in order to analyse "crucial elements of the encounter from a somewhat distanced position". Gelhaus (2012b: 110) illuminated emotional regulation further by explaining that empathy "means not only realising the internal emotional and conceptual reality of the other, but also analysing one's own nearness or distance to the other's experience." Emotional regulation implies dealing with reactions that can be non-beneficial to the patient.

The need to be aware of one's own experiences interrelating with the survivor's experience will be illuminated in the next constituent.

4.2.3 Interrelation between IPV related personal and professional domain experiences

Seen in the light that the goal of health care services is to reduce suffering, Hayes's (2002: 94) question: "How do therapists know about human suffering?" is just as relevant to emergency nurses working with survivors of IPV. Aiming to obtain empathic understanding, healthcare professionals draw from their own life experiences (Hayes 2002: 94), of which for IPV, nurses in South Africa seem to tragically so often have first-hand experience. According to a South African study

(Christofides & Silo 2005: 11) 14.6% of nurses who participated in the study reported physical IPV in their lifetime. A further 37.7% reported emotional abuse in their lifetime. Nearly 41% who had not experienced IPV in their own lives reported having family members or friends who had.

Participants in this study who were exposed to physical IPV in their personal lives described it as an experience with a significant impact. The impact on their lives is not directly related to the study objectives, but does have an effect on the way they respond to survivors of IPV, as will be illustrated in the last constituent. For this reason a brief overview will be provided from the literature on how IPV can alter a person's lifeworld.

Apart from the physical consequences, IPV often have long-term psychological effects such as emotional distress (for example symptoms of depression and post-traumatic stress disorder), self-harm and an altered sense of self (Riger, Raja & Camacho 2002: 192-194; Humphreys & Thiara 2003: 214-215; Romitoo, Molzan Turan & De Marchi 2005: 1722-1723). Intrusive thoughts or images as a long-term consequence of exposure to violence were described by some participants. They described it as sudden, intrusive, involuntary re-experiencing of the incident triggered by witnessing the effects of IPV in survivors. The re-experiencing is similarly described by Burns (2007: 20-23), who mentioned more triggers such as hearing a word or sound, a sensation, or a thought. These triggers usually resemble or symbolise a sensory or perceptual aspect of the traumatic event (Kleim, Ehling & Ehlers 2012: 173; Keane & Miller 2012: 60). Intrusive symptoms are usually of a visual nature but can also include bodily sensations and emotional arousal. They are experienced in the present, as if the traumatic incident is re-occurring (Hackmann *et al.* 2004: 237-238). The nature of a participant's intrusive images is clearly illustrated in her own words: *that thing it came again ... plays like a videotape in my head.... and He (the perpetrator) was dark; he had a scar here (points to her face). When I see people with scars huh! (shivering) I become angry....*

IPV can affect women's relationships with family, friends, children, and future intimate partners. This is illustrated in, for example, a changed attitude toward future intimate relationships coupled with a belief that violence is inevitable in relationships. Relationships with children can be altered related to concern about the children's exposure to violence and changed roles when a child becomes a source of comfort and support. Violence can also affect women's economic position and prevent them from

completing their education, holding employment or pursuing a career (Riger, Raja & Camacho 2002: 192-194).

Talking about caring for survivors of IPV during the interviews reminded some participants of their own exposure to emotional abuse in intimate relationships, which they narrated with anger and resentment. Emotional abuse (also referred to as “psychological violence”) refers to behavior such as threats to physical and psychological health, isolation of the person and attempts to undermine the victim’s self-respect and sense of worth. It involves verbal attacks (insults, humiliations), control and power (isolation from family and friends, impeding decision making, economic abandonment), pursuit and harassment, verbal threats (woman and family’s life threatened, threats regarding the custody of children, intimidating phone calls) and blackmail (economic or emotional) (Pico-Alfonso 2005: 183-184; Blasco-Ros, Sánchez-Lorente & Martinez 2010: 3).

During the interviews emergency nurses also shared their experiences with friends’ and community and family members’ exposure to IPV. Even if IPV was not evident in their current relationships, some participants expressed the awareness that the possibility cannot be excluded from their personal domain.

Participants attempted to understand and explain survivors’ behaviour and responses based on their own experiences with IPV, as the following examples indicate. One participant expressed her understanding for survivors’ entrapment in their circumstances. During the interview she expressed her first-hand experience of entrapment in a violent intimate relationship. A participant who feared that she would hurt her sister by addressing her (sister’s) exposure to gender-based violence, later in the interview revealed the same discomfort to talk to survivors who are in emotional pain.

The findings illustrate how emergency nurses reached into their own experiences, and were reminded of their own wounds as they tried to understand survivors’ experiences. Two studies (Goldblatt & Buchbinder 2003; Goldblatt *et al.* 2009) provide similar examples of the inter-relation between survivors’ and healthcare professionals’ experiences. The studies respectively explored the effects of working with IPV in social work students’ and social workers’ private lives. The findings illustrated how participants compared their private lives with what they experience in terms of intimate relationships in their professional domain. Their private and professional lives became intertwined and boundaries merged, and the survivors’ experiences related to their own experiences. The participants reexamined, scrutinised and at times doubted

their own intimate relationships as they reflected on issues of power and control, and felt that they must constantly be alert for signs of potential violence. Students who experienced abuse in their family of origin were faced with their own realities and attempted to make sense out of these experiences (Goldblatt & Buchbinder 2003: 262-270; Goldblatt *et al.* 2009: 368-369, 371 & 377).

Hayes (2002: 96-98) conceded that a therapist (which also applies to healthcare professionals) can delve into own experiences when having difficulty to empathise in a specific situation or when seeking a deeper understanding of the patient's experience in order to facilitate healing. The phenomenon of countertransference can help to illuminate the role of the healthcare professional's personal experiences in the healing relationship. In classical psychoanalytical terms it is mostly seen as the therapist's negative reaction evoked by the patient's problems (Berzoff & Kita 2010: 342). These reactions are a result of the therapist's personal, unresolved vulnerabilities and unresolved conflicts (Collins & Long 2003: 420; Gelso & Hayes 2007: 42), something to be avoided. Countertransference can manifest itself as a difficulty to identify with or have empathy for the patient or as over-identification with the patient – for example, seeing the patient as a victim (Zachrisson 2009: 180). One participant in this study exposed to IPV described herself as a victim, and pondered about survivors who are helplessly trapped in their circumstances. Davis (2009: 77) indicates the relation between countertransference and the "wounded healer". (See the last constituent (4.2.7.1d) for a discussion on this phenomenon.) The wounds of the patient activate the wounds of the professional. This experience can cloud clinical judgment (Davis 2009: 77) and distorts the way in which a healthcare professional responds to a patient (Alfandre 2009: 38).

In a more contemporary view on countertransference, known as "intersubjectivity" (Zachrisson 2009: 183-184), countertransference issues are rather seen as intrapsychic phenomena which must be understood within the intersubjective context within which they are embedded (Rasmussen 2005: 23). Within intersubjectivity healing takes place in a relationship; there are interconnectedness and a common understanding between the patient and the healthcare professional (Geller 2006: 84; Scott *et al.* 2008: 320-321). The professional brings to the therapeutic relationship his or her subjective self, sometimes altered in ways the professional is not conscious of. A professional's ability to tolerate painful feelings set the stage for the patient to express intense feelings. On the other hand, when the professional feels vulnerable, hopeless or emotionally depleted, a patient may consciously or unconsciously subdue the expression of painful emotions (Rasmussen 2005: 25-26).

For countertransference to be utilised in a healing way, the healthcare professional needs to understand and address the internal and interpersonal origins of his or her reaction to the patient (Zachrisson 2009: 187; Berzoff & Kita 2010: 347). This process requires the ability to differentiate between one's own experience, emotions and needs and those of the patient. The process includes the monitoring of emotional arousal, introspection, self-reflection, self-awareness (awareness of "own wounds") (Berzoff & Kita 2010: 347-348). To ensure that one's own issues in connection with patients' experiences are resolved (Hayes 2002: 96), supervision or psychotherapy might be required (Berzoff & Kita 2010: 347).

Following Alfandre's (2009: 38-39) suggestion that all physicians should be skilled in understanding countertransference in order to enhance patient care, the assumption can be made that such an understanding can also enlighten emergency nurses to utilise their own experiences with IPV as a valuable part of the care provided to survivors of IPV. Berzoff and Kita (2010: 343) confirm this by saying: "what is co-created between the inner world of the therapist and of the client becomes the unit of change". Intersubjectivity, for example, allows for understanding the patient on a deeper level through reflecting on own responses to the patient (Zachrisson 2009: 184 & 187).

4.2.4 Attempts to cope with experiences involving survivors of IPV

Emergency nurses find ways of coping with their experiences with survivors of IPV. Different ways of coping emerged from the interviews: to talk to someone about the experiences and feelings, using spiritual resources; expressing the emotions through crying; and suppression, avoidance, distraction, altruism and acceptance.

"Coping" reflects a person's response to stress resulting from real-life problems (Skinner & Zimmer-Gembeck 2007: 120-121). It is seen as cognitive and behavioural attempts to deal with internal and/or external demands appraised by the person as problematic and threatening his or her resources (Lazarus 1993: 237; Lazarus 2006: 10; Carver & Connor-Smith 2010: 685). Coping attempts to alter the problem and regulate stressful and sometimes intense emotions (Folkman & Moskowitz 2004: 747). The person judges the outcome based on his or her values, goals and expectations (Folkman *et al.* 1986: 993). A successful outcome will produce positive emotions while a less favourable outcome will lead to negative emotions (Folkman & Moskowitz 2004: 747). Ways of coping rely on the person's appraisal of the situation (for example, as

harmful, threatening or challenging) and the options for coping at the person's disposal (Folkman *et al.* 1986: 993 & 999; Whitty 2003: 124).

Ways of coping describe people's behavioural, emotional and cognitive responses to stress (Skinner & Zimmer-Gembeck 2007: 121). A way of conceptualising coping is to distinguish between disengagement- and engagement coping strategies (Compas *et al.* 2001: 92; Skinner *et al.* 2003: 236-237; Connor-Smith & Compas 2004: 348). Engagement coping responses that implicate a direct approach toward a stressor or related thoughts and emotions point to better adjustment than disengagement coping responses (for example, avoidance, denial and withdrawal, which involve distancing from the stressor and related thoughts and emotions (Compas *et al.* 2001: 92). Engagement coping responses can be further distinguished as primary or secondary control strategies. Primary control coping involves attempts to directly change a negative situation or related emotional and physiological responses through strategies such as problem solving, emotional expression, and emotional regulation. Secondary control coping involves efforts to adapt to current conditions through strategies such as distraction, acceptance, and positive thinking (Skinner *et al.* 2003: 236-237; Connor-Smith & Compas 2004: 348; Smith & Kirby 2011: 198).

Despite these different classifications and theoretical approaches, conceptual and empirical analyses came up with 12 families of coping that can be used to classify most if not all of the ways of coping. The 12 core coping strategies that are used most often have been determined to be: support-seeking, information seeking, helplessness, escape (cognitive and/or behavioral), problem solving, self-reliance, delegation, accommodation (for example positive cognitive reappraisal, distraction and acceptance), opposition, social isolation, negotiation and submission (Skinner & Zimmer-Gembeck 2007: 126-127). What is important to note is that the different coping strategies are not inherently good or bad, as effectiveness of coping is determined by the specific context in which it occurs (Smith & Kirby 2011: 197-198). "Optimal coping is planful, strategic, organised, goal directed, linguistically based, and context-specific." (Compas & Boyer 2001: 326)

With the previous discussion in mind, it can be concluded that participants in the study made use of the following ways of coping: (1) obtaining social support from colleagues and spiritual counselors; (2) escape-avoidance (for example, to stay away from an area in the unit where a survivor of IPV is being treated); (3) self-reliance (emotion regulation/self-controlling) as expressed by this participant: ... *but isn't it you won't let others see, you just cry internally?*; and (4) accommodation.

Accommodation is reflected in: positive re-appraisal as evident in finding strength in the idea that the work with survivors is a fulfilment of a spiritual purpose. Distraction could be found in having something to eat, talking to the porters. Acceptance could be to accept and come to peace with the death of a woman exposed to IPV. This last way of coping is also referred to as "religious coping" (Pargament, Feuille & Burdzy 2011: 53). Religious coping helps people to find the strength to endure and to find purpose and meaning in stressful situations (Folkman & Moskowitz 2004: 759). In the case of the study findings the provision of care to survivors of IPV was re-appraised by one participant as part of God's plan for her to help others, a religious way of coping described by Pargament, Koenig and Perez (2000: 521).

The other two ways of coping used by participants namely, suppression and altruism, are viewed as defense mechanisms as will be illustrated in the next discussion.

Cramer (2006) distinguished between coping and defence mechanisms. Both are aroused by situations resulting in psychological disequilibrium. A defence mechanism resembles an unconscious process, opposed to coping, which is conscious, volitional and intentional (Compas & Boyer 2001: 326). Coping attempts to deal with a problem while defence mechanisms change a person's perception of reality (Cramer 2006: 7-8). This altering of internal reality is aimed at restoring psychological homeostasis (Vaillant 2000: 89-90). Defence mechanisms serve to protect against anxiety emanating from a subjective awareness of internal or external stress (Hentschel *et al.* 2004: 9 & 15).

Suppression seen as a mature defence mechanism involves the semi-conscious decision to postpone attending to a conscious impulse and/or conflict (Vaillant 2000: 91-94). Resembling intentional avoidance of thoughts about the source of pain (Kline 2004: 48) suppression was applied by some participants in the study as a conscious decision (Conte, Plutchik & Draguns 2004: 394) to fulfil the perceived expectation that as nurses they should always be in control.

Altruism is defined as "helping or comforting behaviour directed at an individual in need, pain, or distress" (de Waal 2008: 281). Intentional altruism seeks to deliberately benefit either the other or the self, while empathy-based altruism is grounded in empathy (de Waal 2008: 281) or, as explained by Batson (2011: 11), in empathic concern, which includes other-oriented emotions such as sympathy and compassion. The way altruism is described in the study (*...it makes a lot of difference for me ... I can see that at least what I have done it did make a change ... makes me*

more happy and relieved. Then my stress level is gone ... it erased that sadness that was on me...), as a means of relieving the hyper-arousal and tension caused by witnessing another's suffering, does not fit the definition of altruism as described above. According to Batson (2011: 28-29), when the welfare of the other becomes an instrumental means to reach one's own goals, an act cannot be described as altruistic. This differs from other authors acknowledging self-reward as part of the altruistic act that even strengthens the probability of future altruistic acts as it serves as reinforcement (Ainslie 2005: 648; Farsides 2007: 475). As such, altruism can improve a person's well being and self-esteem and enhance meaning in life and feelings of self-efficacy and competence (Post 2005: 68 & 70).

The ways of coping used by clinicians working with trauma survivors will be discussed according to a few studies that have explored this phenomenon. Marriage and Marriage (2005: 116-117) identified the following coping skills used by mental healthcare practitioners working with traumatised families and children: support from family and friends, support from colleagues (peer support) in the form of debriefing, supervision, reflection and mentoring, self-care (for example, hobbies, gardening and reading) and the ability to find meaning and hope in survivors' stories and resilience.

Linley and Joseph (2007) explored positive and negative well being in therapists and found that a sense of coherence – a person's perception of the world as comprehensible – serves as a protective factor against negative psychological changes and compassion fatigue. Sense of coherence and the therapeutic bond together were most protective against burnout. The therapeutic bond is the channel through which therapists can utilise empathy to communicate their vicarious experience of the suffering and distress of clients to bring about therapeutic change (Linley & Joseph 2007: 397-399).

Von Rueden *et al.* (2010) explored STS prevalence and coping strategies in emergency nurses. Support from others and relationships with coworkers may prevent or limit STS. Nurses with STS scored their relationships with coworkers as poor or average, experienced interpersonal conflicts in the working place, were less likely to obtain support from family and friends, and less likely to participate in hobbies (von Rueden *et al.* 2010: 196, 198 & 200).

Wastell (2002: 843) found that ambulance officers using emotion-suppressing defences (for example, withdrawal) are more likely to present with physical and psychological stress symptoms.

The following ways of coping were identified by counsellors working with IPV survivors as helpful (Iliffe & Steed 2000: 404-409): debriefing and peer support to decrease feelings of isolation and validate actions, physical activity, self-nurturing, and acknowledgment of clients' resilience, strengths, autonomy, and resources.

4.2.5 Attempts to make meaning out of IPV/ understand IPV

Emergency nurses struggle to understand and make meaning out of IPV. Some participants attempt to understand the reasons behind IPV, while others try to figure out why a woman would stay in a relationship if she were being exposed to violence. Meaning making is described in the literature in terms of coping (Folkman & Moskowitz 2004: 752; Park 2011: 227). As meaning making seem to make up an important part of emergency nurses' experiences with survivors of IPV it is discussed as a separate constituent.

Human beings live their lives so as to construct a satisfactory sense of meaning. Meaning is constructed through a sense of purpose, efficacy, value and justification, and self-worth (Baumeister 2005: 155-156). Meaning making is an accommodative way of coping associated with strategies such as cognitive restructuring, sense making and benefit finding (Folkman & Moskowitz 2004: 766; Aldwin 2007: 121). Meaning making is described in terms of situational and global meaning. Situational meaning has to do with the way in which a stressful event is appraised in terms of the relevance and implications it holds for a person (Losavio *et al.* 2011: 761-762; Park 2011: 228). Global meaning is described in terms of three concepts: *beliefs*, *goals*, and *subjective feelings* (Park & Ai 2006: 391-392; Park 2011: 228). Experiences in the world, interpreted in terms of *beliefs* (Park & Ai 2006: 391-392; Park 2011: 228) include phenomena such as fairness, justice, luck, control, predictability, coherence and benevolence. Beliefs are reflected in three fundamental assumptions: the world is benevolent, the world is meaningful and the self is worthy (Janoff-Bulman 1992: 6). Most people also tend to believe that the world is reasonably fair and makes sense and engaging in precautionary behaviors can prevent bad things (Janoff-Bulman 2004: 30; Park & Ai 2006: 391-392). People work towards achieving global *goals* such as relationships, work, spirituality and self-transcendence (Emmons 2005: 735). *Subjective feelings* refer to a sense of meaning or purpose in life (Park & Ai 2006: 391-392; Park 2011: 228).

Stress arises when a discrepancy occurs between the meaning appraised to a situation and global beliefs and goals (Park & Folkman: 1997: 124; Park 2011: 230). Disruptive

events like traumatic experiences can violate both global beliefs and global goals. Global life meanings are questioned and cause a sense of uncertainty about the meaning of life (Park & Ai 2006: 391-392). Assumptions are shattered and the world appears meaningless and malevolent. Survivors struggle to understand and make sense of the event (Janoff-Bulman 2004: 32-33). A person will attempt to alleviate this distress and regain consistency through cognitive processing, which entails attempts to understand disruptive life events, transformation of meaning; that is to alter the meaning appraised to the event or alter global beliefs and goals to accommodate the event (Park & Folkman 1997: 124; Park 2005: 708-711; Park 2011: 236; Losavio *et al.* 2011: 762). Previous assumptions that had provided stability seem to be inadequate and coping involves rebuilding global beliefs that acknowledge personal vulnerability and the potential for disruptive life events. "It is built to better withstand the shock of tragedy" The person's belief system might reflect a degree of being disillusioned with the world (Janoff-Bulman 2004: 30-33).

Confronted with the senselessness and painful consequences of IPV, emergency nurses try to find an explanation behind the behaviour of the perpetrator, and the woman who stays in the violent relationship. They reappraise their understanding of intimate relationships within the context of culture, socio-economic factors and gender inequalities. In a certain sense their perceptions of intimate relationships are disillusioned as expressed in the study findings: *They are sharing more than just a normal relationship. It's supposed to be a building relationship, not one that's breaking each other up or down or mm... abusing.*

It could be said that in order to find meaning in and make sense of the adversity they are confronted with, emergency nurses attempt to find explanations for IPV and integrate it into existing schemata for, for example, belief and knowledge systems. Theoretically emergency nurses would either change their global beliefs or their appraised situational meanings attached to IPV in order to avoid distress. Emergency nurses' attempt to reappraise the meaning of IPV, for example, to reappraise the perpetrator's violence as a result of a violent upbringing and the women's reluctance to leave as caring, love or hope. They can also change their global meanings to integrate what they encounter, such as altering their frame of reference, as will be discussed in the next constituent.

4.2.6 Formation of gender perceptions and assumptions regarding IPV

During the interviews emergency nurses verbalised gender perceptions and shared their own personal assumptions related to the experience of providing care to survivors of IPV. Some of these perceptions and assumptions seemed to be a result of professional and personal domain experiences with IPV and other gender-based violence. Gender perceptions and personal assumptions in turn have an effect on the way care is provided to the survivor.

Two themes regarding gender perceptions emerged from the interviews: men as perpetrators and women as victims. Participants also expressed their personal assumptions (sometimes driven by gender perceptions) with reference to the following themes: intimate relationships; children in IPV relationships; IPV; dealing with IPV; and the survivor's autonomy.

Gender is defined as an "institutionalized system of social practices for constituting people as two significantly different categories, men and women" (Ridgeway & Correll 2004: 510). Behaviour, personality attributes and many other aspects of a person's life are affected by gender (Smiler 2004: 16). Situations in which people define themselves in relation to others, called "social relational contexts", together with cultural beliefs play significant roles in the gender system (Ridgeway & Correll 2004: 511). Norms, values and behaviors are culturally assigned to people based on their biological sex; accordingly, gender is characterised by certain culturally expected signifying aspects (for example, clothing) and patterns of conduct that distinguish men and women (Segal 2003: 3 & 5). Cultural beliefs that support gender-specific characteristics and behaviour are known as "gender stereotypes" (Ridgeway & Correll 2004: 511).

Gender stereotypes are prescriptive, linked to gender roles and maintain power inequalities between men and women. Violations of gender stereotypes are sanctioned, even punished in different ways in society (Prentice & Carranza 2002: 269). Ridgeway and Correll (2004: 522) claimed that although Western society continually redefines gender, the fundamental assumption that men are more powerful, persists. IPV is a clear expression of male dominance directly related to women's disadvantaged and unequal position in relation to men that still persists in many regions of the world (UN Department of Economic and Social Affairs 2010:137-138).

Jewkes and Morrell (2010: 2) explain the dominance of men over women in South Africa where gender inequity is still highly evident, by means of the phenomenon of hegemonic masculinity. Hegemonic masculinity is a pattern of practice that legitimates the subordination of women to men. Although it does not implicate violence, it could be exerted by force (Connell & Messerschmidt 2005: 832). Masculinity among South African men requires among other things the ability to establish control and power. The wish to establish power, coupled with the view that violence is a legitimate means to exercise power, provides space for the use of violence in intimate relationships. Although not all women find themselves in subordinate positions in their intimate relationships, subordinate behavior, which is strongly associated with femininity, presents itself in tolerance of men's controlling and sometimes violent behavior. This pattern is maintained by a system of sanctions and rewards (Jewkes & Morrell 2010: 5). Mullick *et al.* (2010: 52) also cited gender inequality as a social dynamic underlying the problem of IPV in South Africa.

Seen in the light of the abovementioned discussion, emergency nurses' gender perceptions expressed in the study findings certainly reflect the South African reality, but are also strongly suggestive of gender stereotyping. For example, the belief is expressed that the latent potential for violence that is present in most men will inevitably present itself one or the other time in an intimate relationship. Most men are believed to be perpetrators and mistrusted as such. These perceptions are grounded in the assumption expressed by some of the participants that men are more powerful, a right they are perceived to enforce and benefit from. Aggression and dominance, characteristics stereotypically assigned to men (Prentice & Carranza 2002: 277; Keshet *et al.* 2006: 107), were identified by Bem (1974: 156) as part of a list of desirable masculine traits. On the other hand women in the study findings are described as vulnerable and powerless. Certain stereotypes related to femininity such as being dependent, gullible and compliant (see Bem 1974: 156; Prentice & Carranza 2002: 277; Keshet *et al.* 2006: 107) underlie emergency nurses' narrations of women as powerless.

The reason why emergency nurses tend to resort to stereotyping is explained by means of the phenomenon of vicarious traumatising. Seen as a category of STS reactions, vicarious traumatising presents itself mostly as shifts in the beliefs, expectations and assumptions that professionals hold (Collins & Long 2003: 419). Developed from constructivist theory, the pattern of disruptive and painful psychological effects following exposure to others' traumatic material was termed

“vicarious traumatization” by McCann and Pearlman (1990: 133 & 137). The way the vicarious trauma is experienced depends upon the professional’s characteristics and vulnerabilities, such as her own history of exposure to abuse (McCann & Pearlman 1990: 133 & 136; Pearlman & Saakvitne 1995: 151-153).

In the next discussion the theoretical framework of vicarious traumatising is applied to the context of the study. The ways in which cognitive schemas may be disrupted by vicarious traumatising are described in terms of six fundamental psychological needs: dependency/trust, safety, power, independence, esteem, intimacy; and frame of reference (McCann & Pearlman 1990: 137-142; Pearlman & Saakvitne 1995: 159-165). Other constituents are integrated as applicable in order to illuminate assumptions held by emergency nurses working with survivors of IPV as a meaningful whole.

- Dependency/trust: Witnessing the betrayal and violations in trust survivors of IPV are exposed to may disrupt emergency nurses’ schemas about trust and cause them to become suspicious of other people's motives.
- Safety: Images involving a loss of safety, including threats or harm to innocent people, may challenge emergency nurses’ schemas within the area of safety. Some emergency nurses verbalised a need to protect themselves, or their daughters against IPV. Interesting to mention is the study by Goldblatt (2009: 1650), which found that nurses’ exposure to survivors of IPV gave way to the assumption that “no one is immune from abuse”. This assumption instilled a fear for one’s self and one’s children’s safety.
- Power: Exposure to the survivor’s experiences of helplessness and vulnerability may evoke concerns about one’s own sense of power or efficacy in the world. A professional may express a heightened awareness of control over potential unexpected life events. In extreme cases, this may lead to feelings of helplessness, depression, or despair.
- Independence: Trauma survivors often experience a disruption in their need for independence. A strong need for independence can cause the emergency nurse to identify with clients who have lost a sense of personal control and freedom. For example one emergency nurse explicitly stated: “*I don’t want to be controlled*”, and identified with a survivor whose independence was violated by her partner.
- Esteem: The exposure to the pain caused by the uncaring or even malicious intentions and acts some survivors suffer at the hands of their partners may cause the diminished esteem some emergency nurses expressed towards men.

One participant verbalised diminished esteem towards men of a certain racial group. (See Chapter 3, 3.2.1 reflecting emergency nurses' feelings of anger towards the perpetrator). Disruptions in esteem may be associated with feelings of bitterness, cynicism, pessimism and anger. On an existential level, professionals may find themselves pondering the fate of the human race.

- Intimacy: As trauma victims often experience a sense of alienation from other people and from the world in general, so too may the emergency nurse experience an uncomfortable sense of separateness from family, friends, or coworkers. "This of course stands in the way of a sense of connection with others, and, unchecked, may grow into a deep sense of alienation." (McCann and Pearlman 1990: 141)
- Frame of reference: This includes disruptions in the sense of identity, central beliefs about the world and spirituality. The emergency nurse may be confronted with certain questions: Who am I as a professional, as a woman, as a parent, as a human being? One such a question is quoted: *...why is it happening to us women, what went wrong...?* Gender roles and own history of abuse come under scrutiny. The emergency nurse's worldview might be affected; beliefs regarding the meaning of life and the nature of humanity are challenged when witnessing the effects of IPV. The work of Janoff-Bulman (1992 & 2004) as discussed under the previous constituent illustrates how a person's attempts to make meaning of exposure to trauma can alter fundamental assumptions about the self and the world.

Another assumption shared by participants reflected their disillusionment with and subsequent apprehension of becoming involved in intimate relationships. McCann and Saakvitne (1995: 162-163) explain the effects therapists working with trauma survivors can experience with regard to their own relationships. Subsequent to the abovementioned disruptions in schema, therapists may believe that others are not trustworthy, feel unable to tolerate the emotions associated with intimate relationships, and eventually experience social isolation.

Dunkley and Whelan (2006: 114) stated in a review paper that vicarious traumatisation still provides the most appropriate concept to explain professionals' responses to trauma work, but studies have identified a number of factors to also consider. These factors include experience, personal trauma history and coping style, as not all professionals respond in the same way. Also vicarious traumatisation fails to recognise the full scope of effects – for example, trauma work can result in positive

changes in the professional's sense of identity and beliefs about self and others (Dunkley & Whelan 2006: 111).

Rasmussen (2005: 22-28) identified complexities in the therapeutic relationship that need to be explored in terms of vicarious traumatization. One of these is the impact of vicarious traumatising on therapeutic interaction. Therapists may also not be aware of the full impact of vicarious traumatising as a sometimes unconscious process (Rasmussen 2005: 28).

Although participants in the study shared their views on how to deal with IPV, they clearly respect survivors' autonomy to take their own decisions. The way emergency nurses' assumptions and beliefs manifest themselves in their responses to survivors will be explicated in the next constituent.

4.2.7 Provision of care to survivors of IPV

The relief of suffering is integral to nurses' work. In their response to suffering nurses provide whole-person care in order to help patients restore a sense of integrity, regain control, seek meaning in distress and cope with vulnerabilities (Ferrell & Coyle 2008: 246-247). A holistic approach that considers the wholeness of the patient is more likely to produce healing interventions that will go beyond an obvious complaint (Jackson 2004: 72). Applied to the provision of care to survivors of IPV, emergency nurses are in an ideal position to enquire about IPV, and establish a therapeutic relationship that allows for disclosure of IPV (Cox 2003: 324).

The priority in the emergency department is to treat the survivor's physical injuries (Boyle, Robinson & Atkinson 2004: 11). Although emergency nurses in the study also described the emergency treatment as their priority, and acknowledged that it sometimes happens that the survivor's care is limited to medical management, all participants displayed an awareness of the survivor's need for emotional care. Some view it as their responsibility to provide emotional care, or at least refer the survivor for emotional and social support.

According to the emergency nurses who contributed to the study, the provision of care to survivors of IPV focuses on three broad categories of interventions: *physical care* mostly in relation to the injuries sustained; *emotional care*, which reflects different ways of approaching and supporting the survivor; and *referral* to other multi-disciplinary members.

4.2.7.1 Emotional care provided to survivors of IPV

From the study findings the provision of (and even the possibility for) emotional care seemed to be determined by two factors: the emergency nurse's ability to detect IPV and get a *disclosure* from the survivor; and *emergency nurses' frame of reference in relation to provision of care to survivors of IPV*

Women who have been exposed to IPV rarely volunteer a history of violence (Elliot *et al.* 2002: 112) and routine history taking and clinical examination are deemed to be an unreliable way of identifying survivors of IPV. As such, screening of every patient presenting to an emergency department is recommended (Boyle *et al.* 2004: 10). Indeed, universal screening for IPV has been endorsed by several health professional organisations in the USA – for example the American Medical Association, the American College of Obstetrics and Gynecology and the American Emergency Nursing Association (Chuang & Liebschutz 2002: 565-566; Elliot *et al.* 2002: 112; Emergency Nursing Association 2006; Hien & Ruglass 2009: 52-53; Todahl & Walters 2011: 356).

Apart from screening (that is not routinely done in South Africa), injury patterns suspect of IPV might help emergency nurses to identify survivors of IPV. Women with head, neck and face injuries should be assessed for possible IPV, especially those with multiple injuries of which the cause cannot be verified (Lau *et al.* 2008: 456; Wu *et al.* 2010: 80). A South African study (Jansen van Rensburg & van Staden 2005: 51) also found face and neck injuries frequently to be associated with IPV. On the other hand, survivors presenting with injuries might just be the tip of the iceberg as Btoush, Campbell and Gebbie (2009: 256) found that of women identified with IPV at emergency departments in the USA 86% presented with pain as the main complaint.

Reisenhofer and Seibold (2007: 7) concluded that less than 5% to 10% of women requiring management resulting from IPV are identified by emergency department staff. Many factors play a role and certain barriers to disclosure exist as also experienced by emergency nurses in the study. These factors will be discussed in terms of *external barriers to disclosure*, which constitute mostly environmental and social factors, and *factors affecting disclosure*, reflecting *firstly the survivor's and secondly the emergency nurse's perspective*. Ways employed by emergency nurses and recommended in the literature to overcome barriers will be highlighted as applicable.

a) External barriers to disclosure

The first barrier pertains to a lack of privacy. Other patients and staff present in the area of the emergency unit can hear everything that is discussed with the survivor. This is a problem mentioned worldwide by emergency nurses (Boyle *et al.* 2004: 11; Minsky-Kelly *et al.* 2005: 1295; Furniss *et al.* 2007: 241) and survivors treated in emergency units (Leppakoski *et al.* 2010: 33-34). Some participants, however, find ways to overcome the privacy barrier, such as to interview the patient in one of the offices if IPV is suspected.

The survivor's partner can pose a significant barrier towards disclosure and provision of care. It is highly unlikely that a woman will disclose IPV in the presence of the partner (Rhodes *et al.* 2007: 622), who sometimes insists to stay with the survivor in spite of the fact that visitors are not allowed in the emergency unit. To overcome this barrier requires the emergency nurse to be very assertive and persistent, as illustrated by one participant in this study, who went so far as to get help from hospital management as she saw it as her duty to advocate for and protect the rights of the survivor. Not all nurses are aware that questioning the survivor in the presence of the perpetrator can endanger the survivor. For example, screening was found to be done at times in the presence of the partner (Rhodes *et al.* 2007: 622), while in some settings the partner was encouraged to be part of the consultation process (Boyle *et al.* 2004: 11). In a study done by Furniss *et al.* (2007: 241) some nurses asked advice on how to ask questions to detect IPV in the presence of the partner, seemingly unaware of the dangers this practice could pose for a survivor of IPV.

Creative ways are used by emergency nurses to manage the situation with the partner. For example, if exclusion of the partner is the rule then the partner who insists on staying with the woman would look more suspicious (Boyle *et al.* 2004: 11). "It is remarkable how often it is the overly compassionate and attentive partner that will start warning bells ringing in a nurse's mind." (Reisenhofer & Seibold 2007: 10) Proactive steps to ensure patient privacy include, for example, a standard procedure to let the partner come in for the last part of the consultation (Minsky-Kelly 2005: 1298).

Other barriers include a lack of time (Minsky-Kelly *et al.* 2005: 1297; Furniss *et al.* 2007: 241; Liebschutz *et al.* 2008: 6), staff shortages and emergency nurses being overworked. On top of that the emergency unit is a busy and stressful place (Reisenhofer & Seibold 2007: 9) and emergency nurses are good at prioritising: ...ok

she's not talking about it what's wrong today, ok 1,2,3 (a sequence of essential medical actions) *that's it...*; rather than to "open Pandora's box" (Boyle *et al.* 2004: 11).

Two participants in the study mentioned language as a barrier. With many patients speaking African languages, an emergency nurse who is English speaking might find this a significant barrier. With many people from other African countries populating urban areas in South Africa, it is not unlikely that nurses can find themselves unable to communicate with a patient.

b) Factors affecting disclosure of IPV – survivor's perspective

According to the study findings, some survivors will talk openly about the IPV while others clearly give the message that they don't want to talk, a right that participants feel should be respected. Anger is seen as a clear sign that a disclosure is not likely to come and to leave the patient. Some participants' narrations explicated their ability to sense the barriers behind the survivor's reluctance to talk; for example: (1) the sensitivity of and shame related to IPV; (2) lack of trust; and (3) the emotional state of the survivor (for example, fear or sadness).

Barriers mentioned in studies include feelings such as shame, guilt and fear – fear of retaliation, fear for themselves and fear for their children (Boyle *et al.* 2004: 11; Hien & Ruglass 2009: 50; Leppakoski *et al.* 2010: 33-34). Hien and Ruglass (2009: 50-52) provide an extensive literature review on barriers to help seeking experienced by survivors, which includes: suffering from a psychiatric disorder as a consequence of exposure to IPV, which has a disempowering and immobilising effect; economic dependence on the perpetrator; the phenomenon of learned helplessness; sociocultural factors (for example patriarchal practices, tolerance for male violence in a society, cultural sanctioning of seeking help outside the family or cultural group); and the ineffectiveness of the legal and criminal justice system that can result in re-victimisation, stigmatisation and retaliation by the perpetrator.

To determine the barriers preventing the survivor from disclosure and implement steps to overcome these barriers require sensitivity and insight. For example, a cultural barrier that prevents the survivor from revealing the sensitivities of IPV to a nurse younger than her age requires the nurse to understand this process and ask an older colleague to help.

A study by Watt *et al.* (2008: 724-725) showed what emergency nurses can do to overcome barriers from a survivor's perspective. Women who are reluctant to disclose IPV need emotional support with the focus on building of trust and rapport. A woman who discloses but refuses interventions needs to be informed about resources so that she could act on the information when she feels ready. When a woman discloses and expresses a desire to take action, the nurse should take immediate action coupled with respect and sensitivity for the woman's vulnerability and fears. The survivor needs to feel in control, not overwhelmed. IPV survivors emphasised the importance of combining interventions with emotional support that focuses on acknowledging and alleviating fears.

c) Factors affecting disclosure of IPV – emergency nurse's perspective

As a prerequisite to improve the quality of care for survivors of IPV, Christofides and Silo (2005: 10) emphasise the importance of standardised guidelines and the operationalisation of such guidelines in the form of screening protocols at health facilities in South Africa. The current situation is reflected in the findings of the study: As the history to be taken relies to a great extent on the emergency nurse's own discretion, some emergency nurses attempt to get the survivor to reveal the IPV; others view it as essential to detect the IPV and get a disclosure; while others feel it is up to the survivor to reveal the IPV.

When a patient gets admitted the emergency nurse attempts to establish the problem by asking questions about presenting symptoms and contributing factors. Realising that survivors will not disclose immediately, emergency nurses are aware that sometimes there is more to the presenting problem than what meets the eye. Some emergency nurses in the current study described how they sometimes feel or sense that something is wrong. This intuitive process seemed to be mostly unconscious; and when probed one participant articulated it in terms of sensations – "becoming aware of" through: hearing (tone of voice, sounds reflecting physical or emotional pain, discrepancies in narrations), seeing (eye contact, facial expression, nature of injuries, discrepancies between verbal and non-verbal messages).

According to Benner, Tanner and Chesla (2009: 141), intuition is a characteristic of expert nursing practice that reveals itself in four components: (1) clinical grasp and response-based practice; (2) embodied know-how; (3) seeing the bigger picture; and (4) seeing the unexpected. Effken (2007: 188) highlights intuition as a nurse's strong feeling that something is wrong, the same way it presented itself in the study findings.

Nurses cannot describe exactly what led to the intuitive judgment, but are often able to provide some supportive information (Lyneham, Parkinson & Denholm 2008: 384). Intuition is the result of interpreting information that is directly obtained from the patient (through, for example, auditory, visual and tactile awareness) by combining nursing knowledge, expertise and experience (Effken 2007: 189). A study by Häggbloom and Möller (2006: 1080) explicated the role intuition play in nurses' interventions with survivors of IPV. Nurses in this study displayed a perceptual ability (described as "a gut feeling") to sense when a story told by a woman did not make sense.

Intuiting prompts a response, it draws on the nurse's inclination to care and sense of responsibility and accountability: *...but if really, if you can see ... I don't know ... we can be like mothers you see: I am not going to leave her, something is wrong....* Some emergency nurses will probe deeper into the history of the problem and reflect on discrepancies in the survivor's behaviour. The probing reflects a process where the nurse builds upon prior knowledge and clinical judgment to identify and investigate verbal and non-verbal cues or conflicting reports obtained from assessing the survivor (Cox 2003: 325).

The literature provides some suggestions on the best way to inquire about domestic violence if deemed appropriate, such as simple, direct, non-judgmental questions. Boyle *et al.* (2004: 11) find the question: "we know that violence at home is a problem for many people. Is there anyone who is hurting you in some way?" useful. Asking a sensible question indicates to the survivor that help is available and might already reduce feelings of helplessness (Boyle *et al.* 2004: 11). Rhodes *et al.* (2007: 626) provide a useful review with examples of questions and empathetic and reassuring responses.

Realising that more than just questioning is needed to get the survivor to reveal the IPV, one participant shared the skills she utilises to overcome the intersubjective barriers that might impede open communication. The description resembles the interpersonal skills utilised by nurses to facilitate rapport and a trusting relationship with patients. Trust is earned through demonstrating a "trustworthy personal moral character" (Tarlier 2004: 238).

Liebschutz *et al.* (2008: 6) confirm that it is not sufficient for professionals to simply ask about IPV, but rather the aim should be on developing a therapeutic relationship with IPV survivors that does not demand disclosure but, instead, empowers. The

authors are of the opinion that extensive training in IPV or counselling is not as vital as establishing a relationship with a survivor. A supportive relationship with confidentiality assured and respect for the survivor's autonomy is more likely to facilitate disclosure.

Also required are skills to deal with the survivor's emotional expressions, such as anger and sadness. Probing the survivor towards disclosure can bring tears. Crying, a sign that defences are dissolving, can be skillfully utilised as an opportunity to get through to the survivor by encouraging her to reveal the reason behind the tears (as explained by one participant). Comforting sadness almost always brings a disclosure, in another participant's experience.

Getting the survivor to disclose is not something all emergency nurses feel able or willing to do. Some rather approach the survivor in a discreet, non-invasive way only addressing the topic of IPV if initiated by the survivor. They clearly feel it is inappropriate to probe the survivor without concrete information. One participant sees a non-invasive approach as a way of showing care and respect for the survivor's reserve. Others withdraw when probing is met with resistance or reservation. Reviews of the vast number of studies undertaken on IPV screening indicate that within certain conditions (for example a non-judgmental attitude, respect for privacy, and provision of a rationale for screening) female patients (including IPV survivors) are mostly supportive of nurses asking about IPV (Todahl & Walters 2011: 363; Plichta 2007: 227). Boyle *et al.* (2004: 11) explain the importance of emergency professionals knowing how to create the opportunity for disclosure so that the survivor can be offered help. A US study by Sharps *et al.* (2001: 377) emphasises this message in a shocking way: two-fifths of the women killed by an intimate partner had sought medical care in the year prior to the femicide. Each contact with the healthcare system represents an opportunity for intervention and an opportunity to reduce the risk of IPV-related injury or death.

Emergency nurses' discomfort with emotions such as anger and sadness might play a role in avoiding questioning the survivor about IPV. Emergency nurses respond differently to emotional expression and crying is seen by some as a sign to leave the survivor and refrain from questioning. A perception that probing will make the crying and the emotional pain worse can constitute a barrier to disclosure. Survivors' anger is seen as a clear sign to back off and stop questioning. One participant revealed that although survivors' anger is a source of discomfort to her, she is able to understand it as anger towards the situation, not directed towards her. She responds by leaving the

survivor a while to compose herself. This understanding stems from her own experience with anger after exposure to gender-based violence.

Research by Minsky-Kelly (2005: 1294 & 1297) revealed that emergency nurses' concerns that screening questions get too involved in survivors' personal lives and beliefs that IPV is a personal matter might stem from a fear to deal with issues of IPV related to one's own discomfort and anxiety. A fear of being inadequately equipped to help an identified survivor and personal experience with abuse might contribute to this discomfort (Minsky-Kelly 2005: 1294 & 1297) and a lower screening rate (Elliot *et al.* 2002: 114-115). Feelings of helplessness and lack of resources to help survivors and a fear that questions might offend, anger or endanger survivors were identified as barriers to disclosure in many studies (Ramsay *et al.* 2002: 314-318; Boyle *et al.* 2004: 11; Furniss 2007: 241).

Peculiar to the emergency environment are two studies (Robinson 2010; Rhodes *et al.* 2007), which indicate that the fast-paced, results-driven environment can make it difficult for emergency nurses to respond to IPV. Feelings of frustration related to survivors staying in the violent relationship and the feeling that screening yields no results opposed to the effectiveness of other emergency interventions may also lead to emergency nurses avoiding the issue of IPV (Robinson 2010: 574). Rhodes *et al.* (2007: 626) pointed out that some professionals as observed in their study were "awkward" in the way they responded to signs of IPV and failed to acknowledge IPV. For example the topic was changed to biomedical concerns, discouraging further discussion of IPV. The authors related this to the clinical environment in the emergency department where professionals might feel uncertain about dealing with issues outside the biomedical realm.

Other factors posing a barrier to disclosure include myths and stereotypes held by nurses related to survivors of IPV and the dynamics of a violent relationship. Examples identified by Robinson (2010: 573) are assumptions that survivors will not comply with recommended follow-up when referred, that IPV is more of a social problem than a health problem, and that survivors will not be honest when asked about IPV.

In the next section the role the emergency nurse's frame of reference plays in provision of care to survivors of IPV will be explained.

d) Emergency nurses' frame of reference in relation to provision of care to survivors of IPV

What shapes the emergency nurse's frame of reference in relation to provision of care to survivors of IPV? What became evident in the study is that for some nurses their assumptions based on personal experiences (of IPV and also gender-based violence) seem to be the most evident determinant of what eventually emanates between them and the survivor. Other evident responses to the survivor were those driven by an inclination to care and a sense of professional responsibility. Although discussed separately, caring, professional and personal assumptions shouldn't be seen in isolation as, although a specific assumption can play a more evident role in a nurse's response to the survivor, all these assumptions interrelate to constitute the emergency nurse's frame of reference.

Cox (2003: 325) named the healthcare provider's own belief system regarding IPV as an important barrier to care. In this study assumptions (belief systems) regarding IPV and certain professional and caring qualities is seen to constitute the emergency nurse's frame of reference, which is viewed as playing a significant role in the emotional care provided to survivors of IPV. As will be illustrated, the nurse's belief system is not necessarily a barrier to care.

Nearly 40% of nurses in a South African study (Christofides & Silo 2005: 13) indicated that they were exposed to either physical or emotional IPV or both in their lifetime. Interestingly the authors did not find this personal exposure to have influenced the quality of care relating to IPV. On the contrary, nurses who had a family member or friend who had experienced IPV, or who had previously intervened in IPV, provided higher quality of care in the area of IPV and rape management. The 20% of nurses that had no personal exposure to IPV and did not know anyone among their family or friends who had experienced IPV provided poorer care to survivors of IPV. The degree to which nurses identify with survivors of IPV seems to play a significant role in quality of care.

Examples of emergency nurses' assumptions based on personal experiences of IPV and gender-based violence that guides the provision of care to survivors of IPV include:

- Talking about a traumatic incident helps and brings relief based on own experience with IPV - this guides the nurse to create opportunities and encourage survivors to talk about their experiences of IPV.

- Being alone, having time to think and the expression of emotions like crying bring relief – the rationale behind the nurse’s recommendation to admit survivors of IPV for hospital care.
- In the healing process, it is important for a survivor of IPV to regain control over her own life, based on the nurse’s experience with rebuilding her own life and obtaining and maintaining self-reliance after exposure to IPV. She makes survivors aware of options such as counselling, while refraining from giving them advice that might undermine independence.
- A nurse helping survivors who don’t have the resources to gain their independence. Her actions are driven by a feeling of gratitude for receiving help and having access to social and financial resources after her own exposure to IPV.
- An assumption that a survivor of IPV may feel responsible based on the nurse’s own experience of feeling responsible for what happened after exposure to gender-based violence (assault and near-rape by a male perpetrator). This results in the nurse reassuring the survivor that she is not to be blamed.
- Understanding the suffering of the survivor of IPV based on one’s own suffering.
- The importance of hope and finding meaning in life after exposure to trauma based on one’s own experience of healing after exposure to trauma. Attempts to generate hope by making the survivor aware of meaningful aspects in her life (for example, her baby). One participant exemplified this with sharing a survivor’s response: *Really sister what you said to me it makes me strong. What you said to me it makes me to think how important my family is to me than this person. What you have said to me it gives me hope that it’s not the end of the world.*

Previous experiences are, however, not always beneficial, as the efforts to help constantly interrelate with and serve as a reminder of own experiences. For example, a participant suddenly remembering that she couldn’t even find relief for her own pain experiences powerlessness and self-doubt while interacting with the survivor. A response based on her own experience might also reflect the participant’s own need more than that of the survivor – for example a participant proposing admission as an intervention to prevent the concerns she often feels after the survivor has left.

The abovementioned discussion reveals a transformation. The wounded emergency nurses use what they have learned through their own exposure to violence to heal others. The term “wounded healer” refers to a person “being wounded in body, mind,

or spirit” who emerged from the healing process with a commitment to “share deep empathy insights, and loving energy with others in need of healing.” (Jackson 2004: 70)

The concept of the wounded healer was originally described by Jung to illuminate the dynamics that may take place between a psychoanalyst and his or her client (Benziman, Kannai & Ahmad 2012: 1). The archetype of the wounded healer can be traced back to the story of the centaur Chiron, a half-horse man in Greek mythology. Chiron was accidentally wounded in the leg by a poisoned arrow. The wound was incurable, leaving the immortal Chiron crippled. From the suffering of chronic pain he emerged with a capability to heal others, in that way transcending his own suffering. Chiron taught others the healing properties of herbs, including Asclepius whose work is believed to have formed the foundation of modern medical science (Jackson 2004: 69; Davis 2009: 77; Benziman, Kannai & Ahmad 2012: 3).

A person’s own wounds become a source of healing through “a constant willingness to see one’s own pain and suffering as rising from the depth of the human condition which all men share” (Nouwen 1972: 88). Seeing that suffering is transcended through acceptance, new connections, and discovery of meaning (Egnew 2009: 171-172), healing interventions should facilitate acceptance and the discovery of meaning, connectedness and hope (Mount 2003: 42; Scott *et al.* 2008: 320-321). Acceptance resembles the integration of suffering as a reality while hope reflects “a perspective on reality, a point of view” and “a degree of inner peace”. “Hope is the product of adversity transcended.” (Mount 2003: 42) In this study findings a participant’s attempts to facilitate a sense of hope and meaning in survivors born of her own suffering is evident in the assumptions discussed previously.

According to Jackson (2004: 70), there is an important difference between a wounded healer and a traumatised person who lacks self-awareness and does not take action to transcend adversity, which results in emotional exhaustion. Transformation and transcendence facilitate the move beyond one’s own needs in order to be fully present to others requiring support and healing.

The way emotional support is provided to survivors of IPV is not only guided by personal experiences with IPV and gender-based violence, but also the emergency nurse’s professional frame of reference, which includes certain professional and caring qualities.

The professional qualities highlighted in the study findings as guiding the provision of care to survivors of IPV include: (1) being an advocate for the survivor who is seen as helpless and not in a position to talk for herself; (2) having a strong sense of responsibility to intervene when becoming aware of serious abuse and; (3) being accountable for responding to the survivor's healthcare needs as long as she is in the nurse's care. Caring and professional qualities are interrelated as reflected by Swanson and Wojnar's (2004: S-46) description of the theory of caring developed by Swanson (1993). Caring is seen as a "nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility" (Swanson 1993: 354).

The caring qualities portrayed as fundamental in the care provided to survivors of IPV include:

- Empathy (providing emotional support based on taking the survivor's perspective) and sympathy for the survivor;
- An open and non-judgmental attitude;
- Communicating reassurance, understanding and a willingness to listen;
- Listening (also to what the survivor is feeling);
- Patient-centred care (asking the survivor what she needs, instead of putting pressure on her to talk or take decisions she is not ready for); and
- Sensitivity (observing the survivor's behavior and being aware of feelings such as shame and fear).
- Open questions to give the survivor the opportunity to express her feelings, which helps the survivor to realise her own feelings.

Caring responses do sometimes pose problems for emergency nurses – for example, the empathy/ sympathy dissonance, and difficulty to deal with sensitive emotions as highlighted in previous discussions. An example is one participant who has reservations about putting herself in the survivor's position as she is not sure how to use empathy without getting too involved and attached and try *"to fix this person's problems whereas you are probably just going to make it worse"*.

The caring qualities mentioned above resemble the attitude and skills essential in establishing a nurse-patient relationship. Integral to nursing, as explained by Swanson and Wojnar (2004: S-45), is a caring perspective (aimed at integrity of mind, body, and spirit) that presents itself within the nurse-patient relationship. The principles of Roger's non-directive therapy had a profound effect on the way the nurse-patient relationship has been taught and practised (Phaneuf 2008: 1).

Among the conditions identified by Rogers (1957: 96) for therapeutic change to occur is the therapeutic relationship that must exist between the professional and the client. The professional displays unconditional positive regard for and an empathetic understanding of the client, which is communicated to the client. Covington (2003: 312) applied these principles within the nursing context: The caring presence of the nurse implies availability and attentiveness and enhances sharing of emotions. The nurse-patient relationship provides a sense of safety within which meaning can be discovered in the patient's experience of illness. Tarlier (2004: 236-238) explicated the nurse-patient relationship as a responsive relationship that contains the three essential elements of respect, trust, and mutuality. Relationship building does not necessarily have to be a lengthy process, as nurses are often skilled to establish responsive relationships quickly in the context of emergency care (Tarlier 2004: 238).

According to Morse *et al.* (2006: 78 & 84-85) the essence of the nurse-patient relationship is grounded in emotional engagement - the ability of the nurse to identify with the patient's suffering and sense the patient's emotions - this in turn triggers caring emotions and a meaningful and appropriate response. Conversely the nurse who lacks emotional insight also lacks the sensitivity to observe some of the patient's needs and to advocate for the patient, a situation with ethical repercussions.

Also termed "caregiver responses" by Morse *et al.* (2006: 78), some of the skills utilised in the nurse-patient relationship will be highlighted from the literature to indicate the differences, value and appropriateness of certain skills within the context of nursing. The concepts of reassurance, sympathy/empathy and compassion will be discussed.

Morse *et al.* (2006: 81-82) distinguish between informative and reflexive reassurance. Informative reassurance occurs when information or explanations are provided in a planned way in order to establish confidence, while reflexive reassurance is a spontaneous response of the nurse to alleviate feelings of anxiety or uncertainty in the patient.

In sympathy the focus is on the nurse's own sorrow that acknowledges and justifies the patient's suffering. It is evidenced in an acceptance of the patient's distress and provides comfort (Morse *et al.* 2006: 79-80). When the nurse becomes overwhelmed by sympathetic concerns, or projects these onto the patient, it can inhibit expression of feelings in the patient and impedes the nurse's ability to accurately perceive the

patient's experience and intervene appropriately (Morse *et al.* 2006: 79-80; Videbeck 2010: 189).

"In what seems a paradox, compassion offers comfort precisely because it makes suffering explicitly visible. This visibility makes very clear to the sufferer that one is not alone." (van der Cingel 2009: 135) Compassion is associated with suffering. Compassionate care entails: entering into a person's experience of suffering to obtain insight; communicating understanding; and sharing the burden of suffering. It is aimed at strengthening and comforting the sufferer (von Dietze & Orb 2000: 169; Morse *et al.* 2006: 80). Compassion is linked with action; for example, listening, comforting and provision of physical help, but also with a caring presence. As a moral virtue it is characterised by the way in which these acts of compassion are carried out: with a full regard of the other person as a whole person, as a fellow human being (von Dietze & Orb 2000: 170-172).

Rogers (1957: 99) describe empathy as follows: "To sense the client's anger, fear, or confusion as if it were your own, yet without your own anger, fear, or confusion getting bound up in it." Rogers (1957: 99) further explains: "When the client's world is this clear to the therapist, and he moves about in it freely, then he can both communicate his understanding of what is clearly known to the client and can also voice meanings in the client's experience of which the client is scarcely aware." In nursing empathy means more than just communicating an understanding of the patient's experience, but also includes nursing actions resulting from recognising the patient's needs (Morse *et al.* 2006: 82). Håkansson and Montgomery (2003: 279) explicates that caring actions and a respectful attitude emanate from the element of concern that is one of the constituents of empathy. Caring actions indicate that the concern is genuine.

What unfolds between the nurse and the patient in terms of empathy can be further explicated through the biological basis for empathy applied by Gallese, Eagle and Migone (2007) to the therapeutic situation. For the purpose of this discussion this biological basis is applied to the nurse-patient relationship. Congruent responses, or responses "attuned to" the patient's experience are possible through the existence of the mirror neuronal system and "automatic embodied simulation" (Gallese *et al.* 2007: 151-152). Embodied simulation refers to the ability to map other's actions, emotions etc. to our own; that is to understand others by cognitively taking their perspective (Gallese 2009: 524). A nurse's "accurately attuned" response to the patient enhances a sense of connectedness (Gallese *et al.* 2007: 151-152). The nurse's response does not entail a literal mirroring of the patient's emotions, but an accurate articulation of

the patient's emotional state that reflects empathic understanding. This enhances the patient's understanding of his or her own emotional state, and provides the opportunity for the patient to reflect on and transform an experience (Gallese *et al.* 2007: 161). Empathy plays a crucial role in the nurse-patient relationship, whereas empathy and the nurse-patient relationship are both linked to improved outcomes (Mercer & Reynolds 2002: S9). In a study by Håkansson and Montgomery (2003: 280), participants verbalised experiences of relief and personal growth as a result of empathy.

The question that arises is: What drives some emergency nurses to go the extra mile and provides emotional support to the survivor? It is described as an urge; a desire to care and help "that takes over". It is attributed to professional training and a nursing career that brings a responsibility to care. It reflects itself in a sense of responsibility – being there to help those who cannot help themselves, in this case the survivor in a state of despair and in need of care. These descriptions point towards the altruistic nature of nursing that drives the provision of holistic care: "I have to help them in totality in everything that I could help them." A study by Jensen and Lidell (2009: 35) described this behavior as resembling the notion of nursing as an act of duty – nurses are obliged to place their duties before themselves and their own needs.

Another factor that motivates emergency nurses to provide emotional support is the feeling of emotional fulfilment experienced afterwards. This feeling can fulfil a personal or professional need as illustrated in the next two examples. In the first example, the emotional fulfilment reflects a professional experience where the nurse feels glad that she could have helped ("nursed") a woman exposed to IPV. The participant even visits survivors who have been admitted in the wards and finds consolation when seeing for herself that the survivor is stable and improving and that she (the nurse) has contributed towards that. The second example refers to the participant who has been exposed to gender-based violence. She feels better in herself when able to help someone. This feeling is confirmed when the survivor expresses her gratitude. It feels good to help, a feeling that prompts the nurse to do even more for the survivor. To be able to provide emotional support to a survivor serves in a way as compensation for a participant who struggled to overcome her own exposure to trauma. The relief brought about to the survivor is also her relief: *...at least I have somebody who I can help to deal with the situation; and: I think that's the difference it can make to the person.*

Altruism is described as a motivational state that has as its ultimate goal to increase another's welfare. Empathy is seen as motivating altruistic behavior. This is related to

the antecedents of empathy: a perception that the other is in need and valuing the other's welfare (Batson, Ahmed & Lishner 2009: 417-418). According to Batson (2008: 5-6), benefiting others as a means to benefit oneself (for example, to get a good feeling, avoid guilt, or ease empathetic emotional arousal) is more egoistic than altruistic. The focus has to be on relieving the other's need. Batson (2008: 5-6) now asks the question: "As long as a person in need is helped, why worry about the nature of the underlying motivation?", and continues to explain that the underlying motivation play a role in the predictability and consistency of helping behavior. For the purpose of this study, it seems to be that some participants' helping behaviour is clearly motivated by altruism, while others want to help the survivor, but the secondary goal of emotional fulfilment might affect the consistency and predictability of the helping behavior.

Staub and Vollhardt (2008) discussed another phenomenon that seems to be applicable to some participants' altruistic approaches to the survivor namely: "altruism born of suffering" (Staub 2003: 10). This phenomenon is substantiated by the following conditions and experiences: certain psychological changes are necessary to shift from a defensive orientation to concern about others; and own experiences of suffering facilitate an ability to understand others' feelings related to suffering and create deep awareness of human suffering. The phenomenon is possibly underpinned by identification and empathy with others in need, feeling responsible for their welfare and a strong commitment to help (Staub & Vollhardt 2008: 276).

On the other hand a person's own distress related to past suffering may be triggered by witnessing others in similar situations (Staub & Vollhardt 2008: 277). If not regulated personal distress can lead to empathetic arousal (Eisenberg 1991: 130). One's own wounds may lead to helping aimed at decreasing one's own emotional arousal (Batson 1991: 109), ineffective helping or overinvolvement with the survivor. "Thus, healing, and the increased self-regulation presumably associated with it, is both important in determining whether one's past suffering results in personal distress, or empathy and sympathy." (Staub & Vollhardt 2008: 277)

In the context of nursing, altruism is associated with a personal commitment to the philosophy of nursing practice that honours being human and human dignity with deep respect; it is a dedication to the service of humankind (Milton 2012: 224). Compassion is associated with altruism: Compassion that puts the interest of the patient first is altruism (van der Cingel 2009: 134-135).

Altruism also reflects itself in the study of Robinson (2010: 574) where the relief nurses felt in knowing the survivor can benefit from screening, encouraged them to persist. It is also sometimes the hope that interventions might benefit the survivor that keeps altruism alive: "I always feel good about it one way or the other. You know, it might not always turn out the way I want it to... I feel good about it because it's helping some." (Participant in a study by Robinson (2010: 574)).

4.2.7.2 Referral of survivors of IPV

The final part of the care the emergency nurse provides is to refer survivors to the appropriate services. Most participants are aware that survivors of IPV need some form of counseling or support. They are also aware of the different referral options and make survivors aware of these options – for example trauma counsellors, psychiatrists, psychologists, social workers, the police and other resources such as support groups and help-lines. Most participants prefer to refer to the counsellors of a hospital-based non-profit Christian faith-based organisation that provides psycho-social and spiritual care, counselling and training, as well as physical support in the hospital. They are perceived to have the necessary skills and are either available in the units, or will quickly respond when called. Other professionals (for example, social workers and psychologists) are not necessarily always available and work office hours, which poses certain challenges, as survivors might not come back for appointments or have the means to execute the advice to consult a professional person. This explicates the phenomenon that survivors are more susceptible for interventions immediately after the abusive episode. That is why admission to hospital is sometimes used as a temporary place of safety and to allow time to start the counselling when serious violence is suspected.

Not all emergency nurses are that attentive about referring survivors and some just provide information regarding referral options and leave the responsibility with the survivor. One participant explains that emergency nurses do not necessarily do referrals, as it is not a priority in the emergency unit. Seeing referral as the medical practitioner's responsibility might be a logical deduction as the doctor usually decides whether referral is indicated and arranges with the psychologist or social worker to see the survivor or request the emergency nurse to arrange the referral.

Although emergency nurses' *authority is limited*, they can still advocate for the survivor when they suspect IPV and see a need for referral. This recommendation seems to be carried out in quite a diplomatic and tentative way, as the final decision is

with the doctor. The feedback received from the psychologist through the doctor brings relief that the survivor has been helped. Not to be able to follow up and know what has happened to the survivor is a part of providing care that emergency nurses are deprived of.

The WHO (2010) provides guidelines for the minimum response that any healthcare setting should provide towards survivors of IPV. These are listening; documentation of the survivor's narrations, any injuries, and, if sexual violence has occurred, documentation of any forensic evidence; validation of the survivor's experiences and a non-judgmental attitude; medical treatment; and information about services that can offer immediate and long-term assistance. Support must be based on the survivor's needs and wants and continuity of care should be ensured as applicable. The next level of support includes: safety planning; referrals within the healthcare facility to professionals who have more experience in dealing with IPV, or to external specialist organisations.

4.3 CONCLUSION

This chapter served to illuminate the essence and constituents identified in the study findings by means of other research findings and applicable theories. The theoretical discussions are incorporated in the findings to clarify meanings and contribute to a fuller understanding of the phenomenon of emergency nurses providing care to survivors of IPV.

CHAPTER 5: DEVELOPMENT AND VALIDATION OF GUIDELINES TO FACILITATE THE ACTUALISATION OF EMANCIPATORY KNOWING IN EMERGENCY NURSES WITH REGARD TO TAKING CARE OF SURVIVORS OF INTIMATE PARTNER VIOLENCE

5.1 INTRODUCTION

In the previous chapter the essence and constituents identified in the study findings were illuminated by means of other research findings and applicable theories. The theoretical discussions were incorporated with the findings and meanings were clarified in order for the researcher to develop a deeper understanding of the phenomenon of emergency nurses taking care of survivors of IPV. This chapter reflects the process followed to develop and validate the guidelines to facilitate the actualisation of emancipatory knowing in emergency nurses with regard to taking care of survivors of IPV. The nine draft guidelines with the changes suggested in the Delphi rounds are presented in the chapter. Lastly, the validity of the guidelines is discussed.

5.2 GUIDELINE DEVELOPMENT

Guideline development as described in the nursing literature focuses mostly on clinical practice guidelines that are developed from systematic reviews. The purpose of guidelines is to link healthcare to a body of evidence with the aim of assisting the practitioner with clinical decision-making and improving the quality of healthcare (Bowker, Lakhanpaul & Atkinson 2008: 1; Krahn & Naglie 2008:436; Shekelle *et al.* 2012: 1).

For the purpose of this study the guidelines developed are linked to a body of evidence through the literature review reflected in the previous chapter. Although the focus is on facilitating emancipatory knowing in emergency nurses, the end goal is to promote care to survivors of IPV based on independent clinical decision-making.

The process followed so far can be summarized as follows:

- Emergency nurses' experiences of taking care of survivors of IPV were explored and described through a phenomenological inquiry.
- The findings, described to reflect the essence of emergency nurses' experiences, were supported by in-depth discussions of the constituents and

participants' quotations that illuminated the meaning attached to the experience.

- Through a literature review, related theories and research findings were integrated into the study findings to further enlighten and clarify the meaning emergency nurses attach to the provision of care to survivors of IPV. The inclusion of literature in the findings was conducted in accordance with a descriptive phenomenological approach (Dahlberg *et al.* 2008: 272-273).

The guidelines were developed and validated in accordance with the following process:

- The draft guidelines were developed by the researcher in accordance with and guided by the following: guiding attributes in the guideline development process (5.2.1); summary of findings (5.2.2); and dimensions of emancipatory knowing in nursing (5.2.5).
- The draft guidelines were validated through a Delphi technique (5.3).
- The draft guidelines were presented with the changes suggested in the Delphi rounds (5.4).
- The final validated guidelines were described (see Chapter 6).

In the next section the guiding attributes in the guideline development process are presented for quality purposes (5.2.1). The discussion of findings and applicable literature served as a point of departure for guideline development (5.2.2). A reflection on knowledge development in nursing guided the researcher to emancipatory knowing processes in nursing (5.2.3). The next discussion serves to uncover injustice and oppression in emergency nurses' experiences of taking care of survivors of IPV (5.2.4). The guideline development process in terms of dimensions of emancipatory knowing in nursing is explained (5.2.5).

The guideline development and validation process is illustrated in Figure 2.

5.2.1 Guiding attributes in the guideline development process

For quality purposes attributes are set for ideal guidelines (Institute of Medicine 1990: 59; Tan 2006: 197-199). These attributes guided the researcher throughout the development process to ensure that the guidelines meet these requirements.

- **Validity:** Guidelines are considered valid if they lead to the desired outcomes. The validity of guidelines can be judged by, for example, the substance and quality of the evidence used in formulating the guidelines. Validity of the guidelines in this study was ensured through obtaining the input and recommendations of a panel of experts through the Delphi technique.
- **Reproducibility:** Guidelines are reproducible if, given the same evidence and methods of guideline development, another guideline group would produce the same recommendations in essence. This attribute was attained by comparing the guidelines developed by the researcher with recommendations of a panel of experts. The guidelines were not tested in practice as it was not part of the scope of this study.
- **Reliability:** Reliability means that given the same circumstances the guidelines would be interpreted and applied consistently by practitioners. Reliability with regard to interpretation was validated by a panel of experts. The application of the guidelines is not part of the scope of the study, so reliability in terms of application can only be judged after completion of the study.
- **Applicability:** The population to which the guidelines are applicable should be stated explicitly. Guidelines developed in a particular context might not be applicable to another population. The guidelines are applicable to emergency nurses providing care to survivors of IPV.
- **Flexibility:** The design of guidelines should focus on ways of facilitating the target group's perceptions and preferences in the care-delivery process. The end result is a patient-centred decision-making process. The guidelines are based on the target group's perceptions obtained through the phenomenological inquiry. Flexibility was also validated by a panel of experts.
- **Clarity:** The language used in the guidelines must be unambiguous. Terms should be precise and recommendations should be logical and easy to follow. The guidelines were validated by a panel of experts to ensure simplicity, clarity and logic flow.
- **Representative process:** Guidelines must be developed by a process that includes participation by representatives of the target group. The guidelines are based on emergency nurse's experiences obtained through in-depth interviews.

- Scheduled review: Guidelines should be reviewed on a regular basis in the light of new evidence or professional opinions. It is recommended that the study guidelines be reviewed every five years.
- Documentation: The process of developing guidelines, the evidence used, assumptions made and participants involved should be accurately documented and described. The process was documented in the research report.

5.2.2 Summary of findings

Emergency nurses take care of survivors of IPV, but are at the same time exposed to survivors' experiences with IPV. Being emergency nurses, they have no choice but to be witnesses to the physical and emotional pain women who are exposed to intimate partner violence suffer. As *nurses, women and human beings*, they cannot stay untouched and aloof.

The nursing profession requires *nurses* to engage, to establish a nurse-patient relationship and respond with compassion and empathy. Furthermore, inherent in the nursing profession is the phenomenon of altruism – a desire to decrease suffering and value another's welfare. As professionals, emergency nurses have a responsibility to identify survivors of IPV and intervene. As *human beings* emergency nurses respond with sympathy, horror and emotional pain to survivors' suffering. As *women*, emergency nurses identify with survivors of IPV and empathise ("feel with") with their experiences. Some emergency nurses in the study had suffered overt or covert violation themselves, while others had had experiences with family, community members or friends exposure to IPV (personal domain experiences). Others were painfully aware of the vulnerable and powerless position some women (seen as victims) find themselves in. They were acutely aware of the potential for IPV in their own lives.

As a result emergency nurses suffer themselves. The exposure to IPV survivors' suffering has an emotional and cognitive impact. The emotional impact reveals itself in emotional distress. The cognitive impact is experienced as troubling and lingering thoughts, concerns for the survivor, and longstanding, recurrent and intrusive memories and disturbing mental images. The emotional and cognitive consequences indicate emergency nurses' vulnerability to developing STS disorder and compassion fatigue. Emergency nurses' own experiences with IPV and gender-based violence interrelate with survivors' experiences and serve as a constant reminder of their own "wounds", vulnerabilities and violation. A fusion in the boundaries between the

emergency nurse and the survivor impedes self-regulation, which is an antecedent for empathy. The dissonance between the painful identification associated with empathy ("feeling with"), and spontaneous feelings of sympathy ("sorrow for") that confirms the suffering of the "victim" can render emergency nurses powerless.

Emergency nurses' suffering is invisible. They employ ways to attempt to cope with the emotional and cognitive effects of experiences with violation in their professional and personal domains so as to fulfil their professional and personal responsibilities. Most of the coping takes place on a cognitive level: As their assumptions about intimate relationships, men and women are shattered and disillusioned, emergency nurses reflect on their experiences and attempt to make meaning of IPV. These nurses see the vulnerabilities of women, the powerful position and aggression of men, the pain and destruction caused by intimate relationships. Vicarious traumatising accounts for the resulting disruptions in the cognitive schemas emergency nurses experience. Resorting to gender stereotyping is an example: intimate relationships are a risky undertaking, men are dangerous, and women are vulnerable and powerless. Some nurses experience changes in their frame of reference related to trust, safety, independence, power and intimacy, and these changes result in existential questions about humanity, self, and meaning in life.

Emergency nurses' assumptions based on personal experiences (with IPV and also gender-based violence) seem to be the most evident determinant of what eventually emanates between them and the survivor. Other evident responses to the survivor are those driven by an inclination to care and a sense of professional responsibility. Although personal experiences seem to sensitize the emergency nurse towards understanding the survivor and her needs, and mostly prompt a caring response, previous experiences are not always beneficial, as the efforts to help constantly interrelate with and serve as a reminder of one's own violation. A response based on one's own experience might also reflect the nurse's own needs more than those of the survivor. These issues in caring are illuminated by two phenomena: "the wounded healer" and "altruism born of suffering", both of which might lead to empathetic caring. On the other hand "suffering" and "wounds" that have never healed are associated with emotional distress, a lack of self-awareness and a lack of self-regulation. Emotional distress prompts attempts to relieve one's distress while a lack of self-awareness and a lack of self-regulation might impede the nurse's empathetic abilities and provision of care to the survivor of IPV.

5.2.3 Reflection on knowledge development in nursing

The interpretation of research findings contributes to the value of research by guiding the researcher towards applying the insights generated (Thorne 2011: 450). To contribute to knowledge development that makes meaning in the practice situation, the interpretation of research data must be grounded within practice and linked with empirical knowledge structures (Chinn & Kramer 2011: 207-208). The insights generated from the research findings of this study prompted the researcher to consider the implications of the findings in terms of knowledge development in nursing.

Chinn and Kramer (2011: 3-4) distinguished between knowledge and knowing. Whereas knowledge is collectively ascertained to be a valid and exact understanding of the components and features of a discipline, knowing entails ways of perceiving and understanding the self and the world. A move beyond formal empirical knowledge development in nursing entails knowing expressed within personal, ethical, aesthetic and emancipatory patterns to provide a more comprehensive picture of the nursing discipline.

Fundamental patterns of knowing in nursing were developed by Carper (1978) to include empirical, personal, ethical and aesthetic knowing (Carper 1999: 12). Chinn and Kramer (2008: 78) developed a fifth pattern of knowing – “emancipatory knowing” – defined as “the capacity not only to notice injustices in a social order, but also to critically examine why injustices seem to go unnoticed or remain invisible, and to identify social and structural changes that are required to right social and institutional wrongs.”

5.2.4 Injustice and oppression uncovered in emergency nurses’ experience of taking care of survivors of IPV

As reflected in the study findings and explicated in the abovementioned summary, the experiences of emergency nurses providing care to survivors of IPV is embedded in a social wrong. The suffering inherent in the social injustice of IPV displays itself in the emergency unit. Emergency nurses are not only witnesses to but also share in the suffering. Moreover, emergency nurses who in their personal domain have had experiences with social injustices at the hands of men are constantly reminded of the oppression they suffered. Through the experiences of survivors emergency nurses are confronted with gender inequalities: the pain caused by power (male in this case)

used to oppress (women in this case). As a result emergency nurses live in constant awareness of the vulnerabilities they are subjected to. This interrelation and subsequent identification with others' suffering comes at a price, leaving emergency nurses in a disadvantaged position – at risk for STS, compassion fatigue and vicarious traumatisation. Sommer and Cox (2006: 13) explain how counsellors are “wounded” when agencies and supervisors place counsellor self-care and well-being low on the list of priorities. The same can be said of emergency nurses in this study: when management does not actively attend to vicarious traumatization, emergency nurses are harmed in the process – an injustice. Being internal and invisible experiences, first-hand- and vicarious exposure to violation may potentially affect emergency nurses' empathetic and caring abilities, which in turn put survivors at a further disadvantage – another injustice.

The injustice emanating from nurses not being able to provide optimal care because of vicarious traumatisation will be illuminated with reference to the article: “Wellness as Fairness” (Prilleltensky 2012). The author drew the comparison between fairness and wellness (which implicates the healthcare system). He distinguished between procedural and distributive justice. Distributive justice means “each person should receive what is due to him or her in a fair and equitable manner”. From a needs perspective, what is due to a person would include anything required to “survive and to thrive”. Procedural justice implies a fair, transparent, informative, respectful, decision-making process that includes the healthcare user. This type of justice builds trust and respect and brings empowerment. Survivors of IPV are potentially deprived from wellness if emergency nurses do not provide care in accordance with the survivor's needs within a supportive nurse-patient relationship. Emergency nurses who provide care while they are clouded by emotional distress and their own “wounded” perspective, and who struggle between sympathy and empathy limited to identification with the survivor's pain, are in a disadvantaged position as far as ensuring that “wellness as fairness” prevails for survivors of IPV.

Prilleltensky (2012: 4-5) also distinguished between intrapersonal, interpersonal, organizational and community justice. Intrapersonal injustice as applicable to this study will be further explicated. Intrapersonal injustice is reflected in unfairness towards the self – what is given to the self and how the self is treated. Unfairness towards the self relates to a form of power described by Foucault (1982: 781-782). He explained how individuals can become subjects of, for example, their own conscience. The individual is tied to a certain identity, category or law of truth by means of his or her own individual expectations (Foucault 1982: 781-782). In relation to nursing,

nurses sculpture and measure their behaviour against what they assume they should be like (Bradbury-Jones, Sambrook & Irvine 2008: 263). These assumptions can lead to nurses being “coerced into docility, utility and obedience” (Crowe 2000: 963-966). Similarly nurses sometimes (in line with hierarchical systems that take advantage of them) deny their own human vulnerability (Sumner 2010: E25).

Personal and hierarchical assumptions originate from somewhere. In nursing, as in any other discipline, knowledge or practices reflect the prevailing hegemony – certain dominant beliefs, assumptions and worldviews that are created and maintained by power structures and social and political contexts. Hegemonic beliefs are often hidden, taken for granted and tend to privilege one group over the other. Without awareness people tend to conform to hegemonic practices, unaware of the disadvantages they create and unaware of alternatives (Chinn & Kramer 2011: 66).

A dominant view in and of nursing is related to its association with altruism, which is seen as a virtue and a professional value in nursing practice (Adams & Nelson 2009: 5; Miller 2006: 472; Milton 2012: 222 & 224). The association with altruism support the view that nursing is orientated to care for and help others, to sacrifice, to give, and to serve (White 2002: 282-283; Helin & Lindström 2003: 417; Miller 2006: 472; Miers, Rickaby & Pollard 2007: 1207; Gray 2009: 171). The emphasis on nursing as a caring profession has been criticized for presenting nursing in a sentimental way as a “virtue script”, and denying nursing its identity as a knowledge-based profession (Gordon & Nelson 2005: 63; Adams & Nelson 2009: 5-6).

The findings of this study reflect how emergency nurses subject themselves (in line with professional expectations) to an altruistic, caring identity and, although such expectations reflect nurses’ integrity and may enhance nursing practice, nurses need to be aware of self-sacrifice and self-scrutiny as discreet forms of power (Bradbury-Jones, Sambrook & Irvine 2008: 263). This form of power disqualifies emergency nurses firstly as human beings and secondly as women (still an oppressed group in many ways). In spite of what they witness and experience in terms of violence and oppression, when encountering a survivor of IPV, they have to put others before themselves while they “cry inside”. This discourse coerces them into silence and individual, covert ways of coping that sometimes have devastating consequences – emotional distress, cognitive disruptions, an altered frame of reference – that impacts on their worldviews, relationships, the whole of their existence. The effects of emergency nurses’ experiences of taking care of survivors of IPV echo with the words

of Husserl (1956:166) who stated: "Experiences are not in a nowhere-land", but "in me".

Persisting injustice related to the mechanisms of *oppression* and *helplessness* give way to suffering (Prilleltensky 2012: 17). *Oppression* results from inequalities in power relations shaped by domination and subordination. The oppressed suffer deprivation, marginalisation, exclusion, exploitation, control and sometimes violation, which also serve as strategies by the oppressor to instill self-deprecating views and suppress the voice of the oppressed (Prilleltensky 2008: 127; Prilleltensky 2012: 17). Through "submersion in the reality of oppression", the oppressed behave in the way prescribed by the oppressor, fall into the security of conformity and become silent (Freire 1972: 22-25). Eventually oppression leads to an inability to explore and realize one's personal potential (Dong & Temple 2011: 171). *Helplessness* comes from repeated unsuccessful attempts to overcome injustice (Prilleltensky 2012: 17). Feelings of helplessness might lead to a nurse not engaging to establish a nurse-patient relationship, which denies the patient the healing opportunities of mutuality and leaves the nurse experiencing ethical conflict (Sumner 2010: E25).

Oppression is a result of inequities in power relations characterized by domination and subordination (Prilleltensky 2012: 17). Power "incites, it induces, it seduces, it makes easier or more difficult; in the extreme it constrains or forbids absolutely." (Foucault 1982: 789) The emergency nurses in this study related their own experiences of male oppression and violation. As they are exposed to survivors' experiences they become more and more aware of women as an oppressed group, which is an awareness that "induces" gender stereotyping, which in itself has a "constraining" effect.

Oppression in nursing reflects itself in oppressed group behaviour; for example, horizontal violence and silencing the self (DeMarco & Roberts 2003: 113; Sofield & Salmond 2003: 276-280; Matheson & Bobay 2007: 232; Roberts, DeMarco & Griffin 2009: 290-292). Fletcher (2006: 50) ascribed oppression in nursing to its historical association with hierarchical, autocratic, and oppressive institutions and the acceptance of patriarchy associated with the medical model. The traditional role and image of nurses reflect notions of an oppressed group. Nurses struggle to claim their power and to "maintain authority of nurses in nurses' hands". Nurses' experiences of oppression relate to the dynamics of power that affect women (Fletcher 2006: 50-53). Although referring survivors of IPV for counselling or social services is the responsibility of any healthcare professional, some of the emergency nurses in the study expressed the view that this decision should be taken by the medical practitioner. They either leave the decision to the medical practitioner or tactfully

suggest to the medical practitioner that the survivor might require counselling. This indicates acceptance of the medical model of decision-making.

The abovementioned discussion illustrate the oppression and injustice that is evident in emergency nurses' experiences of taking care of survivors of IPV. Emancipation equalises power and encourages free choice, but it is only *recognized* oppression that precedes emancipation (Wittmann-Price 2004: 440-441 & 444). The silent and unrecognized nature of the oppression and injustices emergency nurses suffer prompted the researcher to formulate the guidelines in terms of the dimensions of emancipatory knowing in nursing. In this way the study contributes to emancipatory knowledge development.

5.2.5 Guideline development in terms of dimensions of emancipatory knowing in nursing

Emancipatory knowing interconnects with and encompasses the four other patterns of knowing in nursing (Chinn & Kramer 2011: 11-12). It reflects nurses' ability to recognize injustices or inequities in nursing practice, to realise that things do not have to be like that, and the putting together of experience and resources to bring about changes (Chinn & Kramer 2011: 64-65).

Emancipatory knowing requires a critical examination to uncover the reasons for injustices remaining invisible. The awareness of how unjust situations are maintained through certain social constructs is effected in praxis (Chinn & Kramer 2011: 64-65). "Nursing praxis" refers to nursing practice that reflects nurses' engagement in undoing social inequities in the healthcare environment (Chinn & Kramer 2011: 2). In the context of this study emancipatory knowing is seen to be actualised through a facilitative process uncovering the emotional and cognitive effects of providing care to survivors of IPV and the reasons why these effects and emergency nurses' vulnerabilities and "woundedness" remain largely invisible. Nursing praxis is seen as nursing practice where emergency nurses engage in a process of addressing the injustices and oppression uncovered in the provision of care to survivors of IPV.

The process of emancipatory knowing opens the possibility for emergency nurses to realize the wrong and the possibility that it can be changed. The study illuminated:

- The impact of providing care to survivors of IPV on emergency nurses;
- The inter-relation between emergency nurses' personal and professional domain experiences with male violence and oppression and;

- The effect of the two abovementioned experiences on the care provided to survivors of IPV.

So far emergency nurses have attempted to cope with and make meaning of the situation in a “discrete, individual and temporary” (Chinn & Kramer 2011: 67) way. Guidelines were developed to facilitate the actualisation of emancipatory knowing in emergency nurses with regard to taking care of survivors of IPV. Through utilising the guidelines an emancipatory process can be facilitated for emergency nurses to: (1) ask the critical questions to initiate the emancipatory process; (2) define and clarify how IPV-related experiences in emergency nurses’ professional domain that inter-relate with experiences in their personal domain can put emergency nurses in a disadvantaged position; and (3) open ways to challenge this position and take corrective action. As more emergency nurses become aware of their disadvantaged position, actions, insights and knowledge about what is needed to change processes, patterns and structures can be developed (Chinn & Kramer 2011: 66-67).

A critical question that evolves is *how* to facilitate the process of emancipatory knowing. In an essay based on the French philosopher Jacques Rancière’s views on emancipation, Biesta (2010) highlights the contradictions inherent in emancipatory theory: Emancipation that is dependent upon an intervention from the outside - an intervention by an emancipator who is not subjected to the power that needs to be overcome - may install the very dependency and inequality it aims to counteract. The people to be emancipated become dependent upon the intervention of the emancipator when the emancipator is seen to possess knowledge that is inaccessible to the people to be emancipated. Without outside intervention, there is no emancipation. The emancipator is the one with the knowledge, the only one that can perform the act of demystification that is needed to expose the power (Biesta 2010: 44-45).

Rancière (2010: 2-3) sees the emancipator as an authority, but a form of authority that “is only an authority, only a will that sets the ignorant person down a path, that is to say to instigate a capacity already possessed”. Similarly Freire (1972: 42-43 & 67) makes it clear that it is only liberation *with* the oppressed that is valid, that is liberation that transforms dependence into independence. Freire (1972: 68) sees emancipation as a dialectical process: dialogue with the oppressed to understand their objective situation and their awareness of their situation.

In the context of health promotion theory, Laverack (2007: 10) describes the process of "*power-with*", a concept to be distinguished from "*power-over*" and "*power-within*". Power-over is when one person or group has control over the resources or decisions that influence the lives and health of another person or group (Laverack 2007: 9). Power from within is described as personal or psychological power, an internal sense of self-knowledge, self-discipline and strength (Laverack 2007: 11). Power-with increases the power from within of another person. Power-over that has transformed to power-with becomes visible when people seen to be less powerful have obtained sufficient power from within to make their own choices with regard to their lives. The person with the power-over chooses not to dominate and exercise control, but to enable, gain trust, establish common ground, suggest, and initiate a discussion that will increase the other's sense of power from within (Laverack 2007: 10 & 15).

Chinn (2011: 158) describe emancipatory leadership as facilitative rather than descriptive and supportive rather than demanding. In practice development the facilitator is described as a "critical guide": a person who will balance being supportive and challenging in accordance with the group's progress and needs (Crisp & Wilson 2011: 177).

In the context of the study the process to actualise emancipatory knowing is seen as a facilitative process. A facilitator skilled in emancipatory processes and group dynamics will engage in a dialogue with emergency nurses, gain their trust and utilise the guidelines *with* them. The facilitator will act as a critical guide that will challenge emergency nurses' to reflect on their situation and acknowledge and utilise their sense of power from within to make independent choices with regard to taking care of survivors of IPV.

Chinn and Kramer (2011) describe methods to develop knowledge in the different patterns of knowing. Each pattern of knowing is characterized by processes located within five dimensions:

- Critical questions that initiate and generate knowing and knowledge;
- Creative processes that initiate and generate knowing and knowledge;
- Formal practice expressions of knowledge and knowing;
- Integrated practice expressions of knowledge and knowing; and
- Authentication processes used to examine and improve knowledge (Chinn & Kramer 2011: 3).

The draft guidelines will be presented in terms of the abovementioned dimensions of knowledge development (5.4). Each dimension will briefly be described, followed by the applicable guideline(s), rationale and actions.

5.3 VALIDATION OF THE DRAFT GUIDELINES

An e-Delphi technique as discussed by McKenna (1994), Keeney, Hasson and McKenna (2011), and Keeney (2010) was utilized to validate the draft guidelines of this study. Different perspectives and opinions on the draft guidelines were obtained from a panel of experts. The researcher analysed and summarised the panel members' views. A narrower set of guidelines based on the initial responses were fed back to the panel for further input and reformulation. Two rounds occurred after which consensus was obtained as indicated by all participants' agreement on the guidelines.

The Delphi technique is discussed in accordance with the method followed: *selection of participants; inclusion criteria, Delphi Round 1 and Delphi Round 2 (including data collection and analysis)*. The ethical considerations are covered in Chapter 1.

5.3.1 Selection of participants

The researcher selected participants from experts in the field of gender-based violence, emergency nursing and emancipation from academic institutions and the public and private health sectors. A list of potential participants was developed and participants were purposively selected. The researcher selected and invited 17 potential participants in accordance with the inclusion criteria (Chapter 2, 2.6.2.2). Thirteen of these potential participants responded and participated in the Delphi.

Table 2 provides a summary of the professional qualifications, occupations, employment and experience in the field of gender-based violence, emancipation and/or emergency nursing, for each participant.

Table 2 Descriptive information of the Delphi technique participants

	Professional qualifications	Occupation	Employer	Experience in the field of gender-based violence/emancipation/emergency nursing
1	B Cur I et A, B Cur (Hons), M Th (Practical Theology), D Litt et Phil (Religious Knowledge).	Program and nursing service manager.	Clearview private Clinic, South Africa.	Renders individual and group psychotherapeutic interventions to trauma survivors. Conducted research in the field of post-traumatic stress disorder. Rendered in-service training to emergency nurses.
2	MB Ch B, Certificate in Medicine and Law.	Chief medical officer, Tshwane District.	Gauteng Department of Health, Public sector, South Africa.	Coordinates Tshwane Clinical Forensic Medical Services where health services are provided to survivors of gender-based violence.
3	Registered Nurse (General, Mental health nursing), Registered Nurse Tutor, BA, Med.	Retired senior lecturer, Freelance writer.	Self-employed, United Kingdom.	Survivor of gender-based violence. Facilitated groups for women in mental health settings. Rendered mental health crisis intervention in emergency contexts. Conducted research and published in the field of domestic violence.
4	Registered Nurse, Doctorate in Public Health.	Researcher with abused women programs.	Texas Woman's University, United States of America	Published 150 publications on women's health which include gender-based violence. Obtained ten funded intervention grants for violence intervention projects for women and children. Published a book on clinical guidelines. Participant on clinical guidelines committees. Wrote guidelines for use in emergency department on protocol of care for abused women.
5	Dipl. General Nursing, Community Nursing, Psychiatric Nursing and Midwifery, B Soc Sc (Hons), B Soc Sc (Psychology & Biblical Studies), M Soc Sc (Religious Studies), Nurse Educator, DPhil.	Senior lecturer, mental health nursing and gender-based violence.	University of Western Cape, South Africa	Published peer reviewed publications, chapters in books and a book on intimate partner violence. Presented at various national and international conferences on intimate partner violence. Developed and lectures a curriculum on gender-based violence as a public health problem. Conducted research in the field of intimate partner violence.
6	B Cur, M Cur, D Cur.	Nursing Instructor.	University of the Fraser Valley, Canada	Involved in the design and lecturing of intimate partner abuse modules to undergraduate nursing students. Provided interventions to survivors of gender-based violence in psychiatric clinics and units in South Africa and Canada. Conducted research on secondary traumatisation in therapists.

	Professional qualifications	Occupation	Employer	Experience in the field of gender-based violence/emancipation/emergency nursing
7	B Soc Sc (SW Hons), Masters in Public Health, PhD.	Director, Children's Institute.	University of Cape Town, South Africa	Lectures on ad hoc basis at post graduate seminars. Lectured a gender-based violence research training course for more than six years. Rendered therapeutic counselling within family context for 10 years. Conducted two large scale national research studies on intimate femicide, a national epidemiological study on child homicide, a study evaluating the impact of the Domestic Violence Act of 1998, a longitudinal study on mental health adjustment post child sexual assault and a qualitative study with men who killed an intimate partner to develop an understanding of pathways to violent masculinities. Published a wide range of peer reviewed publications including gender-based violence over the past 10 years.
8	D Litt et Phil (Sociology).	Sociologist.	Self-employed South Africa	Conducted research at the Human Sciences Research Council. Directed policy and research at the Commission for Gender Equality. Lectured in Sociology and Gender Studies at University level. Designed curricula and facilitated training on gender mainstreaming. Facilitated workshops on gender-based violence in South Africa and African countries. Published reports on gender-based violence. Conducted monitoring and evaluation of gender-based programmes.
9	RGN, BNS, PDip EN, MSc, PDip Advanced Practice, PDip Prescribing.	Advanced Nurse Practitioner.	Our Lady's Hospital, Navan, Co. Meath, Ireland	Practises as an advanced nurse practitioner in the emergency department. Conducted research and published on domestic violence.
10	MEd (Training and development), BSc (Hons), Professional practice in Healthcare, Dip HE - Critical Care Nursing, ENB 199 - Emergency Nursing.	Practice Development Nurse, Unscheduled Care	Gloucestershire Hospital, NHS Foundation Trust, United Kingdom	Practised for 20 years as an emergency nurse of which 15 years were in a senior position with training responsibilities. Worked with victims and perpetrators of gender-based violence. Provided three years training on gender-based violence. Practised 15 years in a practice development role. Held the Safeguarding Lead for Unscheduled Care for three years (current employer).
11	Registered Nurse, PhD, FAAN.	Professor Emerita.	University of Connecticut, United States of America.	Author of book in which the concept of emancipatory knowing is described. Author of book and website which present a group process used in research, teaching and community activist work.

	Professional qualifications	Occupation	Employer	Experience in the field of gender-based violence/emancipation/emergency nursing
12	Dipl. General Nursing, Psychiatric Nursing and Midwifery, Dipl. Occupational Health Nursing, Sexual assault care practitioner.	Professional nurse, Sexual Assault Care Practitioner	Gauteng Department of Health, Public Sector, South Africa	Working as a Sexual Assault Care Practitioner for four years. Twenty-one years experience in general nursing, psychiatric nursing, midwifery and occupational health nursing. Worked as an emergency nurse for 8 years.
13	Business Management Diploma, National Diploma Cost Accounting.	Chief Executive Officer.	GRIP Intervention program, a non-profit, community-based organisation assisting rape, sexual assault and IPV survivors, South Africa	Received various awards and recognition for outstanding contributions to women in South Africa, promoting human rights issues, community leadership, and for advocating for the rights of sexual and IPV survivors.

5.3.2 Delphi Round 1

5.3.2.1 Data-collection method and instrument

Selected participants were contacted by e-mail through a cover letter explaining the objectives of the Delphi and the conditions of participation. An instrument to validate the draft guidelines, a cover letter including instructions, deadlines, study objectives and a summary of the findings (Addendum H(1)), and informed consent leaflets (Addendum C) were e-mailed to participants who indicated their willingness to respond.

The instrument consisted of biographical information (Addendum I(1)) the nine draft guidelines as well as the actions for each guideline (Addendum I(2)). Participants were requested to rate each guideline and its actions with regard to the criteria of reliability, validity, applicability, clarity and flexibility. The response choices were based on a four-point Likert-type scale to measure levels of agreement (Table 3) (Stitt-Gohdes & Crews 2004: 63; Jones & Rattray 2010: 376). Participants were asked for comments/suggestions at the end of each guideline. Seven participants rated the guidelines and provided comments/suggestions, three participants only rated the guidelines and three only provided comments/suggestions.

Table 3 Criteria and rating scale for validation of draft guidelines

CRITERIA	RATING SCALE			
	Strongly agree (1)	Agree (2)	Disagree (3)	Strongly disagree (4)
Validity Guideline will facilitate emancipatory knowing – emergency nurses reflect on unjust/unfair processes embedded in taking care of survivors of IPV and initiate changes to correct these.				
Reliability Given the same circumstances emergency nurses would interpret and apply the guideline similarly.				
Applicability Target population is clearly stated.				
Clarity Guideline is precise, unambiguous, user friendly and logical.				
Flexibility Guideline will empower emergency nurses to consistently reflect on the practice of taking care of survivors of IPV, implement changes as applicable and re-evaluate.				

(Adapted from Institute of Medicine 1990: 59; Tan 2006: 197-199).

5.3.2.2 Data analysis

Responses from participants were screened, analysed and collated (Stitt-Gohdes & Crews 2004: 62). The scores for each guideline as rated according to the four-point Likert scale are presented in Chapter 6, Table 4. A qualitative analysis of the comments/suggestions was done and themes identified. A summary of the results are presented in Chapter 6, Table 5. The results of Round 1 provided the basis on which the guidelines for the second round were adapted.

5.3.3 Delphi Round 2

5.3.3.1 Data collection method and instrument

Seven participants from Round 1 who indicated their non-agreement with some aspects of the guidelines (Chapter 6, Table 4) were contacted again by e-mail with a cover letter to explain the objectives of Round 2 and the conditions of participation. The adapted guidelines (Addendum I(4)) with a pre-amble (Addendum I(3)) and a cover letter including instructions and deadlines (Addendum H(2)) were e-mailed to them. A summary of the findings from Round 1 was presented according to identified themes.

Participants were requested to indicate their agreement or disagreement with the findings and re-rank their responses according to the Likert-scale if they preferred (Okoli & Pawlowski 2004: 19). All seven participants responded, one rated the guidelines and six commented on the adapted guidelines.

5.3.3.2 Data analysis

Data were analysed and collated in the same way as for Round 1. One participant rated the guidelines and “strongly agreed” with the criteria for all nine guidelines. Six participants commented that they agreed with the adapted guidelines. One participant suggested a change in the wording for two actions and one participant indicated two grammatical errors. The guidelines were corrected accordingly and finalised. Consensus was reached after Round 2 of the Delphi as all participants agreed on the guidelines. The final guidelines are presented in Chapter 6.

5.4 DRAFT GUIDELINES WITH SUGGESTED CHANGES

The nine draft guidelines will be presented in terms of the five dimensions of knowledge development in Nursing (Chinn & Kramer 2011: 3) (5.2.5). Each dimension will briefly be described, followed by the applicable guideline(s), rationale and actions. The changes as suggested in the Delphi rounds were incorporated in the draft guidelines as applicable and are indicated in red font.

GUIDELINES TO FACILITATE THE ACTUALISATION OF EMANCIPATORY KNOWING IN EMERGENCY NURSES WITH REGARD TO TAKING CARE OF SURVIVORS OF INTIMATE PARTNER VIOLENCE

PRE-AMBLE

Emergency nurses have attempted to cope with and make meaning of the phenomenon of taking care of survivors of intimate partner violence (IPV) in an individual way. The experience has remained largely invisible. Through utilising the guidelines an emancipatory process can be facilitated for emergency nurses to: (1) ask the critical questions to initiate the emancipatory process; (2) define and clarify how IPV-related experiences in emergency nurses' professional domain that inter-relate with experiences in their personal domain can put emergency nurses in a disadvantaged position; and (3) open ways to challenge this position and take corrective action. As more emergency nurses become aware of their disadvantaged position, actions, insights and knowledge about what is needed to change processes, patterns and structures for the better can be developed.

Emancipatory knowing requires a critical examination to uncover the reason for injustices remaining invisible and the ability to identify social and structural changes that can correct these. In the context of this study emancipatory knowing is seen to be actualised through a facilitative process uncovering the emotional and cognitive effects of providing care to survivors of IPV and the reasons why these effects and emergency nurses' vulnerability to secondary and vicarious traumatisation remain largely invisible. Nursing praxis is seen as nursing practice where emergency nurses engage in a process of addressing the injustices and oppression uncovered in the provision of care to survivors of IPV.

In the context of the study the process to actualise emancipatory knowing is seen as a facilitative process. A facilitator skilled in emancipatory processes and group dynamics will engage in a dialogue with emergency nurses, gain their trust and utilise the guidelines *with* them. The facilitator will act as a critical guide that will challenge emergency nurses' to reflect on their situation and acknowledge and utilise their sense of power from within to make independent choices with regard to taking care of survivors of IPV.

DIMENSION 1: CRITICAL QUESTIONS

The critical questions to be asked are those that bring social injustices into people's awareness; for example, exploring barriers to freedom and the reasons for invisible processes. Answering critical questions might cause discomfort as the status quo and the "prevailing hegemonies" that people are familiar with are questioned and disturbed (Chinn & Kramer 2011: 74-75).

This dimension is grounded in the assumption that all people deserve freedom and opportunities to actualise their full potential. Freedom and reaching one's potential are not necessarily realised through will, as their attainment is enhanced or impeded by social or cultural structures. This implies that a person's choices might be limited by certain conditions that can be illuminated through asking critical questions. Critical questions create the possibility for changes to take place (Chinn & Kramer 2011: 74-75).

~~Guideline 1: Emergency nurses question the barriers to provision of care to survivors of IPV in relation to external barriers to care and factors pertaining to disclosure from the survivor's and the emergency nurse's perspective (internal barriers), in order to bring these into awareness.~~

Guideline 1: Emergency nurses question the internal and external barriers to provision of care to survivors of IPV in order to bring these into awareness. Internal barriers to care relate to the survivor and the emergency nurse and external barriers refer to barriers in the physical and social environment.

a) Rationale

It is widely recognized that the physical, psychological and social consequences of IPV require healthcare professionals to identify IPV survivors and intervene (Bonomi *et al.* 2007: 994-995; Gutmanis *et al.* 2007: 2; Moran 2008: 194-195), more so emergency nurses, who are often in contact with survivors (Boyle 2004: 9-11; Olive 2007: 1737; Btoush *et al.* 2009: 253-254; Robinson 2010: 512). It is also evident that many barriers to detect survivors of IPV in the healthcare system exist (Chuang & Liebschutz 2002: 570; Hamberger & Phelan 2006: 64, Furniss *et al.* 2007: 240-242).

In the literature, the generic concept “barriers to screening” for IPV refers to the vast body of research exploring the difficulties healthcare professionals face in the identification and management of IPV (Perel-Levin 2008: 20). As universal screening is not part of the healthcare policy in South Africa, “barriers to care”, which implies more than screening, is used in this study context.

The many studies on barriers to screening (e.g. Elliot *et al.* 2002; Minsky-Kelly 2005; Furniss *et al.* 2007; Gutmanis *et al.* 2007) indicate the importance of exploring the deficiencies in the current management of IPV survivors in order to highlight areas that require improvement (Btoush *et al.* 2009: 255) and contribute to improvements in services for women (Fugate *et al.* 2005: 292). Different ways exist of looking at barriers to care; for example, identifying facilitating or inhibiting environmental factors (Minsky-Kelly 2005: 1290), barriers pertaining to the healthcare provider, barriers pertaining to the survivor, and barriers that emerge from the interaction between the professional and the survivor (Hamberger & Phelan 2006: 64).

Many barriers to care exist. Some of them are external and relate to the physical and social environment and some are internal and relate to the survivor or the emergency nurse. The way care is provided to a survivor of IPV is affected by the emergency nurse's approach, which is based on his or her own frame of reference and assumptions – for example, to ask or not to ask about IPV in suspect cases. As such, the emergency nurse's frame of reference and personal assumptions can either facilitate or inhibit care.

Emancipatory knowing requires nurses as a “community of critical reflectors” to explore injustices that exist in practice; nobody can impose emancipation (Chinn & Kramer 2011: 7 & 75). Emergency nurses need to bring into awareness their interpretations and understanding of the barriers to care.

b) Actions

Emergency nurses:

- Acknowledge the fact that IPV is a public health problem with devastating consequences for women and their families in terms of physical and psychological health, social **and spiritual** functioning;
- Acknowledge that survivors of IPV often report to the emergency department with overt or covert signs of IPV;
- Recognise their **professional and legal** responsibility to detect IPV and intervene in order to prevent morbidity and mortality;
- Ask critical questions in order to expose the injustices inherent in the care provided to survivors of IPV:
 - What external (social, organizational, environmental, professional) barriers exist that prevent fair, equal and optimal management of all survivors of IPV?
 - What internal barriers exist in survivors that put some of them at a disadvantage if they disclose IPV and seek help?
 - What internal barriers exist in emergency nurses that could impede survivor disclosure and optimal management?
- Display sensitivity towards and provide support of each other in terms of the dilemmas, discomfort and resistance critical questions might trigger; and
- Acknowledge cultural and social constructs and conditions that impede fair and equal treatment of survivors of IPV **and limit both survivors' and emergency nurses' choices.**

Examples of critical questions to be asked:

What in the emergency unit might deter survivors from acknowledging and talking about IPV?

What is lacking with existing policies in terms of ensuring fair, equal and optimal management of survivors of IPV?

What is wrong/lacking in the physical/professional environment that impedes optimal management of survivors?

What is not working in the referral system that impedes optimal management of survivors?

What makes it difficult for emergency nurses to ask about IPV?

What makes it difficult for emergency nurses to deal with survivor's emotional expressions?

What are the skills/knowledge gaps that impede emergency nurses' management of survivors of IPV?

Guideline 2: Emergency nurses question (reflect on) their experiences of providing care to survivors of IPV in order to explicate their assumptions and gender perceptions (frame of reference) that guide the way in which care is provided to survivors.

a) Rationale

How reality is perceived, thought about, understood, or felt to be – everything in awareness – constitutes a person's internal frame of reference or subjective world (Carducci 2009: 207). Applied to the emergency nursing context, a phenomenological perspective (McIntyre & Smith 1989: 26-28; Yoshimi 2012: 127-138) sheds light on how the emergency nurse's frame of reference can affect the care provided to survivors of IPV: Thoughts about and understanding of exposure to male oppression or violation (be it personal, witnessed in family, friends or the community) are "sedimented" into consciousness and change the way the emergency nurse will approach similar

experiences in future. The provision of care to a survivor of IPV is affected by the interrelation between the horizon of tacit meanings the emergency nurse attaches to male oppression, violation, and IPV and an explicit awareness of the nature of the current experience.

Emergency nurses' identification with survivors' experiences and the interrelation between survivors' and emergency nurses' experiences with male oppression can be explained in terms of countertransference. The phenomenon of countertransference described in psychoanalytic theory, also referred to as "intersubjectivity", resembles itself when a professional unconsciously reacts to a patient (Zachrisson 2009: 180). The reaction is related to the professional's unresolved vulnerabilities (Collins & Long 2003: 420; Gelso & Hayes, 2007:42). Countertransference refers to an emergency nurse's unconscious reaction to a survivor related to her own experiences with oppression and violation. A breakdown in boundaries between the self and another can lead to a person introjecting the other's emotions and thoughts, experiencing them as his or her own and losing awareness of the self (Coplan 2011: 15-16; Coplan & Goldie 2011: xix).

What is suggested in accordance with this guideline is that emergency nurses question (reflect on) their experiences of providing care to survivors of IPV to bring into nurses' awareness tacit assumptions, perceptions, beliefs and vulnerabilities that might play a role and guide the way in which care is provided to the survivor. The idea is that reflection becomes part of the nurse's being (Johns 2009: 3) and part of an integrated expression of emancipatory knowing (Chinn & Kramer 2011: 68).

Reflection is a critical and purposeful process that entails self-examination and transformation (Johns 2009: 3-4) as new meanings and a deeper or a new understanding evolves (Ekebergh 2007: 334). Reflection leads to action and action transforms reality – this process is known as "praxis" (Freire 1972: 41 & 73). Based on their research Gustafsson and Fagerberg (2004: 274-275) propose that reflection is done before and after a nursing experience by thinking about and considering the experience, coupled by mirroring. "Mirroring" refers to seeing an image of the self in relation to the specific experience and is also described as self-awareness "within the moment" – the insight to see things for what they really are (Johns 2009: 3-4). In terms of reflection each "clinical moment" is understood as a "unique human-human encounter grounded in suffering". The reflective practitioner is mindful of and intuitively understands that experiences might be similar but never the same (Johns 2009: 4-5). Reflection is an individual process but can also take place in a supervision situation or a group in the form of reflective conversations (Gustafsson & Fagerberg 2004: 274-275).

Ekebergh (2007: 334) reasons from a phenomenological perspective that a person busy with an intentional act is immersed in and taken up by the act. As such, complete distancing from the situation *in action* is not entirely possible. Reflection during a lived experience might facilitate a questioning attitude. However, real self-reflection entails *reflection upon* the experience and requires one to distance oneself from the experience for "consciousness to completely turn towards itself". Reflection upon the experience in terms of the motives, values and meanings attached to the experience helps to attain awareness of the structure and meaning of the experience and contributes to self-understanding. The nurse needs to adopt an open attitude to question taken-for-granted experiences and earlier understanding. Questioning might lead to confusion as the status quo is challenged. However, through reflection a new and deeper understanding of and insight into the complex nature of caring experiences can be attained (Ekebergh

2007: 334-336). Emancipatory knowing involves an ongoing process of reflection on action (Chinn & Kramer 2011: 68-69).

The following actions are based upon Johns' model of reflective practice (Johns 2000).

b) Actions

The emergency nurse:

- Gets acquainted with reflective techniques;
- Reflects upon the experience of taking care of survivors of IPV:
 - ~~Look in:~~ Finds a space to focus on the self;
 - Becomes aware of what he or she is feeling and thinking;
 - ~~Look out:~~ Describes an experience of taking care of a survivor of IPV in the "here and now";
 - Answers the questions:
 - What essential factors contributed to this experience?
 - What are the significant background factors to this experience?
- Focuses on significant issues regarding an experience of taking care of a survivor of IPV in the four patterns of knowing in nursing by answering the indicated questions:
 - *Aesthetics*
 - What was I trying to achieve?
 - Why did I respond the way I did?
 - What were the consequences of my action for myself and other relevant people namely, the survivor, the survivor's family, the people I work with?
 - How did the others feel about it?
 - How did I know how the others felt?
 - *Personal*
 - Why did I feel the way I did within this situation?
 - How did my thoughts and feelings on IPV influence the way I felt?
 - How did my views on gender influence my feelings in this situation?
 - *Ethics*
 - Did I act for the best?
 - What factors (either embodied within me/within the environment) were influencing me?
 - *Empirics*
 - What knowledge did inform me or could have informed me?
- Does self-reflection by answering the following questions:
 - Does this situation relate to other/similar (personal) experiences?
 - How could I have handled this situation differently?
 - What would be the consequences of alternative actions for the IPV survivor/others/myself?
 - How do I feel about this experience now?
 - Has this experience changed my way of knowing? (empirics, aesthetics, ethics or personal)

DIMENSION 2: CREATIVE PROCESSES: CRITIQUING AND IMAGINING

The processes of critiquing and imagining are circular processes; realising the wrong prompts imagining the way things should rather be. Critiquing means to analyse the current situation from every angle; imagining leads the way to imagine and visualise possibilities of how the current situation could become more equitable and just (Chinn & Kramer 2011: 75-76). Freire (1972: 31) described this critical confrontation of reality as a process that will “unveil the world of oppression”. The creative processes take place in dialogue with a skilled facilitator and others who are disadvantaged by the situation. A group setting helps to generate awareness of the hegemony and injustices and enhance the process of imagining options for action. The facilitator can bring skills to inform the process and assist and support those who come together to share, but cannot direct the actions, as the “people seeking liberation” must bring their own insights and interpretations of the current situation (Chinn & Kramer 2011: 75-76).

Critiquing and imagining are combined with the creative processes associated with the fundamental patterns of *personal* and *aesthetic knowing* in nursing to realise guidelines 3, 4 and 5. The actions are based on a creative group process developed by Chinn and Kramer (2011: 76-79, 116-120). Freire (1972) described this emancipatory process as “pedagogy of the oppressed”; a model that uses education to achieve liberation. This education is, however, not from an authoritarian perspective but entails a facilitative process based on sharing of experiences. During the creative group process the actions might elicit responses addressing more than one guideline in an integrative way at the same time.

Guideline 3: Emergency nurses use *personal knowing processes* (opening and centering) to *critique* their assumptions and perceptions (frame of reference) related to IPV and the provision of care to survivors of IPV. During the personal knowing process emergency nurses focus on experiences in their personal and professional domain that reflect with survivors’ experiences.

a) Rationale

Each person perceives the world in his or her own unique way. The self is made up of ideas, perceptions, concepts and values that characterize the person (Sibaya & Nicholas 2008: 226). The way a person perceives, thinks about, feels about, and understands reality constitutes a person’s internal frame of reference. As such a person’s response towards an event is guided by past experiences and perceptions in relation to that event (Carducci 2009: 207). The way emergency nurses perceive, think and feel about their experiences with IPV in their professional and personal domains leads to the formation of expectations, beliefs and presuppositions that ultimately affect the way survivors of IPV are approached and cared for. This interrelatedness between an emergency nurse’s past experiences with IPV, frame of reference and current experiences with survivors of IPV is explained as it presents itself through the phenomena of countertransference and the “wounded healer”.

The phenomenon of countertransference helps to illuminate the role of emergency nurses’ personal experiences in the healing relationship with the survivor. The more familiar or similar others’ experiences are to one’s own experiences, the more similar the representation and stronger the association with the other (Preston & de Waal 2002: 16-17; de Waal 2008: 291). Witnessing the wounds of the survivor can serve as a reminder of the emergency nurse’s own wounds (suffered as a result of male oppression, or witnessing the results of male oppression). Emergency nurses also realize

that as women, they, or their daughters, are vulnerable to IPV and can find themselves in a situation similar to that of the survivor.

Although one's own experiences can in some instances provide a basis for understanding and responding to the survivor's feelings, fusion between the emergency nurse's and the survivor's experiences can bring unresolved or repressed experiences to the fore. One's own past exposure to injustices might activate emotional distress (Staub & Vollhardt 2008: 277), self-doubt and flashbacks of one's own suffering. This may result in helping aimed at decreasing one's own emotional arousal (Batson 1991:113); and/or over-involvement with the patient (Staub & Vollhardt 2008: 277) that can cloud clinical judgment (Davis 2009:77).

An emergency nurse's capacity to tolerate painful feelings may facilitate expression of feelings (even disclosure of IPV) in the survivor, while the nurse who is emotionally vulnerable or traumatised may cause the survivor to consciously or unconsciously subdue the expression of painful emotions (Rasmussen 2005: 25-26).

Emergency nurses need to understand the origins of their own wounds and engage in a process of self-reflection in relation to the healing relationship (Zachrisson 2009: 184; Berzoff & Kita 2010: 347). This process requires the ability to differentiate between one's own experiences, emotions and needs and those of the patient; and includes the monitoring of emotional arousal, self-reflection and self-awareness (Berzoff & Kita 2010: 347-348). In light of emancipatory knowing certain creative processes are proposed to enhance the abovementioned process in a group context (Chinn & Kramer 2011: 76).

A group of people, who attempts to address an injustice, might not always be clear about the exact nature of the problem or the cause and might blame themselves, or project the blame towards the wrong attribute. Group discussions help to create awareness as members compare their own experiences with others'. Creative group processes make injustices visible and clarify the social structures that constitute and sustain injustices. The wider historical and cultural contexts within which injustices originate, are also explicated (Chinn & Kramer 2011: 77-78). Freire (1972: 81) called this deepening awareness of reality "conscientization". Group members come to realize who are advantaged and who are disadvantaged by the situation. As the injustices are defined and clarified, group members start to imagine alternatives to bring about change. Actions for change should be a spontaneous process arising from group members' desire for liberation.

The dimension of personal knowledge development in nursing contributes to this process by asking the critical question: "Do I know what I do?" It illuminates the gap between the knowing self and the doing self, and enhances personal knowing through the creative processes of *opening* and *centering* (see actions). The aim is to integrate mind, body and spirit, create a feeling of calmness and develop awareness of deeper meanings in order to establish greater congruence and equilibrium between internal intentions and actions. Sharing experiences and stories with others increase awareness of deeper meanings as group members' experiences reflect with each other (Chinn & Kramer 2011: 116-118).

In the actions a concept suggested by Freire (1972: 85), namely "codifications", is used. Codifications imply the use of objects (for example sketches or photographs) to help the oppressed recognize, externalize, reflect on and decode the oppression in their reality (Freire 1972: 85-87).

b) Actions

Emergency nurses:

- **Voluntary** engage in an open group process with other emergency nurses who share the mutual interest of exploring the provision of care to survivors of IPV in relation to one's own assumptions (inclusive of gender perceptions) affecting the caring process:
 - Respectfully listen to and question others' stories of providing care to survivors of IPV in order to explore and bring into awareness similarities and differences in assumptions and perspectives of group members;
 - **Agree to consider information shared in the group discussions as confidential;**
 - **Discuss techniques that will be utilised in the group in order to get acquainted with them for example journaling;**
 - Examine and discuss "codifications" – for example, drawings and pictures that represent group members' experiences of providing care to survivors of IPV in relation to personal assumptions (for example, gender perceptions, assumptions about intimate relationships and IPV);
 - *Critique* – analyse, consider and discuss the current situation of providing care for survivors of IPV from different points of view (for example, female nurses confronted with their own vulnerability in intimate relationships when exposed to the survivor's suffering);
 - *Critique* – identify and clarify what is problematic and wrong with the current situation (for example, how experiences with IPV in the personal domain can cloud a nurse's perceptions on the provision of care to a survivor of IPV);
 - **Explore and identify dominant themes (perceptions and assumptions) in terms of:**
 - **Experiences that contributed to and maintain these perceptions and assumptions;**
 - **The wider historical, cultural, political and socioeconomic context; and**
 - **Links between perceptions and assumptions and the provision of care to survivors of IPV;**
 - *Imagine* – consider possible alternative actions to bring about change (for example, supervision to deal with one's own woundedness);
 - *Imagine* - consider how the current situation can become more equitable and just (for example, understanding the relation between the provision of care and one's own "woundedness");
 - Maintain group continuity through journaling and summarising critiques and imaginings after each group;
 - Follow a circular process through reflection on personal assumptions and perceptions (for example, the origins of assumptions and considering alternative ways to address these), critique each alternative and imagine the possible outcomes on the provision of care to survivors of IPV;
 - ~~Explore and identify dominant themes (perceptions and assumptions) in terms of:~~
 - ~~Experiences that contributed to and maintain these perceptions and assumptions;~~
 - ~~The wider historical, cultural, political and socioeconomic context; and~~
 - ~~Links between perceptions and assumptions and the provision of care to survivors of IPV;~~
- Implement creative personal knowing processes of *opening* and *centering* to become aware of one's own perceptions and assumptions:
 - Ask the critical question: "Do I know what I do?"
 - Utilize journaling, body-mind-spirit meditations **and other creative processes** to create inner calm, self-knowing, self-awareness and integration between actions (provision of care) and intentions (influenced by personal assumptions and perceptions); and

- Journal feelings and thoughts, analysis and insights of the current situation, hopes, dreams and possible solutions in the provision of care to survivors of IPV.

Guideline 4: Emergency nurses use *aesthetic knowing processes* (creating and recreating storylines) to *critique* the ~~depth~~ extent of their vicarious suffering – emotional distress, distressing thoughts and disruptions in frame of reference – in relation to their exposure to survivors’ experiences with IPV during provision of care to survivors of IPV.

a) Rationale

The close interpersonal involvement inherent to the provision of nursing care exposes emergency nurses to others’ responses to illness and injury (Ferrell & Coyle 2008: 246). As can be expected from nurses, compassionate care requires emergency nurses to enter the survivor’s experience (von Dietze & Orb 2000: 169, Schantz 2007: 51-52); the sharing of which involves suffering for the other’s sake (Nilsson 2011: 140-141).

People in helping professions working with trauma survivors reported experiencing emotional distress – for example, sadness, depression, anxiety, horror, fear, anger and hopelessness (Valent 2002: 18; Hernandez Gangsei & Engstrom 2007: 237), and feelings of powerlessness (Taft, Broom & Legge 2004: 2). Similarly, witnessing the suffering survivors of IPV are exposed to leaves emergency nurses with emotional distress and, at times, feelings of powerlessness. Professionals who are aware of the significance of the survivor’s suffering, but feel powerless are at risk of developing secondary traumatisation (Weingarten 2004a: 72). The negative effects resulting from working with traumatised patients include secondary traumatic stress (STS), vicarious traumatisation and compassion fatigue (Way *et al.* 2004: 50).

Apart from emotional distress, emergency nurses also experience cognitive consequences related to being exposed to the survivor’s suffering. Being concerned about the survivor, relates to the concept of empathic concern that is elicited when witnessing someone in need (Niezink *et al.* 2012: 544-555). Some of the injuries or scenarios witnessed, or mental images constructed from survivors’ experiences, become entrenched in emergency nurses’ memories. The memories, which sometimes surface spontaneously or are triggered by similar experiences, seem to resemble the symptoms of STS. STS, also known as compassion fatigue, is described as a natural consequence of stress in professionals working with trauma survivors (Figley 1993: 1; Salston & Figley 2003: 169).

Coetzee and Kloppe (2010: 239 & 241) indicate that the emotional exhaustion associated with compassion fatigue can present itself as desensitization, unresponsiveness and indifference towards patients. These responses implicate the healthcare professional’s ability to feel and care for patients (McHolm 2006: 14) and to bear their suffering (Figley 2002: 1434).

Seen as a category of STS reactions, vicarious traumatisation presents itself mostly as shifts in a professional’s cognitive schemas and frame of reference. Disruptions in cognitive schemas involve six fundamental psychological needs: dependency/trust, safety, power, independence, esteem, intimacy. Disruptions in frame of reference include disruptions in the sense of identity, assumptions about the world and spirituality. This spiritual confusion may lead to hopelessness, a loss of meaning and devaluing others’ experiences (McCann & Pearlman 1990: 133-142; Pearlman &

Saakvitne 1995: 151-165). Vicarious traumatisation can lead to a healthcare professional harming a patient in both overt and subtle ways; for example, a therapeutic relationship driven more by the professional's needs than the patient's, resulting in violation of therapeutic boundaries (Pearlman & Saakvitne 1995: 157).

Emergency nurses scrutinised their own histories with regard to male oppression and violation. Their professional exposure to IPV survivors challenged nurses' gender perceptions and beliefs regarding the meaning of life and the nature of humanity.

The aesthetic methods of *envisioning* and *rehearsing* are recommended by Chinn and Kramer (2011:79) to bring about changes in an unjust status quo. *Envisioning* involves imagining the end point that one hopes to elicit; in nursing the end point might entail a situation of health and well-being; for example, calmness, relaxation, comfort and the ability to manage a health-related situation. In *rehearsing* a skill is performed to a mentor. In nursing a skill is developed through ongoing practice (rehearsal) until it is "fully embodied". For example a simulated situation that is acted before a mentor until it is mastered (Chinn & Kramer 2011: 137-8). Three practices of envisioning and rehearsing are integral to nursing as an art, namely creating and developing embodied synchronous movements, creating and recreating storylines, and rehearsing and engaging a connoisseur-critic (Chinn & Kramer 2011: 137-138). In the study context the term "facilitator" is used instead of "connoisseur-critic". The actions for realising Guideline 4 are based on the *creating and recreating of storylines* and *rehearsing and engaging a skilled facilitator*.

Creating and recreating storylines is based on the premise that the nurse is seen as a participant in shaping the patient's story for the time care is provided. In the study context creating and recreating storylines, by asking the questions: "what does the story mean?" and "how is the story significant?" can help emergency nurses to explore and understand the meaning the experience of providing care to survivors of IPV holds for them (Chinn & Kramer 2011: 138-148).

Rehearsing and engaging a skilled facilitator involve interaction with a skilled and experienced mentor (Chinn & Kramer 2011: 138-146). In the study context the *facilitator* will have specialised knowledge and understanding of nursing and the dimensions of health and healing and the cultural context in which nursing takes place. Emergency nurses can be provided the opportunity to *rehearse* – act out and reflect on – experiences with IPV survivors in the presence of a nurse experienced in working with trauma survivors and the phenomenon of secondary traumatisation. This process has at its purpose the development of insight into and an increasing awareness of the tacit and vicarious effects of providing care to IPV survivors. It also provides the opportunity to critique current care practices and imagine alternatives under supervision of a *skilled facilitator*.

b) Actions

Emergency nurses as participants in the emerging real-life stories of survivors of IPV, create and recreate storylines during *voluntary* creative group discussions:

- Recount (in writing or in group discussions) experiences of providing care to survivors of IPV as it occurred in practice;
- Identify the key characters in the story and their motives, perspectives and intentions;
- Explore the context and key elements of the caring experience;

- Convey the feeling of the story – the vicarious experience (for example, emotional distress about the situation and concerns for the survivor);
- Reflect on one's own and others' meanings attached to and emerging from storylines (for example, recurring disturbing thoughts and disruptions in cognitive schemas and belief systems);
- Recreate situations with IPV survivors by telling the story as the emergency nurse wished the situation could have unfolded – describe different actions, approaches (verbal and non-verbal), intentions and motivations that could have led to different endings;
- Mentally rehearse creative possibilities that bring to awareness different perceptions of meaning to the provision of care to survivors of IPV; and
- Use the knowledge and skills emanating from storylines to transform practice and actualize emancipatory knowing in the provision of care to survivors of IPV.
- Engage a **skilled facilitator** to observe emergency nurses' rehearsals in order to:
 - Integrate the experience of caring for survivors of IPV in the personal history of the self and interpret the meaning of the experience;
 - Draw comparisons with other emergency nurses' experiences of caring for survivors of IPV to substantiate unique and significant aspects of the experience;
 - Consider plausible interpretations of the meaning of the caring experiences;
 - Obtain feedback in terms of the affective and cognitive response the experience elicits; and
 - Obtain guidance in terms of possibilities for similar future caring experiences.

Guideline 5: Emergency nurses use the *personal knowing processes* (opening and centering) to *critique* and *imagine* ways to cope with and make meaning of their vicarious suffering in relation to the provision of care to survivors of IPV (which implicates exposure to survivors' experiences with IPV).

a) Rationale

Coping has as its goal the alteration of a problem that a person perceives as a threat to internal or external resources (Lazarus & Folkman 1984: 141; Lazarus 1993: 237; Carver 2011: 221-222), as well as the regulation of the stressful emotions related to the problem (Folkman & Moskowitz 2004: 747). A successful outcome to coping is evidenced in positive emotions while a less favorable outcome is associated with negative emotions (Folkman & Moskowitz 2004: 747).

A way of conceptualizing coping is to distinguish between disengagement- and engagement coping strategies (Compas *et al.* 2001: 92; Skinner *et al.* 2003: 236-237; Connor-Smith & Compas 2004: 348). Engagement coping implicates a direct approach toward a stressor or related thoughts and emotions and points to better adjustment than disengagement coping responses which involve distancing from the stressor and related thoughts and emotions (Compas *et al.* 2001: 92).

Meaning making is seen as an accommodative way of coping (Folkman & Moskowitz 2004: 766). Meaning making is described in terms of situational and global meaning. Stress arises when a discrepancy occurs between a person's global meanings (beliefs, goals and subjective feelings) and the meaning and personal significance attached to a stressful event (situational meaning) (Park & Folkman 1997: 124; Park & Ai 2006: 391-392; Park 2011: 228-230).

Confronted with the senselessness and painful consequences of IPV, emergency nurses experience alterations in their global beliefs and/or appraised situational meanings attached to IPV. This alteration is reflected in cognitive processes to find an explanation behind the behaviour of the perpetrator and the woman who stays in the violent relationship; reappraisal of intimate relationships within the context of culture, socio-economic factors and gender inequalities; and disruptions in frame of reference.

As the outcome of coping is judged by a person based on his or her values, goals and expectations (Folkman *et al.* 1986: 993), it is assumed that effective coping with the demands of providing care to survivors of IPV will be perceived by emergency nurses as ways of combating emotional distress, symptoms of STS, compassion fatigue and/or vicarious traumatisation.

While coping is conscious, volitional and intentional, defence mechanisms resemble an unconscious process (Compas & Boyer 2001: 326) to change a person's perception towards reality (Cramer 2006: 7-8) in order to restore psychological homeostasis (Vaillant 2000: 89-90). Vaillant (2000: 92) distinguishes between maladaptive and adaptive (mature) defence mechanisms. Unlike maladaptive mechanisms, "mature defenses synthesize and attenuate rather than deny and distort conflicting sources of human behavior like conscience, reality, interpersonal relations, and emotions" (Vaillant 2000: 97).

When a person becomes aware of certain defence mechanisms, the conscious knowledge obtained acts as a point of reference for practising new ways of feeling, thinking and doing (Bleichmar 2004: 1396). Based on this premise, it is recommended that emergency nurses be given the opportunity to reflect on their current defence mechanisms and ways of coping; gain awareness of the consequences and effectiveness of these; and explore, generate and develop alternatives.

Journaling and group supervision are helpful in broadening insight into unconscious processes. Writing helps to induce a state of mindfulness and heightened awareness (Brody & Park 2004: 152). During supervision, professionals have the opportunity to reflect upon their work experiences and analyse their feelings, responses, attitudes and expectations. They can receive support from colleagues, discuss challenging situations and view problems from different perspectives. They learn about themselves, thus broadening their professional and personal experience (Žorga 2007: 210).

The personal knowing creative processes of opening and centering (Chinn & Kramer 2011: 117-120) are recommended to help emergency nurses become more mindful of the current ways of coping and defence mechanisms they utilize. Group discussions are recommended to explore and generate alternative ways of coping and the use of mature defence mechanisms.

b) Actions

Emergency nurses:

- Voluntary engage in a creative group discussion with a skilled facilitator to:

- Reflect on experiences with survivors of IPV, the meaning attached to it, current ways of coping and defence mechanisms, and the consequences of these (for example, ways of coping putting the emergency nurse in a disadvantaged position);
- Use practices such as meditation, journaling and reflection to bring personal ways of coping, defence mechanisms and meaning making into conscious awareness;
- Share these experiences with others in order to *critique* current ways of coping and defence mechanisms;
- *Imagine* and explore new perceptions on coping and meaning making (on a physical, psychological, social and spiritual level) in relation to the provision of care to survivors of IPV;
- Integrate ways of coping and meaning making *perceived by the individual* to relieve emotional distress;
- Integrate mature defence mechanisms;
- Focus on knowing the self as a whole and focus energy towards self-acceptance, positive self-worth and self-healing; and
- Strive towards facilitating wholeness in others, and in the self, thus developing the therapeutic self.

Guideline 6: Emergency nurses use empiric methods to *critique* the use of caring responses (skills and attitudes) in the provision of emotional care to survivors of IPV, and *imagine* possibilities for the provision of beneficial and feasible emotional care to survivors of IPV.

a) Rationale

A caring perspective is integral to nursing (Swanson & Wojnar 2004: S-45). Caring presents itself within the nurse-patient relationship, which is based on Roger's non-directive therapeutic principles (Rogers 1957: 96; Phaneuf 2008: 1).

The nurse-patient relationship provides a sense of safety within which meaning can be discovered in the experience of health and illness (Covington 2003: 312). According to Morse *et al.* (2006: 78 & 84-85) the essence of the nurse-patient relationship is grounded in emotional engagement – the ability of the nurse to identify with the patient's suffering, display caring emotions and respond in a meaningful and appropriate way. Conversely the nurse who loses emotional insight also loses the sensitivity to observe some of the patient's needs and to respond in a caring way to the patient.

Different caring responses can be utilized by nurses to communicate care; for example, reassurance, sympathy/empathy and compassion (Morse *et al.* 2006: 78). Emergency nurses highlighted caring responses they utilize in caring for survivors of IPV; for example, empathy, sympathy an open and non-judgmental attitude, communicating reassurance, listening, patient-centred care, and sensitivity.

Caring responses do sometimes pose problems for emergency nurses – for example, avoiding emotional care related to difficulty in dealing with sensitive emotions, and emotional distress related to feeling emotionally overwhelmed. In relation to empathetic/sympathetic responses the following potential problems emerged: reservations to put oneself in the survivor's position related to a fear of getting too involved and attached; and sympathy, rather than empathy, emerging when sensing the survivor's vulnerability.

As highlighted in the literature, in sympathy the focus is on the nurse's own sorrow that acknowledges and justifies the patient's suffering. Being overwhelmed by sympathetic concerns can, for example, inhibit expression of feelings in the patient and impedes the nurse's ability to accurately perceive the patient's experience and intervene appropriately (Morse *et al.* 2006: 79-80; Videbeck 2011: 189). Feelings of concern and compassion, which entail entering into a person's experience of suffering and sharing the burden of suffering (von Dietze & Orb 2000: 169; Morse *et al.* 2006: 80), can contribute to emotional distress in emergency nurses.

Caring responses are fundamental to the provision of care to survivors of IPV. (See, for example, the study by Watt *et al.* (2008: 724-725)). It is vital for emergency nurses to utilize caring responses to the survivor's benefit, at the same time protecting themselves against emotional distress and feeling emotionally overwhelmed. Models and theories on emotion regulation, psychological mindedness and self-awareness are applicable in this regard (see Gross & John 2003; Beitel, Ferrer & Cecero 2004; Westen & Blagov 2007; Niemiec, Ryan & Brown 2008).

As suggested by Chinn and Kramer (2011: 78), emancipatory knowing may overlap with and gain from the fundamental knowing patterns. Empirically based information on caring responses, such as research findings, models and theories on provision of care to survivors of IPV, can provide emergency nurses with applicable and useful data to critique the use of current caring responses and imagine ways to utilize caring responses in a beneficial and feasible way in future.

b) Actions

Emergency nurses:

- *Critique* the caring responses (or lack of caring responses) they currently use in the provision of care to survivors of IPV in terms of benefits/detriments to survivors and emergency nurses;
- *Identify* and explore different caring responses utilised in the nurse-patient relationship and the provision of care for survivors of IPV through:
 - **Sharing their expertise in group discussions;**
 - Research findings; and
 - Consultation/ training sessions with nurses/ healthcare professionals who have knowledge and expertise in the field;
- *Critique* these responses in creative group discussions in terms of:
 - Feasibility for utilisation in the emergency unit context; and
 - Outcomes for survivors of IPV;
- *Identify* and explore models and theories on self-awareness, psychological mindedness and emotion regulation through:
 - **Sharing their expertise in group discussions;**
 - Research findings; and
 - Consultation/training sessions with nurses/healthcare professionals who have knowledge and expertise in the field;
- *Imagine* what can be done in terms of providing care to survivors of IPV that is:
 - **Compassionate and caring;**
 - Based on emancipatory patterns of knowing;
 - Scientifically and outcomes-based; and

- Holistic;
- *Imagine* the effect of emergency nurses being empowered with emotion regulation and self-awareness strategies.

DIMENSION 3: FORMAL EXPRESSIONS OF EMANCIPATORY KNOWING

The guidelines so far will assist emergency nurses to unearth the injustices embedded in the provision of care to survivors of IPV. This will happen through a process of reflection, asking critical questions and critiquing the situation. The guidelines also provide for imagining possibilities to change the status quo. Guideline 7 sets the actions for a formal expression of emancipatory knowing.

Formal expressions can take different forms; for example, manifestoes, critical analysis, vision statements and action plans. Critical social theory is central to the process of emancipatory knowing as it serves to explicate the injustices and guides the process towards change (Chinn & Kramer 2011: 80-81).

Critical theory evolved after the Second World War from the work of a group of theorists, known as the Frankfurt School. They followed an interdisciplinary, reflective, dialectical and critical approach (Finlayson 2005: 1 & 3). Through questioning existing forms of practice in a critical and reflective way, critical theory enlightens hidden conditions of oppression and possibilities for resistance (Bronner 2011: 1, 8 & 100). Apart from making social inequality apparent, critical theory also informs action that leads to emancipation (Rush 2004: 9) - as put by Chambers (2004: 221): “to break out of the given”. Habermas, known as the leading light of the second generation of Frankfurt School theorists (Finlayson 2005: 1), sees emancipation as the liberation from a confinement into which “we imagine we have fallen”. It is based in self-understanding that brings with it an increase in autonomy (Habermas 1994: 103).

Guideline 7: Emergency nurses formally express emancipatory knowing in terms of critical analysis and an action plan for provision of care to survivors of IPV.

a) Rationale

The provision of care to survivors of IPV focus on three broad categories of interventions: *physical care* mostly in relation to the injuries sustained; *emotional care*, which reflects different ways of approaching and supporting the survivor; and *referral* to other multi-disciplinary team members.

Emotional care seemed to be determined by two factors namely: the emergency nurse’s ability to detect IPV and get a *disclosure* from the survivor and *the emergency nurse’s personal and professional frame of reference*.

Getting the survivor to disclose the IPV is not something all emergency nurses feel able or willing to do. Some rather approach the survivor in a discreet, non-invasive way, only addressing the topic of IPV if initiated by the survivor. They feel it is inappropriate to probe the survivor without concrete information. Others withdraw when probing is met with resistance or reservation.

For some emergency nurses their assumptions based on personal experiences (with IPV and also gender-based violence) seem to be the most evident determinant of the emotional care provided to the survivor. Other evident responses to the survivor are those driven by an inclination to care and a sense of professional responsibility.

Emergency nurses play a role in the referral of survivors to the appropriate services. Emergency nurses are aware that survivors of IPV need some form of counselling or support. Different referral options exist; for example, trauma counselors, psychiatrists, psychologists, social workers, the police and other resources such as support groups and helplines. Some emergency nurses just provide information regarding referral options and leave the responsibility to the survivor. Others see it as the medical practitioner's responsibility.

The formal expression of emancipatory knowing (Chinn & Kramer 2011: 5-6) in the context of the guidelines may include: the injustices inherent to the provision of emergency nursing care to survivors of IPV, critical examination of the reasons why the injustices seem to go unnoticed or remain invisible, and the social and structural changes required to right the injustices

Fontana (2004: 96) identified seven foundational processes characteristic of a critical analysis in nursing: *critique* that exposes forces of injustice and oppression by examining power relations and imbalances; *context* that address the environmental forces that sustain oppression; awareness of the *political forces* at play in these oppressive situations; *emancipatory intent* which lies in raising consciousness and in praxis; *dialectic analysis* which examine contradictory values, interests and conditions, *democratic structure*; and *reflexivity*.

b) Actions

Emergency nurses:

- Use critical analysis to critique and reflect (within a democratic group structure) on the current provision of care to survivors of IPV with relation to:
 - What is – the context - (the current care provided to survivors of IPV);
 - How it came to be – political forces/contradictions; for example, the care is based on emergency nurses' frame of reference, as no formal structure or policies are available to ensure fair and just provision of care to survivors who are already in a disadvantaged position of oppression); and
 - Who is disadvantaged (for example emergency nurses who are vulnerable to vicarious and secondary traumatisation without formal structures for support and supervision).
- Formulate a vision statement describing what is envisioned for the future in terms of provision of fair, beneficial and feasible care to survivors of IPV;
- Formulate an action plan for **the institution with time lines** in order to realise the vision statement (can include treatment and referral guidelines, clinical pathways and policy statements guiding the provision of care to survivors of IPV; and support and supervision structures for emergency nurses). **The action plan should include multi-disciplinary teamwork.**

DIMENSION 4: INTEGRATED EXPRESSION IN PRACTICE (PRAXIS)

“Praxis requires ongoing reflection and action; it is both an individual process and an interactive process.” Nurses engage in an ongoing process as they reflect on unfair or unjust practices and initiate action to correct the unjust (Chinn & Kramer 2011: 83).

Guideline 8: Emergency nurses practice ongoing cycles of reflection and action (praxis): In future emergency nurses reflect on unjust or unfair processes embedded in the provision of care to survivors of IPV and initiate changes to correct these.

a) Rationale

Described from a critical feminist perspective, Georges (2002: 84) views the concepts of reflectivity, contextuality, and emancipation to be integral to praxis. Georges (2002: 84) proposes a conceptualization of an alternative contextual praxis of suffering in which nurses’ responses to suffering are situated in an emancipatory paradigm of authentic presence.

Applied to this study, a contextual praxis of suffering would reflect on the conditions that create suffering and place women at enhanced risk for IPV. Emergency nurses would provide care to IPV survivors within the awareness of the power relations inherent in the South African culture that rendered them oppressed. Praxis would seek to bring into awareness the power differences between the survivor and the emergency nurse (Georges 2002: 85). In a contextual praxis the nurse would seek to “be with” the survivor and consider each encounter with a survivor as unique. Considering the context of suffering inherent to such an encounter and the expectation on the emergency nurse “to create an authentic feeling of presence” with the survivor, such a praxis would implicate suffering on the part of the emergency nurse. To enter the landscape of suffering and allowing the survivor’s suffering to become part of one’s own experience, entails sharing with and being shaped by the suffering of the survivor. Although the shift from a position of power to “being with” in the nurse-patient relationship entails risk for the emergency nurse, it is also “the place in which true healing begins” (Georges 2002: 85).

Praxis opens up opportunities for nurses to reflect on the suffering of survivors of IPV, and to act, to advocate for those who “do not have a voice and for those who may not recognize or understand their oppression” (Dong & Temple 2011: 173). But praxis should also provide opportunities for nurses to reflect on difficult situations influencing the nurse-patient relationship and provide them with supportive actions such as supervision. The importance of supervision is stressed in different studies on secondary traumatisation in professionals working with trauma survivors (for example, Smith, Kleijn & Hutschemaekers 2007; Ben-Porat & Itzhaky 2011; Showalter 2010). Sommer and Cox (2006: 15) stressed the need for research in the areas of vicarious traumatisation and supervision that includes the voices of professionals working with trauma survivors, sharing and reflecting upon their stories. These professionals should be given a “voice and the support they need to continue their challenging work with minimum harm to themselves” (Sommer & Cox 2006: 15).

b) Actions

Emergency nurses:

- View their practice through a “lens of emancipatory knowing” (Chinn & Kramer 2011: 83);
- Reflect on unjust and unfair practices associated with the provision of care to survivors of IPV;
- Stay aware of the power relations inherent in the South African culture that puts women at risk for IPV;
- Stay aware of the potential power differences that exist in the nurse-patient relationship;
- “Create an authentic feeling of presence” through “being with” (Georges 2002: 85) the survivor;
- Acknowledge their own suffering as they share with and are shaped by the suffering of survivors;
- Advocate for survivors of IPV **to ensure fair and effective care;**
- Reflect on their own suffering and the encounter with survivors’ suffering;
- Engage in supervision opportunities to obtain support to “continue their challenging work” (Sommer & Cox 2006: 15).

DIMENSION 5: AUTHENTICATION PROCESSES – SOCIAL EQUITY, SUSTAINABILITY, EMPOWERMENT AND DEMYSTIFICATION

The processes for authenticating emancipatory knowing include sustainability, which indicates the long-term success of the envisioned changes, social equity which determines the extent to which factors causing disadvantages are reduced, empowerment which refers to oppressed groups exercise their will, and demystification which determines the extent to which hidden aspects are openly discussed and managed (Chinn & Kramer 2011: 83-84).

Guideline 9: Emergency nurses use the processes of sustainability, social equity, empowerment and demystification to authenticate emancipatory knowing in the provision of care to survivors of IPV.

a) Rationale

Sustainability refers to the long-term success of the envisioned guidelines. Social equity will be determined by the extent to which factors causing disadvantages for emergency nurses and survivors are reduced (for example, barriers to care). Empowerment will be reflected in emergency nurses’ ability to cope with and make meaning of their exposure to survivors’ experiences. Demystification will be manifested in the extent to which hidden aspects (for example vicarious traumatisation of nurses) are openly discussed and managed.

According to Tengland (2008: 77), empowerment refers to concepts such as control over life or health, autonomy, ability, self-efficacy, self-esteem, and freedom. Tengland’s (2008: 77) definition of empowerment is applied to this guideline: empowerment as a goal resembles emergency nurses having control over the determinants of their quality of life, and empowerment as a process relates to emergency nurses taking control over the change process, determining both the goals of the process and the means to realise it. At the same time they provide survivors of IPV with the opportunity to do the same.

As indicated by Chinn and Kramer (2011: 83), methods to realize guideline 9 can be drawn from any of the fundamental patterns of knowing. Praxis is integral in this process.

b) Actions

Emergency nurses **engage in reflective group discussions to:**

- Evaluate their action plans and vision statements to determine accountability and appropriateness in terms of changing the unjust and unfair **processes** inherent to the provision of care to survivors of IPV;
- Confirm and validate change in the provision of care to survivors of IPV in terms of outcomes (for example, quantitative and qualitative research methods to determine survivors' experiences of care);
- Reflect on self-authenticity and personal change in terms of emotional, cognitive and behavioural responses to survivors of IPV;
- Evaluate effective transformation in terms of feelings of inspiration and appreciation within the nursing team;
- Reflect on the sustainability of the envisioned changes in practice;
- Reflect on the conditions that create advantage for some and disadvantage for others:
 - Is there a movement towards a more just and equal **healthcare** system?
 - Is the provision of supervision and support to emergency nurses regarded as an important aspect of care?
 - Are aspects of countertransference and emergency nurses' own "woundedness" addressed in supervision?
 - Are policies and treatment guidelines in place to ensure identification, management and referral of survivors of IPV?
- Reflect on empowerment:
 - Are emergency nurses' voices heard in the provision of care to survivors of IPV?
 - Which ways of coping are employed by emergency nurses to cope with the experience of providing care to survivors of IPV?
 - What are the meanings emergency nurses attach to the provision of care to survivors of IPV?
- Reflect on demystification:
 - The extent to which survivors of IPV feel free to disclose IPV and seek treatment;
 - The extent to which emergency nurses feel free to talk about the phenomena of secondary traumatising, compassion fatigue and vicarious traumatising and seek help for symptoms related to these phenomena;
- Initiate action to address any of the abovementioned aspects not sufficiently resolved or realized;
- **Consider publication of their emancipatory knowing experiences.**

5.5 VALIDITY OF THE GUIDELINES

The guidelines were based on the findings of the first phase of the study, the research objectives and the feedback of the expert panel who participated in the Delphi. The expert panel reviewed the guidelines for validity, reliability, clarity and flexibility. Participants were chosen from different settings and geographical areas in order to enhance the credibility and acceptability of the policy guidelines. Two participants were from the USA, three from the UK, one from Canada and seven from South Africa. One South African participant was from the private health sector, two from the public health sector, one from a non-profit organisation and three from academic institutions in South Africa.

The response choices in a Delphi are often rated on a 4-point Likert-type scale (Rayens & Hahn 2000: 309). Keeney (2010: 230) indicates that the first round questionnaire is usually unstructured, open-ended questions to increase the richness of data collected on the topic under investigation. In this study the instrument used to evaluate the guidelines allowed for both recommendations/suggestions and level of agreement responses (Addendum I).

To ensure credibility of the Delphi itself, a clear decision trail should be evident in the research report as suggested by Powell (2003: 380). In this study the decision trail to defend the appropriateness of the method is described in point 2.6.2. The way in which the expert panel was selected is described in point 5.3.1, and the data collection method in 5.3.2.1 and 5.3.3.1. The consensus levels are set out in Chapter 6, Table 4.

5.6 SUMMARY

In this chapter, the second phase of the study – namely the development and validation of guidelines to facilitate the actualisation of emancipatory knowing in emergency nurses with regard to taking care of survivors of IPV was discussed. The draft guidelines with the suggested changes were presented. Measures to ensure validity of the guidelines were briefly explained.

Chapter 6 consists of a summary of the main findings, validation and description of the draft guidelines, recommendations for emergency nurses to enhance emancipatory knowing with regard to taking care of survivors of IPV, and possible limitations of the study.

CHAPTER 6: VALIDATION AND DESCRIPTION OF GUIDELINES, CONCLUSIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

In Chapter 5 the second phase of the study, the development of the draft guidelines to facilitate the actualisation of emancipatory knowing in emergency nurses with regard to taking care of survivors of IPV, was discussed. The Delphi technique according to which the guidelines were validated, was described. Measures to ensure validity of the guidelines were explained. This chapter consists of a summary of the main findings and the development of the guidelines. The results of the validation of the guidelines are presented in table formats followed by a description of the final guidelines. Lastly, recommendations are formulated and possible limitations discussed followed by a conclusion to the chapter.

The study was guided by the following aims:

- Explore and describe emergency nurses' experiences of taking care of survivors of IPV; and
- Develop and validate guidelines to facilitate the actualisation of emancipatory knowing in emergency nurses with regard to taking care of survivors of IPV.

6.2 SUMMARY OF MAIN FINDINGS

The findings were presented in terms of the essence of emergency nurses' experiences of taking care of survivors of IPV followed by a description of the eight constituents – the meanings that constitute the essence (Chapter 3). A literature review was conducted to illuminate the meaning of the findings (Chapter 4). The *essence* and *constituents* are summarised below.

In *essence* the care that is provided to a survivor of IPV is guided by the emergency nurse's frame of reference. The nurse's frame of reference is shaped through an interrelation between professional- and personal-domain experiences and emergency nurses' attempts to cope with and make meaning of these experiences.

"Professional-domain experiences" refer to emergency nurses' exposure to survivors' experiences with IPV. This exposure has an emotional and cognitive impact on emergency nurses. The emotional impact is felt in response to being a witness to the

survivor's suffering. The cognitive impact is experienced as concerns for the survivor; longstanding, recurrent and intrusive memories; and disturbing mental images.

"Personal-domain experiences" refer to emergency nurses' experiences with IPV and other gender-based violence at a personal, family, social and community level. Professional- and personal-domain experiences and the emergency nurse's attempts to cope with the exposure to survivors' experiences and make meaning out of IPV shape the emergency nurse's frame of reference. The shaping manifests itself in the formation of gender perceptions and assumptions related to IPV.

The provision of care to survivors of IPV focuses on three interventions: physical care, emotional care and referral to other multi-professional team members. The provision of emotional care relies to a great extent on two factors: firstly the emergency nurse's ability to identify and overcome barriers to disclosure of the IPV, and secondly the frame of reference from which the emergency nurse operates. This frame of reference is shaped by experiences with IPV in the personal and professional domain, the interrelation between these two experiences and the emergency nurse's professional and caring qualities.

6.2.1 Emotional impact related to being a witness to survivors' experiences of IPV

Emergency nurses are witnesses to the effects of IPV, the injuries survivors suffer and the consequences thereof, and the emotional effects survivors experience; for example, fear, sadness and helplessness. They sometimes have to listen to survivors narrating the events surrounding IPV. Sometimes the perpetrator accompanies the survivor to the emergency unit and appears to be a caring partner. It is emotionally painful to encounter the often devastating consequences of IPV, such as a survivor left with a disability and IPV ending fatally.

Witnessing the survivor's suffering elicited emotional responses described by participants as emotional pain, hurt, sadness, depression, fear, stress, horror and shock. An emotional response that stood out was sympathy for the survivor on the one hand and anger towards the perpetrator on the other. Sympathy was evident in situations where the woman was seen as a victim characterised by vulnerability, helplessness and powerlessness.

6.2.2 Cognitive impact related to being exposed to survivors' experiences of IPV

The cognitive impact was characterised by thoughts of a troubling and lingering nature and included concerns for the survivor; longstanding, recurrent and intrusive memories; and disturbing mental images. Certain scenarios tended to raise emergency nurses' concerns more than others – for example, the idea that the survivor is exposed to the IPV repeatedly, a young women being exposed to IPV, and a survivor with a baby. Some experiences led to the construction of vivid mental images of the IPV as it must have happened.

The emergency nurses' concerns for the survivor sometimes interrelated with their personal-domain experiences. The experience with survivors of IPV can become a lingering memory that stays with the emergency nurse for many years. Participants' narratives of some of these lasting impressions reflected the powerlessness felt by the participant. Participants' memories were sometimes triggered by other similar cases.

6.2.3 Identification with IPV survivors' experiences

Identification with the experiences of survivors of IPV revealed itself in participants' narrations that suggested that certain elements in the survivor's experience reflected with a similar situation that occurred, or has the potential to occur, in the emergency nurse's personal domain. Participants sometimes referred to survivors' experiences as if experienced in the first person. Identification manifested itself as empathetic feelings – feeling with the survivor – and as an awareness that the survivor's experiences reflected the nurse's own past and potential future experiences.

Empathy originated for some participants from a realisation that as women, they, or their daughters, are vulnerable to IPV and can find themselves in a situation similar to the survivor's, or the survivor's family members. A strong identification with the survivor's situation elicited intense feelings, for example, participants who were exposed to IPV and gender-based violence in their personal domains. Although the emergency nurse's own experiences can provide a basis for understanding and responding to the survivor's feelings, it can become confusing and bring unresolved/repressed issues/doubts into the fore when the emergency nurse's and the survivor's experiences become intertwined.

6.2.4 Interrelation between IPV-related personal- and professional-domain experiences

Caring for survivors of IPV inevitably interrelates with emergency nurses' experiences with IPV and other gender-based violence on a personal, family, social and community level (personal-domain experiences).

Participants who were exposed to physical IPV in their personal lives described it as an experience with an emotional impact. Personal-domain experiences were remembered and cognitively and emotionally relived when triggered by witnessing IPV or the effects thereof in the professional or personal domain. Talking about caring for survivors of IPV during the interviews reflected for some participants their own exposure to emotional abuse in intimate relationships.

Participants considered reasons why a survivor would stay in a violent relationship. Some of the participants related how women exposed to IPV in their communities sometimes consult them. A participant who had no experiences with IPV in the personal domain described IPV as shocking and found it difficult to understand. Even if IPV was not evident in their current relationships, some participants expressed the awareness that the possibility cannot be excluded from their personal domain.

6.2.5 Attempts to cope with professional-domain experiences related to IPV

Emergency nurses' various ways of coping with professional-domain experiences with IPV emerged from the interviews: to talk to someone about the experiences and feelings; using spiritual resources; expressing the emotions through crying; suppression, avoidance, and distraction; altruism and acceptance.

Participants indicated that talking brings relief. They sometimes talked to a colleague or someone that could provide spiritual support; for example, the pastoral counsellors in the hospital. Some participants used their internal spiritual resources and religion to cope with the exposure to survivors of IPV. To seek distraction in the form of time out after being emotionally upset by a specific case was also described as a way of coping. Another way of coping was to avoid situations that were too threatening or to distance oneself emotionally. The realisation that a survivor had been helped brought relief, and helped emergency nurses to cope with the emotional pain.

Although some emergency nurses sometimes cried when they were emotionally touched by a case, crying was not so much seen as a way of coping as something happening when one is not able to control one's emotions. Most of the time emergency nurses just suppressed their emotions. The suppression of personal emotions was perceived by participants as a clear expectation from different sources; for example, the work environment, healthcare users and their relatives, and the emergency nurse's own sense of duty.

6.2.6 Attempts to make meaning out of IPV/understand IPV

Emergency nurses struggle to understand and make meaning out of IPV. Some participants attempted to understand the reasons that lie behind IPV, while others tried to figure out why a woman would stay in a relationship where she was exposed to violence.

When witnessing the serious injuries inflicted by IPV, emergency nurses wondered about the driving force behind the perpetrator's violent and inhumane behaviour. Participants attempted to explain the survivor's motives to persevere with the relationship in spite of the IPV. Reasons given were children in the relationship, economic dependence on the perpetrator, the control the perpetrator has over the woman and the response of the extended family. Participants agreed that the survivor's decision to leave the relationship is an individual decision that will happen in its own time. Often confronted with IPV, participants reflected on IPV as a social problem and asked themselves why it still seems to be such a common occurrence.

6.2.7 Formation of gender perceptions and assumptions related to IPV

During the interviews emergency nurses verbalised gender perceptions and shared their own personal assumptions related to IPV. Some of these perceptions and assumptions seemed to be influenced by professional- and personal-domain experiences. Two themes with regard to gender perceptions emerged from the interviews: men as perpetrators and women as victims. Participants also expressed their personal assumptions with reference to the following themes: intimate relationships, children in IPV relationships, IPV, dealing with IPV, and the survivor's autonomy.

A perception held by some participants generalised the majority of men as perpetrators of IPV. In order for a perpetrator to maintain power and control, he

needs to keep the woman dependent. Staying in the violent-prone intimate relationship might end fatally for a woman.

Gender perceptions can be accompanied by strong feelings as, for example, a participant who developed a hate towards men of a certain race group. On the other hand, women are seen as susceptible to become victims of male violence, as certain characteristics associated with femininity might cause women to be more prone to IPV. Some quotations reflected participants' disillusionment and negative views of intimate relationships, a perception that some generalised to all intimate relationships. Some emergency nurses concluded that the only way to protect oneself against IPV is to stay single. Participants shared their perceptions pertaining to children in an intimate relationship characterised by violence. Most participants expressed the conviction that IPV is wrong, but were adamant that a survivor of IPV has a choice whether to stay in the relationship or not and to exercise that choice independently. Most participants held the assumption that it is necessary for the survivor to talk about the IPV.

6.2.8 Provision of care to survivors of IPV

Care provided to survivors of IPV focus on three interventions: physical care, mostly in relation to the injuries sustained; emotional care, which reflects different ways of approaching and supporting the survivor; and referral to other multi-disciplinary health care providers. Although most participants were aware of their responsibility to provide physical as well as emotional care, it sometimes happens that the care is limited to the medical management of the survivor.

Emotional care relies on the emergency nurse's ability to detect IPV and get a disclosure from the survivor. The history to be taken of the patient relies to a great extent on the emergency nurse's own discretion. Some emergency nurses try to get the survivor to talk about the IPV; others even view it as essential for emergency nurses to detect IPV and get a disclosure; while others feel it is up to the survivor to reveal the IPV. Many barriers exist that can impede disclosure for example, the lack of privacy in the emergency unit, lack of time, language barriers, the survivor's emotional state and the presence of the perpetrator.

Participants, who suspected IPV as the reason behind a patient's presenting problems, indicated that they would probe the woman to try to get her to disclose the IPV. When probed, the woman might start to cry. Some participants viewed crying as an

opportunity to get the woman to verbalise her exposure to IPV, while others saw it as a sign to leave her alone. Some participants viewed a non-invasive approach as a more respectful way of managing survivors.

For some participants, the provision of care to survivors was based on their personal experiences with IPV and gender-based violence. For example, a participant explained how she encouraged certain behaviours in survivors of IPV that were helpful in her situation, such as talking and self-reliance.

The way emotional support is provided to survivors of IPV is not only guided by personal experiences, but also the emergency nurse's professional frame of reference, which includes certain professional and caring qualities. Professional values that can form part of emergency nurses' frame of reference include being an advocate for the survivor and having a strong sense of responsibility and accountability to overcome the barriers to care. Caring qualities include interpersonal skills such as empathy, open communication, sympathy, listening, patient-centred care and sensitivity. The altruistic nature of nursing also drives the provision of care to survivors in some cases. Altruism is related to a feeling of emotional fulfilment experienced after helping a survivor. This feeling can fulfil a personal or professional need.

The final part of the care the emergency nurse is providing is to refer survivors to the appropriate services. Most participants were aware that survivors of IPV need to be counselled, and of the different referral options. Some participants were also aware that survivors are more susceptible to interventions immediately after the abusive episode. Not all emergency nurses were that attentive, though, about referring the survivor, while some saw it as the medical practitioner's responsibility.

6.3 DEVELOPMENT OF THE GUIDELINES

The development of the guidelines was described in Chapter 5. The draft guidelines were developed in accordance with and guided by the following: guiding attributes in the guideline development process (5.2.1); findings of the phenomenological inquiry (Chapter 3); and dimensions of emancipatory knowing in nursing (Chinn & Kramer 2011).

6.4 VALIDATION OF THE GUIDELINES

The draft guidelines were validated according to the criteria of validity, reliability, applicability, clarity and flexibility. These criteria were developed from the guiding attributes for guideline development as set out in the literature (Chapter 5, 5.2.1). Reproducibility was not used as a criterion for validation, as the panel of experts were not provided with the detailed findings of the research.

The rating scale was explained and the definitions of the criteria provided in the Delphi instrument. The criteria and rating scale, according to which the draft guidelines were validated, are indicated in Table 3.

Of the 17 experts requested to validate the draft guidelines in round 1 of the Delphi, 13 responded. Three participants rated the guidelines, seven participants rated the guidelines and provided comments/suggestions and three participants noted comments/suggestions to improve the guidelines. In Table 4 the ratings of the draft guidelines after round 1 of the Delphi are indicated. The number of participants who indicated the specific rating is indicated (e.g. eight participants indicated they strongly agree with validity by marking 1 for guideline 1).

Table 4 Rating of guidelines - Delphi Round 1

	Validity				Reliability				Applicability				Clarity				Flexibility			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
GUIDELINE 1	8	2			4	6			8	1	1		6	4			4	6		
GUIDELINE 2	6	4			4	5	1		6	4			6	4			7	3		
GUIDELINE 3	6	4			3	5	2		3	7			3	7			3	7		
GUIDELINE 4	6	3	1		3	5	1	1	5	3	2		4	5	1		7	3		
GUIDELINE 5	6	4			4	5	1		6	4			3	5	2		3	7		
GUIDELINE 6	6	4			3	6	1		3	7			3	7			4	6		
GUIDELINE 7	8	2			7	3			4	6			4	6			8	2		
GUIDELINE 8	7	3			6	3		1	3	7			3	6	1		7	3		
GUIDELINE 9	4	6			3	6	1		3	6		1	2	7	1		6	3	1	
TOTAL	57	32	1		37	44	7	2	41	45	3	1	34	51	5		49	40	1	

In Table 5 the comments/suggestions of the panel of experts are summarised according to the themes identified in round 1 of the Delphi.

Table 5 Summary of themes - Delphi Round 1

	THEMES
GUIDELINE 1	Include spiritual aspects. Include legal aspects.
GUIDELINE 2	Ensure nurses will understand how to do reflection.
GUIDELINE 3	Clarify the facilitation process. Include confidentiality in the actions. Include voluntary participation. Ensure nurses will understand how to do journaling.
GUIDELINE 4	Clarify the use of a mentor or a facilitator Consider the extent to which nurses are affected by vicarious traumatising.
GUIDELINE 5	Clarify the facilitation process. Include spiritual aspects. Include voluntary participation.
GUIDELINE 6	Include the sharing of experiences and expertise among nurses. Include compassionate responses towards survivors.
GUIDELINE 7	Allow time to realise the guidelines in practice. Include team work.
GUIDELINE 8	No recommendations.
GUIDELINE 9	Consider publication of the nurses' emancipatory knowing experiences.
GENERAL COMMENTS	Clarify the facilitation process. The guidelines reflect a creative, innovative, appropriate and long-overdue process. The guidelines are in line with emancipatory-knowing processes. Emergency nurses need to be able to recognise signs of IPV before it implodes. Often professionals working with survivors have survived some degree of IPV themselves. Empirical research is needed to ascertain if this degree of self-reflection will be obtained in practice. It takes skills and experience to recognise IPV because it is still a hidden phenomenon and women are still not emancipated enough to deal with this openly

6.5 DESCRIPTION OF THE FINAL GUIDELINES

This section gives a descriptive overview of the final guidelines.

6.5.1 Name of the guidelines

"Guidelines to facilitate the actualisation of emancipatory knowing in emergency nurses with regard to taking care of survivors of intimate partner violence"

6.5.2 Purpose and objectives

The purpose of the guidelines is to actualise emancipatory knowing in emergency nurses with regard to taking care of survivors of IPV.

6.5.3 The scope of the guidelines

The guidelines were developed for emergency nurses to actualise emancipatory knowing, together with a facilitator skilled in emancipatory processes and group dynamics. The facilitator will act as a critical guide that will challenge emergency nurses to reflect on their situation and acknowledge and utilise their sense of power from within to make independent choices with regard to taking care of survivors of IPV.

6.5.4 Development of the guidelines

6.5.4.1 Background

A brief overview of the background to and rationale for the study is provided to introduce the reader to the problem that initiated the development of the guidelines.

6.5.4.2 Guideline development in terms of dimensions of emancipatory knowing in nursing

A brief explanation of emancipatory knowing in nursing illustrates how this pattern of knowing relates to the study findings. The processes located within the dimension of emancipatory knowing were also clarified as these processes guided and provided the rationale for the different guidelines: critical questions that initiate and generate knowing and knowledge; creative processes that initiate and generate knowing and knowledge; formal practice expressions of knowledge and knowing; integrated practice expressions of knowledge and knowing; and authentication processes used to examine and improve knowledge (Chinn & Kramer 2011: 3).

6.5.4.3 Methodology

The researcher provided an overview of the research design and method used to explore emergency nurses' experiences of taking care of survivors of IPV. The data collection and data analysis methods were also briefly explained.

6.5.4.4 Literature review

The literature review was reflected in the rationale provided for each of the respective guidelines.

6.5.5 Validation of the guidelines

The researcher summarised the process followed to validate the guidelines with the help of a panel of experts. The results of the Delphi technique rounds were briefly explained.

6.5.6 Guidelines

Each guideline was stated followed by a rationale and specific actions to facilitate the actualisation of the guideline.

6.5.7 Review and updating of the guidelines

It is recommended that the guidelines be reviewed and updated after they have been implemented and tested in practice.

6.6 RECOMMENDATIONS FOR PRACTICE

In the light of the guidelines formulated, three sets of recommendations are formulated. Firstly, provision must be made for organisational and supportive structures to enable emergency nurses to provide quality care to survivors of IPV. Secondly, support structures must be in place to provide care for the carer. Thirdly, provision must be made to provide emergency nurses with the opportunity to realise emancipatory knowing with regard to taking care of survivors of IPV. Without the first and second set of recommendations being in place, the emancipatory process might be difficult to implement. But it might be possible to initiate the emancipatory process that will then become the vehicle to lobby for, initiate and implement the first and second set of recommendations.

6.6.1 Organisational and supportive structures to enable emergency nurses to provide quality care to survivors of IPV

- At a national level policies need to be developed to structure the healthcare system's response to survivors of IPV.
- At a hospital level policies need to be developed to structure the different departments' (including the emergency unit) responses to survivors of IPV.
- Policies should include guidelines with regard to screening for IPV and the minimum response healthcare professionals should provide to survivors of IPV – for example, supportive interventions, safety assessment and planning, forensic interventions, referral pathways and recordkeeping.
- Referral options and resources should be in place to assist emergency nurses if they have identified a survivor of IPV. These should include an algorithm to guide emergency nurses to the appropriate professional person to assist the survivor; for example, when to refer to a psychologist, social worker or pastoral counsellor and when to involve a police officer.
- Referral pathways should be in place; for example, a list of available professional resources with contact details. This should include shelters and help lines. A professional person should be on-call over weekends and public holidays.
- Training should be provided to all healthcare professionals with regard to the management of survivors of IPV. This should include identification of and screening for IPV, the provision of emotional support, safety planning and implementation, forensic requirements and interventions and recordkeeping.

6.6.2 Support structures to provide care for the carer

- Supportive structures need to be in place to assist emergency nurses who need debriefing, trauma counselling or spiritual support after an experience with a survivor of IPV that was perceived as traumatic. These supportive structures need to be introduced to emergency nurses in an informal and open way so that they do not feel threatened to make use of these services.
- A psychologist or advanced psychiatric nurse practitioner should visit the emergency unit on a weekly basis and have informal talks with emergency nurses to assess their emotional states and identify and refer emergency nurses who require emotional support, supervision or counselling. The person can, for example, be available for the day and leave an open invitation to emergency nurses to see him/her in a private office in or near the emergency unit.

- Support groups for emergency nurses are an option to be explored and assessed by the person providing emotional support to emergency nurses.
- A mentorship system among emergency nurses might be another option to explore. Emergency nurses who are more experienced can provide support and guidance to nurses who are less experienced.
- Supervision should include interventions to enhance emotional regulation and self-awareness in emergency nurses.

6.6.3 Realisation of emancipatory knowing with regard to taking care of survivors of IPV

- Emergency nurses should be provided the opportunity (on-duty time) to participate in a creative group process where emancipatory knowing is facilitated as described in the guidelines.
- Hospital management should be introduced to the guidelines so as to obtain their support and the necessary permission to implement the process.
- A consultant skilled in emancipatory-knowing processes, group dynamics and trauma counselling should be contracted to introduce, initiate and facilitate the process.
- The process should be implemented *with* emergency nurses, so the logistics, creative processes, action plans and sustainability processes will unfold as the group progresses and group members take their own decisions on the process.
- Action plans emerging from the process should be shared with management to ensure implementation and feasibility.
- As the process progresses emergency nurses might decide to gradually take over the responsibility for the emancipatory process and only consult with the facilitator as the need arises.
- The guidelines should be revised after implementation in practice to refine them in accordance with the criteria of validity, reliability, flexibility, clarity and applicability in order to consider implementation in other settings and hospitals.

6.7 RECOMMENDATIONS FOR RESEARCH

The following recommendations are made in terms of future research:

- The guidelines need to be tested in practice, which could include other healthcare settings and healthcare professionals.

- Quantitative research is recommended to ascertain the extent to which emergency nurses in South Africa are vulnerable to secondary traumatic stress and vicarious traumatisation.
- Qualitative research is required to explore nurses' experiences of oppression in their personal and professional domains, and the interrelation between personal and professional domain experiences.
- Quantitative and qualitative research with regard to the ways of coping and meaning making employed by emergency nurses and other healthcare professionals exposed to secondary traumatic stress and vicarious traumatisation, are recommended.

6.8 LIMITATIONS OF THE STUDY

The findings of the study are contextual in nature and focus on emergency nurses' experiences in two specific hospitals situated in an urban area. The findings apply to the South African context, which is unique in many ways, but also universal in other ways. It is up to the reader to decide on the applicability of the findings to other similar contexts.

The interviews required emergency nurses to separate their experiences of being exposed to the consequences of IPV from their daily encounters with patients who were violated and traumatised in many ways. It was difficult for some of the participants to make this distinction and they spontaneously revealed other experiences, such as having to deal with survivors of non-partner sexual assault. Since this information was not relevant to this study, it was not taken into consideration during data analysis. This gives rise to certain questions: Can the experience of taking care of survivors of IPV be seen in isolation? Can it be separated from the total experience of being an emergency nurse? What constitute the boundaries of an experience?

Seen within these limitations the study provided but a glimpse of what emergency nurses experience in their daily encounters with survivors of violence and trauma. It is almost impossible to grasp the depth and extent of the feelings and memories they carry around with them after years of witnessing the effects of and listening to stories of violence revealed by healthcare users.

6.9 CONCLUSION

The researcher was guided by the following aims:

- Explore and describe emergency nurses' experiences of taking care of survivors of IPV; and
- Develop and validate guidelines to facilitate the actualisation of emancipatory knowing in emergency nurses with regard to taking care of survivors of IPV.

The researcher made use of a phenomenological inquiry to explore and describe emergency nurses' experiences of taking care of survivors of IPV. The findings were described in terms of the essence that was illuminated by the constituents that reflected the meanings emergency nurses attached to the experience of taking care of survivors of IPV. The literature review helped to clarify the meanings and deepened the researcher's perspectives on the research phenomenon. Injustices and oppression uncovered in emergency nurses' experiences of taking care of survivors of IPV guided the researcher to formulate the guidelines in terms of emancipatory- knowing processes in nursing.

The draft guidelines based on the findings of the phenomenological inquiry and emancipatory-knowing processes in nursing were validated through a Delphi technique. The guidelines were refined according to the recommendations of a panel of experts who validated the guidelines in terms of the criteria of reliability, validity, applicability, clarity and flexibility.

The guidelines will contribute to knowledge development in nursing and to nursing praxis. Through implementation of the guidelines, emancipatory knowing in emergency nurses with regard to taking care of survivors of IPV can be realised. In order to ensure validity and reliability, the set of guidelines needs to be reviewed and refined after implementation in practice. Future research is recommended to explore the applicability of the guidelines to other healthcare settings and professionals.

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**ADDENDUM A: APPROVAL FROM THE FACULTY OF HEALTH
SCIENCES RESEARCH ETHICS COMMITTEE OF THE UNIVERSITY
OF PRETORIA (125/2010)**

The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.

- * FWA 00002567, Approved dd 22 May 2002 and Expires 13 Jan 2012.
- * IRB 0000 2235 IORG0001762 Approved dd Jan 2006 and Expires 13 Aug 2011.



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences Research Ethics Committee
Fakulteit Gesondheidswetenskappe Navorsingsetiekkomitee

DATE: 26/07/2010

PROTOCOL NO.	125/2010
PROTOCOL TITLE	Emancipating Emergency Nurses Towards Taking Care Of Survivors Of Intimate Partner Violence.
INVESTIGATOR	Principal Investigator: Annatjie van der Wath (A E)
SUBINVESTIGATOR	None.
SUPERVISOR	Prof N C van Wyk
DEPARTMENT	Dept: Nursing Phone: 012-3542274 Fax: 0866499805 E-Mail: annatjie.vanderwath@up.ac.za Cell: 0845063142
STUDY DEGREE	PH D – Nursing Science
SPONSOR	None
MEETING DATE	30/06/2010

The **Protocol and Informed Consent Document** were approved on **30/06/2010** by a properly constituted meeting of the Ethics Committee subject to the following conditions:

1. The approval is valid for 2 years **period**, and
2. The approval is conditional on the receipt of 6 monthly written Progress Reports, and
3. The approval is conditional on the research being conducted as stipulated by the details of the documents submitted to and approved by the Committee. In the event that a need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an **Amendment for approval by the Committee.**

Members of the Research Ethics Committee:

Prof M J Bester	(female)BSc (Chemistry and Biochemistry); BSc (Hons)(Biochemistry); MSc(Biochemistry); PhD (Medical Biochemistry)
Prof R Delpoit	(female)BA et Scien, B Curationis (Hons) (Intensive care Nursing), M Sc (Physiology), PhD (Medicine), M Ed Computer Assisted Education
Prof VOL Karsseit	MBChB; MFGP(SA); MMed(Chir); FCS(SA) - Surgeon
Prof JA Ker	MBChB; MMed(Int); MD – Vice-Dean (ex officio)
Dr NK Likibi	MBBCh – Representing Gauteng Department of Health)
Prof TS Marcus	(female) BSc(LSE), PhD (University of Lodz, Poland) – Social scientist
Dr MP Mathebula	(female)Deputy CEO: Steve Biko Academic Hospital
Prof A Nienaber	(female) BA(Hons)(Wits); LLB; LLM(UP); PhD; Dipl.Datametrics(UNISA) – Legal advisor
Mrs MC Nzeku	(female) BSc(NUL); MSc(Biochem)(UCL, UK) – Community representative
Prof L M Ntlhe	MBChB(Natal); FCS(SA)
Snr Sr J Phatoli	(female) BCurr(Eet.A); BTec(Oncology Nursing Science) – Nursing representative
Dr R Reynders	MBChB (Prêt), FCPaed (CMSA) MRCPCH (Lon) Cert Med. Onc (CMSA)
Dr T Rossouw	(female) M.B., Ch.B. (cum laude); M.Phil (Applied Ethics) (cum laude), MPH (Biostatistics and Epidemiology (cum laude), D.Phil
Dr L Schoeman	(female) B.Pharm, BA(Hons)(Psych), PhD – Chairperson: Subcommittee for students' research
Mr Y Sikweyiya	MPH; SARETI Fellowship in Research Ethics; SARETI ERCTP; BSc(Health Promotion) Postgraduate Dip (Health Promotion) – Community representative
Dr R Sommers	(female) MBChB; MMed(Int); MPharmMed – Deputy Chairperson
Prof TJP Swart	BChD, MSc (Odont), MChD (Oral Path), PGCHE – School of Dentistry representative
Prof C W van Staden	MBChB; MMed (Psych); MD; FCPsych; FTCL; UPLM - Chairperson



DR R SOMMERS; MBChB; MMed(Int); MPharmMed.
Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

**ADDENDUM B: INFORMATION LEAFLET AND INFORMED
CONSENT - PHASE 1**

INFORMATION LEAFLET AND INFORMED CONSENT FOR NON-CLINICAL RESEARCH

TITLE OF STUDY: EMANCIPATING EMERGENCY NURSES TOWARDS TAKING CARE OF SURVIVORS OF INTIMATE PARTNER VIOLENCE

Dear Participant

1) INTRODUCTION

I invite you to participate in a research study. This information leaflet will help you to decide if you want to participate. Before you agree to take part you should fully understand what is involved. If you have any questions that this leaflet does not fully explain, please do not hesitate to ask the investigator Mrs Annatjie van der Wath Tel: 0845063142

2) THE NATURE AND PURPOSE OF THIS STUDY

The aim of this study is to explore and describe the experiences of emergency nurses regarding taking care of survivors of intimate partner violence.

You as a emergency nurse is a very important source of information on the experience of taking care of survivors of intimate partner violence.

3) EXPLANATION OF PROCEDURES TO BE FOLLOWED

This study involves an interview where the facilitator will ask some questions regarding your experiences. The interview will be recorded and will last about an hour.

4) RISK AND DISCOMFORT INVOLVED

There are no risks in participating in the study. The interview may cause emotional discomfort or take some of your time. If the questions I am going to ask you make you feel uncomfortable, you need not answer them if you do not want to. The interview will take about an hour of your time.

5) POSSIBLE BENEFITS OF THIS STUDY

Although you will not benefit directly from the study, the results of the study will enable me to develop guidelines to emancipate emergency nurses towards providing quality care to survivors of intimate partner violence. You will benefit indirectly from the study because at the end of the study we will provide you with the findings.

6) WHAT ARE YOUR RIGHTS AS A PARTICIPANT?

Your participation in this study is entirely voluntary. You can refuse to participate or stop at any time during the interview without giving any reason. Your withdrawal will not affect you in any way.

7) HAS THE STUDY RECEIVED ETHICAL APPROVAL?

This study has received written approval from the Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria and the manager of the hospital. Copies of the approval letters are available if you wish to have one.

8) INFORMATION AND CONTACT PERSON

The contact person for the study is Mrs Annatjie van der Wath. If you have any questions about the study please contact me on my cell 0845063142

9) COMPENSATION

Your participation is voluntary. No compensation will be given for your participation.

10) CONFIDENTIALITY

All information that you give will be kept strictly confidential. Once I have analysed the information no one will be able to identify you. Research reports and articles in scientific journals will not include any information that may identify you or your hospital. All digitally recorded and written study material will be stored in a safe place for 15 years.

CONSENT TO PARTICIPATE IN THIS STUDY

I confirm that the person asking my consent to take part in this research has informed me about the nature, process, risks, discomforts and benefits of the study. I have also received, read and understood the above written information (Information leaflet and informed consent) regarding the study. I am aware that the results of the study, including personal details, will be anonymously processed into research reports. I am participating willingly. I have had the time to contact the researcher and to ask questions and have no objection to participate in the study. I understand that there is no penalty should I wish to discontinue with the study and my withdrawal will not affect me in any way.

Participant's name:

(Please Print)

Participant's signature.....

Date.....

Researcher's name:

(Please Print)

Researcher's signature.....

Date.....

Witness's name:

(Please Print)

Witness's signature.....

Date.....

**ADDENDUM C: INFORMATION LEAFLET AND INFORMED
CONSENT - PHASE 2**

INFORMATION LEAFLET AND INFORMED CONSENT FOR NON-CLINICAL RESEARCH – DELPHI TECHNIQUE FOR PANEL OF EXPERTS

TITLE OF STUDY: EMANCIPATING EMERGENCY NURSES TOWARDS TAKING CARE OF SURVIVORS OF INTIMATE PARTNER VIOLENCE

Dear Participant

1) INTRODUCTION

I invite you to participate in a research study. This information leaflet will help you to decide if you want to participate. Before you agree to take part you should fully understand what is involved. If you have any questions that this leaflet does not fully explain, please do not hesitate to ask the investigator Mrs Annatjie van der Wath Tel: 0845063142

2) THE NATURE AND PURPOSE OF THIS STUDY

The aim of this study is to explore and describe the experiences of emergency nurses regarding taking care of survivors of intimate partner violence in order to develop guidelines for emergency nurses to actualize emancipatory knowing with regards to taking care of survivors of intimate partner violence. You, as an expert in the field of emergency nursing/ gender-based violence, is a very important source of information in the process of validating the guidelines for emergency nurses to actualize emancipatory knowing with regards to taking care of survivors of intimate partner violence.

3) EXPLANATION OF PROCEDURES TO BE FOLLOWED

This study involves a Delphi technique. You are invited to participate in the validation of the guidelines as part of a panel of ten experts in the field of emergency nursing and/or gender-based violence. The panel includes experts on national and international level. It is expected that not more than three rounds of the Delphi will be sufficient to obtain consensus on the content of the guidelines. There are nine guidelines with actions for emergency nurses to actualise emancipatory knowing with regard to taking care of survivors of IPV. You are expected to read through each guideline and action to complete the rating scale in accordance with the criteria which include: validity, reliability, flexibility, clarity and applicability of the guideline. If applicable, suggestions for re-formulation of the guideline can be provided in the space for comments at the end of each section. There is also a section with biographical information to complete. This will enable the researcher to complete a table reflecting the professional and academic experience of participants. This validation process should take approximately 1 hour to complete for the nine guidelines.

4) RISK AND DISCOMFORT INVOLVED

There are no risks in participating in the study. Each Delphi round will take about an hour of your time.

5) POSSIBLE BENEFITS OF THIS STUDY

Although you will not benefit directly from the study, the results of the study will be utilised to actualise emancipatory knowing in emergency nurses with regard to taking care of survivors of intimate partner violence.

6) WHAT ARE YOUR RIGHTS AS A PARTICIPANT?

Your participation in this study is entirely voluntary. You can refuse to participate or stop at any time during the Delphi rounds without giving any reason. Your withdrawal will not affect you in any way.

7) HAS THE STUDY RECEIVED ETHICAL APPROVAL?

This study has received written approval from the Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria. Copies of the approval letter are available if you wish to have one.

8) INFORMATION AND CONTACT PERSON

The contact person for the study is Mrs Annatjie van der Wath. If you have any questions about the study please contact me on my cell 0845063142.

Fax: 0866499805. E-mail: Annatjie.vanderwath@up.ac.za

9) COMPENSATION

Your participation is voluntary. No compensation will be given for your participation.

10) CONFIDENTIALITY

All information that you give will be kept strictly confidential. Once I have analysed the information no one will be able to identify you. Research reports and articles in scientific journals will not include any information that may identify you or your organisation. All written study material will be stored in a safe place for 15 years.

CONSENT TO PARTICIPATE IN THIS STUDY

I confirm that the person asking my consent to take part in this research has informed me about the nature, process, risks, discomforts and benefits of the study. I have also received, read and understood the above written information (Information leaflet and informed consent) regarding the study. I am aware that the results of the study, including personal details, will be anonymously processed into research reports. I am participating willingly. I have had the time to contact the researcher and to ask questions and have no objection to participate in the study. I understand that there is no penalty should I wish to discontinue with the study and my withdrawal will not affect me in any way.

Participant's name:
(Please Print)
Participant's signature.....
Date.....

Researcher's name:
(Please Print)
Researcher's signature.....
Date.....

Witness's name:
(Please Print)
Witness's signature.....
Date.....

Please scan and e-mail or fax the signed copy of the informed consent. Once signed by the researcher a copy will be mailed or faxed to you.

Fax:
E-mail:

**ADDENDUM D: LETTER TO REQUEST PERMISSION FROM THE
DEPARTMENT OF HEALTH AND SOCIAL DEVELOPMENT -
TSHWANE METSWEDING REGION**

Request to perform a research study utilising the emergency nurses working in the emergency unit of the hospital(s).

I am Mrs A E van der Wath, a Doctoral student of the Department of Nursing Science at University of Pretoria, engaged in a study entitled **"EMANCIPATING EMERGENCY NURSES TOWARDS TAKING CARE OF SURVIVORS OF INTIMATE PARTNER VIOLENCE"** Prof NC van Wyk supervises the study.

The purpose of the study is to explore experiences of emergency nurses regarding taking care of survivors of intimate partner violence.

The study will be done as follows:

- Informed consent will be obtained before participation takes place.
- The researcher will conduct the unstructured interviews. The researcher is an advanced psychiatric nurse with clinical experience in the field of psychiatry.
- The participants will be selected from emergency nurses working in the emergency department.
- The normal functioning of the hospital will not be influenced.

The positive outcome of the study:

The experiences of the participants will be utilized to develop guidelines to support nurses to care for survivors of intimate partner violence in order to improve nursing practice. The results of the study will be published in a scientific journal.

The proposal will be submitted to the Research Ethics Committee of the Faculty of Health Sciences of the University of Pretoria for approval of the study. The proposal is attached. If more information is needed, you can contact me during office hours, or my supervisor Prof NC van Wyk: (012) 354 2125

Your kind consideration of my request to conduct the study in the hospital(s) will be appreciated.

Yours sincerely

AE van der Wath
Email: annatjie.vanderwath@up.ac.za
Cell No: 084 5063142

**ADDENDUM E: CLEARANCE CERTIFICATE FROM THE
DEPARTMENT OF HEALTH AND SOCIAL DEVELOPMENT -
TSHWANE METSWEDING REGION (TMREC 2010/51)**



Umnyango wezempilo no Kuthuthukiswa Komphakathi
Lefapha la Maphelo le Tshebeletso le Ntshetsopele ya Sechaba
Department of Health and Social Development
Departement van Gesondheid en Maatskaplike Ontwikkeling

TSHWANE/METSWEDING REGION

Enquiries: Ms M Mosito

+27725602528

Email: Motlalepule.Mosito@gauteng.gov.za

TSHWANE METSWEDING REGION RESEARCH ETHICS COMMITTEE

CLEARANCE CERTIFICATE

Meeting: 02/2010

PROJECT NUMBER: TMREC 2010/51

PROJECT:

Title: Emancipating Emergency Nurses Towards Taking Care Of Survivors Of Intimate Partner Violence.

Researcher: Annetjie van der Wath (A E)

Supervisor: Prof N C van Wyk

Department: Nursing (University of Pretoria)

Degree: PHD

DECISION OF THE COMMITTEE

Approved

Date: 8th September 2010

Dr K.E. Letebele-Hartell
Chairperson Tshwane Metsweding Research Ethics Committee
Tshwane Metsweding Region

Dr PMH Maduna
Chief Director: District Health Services
Tshwane Metsweding Region

NOTE: Resubmission of the protocol by researcher(s) is required if there is departure from the protocol procedure as approved by the committee.

ALL CORRESPONDANCE TO INCLUDE PROTOCOL NUMBER

The Fields Building, 427 Hilda Street, Hatfield, 0028, Pretoria

COPY 2

**ADDENDUM F: EXAMPLE OF A TRANSCRIBED UNSTRUCTURED
PHENOMENOLOGICAL INTERVIEW**

	Interview 36 - 23 December 2010
R	Tell me about your experiences when you come across a patient that has been exposed to violence from a partner?
	You know this situation when a woman came in the unit abused by a partner... and it will depend on the injuries that she's sustained. And its very it effects me emotionally some and even psychologically because you will find that the injury that came with that – I mean a normal living person can't do this to his partner especially if he love the partner, because some others they come with the terrible injuries and its so sad. For my side when I nurse this patient – sometimes I used to put myself in this patient's shoes and try to give her all the care that she needs, and thinking that even myself I am a woman, and then my partner, I cant say that I know my partner to the fullest. Even though its life is just fine but you don't know what is going to happen tomorrow, so I just care of that patient in totality and sometimes talking to her, giving her support as a woman, because you don't know what will happen tomorrow but truly speaking its really affecting. But one other thing if this things happen and I nurse this patient I just pray to God to give me that power, to give me that strength so that I can nurse this patient, because when I see this patient I also see myself like this patient one day so I just pray to God that he must give me that power, he must give me that strength, because this patient really need my help and I have to help her and I have to give her support, you see. Ya that's the things that happened, mm and even at home, when I arrive at home and this things I used to remember it especially for that day when I worked with that patient, even when I am at home, I can still remember I got that patient and sometimes it affects the situation at home because they used to know me that I am talkative I am laughing and stuff like that, but that day is a little bit sad on my side when I think of that thing and even on the news on the radios they used to talk about these things and on TV you see it and its very depressing mm.
R	So mostly the feeling you experience is the sadness...
	The sadness, sometimes the anger towards the partner who has done to his wife or his girlfriend.
R	You sad and you think you are also a woman..
	Ya, you can't predict what is coming tomorrow, because you can be on a relationship for many years knowing your partner is not doing things like that, but sometimes he can change within a second you wouldn't know what make him to change, so sometimes when a woman has got a problem or something happened to him, don't just laugh at her or say funny things about her because you are also a woman and anything can happen, ya so if she's got a problem or may she's abused just give her support. And just advice her of some other support groups, stuff like that or maybe advice her about the telephonic lines for people who have been abused, they have got a number, just advice her where she can get help and stuff like that...
R	So you will always try to advice them or refer to a place where they can get help?
	Mostly I used to advice them and in our hospital we have got the Hospivision the spiritual counselor, and then sometimes I do ask her that if she wants a spiritual counselor or something like that she mustn't be afraid she must tell me so that maybe I can tell our unit manager about this problem so that she can organise the Hospivision counselors to come and see her. Because sometimes when the woman came with the abuser, partner, stuff like that, they are afraid to talk, they are too secretive, so if you are open to her, if you communicate with her openly and show some sympathy or, then you just ah ah relay the anxiety that she's got that she can, whatever she want to say she can say it, you will listen, you will be a good listener and then.... you give the support all the way, you give the advice of the support groups, stuff like that, because really especially in this nowadays the violence for women abusing by partners is very high.
R	Do you often see it in the unit?
	Ya most often in the unit.
R	You try to put yourself in their position and you try to be open?
	The more you be open to her, the more she is trying to cough out all the problems she's got, even the problems that she was hiding. She feel free to cough it out and then the more you cough it out, the more you can get help from others.
R	How do you manage to deal with it so openly?
	You know truly speaking, when I see that patient came in and I see that this patient is for me, there's no other way its for me, the first thing that I do before I can go to the patient, I am just taking a 2 minutes break to ask God for strength, and for power and suddenly I have started to be like that, I have started to stand for that woman to, to try to make her feel at home. I mean that's the only thing that I do I am just asking God and I think God also sees that my child is in trouble, let me give her the strength to do what she is suppose to do. You know sometimes even the way they came you'll see that the injuries that they have sustained they are very bad because sometimes I used to cry, even when I looked at them, and its not good in front of her. I was suppose to calm her down so when I do that I am making things worse but, I am just asking God to give me the strength then I have just wiped off my tears and continue with my nursing to the patient and at the end of the day I can see what a

	difference I have made to the patient.
R	That encourage you to carry on?
	Ya that encourage me to carry on, even yesterday there was a patient who have been abused by her boyfriend, and she was terribly injured. The mouth was torn from this part up until here even from the nose and when we asked her what did the boyfriend used she just said he used his arms like this, and it was very, very bad. But the doctors managed to do everything they have sutured her, she was very nice and was discharged on that day. So it was terrible when you look at her and you think of yourself one day looking like that.
R	So that's the thoughts that went through your mind, and the feelings?
	The feelings sad, very sad and, and it affects me a lot, it affects me a lot but, that's what is happening in this nowadays, so we have to deal with it whether we like it or not, and we have to get some positive results from that.
R	Its part of your work, in what way will it affect you?
	Ah, most of the time I feel sad, I feel sad and ask me some questions, why is it happening to us women, what went wrong and it also affects me a lot because I have got two children and they are daughters, one day they will be women and then they will have partners, that's what I am thinking about it, what kind of partners will they get when they grow up, because its very painful its very much stressing very much depressing, mm.
R	You even fear for your daughters...
	I even fear for my daughters mm....ah, it happens almost every day in different areas. Its very sad, its not good, its not how we should live. Its just that they are powerless to their partners, that's why its happening.
R	In your work you mentioned specific cases, you try to pray, to be strong, it still leaves you with sadness?
	It still leave me with sadness and then that sadness when I am alone this things come back, but when I am with my colleagues we are chatting with something different they cant come back, even when I am at home when I am playing with my daughters I am trying to forget what happened. It's not easy. The moment you are alone it comes back again.
R	How does it come back?
	You know when it comes back when I am alone, that vision, it comes back, you know the way I did see the patients, the injuries that I have seen, I mean the moments that I did see the patient, that vision it comes back and it affects me very deeply because sometimes I used to cry alone. They have just seen me, the tears just dropping and then when they ask me and then I have said, Ay, usually I used to tell them when I have experienced something terrible at work and I have said to them, you know today I have just experienced something very bad at work. Its not me today, if you see me acting like this so its not me I am still emotionally and psychologically affected. So at least they do understand, my family do understand.
R	Who is your family?
	It's my two daughters and my husband.
R	So you also talk to your husband?
	Yes, I also talk to him, because she knows me, as soon as he look at me he can see that something is wrong, and then he is asking: I can see that something is wrong, is it me or is it a work-related thing? Then I have told him it's a work-related thing, then I have told him, you know today I have just experienced this and this and for my side its too stressfull and it affects me emotionally so even he give me a support if I have experienced something bad he support me. He just give me that support and I feel little bit much better.
R	So you have the support system in the family and your religion. What are the care you provide as a nurse to these women?
	You know I think first thing that you have to do, you must make sure that this woman feel free when she's with you. And then you must also ask her that if she wants to say something, even if it's a secret thing, she must be free to talk. And it will depend on the way you are treating her, that she can trust you, so that she can talk. She can tell all the story all the problems, and then even when you are nursing her you can keep on asking her how does she want you to nurse her according to her feelings. So you must listen to her feelings, you must listen to her what does she want, what doesn't she want, and then otherwise when you are doing that you can reach your goals.
R	You talk to her and encourage her to talk to you?
	And then she can also tell you what must I do to her and what must I not do to her, so in other way I should also listen to what she wants and what she doesn't want, so that I can gain trust on her and she can be much open to me.
R	You take what she wants?
	You know what, when they came because when you nurse her it's the first time she sees you, it's the first time you see her so she looks a little bit sad, withdrawn, stuff like that and you can see that this poor woman is being depressed and she's afraid to talk, stuff like that. So if you can approach her nicely and make her understand that you understand the situation so that she can be open to you. And then she can say anything, but you mustn't put pressure on her to say things, you can take it slowly by slowly, you mustn't be short-tempered so that you can understand what is she going through. And then they talk too much and then mostly

	when they see other people passing they think as if this people they know what happened to her, so she feel very scared and most of the time you will see that even when she's lying on the bed in the hospital she don't face where people are walking, she face where there's no one walking on that side, and she also put the blanket on top of the head so that no one can see her, because her mind told her that maybe everyone knows about her situation. There's some other things you don't want some other people to know, so...
R	So you even sense the way they feel that they are sometimes ashamed...
	Even their actions they will tell you that something is wrong because sometimes they came and then you will find that she's not free to tell you what the exact story, what exactly happened. So she's trying to tell you this and that, this and that, but at the end of the story when you tell those things that she told you, when you combine then you can see, no, this is not the real thing that this people came, there's something wrong with this thing because when you take that together they don't connect, the story doesn't connect so that you notice, no, something is wrong. And then that's where you have to sit down by yourself and think, that to get a clear story from that woman what must I do? That's where you have to start sitting down and do your homework. That firstly I have to try by all means to get the whole story from that woman, so that she can be open and tell the story. Because it's the first time that you see each other. She doesn't trust you to tell the whole thing, she thought after maybe telling you, you will tell everyone.
R	You first have to gain her trust?
	Ya you first have to gain her trust and make her feel at home ...
R	Before she will be able to talk to you?
	Exactly mmm...
R	And when they have talked?
	Ah mostly after I have heard the story, I just go to those people, the spiritual counselors. Because after that patient told me about the story it affects me a lot and then its not going to affect me alone it will also affects my family because they are not going to get my full attention I used to give them because I will be sad most of the time and my kids expect me to be with them, my husband expect me to chat with him and whatever we used to do he expect that thing to continue even on my kids. But with these things that is happening at work and it affects me a lot, so it doesn't affect me alone at work, also at home. It affects me, so when I see things like that sometimes if I feel that its heavy for me, that's where I used to see the spiritual counselors and then after that back to normal.
R	So you used the resource, you can talk to the spiritual counselors?
	Ya, also at times I go to my pastor, and then he also relief me because after talking to someone it also relief me because even that patient he didn't say anything to anyone but immediately when you tell the second person it feel much relieved than this thing you were holding it by yourself as soon as you talk to someone and give you the advice you feel a little bit much better than before so even myself when I see things like that so keeping it to myself it will cause me a lot of harm, for me and my family and those who knows me my friends so for me to try to be better I have to talk to someone. And then when I talk to someone that person will give me a lot of advice a lot of things that I can do so that my spirit can be lifted up again so even then the next patient who can come with the very same thing I will feel the courage to do that.
R	You need to do something that enables you to do help the next person?
	If I wouldn't dealt with that emotion I don't know what will happen because it will keep on piling on me so maybe at this moment many mistakes will happen in the unit because I am stressfull. Sometimes you will find that when coming to give the patients medication I will make a mix-up, I am taking the wrong things because that thing is on my mind and it is on my emotion so I won't be able to function properly in my work. There will be lot of mistakes happening.
R	You realized that?
	I have realized if you have a problem cough it out to the next person that you trust and he will give you some advice and even God will help you then everything will be fine. Because I think for us to be here is because of the purpose from God. He knows that there will be some other people outside who need our help so He will give us the strength almost every day so that we can help those people because they are not able to help themselves. So we are here to help them, so I think we will be successful with all the women as time goes on.
R	You see your work as helping other people?
	I need to be there for them because they can't come here if they don't want my help – they are really desperate need my help and I have to help them. That's my main reason to be here I have to help those who can't help themselves and I have to help them in totality in everything that I could help them.
R	How do you see it to help a person in totality?
	You know mostly the patients that I have helped that has been abused by a partner – you know I feel glad, even that patient came into Casualty, I have nursed her and then when the time goes on they have admitted the patient to the ward. I do the follow-ups – during my tea-

	time or my lunchtime, I go straight to the ward. I am willing to find out how is she doing and you know when she's fine now at the end of the day, I can see that that poor woman she's fine now. It makes me to feel fine twice than her, because I can see that at least what I have done it did make a change on her. Ya mostly when I did see something like that and the patient being admitted, I go to the ward. I go to the ward, not even for those patients who are abused, those that I have nursed and they have affected me deeply emotionally. When they have admitted them I go to the ward and try to find out what's going on. When I go the ward and find out that patient is awake and smiling it makes a lot of difference for me. I feel more happy, I can see that at least what I have done, that lady has survived some of the things that's she's going through.
R	It really helps to do that follow-up
	If I see what I have done on the patient make a difference to her then it makes me more happy and relieved. Then my stress level is gone.
R	It helps to see the results?
	And the results – they make me more happy than talking to someone else when I am still on that situation.
R	That really counts a lot?
	Yes it counts a lot, it erased that sadness that was on me or with that patient. When I see that she's improving and she's fine she can communicate and the stress level is a little bit lower then I am the happiest person.
R	And the one that go home that you can't see the results?
	Usually when they came in I just took their tel numbers but I ask them first: "Is it fine if I take your tel number? So that if I don't see you that I can contact you and try to find out how is life going on?"
	So you even contact them?
	Yes most of the time I used to contact them especially those who stays in casualty and they have been discharged home because I didn't spend enough time that I wanted to spend with them so I used to take some contacts and try to find out how is the process, what's going on but if the patient is in the ward then I go straight to the ward.
R	So you have a need to follow-up?
	Exactly, because it's very sad. Just imagine abusing someone who's powerless who doesn't do anything, if it is a beating up you keep on beating her up and she's also begging you to stop, I mean eish it's so painful, it's so sad.
R	You think about what the woman went through when she was abused?
	Yes especially when you see the bruises the injuries, sometimes she's got a fracture of the arm and then you see that I just visualize that moment when the man was beating her up and begging him to stop and it's you know, it's very sad....
R	It hurts when you think about it....
	And you think maybe it wasn't the first time, it wasn't the second or third time, it's a thing that is happening almost every time.
R	It is disturbing to think that the woman is exposed to that over and over?
	You know the thing that affects me mostly is when the woman came abused being beaten almost every day and that poor lady is bleeding inside and the husband or the boyfriend doesn't know and you'll find that at the end of the day when the patient came in here she dies, she dies, you know that one it affects me very badly. I can even take a week or two weeks not being myself when I think of that poor lady.
R	You have seen some of them who haven't survived the abuse?
P	That one has affected me very, very badly
R	The effect on you?
	It stays with me for sometimes, even the situation at home it changes, it changes but my daughter the small one sometimes she makes to forget for a moment because she's 2 years now, so we just play and for that moment I am just forgetting about what I was thinking of. I just play, do things like that but when she started to fall asleep that's when the things started and then I go to my pastor and she prays with me like that and then it goes away little by little but not at the same time, little by little but at the end I just told myself let me accept what has happened, it just happened, let me accept it. And then at the end I accept it but it's difficult to accept it. At the end I just told myself I have got a family I have to look after, I have got a job and I have patients that want my help, let me accept that it happened. And then what is left is just to pray to God to let it not happen again so that's how I cope even though it's difficult, but I have to do that. Sometimes it's very hard to accept – you are in denial of what happened but in the end you have to accept. It's done, she's gone, she's gone she can't come back even though she's gone in a terrible way but what happened, happened. I have to accept it for the sake of the other patients in the hospital and for my family. Let me accept it. I can't walk around with it forever.
R	So there's sometimes that denial, as if you cannot believe it and you slowly come to terms with it. Anything else you can think of?
	You know when coming to this relationship violence, I know it's not simple and that's what we

	are willing, and that's what the media and television used to say. If you are in an abusive relationship, don't keep quiet, but it's not easy, don't keep quiet, seek for help so that this thing can at least the person teach God down. Because this partner especially the males they are enjoying what they are doing to their ladies and their wives and its wrong. We are not suppose to do that so what I can say I can say I wish it could be that way so that each and every women that's in a abusive relationship, she can be open. She mustn't fear because its her life that's in that. She mustn't fear, she must talk. I think if you have got friend or you have family, one of your family members or one of your friends, you can see that you can have five friends but you can see that on top of five there's someone that you can share some problems with her. Even in the family, if you are afraid of your mother or your father, your auntie or whoever, you can say something of your life to her and that person she could help you. So I think keeping quiet doesn't solve that, it doesn't solve anything, even though its not easy, its not easy but I think they should try to do something that can save their lives.
R	It is like a message you want to give...
	It's a message I want to give to those women – they mustn't suffer in silence – they must say something, even though they are afraid of there partners that if I talk I will make the matters worse. On the other hand you are helping yourself and you are also helping other women who are on the same situation as yours,
R	If you say no, others might also start to say no...
	Even nowadays there is a lot of organizations that are supporting this thing. If you suffer in silence that's the main problem, but if you are coughing out the problems that you have got you gonna get a lot of support. I mean around South Africa and around the world you can get a lot of support. So you mustn't stuck in a relationship like that because at the end of the day you will be dead. One day that your partner is going to beat you up to death.
R	It has a fatal outcome...
	And there some other women that they think that beating up by a husband or a boyfriend is a sign of that boyfriend or husband loves you, of which is not. If you love someone you don't want anything that can make her hurtful or sad. You are trained to take care of that person so you can't beat your wife and say that you love her It doesn't work like that. Even your girlfriend, you cant beat her up and say that you love her. That it is not love. And at the end of the day its you whose going to be in a lot of trouble. And at the end of the day you can end up dead because you don't know the harm that he's causing on you when he's beating you up You are looking at your skin outside but you don't know what is going on inside. And it is very bad when something is wrong inside because we can't see it we can't see how the damage is inside. By the time you are trying to find out it's too late. And you have got children whose going to take care of the children while you are not there. The father can't take care of the children because he didn't take care of you, while you are still alive, so when you are gone who is going to take care of your kids. So it's already a problem again on the kids. The kids suffer because the mother did suffer in silence and end up dead.
R	So you should also think of the family?
	And some other kids they will think that whatever especially the boys think that whatever my father is doing to my mom is the right thing. Then he will grow doing the same thing that the father is doing of which is wrong. The kids are also looking what is going on especially the boy, he will grow up beating everyone and if his got a girlfriend he will do the same thing that his father was doing because he thought it's the right thing. Because when we are parents we are the role models of our kids. So when you do things like that your kids will think this is the right thing to do and he will grow up doing that. And that's how the percentage is going up and up.
R	We don't stop the cycle.
	It's going on and its going on very fast. Because its one father with kids maybe three, two boys and one girl so you can see that those two boys they are representing one. They will do the same thing that their father was doing. They are two and their father is one, so you can see that two represented one. So it's going up fast the rate, the percentage of the violence of women.
R	Women need to talk, say no...
	Even though they are afraid but that's the best thing they can do especially these nowadays there is a lot of help for them. The help is all over helping for them. So they must break the chain of silence and get help.

ADDENDUM G: EXAMPLE OF ANALYSED TRANSCRIBED INTERVIEW

(At the end of the interview the meaning units, clustered together, are indicated in different font colours)

	Interview 36 - 23 December 2010
R	Tell me about your experiences when you come across a patient that has been exposed to violence from a partner?
	You know this situation when a woman came in the unit abused by a partner... and it will depend on the injuries that she's sustained. And its very it effects me emotionally some and even psychologically because you will find that the injury that came with that – I mean a normal living person can't do this to his partner especially if he love the partner, because some others they come with the terrible injuries and its so sad. For my side when I nurse this patient – sometimes I used to put myself in this patient's shoes and try to give her all the care that she needs, and thinking that even myself I am a woman, and then my partner, I cant say that I know my partner to the fullest. Even though its life is just fine but you don't know what is going to happen tomorrow, so I just care of that patient in totality and sometimes talking to her, giving her support as a woman, because you don't know what will happen tomorrow but truly speaking its really affecting. But one other thing if this things happen and I nurse this patient I just pray to God to give me that power, to give me that strength so that I can nurse this patient, because when I see this patient I also see myself like this patient one day so I just pray to God that he must give me that power, he must give me that strength, because this patient really need my help and I have to help her and I have to give her support, you see. Ya that's the things that happened, mm and even at home, when I arrive at home and this things I used to remember it especially for that day when I worked with that patient, even when I am at home, I can still remember I got that patient and sometimes it affects the situation at home because they used to know me that I am talkative I am laughing and stuff like that, but that day is a little bit sad on my side when I think of that thing and even on the news on the radios they used to talk about these things and on TV you see it and its very depressing mm.
R	So mostly the feeling you experience is the sadness...
	The sadness, sometimes the anger towards the partner who has done to his wife or his girlfriend.
R	You sad and you think you are also a woman..
	Ya, you can't predict what is coming tomorrow, because you can be on a relationship for many years knowing your partner is not doing things like that, but sometimes he can change within a second you wouldn't know what make him to change, so sometimes when a woman has got a problem or something happened to him, don't just laugh at her or say funny things about her because you are also a woman and anything can happen, ya so if she's got a problem or may she's abused just give her support. And just advice her of some other support groups, stuff like that or maybe advice her about the telephonic lines for people who have been abused, they have got a number, just advice her where she can get help and stuff like that...
R	So you will always try to advice them or refer to a place where they can get help?
	Mostly I used to advice them and in our hospital we have got the Hospivision the spiritual counselor, and then sometimes I do ask her that if she wants a spiritual counselor or something like that she mustn't be afraid she must tell me so that maybe I can tell our unit manager about this problem so that she can organise the Hospivision counselors to come and see her. Because sometimes when the woman came with the abuser, partner, stuff like that, they are afraid to talk, they are too secretive, so if you are open to her, if you communicate with her openly and show some sympathy or, then you just ah ah relay the anxiety that she's got that she can, whatever she want to say she can say it, you will listen, you will be a good listener and then.... you give the support all the way, you give the advice of the support groups, stuff like that, because really especially in this nowadays the violence for women abusing by partners is very high.
R	Do you often see it in the unit?
	Ya most often in the unit.
R	You try to put yourself in their position and you try to be open?
	The more you be open to her, the more she is trying to cough out all the problems she's got, even the problems that she was hiding. She feel free to cough it out and then the more you cough it out, the more you can get help from others.
R	How do you manage to deal with it so openly?
	You know truly speaking, when I see that patient came in and I see that this patient is for me, there's no other way its for me, the first thing that I do before I can go to the patient, I am just taking a 2 minutes break to ask God for strength, and for power and suddenly I have started to be like that, I have started to stand for that woman to, to try to make her feel at home. I mean that's the only thing that I do I am just asking God and I think God also sees that my child is in trouble, let me give her the strength to do what she is suppose to do. You know sometimes even the way they came you'll see that the injuries that they have sustained they are very bad because sometimes I used to cry, even when I looked at them, and its not good in front of her. I was suppose to calm her down so when I do that I am making things worse but, I am just asking God to give me the strength then I have just wiped off my tears and continue with my nursing to the patient and at the end of the day I can see what a difference I have made to the patient.
R	That encourage you to carry on?

	Ya that encourage me to carry on, even yesterday there was a patient who have been abused by her boyfriend, and she was terribly injured. The mouth was torn from this part up until here even from the nose and when we asked her what did the boyfriend used she just said he used his arms like this, and it was very, very bad. But the doctors managed to do everything they have sutured her, she was very nice and was discharged on that day. So it was terrible when you look at her and you think of yourself one day looking like that.
R	So that's the thoughts that went through your mind, and the feelings?
	The feelings sad, very sad and, and it affects me a lot, it affects me a lot but, that's what is happening in this nowadays, so we have to deal with it whether we like it or not, and we have to get some positive results from that.
R	Its part of your work, in what way will it affect you?
	Ah, most of the time I feel sad, I feel sad and ask me some questions, why is it happening to us women, what went wrong and it also affects me a lot because I have got two children and they are daughters, one day they will be women and then they will have partners, that's what I am thinking about it, what kind of partners will they get when they grow up, because its very painful its very much stressing very much depressing, mm.
R	You even fear for your daughters...
	I even fear for my daughters mm....ah, it happens almost every day in different areas. Its very sad, its not good, its not how we should live. Its just that they are powerless to their partners, that's why its happening.
R	In your work you mentioned specific cases, you try to pray, to be strong, it still leaves you with sadness?
	It still leave me with sadness and then that sadness when I am alone this things come back, but when I am with my colleagues we are chatting with something different they cant come back, even when I am at home when I am playing with my daughters I am trying to forget what happened. It's not easy. The moment you are alone it comes back again.
R	How does it comes back?
	You know when it comes back when I am alone, that vision, it comes back, you know the way I did see the patients, the injuries that I have seen, I mean the moments that I did see the patient, that vision it comes back and it affects me very deeply because sometimes I used to cry alone. They have just seen me, the tears just dropping and then when they ask me and then I have said, Ay, usually I used to tell them when I have experienced something terrible at work and I have said to them, you know today I have just experienced something very bad at work. Its not me today, if you see me acting like this so its not me I am still emotionally and psychologically affected. So at least they do understand, my family do understand.
R	Who is your family?
	It's my two daughters and my husband.
R	So you also talk to your husband?
	Yes, I also talk to him, because she knows me, as soon as he look at me he can see that something is wrong, and then he is asking: I can see that something is wrong, is it me or is it a work-related thing? Then I have told him it's a work-related thing, then I have told him, you know today I have just experienced this and this and for my side its too stressfull and it affects me emotionally so even he give me a support if I have experienced something bad he support me. He just give me that support and I feel little bit much better.
R	So you have the support system in the family and your religion. What are the care you provide as a nurse to these women?
	You know I think first thing that you have to do, you must make sure that this woman feel free when she's with you. And then you must also ask her that if she wants to say something, even if it's a secret thing, she must be free to talk. And it will depend on the way you are treating her, that she can trust you, so that she can talk. She can tell all the story all the problems, and then even when you are nursing her you can keep on asking her how does she want you to nurse her according to her feelings. So you must listen to her feelings, you must listen to her what does she want, what doesn't she want, and then otherwise when you are doing that you can reach your goals.
R	You talk to her and encourage her to talk to you?
	And then she can also tell you what must I do to her and what must I not do to her, so in other way I should also listen to what she wants and what she doesn't want, so that I can gain trust on her and she can be much open to me.
R	You take what she wants?
	You know what, when they came because when you nurse her it's the first time she sees you, it's the first time you see her so she looks a little bit sad, withdrawn, stuff like that and you can see that this poor woman is being depressed and she's afraid to talk, stuff like that. So if you can approach her nicely and make her understand that you understand the situation so that she can be open to you. And then she can say anything, but you mustn't put pressure on her to say things, you can take it slowly by slowly, you mustn't be short-tempered so that you can understand what is she going through. And then they talk too much and then mostly when they see other people passing they think as if this people they know what happened to her, so she feel very scared and most of the time you will see that even when she's lying on the bed in the hospital she don't face where people are walking, she face where there's no one walking on that side, and she also put the blanket on top of the head so that no one can see her, because her

	mind told her that maybe everyone knows about her situation. There's some other things you don't want some other people to know, so...
R	So you even sense the way they feel that they are sometimes ashamed...
	Even their actions they will tell you that something is wrong because sometimes they came and then you will find that she's not free to tell you what the exact story, what exactly happened. So she's trying to tell you this and that, this and that, but at the end of the story when you tell those things that she told you, when you combine then you can see, no, this is not the real thing that this people came, there's something wrong with this thing because when you take that together they don't connect, the story doesn't connect so that you notice, no, something is wrong. And then that's where you have to sit down by yourself and think, that to get a clear story from that woman what must I do? That's where you have to start sitting down and do your homework. That firstly I have to try by all means to get the whole story from that woman, so that she can be open and tell the story. Because it's the first time that you see each other. She doesn't trust you to tell the whole thing, she thought after maybe telling you, you will tell everyone.
R	You first have to gain her trust?
	Ya you first have to gain her trust and make her feel at home ...
R	Before she will be able to talk to you?
	Exactly mmm...
R	And when they have talked?
	Ah mostly after I have heard the story, I just go to those people, the spiritual counselors. Because after that patient told me about the story it affects me a lot and then its not going to affect me alone it will also affects my family because they are not going to get my full attention I used to give them because I will be sad most of the time and my kids expect me to be with them, my husband expect me to chat with him and whatever we used to do he expect that thing to continue even on my kids. But with these things that is happening at work and it affects me a lot, so it doesn't affect me alone at work, also at home. It affects me, so when I see things like that sometimes if I feel that its heavy for me, that's where I used to see the spiritual counselors and then after that back to normal.
R	So you used the resource, you can talk to the spiritual counselors?
	Ya, also at times I go to my pastor, and then he also relief me because after talking to someone it also relief me because even that patient he didn't say anything to anyone but immediately when you tell the second person it feel much relieved than this thing you were holding it by yourself as soon as you talk to someone and give you the advice you feel a little bit much better than before so even myself when I see things like that so keeping it to myself it will cause me a lot of harm, for me and my family and those who knows me my friends so for me to try to be better I have to talk to someone. And then when I talk to someone that person will give me a lot of advice a lot of things that I can do so that my spirit can be lifted up again so even then the next patient who can come with the very same thing I will feel the courage to do that.
R	You need to do something that enables you to do help the next person?
	If I wouldn't dealt with that emotion I don't know what will happen because it will keep on piling on me so maybe at this moment many mistakes will happen in the unit because I am stressfull. Sometimes you will find that when coming to give the patients medication I will make a mix-up, I am taking the wrong things because that thing is on my mind and it is on my emotion so I won't be able to function properly in my work. There will be lot of mistakes happening.
R	You realized that?
	I have realized if you have a problem cough it out to the next person that you trust and he will give you some advice and even God will help you then everything will be fine. Because I think for us to be here is because of the purpose from God. He knows that there will be some other people outside who need our help so He will give us the strength almost every day so that we can help those people because they are not able to help themselves. So we are here to help them, so I think we will be successful with all the women as time goes on.
R	You see your work as helping other people?
	I need to be there for them because they can't come here if they don't want my help – they are really desperate need my help and I have to help them. That's my main reason to be here I have to help those who can't help themselves and I have to help them in totality in everything that I could help them.
R	How do you see it to help a person in totality?
	You know mostly the patients that I have helped that has been abused by a partner – you know I feel glad, even that patient came into Casualty, I have nursed her and then when the time goes on they have admitted the patient to the ward. I do the follow-ups – during my tea-time or my lunchtime, I go straight to the ward. I am willing to find out how is she doing and you know when she's fine now at the end of the day, I can see that that poor woman she's fine now. It makes me to feel fine twice than her, because I can see that at least what I have done it did make a change on her. Ya mostly when I did see something like that and the patient being admitted, I go to the ward. I go to the ward, not even for those patients who are abused, those that I have nursed and they have affected me deeply emotionally. When they have admitted them I go to the ward and try to find out what's going on. When I go the ward and find out that patient is awake and smiling it makes a lot of difference for me. I feel more happy, I can see that at least what I have done, that lady has survived some of the things that's she's going

	through.
R	It really helps to do that follow-up
	If I see what I have done on the patient make a difference to her then it makes me more happy and relieved. Then my stress level is gone.
R	It helps to see the results?
	And the results – they make me more happy than talking to someone else when I am still on that situation.
R	That really counts a lot?
	Yes it counts a lot, it erased that sadness that was on me or with that patient. When I see that she's improving and she's fine she can communicate and the stress level is a little bit lower then I am the happiest person.
R	And the one that go home that you can't see the results?
	Usually when they came in I just took their tel numbers but I ask them first: "Is it fine if I take your tel number? So that if I don't see you that I can contact you and try to find out how is life going on?"
R	So you even contact them?
	Yes most of the time I used to contact them especially those who stays in casualty and they have been discharged home because I didn't spend enough time that I wanted to spend with them so I used to take some contacts and try to find out how is the process, what's going on but if the patient is in the ward then I go straight to the ward.
R	So you have a need to follow-up?
	Exactly, because it's very sad. Just imagine abusing someone who's powerless who doesn't do anything, if it is a beating up you keep on beating her up and she's also begging you to stop, I mean eish it's so painful, it's so sad.
R	You think about what the woman went through when she was abused?
	Yes especially when you see the bruises the injuries, sometimes she's got a fracture of the arm and then you see that I just visualize that moment when the man was beating her up and begging him to stop and it's you know, it's very sad....
R	It hurts when you think about it....
	And you think maybe it wasn't the first time, it wasn't the second or third time, it's a thing that is happening almost every time.
R	It is disturbing to think that the woman is exposed to that over and over?
	You know the thing that affects me mostly is when the woman came abused being beaten almost every day and that poor lady is bleeding inside and the husband or the boyfriend doesn't know and you'll find that at the end of the day when the patient came in here she dies, she dies, you know that one it affects me very badly. I can even take a week or two weeks not being myself when I think of that poor lady.
R	You have seen some of them who haven't survived the abuse?
P	That one has affected me very, very badly
R	The effect on you?
	It stays with me for sometimes, even the situation at home it changes, it changes but my daughter the small one sometimes she makes to forget for a moment because she's 2 years now, so we just play and for that moment I am just forgetting about what I was thinking of. I just play, do things like that but when she started to fall asleep that's when the things started and then I go to my pastor and she prays with me like that and then it goes away little by little but not at the same time, little by little but at the end I just told myself let me accept what has happened, it just happened, let me accept it. And then at the end I accept it but it's difficult to accept it. At the end I just told myself I have got a family I have to look after, I have got a job and I have patients that want my help, let me accept that it happened. And then what is left is just to pray to God to let it not happen again so that's how I cope even though it's difficult, but I have to do that. Sometimes it's very hard to accept – you are in denial of what happened but in the end you have to accept. It's done, she's gone, she's gone she can't come back even though she's gone in a terrible way but what happened, happened. I have to accept it for the sake of the other patients in the hospital and for my family. Let me accept it. I can't walk around with it forever.
R	So there's sometimes that denial, as if you cannot believe it and you slowly come to terms with it. Anything else you can think of?
	You know when coming to this relationship violence, I know it's not simple and that's what we are willing, and that's what the media and television used to say. If you are in an abusive relationship, don't keep quiet, but it's not easy, don't keep quiet, seek for help so that this thing can at least the person teach God down. Because this partner especially the males they are enjoying what they are doing to their ladies and their wives and it's wrong. We are not suppose to do that so what I can say I can say I wish it could be that way so that each and every women that's in a abusive relationship, she can be open. She mustn't fear because it's her life that's in that. She mustn't fear, she must talk. I think if you have got friend or you have family, one of your family members or one of your friends, you can see that you can have five friends but you can see that on top of five there's someone that you can share some problems with her. Even in the family, if you are afraid of your mother or your father, your auntie or whoever, you can say something of your life to her and that person she could help you. So I think keeping quiet doesn't solve that, it doesn't solve anything, even though it's not easy, it's not easy but I think

	they should try to do something that can save their lives.
R	It is like a message you want to give...
	It's a message I want to give to those women – they mustn't suffer in silence – they must say something, even though they are afraid of their partners that if I talk I will make the matters worse. On the other hand you are helping yourself and you are also helping other women who are on the same situation as yours,
R	If you say no, others might also start to say no...
	Even nowadays there is a lot of organizations that are supporting this thing. If you suffer in silence that's the main problem, but if you are coughing out the problems that you have got you gonna get a lot of support. I mean around South Africa and around the world you can get a lot of support. So you mustn't stuck in a relationship like that because at the end of the day you will be dead. One day that your partner is going to beat you up to death.
R	It has a fatal outcome...
	And there some other women that they think that beating up by a husband or a boyfriend is a sign of that boyfriend or husband loves you, of which is not. If you love someone you don't want anything that can make her hurtful or sad. You are trained to take care of that person so you can't beat your wife and say that you love her It doesn't work like that. Even your girlfriend, you can't beat her up and say that you love her. That it is not love. And at the end of the day its you whose going to be in a lot of trouble. And at the end of the day you can end up dead because you don't know the harm that he's causing on you when he's beating you up You are looking at your skin outside but you don't know what is going on inside. And it is very bad when something is wrong inside because we can't see it we can't see how the damage is inside. By the time you are trying to find out it's too late. And you have got children whose going to take care of the children while you are not there. The father can't take care of the children because he didn't take care of you, while you are still alive, so when you are gone who is going to take care of your kids. So it's already a problem again on the kids. The kids suffer because the mother did suffer in silence and end up dead.
R	So you should also think of the family?
	And some other kids they will think that whatever especially the boys think that whatever my father is doing to my mom is the right thing. Then he will grow doing the same thing that the father is doing of which is wrong. The kids are also looking what is going on especially the boy, he will grow up beating everyone and if his got a girlfriend he will do the same thing that his father was doing because he thought it's the right thing. Because when we are parents we are the role models of our kids. So when you do things like that your kids will think this is the right thing to do and he will grow up doing that. And that's how the percentage is going up and up.
R	We don't stop the cycle.
	It's going on and its going on very fast. Because its one father with kids maybe three, two boys and one girl so you can see that those two boys they are representing one. They will do the same thing that their father was doing. They are two and their father is one, so you can see that two represented one. So it's going up fast the rate, the percentage of the violence of women.
R	Women need to talk, say no...
	Even though they are afraid but that's the best thing they can do especially these nowadays there is a lot of help for them. The help is all over helping for them. So they must break the chain of silence and get help.

Emotional and cognitive impact – witnessing -The impact of being a witness to the effects of IPV

To see the terrible injuries Bruises, fracture of the arm "And you think, maybe it wasn't the first time....." Terrible to look at it... She explains about a patient that was being beaten almost every day and died in the unit because of internal bleeding which have been inflicted by a partner that is suppose to love the woman, She also imagines/ visualises the abuse, the women being beaten while she pleads the partner to stop – the powerlessness of the woman, also listening to the "story", affect her emotionally "a lot" "I feel that it is heavy for me..." it is so painful..."– she feels sad, very sad, she used to cry, even when she gets home and is not as talkative and laughing as usual. She also feels anger towards the perpetrator. She remembers some of these things, when at home, for weeks..... When she is alone, the image of what she saw comes back and it affects her deeply.

Cognitive impact

It's not easy. The moment you are alone it comes back again.

mm and even at home, when I arrive at home and this things I used to remember it especially for that day when I worked with that patient, even when I am at home, I can still remember I got that patient

And you think maybe it wasn't the first time, it wasn't the second or third time, it's a thing that is happening almost every time.

Identification

The emergency nurse claims that being a woman, things can change and IPV can happen to her. She can see herself in the survivor's position – one day looking like that. She asks the questions: "... why is it happening to us women, what went wrong..." She thinks about her daughters and the partners they will get one day... she fears for them, it is painful, stressing, depressing.

why is it happening to us women, what went wrong and it also affects me a lot because I have got two children and they are daughters, one day they will be women and then they will have partners, that's what I am thinking about it, what kind of partners will they get when they grow up,

Perceptions

"It is just that they are powerless to their partners, that's why it is happening"

"If you are in an abusive relationship, don't keep quiet..... seek for help"

"...keeping quiet doesn't solve it....

"...they mustn't suffer in silence...

"...you are helping yourself and you are also helping other women

"Because this partner esp the males, they are enjoying what they are doing.....

"One day your partner is going to beat you up to death.....

And there some other women that they think that beating up by a husband or a boyfriend is a sign of that boyfriend or husband loves you, of which is not. If you love someone you don't want anything that can make her hurtful or sad.

And some other kids they will think that whatever especially the boys think that whatever my father is doing to my mom is the right thing. Then he will grow doing the same thing that the father is doing of which is wrong. The kids are also looking what is going on especially the boy, he will grow up beating everyone and if his got a girlfriend he will do the same thing that his father was doing because he thought it's the right thing. Because when we are parents we are the role models of our kids. So when you do things like that your kids will think this is the right thing to do and he will grow up doing that. And that's how the percentage is going up and up. Etc...

Provision of care

The emergency nurse believes she is there to help the survivors of IPV "...they can't come here if they don't want my help – they are really desperate..." She is there to help the ones who can't help themselves. Care for them in totality.

She has empathy with the survivor and try to give the best care, to give her the support that she needs. She "stands for that woman"

Communicate with the person, assure her, offer to arrange referral to the counselor. Communicate openly, listen to her, listen to her feelings, how does she want to be treated? relay the anxiety. Show sympathy. Communicate understanding, Make her feel at home, to feel free to talk, to trust you. Don't pressure. The more open you are, the more likely the woman will start talking and she can get help. "...to get a clear story from that woman, what must I do?..."

Ask the unit manager to refer the survivor to the pastoral counsellors

Provide the advice regarding the support groups and crisis lines.

She even follow them up in the wards during her teatime when they have been admitted to see how they are doing, and call them at home after discharge if they have given their tel numbers.

Coping mechanisms

She has to deal with it and get some positive results

Before she nurses the woman she prays to God to give her the power and strength to provide the care. Even God will help, as she believes she is there for the purpose of God who will give her the strength to help the people who are not able to help themselves. She wipes her tears and continues to take care of the person and see what difference she has made. Also in serious cases "...pray to God to let it not happen again so that's how I cope..."

Chatting to colleagues, playing with her children

Cry at home

Support from husband at home.

**ADDENDUM H: DELPHI - LETTERS TO EXPERT MEMBERS OF
PANEL**

ADDENDUM H (1)

LETTER TO EXPERT MEMBER OF THE DELPHI PANEL – ROUND 1

Dear Expert participant

INVITATION TO PARTICIPATE IN THE VALIDATION OF GUIDELINES FOR EMERGENCY NURSES TO ACTUALISE EMANCIPATORY KNOWING WITH REGARDS TO TAKING CARE OF SURVIVORS OF INTIMATE PARTNER VIOLENCE

I am a PhD student in the Department of Nursing Science, Faculty of Health Sciences at the University of Pretoria. I am conducting a study on "Emancipating emergency nurses towards providing care to survivors of intimate partner violence" under the supervision of Professor Neltjie van Wyk and Dr Elsie Janse van Rensburg.

The objectives of the study are to:

- Explore and describe emergency nurses' experiences of taking care of survivors of IPV; and
- Develop guidelines for emergency nurse to actualise emancipatory knowing with regards to taking care of survivors of IPV.

In phase I of the study a descriptive phenomenological approach was used to explore and describe emergency nurses' experiences of taking care of survivors of IPV. Data were collected through in-depth interviews with emergency nurses providing care to survivors of IPV in emergency units in a Level 1 (District) and a Level 3 (Academic) public hospital in an urban area in Gauteng, South Africa.

The findings revealed that exposure to survivors' experiences with IPV have an emotional and cognitive impact on emergency nurses who attempt to cope with and make meaning out of these experiences. Emergency nurses' personal exposure to IPV, or to friends', family and/ or community members' experiences with IPV leave a memory which interrelates with experiences with IPV in the professional domain. Identification with the survivor's experience reveals itself when certain elements in the survivor's experience interrelate with a similar situation that occurred, or has the potential to occur, in the emergency nurse's personal domain. Professional and personal domain experiences and the emergency nurse's attempts to cope with the exposure to survivors' experiences and make meaning out of IPV, give way to the formation of certain (gender) perceptions and assumptions regarding IPV and intimate relationships. These assumptions, as well as certain professional and caring qualities shape the frame of reference from which the emergency nurse provides care to survivors of IPV.

An extensive literature review was done on the essence and constituents that represented the emergency nurses' experiences.

In phase 2 of the study the researcher developed draft guidelines for emergency nurses to actualize emancipatory knowing with regards to taking care of survivors of IPV. The guidelines were developed within the framework of emancipatory knowing in nursing as described by Chinn and Kramer (2011, pp. 63-84) and provide the framework for emergency nurses to: (1) define and clarify how the provision of care to survivors of IPV and their own experiences of male oppression put emergency nurses' in a disadvantaged position; and (2) open ways to challenge this position and take corrective action (Chinn & Kramer 2011 p. 66-7).

The draft guidelines were developed within the dimensions of emancipatory knowledge development which is characterized by processes located within five dimensions namely:

- critical questions that initiate and generate knowing and knowledge;
- creative processes that initiate and generate knowing and knowledge;
- formal practice expressions of knowledge and knowing;
- integrated practice expressions of knowledge and knowing; and
- authentication processes used to examine and improve knowledge (Chinn & Kramer 2011 p. 3).

You are invited to participate in the validation of the guidelines. The Delphi technique has been chosen as the preferred method for the validation process. Ten national and international experts in the field of emergency nursing and/or gender-based violence are expected to participate in the process. It is expected that not more than three rounds of the Delphi will be sufficient to obtain consensus on the content of the guidelines.

There are nine guidelines with actions for emergency nurses to actualise emancipatory knowing with regards to taking care of survivors of IPV. Please read through the each guideline and action and complete the rating scale in accordance with the criteria which include: validity, reliability, flexibility, clarity and applicability of the guideline. If applicable please provide suggestions for re-formulation of the guideline in the space for comments provided at the end of each section. Please complete the biographical information in the first section of the instrument by providing descriptive information on your professional and academic experience. This will enable the researcher to describe the sample. No names or identities will be mentioned in the research report or publications. The validation process should take approximately 1 hour to complete.

Your participation and comments will be highly appreciated. Comments received will be collated and analysed for further validation in round two. Attached is a consent form that should be returned with the comments should you agree to participate in the study. For any clarification that may be required please contact me or my supervisor on the following:

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ADDENDUM H (2)
LETTER TO EXPERT MEMBER OF THE DELPHI PANEL – ROUND TWO

Dear Expert participant

**VALIDATION OF GUIDELINES TO FACILITATE THE ACTUALISATION OF
EMANCIPATORY KNOWING IN EMERGENCY NURSES WITH REGARDS TO
TAKING CARE OF SURVIVORS OF INTIMATE PARTNER VIOLENCE**

Thank you for the first round of feedback received with regard to the study on “Emancipating emergency nurses towards providing care to survivors of intimate partner violence” under the supervision of Professor Neltjie van Wyk and Dr Elsie Janse van Rensburg.

The guidelines were revised in accordance with the feedback received after the first Delphi round. Realising that emergency nurses would require skilled facilitation to actualise emancipatory knowing, the guidelines now include a pre-ambule that indicates the importance of a skilled facilitator that will work *with* emergency nurses during the emancipatory process. The criteria were also revised according to the recommendations received (see changes in red font). Please read through the each guideline and action and complete the rating scale in accordance with the criteria which include: validity, reliability, flexibility, clarity and applicability of the guideline. If applicable please provide suggestions for re-formulation of the guideline in the space for comments provided at the end of each section. No names or identities will be mentioned in the research report or publications. The validation process should take approximately 1 hour to complete.

Your participation and comments will be highly appreciated. Comments received will be collated and analysed in order to finalise the guidelines. For any clarification that may be required please contact me or my supervisor on the following:

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ADDENDUM I: DELPHI INSTRUMENT

ADDENDUM I (2) Delphi instrument Round 1 - Rating scale: Guideline 1

DELPHI ROUND 1																												
Please read through the guideline and actions and complete the rating scale in accordance with the criteria as described.																												
EN = emergency nurse		Criteria																										
Rating scale guide: 1 = Strongly agree 2 = Agree 3 = Disagree 4 = Strongly disagree		Validity: Guideline will facilitate emancipatory knowing = ENs reflect on <i>unjust/unfair</i> processes embedded in taking care of survivors of IPV and initiate changes to correct these				Reliability: Given the same circumstances ENs would interpret and apply guideline similarly				Applicability: Target population is clearly stated				Clarity: Guideline is precise, unambiguous, user-friendly and logic				Flexibility: Guideline will empower ENs to consistently reflect on the practice of taking care of survivors of IPV, implement changes as applicable and re-evaluate.										
Guideline 1		1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4							
Emergency nurses question the barriers to provision of care to survivors of IPV in relation to external barriers to care, and factors pertaining to disclosure from the survivor's and the emergency nurse's perspective (internal barriers), in order to bring these into awareness.																												
Actions: Emergency nurses:																												
1. Acknowledge the fact that IPV is a public health problem with devastating consequences for women in terms of physical and psychological health and social functioning;																												
2. Acknowledge that survivors of IPV often report to the emergency department with overt or covert signs of IPV;																												
3. Recognize their responsibility to detect IPV and intervene in order to prevent morbidity and mortality;																												
4. Ask critical questions in order to expose the injustices inherent to the care provided to survivors of IPV; - What external (social, organizational, environmental, professional) barriers exist that prevent fair, equal and optimal management of all survivors of IPV? - What internal barriers exist in survivors that put some of them at disadvantage to disclose IPV and seek help? - What internal barriers exist in emergency nurses that could impede survivor disclosure and optimal management?																												
5. Display sensitivity and provide support towards each other in terms of the dilemmas, discomfort and resistance critical questions might trigger;																												
6. Acknowledge cultural and social constructs and conditions that impede fair and equal treatment and limit choices.																												
Comments/ Suggestions																												

ADDENDUM I (3) Delphi instrument Round 2 – Pre-amble

Emergency nurses have attempted to cope with and make meaning of the phenomenon of taking care of survivors of intimate partner violence (IPV) in an individual way. The experience has remained largely invisible. Guidelines were developed to facilitate the actualisation of emancipatory knowing in emergency nurses with regard to taking care of survivors of IPV. Through utilising the guidelines an emancipatory process can be facilitated for emergency nurses to: (1) ask the critical questions to initiate the emancipatory process; (2) define and clarify how IPV-related experiences in emergency nurses' professional domain that inter-relate with experiences in their personal domain can put emergency nurses in a disadvantaged position; and (3) open ways to challenge this position and take corrective action. As more emergency nurses become aware of their disadvantaged position, actions, insights and knowledge about what is needed to change processes, patterns and structures for the better can be developed.

Emancipatory knowing requires a critical examination to uncover the reason for injustices remaining invisible and the ability to identify social and structural changes that can correct these. In the context of this study emancipatory knowing is seen to be actualised through a facilitative process uncovering the emotional and cognitive effects of providing care to survivors of IPV and the reasons why these effects and emergency nurses' vulnerabilities and "woundedness" remain largely invisible. Nursing praxis is seen as nursing practice where emergency nurses engage in a process of addressing the injustices and oppression uncovered in the provision of care to survivors of IPV.

In the context of the study the process to actualise emancipatory knowing is seen as a facilitative process. A facilitator skilled in emancipatory processes and group dynamics will engage in a dialogue with emergency nurses, gain their trust and utilise the guidelines with them. The facilitator will act as a critical guide that will challenge emergency nurses' to reflect on their situation and acknowledge and utilise their sense of power from within to make independent choices with regard to taking care of survivors of IPV.

ADDENDUM I (4) Delphi instrument Round 2 – Rating scale: Guideline 1

DELPHI ROUND 2																					
Please read through the guideline and actions and complete the rating scale in accordance with the criteria as described.																					
EN = emergency nurse		Criteria																			
Rating scale guide: 1 = Strongly agree 2 = Agree 3 = Disagree 4 = Strongly disagree		Validity: Guideline will facilitate emancipatory knowing = Through skilled facilitation ENs reflect on unjust/ unfair processes embedded in taking care of survivors of IPV and initiate changes to correct these				Reliability: Given the same circumstances ENs and a skilled facilitator would interpret and apply the guideline similarly				Applicability: Target population is clearly stated: Emergency nurses caring for survivors of IPV				Clarity: Guideline is precise, unambiguous, user friendly and logic				Flexibility: Guideline will empower ENs to consistently reflect on the practice of caring for survivors of IPV, implement changes as applicable and re-evaluate.			
Guideline 1		1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Emergency nurses question the internal and external barriers to provision of care to survivors of IPV in order to bring these into awareness. Internal barriers to care relate to the survivor and the emergency nurse and external barriers refer to barriers in the physical and social environment.																					
Actions: Emergency nurses:																					
1. Acknowledge the fact that IPV is a public health problem with devastating consequences for women in terms of physical and psychological health and social functioning:																					
2. Acknowledge that survivors of IPV often report to the emergency department with overt or covert signs of IPV:																					
3. Recognize their responsibility to detect IPV and intervene in order to prevent morbidity and mortality:																					
4. Ask critical questions in order to expose the injustices inherent to the care provided to survivors of IPV; What external (social, organizational, environmental, professional) barriers exist that prevent fair, equal and optimal management of all survivors of IPV? What internal barriers exist in survivors that put some of them at disadvantage to disclose IPV and seek help? What internal barriers exist in emergency nurses that could impede survivor disclosure and optimal management?																					
5. Display sensitivity and provide support towards each other in terms of the dilemmas, discomfort and resistance critical questions might trigger:																					
6. Acknowledge cultural and social constructs and conditions that impede fair and equal treatment and limit choices.																					
Comments/ Suggestions																					