

**Intimate Partner Violence among women in Sweden-  
a clinical study of experience, occurrence, severity of  
violence and the care given**

Darcia Pratt-Eriksson

Institute of Health and Care Sciences  
Sahlgrenska Academy at the University of Gothenburg



UNIVERSITY OF GOTHENBURG

Intimate Partner Violence among women in Sweden- a clinical studie  
of experience, occurrence, severity of violence and the care given  
© Darcia Pratt-Eriksson 2016  
darciapratt@gmail.com

ISBN 978-91-628- 9781-2  
ISBN 978-91-628-9781-9  
<http://hdl.handel.net/2077/43457>

Printed in Gothenburg, Sweden 2016  
Printer's name

*“For every woman and girl violently attacked, we reduce our humanity. For every woman forced into unprotected sex because men demand this, we destroy dignity and pride. Every woman who has to sell her life for sex we condemn to a lifetime in prison. For every moment we remain silent, we conspire against our women.”*

Nelson Rolihlahla Mandela, at a 46664 Concert, Fancourt,  
George, South Africa, (19 March 2005)

# PREFACE

Over the years I have worked with and provided care for trauma patients in emergency healthcare. During the course of these encounters, I have shared the experiences of a great many women who have encountered violence, many at the hands of their current or ex-partner within the confines of an abusive relationship.

As my curiosity and frustration grew, I questioned why so many abused women were being forced to seek emergency healthcare in a country so renowned for its extensive gender-equality legislation. This research began in 2004 but was put on hold when I fell critically ill. However, much to my dismay it is apparent that, in the intervening years of my recovery, very little has changed with regard to the care offered to abuse women. It is clear to me that there is a pressing need to relate the stories of these women and the journeys they have undertaken. Their silent voices must be heard. These stories have been told many times before but they often fail to focus on the care given and the risks inherent in this abuse.

It is with gratitude that I take this opportunity to share these women's stories, in the hope that this will bring into focus the care currently provided and speed the necessary changes.

# ABSTRACT

Each year a significant number of women are killed or seriously injured as a result of Intimate Partner Violence (IPV). Healthcare professionals have a vital role to play in identifying IPV in their day-to-day encounters with women seeking treatment and care in a variety of healthcare settings.

**Aims:** The overall aim of this thesis was to understand, identify, explore and evaluate women's experience of Intimate Partner Violence and their subsequent encounters during the course of emergency care.

**Methods:** Papers I and IV involve text interpretation. The texts in Paper I relating to the lived experience of 12 women were analysed using the phenomenological hermeneutic method. In Paper IV the case texts were analysed using qualitative content analysis. Papers II and III take an explorative and comparative approach with questionnaires being completed by 234 women (Paper II) and 82 women (Paper III) respectively, using descriptive statistical analysis in both studies.

**Results:** In Paper I the women expressed feelings of betrayal, of not being taken seriously. They felt neglected and invisible. Papers I and IV reveal that the women experienced re-traumatization, uncaring behaviour and unendurable suffering during their encounters with healthcare professionals, social workers and police. In Paper I it is apparent that in cases where a healthcare professional failed to ask about domestic abuse, the women felt no reason to raise the subject themselves. Paper IV reflects the gap in the care given to abused women in emergency healthcare. The study shows three main categories: management of the care given; unconnected care; and being dehumanized. They felt abandoned at a crossroads once discharged, without follow-up care and lacking continuity in the care provided. In Paper II, 54 (67%) women reported being forced to have sex. The study showed that n=18 (7%) women were force into sexual activity during the year prior to becoming pregnant. Thirteen (31%) women reported that they were afraid of their partner. In Paper III, the data showed an increase in the severity and frequency of violence. Significant numbers of women were at risk of being killed. The women disclosed that when their abuser used narcotics and or illegal substance the risk of being violently and severely abuse increased. Several women disclose that a weapon such as a knife or gun was used to harm them.

**Conclusions:** Educating healthcare professionals, police, social-workers and other authorities and the use of questionnaires may facilitate the identification of abuse women and prevent under-diagnosis and the risk of re-hospitalization. Promoting the integration of behavioural and emergency healthcare is important. By acknowledging, evaluating, assessing and documenting the care of female IPV victims, it is possible to give abused women a voice, to empower them to recover and to facilitate and improve their transfer to outpatient care.

**Keywords:** emergency care, intimate partner violence, experience, caring, lethal violence, trauma-informed care

# SAMMANFATTNING PÅ SVENSKA

## Introduktion

Skador hos kvinnor orsakades av fysiskt våld av exempelvis män är ett omfattande men ofta ”dolt” samhällsproblem som påverkar fler än de drabbade kvinnorna och hennes familj. Hälso- och sjukvårdspersonal konfronteras med misshandlade kvinnor framför allt på akutmottagningar, traumaenheter och andra akutvårdenheter men även rehabiliteringsavdelningar och andra typer av öppenvårdsenheter. Offret är oftast i dessa situationer under stor press och har i många fall upplevt dödshot. I många fall identifieras inte skadade kvinnor då de söker eller inkommer på akutmottagningar. De långsiktiga effekterna av våldet och skadorna för kvinnorna och kvarstående konsekvenser av våldet är okänt. Inte heller hur sjukvårdspersonal upplever och påverkas av att möta, vårda och behandla misshandlade och våldsutsatta kvinnor är tillräckligt studerat.

## Syfte

Denna avhandling syftar till att undersöka och beskriva levda erfarenheten, frekvens och svårighetsgrad av våld i parrelationer som upplevs av kvinnor som söker akutvård. De specifika målen var att:

Delstudie I: Få en djupare förståelse för kvinnors levda erfarenhet av partnervåld och deras möten med sjukvårdspersonal, social arbetare och polisen i samband med våldet.

Delstudie II: Identifiera och undersöka förekomsten av rapporterat och upplevt partnervåld pågående eller tidigare i live bland kvinnor som söker akutmottagning med hjälp av ett frågeformulär.

Delstudie III: Identifiera, undersöka och beskriva riskfaktorer kopplade till partnervåld bland kvinnor som söker vård på en akutmottagning med hjälp av ett frågeformulär.

Delstudie IV: Utvärdera dokumentation i patientjournaler när kvinnor sökt vård för våld i parrelationer vid en akutmottagning och beskriva hur vården bedrivits och mötet med sjukvårdspersonal.

## Metod

I denna avhandling har kvantitativ och kvalitativ metod används. I Studie I har data från intervjuer med 12 kvinnors upplevelser om partnervåld tolkats och analyserats med hjälp av en hermeneutisk- fenomenologisk metod. Studie II är en explorativ och jämförande studie. I denna studie användes frågeformuläret/instrumentet Abuse Assessment Screen (AAS) som utvecklades av Campbell (2004). AAS har använts i flera internationella studier. I den här studien användes ett modifierat frågeformulär anpassat till svenska förhållanden bestående av fem frågor. Av de 300 inbjudna kvinnor som sökte vård på en akutmottagning i en liten stad, besvarade 234 frågeformuläret. Studie III är en explorativ och deskriptiv studie. I denna studie användes frågeformuläret ”Danger Assessment Scale”, en modifierad version med 25 ja/nej frågor (originalet hade 20 frågor) för att undersöka de 82 kvinnor som identifierades vara misshandlade genom att de besvarat AAS. Studie IV är en deskriptiv och explorativ studie. I denna studie

används kvalitativ innehålls analys för att analysera texterna i tio patientjournaler.

## **Etiska aspekter**

Studien utfördes enligt de forskningsetiska riktlinjerna (World Medical Association Helsinki Declaration 2015). Studierna godkändes från Göteborg Universitets etiska prövningsnämnd för delstudie I-III, DNR (009-6) och för studie IV erhöles tillstånd från Karolinska Universitetssjukhuset då denna ej ansågs falla inom Etikprövningslagen. Personliga uppgifter om kvinnorna i studien d.v.s. alla namn, person nummer, adress och telefon nummer hade tagits bort innan journalerna studerades.

## **Resultat**

Studie I och Studie IV visar att kvinnorna upplevde sig svikna av dem som skulle hjälpa dem. Det var brist på professionella bemötande från hälso- och sjukvårdspersonalen, socialen, polisen och andra myndigheter (Studie I). Detta bekräftas till stora delar av fynden från studie IV. Det framkom att enbart kvinnornas fysiska skador behandlades och ofta blev de rekommenderade att söka hjälp någon annanstans eller blev avvisade. Kvinnorna återkom flera gånger till akutmottagningen med liknande skador, flera kom till akutmottagningen efter självmordsförsök.

I studie II användes AAS, som frågeformulär. Totalt inbjödes 300 kvinnor att delta i studien genom att besvara två frågeformulär AAS och DAS. Av de 234 som svarade på frågeformulären angav 82 kvinnor att de utsatts för våld. Medelåldern på kvinnorna var 43 år. Av dessa kvinnor angav 27 (33 %) att de var förtidspensionerade eller var pensionerade. Totalt 81 barn bodde hos sina mammor som utsattes för våld. Av de 187 kvinnorna som besvarade frågan uppgav, 54 (67 %) uppgav att de tvingats till sex och nitton av kvinnorna rapporterade att de tvingas flera gånger. Studien visade att våldet minskade vid graviditet i jämförelse med året innan och upp till graviditet.

I studie III användes resultat från de besvarade frågorna i DAS. Av de tidigare identifierade misshandlade kvinnor (n=82 kvinnor), angav 23 (28%) att de blivit hotade att bli dödade av partnern och nio (11%) angav att partnern hotat att skada barnen. Två kvinnor uppgav att partnern varit/är våldsam mot barnen. Sexton kvinnor (19.5%) angav att mannen använde någon form av vapen för att skada dem och i fyra fall användes ett handeldvapen. Arton kvinnor (22 %) var övertygande om att deras partner var kapabel att döda dem, de var extremt svartsjuka (37.8%) och kontrollerade deras aktiviteter (36.6%) och spionerade (35.4%) på dem. Signifikanta skillnader fanns mellan uppgifter om förövaren var arbetslös eller inte, och om de av kvinnorna ansågs som kapabla att döda. Av de 14 kvinnor som angav att partnern var arbetslös uppgav 8 (57 %) kvinnor att

partnern var kapabel att döda jämfört med de 17 % kvinnor som uppgav att partnern var anställd eller hade ett arbete ( $p < 0.004$ ). Signifikanta skillnader fanns också mellan de kvinnor som rapporterade att partnern hotat att skada barnen och partnerns bruk av narkotika och illegala droger. De kvinnor som uppgav att mannen inte använde sådana droger (66 respektive 16 %,  $p < 0.045$ ). Odds för att hotas till döds när förövaren använder narkotika och illegala droger är ungefär 13 gånger större.

De tio kvinnor som ingick i studie IV var i åldrarna 24 till 58 år med en medelålder på 38 år. Kvinnorna gjorde totalt 7 besök under en 5-årsperiod på akutmottagningen och var inlagda på sjukhuset, sammanlagt i genomsnitt 27 dagar (medel 9 dagar). Alla de tio kvinnorna hade blivit utsatta för våld med en traumatisk hjärnskada som följd. Granskning av journalerna visade bristande överföring till öppenvården och till andra vårdformer som kunde ha mött kvinnornas behov av vård och hjälp. Av de tio kvinnorna utsattes sju för partner våld och tre var från en okänd person. Flera berättade historier om hur de var avvisade vid flera tillfällen och uppmanats söka vård på annat håll trots att de var skadade och hade behov av vård och hjälp. Kvinnor som sökt hjälp för emotionell sjukdom eller beteendeproblem förbisågs. Ingen utredning gjordes om deras mentala och emotionella hälsa.

## **Konklusion**

Vården är ej lätt tillgänglig för kvinnor som utsatts för våld. Stora brister i vården förekommer bland annat då det gäller integrering och samarbete mellan akutsjukvården och psykiatri. Vården är segmenterad och brist på samordning mellan de olika inrättningarna avspeglas i de journalanteckningar som finns avseende vården av misshandlade kvinnor. En bättre kontinuitet i vården behövs samt ökat samarbete med andra myndigheter. Denna avhandling bidrar med kunskap om vård av misshandlade och våldskadade kvinnor i riskzonen för dödligt våld. Genom att synliggöra och uppmärksamma IPV kan samt identifiera tidigare och pågående våld och misshandel av kvinnor kan nya och fungerande åtgärder utvecklas som bidrar till att minska antalet våldsbrott men också bidra till att bättre och mer ändamålsenlig vård utvecklas som kan underlätta kvinnornas återhämtning efter att blivit misshandlade.



# LIST OF PAPERS

This thesis is based on the following studies, referred to in the text by their Roman numerals.

- I. Pratt-Eriksson, D., & Bergbom I., & Dahlborg Lyckhage., E. (2014). Don't ask don't tell: Battered women living in Sweden Encounter with healthcare personnel and their experience of the care given. *International Journal of Qualitative Studies on Health and Well-being*, 9: 23166- Doi: 10.3402/qhw.v9.23166. eCollection 2014 of Intimate Partner Violence among Women in Sweden Seeking
- II. Pratt-Eriksson, D., Dahlborg-Lyckhage, E., Lind, C., Sundberg, K., & Bergbom, I. (2015). Identifying Lifetime and Occurrence of Intimate Partner Violence among Women in Sweden Seeking emergency Care. *Open Journal of Nursing*, 5, 548-557. DOI: 10.4236/ojn.2015.56058
- III. Pratt-Eriksson, D., Dahlborg Lyckhage, E., & Bergbom, I. Risk factors with intimate partner violence among women seeking emergency care. (*Submitted*).
- IV. Pratt-Eriksson, D., Bergbom I & Dahlborg- Lyckhage E. A study of the documented care of abused women in emergency care (*Manuscript*).

# CONTENTS

<b>ABSTRACT</b>	5
<b>SAMMANFATTNING</b>	6
<b>LIST OF PAPERS</b>	9
<b>LIST OF ABBREVIATIONS</b>	12
<b>INTRODUCTION</b>	13
<b>BACKGROUND</b>	14
Defining violence	14
Severity of Intimate Partner Violence	16
Impact of IVP on health	17
Re-victimisation/re-traumatisation	18
Encounters with and care of patients	18
Emergency nursing	19
<b>THEORETICAL FRAMEWORK</b>	21
Theory of caring and uncaring	21
Suffering in care	21
<b>RATIONALE FOR THE STUDY</b>	23
<b>AIM OF THE THESIS</b>	24
Overall aims	24
Specific aims	24
<b>METHODS</b>	25
Research setting	25
Participants and procedure	26
Data Collection	28
Qualitative: Interview	28
Qualitative: Medical records	28
Quantitative: Questionnaire	29
Data analysis	29
Phenomenological hermeneutical	29
Content analysis	30
Quantitative data analysis	32
<b>ETHICAL CONSIDERATIONS</b>	33
<b>RESULTS</b>	34
Being betrayed, neglected and re-traumatized	34
Uncoordinated care	35

Occurrence of Intimate Partner Violence	36
Violence increasing in severity	37
<b>DISCUSSION</b>	39
Being betrayed, neglected and re-traumatized	39
Consequences of Intimate Partner Violence	39
Violence increasing in severity	40
Uncoordinated care	40
Methodological consideration	42
Phenomenological hermeneutical	42
Content analysis	42
Questionnaire	42
Validity and reliability	43
Credibility	43
Trustworthiness	43
Strengths and limitations	44
<b>CONCLUSIONS AND IMPLICATIONS</b>	45
<b>Future Research</b>	46
<b>ACKNOWLEDGEMENTS</b>	47
<b>REFERENCES</b>	48
<b>APPENDIX 1</b>	58
<b>APPENDIX 2</b>	59
<b>PAPER I-IV</b>	

## **LIST OF ABBREVIATIONS**

AAS	Abuse Assessment Screen
ANA	American Nurses Association
DAS	Danger Assessment Scale
A&E	Accident and Emergency Department
ICD	International Classification of Diseases
ICU	Intensive Care Unit
IPV	Intimate Partner Violence
SPSS	Statistical Package Social Sciences
USPSTF	U.S. Preventive Services Task Force
WHO	World Health Organisation
WMA	World Medical Association

# INTRODUCTION

This study focus on Intimate Partner Violence (IPV) among women seeking emergency treatment. The prevention of IPV is not easy and in many cases it is difficult to identify ongoing IPV or health problems related to previous IPV. Each year a significant number of men and women experience abuse in Sweden. According to Swedish National Council for Crime Prevention (2014), 85,000 men and women are abused each year. Therefore, identifying IPV at an early stage among women seeking emergency treatment is vital, something which has also been emphasized by Leppäkoski, Flinck, & Paavilainen (2010). Over the years, researchers have advocated the surveying of IPV in order to understand its extent, nature, risk and triggering factors (Butchart & Mikton 2014; John 2010). Despite this, women seeking treatment at Accident & Emergency departments (A&Es) are generally only treated for their injuries and then often sent home (Reisenhofer & Seibold 2013). Previous studies have shown that anything between 10-50% of women experiencing IPV were identified at A&Es (Bagcioglu, Vural, Karababa, Akşin & Sele 2014, John 2010 & Stenson 2004). It was estimated by the Swedish National Board of Health and Welfare (Eriksson & Engvall 2006) that men's violence against women in Sweden costs approximately SEK 3 billion per year.

An extremely limited amount of data is available with regard to violent injuries suffered by women in Sweden as a result of IPV. Violent injuries are problems encountered by health professionals and specialists in their day-to-day care of women. The Swedish Patient Safety Act (SFS 2010:659) emphasizes the importance of the healthcare system providing patients with adequate and good care. Individuals who survive a traumatic injury are usually faced with a long period of rehabilitation, often leading to stress for both the survivor and their family. There is also a great need for abused women to receive information, advice, legal protection, emergency refuge, permanent accommodation, financial support and safe arrangements for children (Covington 2008). Therefore, collaboration is needed between healthcare and social services, police and other governmental agencies to address the issues related to Intimate Partner Violence.

Nurses and other healthcare professionals working at trauma centres and A&E departments encounter victims of violent injuries on a day-to-day basis. Many of these victims are afraid and are forced to keep silent about their experiences of violence. Healthcare professionals need to be well-informed and understanding of the traumatic experiences suffered by abused women in healthcare. They also need to be trained to recognize the symptoms of trauma and clients should have a clear understanding of the rules and policies of the programme. Covington (2008) means that a calm and private environment and enhances the choices available to every woman will promote recovery. Gaps in or a lack of knowledge among healthcare professionals can have several consequences for the care provided, leading to less women seeking help and the risk of repeat victimization (John (2010) and Leppäkoski et al. (2010)). This thesis attempts to describe and

understand the care offered to women seeking emergency treatment as a result of IPV and addresses the women's experiences and the frequency and severity of the violence inflicted on them.

## **Background**

In this section, the thesis is structured as follows: The background provides an introduction to violence, Intimate Partner Violence, and the health issues arising from IVP by reporting/describing/discussing previous research findings and a theoretical framework.

As early as 1864 the husband's right to use corporal punishment against his wife was rescinded under Swedish law (Stenson 2004). According to the Act on Violence against Women (SFS 1999: 845, amendment to the Penal Code chapter 4 section 4a paragraph 1): *"A person who commits criminal acts as defined in Chapters 3, 4 or 6 against another person having, or have had, a close relationship to the perpetrator shall, if each of the acts formed a part of an element in a repeated violation of that person's integrity and suited to severely damage that person's self-confidence, be sentenced for gross violation of integrity to imprisonment for at least six months and at most six years. If the acts described in the first paragraph were committed by a man against a woman to whom he is, or has been, married or with whom he is, or has been cohabiting under circumstances comparable to marriage, he shall be sentenced for gross violation of a woman's integrity to the same punishment."*

In accordance with the Swedish Social Services Act (SFS 2001:453), the social welfare board is required to help and support women who are currently or have previously experienced violence and/or other forms of abuse in their homes to change the situation jointly by the court. The penalty for gross violation of a woman's integrity is imprisonment for a term of not less than six months and no more than six years according to the Swedish Penal Code (SFS1999). On 1 July 2013, the minimum penalty for these crimes and their area of application were broadened in order to further strengthen penal protection against repeated violations of persons in close relationships. (Swedish National Council for Crime Prevention, 2014).

Sabuni and Reinfeldt (2007) underline that certain groups of women are particularly at risk from violence, something that is supported by the United Nations Office on Drugs and Crime (UNDOC 2010) as well as the Swedish Government Official Report (SOU 2015:55) on a national strategy to prevent men's violence against women.

## **Defining of Violence**

IPV and other violence against women is an extensive problem affecting all societies globally, causing suffering and long lasting health problems for all

involved. Violence is mainly perpetrated by men, as can be seen in conjunction with sports, gang culture and different kinds of crimes (Dobash et al. 2007, Krug et al 2002) with violent behaviour appearing in many different contexts. The WHO's *Global status report on violence prevention 2014* (Butchart & Mikton 2014 & Krug et al, p. 2) defines violence as: "The intentional use of physical force or power, threatened or actual, against oneself, another person, or group or community that either results in or has high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation". WHO (Butchart & Mikton 2014) adds, there is no single explanation or factor why some individuals behave violently toward others or why violence is more prevalent in some communities than in others. Krug et al (2002), state that there are three types of violence: Self-directed (suicidal behaviour and self-abuse); interpersonal and collective (social political and economic).

According to the WHO (Butchart & Mikton 2014), Intimate Partner Violence encompasses violence committed by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, emotional abuse and controlling behaviours. Krug et al. (2002) pinpoints the importance of the ecological model which was first applied to child abuse in the 1970,s by Garbarino (1978), Bronfenbrenner (1979), adapted to youth violence abuse and by Heise (1998) in investigating violence. UNDOC (2010) elaborates on the importance of eliminating violence against women, which focus on preventing and stopping the violent behaviour of individual perpetrators, but also changing the attitudes, behaviours and practices which condone the violence at relationship, community and societal levels. In their research, the World Health Organization has used the ecological model to understand violence (Krug et al. 2002).



Figure 1: Ecological model for understanding violence according to the WHO (Krug et al, p. 9, 2002).

Krug et al (2002) emphasizes the importance of the model, which explores the relationship between individuals and contextual factors and considers violence as the product of multiple levels of influence on behaviour.

At this *individual level*, the ecological model seeks to identify the biological and personal history factors that an individual brings to his or her behaviour. In addition to biological and demographic factors, factors such as impulsivity, low educational attainment, substance abuse, and prior history of aggression and abuse are considered. There are no precise figures available as to the number of children who live in families where the mother is abused by their father or stepfather. A total of 100,000-200,000 children in Sweden experience violence in the family according to the Swedish Save the Children (2003). This level of the ecological model focuses on the characteristics of the individual that increase the likelihood of being a victim or a perpetrator of violence.

The *relationship level* of the ecological model explores how proximal social relationships such as relationships with peers, intimate partners and family members increase the risk for violent victimization and the perpetration of violence. In cases of partner violence and child abuse for instance, interacting on an almost daily basis or sharing a common domicile with an abuser may increase the opportunity for violent encounters. Because individuals are bound together in an ongoing relationship, it is likely in these cases that the victim will be repeatedly abused by the offender.

At the *community level*, Krug et al. (2002) contends that if the ecological model examines the community contexts in which social relationships are embedded – such as schools, workplaces and neighbourhoods – it is possible to identify the characteristics of those settings that are associated with becoming the victim or perpetrator of violence. John (2010) pinpoints the isolation and social neglect of women, as well as community tolerance of violence against them, as factors that disadvantage women. Research (John 2010, Krug al 2002 and Heise 1998) on violence shows that opportunities for violence are greater in some community contexts than others, for instance in areas of poverty or physical deterioration, or where there are few institutional supports.

The *societal level* of the ecological model investigates the larger societal factors in society such as norms, cultures, and environment. In the patriarchal society the male has dominance over the female. (Krug et al 2002). According to John (2010), male dominance becomes the acceptable norm in many institutions where the status-quo and other gendered regimes operate to place women at a disadvantage.

This model has shown that healthcare professions alone cannot prevent IPV. Instead, it requires the collaborative efforts of healthcare professionals, police, social workers and other government agencies.

## **Severity of Intimate Partner Violence**

In Sweden, at least a third of all women have experienced serious violence. According to the Swedish National Council for Crime Prevention (2014)



27,000 assaults against women were reported in 2013, which in their opinion represents approximately 20-25% of the actual crimes committed.

A number of issues have been raised regarding the difficulties faced by nurses confronting violent death, with a variety of emotional and physical reactions described due to exposure to these situations (Brysiewicz & Bhengu 2000) while Anderson (2004) states that ending violent relationships can be a difficult and lengthy process. Women use a variety of coping activities, with change generally proceeding in a non-linear direction. In their analysis, Eriksson and Envall (2006) assume that 16 women are killed every year and that yet another woman takes her own life as a result of being subjected to violence by a partner or ex-partner; while on average 4 men commit suicide every year in connection with killing their partner/ex-partner. Campbell et al. (2002) and the U.S. National Violent Death Reporting System (Centers for Disease Control and Prevention, 2006) state that femicide, the killing of women, is most commonly perpetrated by current or former husbands or boyfriends, while homicide is defined as the intentional killing of a person, including murder, manslaughter, euthanasia and infanticide. The Center for Disease Control (2006), estimates that between 40 and 60 percent of murders in North America are committed by intimate partners. Mortality associated with domestic violence includes suicide in women in non-industrialised as well as industrialised societies. For victims aged from 40 to 44 years of age, IPV was/is from their partner or ex-partner.

The Swedish Government has stated that it views IPV as a serious situation that all women exposed to violence must be given the support and protection based on their needs, whoever they may be and whatever background they may have (Sabuni & Reinfeldt 2007). Research (Birath, Bijer, de Marinis, af Klinteberg 2013, & Sabuni & Reinfeldt 2007) indicates women with substance dependence and addiction problems such as homeless women, are at increased risk of exposure to violence and other forms of abuse. It was estimated that women who abuse drugs and alcohol can become dependent on men and be exploited by them (UNDOC 2010 & Krug et al 2002). Sabuni and Reinfeldt (2007) means that woman may use alcohol to alleviate the anxiety she feels as a result of the violence and abuse to which she is exposed. Even older women, when exposed to violence, are more likely than other women to be in a vulnerable and dependency situation.

### **The impact of IVP on health**

Several research (de Boinville 2013, Dillon et al., 2013 Coker, Smith, et al., 2000) identified IPV to be associated with long-term health issues that may be more difficult for a healthcare professionals in A& E to identify as resulting from abuse. Exposure to violence is seen to be linked with central nervous system problems, including back pain, headaches, and seizures, as well as gastrointestinal problems). It has also been shown in several studies (Hess et al., 2012 & Stockman et al., 2012) that sexual abuse is associated with a higher risk of contracting sexually transmitted diseases, such as

HIV/AIDS, either through forced unprotected sex or through the increased likelihood of hazardous sexual behaviour. Research indicates that, IPV is a major risk factor for depression, deliberate self-harm, and suicide (Butchart & Mikton 2014, Van Dulmen et al., 2012, Jaquier et al., 2012; Pico-Alfonso et al., 2006). According to WHO (Butchart & Mikton 2014) there is also a correlation between IPV and alcohol and drug abuse.

## **Re-victimization and re-traumatization**

In 2004, Amnesty International reported on amendments to Swedish legislation meaning that “repeated violations of a woman’s integrity are to be considered jointly and will lead to a more stringent sentence than would be the case were each of the acts to be considered separately” (Amnesty 2004, p. 20). According to Bard and Sandgrey (1986) as quoted by the National Center for Victims of Crime (2008), “people have their own *normal* state of equilibrium which is influenced by everyday stressors such as illness, moving, changes in employment, and family issues. When any one of these changes occurs, equilibrium will be altered, but should eventually return to normal. When people experience common stressors and are then victimized, they are susceptible to more extreme crisis reactions”.

The National Center for Victims of Crime (2008) means that victims of trauma go through several changes following the abuse such as shock; numbness; denial; disbelief; anger and recovery. Covington (2008) highlights that a woman who has experienced a traumatic event also experiences increased vulnerability which may result in difficulty dealing with, expressing and/or modulating her emotions. Covington (2008), explains that traumatized women are at extreme risk of repeated victimization. “Re-traumatization refers to the psychological and/or physiological experience of being triggered. A single environment cue related to trauma “such as time of year, a smell or a sound can trigger a full fight or flight response. Triggers in the environment cannot be completely eliminated” (Covington 2008, p.384). William (2012) in Wikipedia (2014) indicates that secondary victimization or leads to re-victimization following on from the previous victimization. It was noted that negative behaviour such as victim blaming, inappropriate behaviour or bad language may further add to the victim's suffering (Campbell & Raja 1999).

## **Encounters with and care of patients**

Stenson (2004) suggested that the role of healthcare professional should be questioning about IPV and offering specialist care. However, Stenson (2004), Ashcroft, Hart and Daniels (2003) means that by asking healthcare professionals, nurses, police and social workers shows compassion and lower the risk of severe, possibly fatal, violence. Rudman (2000) recommends the documentation of IPV to analyse the effects of the abuse

and the women frame of mind. In 2013, the U.S. Preventive Services Task Force (USPSTF 2013) released a recommendation stating that healthcare professionals should question women of childbearing age for intimate partner violence (IPV) and facilitate or refer women who screen positive, and provide evidence-based practises. (Agency for Healthcare Research and Quality 2007). The American Medical Association (AMA), American Congress of Obstetrician Gynecologists (ACOG), and the American Nurses Association (ANA) recommends universal screening of all women (ACOG, 1995; AMA, 1992; ANA, 2000). Studies exist that patients do not mind being asked, (de Boinville 2013, John 2010, Freidman 1992, MaCauley 1998), barriers such as healthcare professional's fears of harming patients prevent them from questioning and there is still belief that abused women will voluntarily disclose the abuse. Adequate training and educational may remove these barriers (de Boinville 2013; Sprague et al, 2012). ASPE Policy Brief (2013), Gutmanis (2007) & Taft (2008) research shows that not all physicians and healthcare professionals remember to ask about IPV. Most blame lack of time, and lack of effective interventions. Standardised guidelines is suggested, such reminders have been shown by John (2010) & Stenson (2004).

## **Emergency nursing**

In Sweden, emergency nurses care for all ages and the full diversity of the population, and they naturally encounter abused women during the course of administering care. Emergency nursing is a specialty in which the nurse cares for patients in the emergency or critical phase of their illness or injury, focusing on the level of severity and time-critical interventions (Emergency Nurses Society of South Africa 2010 & Suserud 2001). The emergency nurse plays a crucial role in the identification and care of patients suffering from medical, surgical and injury related emergencies. The emergency nurse identifies life-threatening problems, prioritizes care, implements appropriate resuscitative measures and provides information and emotional support to the patient and their family within a supportive healthcare environment (Brysiewicz 2011).

Sheehy's *Emergency Nursing: Principles and Practice* (Howard & Steinmann, 2009) explains that triage is the process by which each patient who enters the emergency department is assessed. It states that the emergency nurse must have a high index of suspicion and remain alert for physical and behavioural clues. The scope of emergency nursing encompasses assessment, diagnosis, treatment and evaluation. Dobash (2007) highlights that IVP risk assessment instruments are now used to assess the risk of lethal and nonlethal violence.

In Sweden there are no specific national guidelines regarding the care of abused women in emergency care. Eriksson and Envall (2006) estimated that the number of women treated in hospitals in Sweden as a result of IPV at approximately 210 and that the number of women receiving out-patient treatment at hospitals, A&Es or primary healthcare facilities is at least

12,000 and possibly as many as 14,000 per year. An A&E department or trauma room can be a frightening place for an abused women and the manner in which she is received and treated is crucial to her recovery. When a woman is abused she is subject to a host of existential questions and concerns such as; what will happen to her following the abuse? How long will she be at the hospital? Questions regarding legal matters and how she will manage financially. Abused women sometimes encounter a variety of healthcare professionals in addition to their contacts with police, social workers and other government agencies. It is therefore necessary for these professional groups to collaborate. In order to further develop the care provided to abuse women, it is vital to investigate and understand how they experience these encounters, both during the course of their treatment and in the time leading up to their discharge from medical care.

# Theoretical framework

## Theory of caring and uncaring

Halldorsdottir's Theory of Caring and Uncaring Behaviours within Nursing and Healthcare proposes that the lived nurse-patient relationship is characterized by a spiritual connection and bond that empowers the patient (Halldorsdottir 2008). Halldorsdottir (1991) emphasizes that the recipient of nursing is a vulnerable person in need of professional care. Halldorsdottir (1996, p.23) describes the following five basic modes of being with another, presented as a continuum of caring and uncaring interactions:

- the biogenic, or life-giving
- the bioactive or life-sustaining
- the biopassive or life-neutral
- the biostatic or life-restraining
- the biocidic or life-destroying mode of being

The life-destroying mode is when the care provider depersonalizes the recipient making them increasingly vulnerable through humiliation. Halldorsdottir's theory (2008) states that caring and uncaring behaviours directly affect the patient's outcome when receiving healthcare services, as they may increase or decrease their vulnerability to poor health. Halldorsdottir (1991) also emphasizes that patients are vulnerable and therefore in need of professional care.

Halldorsdottir (1996) uses two important factors in the theory; the first being *the bridge*, representing the openness in communication and the connectedness experienced by the recipient in an encounter perceived as caring. This *bridge* is developed through a combination of mutual trust and the development of a connection between the professional and the recipient. The second factor is *the wall*, which symbolizes negative or no communication, detachment and a lack of a caring connection, experienced by the recipient as an uncaring encounter. The theory posits the importance of *professional caring* involving competence, intimate care along with respect and compassion. (Halldorsdottir, 1996, p.28).

## Suffering in Care

Abused women endure different kinds of suffering, from their partner and in healthcare. Women's health, well-being and even their lives are at stake or threatened when living in violent relationships. Eriksson (2002) highlights the patient's suffering as the motive for caring. Eriksson describes suffering in three forms: as related to illness, as related to care, and as related to life. This framework states that the main purpose of care is to alleviate this suffering. According to Eriksson (2006), suffering experienced in care is perceived when a patient's dignity and human value have been compromised caregiving situations, thus leading to unnecessary suffering. Berglund, Westin, Svanström, Johansson and Sundler (2012) emphasises that

suffering as the result of healthcare has four factors such as to be mistreated, to struggle for one's healthcare needs and autonomy and to feel powerless, to feel fragmented and objectified. Patients felt mistreated, distrusted, or not listened to as a result of the care given. Eriksson (2006) went on to note that when suffering is inflicted during care, the patient's vulnerability increases. Negative experiences were described resulting from the patient's symptoms being ignored or not taken seriously by professionals. The care that is intended to help the patient sometimes appears to cause the patient to suffer and to endure this suffering without complaint, for example a failure to listen to the patient; or a disinterest on the part of healthcare professionals in the patient's experiences. When this occurs, the patient's suffering increases. Focusing on the disease and not the personal view was experienced as an objectification. This thesis argues that good professional care involves listening to and validating the abused woman as a means of promoting recovery. Under the provisions of the Swedish Health and Medical Services Act (SFS 1982:763), all patients should be involved in decisions about their own care. Berglund et al (2012) state that it is essential that patients be kept informed about their situation and that they are involved in all decisions relating to their treatment and care.

## **RATIONALE FOR THE STUDY**

Each year, women experiencing Intimate Partner Violence are placed at risk of being severely injured or even killed. Assessing IPV and the risk of murder among women is no easy task, which goes some way to explaining the limited numbers of studies and research in the field. What research there is has shown that asking about abuse can be expected to promote communication with women, prevent further violence, break the cycle of violence, reduce feelings of isolation and improve the self-esteem of those who have been subjected to violence. However, despite the evidence, research indicates that women are commonly not asked about IPV when seeking healthcare. There is little or no information regarding IPV among women seeking care at A&E departments or other trauma care facilities. Methods for identifying IPV are therefore of importance in being able to provide optimal care. Moreover, research concerning treatment and care actions directed at women experiencing IPV – as well as notes in patient records – is limited, something which may make follow-up care difficult. It is crucial that healthcare providers document IPV accurately and exhaustively in medical record. By not doing so, the prospects for early intervention and timely care and treatment are inevitably reduced.

In order to develop the care provided to abuse women, it is important to investigate and understand their encounters during treatment and the period leading up to their discharge.

## Aims of the Thesis

The overall aim of this thesis was to understand, identify, explore and evaluate women's experience of Intimate Partner Violence and their subsequent encounters during the course of emergency care.

The specific aims were as follows:

- I To gain a deeper understanding of women's lived experience of IPV and their encounters with healthcare professionals, social workers, and the police following IPV (Study I).
- II To identify and investigate the occurrence of reported experienced intimate partner violence during lifetime among women seeking emergency department by using a questionnaire (Study II)
- III To explore and describe risk factors of IPV reported by women in connection with seeking emergency care (Study III).
- IV To evaluate medical records of the care given to women seeking treatment at an emergency department after having been injured by IPV and to describe women's responses to the care provided and their encounters with health care professionals (Study IV).



## METHODS

The care and experience of women treated for IPV has been the focus in this thesis. The thesis is based on four papers in hope to increase knowledge and awareness of IPV and the care given. A qualitative and a quantitative approach was used. The phenomenon of interest in this present study is to understand and explore intimate partner violence among women. As the aim was to identify and explore the incidence of IPV among women seeking emergency treatment, a quantitative method was used. For describing and understanding women's experiences of IPV, the treatment offered and their encounters and with healthcare and social services qualitative methods were used.

In Table I, an overview of the four studies is presented. In Study I, a phenomenological hermeneutic approach was used to understand the phenomenon of the women's experiences and the meaning ascribed by the women living the experience. The phenomenological hermeneutic method developed by Lindseth and Norberg (2004) and inspired by Ricoeur (1981, 2005) was chosen. In study IV a content analysis according to Elo and Kyngäs (2007) was used to describe the encounters and care given to women seeking care at A&Es as documented in medical records. Elo and Kyngäs (2007) suggest that content analysis is appropriate to analysing sensitive phenomena in nursing. According to Cole (1988) content analysis is a method of analysing written, verbal or visual communication messages and in this study text from medical records was analysed. One advantage of this method is that large volumes of textual data and different textual sources can be dealt with and used in corroborating evidence with either qualitative or quantitative data and can be used in an inductive or deductive (Elo and Kyngäs 2007) while according to Krippendorff (1980) content analysis is a research method for making reliable and valid results and conclusions from and providing knowledge, new insights, a representation of facts and a practical guide to action. . LoBiondo-Wood & Haber (2002) highlighted that qualitative research combines the scientific and artistic natures of nursing to enhance understanding of the human health experience. LoBiondo-Wood and Haber (2002) noted that the qualitative method combines the scientific and artistic natures of nursing to enhance understanding of human health experience. The care and experience of women treated for IPV has been the focus of this thesis.

In Studies II and III, descriptive and analytic statistical methods have been used for analysis of the data based on women's reporting in questionnaires.

### **Research settings**

In Study I, women were recruited from a women's shelter in Stockholm. In Studies II and III, women were recruited at one A&E department in a small town with a total population of approximately 40,000 not far from a larger

city in a rural district of Västra Götaland County in Sweden. In Study IV, medical records from a Stockholm A&E department were investigated.

Table I. Overview of the four studies.

Study	Design	Data sources	Study groups	Data analysis
Study I	Descriptive/ explorative	Interview with audiotape recorder	Women (n=12) cohabitating at a women's shelter in Stockholm	Phenomenological hermeneutics
Study II	Explorative/ comparative	Instruments/ questionnaire AAS	Women from small town ED(n=234)	Descriptive statistic
Study III	Explorative/ descriptive	Instruments/ questionnaire DAS	Abuse women (n=82) from small town ED	Descriptive statistics
Study IV	Descriptive/ explorative	Medical records	10 cases from an ED in Stockholm	Content analysis

## Participants and Procedure

Study I used a convenience sample of 12 women to investigate the full extent of the abuse encountered by the women, in the hope of shedding light on how their experiences are manifested and the underlying processes. They were contacted by the researcher after being recommended by staff at a shelter for abused women. The inclusion criteria were: 18 years or older, able to speak Swedish or English and that they were victims of IPV. All invited women agreed to participate by being interviewed about their experiences. The participating women ages were between 23 and 56 years, with a median age of 28 years.

In Studies II and III, 300 women seeking treatment at the A&E between September 2008 and June 2009 were invited to participate in the study by completing two questionnaires; *Abuse Assessment Screen* and *Danger Assessment Scale*. All women were invited to participate in the study by two trained emergency nurses, both with experience of caring for abused women. These 300 women ranged in age from 18 and 89 years old. During this 10-month period, 22,759 individuals were registered (taken from the hospital records) at the A&E. Of these, 11,120 (48.9%) were women and

11,639 were men, 9,408 were registered as internal medical cases, 11,725 as surgical cases and 1,626 as psychiatric cases (figure 2).

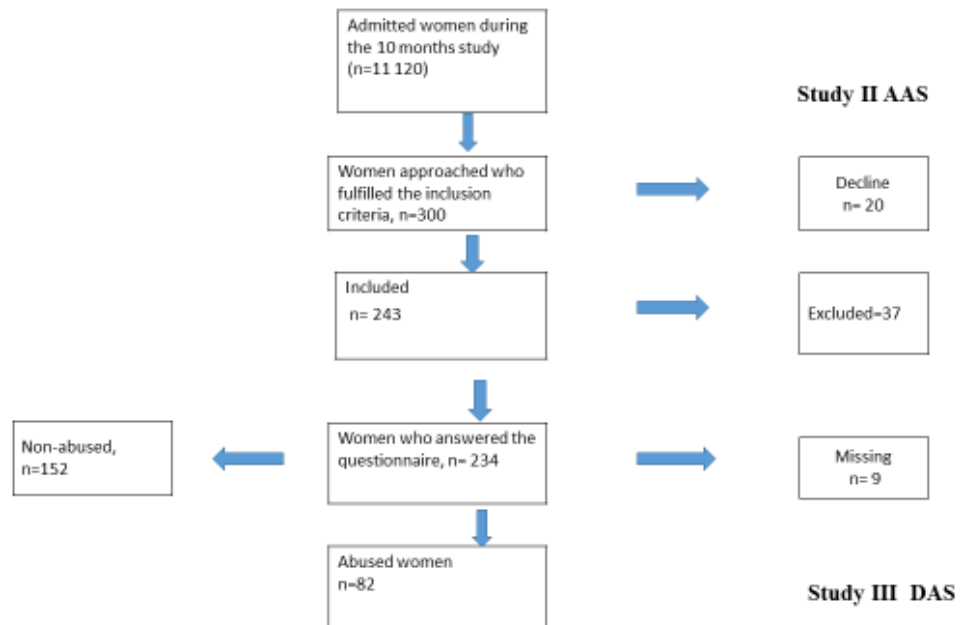


Figure 2. Flowchart of Study II and Study III

Of the 300 women invited, 20 declined to participate and 243 women were accepted as participants. Of these, 234 completed the questionnaires and of these, 82 reported experience of IPV. The inclusion and exclusion criteria are presented in Table II.

Table II. Inclusion and exclusion for Studies II and III.

---

<b>Inclusion criteria</b>
<ul style="list-style-type: none"><li>• Eligible subjects were all women who were at least 18 years old on visiting the A&amp;E and were approached to participate regardless of their reason for seeking treatment.</li><li>• Possessed the cognitive ability to answer questions</li></ul>
<b>Exclusion Criteria</b>
<ul style="list-style-type: none"><li>• Women who were suicidal or had suicidal thoughts</li><li>• Women with mental health problems affecting their ability to respond to the questions.</li><li>• Women who did not understand English or Swedish</li></ul>

---

In Study IV, all patient records of women over 18 years of age registered at the A&E between January 2009 and January 2014 with neurological injuries caused by IPV were included. In total 2,911 patients (men and women) were identified with traumatic brain injury. The exclusion criteria were: men; women under the age of 18; those with injuries that were not neurological and abuse that were not caused by IPV. This resulted in a sample of 1,372 women. Thereafter the ICD-10 (International Classification of Diseases, 2010) diagnosis codes X85-Y09 (which includes assaults, homicide injuries inflicted by another person with intent to injure or kill by any means) were used. Finally, ten women's patient records were identified.

## Data collection

### Interviews

In Study I, an inductive approach using qualitative, in-depth interviews was used. Individual face-to-face interviews were carried out in order to gain an understanding of the women's lived experiences of IPV, how this has affected their daily lives and of the women's encounters with healthcare professionals, social workers and police. During the interview, the women were asked to relate their experiences of IPV and all subsequent encounters in conjunction with seeking help. Follow-up questions were asked in order to avoid misunderstanding and to gain more insight into their statements and experiences. The interviews were audio-taped and then transcribed. The interviews were conducted by the researcher and lasted between 45 and 60 minutes.

### Medical records

For Study IV, data was collected from the medical records of ten women treated and cared for as a result of IPV. This involved summarised information from a computerised database of patient medical records including documentation from doctors, nurses, ambulance staff, counsellors and other healthcare professionals as well as social worker's assessments.

Patient statements, their responses to the care, treatment and encounters were noted, interpreted and analysed.

### **Questionnaires**

In Studies II and III, two A&E nurses with experience in the care of abused women were trained to carry out the data collection by handing over two questionnaires.

In Study II, an Abuse Assessment Screen (AAS), a five item questionnaire translated and adapted to Swedish circumstances, was used. The original AAS was developed by Parker, McFarlane & Soekem (1994) and McFarlane, Parker & Soeken (1998) to assess the occurrence of abuse. AAS has been used in several international studies (Wathen & McMillan 2012, Lawoko, Sanz, Helström, & Castren 2011 & Laisser, Nyström, Lindmark, Lugina & Emmelin 2011). The modified version used in this study was a previous translation into Swedish by Stenson et al. (2001), consisting of specific questions regarding emotional and physical abuse, abuse during or after pregnancy and sexual abuse, using yes/no questions. The question pertaining to sexual abuse was framed to refer to any such acts at any time during her life time instead of “last year”. Participants were also asked to reflect on the violence they have experienced with their partner/husband and indicate how much they were “affected” by various difficulties. In addition to the five questions some demographic data was also collected concerning the woman’s age, relationship to the abuser, number of children, employment status and annual salary.

In Study III, a Danger Assessment Scale was applied to those women (82) who stated that they were experiencing IPV. The original questionnaire was developed by Campbell (1985, 1995, 1997, 1998 & 2004) and consists of 20 questions. A modified version translated into Swedish was used consisting of 25 questions with yes/no answers. The purpose of the questionnaire is to detect the level of risk of IVP resulting in murder.

### **Data analysis**

#### **Phenomenological hermeneutics**

In Study I, the aim was to obtain a deeper understanding of women’s lived experience of IPV and their encounters with healthcare professionals, social workers, and the police. The data collected was interpreted and analysed using a phenomenological hermeneutic method as proposed by Lindseth & Norberg (2004). The recorded interviews were then transcribed verbatim and the text was read in order to obtain a narrative understanding, including suppositions that might motivate further examination of the text. The movement of the text can be followed from sense to reference, which is to say; from what it says, to what it talks about. Interpreting a text means entering the hermeneutical circle. The process of phenomenological hermeneutical analysis follows three steps: naïve reading, structural analysis and comprehensive understanding (see figure 2).

In the first step of *naïve reading* the text as a whole was allowed to speak to the reader, with the interview being read several times. Leaving aside natural inclinations, a phenomenological approach was adopted leading to a first analysis in the form of conjecture or a guess, requiring validation in the next step, the structural analysis.

In the second step of *structural analysis* the text was interpreted and a thematic structural analysis performed (Lindseth & Norberg 2004). The whole text was read again as well as those sentences that illuminated the essential meanings of the women's lived experience of their encounters with healthcare professional, social workers and police and other authority figures. Similar sentences were condensed and grouped together in themes.

In the third step of *comprehensive understanding* (the final step of analysis) the aim was to reassemble the pieces as a whole once again. The research questions, our preunderstanding, the naïve understanding, the structural analyses and reflections from the literature were summarised, providing a comprehensive understanding of the woman's vision of being in the world.

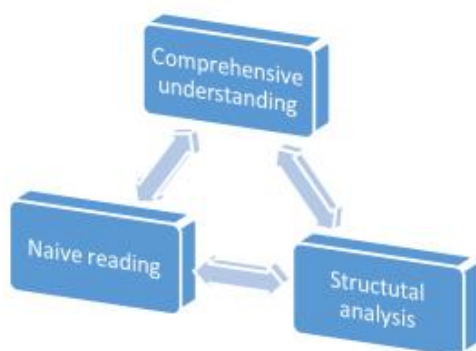


Figure 3. The three steps of the phenomenological hermeneutic procedure

### **Content analysis**

In Study IV, Elo and Kyngäs' (2008) qualitative content analysis was used to interpret the text of medical records. Both inductive and deductive analysis processes are represented as three main phases: preparation, organisation and reporting. The cases were analysed in the following manner:

### Inductive analysis

In the inductive stage, the qualitative data is organized. This process includes open coding, creating categories and abstraction. This involves reading the medical record as many times as necessary. Headings were written down to describe all aspects of the content. The text was read to obtain a general understanding. Patterns of meaning with rich descriptive information called *meaning units* were identified.

### Deductive analysis

Halldorsdottir's theory that it is not necessary to care in order to nurse a patient was used to compare the categories by using the five modes of caring. The researchers sought to identify the reasoning and associations made by the participants. The ten cases were read and lines of inquiry were identified from the theoretical background and from themes emerging in the data, with specific incidents or episodes in the text being analysed. This encompasses the individuals' situation, her concerns, opinions and ideology; stories that capture the meaning of a situation in such way that may prove important. Finally, the data from the inductive and deductive phase was coded into categories and subcategories.

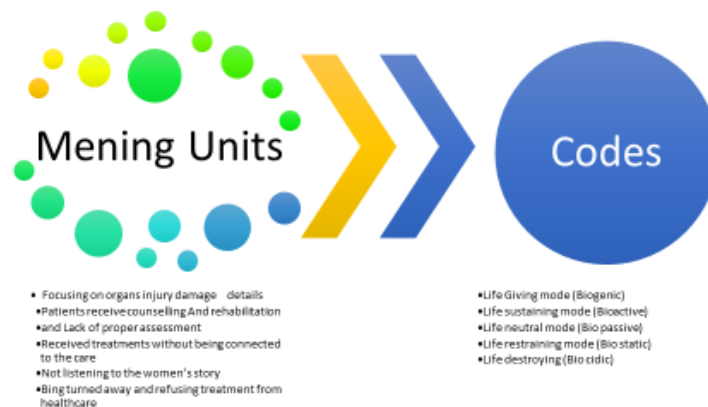


Figure 4. The inductive and deductive process

## **Quantitative data analysis**

The data from the questionnaires in Studies II and III was analysed by using descriptive techniques and the Statistical Package for the Social Sciences (2012). The data and demographic data were described with non-parametric testing. The chi-square test and the Fisher's exact test were applied when comparing two groups; abused and non-abused women. Level of significance was defined as  $p < 0.05$ .

In Study II, analyses were performed using logistic regression to test the association between emotional and physical abuse and the variables of age, marital status, employment status, annual income and the age of the youngest child. The Odds Ratio (OR) and 95% confidence interval (CI) were calculated, while in Study III the OR was calculated with a CI of 95% to test the man's capability of killing in order to estimate the interrelation of risk factors.



## ETHICAL CONSIDERATIONS

All study carried out in this thesis was guided by the WMA Declaration of Helsinki - Ethical Principles for Medical Research Involving Human Subjects (WMA 2016) and by the ICN Code of Ethics for Nurses (2012). The research protocol for Studies I and III was approved by the Ethics Committee of the University of Gothenburg (DNR-009-6). Study IV did not fall under Ethical Committee jurisdiction as the data identifying the participants was erased. Permission was granted for the study to be conducted at the University Hospital by the hospital committee. Intimate Partner Violence is a sensitive issue. The authors of this study have taken into consideration those ethical issues that may arise in conjunction with the study and taken action where necessary in order to meet all recommendations and guidelines. No children or women were put at risk during the course of the study, nor was there any risk of the women's identities being revealed.

In Study I and III, all women participated voluntarily having given informed consent and all were informed that the results from the studies were intended for publication in international scientific journals, but that no data could be traced to any individual. The participants were guaranteed anonymity and confidentiality. Therefore, no data was asked for in the questionnaires concerning the participants' names, personal identity numbers or addresses. Women who attended with their partners or husbands were not questioned although in a few cases, where the nurses were presented with the opportunity without risk of harm to the women, the questionnaires were handed over in a private room at the hospital. In Study I, women were informed that if any child was identified as a witness to ongoing violence or was themselves at risk of violence, the interviewer was obliged to report the matter to the social services. It was not possible to identify which women had children experiencing violence. In Study IV, all information regarding the participants was de-identified or anonymised. The researchers have followed the provisions of the Personal Data Act (SFS 1998:204) where no registration, collection, storage of data documentation or any encrypted codes were used.

In research ethics, the concept of vulnerability is intended to draw attention to those research participants who require special protection (Hurst2008). Sims (2010) highlights the importance of research not harming anyone, no matter its good intentions. The participants in the present study retained the right to terminate their involvement, the right to anonymity and the right to information. Violence against women violates human rights, has a major impact on health and causes great suffering. Physical and sexual abuse is illegal; emotional abuse is unethical and robs people of their basic rights to dignity and individuality. It would be unethical to fail to give abused woman a voice by not allowing their stories to be heard.

# RESULTS

In this chapter, some of the findings of Studies I-IV will be presented. In the first part, the findings of Studies I and IV will be described. In the second part, results from Studies II and III will be presented.

## **Being betrayed, neglected and re-traumatized**

Study I encompassed three main themes and seven subthemes (Table III). The women's experiences show that they became re-traumatized during and after their encounters with professionals in healthcare, social work and the police. They tell of being met with uncaring behaviour which resulted in unendurable suffering. They felt as if they were being betrayed and abandoned by those they thought would help and protect them.

Table III. An overview of the main themes and subthemes of Study I

---

### **Feelings of being betrayed by the system**

*No one care about my suffering*

*I feel the system has failed me*

*Justifying the violence*

### **Feelings of not being taken seriously and respected**

*Fear of losing autonomy*

*Degraded to nothing*

### **Feelings of uncaring attitudes**

*Loosing hope*

*Feelings of neglected and invisible*

---

The themes derive from the women's interaction with healthcare professionals and other figures of authority during which the women's dignity was crushed. In these situations, the women were vulnerable and desired empathy and compassion. Other negative feelings from which they suffered included a sense of powerlessness, humiliation and degradation. The themes revealed the disappointment felt by these women at the way they were treated. They felt as if they were reliving the violence and, in some cases, started to believe that the treatment to which they were subjected by their abuser was justified. The women felt that they had lost their identity and that there was no place for them in healthcare. During treatment and recovery, their actions were questioned by healthcare professionals, social workers and by government agencies, who insisted that

their time, and that of the authorities, was being wasted. Women were left to feel shame and neglect.

## Uncoordinated care

Based on the readings of the ten subject's medical records, it was found that seven women had experienced mild to severe IPV with traumatic brain injury. Two of the women later died, one as a direct result of the IPV and another due to medical complications following the trauma. In three cases the violence was inflicted by an unknown person.

After review and analysis of the text of the medical records, three main categories and five subcategories were identified. The main categories were: management of the care given, unconnected care and being dehumanized.

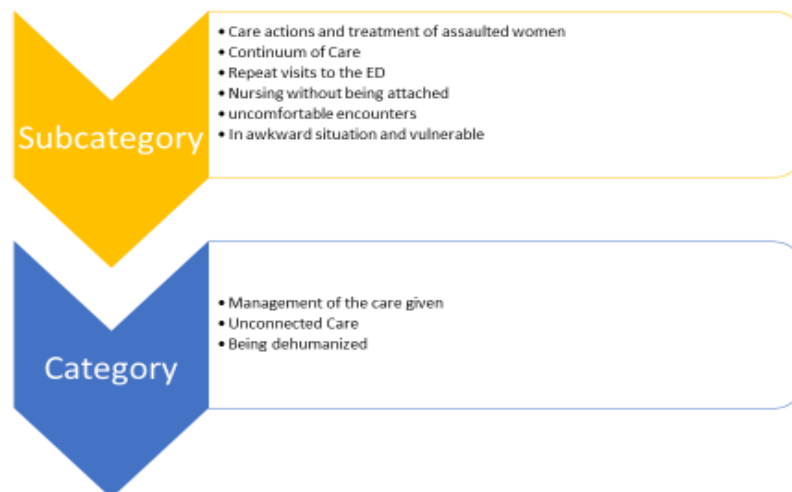


Figure 5. Showing the categories and subcategories

A recurring pattern and major theme was *lack of proper assessment*, with only the physical injuries being dealt with at the A&E. The study also showed women visiting the A&E due to IPV repeatedly over their lifetime and a complete lack of interest in investigating the women's situation and living circumstances. Moreover, it was found that documentation was inadequate regarding the circumstances surrounding their injuries and there was a failure to provide any form of prevention plan.

Several women were suicidal, or had suicidal thoughts, exhibiting symptoms of stress, and there was a lack of proper assessment in a structured manner. The women in the study expressed their disappointed in the care given. Several told stories of being turned away several times and told to seek care elsewhere despite their obvious distress. Women

participating in the study received professional help for their physical injuries but those seeking help for emotional or behavioural problems were overlooked.

## **Occurrence of Intimate Partner Violence**

The AAS questionnaire was collected from 234 women with an average age of 47.67 (SD = 16.9) and ranging from 18-62 years. They had an average of two children. The results identified eighty-two (35%) of the 234 women as being abused psychologically and physically over the course of their lifetime. Injuries experienced included being hit, kicked, shoved or otherwise physically hurt by someone. A total of 13.6% of the women had been forced to engage in sex and sexual activities at some time.

The data showed a greater risk of abuse when unmarried (OR = 1.31; 95 % CI = 0.146, 3.80). Women who were full-time housewives or unemployed seemed to be associated with a higher risk of being abused emotionally and physically. The age of the youngest child was significantly ( $p=0.008$ ) associated with a lower risk of being abused (OR= 0.969; 95% CI= 0.947, 0.991). When comparing non-abused and abused women and the number of children, it was found that significantly more women with four or more children were abused. Of the women, 29 % reported having been abused in the year prior to becoming pregnant and 20% during pregnancy. Of 187 women, 67% stated that on one or several occasions they had been forced to have sex. Of the 82 women who stated experience of IPV, 31 (38%) were afraid of their partner.

The study revealed that the partner or cohabitating partner was not the sole perpetrator. As many as 21% reported having been abused by someone else, identified as an individual other than their partner. In these cases, the perpetrator was identified as a close relative such as a parent, stepfather or cousin or a friend, while six reported having been abused by an unknown person. A small number of women were abused by their parent (n=3) and disclosed being first abused by a parent, then by a partner and then a son. The study identified no significant difference between the abused and non-abused women concerning if they had children or not. Women reported to have been abused the year prior to being pregnant.

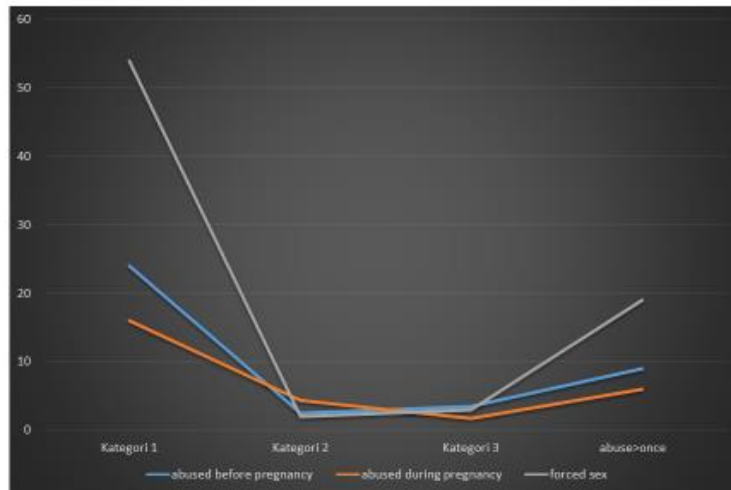


Figure 6. Occurrence of IPV before and during pregnancy in relation to forced sex.

### Violence increasing in severity

In this present study, the sample included eighty-two abused women With an average age of 43 (SD 15.2; r=18-78 years) with a total of 81 children (Md 2). Of these 82 women, 58 had a child between the ages of 0-18 years of age. When answering the Danger Assessment Screen, the data showed 51 women between the ages of 18 and 78 answered yes to 1-10 questions, indicating a high risk; while 9 women between the ages of 31 and 55 answered yes to 11-15 questions, indicating a grave risk; and 4 women aged 41 to 45 answered yes to 16-25 questions, indicating an extreme risk of falling victim to violent injury or murder.

Women in the study experienced serious violence. Using the Fishers exact test there was a statistically significant correlation between violence increasing in the last year and violence increasing in severity;  $p < 0.000$ . A total of 22% of the women predicted that their partner was capable of killing them, while 7% had received death threats. Seven percent had endured choking or attempted choking and 19.5% of women disclosed that a weapon had been used to harm them; with a gun identified ( $n = 5\%$ ) as among the weapons used. It was shown that the risk of being threatened with death is in the region of 13 times greater when the abuser is reported to use narcotics and illegal drugs compared to an abuser who is not using narcotics (OR12.59, CI= 2.74, 54.65) The Fisher exact test also showed a statistically significant ( $p < 0.045$ ) link between the use of narcotics and a perpetrator threatening to harm a child. A total of 13.6% of perpetrators had problems with alcohol or were alcoholics. The abused women disclose that that the violence increase during the last year (4%) and increased in severity (4.5%).

Perpetrators followed and spied on the women (12%), While the odds of threatening suicide were almost 11 times higher if the women reported the abuser as being jealous (OR= 10.59 CI; 2.48, 47.68).

## **DISCUSSIONS**

This thesis is based on four papers with the overall aim being to use a quantitative and qualitative approach to understand, identify, explore and evaluate Intimate Partner Violence and the encounter with emergency care as experienced by abused women.

### **Being betrayed, neglected and re-traumatized**

This thesis has shown that IVP is a sensitive topic, something which adds to the difficulty in making an accurate assessment. Nevertheless, women do experience a lifetime of abuse and suffering (Studies I- IV). This thesis has provided a picture of the abused women's encounters through healthcare. Eriksson (2006) formulates that the suffering we human beings cause one another is frequently concealed. Sometimes this happens quite unconsciously, something demonstrated in Studies I and IV.

The women in the study were re-traumatized during their encounters with healthcare professionals, were silenced and made to feel unworthy. These findings are supported by Halldorsdottir's theory of caring and uncaring (1996). The findings of this thesis showed that the relationships between the abused women and health care professionals could be understood as strained, rushed and non-harmonious. This is congruent with Berlund, Westin et.al (2012) research showing suffering caused from care as a motive for improvement.

There are various reasons why victims of IVP do not disclose or report their experiences (Wall 2012), but what is known is that victims are more likely to report abuse when asked directly about the violence in a sensitive and supportive environment. In his thesis, women disclosed some form of lifetime abuse from a partner, a stranger, a close relative and sometimes both, either as a child or adult. This inevitable raises questions about the backgrounds of these women and the environments in which they live. The ecological framework for understanding violence, as proposed by the WHO (Krug et al. 2002), plays an important role in the care of abused women.

### **Consequences of Intimate Partner Violence**

The risk of murder and serious injury was identified in this thesis and several women had threatened and attempted suicide, something which appeared in two of the studies (Study II and Study IV). A trauma-informed approach is recommended by emergency care professionals. There is other evidence suggesting separation and divorce as risk markers for suicide and suicide attempts (Hart 2010). Study II shows that there is evidence that pregnancy may decrease the likelihood of IVP, something that is consistent with the Australian Bureau of Statistics & Gallup 2004 study (in Wall 2012). Thus, the findings present a puzzle, as seen in Dobash et al (2007), of whether separation constitutes a *solution* to the problem when a violent

relationship is ended; or results in an escalation of the violence when the man allows the woman to leave.

## **Violence increasing in severity**

Findings from Study III present the abuser's use of narcotics and illegal drugs as a seemingly important risk factor in relation to death threats to the woman as well as threats of harm to children. Several abused women, as well as several abusers, had threatened suicide. Our findings are congruent with the study conducted by Dobash et al (2007) in that the use of an instrument or weapon and sexual assault may be associated with an increased risk of serious violence or lethality. In this study several women disclose that the man used a weapon such as a gun to harm them.

An A&E department is a busy, noisy and frightening place and one which abused women may easily find intimidating. As stated by Rehnström and Dahlborg Lyckhage (2016), at A&E departments in Sweden, long waiting times and overcrowding has become the norm, which not only creates dissatisfaction among patients but also involves medical risks. An abused woman is like a bird with a broken wing; helpless, she feels trapped and in need of help to survive. Two of the studies (III and IV) conclude that IVP provoked a suicide attempt and an attempt to take one's own life is a cry for help. This is consistent with Hart's 2010 study showing that suicide attempts by abused women are methods of help-seeking and not intended to be fatal. Emergency nurses and other healthcare professionals in emergency care need to be trauma-informed. They must screen abused women for suicide risks. Hart (2010) highlights research on suicide or suicide attempts by battered women which offers preliminary insight into the significant risk that IVP poses for suicide and attempted suicide by battered women.

In Study III, women and children had experience extreme violence and threats. Surprisingly, having a child that was not the perpetrator's own did not increase the risk to the child themselves. More caution should be exercised with children who witness violence and with children witnessing choking or strangulation.

## **Uncoordinated care**

In line with the study by Nagle (2013), uncaring healthcare professionals negatively affect the abused women by disempowering and demoralising them. Their health is threatened, compounding their already vulnerable state. Halldorsdottir (1991) contends that lack of competence can be seen as one of the main reasons behind the caring and uncaring in the theory. Leppäkoski, Flinck and Paavilainen (2014) and Husso, Virkki, Notko, et al. (2012) indicate that lack of knowledge of the causes and effects of IPV often leads to feelings of inadequacy and frustration. Husso, Virkki, Notko, et al. (2012) pinpointed that, for healthcare professionals, encountering victims of IPV is fraught with ambivalences. Metaphors such as *opening a*



*can of worms* or *Pandora's Box* indicate the view that something is being allowed to escape that would be better left confined. Professionals often express their concerns about doing more harm than good. Unfortunately, healthcare professionals do not engage with these issues and they do not routinely screen for health risks such as IPV or child abuse (CA) and neglect (Leppäkoski, Flinck and Paavilainen 2014). Based on the empirical findings (both qualitative and quantitative) from this thesis, there are several practical implications in improving the ability to predict severe violence by abusers (i.e. violence likely to result in injury or death). For a variety of reasons, survivors may be reluctant to disclose their victimization; whether to law enforcement or to family and friends. These may include shame, embarrassment, fear of retribution from perpetrators or a belief that they may not receive support from those charged with protecting them and enforcing the law. More attention needs to be paid to vulnerable groups, for example women with substance abuse/addiction problems, disabled groups, women over 65 and women born outside Sweden. However, by not screening women who have been silenced by their male partners; healthcare denies women the help they need. Sweden has one of the best crime reporting systems in the world and yet very few charges lead to a successful conviction.

*The National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Healthcare Settings*, developed in 1999 by Futures without Violence (formerly the Family Violence Prevention Fund), recommends regular screening as part of routine health history and during every new patient encounter. These guidelines, recommending frequent screening regardless of risk factors or warning signs, demonstrate a universal screening approach. The USPSTF (2013) recommendation takes a modified universal screening approach, stating that all women should be screened regardless of risk factors, but it places an age restriction, limiting the recommendation to women of childbearing age, and does not specify under what conditions screening should occur. Patients in whom abuse is suspected should receive proper documentation of the incident and physical findings treatment for physical injuries; arrangements for skilled counselling by a mental health professional; and the telephone numbers of local crisis centres, shelters and protective service agencies.

The ecological model for violence goal is prevention. The findings from this study suggest that violence prevention should be targeted on all level. Violence in this study has affected both women and children on all four levels; i.e. individual, relationship, community and society. Therefore, early intervention by healthcare professional may alleviate suffering, reduce the risk of post-traumatic stress, and create better conditions for the female victims of IPV to return to a normal life.

Several studies (Choo, Nicolaidis et al., 2012, Mitchell 2009 and Rudman 2009) have indicated that abuse victims often endure repeated undisclosed or undetected violence to the head as seen in Study IV. In Study IV, only women with diagnosis codes were identified which means that women who had no diagnosis code but were abused were not found, something which

may have affected the prevalence rate. Similar findings were reported by Mitchell (2009). Rudman (2000) found that if IPV is not identified or documented it will not be coded, something which is consistent with this study. The caring and uncaring theory presented in this thesis considers competence in educating people as an essential aspect of professional caring.

Several similarities were found in Study I and Study IV, which shows a scarcity of victims being transferred to outpatient care. Women faced difficulties after being discharged, something confirmed by a variety of sources which unanimously show that lack of coordination is one of the biggest challenges for health and social care in Sweden. The *OECD Reviews of Health Care Quality: Sweden (2013)* emphasised the emergence of just such a lack of coordination between hospitals, primary healthcare and social services as the biggest challenge facing Sweden's comparatively good healthcare system.

The Swedish Patient Safety Act (SFS 2010:659) defines the systematic patient safety work that every hospital must implement to protect against medical error. Halldorsdottir's theory (1996) states that lack of competence is seen as one of the main reasons behind uncaring. It is clear from the findings of this thesis that behavioural or emotional problems have some effect on the health of abused women, particularly those women who have been overlooked (Study I) and turned away (Study IV) from healthcare facilities that question the urgent nature of the women's psychological status. Therefore, screening for abuse will improve women's health and decrease or prevent incidents of readmission.

## **Methodological Considerations**

### **Phenomenological hermeneutic**

In Study I, Lindseth and Norberg's phenomenological hermeneutic method (2004), has given voice to the abused women's lived experience.

### **Content analysis**

A qualitative content analysis method was used in Study IV, in line with Elo and Kyngäs (2007). One advantage of the method is that large volumes of textual data and different textual sources can be dealt with and used in corroborating evidence.

### **Questionnaires**

In Study II, the level of pregnancy resulting from rape was unknown, yet the AAS questionnaire was found to be useful in identifying IPV and easy to use in an emergency setting. However, it is plausible that all women who were currently or had previously suffered abuse were not detected. Study III shows the DAS is a useful and helpful instrument to identify re-traumatization, the risk of lethal violence and murder and for aiding

healthcare professionals in emergency settings in providing abused women with safety plans.

### **Validity and reliability**

Validating the evidence is important in qualitative and quantitative studies. By using different data sources, the accuracy and credibility (construct validity) of the findings have been increased. It facilitates our corroboration of the findings (Lincoln and Guba 1985, Polit & Beck 2006). Prior to the interview, the interviewer had no relationship with the participants; thus preventing bias (Study I). The presupposition of understanding, including one's perceptions and biases must be acknowledged as clearly as possible (Benner 1994). Polkinghorne (1989) emphasizes that the validity of the findings of any phenomenological research project depends on the ability of its presentation to convince the reader that its findings are accurate.

In the quantitative method two questionnaires were used (Study II and Study III). The modified AAS (as used in Study II) has been tested in Stenson, Heimer, Lundh et al. (2003), where content validity was achieved. DAS has been used internationally (Campbell 2004), and modified in several languages. The modified version used in this study (Study III) was checked by a group of researchers and by Jacquelyn Campbell the author of *Danger Assessment* (2004), one of the first risk assessment instruments for battered women. Power analysis was not calculated in the AAS or the DAS. Polit (2004) posits power analysis as a method of reducing the risk of Type II errors and for estimating their occurrence. Statistical Significance levels in study II and Study III were  $p < 0.05$ , limiting the risk of Type II error.

### **Credibility**

Lincoln and Guba (1985) emphasize the importance of credibility in qualitative research. Sandelowski (1993) recommends that a qualitative study is credible when it reflects accurate and truthfull interpretation of human experience.

### **Trustworthiness**

In Study IV, the assessment of the medical records has proven to be beneficial in uncovering those phenomena that might otherwise have gone undiscovered. By following three principles of data collection: (1) using multiple sources of evidence; (2) establishing a case study base; and (3) maintaining a chain of evidence (Lincoln and Guba 1985) and by using qualitative content analysis, we have increased the trustworthiness and quality of a case study. In Study I and Study IV authentic citations was used to increase the trustworthiness of the research and to point out to readers from where, or from what kinds of original data, categories are formulated Sandelowski (1993).

## **Strengths and Limitations**

Several benefits were found in identifying abused women. The study provides a rich source of qualitative information and insight for further research. Sexual abuse is difficult to identify; it cannot be assumed that sexual abuse will be uncovered by direct questioning (Wall 2012).

However, in this study we have identified women who have experienced sexual abuse (Study II and Study III). As elaborated by Spangaro (2011), by asking (Study II and Study III) about whether the abuse is a form of intervention in itself which gives the woman an opportunity to talk. Study II has several strengths that should be acknowledged. The study has a 78% participation rate. The transferability of the results of this thesis is supported and confirmed by the findings of other studies.

The findings of Study I and Study IV should be approach with some caution due to the sample size. However, they can be used in similar settings.

McLeod (2008) explains that the analysis of qualitative data depends on the interpretation on the information. In Study II, there was some internal dropout due to some of the women failing to answer all of the questions. In Study III, some data was missing and the CI was found to be wide, meaning the certainty of how big the risk really is may be lower or higher.

## Conclusions and Implications

This thesis has provided new knowledge on IPV among women seeking emergency treatment. There is very little scientific knowledge on the care offered and the reception that an abused women suffering from violent injuries can expect to encounter. The use of structured questionnaires helps to detect IPV. The knowledge gained from this thesis can contribute to improving the quality of care available to abused women and their children and will enable healthcare professionals and other authorities to discover at an early stage when women or children, or those in an intimate partner relationship, are being or have been exposed to violence.

Health professionals cannot afford to disregard women's experiences of violence, abuse and discrimination. By using research findings, the researchers hope to raise the level of interest in interpersonal violence, the long-term effects the violence has both on the victims themselves and nurses caring for patients with violent traumatic injuries. By acknowledging female IPV victims, it is possible to give them a voice and empower them to recover. Information about the various forms of care and assistance available can give a woman a sense of control over the situation and enable her to decide on the best course of action. This thesis shows valuable results and highlights the factors that can lead to serious injuries, suicide or murder. Emergency care professionals must be trauma-informed; that is, they must acknowledge, validate and empower the abused women.

## Future Research

The education of nurses and specialist emergency and trauma nurses on caring for abused women plays an important role in the continuum of care necessary to prevent repeat assaults, return visits to A&E departments and re-traumatization by healthcare professionals.

- More studies are needed to develop a trauma-informed model for the emergency treatment and care of abused women.
- Research is needed to identify the frequency of child abuse and the impact of domestic violence on the children who witness it.
- Implement and evaluate the importance of documentation and coding of abused women visiting A&E departments.

# ACKNOWLEDGEMENTS

This thesis is the result of a long and educational journey. It has been an inspiring process if not without challenges. It is an honour and privilege and I am eternally grateful to everyone who has followed me on my path. I would like to thank:

The abused women who have contributed by participating in this study; without you this study would not have been possible.

Special thanks to Caroline Lind, Katarina Sundberg and the staff at Kungälv's Hospital A&E Department and Psychiatric Care Unit for making this study possible.

My main adviser Ingegerd Bergbom, a wonderful coach and friend who, having read many versions of my thesis, has watched it grow and develop like a flower until it finally bloomed.

Elisabeth Dahlborg-Lyckhage, thank you for the very wise and inspiring words over the years and for keeping me on my toes and pointing out my weak as well as my strong points. You have been a good mentor.

Nemes Szilzard and Lars-Olof Persson for assisting with the statistics. Thanks for helping me grow from a bud to a tree.

Bo Olsen. Thank you for your patience and guidance in helping me to understand statistics.

Special appreciation to Annelie Amin, thank you for helping me with the medical journal statistic and for making my search possible.

To my research associates and colleagues; thanks for your kind words during our many seminars and thank you for lifting me up when I was down and being there as a colleague.

Thanks to my family, my mother who has guided me to be strong during the rough times over the course of this study. To my lovely children Jessica and Victoria who have been patient with moms many trips between Gothenburg and Stockholm over the years and my sister who has helped me with my kids during my many trips. Håkan you are my rock and it is your countless and amazing words of encouragement that have kept me going.

This thesis was funded by the University of Gothenburg Sahlgrenska Academy, Karolinska University Hospital Neurological Clinic, Riksföreningen för Sjuksköterskor inom Trauma (Swedish Association of Trauma Nurses), Nordic Holistic Care AB.

## REFERENCES

Agency for Healthcare Research and Quality. (2007). AHRQ. "Evaluation of the U.S. Preventive Services Task Force: Final Report." December 2007. Accessed 3 March 2013 from <http://www.ahrq.gov/research/findings/final-reports/uspstf/index.html#contents> .

Amnesty International. (2004). Men's Violence against Women in Intimate Relationships An account of the situation in Sweden. An account of the situation in Sweden. Report, April.

American Congress of Obstetricians and Gynecologists. (1995) "Domestic Violence: ACOG Technical Bulletin No. 209". Accessed 10 February 2013 from <http://www.ncbi.nlm.nih.gov/pubmed/8635639>

American Medical Association. (1992). "American Medical Association Diagnostic and Treatment Guidelines on Domestic Violence." Arch Family Medicine Vol. 1, No. 1. Accessed 31 October 2012 from [http://triggered.edina.clockss.org.ezproxyhhs.nihlibrary.nih.gov/ServeContent?url=http percent3A percent2F percent2Farchfami.ama-assn.org percent2Fcgi percent2Freprint percent2F1 percent2F1 percent2F39](http://triggered.edina.clockss.org.ezproxyhhs.nihlibrary.nih.gov/ServeContent?url=http%3A%2F%2Farchfami.ama-assn.org%2Fcgi%2Freprint%2F1%2F1%2F39)

American Nurses Association. (2000). "Position Statement on Violence Against Women" American Nurses Association. 2000. Accessed 10 February 2013 from <http://www.nursingworld.org/MainMenuCategories/Policy-Advocacy/Positions-and-Resolutions/ANAPositionStatements/Position-Statements-Alphabetically/Violence-Against-Women.html>.

Andersson, C. (2003). *Research and Theory for Nursing Practice*. Fall; 17(3): 225-40.

Ashcroft J., Daniels, D. J., Hart, S.V. (2003). Youth victimization: Prevalence and implications. U.S. Department of Justice; Washington, DC: 2003.

Australian Bureau of Statistics. (2006). *Personal Safety Survey Australia Reissue* (cat. no. 45230). Canberra: ABS.

Bard, M., & Sangrey, D. (1986). *The Crime Victim's Book*. Secaucus, NJ: Citadel Press.

Bagcioglu, E., Vural, M., Karababa, I.F., Akşin, M. and Selek, S. (2014). Decrease in Domestic Violence during Pregnancy: A Study from Turkey. *Journal of Interpersonal Violence*, 29, 203-216. <http://dx.doi.org/10.1177/0886260513505147>



- Berglund, M., Westin, L., Svanström, R., Johansson-Sundler, A. (2012). Suffering caused by care- Patients' experiences from hospital settings. *Int J Qual Stud Health Well-being*. 2012; 7: 10.3402/qhw.v7i0.18688
- Birath Scheffel, C., Beijer, U., DeMarinis, V., & af Klinteberg, B. (2013). Women with substance abuse problems exposed to men's violence - A public mental health challenge. *Journal of Addiction Research & Therapy*, 4(2), 149, doi:10.4172/2155-6105.1000149.
- Benner. (1994). *Intepretive Phenomenology.Embodiment, caring and ethics in healthcare and illness*. Thousand Oaks, CA: Sage Publications.
- Butchart, A., & Mikton, C. (2014). *World Health Organization*. [WHO] Global status report on violence prevention. Geneva.  
[http://www.who.int/violence\\_injury\\_prevention/violence/status\\_report/2014/en/](http://www.who.int/violence_injury_prevention/violence/status_report/2014/en/)
- Bronfenbrenner, V. (1979). *The ecology of human development: experiments by nature and design*. Cambridge, MA, Harvard University Press.
- Brysiewicz P. Editorial. (2011). Emergency nurses: an essential component of emergency care in Africa. *African Journal of Emergency Medicine* 2011; 1(1):3-4. 10.
- Brysiewicz, P., & Bhengu, B.R. (2000). *Curationis*. Dec; 23(4):15-21.
- Campbell, J. C. (1986). Nursing assessment for risk of homicide with battered women. *Advances in Nursing Science*, 8, 36-51.
- Campbell, J. C. (1995). *Assessing Dangerousness*. Newbury Park: Sage.
- Campbell, J. C., & Lewandowski, L. (1997). Mental and physical health effects of intimate partner violence on women and children. *Psychiatr Clin North AM*. 20:2:353-74.
- Campbell, J. C., Soeken, K., McFarlane, J., & Parker, B. (1998). Risk factors for femicide among pregnant and non-pregnant battered women. In J.C. Campbell (Ed.), *Empowering survivors of abuse: Health care for battered women and their children*. 90-97. Thousand Oaks, CA: Sage.
- Campbell, J. C., & Soeken, K.L. (1999). Forced sex and intimate partner violence: effects on women's risk and women's health. *Violence against women*. Vol. 5. No. 9, September. 1017-1035.
- Campbell, J. C. (2004). DANGER ASSESSMENT. Johns Hopkins University, School of Nursing.  
[.https://www.dangerassessment.org/DA.aspx](https://www.dangerassessment.org/DA.aspx).

- Campbell, R., & Raja, S (1999). "Secondary victimization of rape victims: insights from mental health professionals who treat survivors of violence". *Violence Vict* 14 (3): 261–75. PMID 10606433
- Campbell, D., Sharps, P., Gary, F., Campbell, J. C., & Lopez, M. (2002). Intimate Partner violence in African American women. *Online Journal in Nursing*. January 31, Vol 7, no 1.
- Choo, E. K., Nicolaidis, C., Newgard, C. D., Lowe, R. A., Hall, M. K., & McConnell, K. J. (2012). The Association between Emergency Department Resources and Diagnosis of Intimate Partner Violence. *European Journal of Emergency Medicine*, 19(2), 83–88.  
<http://doi.org/10.1097/MEJ.0b013e328348a9f2>
- Centers for Disease Control and Prevention [CDC]. (2006): "Homicides and Suicides—National Violent Death Reporting System, United States, 2003-2004." 2006. Accessed August 2013 from  
<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5526a1.htm>.
- Coker, A., Smith, P., Bethea, L., King, M., McKeown, R (2000). "Physical Health Consequences of Physical and Psychological Intimate Partner Violence." *Archives of Family Medicine*. Vol. 9. Accessed 30 October 2012  
 from [http://www.clockss.org.ezproxyhhs.nihlibrary.nih.gov/clockss/Archives\\_of\\_Family\\_Medicine](http://www.clockss.org.ezproxyhhs.nihlibrary.nih.gov/clockss/Archives_of_Family_Medicine).
- Cole, F.L. (1998). Content analysis process and application. *Clinical nurse specialist*. 2(1), 53-57.
- Convington, S. (2008) Women and Addiction: A Trauma-Informed Approach, *Journal of Psychoactive Drugs*. 377. SARC Supplement 5, November.
- de Boinville, M. (2013). Screening for domestic violence in healthcare settings. *ASPE Policy Brief*. (Office of the Assistant Secretary for Planning and Evaluation. Office of Human Services Policy- U.S. Department of Health and Human Services). August. Washington, DC 20201.  
<https://aspe.hhs.gov/report/screening-domestic-violence-health-care-settings>.
- Dillon, G., Hussain, R., Loxton, D., Rahman, S. (2013). "Mental and Physical Health and Intimate Partner Violence Against Women: A Review of the Literature." *International Journal of Family Medicine*. 2013. Accessed 4 March 2013  
 from <http://www.hindawi.com.ezproxyhhs.nihlibrary.nih.gov/journals/ijfm/2013/313909/>.

- Dobash, R. E., Dobash, R.P., Cavanagh, K., & Medina-Ariza, J.(2007). Lethal and non-lethal violence against an intimate female partner: Comparing male murderers with non-lethal abusers. *Violence Against Women*, 13, pp 329-353
- Elos, S., & Kynga, H. (2007). The qualitative content analysis process. *Journal of Advanced Nursing* 62 (1), 107–115 doi: 10.1111/j.1365-2648.2007.04569.x
- Emergency Nurses Society of South Africa (ENSSA). (2010). Practice Guideline EN001 Definition of emergency nurse and emergency, nursing.
- Eriksson A & Envall E. (2006). Costs of Violence against Women *National Board of Health and Welfare, Sweden*.
- Eriksson K. (2006). *The Human Suffering*. Chicago, IL: Nordic Studies Press.
- Eriksson K. (2002). Caring science in a new key. *Nursing Science Quarterly*. 15(1):61–65.
- Friedman, L. S., Samet, J.H., Roberts , M.S., Hudlin, M, Hans, P. (1992). Inquiry about victimization experiences. A survey of patient preferences and physician practices. *Arch Intern Med*. 152:1186–90.
- Garbarino J, Crouter A. (1978). Defining the community context for parent–child relations: the correlates of child maltreatment. *Childdevelopment*, 1978, 49:604–616.
- Gutmanis, I., Beynon, C., Tutty, L., Wathen, C.N., MacMillan, H. L. (2007). Factors influencing identification of and response to intimate partner violence. A survey of physicians and nurses. *BMC Public Health*, 7. pp. 12–22.
- Hart, B. (2010). *Battered women- Suicide*. Fatality Revue Bulletin, (Winter). National Domestic Violence Fatality. Revue Initiative.
- Halldorsdottir, S. (2008).The dynamics of the nurse patient relationship: introduction of synthesized theory from the patients perspective. *Scandinavian journal of caring science*, 22. p. 643-652.
- Halldorsdottir, S. (1996). *Caring and Uncaring Encounters in Nursing and Health Care- Developing a Theory*. Dissertation. Department of Caring Sciences, Faculty of Health Sciences, Linköping, Sweden.
- Halldorsdottir, S. (1991). Five basic modes of being with another. In Watson, J., & Gaut, D. eds. *Caring: The compassionate healer*. National League for Nursing, New York, 37-49.

- Howard, P. K., & Steinmann, R.A. (2009). Sheehy`s Emergency Nursing. Principles and Practice. 6<sup>th</sup> edition. *Emergency Nursing Association (ENA)*. Mosby.
- Heise, L. L. (1998). Violence against women: an integrated ecological framework. *Violence against women*, 4:262–290.
- Hess, K. L., Javanbakht, M., Brown, J., Weiss, R., Hsu, P., Gorbach, P. (2012).“Intimate Partner Violence and Sexually Transmitted Infections Among Young Adult Women.” *Sexually Transmitted Diseases* Vol. 39 No. 5 PP. 366-71 May 2012. Accessed 4 November 2012 from <http://www.ncbi.nlm.nih.gov/pubmed/22504601>
- Husso, M., Virkki, T., Notko, M., Holma, J., Laitila A, Mäntysaari, M. (2012). *Health Soc Care Community*. Jul; 20(4):347-55 Making sense of domestic violence intervention in professional health care. DOI: 10.1111/j.1365-2524.2011.01034.
- Hurst, S. A. (2008) Vulnerability in Research and Health Care; Describing the Elephant in the Room? *Bioethics*, 22 (4): 191-2002
- ICD- 10 Codes. (2010). International Statistical Classification of Diseases and Related Health Problems 10th Revision. <http://apps.who.int/classifications/icd10/browse/2010/en>
- ICN (International Council of Nurses). (2012). *The ICN Code of Ethics for Nurses*. Geneva, Switzerland. [http://www.icn.ch/images/stories/documents/about/icncode\\_english.pdf](http://www.icn.ch/images/stories/documents/about/icncode_english.pdf)
- Jaquier, V., Hellmuth, J.C., Sullivan. T. P. (2013)“Posttraumatic stress and depression symptoms as correlates of deliberate self-harm among community women experiencing intimate partner violence.” *Psychiatry Research*. Vol. 206 No. 1. March. Accessed 1 April 2013 <http://www.deepdyve.com/lp/elsevier/posttraumatic-stress-and-depression-symptoms-as-correlates-of-7dNceZfWYO>.
- John, I. A. (2010). *Screening for intimate partner violence in Kano Nigeria: barriers and challenges for healthcare professionals*. University dissertation from Stockholm: Karolinska Institutet, Department of Public Health Sciences.
- Krug, E.G., Dahlberg, L.L., Mercy, J.A., Zwi, A. B., & Lozano, R. (2002). World report on violence and health. *World Health Organization (WHO)*. Geneva.
- Krippendorff, K. (1980). Content analysis. An Introduction to its Methodology. Beverly Hills: Sage.
- Laisser, R. M., Nyström, L., Lindmark, G., Lugina H.M.I., and Emmelin, M. (2011) Screening of women for intimate partner violence: A pilot study

intervention at an outpatient department in Tanzania. *Global Health Action*. 4:7288.

Lawoko, S., Sanz, S., Helström, L. and Castren, M. (2011). Screening for Intimate Partner Violence against Women in Healthcare Sweden: Prevalence and Determinants. *ISRN Nursing*, 1-7.  
<http://dx.doi.org/10.5402/2011/510692>

Lincoln, Y.S. & Guba. E.G. (1985). *Naturalistic Inquiry*, NewburyPark, CA: Sage Publications.

Lindseth, A., & Norberg, A. (2005). A phenomenological hermeneutical method for researching lived experiences. *Scandinavian Journal of Caring Sciences*, 18. 145-153.

Locke L. M., & Richman. C. L. (1999). Attitudes towards domestic violence: Race and gender issues. *Sex Roles*, Vol 40, Nos, 314.

LoBiondo-Wood, G & Haber, J. H. (2002). *Nursing Research: Methods, Critical Appraisal, and Utilization*. Mosby.

Leppäkoski, T., Flinck, A., & Paavilainen, E. (2014). "Assessing and Enhancing Health Care Providers' Response to Domestic Violence," *Nursing Research and Practice*, vol. 2014, Article ID 759682, 8 pages, 2014. doi:10.1155/2014/759682.

McFarlane, J., Greenburg, L., Welge, A., & Watson, M. (1995). Identification of abuse in emergency departments: Effectiveness of a two-question screening tool. *Journal of Emergency Nursing*. Vol 12: no: 5, 391-395.

Parker, B., McFarlane, J., Soeken, K. (1994). *Obstet Gynecol. Sep*; 84 (3): 323-8.

McCauley J, Yurk RA, Jenckes M, Ford DE. (1998). Inside "Pandora's box." Abused women's experiences with clinicians and health services. *J Gen Intern Med*. 13: 549-55.

McLeod, S. A. (2008). Case Study Method. Retrieved from [www.simplypsychology.org/case-study.html](http://www.simplypsychology.org/case-study.html)

Mitchell, C., & Anglin C. (2009). *Intimate Partner Violence: A Health-Based Perspective*. Oxford University Press. New York.

Nagle. D. (2011). Framing client care using Halldorsdottirs theory of caring and uncaring behaviours within nursing and healthcare. *International journal of human careing*. Vol.15, N0.4. p. 54-65.

- National center for victims of crime (2008). The Trauma of Victimization. <https://www.victimsofcrime.org/help-for-crime-victims/get-help-bulletins-for-crime-victims/trauma-of-victimization>
- Nation Council for Crime Prevention [BRÅ]. (2014). Offenses in close relationship. National Survey. Brå report 2014.8
- National Council for Crime Prevention (BRÅ). (2004). Violent crime rising, robbery crimes lessens. *Pressmeddelande*. Nr. 1. (English Version).
- Nation Council for Crime Prevention [BRÅ]. (2002). Violence towards women in close relationship. A Survey.
- OECD. (2013). OECD Health Care Quality Review of Sweden. Paris: OECD.
- Polit, D., & Beck, C. T. (2006). *Essentials of Nursing Research. Methods, appraisal and utilization*. 6<sup>th</sup> Edition. Lippincott Williams &Wilkins.
- Polkinghorne, D. E. (1989). Phenomenological research methods. In R.S. Valle & S. Halling (Eds.) *Existential-phenomenological perspectives in psychology* (pp. 41-60). New York: Plenum.
- Pico-Alfonso, M., Garcia-Linares, I., Navarro, N. C., Blasco-Ros C., Echeburua E., & Martinez, M. (2006). "The Impact of Physical, Psychological, and Sexual Intimate Male Partner Violence on Women's Mental Health: Depressive Symptoms, Posttraumatic Stress Disorder, State Anxiety, and Suicide." *Journal of Women's Health*. Vol. 15. November. Accessed 1 April 2013 from [http://empower-daphne.psy.unipd.it/userfiles/file/pdf/Pico-Alfonso%20M\\_%20-%202006.pdf](http://empower-daphne.psy.unipd.it/userfiles/file/pdf/Pico-Alfonso%20M_%20-%202006.pdf).
- Rehnström, K., Dahlborg-Lyckhage., E. (2016). Proactive Interventions: An Observational Study at a Swedish Emergency Department. *Sage Open* Jul, 6 (3) 2158244016658083; DOI: 10.1177/2158244016658083.
- Reisenhofer, S., Seibold, C. (2013). Emergency healthcare experiences of women living with intimate partner violence. *J Clin Nurs*. Volume 22, Issue 15-16, p. 2087–2361. <http://onlinelibrary.wiley.com/doi/10.1111/jocn.2013.22.issue-15pt16/issuetoc>.
- Ricoeur, P. (1981). *Hermeneutics and the Human Sciences. Essays on Language, action and interpretation* ((Thompson J.B., Trans. 1998 ed.) ed.). Paris and Cambridge: Editions de la Maison des Sciences de l'Homme and Cambridge University Press.
- Rudman, W. J. (2000). Coding and Documentation of Domestic Violence. Family Violence Prevention Fund.

- Sabuni, N., & Reinfeldt F. (2007). Action plan for combating men's violence against women. Ministry of Integration and Gender Equality. *Government offices of Sweden*.
- SFS, (2010). 2010:659. *Patientsäkerhetslagen* [Patient Safety Act]. Swedish Code of Statutes. Retrieved from <https://lagen.nu/2010:659>.
- SFS (1999). 1999:845, amendment to the Penal Code. Chapter 4 section 4a paragraph 1.
- SFS (1998). 1998:204 The Swedish Data Protection Authority.
- SFS (1982). 1982: 763. The Swedish Health and Medical Services Act
- SFS, (2001). Social Services Act. (SoL 5 kap. 11 §): *A follow up of the National Board of Health and Welfare*.
- Sandelowski, M. (1993) Theory unmasked: the uses and guises of theory in qualitative research. *Research in Nursing & Health* 16, 213–218.
- Save the Children Sweden. (2003). Anmälningar som försvann.”The reports that disappeared”.
- Soeken, K.L., McFarlane, J., Parker, B. and Lominack, M.C. (1998) The Abuse Assessment Screen: A Clinical Instrument to Measure Frequency, Severity, and Perpetrator of Abuse against Women. In: Campbell, J.C., Ed., *Empowering Survivors of Abuse: Health Care, Battered Women, and Their Children*, SAGE Publications, Inc., Thousand Oaks, 195-203. [
- Suserud, B.O. (2001). Emergency Nursing Sweden. *Emergency Nurse*; Nov 2001; 9, 7; ProQuest Central pg. 10.
- Sims, J. M. (2010). A brief review of the Belmont report. *Dimens Crit Care Nurs*, 29(4), 173-174.
- Spangaro, J., Poulos, R., & Zwi, A. (2011). “Pandora doesn't live here anymore: Normalization of screening for intimate partner violence in Australian antenatal, mental health and substance abuse services” *Violence and Victims* 26 (1) pp 130-144 (Springer Publishing Company).
- Statens Offentliga Utredningar [SOU]. (2015). *SOU (2015:55)*. Nationell strategi mot mäns våld mot kvinnor och hedersrelaterat våld och förtryck. (National Strategy Against Men's Violence Against Women and Honour-Related Violence and Oppression).
- Statistical Package for the Social Sciences, [SPSS]. (2012) .version 21. Chicago. Copyright IBM Corporation.

Stenson, K. (2004). Mens violence against women- a challenge in antennal care. Doctoral Thesis. The Faculty of Medicine. Uppsala University, Uppsala, Sweden.

Stockman J. K., Marguerite, B. L., Campbell, J. (2013). "Forced Sexual Initiation, sexual intimate partner violence and HIV risk in women: A global review of the literature." *AIDS and Behavior*. Vol. 17 No. 3. March Accessed 1 April 2013 from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3586980/>.

Sugg, N. K., Inui, T. (1992). Primary care physicians' response to domestic violence. Opening Pandora's box. *JAMA*.;267:3157–60.

Taft, A., Broom, D., & Legge, D. (2004). General practitioner management of intimate partner abuse and the whole family: a qualitative study. *BMJ*, 328, pp. 618–621

U.S. Preventive Services Task Force. (2013). "Screening for Intimate Partner Violence and Abuse of Elderly and Vulnerable Adults" U.S. Preventive Services Task Force. Accessed 10 February 2013 from <http://www.nursingworld.org/MainMenuCategories/Policy-Advocacy/Positions-and Resolutions/ANAPositionStatements/Position-Statements-Alphabetically/Violence-A>

United Nations Office on Drugs and Crime, [UNDOC]. (2010). Handbook on Effective police responses to violence against women. Vienna.

United Nations General Assembly. (1994). Declaration on elimination of violence against women. A/RES/487104

Van Dulmen, M, Klipfel, KM., Mata, AD, Schinka, KC., Claxton, SE., Swahn, MH., M. Bossarte, RM.( 2012) "Cross-Lagged Effects Between Intimate Partner Violence Victimization and Suicidality From Adolescence Into Adulthood." *Journal of Adolescent Health*. Vol. 51., No. 5, November. 2012. Accessed 1 April 2013 from <http://www.jahonline.org/article/S1054-139X%2812%2900097-3/abstract>.

Van Loon, M-AM., & Kralik, D. (2005). Reclaiming myself after child abuse. Adelaide. Royal Distric Nursing Service Foundation Research unit Catherine House, Alcohol Rehabilitation Foundation. [http://www.rdns.org.au/research\\_unit/documents/Reclaiming\\_Myself\\_Reurce.pdf](http://www.rdns.org.au/research_unit/documents/Reclaiming_Myself_Reurce.pdf)

Wall, L. (2012). The many facets of shame in intimate partner sexual violence (ACSSA Research Summary). Melbourne: AIFS.

Wagnhild, G. M., & Young, H. M. (1993). Development and psychometric evaluation of the Resilience scale. *Journal of Nursing measurements*. 1, 165-175.



- Wathen, N. & MacMillan, H. (2012). Partner Violence Screening and Women's Quality of Life. Letters. *Journal of American Medical Association*, 308, 2334-2336.
- Widom, C. S. (1984). Sex roles, criminality and psychopathology. Pp. 183-217 in, ed., *Sex Roles and Psychopathology*. New York: Plenum.
- World Health Organization. [WHO] (2013). "Definition and typology of violence." Accessed 3 March 2013 from <http://www.who.int/violenceprevention/approach/definition/en/>.
- World Health Organization. (2002). *Violence: a public health priority*. Global consultation on Violence and Document Health. Geneva. WHO/eha/SPI.POA.2).Geneva.
- World Medical Association Helsinki, [WMA]. (2016). WMA Declaration of Helsinki - Ethical Principles for Medical Research Involving Human Subjects. <http://www.wma.net/en/30publications/10policies/b3/>
- Wathen, N., & MacMillan, H. (2012). "Partner Violence Screening and Women's Quality of Life." Letters. *Journal of American Medical Association*. Vol. 308. No. 22. December. Accessed 10 February 2013 from <http://jama.jamanetwork.com.ezproxyhhs.nihlibrary.nih.gov/article.aspx?articleid=1484502> . Woods, Stephanie J., Rasalie
- Wikipedia. (2014). [http://en.wikipedia.org/wiki/Victimisation#cite\\_ref-criminologytoday\\_2-1](http://en.wikipedia.org/wiki/Victimisation#cite_ref-criminologytoday_2-1).
- William, D. (2012). *Victimology*. Burlington, MA: Elseiver, Inc. ISBN 978-1-4377-3486-7.

# APPENDIX 1.

## Abuse Assessment Screen (Svenska versionen)\*

1. Har du någon gång utsatts för psykisk eller fysisk misshandel av din partner eller av någon annan för dig betydelsefull person? Ja... Nej...

### Här följer frågor som handlar om du är eller varit gravid:

2. Har du **under året före** du blev gravid blivit slagen, sparkad eller knuffad eller på något annat sätt fysisk skadad av någon?

Om ja- av vem?

Make... fd make... pojkvän... fd pojkvän... okänd

Annan...antal gånger ...

3. Har du **sedan du blev gravid** blivit sparkad? Blivit slagen, sparkad eller knuffad eller på annat sätt fysiskt skadad av någon?

Om ja- av vem?

Make... fd make... pojkvän... fd pojkvän... okänd

Annan...antal gånger ...

4. Har du någon gång tvingats till eller utsatts för sexuella handlingar mot din vilja?

Om ja- av vem

Make... fd make... pojkvän... fd pojkvän... okänd

Annan...antal gånger ...

5. Är du rädd för din partner eller någon annan du nämnt här?

Ja..... Nej.....

Modifierad version (Stenson 2004, p.18)

- The original version was developed by the Nursing research Consortium on violence and abuse (McFarlane, Parker & Soeken 1994).

## APPENDIX 2.

### DANGER ASSESSMENT SCREEN

Jacquelyn C. Campbell, PhD, RN, FAAN

Copyright 2004 Johns Hopkins University, School of Nursing

En Modifierad version anpassad till svenska förhållanden

Ingegerd Bergbom, Elisabeth Dahlborg, Darcia Pratt-Eriksson

Lyckhage, Copyright 2006 Institutionen för Vårdvetenskap och

Hälsa, Sahlgrenska Akademin Göteborgs Universitet

Flera risker faktorer har blivit förknippade med en ökad risk för mord eller dråp av kvinnor och män i våldsbenägna relationer. Vi kan inte förutsäga vad som kommer att hända i ditt fall men vi vill att du ska vara medveten om risken för mord eller dråp i relationer med misshandel och att du ska förstå hur många av risk faktorerna som är tillämpliga i din situation.

Använd kalendern och notera de ungefärliga datum under det senaste året då du blev misshandlad av din partner eller ex partner. Skriv vid detta datum hur allvarlig incidenten var i enlighet med följande skala:

1. Örfilar och knuffar, inga skador eller bestående smärtor
  2. Slag, sparkar som ger blåmärken, sår och/eller varaktig smärta
  3. Stryk, svårare blåmärken eller blödning under huden, brännskador, frakturer, missfall
  4. Hot att använda vapen, skall skador, inre skador, permanenta skador, missfall
  5. Vapen används, skottskador
- (Om något av exemplen ovan har förekommit mer ofta så anteckna det högre numret t.ex. om örfilar och knuffar mest förekommit så ange nr 1).

Datum:

Fyll i JA eller NEJ för följande frågor nedan

	JA	NEJ
1. Har det fysiska våldet ökat i frekvens/alltmer våldsamt under det senaste året?	-----	
2. Har det fysiska våldet blivit alltmer våldsamt Och allvarligt under det senaste året?	-----	-----
3. Finns ett handvapen i hemmet/bostaden?	-----	----
4. Äger din partner en sådant?	-----	---
5. Har hot med vapen eller vapnet förekommit/använts de senaste året?	-----	---

6. Har han/hon någonsin använt ett vapen  
Eller tillhygge mot dig eller hotat dig med  
ett dödlig vapen? ----- ----
- 6a. Om ja var det ett handeldvapen-----?)
7. Har du lämnat honom/henne under det senaste året? ----- ----
- 7a. (Om ni aldrig har levat tillsammans kryssa här \_\_\_\_\_)
8. Är han/hon arbetslös? ----- ---
9. Hotar han/hon med att döda dig? ----- ----
10. Har han/hon hållit sig undan polisingripande  
för familjevåld? ----- ----
11. Har du ett barn som inte är  
hans/hennes? ----- ----
12. Har han/hon någonsin tilltvingat  
sig sex mot din vilja? ----- ----
13. Har han/hon någonsin försökt att kväva dig? ----- ----
14. Använder han/hon någonsin narkotika?  
(Med narkotika avses i detta fall uppåtjack eller  
amfetaminer, PCP (ängladamm), kokain, marijuana,  
hasch, heroin, Cat, anabola steroider) ----- ---
15. Är han/hon alkoholist eller har alkoholproblem? ----- ----
16. Kontrollerar han/hon dina dagliga aktiviteter?  
(Till exempel talar Han/hon om för dig  
vilka du kan vara vän med, när du kan träffa din familj,  
hur mycket pengar du får spendera eller När du får lov  
att använda bilen?) ----- ----
17. Är han/hon våldsam och konstant svartsjuk?  
(Säger han/hon exempelvis att kan inte  
Jag få dig skall ingen annan få dig heller? ) ..... ----
18. Har han någonsin misshandlat dig  
då du varit gravid? ..... --- ----
- 18a (Om du ej varit gravid med honom kryssa här \_\_\_\_\_)
19. Har han någonsin hotat med  
eller försöker begå självmord? ----- ----
20. Hotar han/hon att skada dina/era barn? ----- ----
- 20a. Är han våldsam mot dina/era barn? ----- ----

- |   |       |       |
|---|-------|-------|
| 21. Är han våldsam utanför hemmet?  | ----- | ----- |
| 22. Tror du att han/hon är kapabel att döda dig?  | ----  | ----  |
| 23. Har han/hon hotat att döda dig?   | ----- | ----- |
| 24. Följer han/hon efter dig eller spionerar på dig?<br>lämnar Han/hon hotelser i meddelanden eller<br>på telefonsvararen? Förstör han/hon din egendom<br>eller ringer dig då du inte vill? | ----- | ---   |
| 25. Har du någonsin hotat med eller försökt<br>begå självmord?  | ----- | ---   |

**Totala antalet Ja svar.**

---

**Tack för din medverkan.**

**Vänligen tala med din sköterska, advokat eller socialassistent om vad denna riskbedömning betyder i din situation.**