Survival of intimate partner violence as experienced by women

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Aims and objectives. The study set out to describe women's experiences of intimate partner violence, the consequences of such violence, the help they received and women's experiences of their survival.

Background. Social and health professionals do not have sufficient ability to identify and help families who suffer from intimate partner violence. Methods for identifying and treating partner violence not have been developed adequately.

Method. The study was conducted in Finland by loosely formulated open-ended interviews with seven battered women. The data were analysed by inductive qualitative content analysis.

Findings. Women had past experience of maltreatment and a distressing climate at their parental home. Women experienced both themselves and their spouse as having weak identities; their ideals, patterns of marriage and sexuality were different. Violence occurred in situations of disagreement. Women tried to strike a balance between independence and dependence in the relationship. The different forms of couple violence were interlinked. The women sought help when their health and social relationships got worse. An awareness of the problem, taking action, counselling and social relationships helped them survive. Religiousness was a factor that involved commitment to the couple relationship, made religious demands on women and promoted the recovery of integrity.

Conclusions. Intimate partner violence was associated with the family model, childhood experience of maltreatment, the partners' weak identity and conflicts between individualism and familism. Social and healthcare professionals need competence in early intervention and skills to discuss moral principles, sexuality, and violence in a way that is free of prejudice and condemning attitudes. Spiritual approaches in the context of interventions should be taken into consideration.

Relevance to clinical practice. In a clinical context, nurses should be aware of the symptoms of violence, and they should have skills in dealing with intimate moral and spiritual issues.

Key words: domestic violence, intimate partner violence, nursing, violence against women, violence in the couple relationship

Introduction

The couple relationship based on love is a subsystem of the family, which is marked by publicity, on the one hand, and by secrecy and privacy, on the other. Changes in the family structure have entailed problems in families, which may manifest themselves in violent behavioural changes (Frost 1999, Marin 1999, Paunonen 1999, Åstedt-Kurki & Paunonen 1999). The presentation of intimate partner violence is often culture specific (Fischbach & Herbert 1997, Johnson & Ferraro 2000). The inadequacy of support systems, the stereotypical attitudes, the lack of skills and negative feelings of helpers may prevent violence from being revealed (Campbell 1994, Cohen 1996, Frost 1999, Johnson & Ferraro 2000, Waalen *et al.* 2000). It is necessary to develop clinical skills to help the family.

Violence is universally under reported. A survey published by Statistics Finland (1998) showed that 40% of women had been subjected to physical or sexual abuse or threats by a man in their lifetime (Heiskanen & Piispa 1998). It has been estimated that some 2–3 million American women are sexually abused annually (Fontaine 1995a). The British Crime Survey (1992) reported that 11% of women experienced some degree of physical violence in their partnerships (Frost 1999). In South Africa the lifetime prevalence of experiencing physical violence from a current or ex-husband or boyfriend was 24.6% (Jewkes *et al.* 2002).

Various reasons have been suggested for why people perpetrate violent behaviour, including biological, social and cultural factors and the individual's own traumatic experiences. In the feminist literature, violence against women is often seen as an extension of a more general power relationship between the sexes. In some cultures, the belief system may be offered as a justification for spouse abuse by men (Janssen 1995, Miles 1999, Russel & Wells 2000, Simoneti 2000, Kim & Motsei 2002). Women also behave violently against men, and violence also occurs in same-sex relationships (Magdol *et al.* 1997, Coker *et al.* 2000, Hines & Malley-Morrison 2001).

Intimate partner violence can be defined to include physical and sexual violence, threats of violence and psychological and emotional abuse. The perpetrator may be a current or former spouse, boyfriend/girlfriend or dating partner (Gelles 1997, Campbell & Soeken 1999, Saltzman *et al.* 2000, Watts & Zimmerman 2002). The recurrence of violent incidents tends to exacerbate the violence (Langford 1998). Based on studies of domestic violence in the 1990s, violence can be classified as follows: (i) common couple violence, (ii) intimate terrorism, (iii) violent resistance and (iv) mutual violent control (Johnson & Ferraro 2000).

Spouse abusers are not a homogeneous group and no one factor can predict the likelihood of spouse violence. The characteristics that research has associated with domestically violent men include low assertiveness, low self-esteem, poor social skills, alexithymia, history of childhood abuse, alcohol and drug abuse and higher spouse-specific dependency. Poor body-image satisfaction is reportedly related to aggressive behaviour (Murphy *et al.* 1994, Danielson *et al.* 1998; Dutton 1999: Russel & Wells 2000, Simoneti 2000, Arseneault *et al.* 2002, Caspi *et al.* 2002, Shelton & Liljequist 2002, Dixon & Browne 2003).

Battered women suffer from physical and psychological hypervigilance and hyperalertness, sleeping problems, fragmentariness of memory, forgetfulness and difficulty concentrating (Graham-Bermann & Levendosky 1998, Heiskanen & Piispa 1998, Langford 1998, Campbell & Soeken 1999, Frost 1999, Campbell 2002). Children living in a violent home are also exposed to the aftereffects of violence (Adamson & Thompson 1998, Graham-Bermann & Levendosky 1998, Dutton 1999).

In Finnish society, the problem of violence against women has been mainly tackled by voluntary organizations. Resources have been allocated particularly for helping female victims. The professional staff's threshold for intervention is high.

The study

Aims

The aims of this study were to:

1 Describe women's experiences of intimate partner violence and its consequences;
2 Look at what kind of help and support they received and hoped to receive;
3 Address women's experiences of factors that enhanced their survival.

Method

A qualitative approach was used to examine the depth, multifaceted nature and complexity of the phenomena of

violence. Through women's own accounts, the qualitative method was used to gain insight into their experiences of intimate partner violence and their survival of violence. Women were studied in their own environment while speaking their own language (Alasuutari 1993, Nieswiadomy 1998, Burns & Grove 1999).

Data collection

The data were collected in Finland in 2000. A voluntary organization, the Dolphins, engaging in work with abused women and children informed its members about the study. Seven anonymous women representing different ages, occupations and social classes contacted the researcher and expressed their wish to volunteer for the study. Six of the women had been married and had children, four of them had Christian conviction.

The interview themes were selected based on earlier literature and studies (Serra 1993, Gelles 1997, Campbell & Soeken 1999, Frost 1999). The data consisted of loosely formulated interviews with themes of women's childhood, couple partnership, experiences of violence and survival. The women participating in this study had gone through counselling and they had the possibility of receiving further counselling if distress arose during the interview. They were invited to talk in their own words of intimate partner violence (Dreher 1994, Nieswiadomy 1998, Devine & Heath 1999, Suto 2000). The interviews took place in the women's homes or in the offices of health care clinics. Each interview took 1.5–2 hours. All the interviews were recorded on tape and transcribed. The data collection took 2 months.

Data analysis

After completing all the interviews, one of the researchers (A.F.) analysed and coded the data using qualitative content analysis through inductive category development (Dey 1993, Morgan 1993, Miles & Huberman 1994, Burns & Grove 1999, Kyngäs & Vanhanen 1999, Tuomi & Sarajärvi 2003). The purpose of the study and the data guided the analysis, which began with listening to the tapes and by recording observations. The transcripts were read several times whilst keeping in mind the data research questions. Sentences and sentence parts were chosen as units of analysis. Units of analysis were highlighted, with coloured pens identifying the themes, specific elements, similarities and differences and ensuring that no data and its specific features would be lost. The line-by-line reading and continual asking of research questions forced the analyst to verify and saturate categories. Original expressions were reduced, clustered and named according to similarities. The clustered groups with similar content were then conceptualized into subcategories, which were further conceptualized into main categories and aggregate categories while seeking to find a connection with the original texts. The findings and conclusions were then interpreted. The steps of the analysis are presented in Table 1.

Table 1 Process of content analysis (Dey 1993, Morgan 1993, Miles & Huberman 1994, Kyngäs & Vanhanen 1999, Tuomi & Sarajärvi 2003)

1. The tapes were listened to and observations recorded
2. The interviews were transcribed
3. Sentences and sentence parts were nominated as units of analysis
4. The transcripts and notes were reviewed and read several times whilst keeping in mind the data research questions, highlighting units, identifying themes and specific elements and ensuring no data were lost
5. Original expressions were reduced, clustered and named according to similarities
6. The clustered groups with similar content were conceptualized into subcategories, main categories and aggregate categories
7. Findings and conclusions were interpreted

Ethical issues

Only voluntary women who had sought help from support systems and were receiving counselling participated in the study. The participants were provided with an opportunity to ask questions about the study. The safety of the respondents and confidentiality were ensured, and care was taken that the interview process was affirming and did not cause distress. Women had the right to withdraw from the study and they were given an opportunity to obtain the results of the study (Hutchinson & Wilson 1994, Punch 1994, WHO 1997, Nieswiadomy 1998, Suto 2000, Ellsberg & Heise 2002). The study was approved by the Research Ethics Committee of the Pirkanmaa Hospital District in Finland and by the voluntary organization.

Findings

The study revealed five aggregate categories that emerged from the research questions. The aggregate categories 'family with no security', 'family life behind the scenes', and 'women's secrets, symptoms and signs' describe women's experiences of intimate partner violence and its consequences. The aggregate categories 'received support' and 'supporting factors' describe women's experiences of the support they received and of survival enhancing factors (Fig. 1). The phrases are numbered according to the name of the interviewee (I).

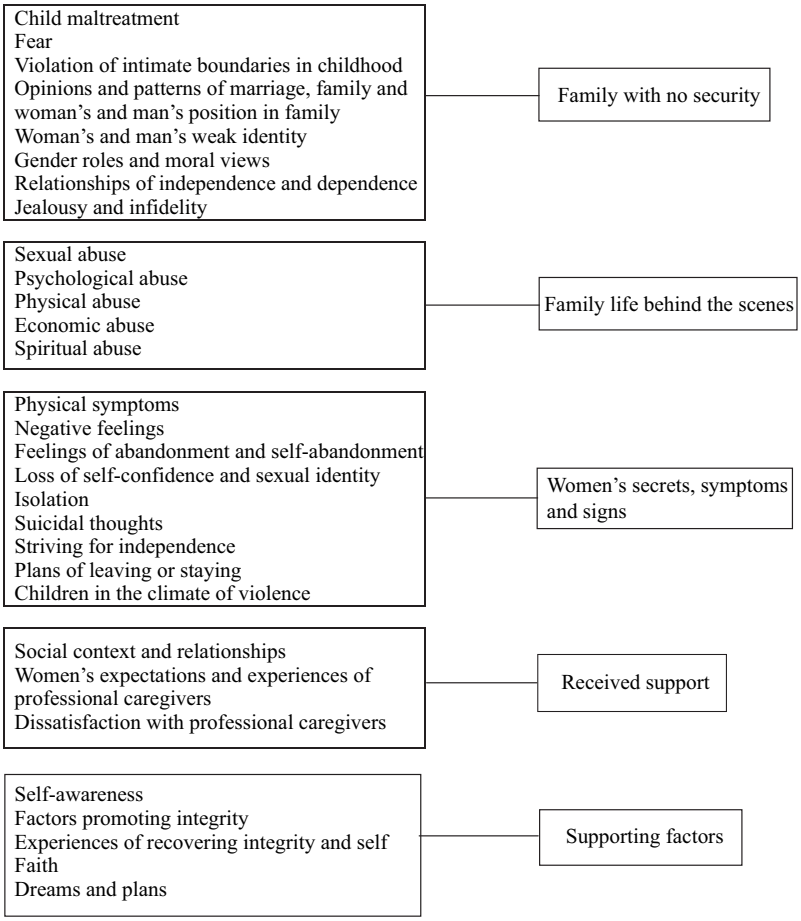

Figure 1 Main categories and aggregate categories describing women's experiences of 'family with no security', 'family life behind the scenes', 'women's secrets, symptoms and signs', 'received support' and 'supporting factors'.

Family with no security

It was the women's experience that intimate partner violence was associated with the opinions and patterns of the family, marriage and sexuality. Cultural, religious and moral perceptions and patterns adopted in the childhood family gave rise to conflict concerning the man's and the woman's position in the family. Women felt that their husbands tended to emphasize their masculinity through their sexuality. Women wanted to save the marriage on the one hand and become independent on the other:

I quarrelled a lot with mother. She always took the side of the boys, and everything was my fault, I was treated like a wild beast. (I3)

My husband said that sex is the privilege of a man. (I2)

Strivings for independence exhibited by the sexes, differences in values and differing sexual needs manifested themselves as conflicts. Women expected the couple relationship to give them a feeling of security and to satisfy their affection needs, but they felt that the relationship had failed to meet these expectations. Five interviewees had childhood experiences of maltreatment and fear. These women felt that the violation of intimate boundaries in childhood was as a factor related to predisposing them to intimate partner violence:

When I was six years old, the man touched me in a way which is not allowed and I did not understand what happened. (I3)

I thought he would free me by marriage from the castle of taboo in my parental home. (I7)

Family life behind the scene

The women described their lives as loveless and devoid of emotion. The women experienced their husband portrayed as reliable, accurate, extrovert, sexually active and socially skilled, but repressive and abusive towards their wives. The couple relationship was characterized by jealousy and infidelity, as well as sexual problems. An abusive man might have had extra-marital affairs:

He said he needs another woman because I don't satisfy his requirements. (I4)

Everybody said you have a kind and gentle man. He was so unaffected and sociable. (I1)

All the women viewed themselves as sexual objects. Sometimes they agreed to sexual intercourse to escape the threat of violence or out of duty. Some of them signalled their discontent by refusing to have sex or to do domestic chores and by seeking security from their friends. Conflicts could result in violence. The behavioural pattern of these women involved periods of soothing, forgiveness, apologies and indulgence. Temporarily, the women believed they could change the man. Women felt that their hopes of an everlasting marriage had been ruined and felt fear and shame for the failure of the most important personal relationship:

Sometimes I'd cook something he liked and then acquiesced to sex, thinking he might be nicer. (I1)

Then I stopped serving him, and he didn't like it. (I2)

The violence involved sexual, psychological, physical, economic and spiritual abuse. Sexual abuse involved treating women as a sexual object, intercourse by coercion, undressing the victim, demands related to clothing, derogatory name-calling and infliction of pain. Psychological abuse involved name-calling, rejection of the woman's values, feelings, needs and wishes or belittling of and derogatory comments about the woman's appearance, sexuality and intelligence. It also involved verbal abuse, ridiculing, drawing comparisons with other women and threats of infidelity. An experience of being in mortal danger was sometimes a manifestation of psychological abuse. Physical abuse involved various forms of exertion of power, punches and physical force. The man might use physical force by tearing the woman's clothes, tying her to the bed, choking her, or preventing her from sleeping. Economic violence involved neglecting his economic duties. Spiritual abuse involved preventing women from attending a church service or reading spiritual literature.

Women's secrets, symptoms and signs

Living in an abusive relationship had repercussions for the physical and psychological health and social relationships of women. Men blamed their spouses for sexual frigidity, appearance-related issues and economic irresponsibility. Women blamed their husbands for the lack of empathy and dialogue, and for having extra-marital affairs. Women blamed themselves for sexual frigidity, appearance, personality and marital discord. They felt that they had failed in fulfilling the Christian expectations of marriage:

I thought that I had no right to divorce without any biblical grounds, and I had no courage to do it. (I1)

I wondered if I were frigid, because I did not want sex. (I6)

Women experienced that they were tied to an abusive relationship, but they also had flight reactions. Women were ashamed of their own bodies, social status, human relationships and failures in the marriage. Silence and secrecy were characteristic of the women:

If I leave him, everybody thinks that it is me who is to blame. (I6)

As the women became aware of the violence, they recognized their repressed anger, hate and self-hatred. Sometimes the negative feelings manifested themselves in self-destructive behaviour, a tendency to isolate oneself and addictions. Three women described their addiction behaviour. Women reported bitterness, disappointment, paralysis, abandonment, self-rejection and loss of self-confidence. Sometimes the prospects for freedom were associated with thoughts about their own or the spouse's death. Five of these women had suicidal ideation, three of them were afraid of injuring their husbands, which often prompted them to seek help. They hoped to find a safe way out of the relationship:

I thought that I would kill myself to get rid of it. (I4)

I said that I couldn't put up with this any longer, that I was no longer his slave. I stood up to him. (I2)

The loss of feminine self-confidence was manifested as a desire to conceal female characteristics. The women depicted themselves as floor cloths, doormats, whores, utensils or pieces of furniture:

I wanted to cover myself with large clothes, I did not want to look like a woman. (I5)

I was dependent upon him until I was thirty, I was a doormat and a slave, nothing more. (I1)

The children in these families had been subjected to sexual harassment or had heard or been aware of the violence. In one of the families the children had had to witness sexual acts. In two families the children had been in mortal danger in one situation. In two other families the children exhibited panic disorders, mental problems and suicidal thoughts in later life. Typically, one of the children would stand up for the mother:

This child from my first marriage always stood up for me. (I4)

Received support

Seeking help was complicated by the social and religious expectations experienced by the women. Marital vows made it difficult for a woman to leave. The women pondered their own guilt or they were afraid that the man would prevent them from talking about the violence or that seeking help

would lead to more violence. An attempted suicide or fear of injuring the man may have served as the first steps towards leaving. Sometimes religious reasons prevented them from considering divorce. Remembering and forgetting the experiences of violence alternated. Remembering was associated with touch, smell, taste, emotional memory and body memory. Remembering could trigger a crisis in which women needed help. The first attempts to seek help had to be kept secret, because the man opposed the woman's care relationship.

Women sought help from mental health clinics, family centres and voluntary organizations. Four of the women sought help from spiritual communities. Women found it difficult to name their experiences and talk about them:

> At first I had no words for the abuse. But then I started to write some of it down and here it received a name. (I5)

Support from friends, a peer group, or confidential long-term care relationships were much appreciated by women. They expected a safe climate and longed for consolation and physical contact. Most of the women were disappointed with the caregivers who were prejudiced, or underrated the violence, or were reluctant to tackle abuse. Four women were dissatisfied with how the effects of physical abuse were treated and expected proper focusing on psychological issues and appropriate referral to specialist care. They expected healthcare professionals to be outspoken, empathetic and to have the courage to listen to difficult issues. Women hoped to proceed slowly. Women interpreted the caregiver's body messages, looks, and authenticity in relation to verbal messages. Women also hoped that caregivers had the courage to ask about the violence without blaming and condemning:

> When I told the doctor what he had done to me, the doctor could have asked if I needed help or something instead of just examining the bruises and contusions impersonally. (I3)

Supporting factors

Awareness, taking action and counselling had contributed to the women's survival. Awareness of violence was facilitated by auditive, visual and emotional memory and drama. Survival was promoted by support from a good therapist, a spiritual community, a good physician of souls, faith in God, family of origin, friends, a new partner relationship, positive feedback on work, strengthening of self-esteem and hobbies. Being released from guilt and an experience of setting one's boundaries made the women stronger:

> I survived because of a good therapist and my family. My faith in God and his presence and the fact that I have been able to use my experience to help others have also helped. (I7)

The women associated the experience of survival of violence with the ability to dream and make future plans, and to rediscover their own feelings, femininity, sexuality and self-respect. Their future plans often included the establishment or hope of a new, safe and healthy couple relationship:

> I've had terrible times in my life, but now my life is a bit more tranquil, and I have been able to dream and that's a good thing. (I5)

Discussion

Conclusions

Intimate partner violence was associated with conflicts between familism and individualism, independence and commitment, gender roles and sexuality. Perceptions of an everlasting marriage and love had contributed to the violence in the couple relationship. Rigorous behavioural, moral and gender patterns adopted in the family of origin failed to support the gender identity and the couple relationship. It was typical of the abusive couple relationships that the women had married to escape a distressing climate in the home and expected marriage to give them a feeling of security. A study by Kearney (2001) showed similar results of the process from enduring love towards a new life. Variations in the manifestation and duration of different phases were linked to personal and cultural contexts. The studies of Fischbach and Herbert (1997) and Johnson and Ferraro (2000) have also indicated that the presentation of partner violence is often culture specific.

Most abused women reported some form of maltreatment and violation of intimate boundaries in childhood. The women participating in the present study and their children suffered from traumatic childhood memories in their adult lives. The studies of Hall (1996), Graham-Bermann and Levendosky (1998), Hall *et al.* (1998) and Attala and Summers (1999) into the victims of child maltreatment and their parenting skills showed that victims of child abuse were particularly sensitive to violent behaviour as future parents and the children who had witnessed abuse in their homes suffered from post-traumatic stress. The findings lend support to the findings of the present study and suggest that special support for parenting skills and protocols to identify and address abuse in families are necessary.

The women's self-image was marked by Christian values, low self-esteem, submissiveness, kindness and family commitment. On the contrary, the study of Merrit-Gray and Wuest (1995) revealed that abused women were not passive victims.

The partners' denial of one's own and the other's human dignity were activated in the couple relationship. The present study showed that the man took the woman's refusal to have sex with him as an insult and that the women's behaviour was a threat to their masculinity. These findings are consistent with those obtained by Goldner *et al.* (1990), Janssen (1995), Dutton (1999), Franchina *et al.* (2001) and Eisler *et al.* (2000). The experiences of the women participating in this study suggest that men who behave violently have low self-esteem. Studies by Murphy *et al.* (1994), Umberson *et al.* (2002) and Caspi *et al.* (2002) indicated that violent behaviour is associated with poor body image satisfaction and the inability to manage stress.

The findings of the present study show that many of the women felt themselves to be in mortal danger. The finding is consistent with those obtained by Campbell (1994), Campbell and Soeken (1999) and Tollerstrup *et al.* (1999), in which abused women were in greater danger of being murdered. Leaving the abusive relationship may involve a particular danger to life. A study by Shalansky *et al.* (1999) showed that the danger is not over when a woman and children leave the abuser, but in fact grows. A study by Langford (1998) showed that a woman's relationship with an abusive man could be described through the concepts of social chaos and danger associated with undefined rules, contradictions related to the use of violence, erosion of emotions and secrecy and isolation.

The spiritual conviction of four of the women tied them to the couple relationship on the one hand, making religious demands on them and yet supported them in their recovery on the other. Not enough is known about spirituality as a factor that both ties a person to an abusive partner relationship and helps in the survival of violence (Treloar 2002).

This study showed that seeking help was the result of lengthy consideration and the women needed resources to leave. The attitudes and behaviour of significant others and professional caregivers may define the way intimate partner violence is perceived. Paavilainen (1998) found in her study that caregivers acted inconsistently while working with abusive families. Women often tend to give subtle hints about their situation and rely on caregivers to carry the discussion forward (Fontaine 1995b, Anderson 1997, Frost 1999, Johnson & Ferraro 2000, Waalen *et al.* 2000). Women tell caregivers about domestic abuse and violence if they are asked. Routine screening should be developed (Titus 1996, Waalen *et al.* 2000, D'Avolio *et al.* 2001).

Helping battered women is a difficult and demanding task for nursing staff as they have to face their own attitudes, fears, distress, helplessness and insecurity (Anderson 1997, Francis 1997, Frost 1999). In the caregiver/victim encounter, it was crucial for the women's recovery of wholeness that the listener consented to listening to difficult matters and endured possible anger and bitterness. Studies by Shephard *et al.* (1999) and Frost (1999) also showed that the staff of prenatal and child welfare clinics and public health nurses were in a key position to identify domestic violence. As Hague (1998) suggests, multi-agency work as a response to domestic violence is also needed.

The findings showed that survival of intimate partner violence was closely related to remembering, recognition and reminiscing. The findings were similar to those obtained by Hall and Kondora (1997) in their study of sexual abuse against women. Their study also described women's body memory and the alternation between true and false memories.

Women were helped in their coping by the social context and relationships, self-awareness and factors promoting integrity, faith and orientation towards the future. A survivor may face many complex issues. If marital violence was regarded as normal and an everlasting marriage as an ideal, women were released from an abusive relationship through a prolonged and multi-stage process (cf. Merrit-Gray & Wuest 1995, Kearney 2001, Wuest & Merrit-Gray 2001). Elkan *et al.* (2000) and Iliffe and Steed (2000) explored the impact of working with domestic violence clients on caregivers, and reported the challenges of domestic violence work.

After coping, many women wanted to help other sufferers. A study by Long and Smyth (1998) suggested that caregivers who had been subjected to sexual abuse were the most empathetic helpers for victims of sexual abuse. The findings emphasized that all nurses should be trained to identify, deal with and treat emotional and mental pain. Healthcare professionals should also be aware of the different cultural and religious perceptions and interpretations to be able to help on an individual basis and to discuss spiritual issues and give advice for seeking help.

Children and the family suffered from living in a climate of violence. The findings of the present study were consistent with those obtained by Campbell (1994) and Paavilainen (1998), indicating that child maltreatment and intimate partner violence are interconnected.

Study limitations

The findings cannot be generalized due to the small sample size of seven Finnish battered women. The researchers had no influence on the sample selection, as the participants were volunteers, and therefore the sample lacks sufficient variation. Self-reported outcomes may be subject to bias introduced by the provision of socially desirable responses. As the

participants already had a care relationship, there might also be a bias in favour of views that see the women as a victim. The validity of the results was verified by one participant who read the results and confirmed they were a good reflection of her experiences.

Our interviewees participated willingly in the study and had the desire to regain wholeness, which may have led to a selection bias. Further research is needed to gain insights into women's experiences in different cultures and societies. A feature of qualitative research is that each story that serves as data is unique and that the experiences described are highly individualized. The study showed that these women had particularly traumatic experiences of intimate partner violence.

Most of the women were of Christian conviction, which may have added secondary meanings to their experiences and to the way these were experienced and described, such as the wife's subordinate status, guilt and forgiveness. The family pattern and the male and female role models in the context of this study stem from the Finnish culture and Lutheranism. Women of different ages and education may have different views of the phenomenon under examination. Experiences of survival and the factors that contribute to it are also subjective. These questions may be of relevance when examining the reliability of the findings.

Men's perceptions of violence were not included in the study. Their perspective would have contributed to the validity of the study.

To assess the reliability of the analysis, the steps in the analytical process were carefully described and authentic excerpts from the data were provided. The research procedure was documented so as to allow the reader to follow and assess the course and reliability of the study. Repeat measurement cannot provide similar research findings, as the transferability of findings is affected by societal, legislative and cultural factors and by various models explaining violence. The findings of this study can be judged justifiable in lieu of definitive knowledge. The study was confined to a woman's perspective, and the investigator's frame of reference is that of a woman. One must consider the effect of a female investigator's intuition and interpretations on the analysis and conclusion of the data when assessing the transferability of findings. However, these results increase the understanding about domestic violence as the basis of care.

Suggestions for nursing practice and further research

The way intimate partner violence is experienced depends on the individual and is linked with the cultural context and the ideals created by it. A family perspective and the identification of possible risk factors, e.g. suicidal and homicidal ideation are important. Appropriate recording mechanisms that take account of the perpetrator's and victim's views should be further developed. Services for perpetrators and victims and a clear care system should be put in place. Additional research should be conducted into the incidence of intimate partner violence to ascertain the experiences of men and families.

Women were disappointed with the professionals' attitudes and inability to talk about the intimate aspects of the partner relationship. Tackling intimate partner violence is experienced as difficult, and interventions are easily postponed or rejected. Impartiality and avoidance of blaming and condemning are necessary in nursing. Future challenges involve the development of new care models, lowering the threshold for seeking help, training, clinical supervision, multi-professional service chains and projects on violence prevention and the development of legislation.

Women participating in the study found it difficult to bring up the subject themselves. Social and healthcare services and related education should enhance knowledge, screening and communicating skills and confidence in dealing with the clients. What is needed is competence in early intervention, direct asking, discussion and listening skills. The nursing staff should develop skills in strengthening and supporting the sexual identity and self-image of both partners. It would also be topical to develop nursing that is sensitive to the needs of both genders.

In intimate partner violence both parties should be listened to, and subjective truths and false perceptions should be taken into account, while avoiding blaming and condemning. Support systems should be gender based, and dialogue is needed between the victims and perpetrators and the helpers. It is important to consider whether dimensions of spiritual well-being correlate with sexuality, spouse abuse and coping with violence. Further research could be focused on religious and cultural stereotypes and on beliefs and myths underlying sexuality. Research into attitudes and sexual morals could explore the possible cultural and societal differences in moral views related to the couple relationship, family, sexuality and abuse.

Additional information is needed on the effectiveness, usefulness and appropriateness of various care models. Research is also needed to explore the suicidal and homicidal threats, effects of women's aspirations for equality and individualization on the perceptions of marriage and family, and on sexual morals.

The general assumption and research findings suggest that women are most commonly the victims of abuse while men are the perpetrators and there is no exact knowledge of the

extent and nature of domestic violence against men. Nursing research into female forms of violence is needed.

Research on intimate partner violence deals with intimate aspects of life, to which different meanings are given by the different sexes and by different individuals. Intimate partner violence is linked with contradictory societal, social and criminal policy considerations. As different research approaches may produce contradictory results, there is a need for multi-disciplinary and methodologically varied research.

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Contributions

Study design: AF, EP, PÅ-K; data analysis: AF, EP, PÅ-K; manuscript preparation: AF, EP, PÅ-K.

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