A Qualitative Study on Intimate Partner Violence Screening Practices by Registered Nurses in the Emergency Department

A Thesis

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Dedications

This research is dedicated to my husband, Jerry; my beautiful children, Karl, Patrick, and Alice; my mother, Alice; and my siblings, who had more faith in my academic endeavors than I did. I also want to thank all of my other family and friends who have been supportive throughout this journey. I am truly blessed.

I especially dedicate this work to my father, Joe, who was taken from this earth far too soon. He always supported my academic pursuits. I am eternally grateful that he showed me by example the importance of caring about the lives of other people. My dad was a gentle soul with an extremely kind heart.
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ABSTRACT

A Qualitative Study on Intimate Partner Violence Screening Practices by Registered Nurses in the Emergency Department
Theresa M. Fay-Hillier

**Background:** Approximately 30% of women and 10% of men in the United States have been the victims of intimate partner violence (IPV)—which is defined and divided into four types of violence: physical violence, sexual violence, threats of physical or sexual violence, and psychological or emotional abuse. Intimate partners include current or former spouses, significant others and dating partners. Victims of IPV are frequently evaluated by registered nurses (RNs) at a hospital emergency department (ED). Although health care providers are encouraged to screen for IPV, most studies have indicated that routine screening does not consistently occur. The purpose of this study is to explore the experiences, views, and perceptions of RNs working in the ED with regard to screening for IPV.

**Methods:** This qualitative study developed using Bandura’s social cognitive theory as the theoretical framework, involved 21 semi-structured interviews with ED RNs. The transcripts were analyzed using Interpretative Phenomenological Analysis (IPA).

**Results:** Most of the nurses indicated a lack of clinical preparedness through their formal educational experiences, or through hospital in-services, to address screening for IPV. Three key factors in motivating nurses to screen for IPV were the assessment prompts of the electronic medical record (EMR), a perceived role as a patient advocate, and suspicion that the patient may have been abused. All participants stated that the design of their EMR system included a component that addressed domestic violence. Although most
nurses said that they function as a patient advocate when screening for IPV, they varied as to how they applied this perception to the actual screening experience.

Supporting the patient’s autonomy, credibility of the nurse and/or patient, and screening the patients alone were perceived obstacles in screening for IPV. For most nurses, supporting the patient’s autonomy meant letting the patient decide whether to disclose the abusive relationship and affected how the nurse proceeded if any abuse was mentioned. Perceived credibility was an obstacle in two ways; nurses were often unsure if the patient was providing accurate responses when screened and felt unsure of whether they were the best people to provide appropriate interventions to patients who disclosed abuse. Although all the nurses agreed that it is preferable to screen patients with no one else present, some of them indicated difficulties in being able to do so. Some nurses described techniques that they implemented in order to screen patients privately, whereas others did not attempt to gain privacy.

**Conclusions:** This study found that nurses are not usually involved in the development of or in providing feedback on the tools used to screen for IPV, the clinical flow and practice design of the environment (hospital unit) to support screening patients privately, the type and timing of educational training (if any is even provided), or assessment of the effectiveness of resources available to provide to identified victims. Moreover, they do not receive follow-up information as to what impact their intervention and resources had on the victims. Nurses should be included in the development of these procedures and of laws and policies that directly impact their role in addressing identified victims of IPV (such as mandatory reporting of victims).
Keywords: intimate partner violence, emergency department, screening, registered nurses, Bandura, Interpretative Phenomenological Analysis
CHAPTER 1: INTRODUCTION

Significance of the Problem

In the United States approximately 30% of women and 10% of men have been the victims of IPV (Centers for Disease Control and Prevention [CDC], 2015; Black et al., 2011). The numbers are virtually identical globally as one in three women and one in ten men report being a victim of intimate partner violence (IPV)—defined as rape, physical violence, and/or stalking by an intimate partner—in their lifetime (WHO, 2015a). According to the CDC (2016a) and Futures Without Violence (FWP, formerly the Family Violence Prevention Fund) (2014), IPV, can entail either a single episode or a pattern of physical violence, sexual violence, the threat of physical or sexual violence, or psychological harm committed by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy. According to the CDC (2016a), the term “intimate partner” includes current and former spouses, significant others and dating partners. Annually, 5.3 million heterosexual women are victims of IPV in the United States (U.S. Department of Justice, 2011). The CDC (2016c) stated that 20 people per minute are victims of IPV; this is equivalent to approximately 10 million men and women in one year.

In addition to the magnitude of heterosexual women being impacted by IPV, the National Violence against Women (NVAW) survey found that 21.5% of gay men and 35.4% of lesbian women identified themselves as having been victims of IPV by their same-sex partner (Arid & Makadon, 2011; Tjaden & Thoennes, 2000). Transgender individuals are also at high risk. A survey of transgender individuals in Massachusetts
found that they had a 34.6% lifetime prevalence rate of being victims of IPV (Ard & Makadon, 2011; Landers & Gilsanz, 2009). Anyone who is in an intimate relationship is at risk of becoming a victim of intimate partner violence.

Many victims of domestic abuse (which includes IPV) in the United States seek medical services at a hospital emergency department (ED). Female victims of IPV have a 50% higher rate of using ED services and a 14%–21% higher rate of primary and specialty care visits than patients without a history of IPV (Davila, Mendias, & Juneau, 2013; Sprague et al., 2012). These figures suggest a widespread need for screening, assessment, and referral for IPV, as victims who are not identified cannot be offered treatment.

Specifically, American nurses, particularly in the ED, have the opportunity to screen patients for signs of IPV and provide victims with options to increase their safety.

Since IPV victims in the United States are more likely to be seen and evaluated by nurses in the ED than in most health care settings, ED registered nurses have the opportunity to both identify such patients and refer them for services. Provision 3 of the American Nurses Association’s Nursing Code of Ethics states that nurses have an ethical duty to advocate for the safety of their patients (American Nurses Association [ANA], 2015). This duty to advocate has been further defined by the Emergency Nurses Association (ENA; 2013) to stipulate that ED nurses must provide universal screening for IPV to all patients who are medically stable and can be screened. Even though health care providers are encouraged to screen, most studies find that routine screening does not consistently occur (Campbell et al., 2001; DeBoer et al., 2013; Glass et al., 2001; National Network to End Domestic Violence, 2012; Roush, 2012; Sprague et al., 2012). This study will explore why and how some nurses screen for IPV while other nurses do not.
Purpose of the Study

The purpose of this study is to better understand the perceived knowledge and attitudes toward IPV and self-reported behaviors when screening patients for IPV among American ED nurses. Social cognitive theory (SCT), developed by Bandura (1989a, b, & c) and discussed in the theoretical framework section of the proposal, was used as a basis for the research. SCT is based on the premise that human behavior or agency is the result of interactional links between a triad of three determinants: environment, behavior, and personal factors. This interaction is described as triadic reciprocal determinism (Bandura, 1989b & c). SCT would thus suggest that the screening practices (the behavior) of ED registered nurses are the result of both their beliefs (personal factors) and the people and the location where the screening is performed (environment) (Bandura, 1989b & c). Prior research has not examined how personal factors related to the RN and the environment of the ED influence the RN’s screening practices.

Specific Aims and Research Questions

The screening process for IPV includes not only the screening forms used, but also the behaviors exhibited by the RNs when interacting with their patients and the locations where the nurses do the screenings. In addition to the screening tools selected, both the manner in which the nurses screen their patients and the location where patients are screened may have an impact on whether the patients disclose or deny the presence of abuse. The specific aims of this study were to explore the IPV screening practices of RNs who currently work in the ED and what influenced their screening practices. I adopted the following research questions to guide the study.
1. What do ED nurses currently believe, know, and do about screening for IPV? The rationale for this question is based on the studies by Wadman and Muellman (1999) and Kothari et al. (2011), who determined that, although a significant number of women victims of violence seek services from the ED, most are not screened or provided with referrals when abuse is suspected or confirmed. Beynon et al. (2012), Clements et al. (2011), and Waalen et al. (2000) have all identified a lack of training for nurses on how to screen and treat IPV victims. The purpose of this question is to understand what nurses report about their knowledge, attitudes, and actions toward addressing IPV.

2. What factors do ED nurses believe influence the likelihood of screening for IPV? There is a gap in prior research on how personal factors of the RN and the environment of the ED influence the behaviors or screening practices for IPV. The goal of this question is to identify any factors that the nurses perceive as motivating or supporting their screening experience in addressing IPV. The same RN could have different screening practices based on a change in any of the factors explored. This aim is supported by Smith and Osborn (2008), who stated that a study that focuses on exploring what motivates or influences behavior can deepen or enhance the understanding of the overall phenomenon being explored.

3. What factors do ED RNs perceive as barriers to screening for IPV? The rationale for this question is to explore the perceived barriers identified by RNs that impact their ability to effectively screen for IPV. Beynon et al. (2012), Bryant and Spencer (2002), Campbell et al. (2001), D’Avolio (2010), DeBoer et al. (2013), Glass et al. (2011), Herzig et al. (2006), the National Network to End Domestic Violence (2012), Roush (2012), Sprague et al. (2012), and Watts (2004) have shown that lack of knowledge is not
the only barrier to screening for IPV. Some of the nurses who identify barriers (which may include limited knowledge or other factors) may still screen. Despite the presence of obstacles, some nurses are still able to screen whereas others, even those provided with training, do not screen.

**Definition of Terms**

Table 1.1 provides definitions of the key terms used in this study.

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<tr>
<th>Table 1.1</th>
<th>Definitions of Key Terms</th>
</tr>
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<tbody>
<tr>
<td><strong>1. Advanced practice nurse (APN)</strong> refers to registered nurses with</td>
<td>advanced training in a specialty. APNs may be any of the following: nurse practitioner (NP),</td>
</tr>
<tr>
<td>advanced training in a specialty. APNs may be any of the following:</td>
<td>clinical nurse specialist (CNS), nurse anesthetist, or nurse midwife (American Nurses</td>
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<tr>
<td>nurse practitioner (NP), clinical nurse specialist (CNS), nurse</td>
<td>Association, 2014).</td>
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<tr>
<td>anesthetist, or nurse midwife (American Nurses Association, 2014).</td>
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<tr>
<td><strong>2. Domestic violence</strong> is the term most commonly used to refer to</td>
<td>family or intimate partner violence. Domestic violence or abuse as defined by Pennsylvania</td>
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<td>family or intimate partner violence. Domestic violence or abuse as</td>
<td>law (Title 23, Section 6102) as any type of violence between “family or household members,</td>
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<td>defined by Pennsylvania law (Title 23, Section 6102) as any type of</td>
<td>sexual or intimate partners or persons who share biological parenthood” (Pennsylvania</td>
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<tr>
<td>violence between “family or household members, sexual or intimate</td>
<td>General Assembly, 2016). Because domestic violence is a more broadly encompassing term and</td>
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<tr>
<td>partners or persons who share biological parenthood” (Pennsylvania</td>
<td>this research specifically targets intimate partner violence (IPV), the term IPV has</td>
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<td>General Assembly, 2016). Because domestic violence is a more broadly</td>
<td>generally been used in this study.</td>
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<td>encompassing term and this research specifically targets intimate</td>
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<td>partner violence (IPV), the term IPV has generally been used in this</td>
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<td>study.</td>
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<tr>
<td><strong>3. Domestic violence services</strong> refer to any victim support agency</td>
<td>(government- or privately funded) that provides assistance to victims of violence.</td>
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<td>(government- or privately funded) that provides assistance to victims</td>
<td></td>
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<tr>
<td>of violence.</td>
<td></td>
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<tr>
<td>therapists, counselors, and emergency medical service personnel (“HIPAA</td>
<td>Act,” 2015).</td>
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<td>Act,” 2015).</td>
<td></td>
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<tr>
<td><strong>5. Interpersonal violence</strong> “refers to violence between individuals”</td>
<td>and is separated into two categories. The first category is family and partner violence,</td>
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<tr>
<td>and is separated into two categories. The first category is family and</td>
<td>which is further divided into child, elder, and intimate partner violence. The second</td>
</tr>
<tr>
<td>partner violence, which is further divided into child, elder, and</td>
<td>category is community violence, which includes “acquaintance and stranger violence” (WHO,</td>
</tr>
<tr>
<td>intimate partner violence. The second category is community violence,</td>
<td>2015b).</td>
</tr>
</tbody>
</table>
6. **Intimate partner violence (IPV)**, also commonly referred to as domestic violence, is divided into four types of violence: physical violence, sexual violence, threats of physical or sexual violence, and psychological or emotional abuse (CDC, 2016a). The last of these four categories, psychological or emotional abuse, is defined in this context as the systematic perpetration of malicious and explicit nonphysical acts against an intimate partner (Hamby & Sugarman, 1999). Intimate partners include current or former spouses, significant others and dating partners (CDC, 2016a). Both the CDC (2016a) and the World Health Organization (2010) support the use of consistent definitions and terms to describe IPV. Consistent definitions enhance the collection of data, research, and ultimately the measurement of interventions when addressing IPV on both a national and international level (CDC, 2016a; Saltzman, Fanslow, McMahon, & Shelley, 2002; WHO, 2010).

7. **Referral** can include the health care provider directly contacting resources on behalf of the patient, such as social workers, or providing resource numbers of local IPV advocate services (Rhodes et al., 2011).

8. **Registered nurse (RN)** refers to a person who has passed a National Council Licensure Examination (NCLEX), is at least 18 years old, must be registered in the specific state of practice (each state has a board of nursing that interprets the scope of practice), and follows the National Code of Ethics. The RN’s educational background in nursing can include any of the following: diploma, associate degree in nursing (ADN), bachelor of science in nursing (BSN/BS), master’s degree in nursing (MSN), doctor of philosophy (PhD), and doctor of nursing practice (DNP) (ANA, 2014).

9. **Safety assessment** refers to the health care provider addressing both the safety and potential plan for safety of all patients who screen positive for IPV.

10. **Screening for IPV** refers to any questions by health care providers that explore whether a patient is a victim of IPV. The questions can be part of an intake form or added by the health care provider during the encounters with the patient.

11. A **sexual assault nurse examiner (SANE)** is a forensic nurse trained to care for patients who have been sexually assaulted (International Association of Forensic Nurses, 2013).
Table 1.1
Definitions of Key Terms

12. **Universal screening for IPV** refers to health care providers screening all patients, not just selectively screening those people thought to be at risk for being a victim due to physical symptoms, age, or other visual cues such as describing a partner as hostile (Zink, Regan, Goldenhar, Pabst, & Rinto, 2004).

13. **Victim** refers to the person who is the target of violence or abuse by a perpetrator that results in the individual having both short- and long-term physical and/or mental injuries (Burgess, Regehr, & Roberts, 2013; Saltzman et al., 2002).

14. **Victimization** is the process of being victimized or becoming a victim (Burgess et al., 2013). Although the victim can be a male or female, most frequently the victim in IPV cases is female. The term *perpetrator* refers to the person who inflicts the violence or abuse or causes the violence or abuse to be inflicted (Saltzman et al., 2002). The perpetrator can be either male or female, but is most common to be male in IPV instances.

**Importance of the Study, Innovation, and Potential Contributions**

The CDC (2003, 2015) has estimated that the cost of IPV exceeds $5.8 billion each year, over two-thirds of which is associated with health care services. It is also estimated that more than three women in the United States are murdered a day by their husband or boyfriend; in 2007, intimate partners committed 14% of all homicides in the U.S. (Catalano & Snyder, 2009; Futures without Violence (FWV), 2014). In their seminal study, Wadman and Muelleman (1999) explored the connection between women murdered by an intimate partner and previous contact with the health care system. Of the 34 homicide cases studied, 44% of the women had encounters with health care providers in the ED within two years prior to their death (de Boinville, 2013). The study further identified that 8 of the 15 women murdered by their intimate partner who had been treated previously in the ED were identified in the medical records by either the nurse or physician as having signs leading
them to suspect abuse. Nevertheless, none of the 15 women received referrals for domestic violence services or a safety assessment (Wadman & Muelleman, 1999). Rhodes et al. (2011) found that of 993 women who had documented cases of IPV in the criminal justice system over a 12-month period in the year 2000, 785 of those victims used the services of the ED within a four-year time frame (from 1999 to 2002).

Often the nurse is the first health care provider to make contact with an ED patient and the last to see the patient prior to discharge. ED nurses who routinely screen for IPV have the opportunity to begin the early intervention and prevention process during the patient’s ED experience (Robinson, 2010). The patient may be subjected to further violence if nurses miss the opportunity to intervene. In 1992, The Joint Commission on Accreditation of Hospital Care Organizations (JCAHO) was the first to address the role that health care providers in the ED must fulfill by screening for domestic violence and providing resources to any identified victim. The mandate enacted by JCAHO in 1992 declared that to receive accreditation, emergency departments needed to have policies on identifying and treating identified victims of IPV (de Boinville, 2013; JCAHO, 2009). After JCAHO’s mandate in 1992, both the Emergency Nurses Association and the International Association of Forensic Nurses (ENA & IAFN, 2013) recommended that ED nurses universally screen for IPV. The recommendations from the ENA and IAFN are consistent with those of both the World Health Organization (WHO, 2010) and the Centers for Disease Control (CDC, 2016b) who have also recommended that health care providers (HCPs) should be more active in addressing the needs of IPV victims. Other health care organizations that have also supported routine screening for IPV include the American Nurses Association (ANA, 2000) and the American College of Obstetricians and
Gynecologists (ACOG), 2012. Despite these recommendations to screen for IPV by professional organizations including the CDC and WHO, most HCPs still do not routinely screen for IPV (Campbell et al., 2001; Ellis, 1999; Kershner & Anderson, 2002; Rhodes et al., 2011; Trautman, McCarthy, Miller, Campbell, & Kelen, 2007; Watts, 2004).

In 2011, there were an estimated 421 visits to the ED for every 1,000 individuals in the U.S. population (Weiss, Wier, Stocks, & Blanchard, 2014). In some cases, victims and perpetrators of IPV have their only encounters with HCPs in the EDs (Glass et al., 2001). Nurses who work in the ED therefore have a greater opportunity than nurses in other health care settings to encounter victims of IPV. These encounters may be the only opportunity for some people to be screened and provided with resources for IPV. Studies of nurses’ experiences in the ED provide the chance to inform nurses and other ED personnel as to the positive impact that their interventions to screen for and address IPV could have (Schriver, Talmadge, Chuong, & Hedges, 2003).

Although most research focuses on female victims of IPV, male victims also seek treatment in the ED. Victims of IPV are not only heterosexual women, but males and females of all sexual identities. Therefore, many have called for universal IPV screening of all ED patients as a standard practice (Houry et al., 2008; Kothari & Rhodes, 2006; Rhodes et al., 2011). A study of nurses who screen all patients would provide the opportunity for ED RNs to share a wide range of experiences with individual victims, not limited to heterosexual women.

In the United States, all HCPs including medically licensed staff and nurses who work in the ED are legally and ethically mandated to treat any person who seeks medical services and to address any safety issues that could have an impact on the individual’s
health (Chase, 2005; Schriver et al., 2003). Despite the major health and safety implications that can result from IPV, however, many HCPs receive little or no formal training in either their academic or practice setting on screening, treating, or providing referrals to victims of IPV (Beynon, Gutmanis, Tutty, Wathen, & MacMillan, 2012; Clements, Holt, Hasson, & Fay-Hillier, 2011; Waalen, Goodwin, Spitz, Peterson, & Saltzman, 2000). The information that nurses share about the impact of their IPV training could be incorporated into the development of specific curricular programs, which in turn would strengthen nurses’ capacity to screen for IPV.

Beynon et al. (2012) found that out of 527 nurses working in Ontario, Canada who responded to a mailed survey exploring screening practices, 61.5% stated that they had received no formal training for IPV and 30.4% had never had a patient disclose being a victim of IPV. Waalen et al. (2000), in a systematic review of 12 published research articles on the practice of and barriers to screening, determined that lack of education or hands-on training was one of the leading barriers.

One of the few recent studies that might be useful in the development of hospital-based training for all HCPs explored the impact of providing a structured in-service program to resident physicians in training (not nurses). Specifically, Sims et al. (2011) provided one-hour training on IPV that included information on prevalence, universal screening, how to screen, and documentation to all trauma care residents at a Pennsylvania level 1 trauma center. After the implementation of the one-hour training, a retrospective chart review of the documentation of screening by trauma residents was performed and then compared with the 39% of all patients who were screened for IPV after the training. Sims et al. found that the training session did not have a significant effect on the trauma
residents’ screening practices. This result suggests both that the training may need to be longer than one hour and that nurses might be a more fruitful target than residents.

As noted above, despite this lack of training and other obstacles to carrying out screenings, many nurses find ways to screen for IPV. Conversely, some HCPs do not screen for IPV even when they have the time and training (Beynon et al., 2012; Bryant & Spencer, 2002; Campbell et al., 2001; DeBoer, Kothari, Kothari, Koestner, & Thomas, 2013; Glass, Dearwater, & Campbell, 2001; National Network to End Domestic Violence, 2012; O’Campo, Kirst, Tsamis, Chambers, & Ahmad, 2011; Roush, 2012; Sprague et al., 2012). The present study sought valuable firsthand insight on the situation by asking nurses to share their experiences of perceived personal and environmental factors that influenced their screening practices.

Summary

This chapter has introduced the significance of the global and national public health problems associated with IPV. Although both professional and certifying organizations have called on HCPs to screen and provide interventions to victims of IPV, many studies have found that nurses and other HCPs do not consistently do so (Campbell et al. 2001; DeBoer et al., 2013; Glass et al., 2001; National Network to End Domestic Violence, 2012; Roush, 2012; Sprague et al., 2012). After presenting the significance of the problem, I addressed the purpose of this study, which was to fill gaps in existing research about the perceptions of American ED RNs with regard to IPV screening. I then presented the specific aims of the study and the three research questions designed to address these aims. Bandura’s SCT framework (1989a, b, & c), to be discussed at greater length in chapter 3, was used to structure the research questions. In this introductory chapter, I have also
provided definitions of key terms, and I have discussed the importance of this study and the potential contributions it could make to future educational programs on IPV screening. Chapter 2 will offer a literature review and will more specifically identify the research gaps to be addressed. In chapter 4 the results of the major themes that were uncovered in addressing the three research questions will be presented. In addition to the conclusion, Chapter 5 includes an overall discussion of the implications of the study, addressing the gaps in research, nurses’ perceived self-efficacy, limitations, and recommendations for future studies.
CHAPTER 2: LITERATURE REVIEW

I begin this chapter with a historical overview of HCP screening practices in the United States, as the focus of my study was on the practices of ED RNs in the United States. I will then focus on studies in different health care settings and specialties. Although my study focuses on nurses, I included studies that explored either physicians’ and/or nurses’ experiences, because they can be used to support or call for changes in the current health care practices that address IPV. The development of existing screening practices that address IPV in EDs is based on available studies that might not include nurses or might use experiences of HCPs in other health care settings; accordingly, all such studies are pertinent to this review.

In this chapter, through an examination of prior studies in the United States, I seek to identify gaps in current practice. I conclude with a discussion of qualitative studies that included HCPs and parents, HCPs in prenatal settings, perceptions of victims who have contact with HCPs, physicians as role models, registered nurses screening for IPV who were not in the ED, and registered nurses screening in the ED. All these studies explored HCPs’ screening for IPV and are used to guide the development of practices to address IPV.

**Historical Overview of HCPs’ Screening Practices**

A review of scholarly literature found relatively few studies on the screening practices of HCPs who work in the ED. Stayton and Duncan (2005) synthesized published research articles from 1992 to 2002 that addressed IPV screening. The inclusion criteria for the study required a reference to IPV screening of adult women by HCPs in the U.S. This search yielded 44 published articles. Thirty-two of these were descriptive and focused
on the reporting of IPV by HCPs using chart reviews, HCP surveys, and patient surveys as the primary source for data. The other 12 explored the impact of various interventions, such as variations in educational training and/or adjustments to practice, on the screening practices of HCPs. Among the 32 published descriptive articles, 11 surveyed physicians and patients, eight included chart reviews, and only five included surveys with nurses. Of the 12 studies that focused on the impact of interventions, only two included educational in-service training and intervention strategies directed at HCPs in the ED (Campbell et al., 2001; Larkin, Rolniak, Hyman, MacLeod, & Savage, 2000; Stayton & Duncan, 2005).

A more recent systematic review by Sprague et al. (2012) examined the perceived barriers faced by HCPs in screening for IPV, using studies published between 1995 and 2010. The authors divided this time period into 1995–2005 and 2006–2010 to evaluate trends over time. Of 22 articles that addressed barriers to screening by HCPs, 59% included physicians, 45.4% included nurses, and 18.2% included emergency medicine. The authors determined that in more recent studies, a more prominent barrier to screening, seldom mentioned in earlier research, was HCPs’ own discomfort with screening. In 33.3% of the more recent studies, as opposed to 7.7% of the earlier studies, HCPs identified personal discomfort as a significant barrier. The authors stated that “provider-related barriers were reported more often than patient-related barriers in the current literature” (Sprague et al., 2012, p. 601). Patient-related barriers included such issues as language, the nurses’ perception that the patient was difficult or had mental health issues, or the patient’s fears that disclosure of IPV victim status might result in an increase in abuse.

The findings of this review suggest that future research exploring the perceptions and experiences of HCPs in addressing IPV could be beneficial in the development of IPV
training programs for HCPs. The training programs could address those perceptions and include ways to successfully manage the identified barriers. To further explore the relevant literature, I distinguished the studies according to the methods used.

**Quantitative Studies**

**Emergency Department Resources and the Diagnosis of IPV**

A two-phase observational study by Choo et al. (2012) explored the impact of various resources available to health care providers in 21 Oregon hospital EDs on the actual diagnosis of IPV with female patients under age 65. The first phase of the study consisted of reviewing the records of female patients who met the inclusion criteria (totaling 2,228,169 ED visits over a 42-month time frame) to identify how many women were diagnosed with IPV. The second phase of the study consisted of a telephone survey administered to each nurse manager at the 21 hospital EDs to obtain information on the available resources and policies associated with that hospital. The most significant finding was that hospitals that provided HCPs with a checklist for assessing patients and providing interventions had a greater number of IPV diagnoses. Although the study was limited to one state and may have limited generalizability, further studies exploring the experiences of HCPs in screening for IPV and resources that enhance or limit their ability could help to guide investment in effective interventions.

In another quantitative randomized, controlled study, Rhodes et al. (2007) explored HCPs’ actual approach to screening for and addressing IPV in the ED. The study included 76 physicians and 4 advanced practice nurses who audiotaped their interactions with English-speaking women age 16 to 69. The analysis of the tapes focused on the providers’ approach to and engagement with their patients when and if they screened for domestic
violence. Rhodes et al. (2007) found that HCPs whose communication and approach was more open and caring presentation had a positive impact on the patient’s willingness to disclose being abused.

Stayton and Duncan (2005) identified two studies that included comparisons between the frequency of IPV screening practices among nurses and physicians. Both found that, overall, nurses screened more frequently than physicians (Derk & Reese, 1998; Goff, Byrd, Shelton, & Parcel, 2001). Goff et al. (2001) surveyed 33 nurse practitioners (NPs) and 82 physicians in Texas on screening practices for IPV; they found that 45.7% of the NPs and 29.4% of the physicians screened for IPV (Goff et al., 2001, p. 43; Stayton & Duncan, 2005, p. 274). Derk and Reese (1998) surveyed 28 physicians and 28 nurses working in a primary care clinic on their screening practices, finding that 16% of physicians and 21% of the nurses routinely screened for IPV with women (p. 671).

Studies of IPV screening rates by nurses without the provision of training or any other interventions varied depending on the nursing specialty, from as low as 0% among adult nurse practitioners (ANPs) during the first prenatal care visit (Bryant & Spencer, 2002) to as high as 70.1% among public health nurses (Moore, Zaccaro, & Parsons, 1998). A more recent quantitative study (DeBoer et al., 2013), using a cross-sectional survey of 156 nurses who worked in various inpatient health care settings including the ED, also explored attitudes toward and barriers to IPV screening. This study found that although 90% of the nurses considered screening important, only 77% felt comfortable screening and almost half (45.8%) said they had never knowingly served a victim of IPV, despite the IPV prevalence rate of at least 16% of the population. In addition, 95% of the nurses surveyed indicated that nurses had a responsibility to identify victims of IPV, 81% nurses thought
they had adequate time to screen, and 44% thought that a major barrier in screening was lack of training in identifying people who were abused (DeBoer et al., 2013).

**Interventions That Included Registered Nurses**

Some of the quantitative studies explored the impact of educational training on the IPV screening practices of HCPs (including RNs) in various health care settings (Baker, Harper, & Reif, 2002; Larkin et al., 2000; Shattuck, 2002; Stayton & Duncan, 2005; Wiist & MacFarlane, 1999). Wiist and MacFarlane (1999) included both physicians and nurses who worked in prenatal clinics in their training for IPV screening. They used a quasi-experimental design that included both pre- and post-training intervention measures to explore the effect of a 90-minute training on the HCPs. The evaluation included measuring the HCPs’ use of an IPV screening tool, their knowledge related to information about victims of abuse, and the referrals that they provided in instances of positive screenings. The HCPs trained included nurses and physicians at two prenatal clinics, with those at a third clinic serving as the control group for the study. Random chart reviews were performed to evaluate pre- and post-intervention performance. The results indicated that prior to the intervention, there was 0.8% frequency of IPV detection in the intervention clinics and a 0.6% in the comparison clinic; the post-intervention figures were 7.22% in the intervention clinics and 0.83% in the comparison clinic.

Larkin et al. (2000) explored the impact of a four-tiered formal, hospital-approved disciplinary action with all ED nurses who were less than 90% compliant with screening for IPV. Administrative disciplinary action was implemented if education and feedback to the nurses did not improve compliance with screening. The disciplinary action for the first offense involved verbal counseling and further education, with subsequent actions
increasing to termination for a fourth offense. A chart review of 1,638 women pre-intervention and 1,617 post-intervention, age 18 or older, was used to compare the screening rates of nurses. Although the IPV screening rate among ED nurses increased from 29.5% pre-intervention of the implementation of the disciplinary action to 72.8% post-intervention, the actual rate of identifying victims of IPV only increased from 5.3% to 8.0%. Bandura (1991) observed that behavior can be motivated by a desire to avoid negative consequences such as the disciplinary actions identified in this study. Although the disciplinary action did appear to increase screening practices, the actual detection of victims was not significant. These findings suggest that the actual manner in which HCPs screen for IPV might also influence the response provided by the individuals being screened. The nurses’ motivation to screen might have been to avoid negative consequences, but not to actually obtain a positive response from their patients.

Shattuck (2002) also explored the impact of providing educational interventions, but did not include disciplinary action and did find an improvement in detection of victims of IPV. Shattuck provided a two-hour training program on IPV screening to six nurses who worked in a family planning clinic. The intervention also entailed placement of material on IPV in various areas within the clinic. Prior to the training, no female patients were screened for or identified as victims of IPV; afterwards, 61% of the patients were screened, and 11.5% of those screened were identified as victims of IPV and provided with resources.

Kramer, Lorenzon, and Mueller (2004) surveyed 1,268 women who were seeking health care services at either an ED, an academic clinic, or a non-academic clinic in rural, urban, and suburban communities. The survey focused on the participants’ experiences of
being a victim of IPV, health issues, screening by HCPs for IPV, and factors that would promote or hinder disclosing abuse to a nurse or physician. Although questions related to screening for IPV were asked, the authors did not separate out screening rates by health care facility or provider. Of the 1,268 women, 50% to 57% had experienced physical and/or emotional abuse and 26% reported sexual abuse in their lifetime. The prevalence of abuse within the last year was as follows: 28% reported emotional abuse, 12% reported physical abuse, 6% reported severe physical abuse, and 4% reported sexual abuse (Kramer et al., 2004). Although only 25% of the women in the study reported being asked about IPV, 83% of the participants said they would have welcomed being asked this question. Also, 86% of the participants indicated that they would disclose abuse to HCPs who asked direct questions about abuse, were respectful, and maintained confidentiality. This study confirmed that the manner in which an HCP addresses IPV (which is influenced by the professional’s personal perceptions) impacts the victim’s decision whether to disclose the abuse.

Mixed-Method Studies

Inclusion of Emergency Department Nurses and Evaluation of Interventions

Campbell et al. (2001) conducted a mixed-method experimental study to evaluate the implementation of a model training program that focused on the improvement of HCPs addressing IPV in the ED. The study covered the EDs of six Pennsylvania and six California hospitals, each of which was randomly assigned to either a control or experimental group. Select ED HCPs (nurses, physicians, and social workers) from hospitals in the experimental group were provided with a two-day training workshop. The trained HCPs then coordinated implementation of the training at their place of employment.
Evaluation of the program was based on chart reviews, patient and employee surveys, and qualitative interviews with staff who participated in the training session workshop. The study found an increase in knowledge and attitudes in addressing IPV between the control and experimental EDs, and the experimental group hospitals had significantly higher patient satisfaction. However, there was no significant difference in the identification of IPV between the control and experimental EDs, with a total of 83 women who self-reported being a victim of abuse when surveyed but only 40 of them identified in the medical records.

Campbell et al. (2001) indicated that perhaps one factor in the lack of detection of IPV was due to the training’s recommendation of selectively screening only those women who displayed relevant symptoms. The authors thus encouraged use of universal screening rather than selective or symptom-based screening for IPV. The authors did not distinguish the IPV detection rates by type of professional (e.g., nurses as opposed to physicians). An evaluation of the perceptions of success and barriers to implementation of the program was completed by using open-ended questions to interview 19 ED staff who had attended the training workshop. Interviewees suggested that the following components might be helpful in ensuring the success of the training program: staff and administrative support in implementing an IPV program, allowing sufficient time to implement the program, inclusion of screening questions on charting forms, including written policies and procedures on addressing IPV, mentoring to support staff compliance in conducting IPV screening and referrals, and providing funding and time for ongoing IPV training (Campbell et al., 2001).
Minsky-Kelly, Hamberger, Pape, and Wolff (2005) also used a two-phase, mixed-method research design to evaluate the impact of a domestic violence training program. In this study, 752 HCPs in various health care departments (including staff from the ED) participated in three-hour training sessions. Six months after the training, 39 participants attended one of seven focus groups that explored their experiences in utilizing the training provided. Overall, the comments from the ED participants focused on barriers including lack of available time, not being able to screen in private, the complex mental health needs of some patients, discomfort with screening, limited social work resources, and questioning both the significance of screening and the mandate to screen.

Davila (2006) used a two-phase, mixed-method design to provide and evaluate an IPV training program for nurses working in public health clinics. The focus of the training program was to increase both the knowledge and the skills of nurses in screening for IPV. The first phase used qualitative methods to explore nurses’ learning needs with regard to IPV. Semi-structured interviews with seven public health nurses were completed and analyzed, yielding four main categories of information. With regard to IPV knowledge, overall the nurses were knowledgeable regarding the prevalence and health risks of IPV. Second, in the category of clinical skills, the participants identified feelings of uneasiness and of not being prepared to address IPV with their patients. With regard to experience in caring for IPV victims, all the nurses reported routinely screening for IPV, yet none of them reported that they had detected a victim of IPV. The fourth category of responses focused on the content and skills needed to improve the nurses’ ability to effectively screen and address IPV with their patients. The nurses identified the need for training on caring
for victims of IPV, the actual screening process, and knowledge of community resources that could be provided to victims.

The second phase of Davila’s (2006) study used a pretest-posttest design to measure nurses’ knowledge and skill development with regard to IPV after they attended a training session. The training program, designed using information obtained in phase one, was delivered to 41 nurses, 20 of whom completed the posttest. No significant change in knowledge about IPV was found, but there was a significant ($p < .003$) improvement in skill levels. Interestingly, 27% (11 of 41) of the sample reported personal experiences with IPV on the pretest, and 8 of the 11 nurses who had such personal experiences failed to return the posttest. Davila (2006) theorized that a nurse’s personal history of IPV may have a negative impact on his or her ability to screen and provide referrals as needed.

**Experience of RNs with Mandatory Reporting**

Smith, Rainey, Smith, Alamares, and Grogg (2008) conducted a mixed-method study that explored the barriers presented by the mandatory reporting requirement should nurses encounter a case of domestic violence. The authors distributed a questionnaire to 1,000 RNs in a Florida county, containing questions on barriers in reporting domestic violence and a qualitative question related to personal experiences with domestic violence. The questionnaire yielded a valid sample of 184 responses. No information was available on the nurses’ specialty areas. Of the 184 RNs in the study, 176 were female, primarily Caucasian (75%), with a median age range of 46–65. Of the 73 RNs (39.7%) who had reported abuse as mandated by the state of Florida, 30 (44.8%) also had a personal experience with abuse. In contrast, among those who had never reported abuse, only 16 (18.4%) had a personal experience with abuse. Contrary to Davila (2006), this study
suggests that nurses with personal experiences with domestic violence are “more likely to report” (Smith et al., 2008, p. 11). Of the 16 identified barriers that the nurses could select on the questionnaire as preventing them from reporting domestic violence, the major barrier identified was “not enough evidence,” followed by “patient did not want episode recorded” (p. 10). The authors contended that nurses who are mandated to report domestic violence should be provided with more education on IPV and resources that can be used to support the safety of the identified victims.

**Qualitative Studies**

**HCPs and Parents**

A growing body of qualitative research exists on the IPV screening practices of HCPs. One such study explored the attitudes and beliefs of mothers and HCPs about routine screening for IPV in a pediatric ED (Dowd, Kennedy, Knapp, & Stallbaumer-Rouyer, 2002). The semi-structured interviews conducted in this study consisted of six focus groups of mothers (for a total of 59 mothers) and four focus groups containing 21 nurses and 17 physicians. Mothers generally indicated that after their child’s needs were addressed, HCPs should explain the reason for asking about IPV, inquire in a caring manner as to whether the patient has experienced IPV, and be able to provide resources if abuse is detected. The results from the focus groups with the nurses and physicians identified, overall, an awareness of some behaviors by children and mothers that suggested that the mother was a victim of IPV and that the children had witnessed the abuse. Female nurses and physicians were more prone to think that IPV detected in the pediatric ED should be reported to child protective services. Time constraints, fear of offending the parent, and lack of knowledge about screening and about available resources should IPV be
detected were identified as barriers to screening (Dowd et al., 2002). Although this study focused on the pediatric setting, it supported the value of understanding the perceptions of both the patients and HCPs about screening for IPV and using this information to inform the development of educational in-service programs.

Herzig et al. (2006) compared the different approaches used by prenatal health care providers in addressing four known risks in pregnancy: alcohol use, smoking, drug use, and IPV. The authors conducted six focus groups, using a previously constructed set of open-ended questions. The 49 participants consisted of 40 obstetricians/gynecologists, five nurse midwives, three nurse practitioners, and one RN. Overall, the professionals considered IPV the most difficult of the four pregnancy risks for them to address with their patients, and it was the only risk that most participants did not routinely include in their screening practices. The major barriers to IPV screening identified included discomfort with screening, lack of available resources, and a tendency to defer the screening practices to other providers such as social workers. It thus recognized the impact of both personal and environmental factors in discouraging screening.

Gerbert, Abercrombie, Caspers, Love, & Bronstone (1999) used semi-structured interviews to explore the experiences of 25 women who had been victims of IPV and who identified having had at least one helpful encounter with an HCP (physician, nurse practitioner, or nurse) on the topic. The study encompassed both the circumstances of the encounter with the HCP and the perceived impact of the encounter on the victims’ thoughts or feeling about being a victim of IPV. Data analysis identified two major themes. The first was “the complicated dance of disclosure by victims and identification by health care providers” (Gerbert et al., 1999, p. 120). The women stressed that they found HCPs who
were respectful and receptive, supporting the women’s autonomy in deciding whether or when to disclose being abused, to be the most helpful. Some women who chose not to disclose their abuse due to safety concerns or not being prepared to end the relationship said that, even despite this nondisclosure, supportive HCPs were in fact helpful in contributing to future decisions that ultimately improved their safety. The second major theme of this study was that women found it helpful when HCPs verbally acknowledged the victim’s self-worth. “The power of receiving validation (acknowledgment of abuse and confirmation of patient worth) from a health care provider” was consistently identified as valuable, whether or not the women chose to disclose the abuse (Gerbert et al., 1999, p. 120). This study highlighted the fact that the manner (not just the act itself) in which HCPs address IPV with their patients can have a significant impact on the victim’s decisions in seeking future assistance.

**Physicians as Role Models**

Some of the same authors in the aforementioned study were involved in another qualitative study that explored the IPV interventions of 45 physicians identified as providing established quality health care to victims of IPV (Gerbert et al., 2000). In this study, semi-structured interviews were conducted by means of six focus groups. Some of the themes identified through analysis of the interviews were validation of the victims’ self-worth, being respectful, listening, providing referrals, discussing safety plans, and documentation. The findings of this study reinforced those of Gerbert et al. (1999) regarding victims’ reports on their positive encounters with HCPs. Although no nurses participated in the study, the findings are certainly applicable to nurses as well.
Registered Nurses Not in the Emergency Department

Hindin (2006) explored IPV screening practices in a descriptive study that involved in-depth interviews of eight nurse midwives. Although all participants stated that they screened all patients for IPV on their first encounter, most were inconsistent in screening on subsequent visits. Some of the participants described factors that impacted their decisions on subsequent screening practices. These factors included time constraints, concerns with regard to the available resources to assist patients in need, and selective screening of certain cultures, such as questioning Arabic patients while being reluctant to address suspected IPV in Navajo patients (Hindin, 2006). The participants agreed that developing a trusting relationship and having the opportunity to validate the patient’s self-worth were essential in working with victims of IPV. They also observed that “planting seeds” with references to the patient’s right to be free from a violent relationship might help the patient to make changes that would increase her safety. This study’s identification of the themes of validating self-worth, expressing support for a patient, and the possible positive effect of such support on the patient’s future safety-related decisions is parallel to the themes highlighted by Gerbert and others (Gerbert et al., 1999; Gerbert et al., 2000). It again indicated how personal beliefs can impact the effectiveness of screening.

Brykczynski, Crane, Medina, and Pedraza (2011) used an interpretative phenomenology approach to interview 10 advanced practice nurses (APRNs), all with master’s degrees in nursing and with more than 10 years of experience with IPV. The focus of the study was to explore how these experienced nurses established relationships with those victims and addressed challenges, and how their experiences impacted changes in their screening practice. Brykczynski et al. (2011) found that the nurses understood the
importance of developing a relationship of respect and support with victims of IPV. They also grasped the complexity of the relationship and bonds that victims have with their abusive partner, and they were skilled at addressing both the physical and emotional needs of victims. All the nurses in this study supported universal screening as a means to assist in increasing both IPV identification and patient safety (Brykczynski et al., 2011). This study offered further evidence that both personal and environmental factors can influence the impact of IPV screening on a victim, and that it is important for HCPs to screen everyone for IPV. Although some personal factors were explored, the study did not pursue a deeper understanding of the nurses’ actual experiences in screening for IPV. ED RNs have the opportunity to screen universally for IPV, but without a deeper understanding of what can influence screening experiences and decisions, universal screening is not likely to occur and the quality of interventions will not improve.

Registered Nurses in the Emergency Department

Few studies have investigated the experiences of ED RNs. Robinson (2010) conducted a phenomenological qualitative study of the role of the ED RN in addressing IPV. Eight female and five male RNs were interviewed. All of them worked at one of three hospitals in a mid-sized urban county in the south central United States. All three hospitals had universal IPV screening policies. The interviews revealed four major themes: (1) myths, stereotypes, and fears associated with nurses’ beliefs and preconceptions regarding IPV; (2) demeanor issues, or the specific behaviors by a patient that would trigger the nurse to screen for IPV; (3) frustrations in the complexity of addressing IPV and the lack of immediate or clear resolutions; and (4) the safety benefits that victims identified through screening receive, thereby encouraging nurses to continue to screen and to provide
interventions (Robinson, 2010). One reason why most of the nurses screened only those patients who exhibited a particular demeanor was lack of knowledge, as only 5 of the 13 nurses (38%) indicated having any formal education on IPV. The nurses also identified feelings of frustration with victims’ frequent decisions to return to the abusive relationship. Only 2 out of the 13 nurses in the study screened all patients for IPV, despite their hospitals’ policies. Robinson (2010) did not include any information on how the nurses were expected to document fulfillment of the universal screening requirement or whether there was a specific question addressing IPV on the intake assessment form. The author recommended further qualitative studies of ED RNs in other parts of the United States.

Bracken and Clifton (2015) conducted a phenomenological study of the experiences of nine ED nurses in the use of a lethality tool with identified victims of IPV. Forensic nurse examiners (FNEs) and charge nurses were trained to use this tool, which was developed to assess the level of danger of an identified victim and provide resources to increase the identified victim’s safety. The nurses described their views about the tool, identified barriers, and provided some solutions to those barriers. Overall, they believed that the tool was worthwhile. The major barriers and frustrations identified in implementation were the difficulty involved in administering the tool in a private setting away from the patient’s visitors; the emotional stress of using the tool; and not learning the outcomes of the patients they treated. Some solutions provided by the nurses were to have annual trainings, have access to information on the outcome of the victims treated in the ED, and receive debriefings after stressful victim encounters. The article did not provide any demographic information on the nine nurses who were included in the study, nor was it clear whether all participants had been trained in how to use the tool. There was no
description of which nurses conducted initial screenings or what training they received. The tool was used only with ED patients who screened positive as IPV victims. Nevertheless, the study did demonstrate that nurses can generate useful, practical solutions to identified barriers that HCPs encounter when working with victims of IPV.

Summary

Although most of the qualitative studies summarized in this chapter indicated that knowledge and beliefs can influence screening practices for IPV, only two studies focused on the screening practices of ED nurses in the United States. Most of the studies examined HCPs’ screenings of IPV victims more broadly, without focusing on the HCPs’ actual experience of carrying out the screenings or the impact of factors present in the ED, such as the high level of activity, on HCPs’ ability to carry out effective screenings. In addition to these limitations, none of the studies explored what IPV-related questions were on the intake forms used by RNs or what additional questions they may ask that could impact screening practices. Investigating the actual perceptions and understandings of nurses in the ED concerning screening for IPV can shed light on both the overall process and some of the issues identified in the existing literature (Smith & Osborn, 2008, p. 56). The information obtained through the present study can be useful in the development of future training sessions that may ultimately improve the overall practices of HCPs in addressing IPV in the ED.
CHAPTER 3: METHODOLOGY AND RESEARCH DESIGN

Interpretative Phenomenological Analysis (IPA)

In this study, a qualitative research design was used to collect descriptive data from nurses who work in the ED and interpretative phenomenological analysis (IPA) was used in the analysis of the data. Smith, Flowers, and Larkin (2013) described IPA as a blend of phenomenology, hermeneutics, and idiographic investigation that focuses on exploring how people make sense of their life experiences. D’Avolio (2010), in her ethnographic study of 23 HCPs who address IPV in their practice, proposed that IPV screening by HCPs is a life experience worthy of exploration. In her study, all the participants described having fears and worries about the lack of organizational resources they could offer to patients who screened positive. Making sense of the screening practices of ED RNs in addressing IPV would include having the RNs describe their screening behaviors and then exploring the motivations underlying those behaviors. As noted in the literature review, there is a paucity of research on exploring the stories or experiences of ED RNs in screening for and addressing IPV. Such personal stories can add deeper meaning to the factors that influence the RNs’ ability to address IPV successfully with their patients. The identified influencing factors should be addressed and integrated into academic and hospital-based educational programs and should be considered in future hospital protocols.

The Phenomenological Component

The phenomenological components of IPA are based on ideas developed by Husserl, Heidegger, Merleau-Ponty, Sartre, and van Manen who are considered the principal authorities in phenomenological philosophy (Dowling & Cooney, 2012, p. 21; Heidegger, 1966; Husserl, 1982; Merleau-Ponty, 1962; Sartre, 1956; van Manen, 1990).
The phenomenological approach, initially described and developed by the philosopher Husserl, focuses on finding the “essence” or true meaning of a personal experience, asserting that it can be understood only through the thoughts generated by those people who have had that experience (Dowling & Cooney, 2012, p. 21; Husserl, 1982; Porter, 2000). Husserl’s approach was revised and further developed by other phenomenological theorists. Smith et al. (2013) summarized the contributions of the leading phenomenological theorists to IPA as follows:

Husserl’s work establishes for us, first of all, the importance and relevance of a focus on experience and its perception. In developing Husserl’s work further, Heidegger, Merleau-Ponty and Sartre each contribute to a view of the person as embedded and immersed in a world of objects and relationships, language and culture, projects and concerns. They move us away from the descriptive commitments and transcendental interests of Husserl, towards a more interpretative and worldly position with a focus on understanding the perspectival directedness of our involvement in the lived world—something which is personal to each of us, but which is property of our relationships to the world and others, rather than to us as creatures in isolation.

Thus, through the work of all of these writers, we have come to see that the complex understanding of experience invokes a lived process, an unfurling of perspectives and meanings, which are unique to the person’s embodied and situated relationship to the world. In IPA research, our attempts to understand other people’s relationship to the world are necessarily interpretative, and will focus upon
their attempts to make *meanings* out of their activities and to the things happening to them. (p. 21)

IPA expands on the phenomenological approach by including the idea that lived experiences are impacted by the meaning that the participants place on those experiences (Smith et al., 2013, p. 34). The phenomenological approach developed in IPA supports the purpose of the present study in focusing on having ED nurses share their lived experiences, using their own words and perceptions and being granted the opportunity to share their stories with minimal input from the investigator (Smith et al., 2013, p. 32). The phenomenon explored through this study was the experiences of ED nurses in addressing IPV, along with factors that impact the screening process. Social cognitive theory (SCT) reaffirms that human behavior is interconnected with personal and environmental experiences that can either support or discourage actual behavior (Bandura, 1989a & b). Exploring nurses’ experiences, including their perceptions of the overall environment and their own thoughts and feelings about screening, will advance understanding of the IPV screening practices of RNs who work in the ED.

**Semi-Structured Interviews**

To gather information about how ED nurses feel, think, and make meaning or sense of their screening practices, I used semi-structured interviews. The semi-structured interview provides an opportunity for the researcher and the participant to discuss the topic, while the researcher constantly modifies the initially prepared questions to address the points mentioned by the participant as the interview progresses (Smith & Osborn, 2008, p. 57). Smith et al. (2013) stated, “Used effectively and sensitively, semi-structured interviews can facilitate rapport and empathy, and permit great flexibility of coverage” (p.
The use of semi-structured interviews supports the exploration of the meaning of the phenomenon of screening while using the nurses’ own words. The set of questions prepared for these interviews provided suitable flexibility as well as the opportunity for the nurses to share their stories, and it was used to “guide” the interview “rather than dictate it” (Smith & Osborn, 2008, p. 58).

**The Interpretation Component**

In addition to phenomenology and exploring the phenomenon, IPA also incorporates the theory of interpretation into the analysis process. During the interviews the researcher explores the phenomenon while engaging in little or no interpretation. On the other hand, during the analysis, the researcher attempts to interpret the meaning of the phenomenon for both the participant and the researcher in understanding how stories fit or differ from others. The interpretation process in IPA is primarily based on the participants’ stories themselves, but secondarily seeks to place these initial descriptions in a broader context of sociocultural factors and potentially even a theoretical framework (Larkin, Watts, & Clifton, 2006). In the present study, this approach allowed the phenomenon of the screening practices to “shine forth” and enabled me to “make sense of it once it has happened” (Smith et al., 2013, p. 36).

**The Hermeneutic Circle**

The hermeneutic circle is a foundational method of interpretation that I used to analyze the nurses’ stories. Overall, the process of the hermeneutic circle is to analyze each participant’s story as viewed in its entirety or the whole, and then as viewed in each part or line by line. The circle is in reference to exploring “the dynamic relationship between the part and the whole, at a series of levels” (Smith et al., 2013, p. 28). IPA
involves moving back and forth, often repeating steps in the analytical process, to view the
data from different ways of thinking instead of completing the steps in a sequential order
(Smith et al., 2013, p. 28). The method of moving from parts to a whole is also applied
when comparing and contrasting all of the stories shared. The conceptual approach to
interpreting the stories is based on “the idea is that our entry into the meaning of a text can
be made at a number of different levels, all of which relate to one another, and many of
which will offer different perspectives on the part-whole coherence of the text” (Smith et
al., 2013, p. 28). Smith et al. (2013) summarized the incorporation of both phenomenology
and interpretive qualitative research as follows: “Without the phenomenology, there would
be nothing to interpret; without the hermeneutics, the phenomenon would not be seen” (p.
37).

Each interview was completed using a semi-structured guide that was developed to
enable the RNs to share their stories about IPV screening while addressing the personal,
environmental, and behavioral facets of the phenomenon. The initial analysis of the stories
shared by each RN was conducted by me, and the identified personal, environmental, and
behavioral factors were connected to the overall screening practices. It is essential to base
the interpretations on the actual stories told by the RNs (i.e., the phenomenon) and on the
words used throughout the analysis process. Often, people do not make connections
between factors that have an impact on their overall behavior. Throughout the process, I
returned repeatedly to reviewing the actual interviews, to ensure that my interpretations
were based on the actual words shared by the nurses and not my personal interpretations of
what was said.
The Idiographic Component

In addition to the phenomenology and interpretive ideas that are embedded within IPA, this method is idiographic in that it provides for an analysis of “particular instances of lived experience” and a “detailed analysis of each case” (Smith et al., 2013, pp. 37–38). The individual cases are each analyzed, and emerging themes are then compared in search of similarities and differences (Smith et al., 2013, pp. 37–38). The analysis of each story is based on a conviction that every individual has a unique perspective about any given phenomenon of concern (Smith et al., 2013).

The idiographic approach is frequently contrasted to the more traditional, nomothetic approach often used in research. The nomothetic approach focuses on establishing “what is shared with others” and in “establishing laws of generalizations.” The idiographic method, on the other hand, is interested in exploring “what makes each of us unique” (McLeod, 2007, paras. 1–2). The idiographic approach is often viewed as providing the added depth or stories that are missing in the nomothetic approach, which provides the breadth (Bromley, 1986; Smith et al., 2013). The idiographic or particular focus for this study is that both the meaning of IPV screening for each RN and my interpretation of the meaning described by each RN contain unique details associated with each participant. I will refer to the specific details described by each participant and to key perceived variations in their experiences as appropriate throughout the analysis process. Although each story is unique, the coding process should identify emerging commonalities as well as the saturation point, which occurs when no new themes are discovered in the analysis of additional interviews (Glaser & Strauss, 1967).
I believe that the integration of phenomenology with the interpretive and idiographic approaches in my analysis was the best method to fulfill the aims of this study. IPA researchers focus on the experiences of those involved and how they personally have come to understand the phenomenon, so as to grasp the deeper meaning of a specific experience (Smith et al., 2013, p. 46). The basic assumption is that the data obtained from the interviews shed light on the ED nurses’ “involvement in and orientation” towards the screening process and “how they make sense” of that “lived experience” (Smith et al., 2013, p. 47).

**Theoretical Framework**

**Social Cognitive Theory**

Social cognitive theory (SCT), developed by Albert Bandura, was the theoretical framework used in this qualitative study (Bandura, 1989a, b, & c). SCT was used to support the exploration of the interactions between environmental influences, thoughts, and personal factors that influence behavior (Bandura, 1989b). The behaviors in this study focus on the screening practices of the RNs. SCT is based on the premise that human behavior or agency is to “intentionally make things happen by one’s actions” (Bandura, 1989b, p. 2). An individual’s actions are influenced by the interactional links between three determinants—environmental, personal, and behavioral factors—known collectively as triadic reciprocal determinism (Figure 3.1) (Bandura, 1989a, b, & c). The personal determinant includes such factors as thoughts, feelings, health status, age, sexual identity, race, ethnicity, self-beliefs or self-efficacy, and physical characteristics. The environmental determinant is related to any outside interactions that can influence behavior, such as social relationships (intimate, family, friends, colleagues, authority
figures, role models, and even strangers), laws, policies, and the physical environment (e.g., resources, the place of employment, and the size of patient rooms) (Bandura, 1989b & c). The behavioral determinant asserts that an individual’s behavior is a conscious act implemented to achieve what the individual expects and thinks will be the response from the environment. Behavior is influenced by the response from the environment and the personal thoughts held by that individual (Bandura 1989b & c).

The interactions between the three determinants of human behavior are bidirectional; each has an influence on the other (Bandura, 1989c). Human agency is also self-regulated by an individual’s reflections on the overall outcome of his or her actions. Individuals reflect on the overall determinants that have the greatest impact on the outcome of the action. As a result of this reflection, they consciously decide either to continue the action or to make changes to any or all of the determinants. The eventual goal of reflection is to create or maintain a favorable response. Foundational to all human behavior is an individual’s level of perceived self-efficacy or belief in achieving the desired outcome. As Bandura (1989b) noted, “Unless people believe they can produce desired results and forestall detrimental ones by their actions, they have little incentive to act or to persevere in the face of difficulties” (p.10).
Figure 3.1. Albert Bandura’s social cognitive model of triadic reciprocal determinism.

Source: Created by the author based on Bandura (1989c), pp.2-5.

Interactions between Personal Factors and Behavior

One of the bidirectional relationships incorporated into an individual’s overall assessment of perceived self-efficacy involves personal factors and the individual’s behaviors. Behavior is influenced by an individual’s thoughts, feelings, and beliefs (i.e., personal factors). The implementation of the behavior, in turn, impacts those thoughts, feelings, and beliefs. The behaviors can also impact on the person’s physical responses and thereby further shape future behaviors (Bandura, 1989c, p. 3).
An example of how behavior and personal determinants can influence each other is that RNs who believe that screening for IPV can make a positive difference (a personal factor) are more likely to carry out screenings (behavior). If RNs find their screening does not cause abused women to leave their abuser, they may reconsider their commitment to screening. In chapter 4, specific examples related to the participants in this study were provided to further expand on this concept.

**Interactions between Personal Factors and the Environment**

The bidirectional interaction between personal factors and the environment considers how social encounters or physical encounters with aspects of the surrounding environment can influence an individual’s thoughts, feelings, and beliefs, and vice versa (Bandura, 1989c). One example of the social encounters that can influence personal factors is role modeling by either other HCPs or faculty in their formal educational experiences, peer pressure, in-services, or formal education (Bandura, 1986, 1989a, b, & c). Social contact could also include managers or patients. Conversely, personal factors of the nurse such as age, sex, ethnicity, or race can also influence social contacts prior to the initiation of actual verbal contact (Bandura, 1989b; Lerner, 1982). The perceived responses from the environment influence personal beliefs, behaviors, and feelings (Bandura, 1989c).

Exploring the social and physical interactions that characterize ED nurses’ IPV screening activity would shed further light on their overall experience. For example, an RN may observe a colleague in the ED (an environmental factor) who consistently and effectively screens for IPV. Specific examples of both perceived supportive and obstructive environmental influences are discussed in chapters 4 and 5.
Interactions between Behavior and the Environment

The last component in triadic reciprocal determinism is the interaction between behavior and the environment. Bandura (1989c) described this dynamic interaction as follows: “In the transactions of everyday life, behavior alters environmental conditions and is, in turn, altered by the very conditions it creates” (p. 4). The perceived environment is influenced by individual behaviors, and the environmental responses that result from these behaviors will have an impact on their future behaviors within that environment (Bandura, 1989c). For example, an RN who assumes that no men will report being victims of IPV (perceived environmental response) will not screen men for IPV (behavior). This behavior could change if the RN sees a peer screen a male patient who discloses that he is a victim of IPV (environmental factor). After the RN observes the peer, the RN may begin to screen all men and women for IPV.

Overall, in the SCT framework, self-efficacy has a significant impact on behavior and an individual’s decision with regard to making changes to that behavior. People with greater perceived self-efficacy will be more prone to changing their behavior. To pursue a change in behavior, people must believe that they have the power to produce effects by their actions. Self-efficacy beliefs affect adaptation and change not only in their own right, but through their impact on other determinants. They play a role in self-regulation and motivation, affecting what people choose to undertake and how much effort they exert (Bandura, 1989c).

This concept can be applied when discussing both barriers and motivating factors identified by HCPs in reference to screening patients for IPV. One significant barrier identified through qualitative studies is HCPs’ preconceived assumptions about the patient
or the screening process. Some HCPs believe that the person being screened may be offended if questioned about abuse, or that it is not part of their responsibility to screen for IPV. HCPs have also identified time constraints, discomfort with the topic, lack of support, and perceived powerlessness to change the problem as other reasons not to screen for IPV (D’Avolio, 2010; Herzig et al., 2006; Watts, 2004). In my study, I was able to dig more deeply into these issues by giving the participating nurses an opportunity to reflect and comment on how their perceptions influenced their screening experiences. Refer to the Interview Guide (Appendix A) for how I framed the interviews. Using the SCT framework provided the structure for this endeavor.

The Researcher’s Qualifications

I am the sole researcher for this study and am also an assistant clinical professor at Drexel University, in the School of Nursing and Health Professions. I have connections with urban hospitals and HCPs who work with victims of violence. Since the study methodology required extensive interviews on the phenomenon of IPV screening by nurses in the ED, my expertise in interviewing people on issues of abuse was an asset. I am a mental health clinical nurse specialist with extensive experience and expertise in working with people who have experienced trauma. I am also certified in critical incident stress debriefing and danger assessment associated with homicide and IPV. Additionally, I have had the opportunity to work with both victims and abusers of violence. I teach a course to HCPs on how they can assist victims of violent crimes. Furthermore, I sought supervision from both my chair and select committee members as well as professional peers familiar with my work throughout the research process.
The Researcher’s Role

I conducted all the interviews personally as the sole investigator. Although the interviews were for research and not for therapeutic purposes, my experience as a therapist and my expertise in therapeutic communication assisted me in the interview process. As a therapist, I am accustomed to acknowledging and separating out my own thoughts and biases when working with patients in order to increase objectivity. I have also learned how to constantly clarify with patients the meaning of their stories, to ensure that my interpretation of the shared information is correct. I believe that my skills in interviewing and in understanding other people’s perceived reality were an asset in the interview process. I also recognize the importance of appearing neutral in both verbal and nonverbal behaviors, and I am experienced in choosing nonjudgmental terminology and in carefully seeking clarification without asking leading follow-up questions. My experience in helping others to explore their experiences of illness or trauma, thoughts, or descriptions of a specific event enhanced my ability to interview the participants in this study. As Smith and Osborn (2008, p. 63), stated, “The interviewer’s role in a semi-structured interview is to facilitate and guide, rather than dictate exactly what will happen during the encounter.”

I have coauthored several publications that address IPV and other forms of family violence (Clements et al., 2011; Clements, Burgess, Fay-Hillier, Giardino, & Giardino, 2015; Fay-Hillier, Clements, & Solecki, 2016). I was also involved in the development of two simulation experiences for undergraduate nursing students that focus on screening for IPV. I include content on victims of IPV and the nurse’s role in identifying those victims in the mental health undergraduate nursing course, for which I am the chair. As chair of the course, I am responsible for the integrity and coordination of both the course content and
clinical experiences. In addition to the aforementioned activities, I believe that my interviewing skills, my previous experience in conducting a qualitative study using semi-structured interviews, my supervision from experienced committee members, and my peer supervision have all prepared me for conducting this study.

**Bracketing**

In addition to being a skilled interviewer, in qualitative research it is essential for the researcher to be aware of his or her own biases and preconceived ideas. This awareness can increase a researcher’s objectivity and can assist in obtaining the essence of the stories shared by the participants. To help researchers to achieve objectivity, Husserl (1982) developed a process known as bracketing that can be applied to both interviewing and analysis. Bracketing involves separating ourselves from our normal way of viewing the world in order to focus on our perception of the world (Smith et al., 2013, p. 13). The preconceived ideas or assumptions that I bracketed in reference to ED nurses were as follows:

- ED nurses prefer taking care of patients’ physiological needs as opposed to their psychological or emotional needs
- Most encounters that ED nurses have with victims of IPV will cause the nurse to experience distress and will be perceived as negative experiences
- ED nurses do not feel comfortable screening for IPV victims
- Most ED nurses do not have sufficient training on screening and providing interventions for victims of IPV

As Sabella-Monheit (2010) noted with reference to bracketing, “Such setting aside or bracketing of preconceptions is believed to aid researchers in working inductively with
the data, thereby allowing them to understand others’ meanings of their experience without having their own get in the way” (p. 140). Bracketing must continue throughout the research process, because participants may share information that could evoke pre-conceived ideas not covered in the initial bracketing process. Smith et al. (2013) stated that researchers engaged in IPA should develop “reflective practices” that include a “cyclical approach to bracketing” throughout the research process (p. 35). One such instance occurred in my first interview with a male ED nurse. Though initially uncomfortable with interviewing a male on this topic, I quickly self-reflected on my reasons for the discomfort and proceeded with the interview. After bracketing my preconceived perception that male nurses would not want to talk about IPV, I found that I could achieve a similar comfort level in all subsequent interviews, regardless of the participant’s gender.

**Study Design**

**Participants**

The sample for this study consisted of 21 RNs working in hospitals in the Philadelphia, Pennsylvania geographic area. Demographic characteristics of each participant were obtained by using a demographic data questionnaire (Appendix B). The demographic characteristics of the participants are located in Chapter 4. See Table 4.1 for a summary of the collective demographic characteristics of all of the participants. Appendix C contains detailed demographic information on each individual participant. The number of participants included was based on a desire to reach informational redundancy or saturation, which is achieved when no new themes are emerging from the data (Cohen & Crabtree, 2006). Although there is no definitive target sample size in qualitative research, Smith et al. (2013) recommended that, when using IPA, one should
complete 4 to 10 interviews. The sample obtained for this study exceeded this figure substantially in order to achieve both saturation and provide sufficient stratified representation of the population, as discussed in the next section.

**Recruitment**

The recruitment process included approved placement of recruitment flyers at one center city hospital in Philadelphia (see Appendix C) and snowball sampling using nurses who worked in Philadelphia hospital EDs. The initial screening of some participants was completed by phone. A screening script (see Appendix D) was used to ensure that sensitive data were not obtained during the screening process. The data obtained from the screenings were stored in a locked file to which I alone have a key and access. All participants screened met the eligibility requirements.

The recruitment process was designed to achieve a purposive stratified sampling of ED RNs working in Philadelphia-area hospitals. The distribution of approved flyers at one hospital, in combination with snowball sampling, was sufficient to fulfill this aim. The initial stratification plan had the following goals:

- at least 10% or 4 participants (whichever is greater) are male
- at least 20% of participants have had a patient disclose being a victim of IPV as a result of screening in the ED
- at least 20% of participants have never had a patient disclose that they were a victim of IPV as a result of screening
- at least 20% of the participants were born in or before 1960
- at least 20% of the participants were born in or after 1961
To align the sampling plan with current trends regarding the age of ED RNs, I subsequently adjusted the age ranges in the stratification plan. The average age of nurses in EDs is younger than in other specialty areas, with a mean age of 40 (McGinnis, Moore, & Armstrong, 2006). The revised plan for stratification of age was updated to stipulate having at least 20% of the RNs born in or before 1976 and 20% born after 1976. In this way, the older age group consisted of more traditional generations: veterans (born between 1925 and 1940), baby boomers (1941 to 1960), and generation X (1961 to 1976). The younger age group, born after 1976, consisted of millennials, also known as generation Y or the “me” generation (Glass, 2007; Stein, 2013).

Gender was also included in the stratification plan because previous studies focused on female victims and female RNs who screen for IPV, excluding males (Baker et al., 2002; Bryant & Spencer, 2002; Kramer et al., 2004; Rhodes et al., 2011; Stayton & Duncan, 2005). Having at least four male nurses in the sample would facilitate an examination of how ED male nurses perceived the experience of screening for IPV. Finally, stratification with regard to whether participants had ever had a patient disclose being an IPV victim was intended to investigate whether this factor might influence nurses’ feelings about IPV screening (Beynon et al., 2012; Bryant & Spencer, 2002; Campbell et al., 2001; DeBoer, Kothari, Koestner, & Thomas, 2013; Roush, 2012; Sprague et al., 2012).

After the age divisions were readjusted, the sample of participants met all stratification protocols. Six of the 21 participants were born before 1976 (29%) and four (19%) were male; four participants (19%) indicated that they had never had anyone disclose being a victim of IPV as a result of their screening.
The RNs who participated in this study had all triaged at least 500 patients in the ED within the last year (including the nurse who had worked in the ED for three months). The rationale for this inclusion criterion was it would be reasonable to assume that with a lifetime prevalence of 35.6% of women and 28.5% of men being victims’ intimate violence the RNs who screened at least 500 patients would encounter victims of IPV (Black et al., 2011). Although nurses could be thinking about screening for IPV even if universal screening was not required, it was my belief that it was essential to ensure that all nurses were required to screen for IPV so that their situations would be relevant to the phenomenon being studied (Cohen & Crabtree, 2006).

It is certainly reasonable to expect ED nurses to assess well over 500 patients annually, since the average number of patients per eight-hour shift seen in the ED is 54.2 (Rathlev et al., 2012). Even at times of low census, most hospital EDs have a minimum of 11 nurses over a 24-hour period (Rathlev et al., 2012, p. 165). These figures would suggest that the average ED nurse should see approximately 15 patients per day (Ray, Jagim, Agnew, McKay, & Sheehy, 2003, p. 250).

Setting

To maintain confidentiality, I interviewed 15 of the 21 participants in a private setting that was conveniently located and comfortable for the participant. As noted by Smith et al. (2013), “The site of the interview is important: a comfortably familiar setting (for the participant) is preferable, but this must also be safe (for all parties) and reasonably quiet, and free from interruptions” (p. 63). Six participants who were not able to meet face to face instead participated in Blackboard communication sessions that were secured by means of a password-protected site. Blackboard is designed to provide virtual private
interactions that can be recorded and is used for meetings, presentations, and classroom activities (University of Arkansas at Little Rock, 2016). This resource was available to me because of my faculty position at Drexel.

**Inclusion Criteria**

All participants in this study met the following inclusion criteria:

1. Is an RN who is at least 18 years old and currently works in an ED as a staff nurse in a Philadelphia-area hospital (full-time, part-time, or per diem).

2. Has completed an initial assessment as an RN in the ED in a hospital in Pennsylvania on at least 500 ED patients in the last year.

3. The intake form used by staff RNs at their hospital includes at least one question that screens for IPV.

It would be highly unlikely for an ED nurse who screens at least 500 patients in a year not to have encountered at least one victim. Therefore, nurses who met the inclusion criteria but indicated never having had a patient screen positively for IPV were an important group to examine. All the nurses in this study had the opportunity to screen actual victims of IPV (even if the victims chose not to disclose their abuse). The inclusion criteria did not require the RNs to use an electronic medical record (EMR) that included a screen for IPV, but in fact all participants did use such an EMR at their hospitals.

A limitation of the inclusion criteria is that nurses not meeting these criteria were not given the opportunity to share their story (Wiklund-Gustin, 2010). However, as noted by Smith et al. (2013, p. 50), homogeneous sampling, by “making the group as uniform as possible,” permits a researcher to examine psychological variability within a group in greater detail. This sample was homogeneous in many respects: all participants were ED
RNs in the same large U.S. city who were expected to screen for IPV, had prompts in their EMR that addressed IPV screening, and were not mandated to report identified adult victims of IPV to the police or any other designated agency (as long as a lethal weapon was not used).

**Study Time Frame and Procedures**

I conducted all the interviews and analysis within a nine-month time frame, on a rolling basis as candidates were screened and became available. Each interview’s length was between 15 and 60 minutes. Because sharing this information could conceivably be emotionally upsetting, I had information available regarding referrals for mental health support if needed; no participant requested this information. Each participant was reminded at the start of the interview that he or she had the right to stop the interview, request a break, or withhold any information that he or she did not want to share. Each participant received $25 in cash as compensation for their time. Information on the availability of compensation was provided throughout the screening and interview process (Duke University Health System, 2016). Compensation was provided immediately after the interview and was not contingent on the participant’s ongoing consent to remain in the study.

**Preparation for the Study**

Although I have been involved with previous research studies on the role of HCPs in addressing IPV and other types of family violence (Clements et al., 2011; Clements, Burgess, Fay-Hillier, Giardino, & Giardino, 2015; Fay-Hillier, Clements, & Solecki, 2015), I took a course to improve my techniques and skill in qualitative analysis. Also, the first three interview recordings were sent to my committee chair for review and feedback.
Data Collection

The primary source of data collection for this study was the information shared by the participants in their recorded semi-structured interviews. The sharing of stories is a personal experience that deserves respect and attention. Throughout the interviews, I remained neutral and did not frame questions in a manner that could be perceived as requiring a specific correct or incorrect response (Wiklund-Gustin, 2010). To protect my neutral stance, I used broad opening questions and avoided directive questions. The use of open-ended questions permitted participants to share their experiences freely without misinterpreting structured questions as having socially desirable answers. I recorded all the interviews and used a password-protected virtual collaborative site to interview participants who were unable to schedule a face-to-face meeting. I kept field notes on any impressions or thoughts about each participant immediately after each interview, to help me in interpreting the phenomenon under study. The notes also included nonverbal behaviors that would not be included in the tapes. Moreover, I used the field notes to document any unexpected biases or beliefs that arose during an interview and had not been covered during my initial bracketing or reflexivity process.

Using the field notes as an outline, I composed more comprehensive notes after the completion of each interview. This method of preparing notes was modeled after the recommendations of Cohen & Crabtree (2006) and Smith et al. (2013). My interview guide (see Appendix A) consisted of questions designed to encourage participants share their experiences related to screening. The questions were reviewed by committee members and initially tested by having my chair listen to the recordings of my first three interviews. Throughout the interview process, I worked from the questions in the interview
guide, probing and seeking further clarification of responses. I also applied information and observations gained from prior interviews to facilitate further exploration.

After consent was obtained, participants completed a demographic form (Appendix B). The descriptive information provided on this form contributed to my interpretive process. To apply Bandura’s (1989a, b, & c) social cognitive theory, it was essential to consider the personal factors of each participant and the impact that those characteristics may have had on the overall screening experience.

**Ethical Considerations**

Institutional Review Board (IRB) approval was obtained through Drexel University to ensure that all ethical research principles were maintained throughout the research process. All participants completed a consent form. The form included the purpose of the study, indicated that participation was voluntary, explained how anonymity would be maintained, and stated that participants could withdraw from the study at any time up until the publication of the data. The consent form also included the risk-benefit ratio of the study and how the data provided would be protected. Each participant selected a pseudonym to be used throughout the interview and on any other materials related to the study. Each interview was tape-recorded, and the tapes were transcribed by a professional transcription service, which executed a written agreement stipulating that the tapes would be destroyed once the transcription process was complete. As a further protection, before submitting each tape for transcription, I listened to it to verify that no names or identifying data were mentioned on the tape. Any future publications will also refer to participants by pseudonyms. Any specific names or sites mentioned during the interview were also changed or deleted to further ensure anonymity. The original tapes and the list of actual
participant names were retained in a secure safe for which I had the only key. The
computer used to store all of the data is password-protected and encrypted.

Validity

In qualitative research studies, the term often used in place of validity is
trustworthiness. The more traditional view of validity in research studies is based on using
criteria to measure precision and accuracy, which cannot be done in studies of human
perceptions of experiences. Trustworthiness implies ability to demonstrate not precision,
but that the research is believable and logical (Glesne, 2011). Creswell and Miller (2000),
on the other hand, contended that use of validity is appropriate in qualitative studies as long
as the term is defined. Validity in qualitative studies is based on the application of three
viewpoints or lenses that focus on credibility in addressing the views of (a) the researchers,
(b) the study participants, and (c) the “people external to the study” such as reviewers and
readers (Creswell & Miller, 2000, p. 126). For each lens within the qualitative study,
several strategies can be implemented to achieve credibility. Creswell and Miller (2000)
recommended that to increase the validity or credibility of a qualitative study, the
researcher should implement one strategy from each lens or viewpoint (p. 129).

My primary strategy to increase credibility and enhance the trustworthiness of my
study was research reflexivity. I documented my biases and preconceived ideas using the
process of bracketing, as discussed above. I also maintained a journal throughout the
interview and analysis process that documented my ongoing reflections and thoughts. The
journal, commonly referred to as an audit trail (Bloomberg & Volpe, 2006; Creswell &
Miller, 2000; Lincoln & Guba, 2000), was used to provide a timeline of the steps taken as I
developed my interpretations of the participants’ experiences. To further enhance
transparency and increase the credibility of my analysis, I sent my memos, a coding of one of the first interviews with corresponding lines from transcripts, and an initial outline of the three major themes that I developed to my chair and committee members, who provided ongoing supervision and guidance throughout the analysis process. The initial codes were used to seek clarification and further guidance with regard to my developing analysis.

To ensure accurate understanding of the participants’ descriptions of their experiences, I engaged in member checking (Creswell & Miller, 2000). Throughout each interview I sought clarifications of statements by probing further or by rewording them to verify proper understanding. As an illustration, I had this discussion with Hank as he described his understanding of IPV:

Hank: That is prominent. It’s often undetected and usually the victims are less willing to speak to medical providers as the first line. If you ask, a lot of times they’ll answer you truthfully, but only if you ask sometimes.

Interviewer: If you don’t ask, then they’re not going to disclose. Is that what you’re saying?

Hank: I don’t want to say that’s the case, but I think that the probability decreases significantly.

Another example of member checking arose in my interviews with participants from a hospital where another ED nurse had been murdered by her husband, from whom she had recently separated. Since I was aware of this tragic incident prior to the interviews, I sought clarification when respondents said that they had not had a personal experience of IPV. Some of the participants did not know the murdered nurse, so their statement was accurate. Others acknowledged that they did know the nurse and that, therefore, their
statement that they had not personally known a victim of IPV was incorrect. Surprisingly, one interviewee who said that the murdered nurse had been like a family member to him did not change his negative response, maintaining his view that the murder was attributable to jealousy rather than IPV.

In addition to the above forms of member checking, I also contacted interviewees subsequently to clarify responses and validate the accuracy of my interpretations.

My third lens to enrich the credibility or trustworthiness of my study was the incorporation of peer debriefing (Creswell, 2000; Glesne, 2011). I asked a peer who was familiar with my study and could provide constructive feedback to review my work periodically throughout the process. In addition, I discussed my analysis process with other peers who were actively involved in their own qualitative studies. These peers posed questions and challenged me to clarify my approaches and the organization of my thoughts. Moreover, I utilized the supervisory input of committee members who had expertise in both qualitative research and how HCPs address violence.

Data Analysis

Qualitative Analysis

The descriptive data obtained through the semi-structured interviews were transcribed verbatim and placed in a qualitative analysis program using NVivo 11. The transcriptions contained the words that were spoken throughout the interview, but not the prosodic units of their speech (such as pauses and tempo). I used the analysis program to categorize and organize the coding and thematic development process within each case as well as across cases. The coding and analysis of the data were based on exploring the personal and environmental factors described by each participant when discussing his or
her individual screening experiences. Although I completed the analysis primarily on my
own, I benefited from supervision and input provided by my chair, committee members,
and other peers. Supervision throughout the analytical process was used to “help test and
develop the coherence and plausibility of the interpretations” (Smith et al., 2013, p. 80).

Four research activities described by van Manen (1990) were used in the analytical
process to maintain the primary focus on analyzing each participant’s lived experience of
IPV screening (the phenomenon) using the participant’s own words and expressed
meaning. These four research activities were as follows:

(1) Reflecting on the essential themes which characterize the phenomenon;
(2) Describing the phenomenon through the art of writing and rewriting;
(3) Maintaining a strong and oriented pedagogical relation to the
phenomenon; and
(4) Balancing the research context by considering parts and whole. (van Manen,
1990, pp. 30–31)

I incorporated these activities into the development of the IPA analysis process. Although
the primary aim was to keep the focus on the participants’ lived experiences as identified
by van Manen, IPA contains a double hermeneutic, in that “the end result is always an
account of how the analyst thinks the participant is thinking” (Smith et al., 2013, p. 80),
thereby creating subjectivity. Smith et al. (2013) indicated that this subjectivity can be
controlled if the interpretive process is “dialogical, systematic and rigorous in its
application and the results of it are available for the reader to check subsequently” (p.80).
Accordingly, throughout the analytical process I continually evaluated the meaning of parts
of the interview within the context of the entire interview, based on my foundational premise that all the parts are interrelated within the entire story.

**Review of transcripts.** After verifying the accuracy of the transcriptions by comparing them to the original audio tapes that were copied and sent to the transcription service, I reviewed each interview several times, writing notes on my thoughts and impressions. The first three interviews were reviewed by my chair, who provided valuable feedback that I incorporated into subsequent interviews. The field notes and audit trail were added to a running log, maintained in NVivo 11. Reading each story several times helped me to understand how key pieces of the stories were linked, both within and across stories.

**Documentation of the descriptions.** After I had read a transcript several times to become very familiar with the entire interview, I then explored its parts, examining specific lines within the text for words and phrases used to describe or give meaning to the participants’ experiences (Smith et al., 2013). I used NVivo 11 to assist in the categorizing and organization of themes that I developed. I concentrated on three levels of communication: the participant’s descriptions, the words chosen, and conceptual observations using Bandura’s theoretical framework and my professional experience.

I used my three research questions (RQs) as a primary guide during the analysis process. With regard to RQ1 (What do ED nurses currently believe, know, and do about screening for IPV?), I explored how each nurse’s personal factors (such as knowledge, feelings about having to screen, education, age, consistency of screening, and what they do with the information after screening has taken place) influence their practices in screening or not screening. In reference to RQ2 (What factors do nurses perceive as influencing the
likelihood of screening for IPV?), I considered how each nurse’s perception of both environmental factors (such as how they screen, location, documentation, influence of other HCPs, changes in screening practices, hospital training, peers) and personal factors (such as previous experiences with IPV victims) that motivated their screening practices. In reference to RQ3 (What factors do ED RNs perceive as barriers to screening for IPV?), I explored each individual’s perceptions to patient responses that might create barriers (such as how frequently each nurse has had a patient disclose abuse, or how often a patient seeks clarification of the screening questions) in the screening process. I also searched for any notable feelings, thoughts, or events described by each participant when discussing difficulties in screening for IPV. The incorporation of the idiographic aspect of the analysis process was maintained by moving from the “generic” or common experiences shared by the participants and using “extracts” of specific participants to connect to the overall themes (Smith et al., 2009, pp. 115-116). As recommended by Smith et al. (2009), extracts should be obtained as a result of completing a detailed analysis of each of the 21 participants’ transcripts. The idiographic analysis was included in the writing of the results in chapter 4 when specific personal and environmental details of selected participant’s extracts were included in the discussion of the overall themes.

During the initial analysis process, I highlighted phrases and words used by each participant to describe personal and environmental factors involved in specific aspects of the screening process, such as the nurse’s perception of his or her role (a personal factor) and the location in which screening took place (an environmental factor). I then used the highlighted information to further explore connections within each participant’s overall experiences. Third, I developed connections with similar information provided by other
participants. Fourth, I compared the descriptions, noting contrasting, complementary, or consistent responses.

**The interpretive process.** I then moved to the third level of my review: the interpretive process, which involved making conceptual comments and coding that moved away from the exact expression of each participant to focus on implied or overall understandings of specific subjects as expressed throughout the interview (Smith et al., 2013). The conceptual comments were often inquisitive, based on questions that arise about specific comments by the participants or areas of interest within the transcripts that warranted further investigation (Smith et al., 2013),

The conceptual comments included some of my personal observations, experiences and comments. For example, I have observed that some younger nurses’ verbal communication skills are not as fully developed as compared to nurses born before 1976, presumably because of their increased use of electronic devices. As a result of my personal experience with Generation Y (individuals born after 1976), I further explored the cases in which participants expressed being uncomfortable with knowing how to respond if a patient disclosed being a victim during screening. I contrasted these respondents with those who indicated intentionally creating an environment to increase the opportunity for victims to disclose and who provided empathetic responses when they identified a victim.

During the interpretive process, I also looked at other environmental and personal factors that might have influenced the nurses’ IPV screening experiences. I also continued the ongoing bracketing of my own preconceptions, and I included the conceptual concepts that I applied throughout the interpretive process in my peer and expert supervisions to
ensure that I was consistent in applying the concepts. This part of the hermeneutic circle should continue throughout the analytic process.

The exploratory processes that concentrated on three levels of communication (the participant’s descriptions, the words chosen, and conceptual observations) are different approaches, each of which offers an alternative method of analyzing the text to determine or interpret new meanings (Smith et al., 2013). The process is circular and required me to continually check the actual text in the transcripts to ensure that interpretation was foundationally based on the words and expressions of each participant.

**Emerging themes.** The next step in the analysis process was the analysis of emerging themes, which were uncovered from the notes taken up to that point. My approach was guided by the recommendation of Smith et al. (2013) that one should look for emerging themes by “breaking up the narrative flow of the interview” and ultimately having the pieces of the narrative “come together in another new whole at the end of the analysis in the write-up” (p.91).

The initial coding was based on the identification of personal factors (such as “IPV education,” “role in screening,” “defining IPV,” and “personal experience”) and environmental factors (such as “resources provided in screening,” “training in screening,” “male,” “suspected,” “peers,” “patients’ intoxicated,” “in front of the partner,” and “bathroom”) that were mentioned when participants described their screening practices. The initial, general themes that emerged at this step continued to be refined throughout the analytic process.

Next, I looked for emerging connections between themes. As I began to uncover the themes, I categorized them into a structure to support connections to the significant
aspects of the stories shared by each participant. Here I incorporated various methods to
categorize the emerging themes, such as the clustering of similar themes, which would
ultimately be combined into an overarching theme. This abstraction process resulted in a
higher level of interpretation. Similarly, I sometimes applied the “subsumption process”
(Smith, 2013, p. 96), in which one emerging theme proves to be large enough to subsume
others. I also used “polarization,” which involved exploring dissimilar or opposite themes
arising within the same transcript (Smith, 2013, p. 97). Exploring both the positive and
negative aspects of emerging themes within the same transcript also assisted in the
uncovering of overarching themes. Furthermore, I explored the impact of particular
influences across interviews, such as the characteristics of the patient being screened, the
ED’s level of acuity, and the presence of other staff. Throughout this process, the themes
that emerged at the individual level were categorized using more than one method and
included note review and supervision. As recommended by Charmaz (1990), supervision
helped to ensure that I was not trying to fit the data into any preconceived notions.

Clustering of themes. After completing my analysis of each individual interview,
I looked for themes that were consistent across cases and clustered them. The clusters
included various personal and environmental factors (such as location of screening,
training, and previous personal experience with IPV) as well as similarities in perceived
outcomes. This process explored deeper meanings of the themes extracted from each
participant and mapped them to comparable views of other participants. Key themes,
expressed by all or most of the participants, are discussed in my summary of results in
chapter 4.
**Quantitative Statistical Analysis**

A descriptive analysis of the demographic data obtained by the participants was also completed. Analysis included calculating frequency and percentages of the data, as well as the range of the ordinal data (Houser, 2008). Careful consideration of the demographic data made possible a fuller understanding of the personal factors that might influence the screening experience of each nurse, and it also informed comparisons of the participants’ screening experiences. Furthermore, the descriptive data aided me in comparing the results of this study to those of previous quantitative and qualitative studies and in making recommendations for future studies and practices.

**Summary**

In this chapter, I have presented the qualitative methods, theoretical framework, research design, implementation of the research protocol, and the process of analyzing the qualitative and descriptive data obtained from the participants. In chapter 4, I present the key findings and major themes that emerged from the qualitative analysis.

I would like to comment briefly on my experience of applying the IPA methodological framework. I believe that the approach helped me to become deeply familiar with each participant’s experience and in exploring perceived personal and environmental factors that could impact how each nurse dealt with similar situations. My major challenge was that, due to my desire to share and appreciate each participant’s individual experiences, I found it difficult to develop common themes. I felt as if I wanted each participant’s story to be shared, even though I recognized that doing so would be neither practical nor realistic to achieve. Wagstaff et al. (2014) discussed similar experiences of the strengths and difficulties of using IPA. It was comforting to know that
seasoned researchers had identified some of the same challenges. As the analysis process continued, I believe that I was able to develop a balance that represents the overall experiences encountered by all or most of the participants while still reflecting the diversity of individual perceptions contained within those experiences.
CHAPTER 4: RESULTS

The purpose of this study was to develop a better understanding of the experiences of ED RNs in screening for IPV. Included in the overall understanding of the experiences of the RNs was a descriptive analysis of selective demographic information of each participant as well as the collective frequency and distribution of all the participants. In summary of the collective demographic characteristics, the participants’ ages ranged from 24 to 60 years. Six of the 21 participants (29%) were over age 40. Four of the participants were male (19%) who ranged in age from 29 to 32. The seventeen female nurses’ ages ranged from 24 to 60. Nineteen of the participants (90%) identified their race as White/Caucasian. See Table 4.1 for a summary of the demographic characteristics; in addition to age, gender, and race, information was also collected on sexual identity, marital or relationship status, highest nursing degree, primary job, years of practice as an RN, years of practice in the current ED, certifications beyond employment requirements, and advanced practice nurse status. Appendix C contains detailed demographic information on each individual participant. The demographic information was used to explore personal factors that could influence the overall screening experience.

<table>
<thead>
<tr>
<th>Table 4.1</th>
<th>Demographic Characteristics (N = 21)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>24-29</td>
<td>6 (28%)</td>
</tr>
<tr>
<td>30-39</td>
<td>9 (43%)</td>
</tr>
<tr>
<td>40-49</td>
<td>3 (14%)</td>
</tr>
<tr>
<td>50-59</td>
<td>2 (10%)</td>
</tr>
<tr>
<td>60</td>
<td>1 (5%)</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>4 (19%)</td>
</tr>
<tr>
<td>Female</td>
<td>17 (81%)</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
</tr>
<tr>
<td>White, Caucasian; not Hispanic</td>
<td>19 (90%)</td>
</tr>
<tr>
<td>Irish/Puerto-Rican</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Refused</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Table 4.1</td>
<td>Demographic Characteristics (N = 21)</td>
</tr>
<tr>
<td>-----------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td><strong>Sexual identity</strong></td>
<td></td>
</tr>
<tr>
<td>Straight</td>
<td>20 (95%)</td>
</tr>
<tr>
<td>Gay</td>
<td>1 (5%)</td>
</tr>
<tr>
<td><strong>Relationship status</strong></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>4 (19%)</td>
</tr>
<tr>
<td>Never married</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Married</td>
<td>11 (52%)</td>
</tr>
<tr>
<td>Living with partner</td>
<td>3 (14%)</td>
</tr>
<tr>
<td>Divorced</td>
<td>2 (10%)</td>
</tr>
<tr>
<td><strong>Highest Nursing Degree</strong></td>
<td></td>
</tr>
<tr>
<td>MSN</td>
<td>6 (28%)</td>
</tr>
<tr>
<td>BSN</td>
<td>12 (56%)</td>
</tr>
<tr>
<td>ADN</td>
<td>2 (10%)</td>
</tr>
<tr>
<td>Diploma</td>
<td>1 (5%)</td>
</tr>
<tr>
<td><strong>Primary job</strong></td>
<td></td>
</tr>
<tr>
<td>RN (working as a staff nurse in ED)</td>
<td>18 (85%)</td>
</tr>
<tr>
<td>Trauma nurse</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Hospital nurse educator</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Professor of nursing</td>
<td>1 (5%)</td>
</tr>
<tr>
<td><strong>Years of Experience Working as an RN</strong></td>
<td></td>
</tr>
<tr>
<td>2-4</td>
<td>7 (33%)</td>
</tr>
<tr>
<td>5-10</td>
<td>6 (29%)</td>
</tr>
<tr>
<td>11-15</td>
<td>3 (14%)</td>
</tr>
<tr>
<td>16-20</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>21-39</td>
<td>4 (19%)</td>
</tr>
<tr>
<td><strong>Years of Experience Working in the ED at Current Hospital</strong></td>
<td></td>
</tr>
<tr>
<td>0.25</td>
<td>2 (9%)</td>
</tr>
<tr>
<td>2-4</td>
<td>6 (29%)</td>
</tr>
<tr>
<td>5-10</td>
<td>7 (33%)</td>
</tr>
<tr>
<td>11-15</td>
<td>3 (14%)</td>
</tr>
<tr>
<td>16-20</td>
<td>2 (9%)</td>
</tr>
<tr>
<td>29</td>
<td>1 (5%)</td>
</tr>
<tr>
<td><strong>Certifications Beyond Basic Requirements of Employment</strong></td>
<td></td>
</tr>
<tr>
<td>Acute Trauma Curriculum Nurse (ATCN)</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Certified Emergency Nurse (CEN)</td>
<td>8 (38%)</td>
</tr>
<tr>
<td>Nurse Practitioner (NP)</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Sexual Assault Nurse Examiner (SANE)</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>School Nurse</td>
<td>5 (24%)</td>
</tr>
<tr>
<td>Trauma Nurse Core Course (TNCC)</td>
<td>2 (9%)</td>
</tr>
<tr>
<td>More than one certification</td>
<td>7 (33%)</td>
</tr>
<tr>
<td>None</td>
<td></td>
</tr>
<tr>
<td><strong>Advanced Practice Nurse</strong></td>
<td></td>
</tr>
<tr>
<td>Adult Health NP</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Adult Educator</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Clinical Educator Specialist</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Family NP</td>
<td>2 (10%)</td>
</tr>
<tr>
<td>No</td>
<td>16 (76%)</td>
</tr>
</tbody>
</table>
In addition to the above descriptive analysis of the quantitative demographic data, this chapter discusses the major findings of the qualitative study. The three research questions that guided this study each yielded major themes, which are organized under each question. Tables 4.3 through 4.5 provide examples of each theme and appear at the end of the three sections devoted to a research question. The three research questions that collectively impact the nurses’ human agency when they screen for IPV were as follows:

1. What do ED nurses currently believe, know, and do about screening for IPV?
2. What factors do ED nurses believe influence the likelihood of screening for IPV?
3. What factors do ED RNs perceive as barriers to screening for IPV?

Research question 1 focused on nurses’ perceived self-efficacy with regard to IPV screening. Bandura (1994) defined perceived self-efficacy as “people’s beliefs about their capabilities to produce designated levels of performance that exercise influence over events that affect their lives,” and he added, “Self-efficacy beliefs determine how people feel, think, motivate themselves and behave” (p. 71). The most prominent themes related to nurses’ perceived self-efficacy in screening for IPV were preparation, the nurse-patient relationship, and distinguishing victims of IPV. Two subthemes also emerged: redefining abuse and normalization of the screening process (see Table 4.3).

**Research Question 1: Nurses’ Perceived Self-Efficacy**

**Preparation**

Although all the nurses were able to share some knowledge about IPV, there was considerable variation in their perceived degree of the preparation in screening for IPV, in terms of both the amount and quality of information with which they were provided. The preparation that they received included various levels of formal and self-directed education,
obtaining information from peers, and employee training. The specific types of preparation that each participant described are presented below in Table 4.2 and are used as sub-headings in the discussion of the different levels of preparation experiences.

<table>
<thead>
<tr>
<th>Table 4.2 Level of Preparation to Screen for IPV</th>
</tr>
</thead>
<tbody>
<tr>
<td>(parentheses indicate number of nurses in each category; N = 21)</td>
</tr>
<tr>
<td><strong>Formal education, in-service training, self-directed educational opportunities (2):</strong></td>
</tr>
<tr>
<td>Tamara, Valerie</td>
</tr>
<tr>
<td><strong>Formal education and in-services (9):</strong></td>
</tr>
<tr>
<td>Bob, Connie, Debbie, Florence, Genevieve, Hank, Ijay, Marie, Natasha</td>
</tr>
<tr>
<td><strong>In-services and self-directed (5):</strong></td>
</tr>
<tr>
<td>Ann, Kay, Lyndsay, Samantha, Ursula</td>
</tr>
<tr>
<td><strong>Formal education and self-directed (2):</strong></td>
</tr>
<tr>
<td>Ernie, Joanne</td>
</tr>
<tr>
<td><strong>Self-directed only (2):</strong></td>
</tr>
<tr>
<td>Pam, Quincy</td>
</tr>
<tr>
<td><strong>In-service only (1):</strong></td>
</tr>
<tr>
<td>Optimistic</td>
</tr>
</tbody>
</table>

The most common preparation for dealing with screening for IPV, reported by nine nurses, was a combination of some formal education in their nursing programs and an in-service at their place of employment. Only two nurses had experienced both formal and self-directed educational opportunities as well as receiving hospital in-service training on how to screen.

**Formal education.** The nurses who reported having received some formal IPV education in their nursing programs had 2 to 14 years of professional experience. The eight nurses who reported no such preparation had 7 to 39 years of experience. These figures suggest that perhaps IPV has become a more common, though not a universal, topic in nursing education over time.

Of the 13 nurses who received some formal education in their nursing programs, most described it as minimal. Several participants thought that IPV might have been
mentioned in their nursing programs but, like Bob (who has been a nurse for seven years),
could not recall any specific information: “I’m sure we covered something in nursing
school, but … I don’t ever remember having to take any tests on it or anything like that.”

Some of the nurses could identify minimal details about what they learned in their
nursing program. Debbie’s comments are typical: “It’s been mentioned in school. I
wouldn’t say they had a class on it or anything or really gave us any kind of … they just
said it’s important to screen for it.” Although Valerie completed her nursing program 10
years prior to Debbie, she shared a similar experience in reference to her formal
educational experience regarding IPV: “I would say emotional and mental abuse was
something that wasn’t really addressed that I remember when I first learned about it. It was
questions that were [like] ‘Were you hit or threatened?’ ”

Tamara, who is certified as a Sexual Assault Nurse Examiner (SANE) and
completed her undergraduate nursing program eight years earlier than Debbie, said, “They
do talk about it in nursing school. They talk about screening for [IPV] not in the room, so
you’re getting direct answers.” Joanne, who has been a nurse for two and a half years, also
recalled some specifics: “Maybe through nursing school, [I learned] just to watch out for if
people are guarded or refusing to answer questions, or if you can kinda just pick up on
someone that’s answering to what they want somebody else to hear maybe.”

Natasha, who has been a nurse for four years, also recalled a few specific details
provided in her formal nursing education:

That’s part of our nursing school training … to recognize if a patient’s being abused
or how to recognize the situation, get the spouse out of the room when you’re
triaging the patient so you know exactly what you’re dealing with and not that person controlling the other person when you’re triaging.

A few nurses recalled a specific nurse educator in their formal educational experience who invested time in providing education about addressing IPV in clinical practice. Florence, who has been a nurse for two years, provided an example of such an encounter:

We probably touched on it in psych a little bit. I think a couple professors did. I remember one of my clinical instructions in maternity talking about when you suspect intimate partner violence you ask for a urine sample and follow the woman into the bathroom, say you have to watch her or something. So you could get the man away from the woman if that’s the scenario. If it’s a man, then it’s a little more difficult if you think the woman is the abuser.

Connie, who has been a nurse for three and a half years also shared her experience of a specific instructor who left an impression on her:

We had one of the teachers [who] did like all the makeup and stuff like that, but when you got her undressed, she had all this bruising everywhere. And she kept giving weird answers as to why the bruising was, and you’re supposed to keep going through [exploring further], so I remember that from nursing school, because they really were [emphasizing] how important it is that you are the voice for these people sometimes.

Overall, the nurses’ formal educational experiences reflected inconsistency with regard to providing information and training that would prepare them to safely address and screen for IPV. Although all eight nurses who had completed their nursing programs
within the last five years identified recalling some mention of IPV, the information they cited was vague or inconsistent. Hank (who has been a nurse for three years) provided an example of the typical context in which the topic was addressed:

    It may have the aspect of education in mandatory reporting and things like—or not mandatory reporting, but the types of reporting that are not mandatory versus more pediatric for mandatory.

**Self-directed educational opportunities.** Ten nurses indicated having taken steps on their own to read about or seek additional information on IPV. Ann (who has been a nurse for nine years) described where she got her information:

    Yeah, I mean in ER magazines, you know, like in the ED nursing journal; so in educational articles they send us that we have to complete every year, [something] will be about domestic violence. But other than that—and you know, from the media and things along those lines, but nothing in a degree program or nursing school or anything like that, that I remember, anyway.

Joanne described attending a session on IPV at a professional conference as the only form of formal education that she received:

    I went to the transgender cultural health conference…that talked about violence between transgenders or against transgenders. … It was more just to recognize if there was, like, any sort of violence or just to promote education about or awareness, I should say, not education; but besides that, no. I don’t want to really say too much formal education.

**In-service training.** With regard to training at the hospital where they were employed, although all the nurses were required to screen for IPV, only 17 reported
receiving some form of training or in-service on the topic during their orientation. Of those 17 nurses, most said that the information consisted essentially of just being told that they needed to screen, with little information on IPV or on how to screen. Kay’s experience was typical: “I mean, we’re told that we should screen them in triage so when I had my original triage class when I first started here years ago, they briefly went over that you should screen people.” Ernie shared a similar experience, but also mentioned being introduced to resources that nurses could provide if a patient disclosed being an IPV victim during screening: “More just in the triage process, to ask. And I remember once when we started, we got handed those pamphlets in triage that we can actually hand to people if they say yes to that question.” In contrast, Joanne, who was just completing her orientation in the ED, stated straightforwardly, “No formal training here.”

A few nurses reported experiencing a much more structured in-service training that specifically addressed IPV screening during their orientation experience. Valerie explained, “We received training … we learned approaches and techniques to address patients about sensitive subjects such as abuse and domestic violence.” She elaborated further on some of the techniques covered:

Approaching detailed, sensitive information, when to address it. Triage—we also had triage training. And that was to kind of organize your questions as far as domestic violence, and when to ask: when nobody else is around; if it can’t be addressed at the time of your triage, to let your nursing staff that’s taking care of the patient when the patient’s by themselves. And what we do as far as the hospitals to give patients information about domestic violence when it’s appropriate or suspected.
Two nurses who reported receiving structured in-services stated that it was provided at the time of a change in hospital policy that mandated universal screening. Optimistic (who has been a nurse for 16 years) shared her experience of how the hospital prepared her for this change: “It was probably about 45 minutes of education, what to look for, questions, answers … just some clues that you can look out for and ways to help different people who present with that.” Optimistic added that the training covered interventions that nurses could provide to patients who screened positive, such as giving them pamphlets “that are small that they can hide in their shoe” or calling on the hospital’s domestic violence coordinator for assistance.

But not all nurses reported a similar experience when hospital policy changed to require mandatory IPV screening. Quincy, who has been an ED nurse for 33 years, commented, “I don’t really remember having any formal education. I think they just said to ask the question ‘Do you feel safe at home?’ as part of the triage.” Quincy said that, in lieu of a formal in-service, the ED nurses talked with each other about what they should do if they got a positive response to IPV screening.

Like Quincy, most of the nurses mentioned observing peers as a means of helping to prepare for screening for IPV. Bob stated, “It definitely makes you think about how you ask the question, or if they do something differently and it works really well, changing and doing what they do.”

Connie also noted the influence of experienced peers in the development of her screening practices:

I think in general how I came up with my questioning was from hearing other people ask it, because it’s not worded that way. It’s not like I’m reading a script off
of a thing. It’s just things that have to be answered, and these are ways to ask for it, and I’ve heard other people do it and I’ve just kind of taken pieces of other people’s stuff and made it my own, so I … give people the opportunity to answer the question appropriately.

Several nurses stressed the importance of their peer relationships, describing fellow nurses as like family. For example, Kay said, “Yeah, you become a family here. I mean if you think about it, half your life is spent in that work.”

Overall, there was significant variability in the quality and amount of training provided to nurses, but most participants said they did not feel well prepared to address IPV situations. Joanne wondered, “I mean, now that it triggers something that we don’t really have too much training on, … how are other people training?” Several nurses included that the preparation should cover how nurses interact with their patients when screening for IPV. For example, Ernie said, “I do think we should have more training on it.” Genevieve, who has been an ED nurse for 9 months, also supported the need for further training:

I think this is a really good topic, honestly. I feel a lot of times when you’re in the ER you focus so much on—do they have chest pain? Do they have this? Do they do that? And I feel their emotional being sometimes gets thrown by the wayside. I think it would be good if we had, maybe, a refresher course on some scenarios and how to approach people because sometimes it’s really hard.

In summary, most nurses felt that they were not well prepared to screen for IPV and that more training should be provided. They identified peer support, formal education, and hospital in-services as the main potential methods of delivering that training.
The Nurse-Patient Relationship

An important theme that emerged from participants’ discussions on initiating the screening process was the concept of developing a patient-centered relationship (Peplau, 1999). The nurse who can demonstrate to the patient that he or she is caring and respectful throughout their interaction can create an environment in which the patient is more willing to disclose concerns. In my discussion of this topic, I include the nurses’ ages because several of the nurses who indicated feeling uncomfortable about addressing IPV were 40 years old or younger. (I will return to this issue in chapter 5.)

Several participants included, in their description of IPV screening, how they connected with the patient during the screening process. Quincy (age 60) stated:

We try to do it privately. And we ask kids, too. Like “Come with me, I want to see how tall you are,” and I take them in another room and talk to them about some other things, and then I just kind of—as we’re talking about other things—just kind of slip it in. “Do you feel safe at home? Anybody hurting you?” And that way, it’s more of a—they’re not on guard, and I feel like they answer more truthfully if you do it that way.

Genevieve (age 27) described how she adapted the screening process to address the patient’s level of understanding:

I try to phrase it, “Do you have any concerns about your living environment? Is anybody hurting you?” … I think it’s just the words that you use. Here, especially, I feel sometimes you have to bring it down; I try to bring the medical terminology down for patients in general. Here there’s a lot of patients that I find are lower literacy and might honestly not understand what you’re saying.
Genevieve, who is fluent in Spanish, went on to discuss the need for sensitivity to cultural differences:

Sometimes in cultures, I feel too, it’s hard to bring up violence because it might be frowned upon, or we don’t talk about that. I think that makes it hard too if you’re a woman talking to a guy, that might be offensive or things like that. That makes it hard too, as well, to screen people for abuse as well if you’re not familiar with their cultural traditions or beliefs.

Other nurses shared a different approach to the nurse-patient relationship when screening for IPV. Of the four nurses who shared that they had never had a patient screen positive for IPV, one was in orientation and the other three, in describing their approach, did not seem to display any focus on the patient’s attributes, such as Genevieve described in her interactions with patients. Marie (age 40), one of these nurses, gave a typical answer: “No, we just say, ‘Do you feel safe at home?’ just generally. That’s pretty much the domestic violence [question], I guess.” Similarly, Kay (age 27) explained, “I don’t go any farther. I just say, ‘Do you feel safe at home?’ That’s it. In chapter 5, further discussion on how future training of nurses should include strategies in the development of an effective nurse-patient relationship as an essential component when approaching sensitive topics, such as IPV, with their patients.

In contrast, other nurses, such as Debbie (age 32), who have identified victims of IPV as a result of screening spoke of asking follow-up questions when patients said “What do you mean?” in response to the query whether they felt safe at home. She said that patients responded in that way “all the time.” However, Debbie said that she only added additional questions when patients asked for clarification and did not otherwise adjust her
screening practices. Other nurses reported that they made more extensive alterations in their approach based on patient responses. As Bandura (1989a, b, & c) explained, individuals’ behavior is influenced by the perception of the response they receive from the environment. One subtheme in the nurse-patient relationship, “normalization,” also reflected nurses’ adjustments to common patient attitudes.

**Normalization**

Some nurses indicated that they make a general statement to patients prior to initiating IPV screening. This general statement usually explains to patients that the screening questions are asked of everyone. It thus functioned as a means of “normalizing” the screening process and eliminating any sense that patients might be receiving that question because of specific suspicions. All the nurses who stated that they provide a general statement to normalize the screening process said that they had developed this practice as a result of being frequently questioned by patients, out of either curiosity or annoyance. Some nurses said that they were selective with regard to the patients with whom they used such a normalizing statement. Lyndsay, age 28, gave an example of how she normalized the screening process with select male patients: “Sometimes, if it’s like a big guy or something I’ll be like, ‘This might sound like a silly question but do you feel safe?’” The normalization was in the form of adding the phrase “silly question” when asking “big guys.” The concern with using “silly question” would be that even if a “big guy” was being abused, he would not disclose that information after being informed it was “silly” to even ask him. While the nurse may be a competent clinician, she may not have been knowledgeable and skilled in how to approach and address sensitive topics that might
be distressing to the patient during the interaction (DeChesnay, Murphy, Harrison, &
Taualii, 2008; Kavanaugh & Ayres, 1998; Morris, 2001; Sadler, 2016.).

Other nurses took a universal approach to normalization. Ijay (age 32) explained
that he prefaced his screenings by providing education on the universal screening process:

So what I do now is I preface all those screening questions [which include IPV] that
they end with [by saying], “Now I’m going to ask you a series of questions. These
are questions that every patient in the ER gets asked. We’re required to ask all
these questions. And it’s not directed specifically at you or your situation.” … And
then at the end, usually the last thing I do is I ask about intimate partner violence or
any sort of violence against that patient.

Other nurses said that they engaged in normalization when patients requested an
explanation of why they were being screened for IPV. Optimistic (who is 43 years old)
stated:

They’re like “Why are you asking me that?” and I say we ask everybody that.
They’re like “I’m here for like a cut on my hand.” I go, “I understand that, but
you’d be surprised how many people say ‘Yeah, I’m not [safe], how can you help
me?’ So we screen everybody; it doesn’t matter if you come for a stubbed toe, we
screen everybody that comes in.”

Some nurses turned to normalization as a way of supporting patients who might appear
hesitant to respond. Quincy recalled one such exchange:

I explained to her why I was asking, and that I wasn’t going to call anybody, and I
went and got her—we have [domestic violence] cards with a number on it to call.
And I just said, “This is for you. If you feel that you need to talk to somebody
about what’s going on in your life, or if there’s something that we need to do now.”

And I give them that option, too.

The nurses’ level of engagement in developing the nurse-patient relationship when screening for IPV will be further discussed in chapter 5. Included in the discussion will be implications in regards to needed education on the use of normalization by RNs when interviewing and screening for sensitive topics such as IPV.

**Distinguishing IPV**

Along with their experiences in obtaining information about IPV and how they screened for it, the nurses also shared their own thoughts on IPV. There was considerable variability in how they distinguished IPV from other forms of domestic violence, their understanding of the complexity of addressing IPV, and who could be a victim. One subtheme that arose in these discussions was the process of distinguishing between nurses’ personal beliefs and their patients’ beliefs in defining IPV.

Some participants viewed IPV as equivalent to domestic violence, whereas others did not. In Pennsylvania (where all the nurses in this study were licensed), although IPV is a subset of domestic violence, the required interventions for nurses in cases of IPV differ from those in other instances of domestic abuse. Nurses licensed in Pennsylvania are mandated to report suspected child or elder abuse, but unless a lethal weapon was used in the assault or the victim was a child or older adult, they are not required to report IPV (Durborow, Lizdas, O’Flaherty, & Marjavi, 2010). Connie, age 39, was one example of a nurse who saw no difference between domestic violence and IPV:

I mean, just in general, like you’re at your home or anyone that you live with, are you feeling safe? Like it could be anything from elder abuse to spousal abuse to
just somebody that you’re with, or even same-sex type of abuse at home—and child
abuse, too. So it’s pretty much all we’re talking about is—at the home are you
experiencing—is anyone hurting you, physically or emotionally?

Joanne, age 30, described incorporating IPV into the broader category of domestic violence
because she more frequently experienced other forms of abuse, such as elder or child
abuse, in the ER. On the other hand, some of the nurses who have experienced patient
disclosures of IPV during the screening process offered more detailed descriptions of this
type of abuse. Samantha provided an example of what some nurses say to patients about
IPV specifically:

Just that an abused partner will leave an average of eight times before they will
successfully stay gone, that a fair number of people don’t survive to leave eight
times, [and] the types of partner. There’s a snake kind of partner that’s focused on
one person but that’s very quiet, that people may not realize that they are a violent
person and they’re like a stalker kind of person that just thinks ahead and
methodically isolates somebody, versus somebody who’s like a bulldog who
everybody can tell and is very up front that they’re very territorial and aggressive,
so to be careful for both kinds.

As noted in chapter 3, Ernie’s understanding of IPV did not include the risk factor
of increased danger when a victim attempts to leave the relationship. Victims of IPV are at
greatest risk for homicide when leaving their abusive partner (Campbell et al., 2003;
Wiltsey, 2008). Ernie described the murder-suicide case involving his former colleague,
who had just separated from her husband, but when asked whether it represented an
instance of IPV, he stated:
We more took it as a jealousy thing from her husband that didn’t want to lose her, didn’t want to have her be with anybody else. It devastated him. He was in a suicidal-homicidal state. I don’t know who left who—well, I guess maybe she had left him, if he was going to act that way. But as far as prompting us to better screen people, not really. It just was a tragic thing, and it was more [that] everybody was so upset that it happened.

The implications of not covering high-risk situations such as when the victim leaves the abuser in training on IPV will be addressed in chapter 5.

In addition to delineating what they viewed as constituting IPV, the nurses described whom they considered the most likely or traditional victims. Most distinguished between traditional and nontraditional victims when they described victims they encountered as a result of screening for IPV. They identified traditional victims as women of childbearing age, consistent with the opinion of the U.S. Preventative Services Task Force (USPSTF) as to who should be screened for IPV (USPSTF, 2014) and anyone who did not meet the USPSTF guidelines as nontraditional. Most nurses who reported having had a patient disclose being a victim of IPV also indicated that the patient had come to the ED alone and was therefore screened with no family or friends present. Hank, for example, said that both cases of patients who responded positively to the IPV screening question were young females who came to the ED by themselves.

Some nurses offered further details about their encounters with traditional victims of IPV and the feelings they had with the screening process. Genevieve recalled:

I actually had a patient—a young girl, probably early twenties, that came in—she was pregnant and she wanted to get some blood work and things done. … And here
I found out that her boyfriend strangled her and held her head underwater for a couple minutes. You could see the mark around her neck. For me, I think it was just really hard trying to figure out how to bring it up without making her feel uncomfortable. I went in and I sat in the chair next to her because I wanted to be eye level. I didn’t want her to feel I was talking over her. And I said, “What brings you in today? What are some of your concerns?” And she got really quiet. I was like, “Is anybody—are you concerned about anybody hurting you?” And she just started to cry. And she said, “Yeah. I’m really worried. My boyfriend strangled me and I’m really concerned. I’m here because I’m afraid that he might have hurt the baby.”

Genevieve’s encounter with a traditional victim included having her pregnant patient disclose that she was a victim of nonfatal strangulation. IPV victims who have experienced nonfatal strangulation are at increased risk for mental and physical health problems (Sorenson, Joshi, & Sivitz, 2014). Obtaining vital information in reference to the patient having experienced nonfatal strangulation can add to further health screenings and safety interventions by the HCPs.

Many nurses, however, also described encounters with nontraditional victims—i.e., someone other than a heterosexual woman of childbearing age who had been abused by a male. Since most studies focused on female heterosexual victims of IPV, including the nurses’ stories of nontraditional victims can add support for universal screening and education and will be included in the discussion in chapter 5. Most of the nurses who did receive any education on IPV, were only provided with information about traditional victims. Pam explained:
The last case I had was a male, not a female… you know you don’t usually expect to have a male…this was a male partner on a male partner… he was tearful in triage …arriving with facial wounds. And it turned out there was some sexual abuse as well…he did come in with his partner [and] some female friends, so we took him right back into his room and we asked him the triage questions there.

Although several of the nurses did identify that anyone could be a victim of abuse, they distinguished the level of severity of different victims. Ernie provides an example of what several of the nurses shared when discussing male victims of IPV:

It’s tough, because if a grown man comes walking into your ER … and I come in there and say, “Ah, domestic violence,” or “Do you feel safe at home?” … the person’s like, “What do you mean, do I feel safe at home?” … So is it a question that I feel should be asked to men? Yeah, I think it still should be asked to men. I think you maybe get more verbally abusive cases. I mean sometimes they’re physical. … But can a woman hurt a man as much as a man can hurt a woman? I don’t think so. I mean, with a weapon, I believe so, but with fists and what not, I don’t think so. I mean, you can still hurt a man by punching him in the head, you know, and it happens recurrently. But when I think of domestic violence, I mostly think of a man beating a woman, or sexually assaulting a woman. That’s what first pops in my head. I mean if you think about it, in media today, and social media, and all that, you rarely see it the opposite way. So I guess it kind of gets engraved in you that it’s usually the one way.
Ernie’s beliefs about women being the primary victims of IPV reflected the nurses’ formal educational experiences and in-service training. However, an interesting subtheme emerged as some nurses described the process of how they began to redefine IPV.

**Changing Views of IPV**

Several of the nurses who began their careers prior to the implementation of a mandatory IPV screening policy shared their beliefs on how the change impacted their thoughts on screening. Quincy stated, “I think it’s more talked about. I think it’s been hidden in the past … nobody talked about it.” As identified by Quincy, historically IPV was viewed as a private matter and HCPs did not take an active role in addressing victims. The current trend of addressing IPV as a “human rights issue” changes the view of IPV from being private or a personal issue to one that needs to be addressed on a societal level (Carney, 2015, p.18). The change of view for Quincy also changed her behavior from one of not talking about IPV to universally screening all of her patients. In addition, several nurses referred to redefining the implications of IPV. Ursula discussed how her encounters with victims of IPV changed her perceptions with regard to distinguishing the different types of victims:

> When we used to think of domestic violence, we used to think of all intimate partner violence. So, anyone that you had a relationship with, it was considered domestic violence. Now I feel like it’s split for me. I don’t know how well it’s spelled out for the rest of the community, but that definition has definitely been sectioned out, for me. … An intimate relationship and connection between the partners is different than other types of abusive relationships. See, folks who are
assaulted talk about betrayal with the partner they love. There is a different emotional mindset.

Several nurses shared how their understanding of who could be a victim of IPV changed as a result of their experience in the ED. Limiting the focus in both formal education and in-services to women of childbearing age as the only victims could initially reduce the nurses’ openness to the possibility of nontraditional victims. Genevieve, like several other nurses, described how her view of victims and perpetrators changed over time:

I feel we’re always taught that it’s always the girl that’s the victim and not the guy. But I think working here, I’ve definitely seen it the other way, especially with people that are in same-sex relationships. We’ve had a lot of guys come in who that their partner abused them or tried to hurt them. … I think we get that mindset that it’s always the girl that’s the damsel in distress and it’s always the guy that’s hurting her. It can happen across the board.

Other nurses shared how their encounters with patients helped them to separate their personal beliefs from their professional practice. Some of the nurses’ personal beliefs on what they thought were victims of IPV changed as a result of their professional encounters with patients. Kay offered these reflections:

[There is] a lot of verbal violence. I mean, people wouldn’t think that that’s violence sometimes. I think people overlook that a lot. But I mean the way partners talk to each other, I would never in my million years ever think to talk to my husband like that. But they do, and it’s okay. It’s just normal living for them, a lot of them. So that’s definitely different. … If I would consider violence being
like verbal abuse and stuff like that, [I would be seeing IPV] every shift. … Just like the tone and the cursing and the—yeah, it’s horrible.

In summary, there was a significant variability in the nurses’ observations as to what they knew, did, and thought about IPV. Their level of preparation, their engagement in the nurse-patient relationship, and their delineation of IPV impacted their encounters with patients. In chapter 5, I will discuss the need for consistent educational opportunities and training throughout nurses’ professional careers that includes the complexity of the relationship between the victim and perpetrator. The nurses’ knowledge about screening, the approach or behavior in screening for IPV, and their beliefs in how they distinguished IPV collectively influenced their perceived self-efficacy in the screening process. As previously discussed, self-efficacy is the belief in oneself in being successful in the completion of a specific task (Bandura, 1994). The themes that emerged when the nurses discussed motivations and obstacles associated with research questions two and three, in the next two sections, further explore factors that influenced the nurses’ perceived self-efficacy or belief in screening for IPV. Table 4.3 provides a representative example of each of the themes that emerged from discussions of research question 1 and nurses’ self-efficacy.

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**Perceived Self-efficacy in Addressing IPV**

The following themes emerged in discussions related to RQ1: *What do ED nurses currently know, do, and believe about screening for IPV?*

**1. Preparation**

Bob: “I’m sure we covered something in nursing school, but … I don’t ever remember having to take any tests on it or anything like that. … I’m sure there was training, an online training that we had to do at some point. … But I would say, you know, most of the times [I am] probably asking what the policy is or going to the experienced nurses and figuring out what they do and how they report it.”
2. The Nurse-Patient Relationship
Genevieve: “I try to phrase it, ‘Do you have any concerns about your living environment? Is anybody hurting you?’ … I think it’s just the words that you use. Here, especially, I feel sometimes you have to bring down—I try to bring the medical terminology down for patients in general. Here there’s a lot of patients that I find are lower literacy and might honestly not understand what you’re saying.”
Marie: “We just say, ‘Do you feel safe at home?’ just generally. That’s pretty much the domestic violence, I guess.”

2a. Normalization
Ijay: “‘Now I’m going to ask you a series of questions. These are questions that every patient in the ER gets asked. We’re required to ask all these questions. And it’s not directed specifically at you or your situation.’ … Usually the last thing I do is I ask about intimate partner violence or any sort of violence against that patient.”
Lyndsay: “Sometimes, you know, if it’s like a big guy or something, I’ll be like, ‘This might sound like a silly question but do you feel safe?’ ”

3. Distinguishing IPV
Pam: “The last case I had was a male, not a female… you know you don’t usually expect to have a male…this was a male partner on a male partner…”

3a. Changing views of IPV
Quincy: “I think it’s more talked about. I think it’s been hidden in the past—nobody talked about it. I think it’s becoming more prevalent. Not prevalent—that it’s becoming more talked about.”

Research Question 2: Motivation to Screen for IPV

The Nurse as Patient Advocate

As noted in the introduction to this chapter, research question 2 focused on perceived personal and environmental factors that motivated the nurses to screen for IPV. Bandura (1991) indicated that an individual’s motivation to continue with behaviors is influenced by the perception of either receiving a positive or preventing a negative outcome. Further discussion of motivational issues is provided in chapter 5. The perceived factors that motivated nurses to screen were advocacy, the design of the EMR, and suspected abuse (see Table 4.4).

The main personal motivating factor was the nurses’ perceived role as a patient advocate. Although most of the nurses affirmed this role, they varied as to how they
applied it to the actual IPV screening experience. *Advocate* is defined by the *Merriam-Webster Collegiate Dictionary* (2015) as “a person who argues for or supports a cause or policy.” Both the ANA and the ENA indicate that one of the major ethical roles of registered nurses is to be a patient advocate (ANA, 2015; ENA, 2015; Epstein & Turner, 2015).

Several participants cited their role as advocate as a reason for screening all patients. Florence described her view in a fashion shared by several other nurses:

> I think the more maturity I gain as a nurse, I feel everyone deserves the same treatment. … My job is to get the information from the patient, and every patient should have the time to answer all the questions that they’re supposed to be asked. … Everyone says they trust nurses the most, so I feel other than their hairdresser [or] nail person, … the odds of them opening to someone that they can trust or they perceive to trust—not that all nurses are great—would be [high for] me or another nurse.

In addition to referring to universal screening as part of their responsibility as patient advocates, several nurses also described their role in ensuring the patient’s safety and making referrals to other hospital HCPs when a patient identified being a victim of abuse. Natasha described a typical approach: “To figure out first … if they are having any issues at home, and then to advocate for the patient, let the doctor know you have a concern that the patient is being abused, and contact social work.”

A few nurses described how they went further in interacting with patients and other HCPs to further support patient safety. Genevieve gave one example, referring to the pregnant woman abused by her boyfriend:
I actually spent a little bit of time with her. I told her, “Listen, you don’t have to be afraid. What can I do to help you? Can you at least talk to somebody?” That was my big thing. If you don’t want to file a report, I can’t make you do that. I told her, “You got to think about the baby now, too. It’s not just going to be you and you don’t want the baby growing up around somebody that’s abusive and it’s not good for you or the baby.” I think her talking about it out loud kind of helped. … I was the first person to see her and then I talked to the resident and the doctor about it, [and they said,] “Oh, she didn’t even—she didn’t really talk about that at all. She made it sound like she fell but left out the part that she was actually strangled.” They’re like, “Oh, she talked to you about it?” And I was like, “Yeah.” I think it’s just the approach and if they feel comfortable with you and how they’ll open up. That’s what I really like about nursing is I feel you always know more because you’re the first person. You’re on the front lines.

Many of the participants who spoke of being advocates for their patients also described personal experiences with addressing IPV. Although their individual stories varied, the common components were that they viewed the experience as empowering and the victim does not need to continue to be abused. Ursula related how she had advocated for herself and her family:

I was a senior in high school … I am one of five. It [the abuse] had been going pretty much all my life, and all of theirs. So it came to the point where we were old enough to basically make the decision for her [Ursula’s mom] and say, “Okay. Time to leave.” So we packed up and off we went, and still had a relationship with
the perpetrator, of course, afterwards, and took care of him, nursed him when he was dying.

Ursula’s personal experience seems to have influenced how she interacts with her patients: So I provide them with the resources, but I also tell them that there are people at these places that can talk to you more about the situation that you are personally in. I can’t understand what you’re going through, and I can’t understand the dynamics of your life, but I can tell you that there are safe places for you to go, and there are ways for you to navigate out of the bad situation that you’re in. And I give them some hope [by saying], “There are people that can help you be [strong] … until you can be strong enough to help yourself.” I don’t know that I word it that way, because I don’t want them to think that they’re weak or anything like that.

All of the nurses indicated that they considered screening for IPV as part of their role as a patient advocate. Although this perception motivated the nurses to screen, their level of engagement in seeking to address their patients’ needs varied. Further implications of this perceived role are discussed in chapter 5.

The Electronic Medical Record

All 21 nurses also identified the electronic medical record (EMR) as an environmental factor that motivated screening for IPV. The EMR was implemented to support efficiency in care delivery and decrease medical errors, creating a projected savings of billions of dollars (Hillestad et al., 2005). The nurses who lived through the change from paper-and-pencil note-taking to the EMR pointed out that implementation of the universal IPV screening policy was advanced by the introduction of the EMR system. Pam, for instance, said that IPV screening was not routine “until the computer system came
along.” As the nurses explained, the EMR’s design includes a screen that addresses domestic violence, and most nurses observed that a response from the patient must be recorded on this screen before the record can be closed. Ijay stated, “It’s something you have to answer on every chart. You’re required to answer it. And if you don’t answer, it won’t let you proceed with the electronic laptop.”

Several nurses worked at a hospital where the EMR’s domestic violence screen was changed to an optional response screen that could be bypassed, even though the hospital’s policy on mandatory universal screening for domestic violence did not change. Ernie explained the change and its rationale:

We just got a new computer system, so in our old computer system, it was very user-friendly. If I wanted to put an addendum note in there with your body posture or what I had seen, it was very easy for me to do. With this new system, the whole point—at least from what I’m getting from my director—is deck space. [The point] is to get them in and out of triage fast, because we have a ton [of people] out there; get them in the back to see the doctor. So our triage is very basic. History, meds, complaint, past medical history, and vitals, and that’s it. … So if I have to write anything in this new system, … it takes a lot of time out to do that, and it’s not user-friendly at all—and it’s against what they want us to do with triage, as far as get them in, get them out. So it’s tough to write a note in there.

Ernie and the other nurses who had experienced this change in the EMR stated that the new system resulted in a change in the quality of their screening practices. Debbie articulated similar concerns:
[Since] we started the new system, I haven’t ever had anyone say yes to [the IPV screening question]. It was when we had the old charting system. Then it was a part of the screening process, like you had to document that they said, “No,” or that they feel safe. This new system, I don’t think … unless I don’t know the place to document it … has it. … I guess if when I ask it, I would write a note, like free-text a note in there. But I’m not sure where, if there’s an official place to document it.

Most of the nurses who experienced a change from having to complete the screen that addressed IPV to optional completion in the new EMR system added that this change decreased their motivation to universally screen all their patients.

As I approached the end of my set of interviews, I had the opportunity to speak with additional nurses from the same hospital who said that another update of the EMR system had occurred, and that completing the IPV screen was required once again. Lyndsay described the impact of this reversal on her consistency in screening for IPV: “You didn’t, and now they redid it that you have to. … Yeah, just a couple weeks ago I noticed that now it’s required. So I don’t know what prompted them to redo it.” In fact, Lyndsay wondered if I had been responsible for urging the hospital to reconsider its system! After I assured her that I had not been involved in any changes, she shared further: “I guess maybe three or four weeks ago it became mandatory … which is a good thing. Because a lot of times you forget to ask it. … I haven’t really had anybody say yes since we’ve had this new system.”

I found it significant that both Debbie and Lyndsay indicated having no positive screens for IPV while the EMR system did not mandate obtaining a response to this
screening question. I will further discuss the relationship between EMR system and nurses’ motivation to screen in chapter 5.

**Suspected Abuse**

Another prominent theme among motivations to screen was that, on some occasions, nurses suspected that a patient might be a victim of IPV. Most nurses indicated that the IPV training provided at their hospital, if any, highlighted ways to identify patients who might appear to be victims of abuse. The nurses varied as to what patient behaviors they considered suspicious as well as with regard to what they did when they suspected abuse. Several nurses emphasized that such suspicions caused them to provide a safer environment for the patient to disclose abuse by screening the patient alone. Although all IPV screening should be performed in privacy, most nurses said that they took extra steps to screen alone only when abuse was suspected. Pam (one of the eight nurses who has had five or more patients screen positive for IPV) explained:

I’ve never skipped it, but if it’s something that I think may be a case, I’m sure to isolate the patient. But very often … if they fell down and sprained their ankle or whatever, then I may actually ask it in front of whomever they’re with. So I always ask it, but it’s where I ask it and in whose presence I ask it that’s a little bit different. … I would look for those warning signs … like if they came in with somebody [who] was really overbearing and answering questions for them, if it was somebody who didn’t meet my eye, who just seemed uncomfortable, then I would ask that question later.
Most participants also affirmed that obvious physical evidence would cause them to screen further. Ijay (another nurse who has had five or more patients screen positive for IPV) gave a typical description of how nurses look for such signs:

As far as physical exam findings, I would look for things like unusual areas of bruising, scratch marks, cut marks, choke—redness around the neck like they had been strangled. As far as psychological symptoms, they might be very quiet, withdrawn, not answering questions, and then the other big thing that really [is a strong sign]—and sometimes it’s cultural—is when the partner answers all the questions for the patient.

Several participants discussed how they would incorporate their understanding of cultural norms into their determination of what might be suspicious behaviors. They showed awareness that behaviors often viewed as suspicious in most American contexts, such as a partner answering all the questions as described by Ijay, would be culturally appropriate in some other settings. Kay provided an example of considering cultural factors in her evaluation of a situation:

There was a Muslim lady and her husband was there. Now I know the husbands speak over them a lot or speak for them. I know that’s in their culture a lot. But I remember me and one other nurse just felt like there was just something, there was something weird about their relationship. Maybe we were looking too into it because of their culture. Maybe they really like took on that culture and that’s—I don’t know. But we weren’t used to it. Because we have all types of religions and stuff coming here and sometimes Muslims come here. They’re a little bit more lenient, I guess you could say, whereas like this one was very intense. He was very
like over top of her. I forget what her complaint was. But things weren’t matching up. You know, you just like thought about it. So, I remember I did tell the doc about it. It was like “There’s something about this situation and I don’t know what to do about it, but something is weird.”

Several nurses also shared how their suspicions were aroused when the injury did not match the description provided by the patient. Bob explained:

It’s just the feeling that you get when somebody’s not really telling you what’s going on, or not telling you the whole truth, kind of hiding details from you. …

Their story just doesn’t add up, or they’re telling you one thing and you’re seeing something completely different. … Like somebody with multiple bruises, and they tell you no, nothing’s happening at home … or they were beat up or it looks like they were hit by something, and then they tell you that they fell, or along those lines.

Tamara, who reported having at least five patients screen positive for IPV in her experience, provided further details about her experience of perceiving discrepancies between the reported cause of the injury and the actual presentation of the injury:

In the trauma bay a lot of times, if the trajectory of the wound doesn’t match the description of the event—for example, somebody says “Some guy shot me,” but then the wound looks like a gun going off in a pocket or something like that. If it just doesn’t make any sense, if it’s an injury that happened on the person’s dominant side or something like that, those would all be reasons to delve a little bit deeper and make sure. Somebody could say, “Oh, I cut my hand cooking,” but if they’re right-handed and it’s their right hand that’s cut, then that doesn’t make a
whole lot of sense. … Things like that. If the wound doesn’t make sense with the story, that definitely opens up a whole new conversation.

Also, a few nurses shared gender-specific health complaints that raised suspicion of abuse. For instance, Ursula said, “I tend to poke around a little bit more about [gynecological] issues.”

Several nurses discussed what they do when they suspect that the patient is a victim of abuse. Valerie, another of the eight nurses in the sample who reported at least five positive IPV screenings, shared a typical explanation:

Especially if the injury doesn’t match the situation, I’ll ask more questions. …

Well, I can’t push boundaries if they don’t want me to give me something to go off of. You know, there have been times that I flat-out knew it and asked repeatedly, and they just didn’t want to disclose.

Valerie, like several other nurses, went on to describe the additional interventions that she provides when she suspects abuse but the patient denies it. “In those cases, you know, you can provide information. But, in most cases when I provided information, it was just like I would ask, ‘Do you want information just in case?’ Or things like that.” Quincy, who also had experienced five or more disclosures of abuse as a result of IPV screening, said that she takes an additional step in offering information when she suspects abuse but the patient does not want further information:

[When] I get the feeling that they’re not telling the truth, I might get one of the cards and just explain to them what the card is, and just leave it on the table. If it’s gone when they leave, fine. If it’s still there, then that’s also their choice, too.
In addition to describing behaviors and reported injuries that did not match the physical presentation, many of the participants described observations of the partner (if present) that would be cues causing them to take additional steps in the screening process. Ijay offered a description of how an overbearing partner can raise suspicions:

One of my strong beliefs is when the male husband or boyfriend answers all the questions. Before I can even finish my sentence, he is in my face answering the question… You know I feel like he’s afraid that she’s going to tell me something when he’s not there.

Tamara also highlighted how observation of a partner can sometimes be a stronger clue indicating IPV than observation of the victim, “If I ask the question and the patient looks away and says no and they turn their head and they won’t make eye contact any further, then I know that I have to start asking more questions and try to dig a little bit deeper into what’s going on.”

Besides asking more questions and offering referrals, most of the nurses who have had five or more patients disclose being a victim of IPV indicated that they provide both a verbal and written report about their suspicions of the patient being abused. They deliver their verbal report to both the nurse and physician assigned to follow up with the patient after the completion of the triage assessment; in addition, they document the suspicious behavior in the EMR. Florence explained the steps that she takes in such cases:

But I feel I have a pretty good sense for people, so if I sense any kind of weirdness, I always let the doctor know. A couple of times they’ve screened negative and I’ve just said something to the doctor like, “There’s something weird in that, so I don’t know if you want to keep an eye.” But if they don’t say yes, there’s really not
anything we can do, unfortunately. … Sometimes I guess I have clicked yes even if they haven’t said yes because I just—something felt wrong. Because I assume that somewhere it flashes—it pops up for someone else—but I guess not. And then I can just write a note like “Flat affect. Male answering all questions for female. Female making poor eye contact.” I just try to describe their behavior.

Contrary to these examples from the eight nurses with the highest frequency of positive responses to IPV screenings, the four nurses who had never had a patient disclose abuse as a result of screening did not document suspected behavior. Kay, one of these four, stated that in a case in which she suspected abuse but the patient had no injuries, “I didn’t document that in the record.” Kay further shared her concerns with documenting suspicious behavior:

You think about it, that documentation is always—if I ever went to court, your feeling is that you can’t back that up with anything. Like if there was [something] physical—like if she had a bruise on her, like if she had a raccoon bruise on her eyes but she said she fell and hit the back of her shoulder, well, something is not matching up. You could put that in, not say it’s not matching up but saying like “Patient complains that she fell and hit shoulder; however, she has bruises on her eyes and can’t explain them.” Something like that.

In summary, all the nurses identified being a patient advocate, being required to complete the assessment in the EMR, and having patients whom they suspected of being victims of abuse as motivators to screen for IPV. Although the nurses described similar motivating factors, there was variation in how those factors influenced each nurse’s screening experience. Implications of these findings with regard to nurses’ advocacy for
patients, incorporating nurses’ feedback in the development and implementation of the EMR system, and providing training that includes documentation of suspected behavior will be discussed in chapter 5. Table 4.4 provides an example of each of the themes that emerged with regard to perceived motivation in screening for IPV.

Table 4.4
Perceived Motivators to Screen for IPV

<table>
<thead>
<tr>
<th>The following themes emerged from discussions related to RQ2: What factors do ED nurses perceive as influencing the likelihood of screening for IPV?</th>
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<tbody>
<tr>
<td><strong>1. Advocacy</strong></td>
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<tr>
<td>Natasha: “To figure out first … if they are having any issues at home, and then to advocate for the patient, let the doctor know you have a concern that the patient is being abused, and contact social work.”</td>
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<td><strong>2. EMR</strong></td>
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<td>Debbie: “Actually, in the new system, it doesn’t really ask us to document it, but in our old system it did, so it’s just part of my routine. Since we started the new system, I haven’t ever had anyone say yes to it. It was when we had the old charting system. Then it was a part of the screening process, like you had to document that they said no, or that they feel safe.”</td>
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<td><strong>3. Suspected abuse</strong></td>
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<tr>
<td>Valerie: “Especially if the injury doesn’t match the situation, I’ll ask more questions”</td>
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**Research Question 3: Obstacles to Screening for IPV**

My third question initially inquired about barriers to screening for IPV, but the input received from the nurses caused me to change my selected term from *barriers* to *obstacles*. Although all the nurses identified similar obstacles, not all of them perceived the obstacles as barriers. The *Merriam-Webster Collegiate Dictionary* (2015) defines an obstacle as “an object that you have to go around or over; something that blocks your path.” Some nurses
worked around perceived obstacles; others did not and were blocked from completing the screening process. Three main themes emerged from the nurses’ various descriptions of the obstacles they faced: barriers versus challenges, patient autonomy, and credibility. Two subthemes within the larger theme of credibility were impact and moral distress. An example of each theme and subtheme is presented in Table 4.5 at the end of this discussion.

**Barriers versus Challenges**

All the nurses identified perceived obstacles when the screened for IPV. One of the most common obstacles was the difficulty of screening the patient alone with no one else present. All nurses agreed that it was preferable to screen the patient alone, but some perceived making arrangements to be alone with the patient as a barrier that they did not attempt to surmount. Other nurses viewed this problem as a challenge and discussed the techniques that they used so that they could screen the patient alone. Pam provided one example (which was similar to the information that Florence shared was provided in her formal education):

> I will ask them on my way to x-ray. If it’s somebody who’s not [getting an x-ray], I’ll walk them to the bathroom, [saying,] “We need a urine specimen; let me walk you to the bathroom.” And I’ve gone to the bathroom and asked them in there.

Several of the female nurse participants in this study and all the male participants described asking family members or partners to leave the room as a challenge. Ernie said that if a patient had others present (even parents), he would ask them to step outside the room and would then ask the patient again, “Is there anything else bothering you? Are you sure you feel okay at home?” But he said that he has never received a “yes” answer in such circumstances.
Whereas Pam and Ernie described screening the patient alone as a challenge, Ann typified those nurses who viewed this issue as a barrier:

Sometimes I find that it’s silly. I’ll ask it, just because it’s a legality issue, but a lot of times—for instance, if you’re married and you come to the ER, chances are you and your husband are both coming in the triage room. So if I say, “Are you a victim of domestic violence or abuse?” you’re probably not going to answer at that time honestly, if you are. And it’s hard for me, as a triage nurse, to be like, “I need you to step out for one question and then step back in.”

Nurses also identified the amount of time available to screen, the patient’s willingness to disclose abuse, and the patient’s reluctance to accept help as barriers in the screening experience. When asked for her view of barriers to screening, Debbie commented:

Time would be a big one. I feel like we’re cramped to do a lot of different things, depending on the situation. Some things aren’t true emergencies. … People’s willingness to get help would be a factor. You get to a point where if they don’t want help, how are you supposed to help them? And other than that, just time, I guess. Like it’s overlooked maybe, I mean outside of triage.

Related to the issue of time constraints, Genevieve and other nurses focused on the high volume of patients needing to be screened and their level of acuity as barriers:

…in triage, it’s really—it’s just hard, when you have 50 in the waiting room and it’s just—sometimes there’s supposed to be two nurses out there, but sometimes if we’re short-staffed or I have some things going on, sometimes you just can’t.

You’re just trying to get people back and if you have people with chest pain, then
you need an EKG...I feel you get pulled in eight million directions... you honestly
don’t have time to do [IPV screening]...You have somebody screaming at you and
somebody else that comes in that’s in respiratory distress...and they have to come
back right away. It’s hard to do that in that kind of environment.

In contrast, others viewed time and willingness to disclose abuse or receive assistance as
challenges. Ursula described her commitment to screening each patient with “integrity”
but acknowledged that “patient flow is a tremendous distractor from being able to keep that
integrity.” Valerie, like several other experienced nurses, in addition to previously
describing additional interventions she provides when she suspects abuse further described
her willingness to push as far as possible in cases where she suspected undisclosed abuse,
“And if they accepted, I gave it to them. And if they didn’t—you know, they just weren’t
going to give me any more information.”

Some nurses cited the patient’s age as a barrier to screening. Natasha, for example,
stated firmly, “Older adults I don’t usually screen,” referring to people age 65 and over,
even if they are cognitively intact. On the other hand, Ursula shared a poignant story of a
case where screening an older man yielded an unexpected result:

It was a gentleman who confessed that his wife assaulted him on a regular basis.
And it was ... it was just our standard question, but she happened to not be there,
and he admitted it freely and became tearful. ... He ended up being admitted for
whatever. ... And he ... just that one question was all it took to get him what he
needed. And he [was] so sad, telling us that answer. But he had reached his
breaking point. ... I think he was in his seventies. ... I think one of the biggest
challenges is, to be able to interact with that generation.
Perceptions of similar obstacles as either barriers or challenges impacted the nurses’ decisions whether to proceed with or omit the IPV screening process. Further implications for education, training, and environmental support in addressing obstacles will be discussed in chapter 5.

**Patient Autonomy**

Many of the participating nurses identified supporting their patient’s autonomy as an obstacle to effective screening, because this commitment to autonomy implied supporting the patient’s decision on whether to disclose an abusive relationship or how to proceed if abuse was disclosed. As discussed in chapter 3, HCPs in Pennsylvania are not mandated to report victims of IPV to the police or other protective agencies, unless the assault involved the use of a lethal weapon or involves minors (Durborow et al., 2010). Although most nurses identified supporting their patients’ autonomy as an obstacle, they varied as to how their perception of the obstacle influenced their screening experience.

Several nurses described difficulty in supporting patient autonomy when a patient disclosed abuse but then declined to use available resources. Genevieve stated:

> I feel sometimes it’s just really hard to get the person to open up and follow through if they’re not willing to make a report. … But I think that’s the hardest part is you want to remove them from that environment, but you can only do it if they want to. I think one of the hardest things is trying to help somebody who feels stuck in the situation if they’re co-dependent on [the partner] or if they’ve been physically, mentally and emotionally abused. It’s like, you don’t know anything else. … It’s just really hard.
Some nurses described what they say to patients who may be victims while still respecting their autonomy. For example, Ursula explained:

We hand them a card and we feel like we’re not doing enough, because a lot … that choice is really that person’s, whether or not they feel comfortable enough to say to their husband or wife or their significant other, “I need to be safe from you. When I’m around you I’m unsafe.” And helping them make that choice is non-controlling and letting them be in control of that situation is really … it’s difficult, it’s frustrating, because you can hand them so much information, but at the end of the day it’s their choice.

On the other hand, some nurses admitted not knowing what to say in such cases. Natasha was an example:

Yeah, I can’t let somebody just come in and be abused and then go right back to it. It’s like, “That’s not fair. You don’t deserve it.” [The patient] says, “You’re right.” But some of them don’t file police reports, so I don’t know what to do in that situation. What can I do?

Whereas Natasha expressed frustration about that dilemma, others seemed not to experience comparable frustration. Ann was an example of the nurses who discussed supporting patients’ autonomy and offering resources without becoming frustrated with their decisions:

I think it’s essential that we screen, … but our role is to help them find the appropriate resources, whether that be patient social work, calling family members for them, contacting the police if it’s a rape case, even if it’s a regular assault case. So [I am] more of an interventionist in the sense of trying to put them down the
right path to get the resources that they need. [I] kind of map it out for them. … I do tell them there’s resources available, and we’ll try to get them as much help as possible, and one day at a time.

Debbie also identified her role in supporting the victim’s autonomy without any indication of frustration:

Usually you get used to so many people saying they feel safe that when they actually say, “No, I don’t feel safe,” you’re like, “Oh. Okay.” You try to tease that out a little more, and then I usually offer them resources. Like the paper we have with the hotline or whatever to call that they can follow up with. If their injury was caused by a domestic dispute or violence, I’ll let the doctor know just that that’s an option, or I’ll tell them, “You can file a police report too.” But that’s about as far as I would take it, I think; I leave it up to them if they want to follow through or not.

Some nurses indicated that their frustration, in cases where patients are considering whether to leave an abusive relationship, is primarily with the limited options available to victims, not with patients’ reluctance to use them. Ijay discussed how some victims could view leaving an abusive relationship as having a negative impact on their autonomy:

In a few cases, I’ve been able to get them resources that were probably appropriate for them. [But] quite frankly, a lot of times people, if they do say yes, and you offer to call police and things like that or [have them] go to a shelter, they say no. People don’t want to go to a shelter. A lot of people would rather go home to their abusive partner than go to a shelter. … They hear the word shelter and they—maybe there’s a different word we could start using. But shelter, they think about like homeless shelters and they think, “That’s not me. I’m not poor.” Or there’s kids
involved, which makes it even more complicated, because now maybe you have a married couple with kids and no one person has custody. So if the abused partner leaves, he or she can’t just take the kids along unless the kids are being abused.

In summary, a strong majority of the nurses acknowledged that part of their role in addressing IPV was to support their patients’ autonomy. Some of them described doing so as a source of frustration when victims declined to use available resources, but others did not express frustration. Some of the frustration was directed toward the limited options available for IPV victims in distress. Implications for addressing issues of patient autonomy will be discussed in chapter 5.

Credibility

The perceived credibility of either the patient or the nurse was another common theme that emerged in discussions of obstacles to screening. The *Merriam-Webster Collegiate Dictionary* (2015) defines credibility as “the quality of being believed or accepted as true, real, or honest.” With regard to patients, the credibility issue involved either the nurse’s doubts about the accuracy of the patient’s responses when screened for IPV or the patient’s inability to respond to screening questions due to mental or physical limitations. The perceived credibility of the nurses was related to either the patient questioning the nurse on the value of universal screening or the nurse’s own uncertainty about being able to provide appropriate interventions to patients who disclosed abuse.

In the category of not trusting patients’ responses during IPV screening, we have previously noted cases in which the nurses suspected abuse but the patients denied it. On the other hand, Ijay was a typical example of several nurses who felt that some patients gave false positive responses:
That’s why these questions are really sometimes very painful for the nurse, because some people really want attention. And while I understand that there are lots of people out there who are abused and we need to screen them and get them help if they want it, at the same time, when you ask the same questions to everyone, sometimes it just offers an invitation for more attention-seeking behaviors. And when they say yes to everything, then I’ll say, “Okay, so you said yes, you’re being abused. Who is abusing you?” “Well, my brother is abusing me” or “my boyfriend is abusing me” or “my husband is abusing me.” “Okay, what type of abuse is it?” “Well, he threatens me.” “Okay, how does he threaten you?” And then you’ll say, “Well, do you want to notify the police or do you want referral for a shelter.” And they’ll just say no. And I think when they realize that that’s the direction it’s going, that it’s not going to get them seen faster or it’s not going to get them some special attention … And they didn’t get maybe what they thought they were going to get out of answering yes. Then they sort of act like, “No, I don’t want anything.”

All the nurses who stated that they sometimes questioned the positive response disclosed by patients who were screened for IPV stressed that they did not change their interventions for those patients. Florence stated:

A lot of people come in here looking for attention and … I take every single person seriously no matter what my personal thoughts are. If you screen yes, social work gets called immediately. And I leave it up to their judgment and psych’s judgment what they feel is actually happening.

Along with attention-seeking patients, some nurses identified intoxicated patients as another category of persons whose positive responses when screened for IPV carried
questionable credibility. Although victims of IPV are at greater risk of having an addiction
than the general population, how to serve intoxicated patients is widely recognized as a
challenge (CDC, 2015). Many nurses related instances in which, after an intoxicated
patient sobered up, he or she recanted the original story and denied being a victim of abuse.
Genevieve stated:

I think the biggest thing is when people say things when they’re intoxicated. I think
that’s the hardest … because we’ve had a lot of altercations where people have said
that so-and-so strangled me or so-and-so threw me down a flight of stairs or
whatever the scenario might be. And then their [blood alcohol] level comes back
through the roof and their drug screen urine is positive. How much can you
believe? And when they sleep it off, they’re like, “Oh, I didn’t say that. What are
you talking about?” … When they’re on any kind of chemical, whatever it might
be, I think the hardest part is … one, did it actually happen, and two, is it actually
legit like they’re saying that it happened? That’s the hardest problem, I feel like.
A few nurses specifically referred to questioning the credibility of patients who are
severely mentally ill. Tamara explained:

For example, somebody who comes in who is a paranoid schizophrenic, who is …
rambling, that question may always come up positive because they’re completely
tangential and rambling on and not really understanding the question. … They’re
too psychotic to give you a straightforward answer.

On the other hand, several nurses talked about the problem of patients questioning
the nurses’ credibility, even though the Gallup Poll (2016) has consistently identified
nurses as one the most honest and ethical professions according to popular opinion.
Valerie noted that one common problem is that patients do not treat the nurse’s IPV screening questions seriously:

I mean, it gets aggravating when people laugh about it. We’ll ask a direct question like “Do you feel safe in your home? Is anyone hurting you?” and we have people who are saying, “Yeah, just him,” and pointing to their partner, or making a joke out of it, when we’re just trying to do a thorough assessment.

Despite getting annoyed when a patient laughs at questions about abuse, Valerie said that she uses the interaction as a teaching opportunity: “We address it by saying, ‘It is a question that we ask in the emergency room because a lot of patients come in and we have this [the patient is a victim of IPV].’ Or ‘It’s a serious question,’ sometimes. It depends.”

Additionally, several of the nurses questioned their own credibility in screening, in the sense that they wondered whether they could provide effective interventions to patients who disclosed abuse. Nurses are accustomed to having their patients trust them, but, as Lyndsay noted, they sometimes feel unable to fulfill that trust in IPV-related situations:

I think for me it’s hard because they tell us to just ask about it during triage. And my thoughts were kind of, then what? If they say yes, then what do you do? And still now, after I’ve been doing this for six years, they don’t really give us many resources to provide these people with. So you feel like your hands are kind of tied. It puts you in a weird situation. You know, they give us the cards to give to people, but a lot of times you’ll encourage people to call and they’ll tell them they can find placement for them for two or three days and then, you know, what are we supposed to do with them?
In contrast, other nurses did perceive their interventions with victims as credible. Ursula, one of these nurses, described her efforts as follows:

just trying to give them the knowledge that they have resources to help them get past this, that this is a horrible time but it doesn’t have to be the rest of your life, that this could be a time that they look back on to say, “I was strong, and I got out of that.” … I feel like it’s our job to make sure that people are safe where they live, that they’re going back to a safe environment. … If I was sending someone home with a broken ankle, [I would ask,] “How’s your home? How many steps do you have to go up? Do you have throw rugs? You have to make sure that you can navigate around. Can you get around with crutches? How are you getting up and down the steps?” It’s the same if I’m sending someone home who’s been injured by the person they’re living with. I want to make sure that they’re not going home and going to get hurt again. And I don’t mean to look at it that clinically, because there’s a huge emotional component to it. But it’s really the same. Are they going home to a safe place? Are they going to get hurt again?

Impact

Two subthemes emerged within the broader theme of credibility: lack of knowledge of the impact that the nurses’ interventions had on their patients, and a sense of moral distress. First, in most instances where a patient indicated being a victim of abuse during IPV screening, the nurses were not aware of what happened to the patient after discharge and thus could not know the impact of their intervention on the patients. Perhaps awareness of this impact would increase the perceived value of the interventions that nurses provide to victims who disclose abuse. Ijay offered a typical comment:
The thing about the ER is you almost never get to hear what happens. So you never find out—you know they might get a referral. You might have something like a shelter that you use, but you never find out if it’s a good shelter. Or if they were able to help people. You assume they are, but we don’t know. You never know what—you don’t get to follow up on a lot of things there.

Florence similarly highlighted the limited feedback that she receives on any of her patients:

No, we really don’t find out about anything that happens with anything. Sepsis—you know, it’s [something] you screen here. You do what you’re told, and then there’s no one that reports back to you that this great outcome happened. Although social work will let me know if they hear about someone, but I’ve never heard about anything as far as domestic violence abuse.

**Moral Distress**

Moreover, a few nurses described the negative impact that the added responsibility of screening for IPV, without any sense of the effectiveness of this intervention, had on their screening practices. These nurses reported a dilemma of sorts: they would like to know that the interventions they provide keep their patients safe, whereas they felt that in reality they were unable to offer effective interventions that would support their patients’ safety. Such an internal conflict—knowing that it is not possible to provide but one believes that patients need—is referred to as moral distress (Fernandez-Parsons, Rodriguez, & Goyal, 2013; Wilkinson, 1988; Wolf, Perhats, Delao, Moon, Clark, & Zavotsky, 2016). Kay, after asking me how she can improve her screening skills, provided an example of how some nurses experienced moral distress when screening for IPV:
[Suppose that somebody comes in] and they say, “Well, no, I don’t feel safe.” So
we just asked them that question; they just opened up to us. Well, now it’s up to us
to help them, and I don’t really remember any situations like if they went to a
women’s shelter or anything like that. But what if we can’t help them? Then we’re
just going to send them back out in the streets and they’re going to be like, “Okay, I
just opened up but they can’t help me, so I guess I’ll just have to go back to my
house.”

As addressed by Kay, some of the nurses’ moral distress was the result of thinking
that the interventions they provide by screening patients who disclose they are victims of
IPV may not be helpful. Kay in making the statement, “But what if we can’t help them?” is
the key line that highlights the moral distress. It is her job to help and she is concerned
that she will not be able to help a patient who discloses that they are a victim of IPV.

Mosby’s Medical Dictionary (2009) defines metacommunication as “communication that
indicates how verbal information should be interpreted.” Although Kay does not directly
say it, the metacommunication of the implications of what she expresses is that she is
questioning her effectiveness as a nurse in providing patients who share that they are
victims of IPV what they need.

Some nurses shared how they attempted to address the moral distress presented by
their sense that limited resources were available to support the safety and dignity of their
patients. Ijai shared an example of what some nurses did in one instance to increase their
confidence in the credibility of their interventions:

Someone came in and was beat up by a partner, and it was night shift again. And
the nurses—this is probably beyond what they should have done, but I would say it
was more of an ethical decision that they made—they actually called a local hotel. They didn’t give the patient money, but the three nurses on night shift chipped in and got the patient a hotel room for a night and paid for it. And they had it prepaid so that when she went to the hotel it was already paid for. A lot of the shelters don’t let people in after like 9:00 or have cutoff points, and if you’re not there by that time, they’re done. They won’t unlock the door.

In summary, all the nurses identified obstacles that they encountered when screening for IPV. Many of the obstacles, such as needing to make special arrangements to screen the patient alone, were actually surmountable challenges for some nurses but barriers for others. Other obstacles included the patient’s autonomy, the credibility of the patient’s answers, and the nurses’ sense of the effectiveness of their own interventions. These obstacles influenced each nurse’s screening experience in widely varying ways. Further discussion of the implications of these obstacles will be presented in chapter 5. Table 4.5 provides examples of themes related to perceived obstacles when screening for IPV.
Table 4.5 *Perceived Obstacles in Screening for IPV*

The following themes emerged from discussions related to RQ3: *What factors do ED nurses perceive as barriers to screening for IPV?*

<table>
<thead>
<tr>
<th>1. Challenges versus Barriers</th>
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<tr>
<td><strong>Challenge</strong></td>
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<tr>
<td>Pam: “I will ask them on my way to x-ray. If it’s somebody who’s not [going to x-ray], I’ll walk them to the bathroom, [saying], ‘We need a urine specimen; let me walk you to the bathroom.’ And I’ve gone to the bathroom and asked them in there. So sometimes it can be a bit challenging.”</td>
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<tr>
<td><strong>Barrier</strong></td>
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<td>Ann: “Sometimes I find that it’s silly. I’ll ask it, just because it’s a legality issue, but a lot of times—for instance, if you’re married and you come to the ER, chances are you and your husband are both coming in the triage room. So [if I] say, ‘Are you a victim of domestic violence or abuse?’ you’re probably not going to answer at that time honestly, if you are. And it’s hard for me, as a triage nurse, to be like, ‘I need you to step out for one question and then step back in.’”</td>
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<th>2. Patient Autonomy</th>
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<td>Genevieve: “But I think that’s the hardest part is you want to remove them from that environment, but you can only do it if they want to. I think one of the hardest things is trying to help somebody who feels stuck in the situation if they’re co-dependent on [the partner] or if they’ve been physically, mentally and emotionally abused. It’s like, you don’t know anything else. … It’s just really hard.”</td>
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<th>3. Credibility</th>
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<td>Tamara: “For example, somebody who comes in who is a paranoid schizophrenic, who is … rambling, that question may always come up positive because they’re completely tangential and rambling on and not really understanding the question. … They’re too psychotic to give you a straightforward answer.”</td>
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<th>3a. Impact</th>
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<td>Florence: “We really don’t find out about anything that happens with anything. … You do what you’re told, and then there’s no one that reports back to you.”</td>
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<th>3b. Moral Distress</th>
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<td>Kay: “[Suppose that somebody comes in] and they say, ‘Well, no, I don’t feel safe.’ So we just asked them that question; they just opened up to us. Well, now it’s up to us to help them, and I don’t really remember any situations like if they went to a women’s shelter or anything like that. But what if we can’t help them? Then we’re just going to send them back out in the streets and they’re going to be like, ‘Okay, I just opened up but they can’t help me, so I guess I’ll just have to go back to my house.’”</td>
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Summary

The nurses in this study identified numerous personal and environmental factors that influenced their behavior regarding universal screening for IPV. Although all the participants agreed that screening is important, some of them questioned the practice of universal screening. In some cases, their doubts about the value of universal screening impacted their screening practices. Another frequently identified concern was uncertainty about the effectiveness of their interventions in ensuring the safety of patients who disclosed being victims of abuse. Most participants reported being unaware of the impact their interventions had on the victims whom they identified through IPV screening. This lack of feedback may influence the nurses’ consistency in screening for IPV.

The primary personal and environmental factors that impacted the nurses’ human agency in addressing IPV screening behavior are provided in Figure 4.1. The personal factors were related to the factors identified by the nurses that were generated within the nurses’ self-efficacy. The perceived personal factors identified by the nurses that influenced their screening experiences with IPV were: personal experiences with IPV that were not related to their professional expectations as an RN working in the ED, educational experiences that were self-directed rather than provided through in-service trainings or their formal education, the nurses’ perceived role as being an advocate for their patients, the nurses’ perceived credibility that screening for IPV was important, some of the nurses’ perceived moral distress, what the nurses’ shared when they distinguished or described IPV, and changing views of how they distinguished IPV as they began to practice as a nurse. The environmental factors that impacted the nurses’ human agency for screening for IPV were those social factors in the environment that influenced the nurses’ reactions in
screening their patients (Bandura, 1989c). The environmental factors that influenced the nurses’ reactions in their perceived screening experiences were: role models within either their formal educational experiences or hospital, the patient’s credibility in accurately disclosing abuse, the patient’s autonomy in making decisions in both disclosing the abuse and future steps in addressing it, suspected abuse in reference to behaviors demonstrated by the patient, the design of the EMR, identified obstacles being either perceived as barriers or challenges, curriculum in formal education, and training provided in hospital in-services. These factors are considered in the recommendations presented in chapter 5. In addition to the factors, further discussion of the implications of the findings in addressing the nurses’ perceived human agency in screening for IPV is also provided in chapter 5. In summary, this study supported the findings of some prior studies and also added insights that could be applied in future educational programs on IPV screening.
Figure 4-1 Nurses’ Human Agency with Screening for IPV

*Source:* Created by the author based on Bandura (1989c), pp.2-5.
CHAPTER 5: DISCUSSION AND CONCLUSIONS

This chapter discusses the study’s implications and applies the findings identified in chapter 4 that can address the current gap in research in the IPV screening practices of ED RNs. In addition, this chapter includes the study’s limitations, recommendations for future studies, and concludes with my overall impressions.

Implications of the Study

This study provided a better understanding of the lived experiences of ED nurses in screening for IPV such as, the self-efficacy of the nurses were impacted by the inconsistency in the educational information provided to them and that the design of the EMR influenced the consistency of their screening practices. The information gained can be incorporated into the development and implementation of future educational opportunities and trainings that will prepare nurses to screen effectively, as well as environmental adjustments to support success in the screening process. For example increasing mandatory hospital in-services, expanding the curriculum provided on IPV in the nurses’ formal training, and including nurses in the design of the EMR. The information that the nurses shared on the perceived impact of interventions they provide to victims who disclosed being a victim of IPV as a result of their screening can contribute to the development of policies and practices. Most of the nurses stressed that interventions should enhance victims’ safety and quality of life. HCPs (including RNs) must be well informed about available resources they can provide as a result of the screening process in order to make competent referrals. Although this study did not focus on the resources nurses provide to victims of IPV, most nurses shared what they were able to provide patients who disclosed being a victim when they shared their experiences with the
screening for IPV. Few qualitative studies have specifically explored the ED RNs’ experience with screening for IPV and none have used an Interpretative Phenomenological Analysis (IPA) approach applying Bandura’s social cognitive theory (1989a, b, & c) as a framework to interpret the findings and implications.

The information provided by the nurses in answer to the study’s research questions yielded a set of key factors that impact the nurses’ human agency in addressing IPV. Although there are personal factors unique to each individual, the nurses identified common factors that influence their overall experience of IPV screening. The term “nurses’ human agency,” as used in Figure 4.1, refers to specific determinants in the triadic reciprocal determinism process that the nurses identified as impacting their screening experiences. Many of those determinants can be included in the development of future training and educational experiences to improve the overall IPV screening procedure.

**Addressing the Gaps in Research**

The gap in research on ED RNs’ experiences with screening for IPV was addressed by using three research questions, which yielded the major themes identified in chapter 4. Here, I will discuss the implications of the nurses’ differing levels of preparation (see Table 4.1), the reported number of positive responses the nurses obtained as a result of screening (Table 5.1), their thoughts about IPV, and perceived motivations and obstacles that influenced their screening experiences. I will begin by discussing the nurses’ experiences from the perspective of their perceived self-efficacy, in accordance with Bandura’s social cognitive theory (Bandura, 1989a, b, & c).
Nurses’ Perceived Self-Efficacy

The first research question addressed what the nurses’ knew, believed, and did about screening for IPV in their role as an RN working in the ED. The nurses’ perceived self-efficacy is a foundational component of their human agency in addressing IPV.

Preparation for IPV screening was the first prominent factor raised. The nurses identified three main forms of preparation: formal compulsory education in their nursing program, in-services provided by the hospital at which they were employed, and self-directed learning such as reading information about the topic or attending a conference (see Table 4.2). As indicated by prior literature, there was significant variability in the amount and quality of the preparation that participants received (Bryant & Spencer, 2002; Clements et al., 2011; DeBoer et al., 1998; Robinson, 2010). The information that the nurses shared about the impact of their training could be incorporated into the development of future training programs, including both formal compulsory education and subsequent in-services and other offerings for healthcare professionals.

Most of the nurses stated that the preparation they received from both their compulsory educational experience and hospital in-services did not prepare them adequately to screen their patients for IPV. The compulsory educational experience should consistently provide comprehensive information that addresses the risk factors for abuse, the complexity of the victims’ situation, the elevated levels of danger present when victims decide to make changes in their life situation, the impact on other family members, and who can be a victim and perpetrator (Campbell et al., 2003). Education should also cover relevant laws within the state where the screening is implemented and should provide opportunities for the student nurses to practice screening for IPV. Educational experiences
on how to address violence throughout the lifespan of patients would increase the students’ preparedness for working with any victim of violence (Tufts, Clements, & Karlowicz, 2009). The more the RN screens for IPV (behavior), the more confident the RN will become in completing the skill and believing that it is important to do (personal factors of self-efficacy).

In addition to comprehensive information about IPV, providing opportunities for student nurses to initiate and engage in the nurse-patient relationship is essential. Although the nurse-patient relationship is consistently discussed and incorporated into nursing programs, this study supports the growing trend of younger nurses toward indicating personal discomfort in addressing IPV (Robinson, 2010; Sprague et al., 2012). In this study, all the nurses who said that they had never had a patient disclose being a victim of IPV as a result of their screening were millennials, age 40 or younger (see Table 5.1). Out of the 16 nurses who were age 40 or younger, only 25% of those nurses identified that they had at least five or more of their patients disclose they were victims of abuse as a result of screening. Additionally, the five nurses in this study who were over the age of 40, 80% of those nurses identified that they had at least five or more of their patients disclose they were victims of abuse as a result of screening (see Table 5.1). Recent studies have shown that the millennial generation is much more skilled in the application of technology than their predecessors but less skilled in direct verbal communication (Glass, 2007; Stein, 2013). Future educational programs should include deeper understanding of and comfort levels with the nurse-patient relationship; for example, education on screening for IPV should incorporate simulations and role playing into the educational experience (Bracken & Clifton, 2015; Fay-Hillier, Regan, & Gallagher Gordon, 2012). Nurses with good nurse-
patient interaction skills can establish a caring relationship with their patients. Victims of IPV are more likely to disclose abuse or be open to seeking future treatment if HCPs who treat them appear to care and take time to establish a relationship (Liebschutz et al., 2008). Included in educational instructions should be appropriate techniques that could be used to introduce sensitive topics such as screening for IPV. Included in the educational training should be the appropriate manner in which documentation of abuse should be completed.

Table 5.1

*Participants Reporting Positive Responses as a Result of Screening for IPV*
(parentheses in section headings indicate number of nurses in each category; N = 21)

<table>
<thead>
<tr>
<th>Participants who have received five or more positive responses (8):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 20-29: Florence</td>
</tr>
<tr>
<td>Age 30-39: Ijay; Tamara; Valerie</td>
</tr>
<tr>
<td>Age 40-49: Optimistic; Ursula</td>
</tr>
<tr>
<td>Age 50-59: Pam</td>
</tr>
<tr>
<td>Age 60-69: Quincy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Participants who have received at least one but fewer than five positive responses (9):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 20-29: Genevieve; Hank; Lyndsay</td>
</tr>
<tr>
<td>Age 30-39: Ann; Bob; Connie; Debbie; Ernie</td>
</tr>
<tr>
<td>Age 50-59: Samantha</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Participants who have never received a positive response as a result of IPV screening (4):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 20-29: Kay; Natasha</td>
</tr>
<tr>
<td>Age 30-39: Joanne</td>
</tr>
<tr>
<td>Age 40-49: Marie</td>
</tr>
</tbody>
</table>

Similarly, hospital in-services should also provide structured educational information on addressing victims of violence (which would include victims of IPV). ED nurses should be involved in the development of these in-services, which should feature role models whom new nurses can observe and use as resources during the training. Applying Bandura’s framework (1986b & c) in reference to role models, an RN who observes a peer’s behavior could begin to think (personal factor) that consistently and
effectively screening for IPV is possible. Hence, the influence of a peer who effectively screens may result in the RN choosing to spend additional time (personal factor) with that peer, thereby reinforcing the belief that screening for IPV is important. As part of my commitment to the hospital that provided access to their nurses for this study and was provided with permission from both the hospital and IRB to display flyers, I will be involved in the development of IPV training protocol for the nurses.

The data obtained from the nurses in this study also supported Bracken and Clifton’s (2015) findings that ED nurses would like to have the opportunity to know what happened to patients who were provided with resources. Accordingly, nurses should be provided with this information where possible. In addition to follow-ups with other hospital staff, nurses could perhaps participate (while appropriately maintaining confidentiality) in quarterly meetings with local victim referral agencies who could share stories of victims whom they have encountered. If it is not possible to have the agency share information on specific clients referred from the nurses, it could be helpful to provide general information on clients the agency have assisted. The meetings with victim agencies could also serve a collaborative purpose by further informing the nurses on what was helpful to the victims treated and increasing the perceived credibility of their interventions. This study also supported Bracken and Clifton’s (2015) recommendation that nurses working with victims of IPV should have the opportunity to debrief or process their experiences. Hopefully providing both emotional support and information on the impact of providing interventions will decrease the risk of the nurses developing moral distress and strengthen their perceived patient advocate role.
Although the current prevailing practice is to attempt to identify victims of IPV through universal screening, another current trend is to provide universal education (Hamberger et al., 2015). Providing education to all patients about IPV and offering resources would enable patients in need to learn relevant information without having to disclose abuse to the hospital staff. Perhaps opening a dialogue about IPV and providing universal education might also encourage victims to seek assistance and ultimately to disclose their victimization.

Another way to address an important environmental factor would be to include nurses in the development of the EMR, in order to provide a more effective tool to assist with the screening process. Most of the nurses identified the EMR as a useful tool that supports the screening process. Since the nurses’ assessment forms are part of the EMR, it would seem valuable to include nurses in determining how their assessments are incorporated into the program. In addition to offering this chance for input into EMR development, hospitals should provide orientations to the staff when any revisions of the program have been made.

In conjunction with this involvement of nurses in EMR development, hospitals should reinforce the standard practice of screening patients alone. Although all of the nurses were aware that they should screen alone, many of them described their hospital environment as not well suited for private screening.

Limitations

This study was limited to RNs in a single geographic area in Pennsylvania. Therefore, the findings from this study are not generalizable and could be different from those in other locations.
Also, the sample of nurses contained relatively limited diversity. Nurses from different ethnic and racial cultures may have shared experiences different from those presented in this study. In addition, the participants were self-selected and actively expressed interest in participating in the study; therefore, their views may not be representative of other nurses who were less interested in the topic.

The sample size for this study was larger than the minimum recommended for the use of IPA (Smith et al., 2013), but each person was interviewed just once. Meeting with the same people over a longer period of time could have yielded more comprehensive descriptions of nurses’ experiences with screening for IPV.

**Recommendations for Future Studies**

It would be useful to replicate this study using a more heterogeneous group of participants, in terms of demographic and geographic diversity. Also, a qualitative study on the experiences of RNs in states where HCPs are mandated to report all victims of IPV would be beneficial. The experiences of nurses in states that mandate reporting of IPV may differ significantly from that of nurses in states without this mandate.

Contrary to most other studies, the majority of the nurses in this modest sample (N = 21) encountered victims of IPV who were not covered by the screening recommendations of the U.S. Prevention Service Task Force (USPSTF, 2014). It is difficult to obtain evidence on the presence of nontraditional victims of IPV, because most studies focus on women of childbearing age and exclude other populations. The evidence will never be collected until universal screening is conducted with all patients. Even then, quantitative studies may lack statistical power with regard to nontraditional groups of victims. Future studies should continue to encompass all populations; if they do so, they may generate
further evidence to support the practice of universal screening and intervention. In addition to addressing all potential victims of IPV, ED staff should be prepared to share resources that are appropriate for nontraditional victims. A few of the nurses who shared stories of encounters with male victims referred them to organizations that were dedicated to serving females, such as Women against Abuse.

**Conclusion**

IPV is a major public health issue, with an estimated national cost as high as $6.4 billion per year (Max, Rice, Finkelstein, Bardwell, & Leadbetter, 2004). ED nurses may encounter patients who are victims of violence, regardless of whether the acute medical issue bringing them to the ED is the direct result of an injury from their partner (DeBoer et al., 2013). Anyone involved in an intimate relationship could become a victim of IPV.

Although most information on addressing victims of IPV focuses on women in heterosexual relationships, a growing body of research indicates that other less studied populations (such as gays, lesbians, bisexuals, transgender persons, and heterosexual males) can also be victims of IPV. All categories of victims may turn up in the ED, so nurses must be prepared to assist any of them.

Education that does not include an understanding of the relevant personal and environmental factors and does not give learners the opportunity to practice essential skills will not significantly change screening practices. Exploring the actual experiences of ED nurses who screen patients for IPV can add depth to our understanding of the process. The findings of this study demonstrate the importance of taking into account nurses’ feelings, thoughts, and beliefs about screening as well as the perceived environment surrounding the screening process in order to develop a fuller understanding of their actual screening
behaviors (Bandura, 1989a, b, & c). This study has shed light on factors that should be addressed in the development of future training programs on IPV. As education on screening for IPV for HCPs becomes more consistent and relevant to practice, it can be hoped that this screening process will become as routine and effective as screening for other major health conditions such as diabetes or high blood pressure (U.S. Department of Health and Human Services, 2013).
References


DeChesnay, M., Murphy, P., Harrison, L., & Taualii, M. (2008). Methodological and ethical issues in research with vulnerable populations. In M. DeChesnay & B. Anderson (Eds.), Caring for the vulnerable: Perspectives in nursing theory, practice and research (pp. 155-170), Sudbury, MA: Jones & Bartlett.


Kavanaugh, K., & Ayres, L. (1998). Not as bad as it could have been: Assessing and mitigating harm during research interviews on sensitive topics. *Research in Nursing and Health, 21*, 91-96.


APPENDICES

Appendix A

Interview Guide for the Research Study

Following is a sample of questions, aligned with the study’s research questions, that constituted the interview guide used to elicit relevant information from study participants.

**RQ1: What do ED nurses currently know, do, and believe about screening for IPV?**

- What formal educational training did you receive about IPV? (If the response is that the nurse received little or no training, a follow-up question would be: So have you ever read or heard anyone talk about IPV?)

- What do you think when you hear a reference to IPV (or whatever words the participant used that are associated with IPV)?

- What were your thoughts when you discovered that you would be screening for IPV as part of your role as an emergency department nurse? (If further prompting is needed, ask how the nurse believes that this screening fits in with the whole screening process.)

- What training did you receive in screening for IPV? (If the response is negative, a follow-up question might be: So you have never attended an in-house training session at the hospital on IPV (e.g., on resources and referrals)?)

- Do you screen every person for IPV? If not, how do you decide whom to ask or screen, and how do you complete the question on the form for those whom you do not ask or who you think do not need to be screened?

- Tell me how you screen for IPV (or use the words that the nurse shared, such as domestic violence). Please include how far into the interview your screen for IPV, the location and who is present when you screen.
• Please indicate the questions you ask or behaviors you observe from the patient in deciding whether to screen for IPV.
• How do you document the response or observed behaviors?
• Have you ever had a person screen positive for IPV? What happened? What did you do? What did the other people in the ED do? What did the patient do? What was the outcome—did you ever learn what happened to the patient?

RQ2: What factors do ED nurses perceive as influencing the likelihood of screening for IPV?

• What role do you believe you have as a nurse with regard to screening for IPV?
• How do you know whether or not a patient in the ED has experienced IPV?
• Have you ever had a patient disclose that he or she was a victim of IPV? If so, what was the result of the disclosure?
• Have you ever had any personal experience with IPV? If so, what was the outcome of that experience?
• Are there any events that occur in the ED that might impact your decision to screen or the location where you screen?
• Are there any staff present in the ED that might impact your decision to screen or the manner in which you screen?
• Have you ever observed any other healthcare practitioner screen for IPV? If so, please describe that experience and include what you thought when it occurred, how you felt, the location, and the outcome of the screening you observed.
RQ3  What factors do ED RNs perceive as barriers to screening for IPV? (Many of the responses to the above questions could be included as barriers and would thus be used in the analysis of this question.)

- Has anyone ever asked you for clarification on the question(s) you use to screen for IPV? If so, describe your experience and include the questions and your responses.

- Have you ever included more questions about IPV than are on the form? If so, what were they? Tell me about what influenced your decisions to ask more questions related to IPV.

- Do you see the possibility of someone screening positive for IPV as a potential barrier, i.e., it may require more work for you, the patient, or the ED?

- Do you ever talk about screening for IPV among your nurse colleagues? What have others said regarding potential barriers?

The last question provides the nurse with an opportunity to address any area of the research questions:

- Is there anything else you would like to ask or that I missed in this discussion?
Appendix B

Demographic Survey

1. Age: What is your age?

___________ Years (RECORD EXACT AGE 18–96)

2. Race: How would you describe your race? _______________________

3. Ethnicity: How would you describe your ethnicity? ________________

4. Sexual orientation: Do you consider yourself to be one or more of the following (check all that apply)?

- Straight
- Gay or lesbian
- Bisexual
- Transgender
- Asexual
- Other
- Refused

5. Gender: What is your gender identity?

- Female
- Female-to-male transgender
- Male
- Male-to-female transgender
Transgender
Transsexual
Other
Refused


Married
Living with a partner
Divorced
Separated
Widowed
Never been married
Single
Refused

7. Education
   a. What is the highest level of education in nursing that you completed?

Diploma
Associate’s
Bachelor’s
Master’s
Doctorate
Refused
b. If you have a degree from another discipline: What is the degree and from what discipline? ___________________________________________

8. Employment: What is your primary job?

________________________________________ (Record exact name and title)

9. How many hours do you work as a staff nurse in the Emergency Department per week?

________________________________________ (Record exact hours)

10. Do you have any nursing certifications above the basic requirements for employment?

   If yes, __________________________ (Record exact certifications)
   ○ No

11. Years of practical experience as a registered nurse

    ____________________________________ (Record exact years)

12. Years working as a registered nurse in any ED

    ____________________________________ (Record exact years)

13. Years working in current hospital as a registered nurse in the ED

    ____________________________________ (Record exact years)

14. Are you an advanced practice nurse?

   ○ If yes, ______________________________(Record the specialty and if nurse practitioner or clinical nurse specialist)
   ○ No
## Appendix C

### Detailed Demographic Characteristics of Participants

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Race/Ethnicity</th>
<th>Gender</th>
<th>Relationship Status</th>
<th>Highest Degree</th>
<th>Work Hours</th>
<th>Work Position</th>
<th>Work Experience</th>
<th>Overall RN Experience</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ann</strong></td>
<td>30s</td>
<td>Caucasian/American/Irish</td>
<td>Female</td>
<td>Married</td>
<td>BSN</td>
<td>36 hours</td>
<td>Staff Nurse</td>
<td>8 years</td>
<td>9 years</td>
<td></td>
</tr>
<tr>
<td><strong>Bob</strong></td>
<td>30s</td>
<td>Caucasian/French Canadian</td>
<td>Male</td>
<td>Married</td>
<td>BSN, CEN</td>
<td>36 hours</td>
<td>Staff Nurse</td>
<td>5 years</td>
<td>7 years</td>
<td></td>
</tr>
<tr>
<td><strong>Connie</strong></td>
<td>30s</td>
<td>Caucasian/Italian/Irish/American</td>
<td>Female</td>
<td>Married</td>
<td>ADN, BA in Psychology</td>
<td>36 hours</td>
<td>Staff Nurse</td>
<td>3.5 years</td>
<td>3.5 years</td>
<td></td>
</tr>
<tr>
<td><strong>Debbie</strong></td>
<td>30s</td>
<td>Caucasian/Italian</td>
<td>Female</td>
<td>Married</td>
<td>MSN as Family Nurse Practitioner, BS in Chemistry</td>
<td>36 hours</td>
<td>Staff Nurse</td>
<td>3 years</td>
<td>4 years</td>
<td>Waiting for FNP certification</td>
</tr>
<tr>
<td><strong>Ernie</strong></td>
<td>30s</td>
<td>White/American</td>
<td>Male</td>
<td>Living with Partner</td>
<td>BSN</td>
<td>36 hours</td>
<td>Staff Nurse</td>
<td>5 years</td>
<td>7 years</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Age</td>
<td>Race/Ethnicity</td>
<td>Gender</td>
<td>Relationship</td>
<td>Education</td>
<td>Work Schedule</td>
<td>Work Experience</td>
<td>RN Experience</td>
<td>Notes</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Florence</td>
<td>twenties</td>
<td>Caucasian and American</td>
<td>female</td>
<td>single</td>
<td>BSN</td>
<td>36 hours per week</td>
<td>2 years</td>
<td>2 years</td>
<td>All in ED</td>
<td></td>
</tr>
<tr>
<td>Genevieve</td>
<td>twenties</td>
<td>Irish/Puerto-Rican and Multicultural</td>
<td>female</td>
<td>single</td>
<td>BSN, BA in Biology</td>
<td>36 hours per week</td>
<td>9 months</td>
<td>3 years</td>
<td>9 months in ED</td>
<td></td>
</tr>
<tr>
<td>Hank</td>
<td>twenties</td>
<td>Caucasian</td>
<td>male</td>
<td>living with a partner</td>
<td>BSN, CEN</td>
<td>48 hours per week</td>
<td>3 years</td>
<td>3 years</td>
<td>All in ED</td>
<td></td>
</tr>
<tr>
<td>Ijay</td>
<td>thirties</td>
<td>White</td>
<td>male</td>
<td>single</td>
<td>MSN</td>
<td>12 hours per week</td>
<td>9 years</td>
<td>11 years</td>
<td>All in ED</td>
<td></td>
</tr>
<tr>
<td>Joanne</td>
<td>thirties</td>
<td>White</td>
<td>female</td>
<td>single</td>
<td>BSN, BS in environmental health</td>
<td>36 hours per week</td>
<td>3 months</td>
<td>2.5 years</td>
<td>3 months in ED</td>
<td></td>
</tr>
<tr>
<td>Kay</td>
<td>twenties</td>
<td>Caucasian</td>
<td>female</td>
<td>married</td>
<td>BSN, TNCC</td>
<td>36 hours per week</td>
<td>5 years</td>
<td>7 years</td>
<td>5 of them in ED</td>
<td></td>
</tr>
<tr>
<td><strong>Lyndsay</strong></td>
<td>is in her twenties and identified her race as Caucasian and ethnicity as American. She is straight, female, and married. She has earned a BSN. She works 36 hours per week as staff nurse in the ED and has 6 years of experience working at her current hospital. Overall, she has 6 years of RN experience, all of them in the ED.</td>
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<tr>
<td><strong>Marie</strong></td>
<td>is in her forties and identified her race as White and ethnicity as Irish/Italian. She is straight, female, and has never been married. Her educational experience consists of a diploma in nursing and an associate degree in general science. She works 36 hours per week as staff nurse in the ED and has 4 years of experience working at her current hospital. Overall, she has 5 years of RN experience, 4 of which are in the ED.</td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Natasha</strong></td>
<td>is in her twenties and identified her race as Caucasian and ethnicity as White. She is straight, female, and married. She has earned an ADN. She works 36 hours per week as staff nurse in the ED, has a TNCC, and has 2 years of experience working at her current hospital. Overall, she has 4 years of RN experience, 2 of them in the ED.</td>
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</tr>
<tr>
<td><strong>Optimistic</strong></td>
<td>is in her forties; she identified her race as Caucasian and did not identify her ethnicity. She is straight, female, and married. She has earned a BSN. She works 36 hours per week as staff nurse in the ED, has a CEN, and has 16 years of experience working at her current hospital. Overall, she has 16 years of RN experience, all of them in the ED.</td>
<td></td>
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<td><strong>Pam</strong></td>
<td>is in her fifties and identified her race as White and ethnicity as Irish. She is straight, female, and married. She has earned an MSN. She works 24 hours per week as a staff nurse in the ED; she is an advanced practice nurse and also an adult educator. Pam has a CEN and 15 years of experience working at her current hospital. Overall, she has 31 years of RN experience, 15 of which are in the ED.</td>
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**Quincy** is in her sixties and identified her race as White and ethnicity as Caucasian. She is straight, female, and married. She has earned a BSN. She works 36 hours per week as staff nurse in the ED, is certified as a school nurse, and has 29 years of experience working at her current hospital. Overall, she has 39 years of RN experience, 33 of them in the ED.

**Samantha** is in her fifties and identified her race as White and ethnicity as European. She is straight, female, and divorced. She has earned an MSN and achieved certification as an Adult Health Nurse Practitioner (although she has not currently maintained her certification). She works 40 to 50 hours per week as staff nurse in the ED and has 16 years of experience working at her current hospital. Overall, she has 31 years of RN experience, 16 of them in the ED.

**Tamara** is in her thirties and identified her race as Caucasian and ethnicity as American. She is straight, female, and living with a partner. Her educational experience includes a BSN and a BA in psychology. She works 36 hours per week as staff nurse in the ED and has 1 year of experience working at her current hospital. She has the following certifications: SANE, ATCN, and CEN. Overall, she has 12 years of RN experience, all of them in the ED. Tamara’s entire nursing career has been spent in the same hospital system, but one year ago she moved to another hospital ED within the same hospital system, in the same geographic area as the first ED.

**Ursula** is in her forties and identified her race as Caucasian and ethnicity as American. She is straight, female, and married. She has earned an MSN. She works 8 plus hours per month as staff nurse in the ED, has a CEN, is a clinical education specialist, and has 12 years of experience working at her current hospital. Overall, she has 25 years of RN experience, 22 of them in the ED.

**Valerie** is in her thirties and identified her race as White and ethnicity as American. She is straight, female, and divorced. She has earned an MSN in nursing education and is a certified family nurse practitioner (FNP). She works 36 hours per week as staff nurse in the ED, has a TNCC, and has 8.5 years of experience working at her current hospital. Overall, she has 14 years of RN experience, all of them in the ED.
Appendix D

Recruitment Flyer

Drexel University
Recruiting Volunteers for a Research Study

Research Title
A Qualitative Study on Intimate Partner Violence Screening Practices by Nurses in the Emergency Department

Research Objectives
The purpose of this study is to explore the experience of registered nurses who currently work in the emergency department in screening for intimate partner violence (IPV) and what influences their screening practices. The interview will take approximately 60 minutes to complete.

Information for Research Subjects Eligibility
You can participate in this study if you are at least 18 years old and a registered nurse (RN) who currently works in an emergency department (ED) in a Philadelphia, Pennsylvania hospital (full-time, part-time, or per diem), if you completed an initial assessment as an RN in the ED in a Pennsylvania hospital on at least 500 ED patients in the last year, and if the hospital intake form used by staff RNs includes at least one question that screens for IPV.

Remuneration
You will be given $25 to participate in the study.

Location of the research and person to contact for further information
This research is approved by the Institutional review board.
If you are interested in participating in this study, please contact:
Theresa Fay-Hillier, MSN, PMHCNS-BC
215-805-3371
Interviews will be conducted in a private center city office or via the internet.

_________________________________________________
This research is conducted by a researcher who is a member of Drexel University
Appendix E

Drexel University

Phone Screen Script Template

Title of Study: A Qualitative Study on Intimate Partner Violence Screening Practices by Registered Nurses in the Emergency Department

Hello, my name is Theresa Fay-Hillier from the Department of Nursing and Health Professions at Drexel University.

The reason I am calling is to conduct a screening interview to see if you meet the criteria for taking part in our research study to explore the experience of registered nurses who currently work in the emergency department in screening for IPV and what influences their screening practices. I am going to go through a list of questions. The questions I ask will determine your eligibility to participate in the study. You may choose not to answer these questions. You also may choose to stop participating in this interview at any time; if you want to stop, please tell me.

This interview will take approximately 5 minutes.

Do I have your permission to continue? Circle one: YES NO

We will keep the information we talk about in our files until you come in to consent for participation in the study. If you qualify and choose to be part of the study, this information will become part of your study file. If you don’t come in or if you don’t qualify for the study, we will keep this information until the study is over and then we will destroy it. We are required by law to keep this information confidential and we will not use it for any purpose other than to see if you qualify for this study. However, it is possible that the Food and Drug Administration, and other federal and state authorities, may inspect this record.

You can choose if you want or do not want to take part in this research screening procedure—it is up to you. If you refuse to answer the questions or stop answering them at any time, there will be no penalty, and you will not lose any benefits to which you would otherwise be entitled.

The risk into taking part in this interview is very small. The screening interview is not designed to ask you for sensitive personal information, but it is possible that some people may feel uncomfortable answering these questions with a person they do not know.

There are no benefits to you to taking part in this screening interview. However, it is possible that the information from the study that we will be doing may help researchers to learn more about the experiences registered nurses have in screening for intimate partner violence and may benefit others in the future.
You will not be paid for answering questions in this interview since it is only to see whether you qualify to take part in the study.

If you have any questions, concerns, or complaints about this interview, contact please let me know. If you want to talk to someone separate from the research team about a concern or complaint or your rights as a possible research subject, please contact Human Research Protection at 215-255-7857 or at HRPP@drexel.edu.

Now I would like to ask you some questions:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Additional comments</th>
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<tr>
<td>Are you an RN who is at least 18 years old or older and who currently works in an ED as a staff nurse in a Philadelphia, Pennsylvania hospital (full-time, part-time, or per diem)?</td>
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<td>Does your initial intake form used by staff RNs in the ED include at least one question that screens for intimate partner violence or safety at home?</td>
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<td>Have you screened at least 500 ED patients in the last 12 months using an intake form that includes screening for intimate partner violence or safety at home?</td>
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<td>Are you able to provide your own consent?</td>
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<td>Are you currently dependent on another individual to take care of you or do you have an intellectual disability?</td>
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If you are eligible to participate in the study, with your permission I would be recording our interview (which should take approximately 60 minutes to complete) and taking some notes as I do not want to miss any of your comments. I will ensure that you remain anonymous and will protect your confidentiality. Your real identifying information will not be used in any written reports that may follow this interview. Names and identifiers of participants will not be used during data collection or with potential publication of research results. Interventions used to protect the collected data include using pseudonyms, using a secure e-mail account, limiting access to the data to the researcher, using a secure location for the data storage such as a locked drawer or cabinet, secured computer portals if the interview is conducted via Skype, and destroying all data that have a potential link to research participants at the conclusion of the study.

Closing: Eligible Participant
Based on the information you gave me, it looks like you may be eligible for this study. At this point, you have three choices. (1) I can take down your contact information and have our staff contact you to set up an appointment; or (2) I can give you the number to call to set up an appointment yourself; or (3) if you are not interested in learning more about the study, you should say that and I will not keep the information collected in this interview.
_________ OKAY TO CONTACT  (*collect contact info*)

_________ SUBJECT TO CONTACT  (*give contact info*)

_________ NOT INTERESTED  →  (*destroy all information collected*)

_________ CALL BACK  →  (Phone #: __________________________)

_________ MAIL ADDRESS  →  ________________________________

Thank you for your time.

**Closing: Ineligible Participant**

Based on the information you gave me, you are not eligible for this study. Thank you for your time.
VITA

Theresa Fay-Hillier is an Assistant Clinical Professor in the College of Nursing and Health Professions. She earned her Doctorate in Public Health from Drexel University's School of Public Health, her Master's Degree in Psychiatric Mental Health Nursing from the University of Pennsylvania and a Bachelor of Science in Nursing from Holy Family University. She is a board certified Clinical Nurse Specialist in Psychiatric and Mental Health Nursing by the American Nurses Credentialing Center. Dr. Fay-Hillier was a co-leader of a homicide bereavement group for families at the City of Philadelphia Office of the Medical Examiner. She was also a co-owner of a nurse owned business providing critical incident stress debriefing services to employees who worked in both health care agencies and general business facilities. After the 911 tragedy, Dr. Fay-Hillier was involved with debriefing employees who worked in or around the New York City area.

She has presented at both national and international conferences on issues related to intimate partner violence (IPV), harm-reduction strategies in addressing individuals addicted to opioids, and implementation of collaborate simulation experiences into nursing programs. She has also co-authored several peer reviewed articles and is co-editor of a textbook on Child Maltreatment. Dr. Fay-Hillier traveled to Bolivia to provide consultation and education to judges, prosecutors and forensic psychologists to enhance the evaluation of sexually assaulted children and teens and to explore strategies for successful prosecution of the offenders. Dr. Fay-Hillier's focus of research in obtaining her DrPH from Drexel University's School of Public Health was related to health care providers' experiences in addressing IPV.