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# Nurse-Led Intervention To Reduce Intimate Partner Violence And Associated Health Risks: Qualitative Program Evaluation And Nurse Reflections

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**Nurse-Led Intervention to Reduce Intimate Partner Violence and  
Associated Health Risks: Qualitative Program Evaluation and  
Nurse Reflections**



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Yale School of Public Health 2015

## **Abstract**

*Background:* Intimate partner violence (IPV) is a highly prevalent issue worldwide. A large randomized controlled trial (RCT) evaluating a nurse delivered intervention to reduce IPV and associated health risks took place between 2012 and 2014 in Mexico City. This study will focus on qualitative interviews performed with a sample of the nurses who were the interventionists in the large RCT. Minimal work has explored implementation issues around large RCTs in resource poor settings or characteristics of the interventionists that may influence the implementation of the intervention and their health care delivery after completion of the intervention.

*Methods:* Semi-structured, qualitative interviews were conducted with 19 nurses who participated in the RCT in Mexico City. The nurses were chosen using purposeful sampling to obtain a diverse sample. Interviews were conducted and recorded by research assistants in Spanish, then translated into English and analyzed using thematic analysis and grounded theory. A coding tree was developed and themes and problems/questions were discussed with the research team. One researcher coded the interviews QSR NVivo 10.

*Results:* Themes include: changes in knowledge about IPV, emotional challenges for nurses including, mixed feelings about their participation in the study and the feeling on the part of nurses that their work in this study was worthwhile and important, a broader scope of the intervention than initially anticipated, nurses as trusted advisors and confidants, a gain in confidence on the part of nurses, the belief that IPV prevention and treatment is a part of the job description of a nurse and the differences between theoretical and practical trainings.

*Conclusion:* Implications of this study include the knowledge that practical training that includes tools for immediate use are more effective than theoretical training. Nurses believe that IPV is an issue they can and should address in their everyday practice and therefore are a logical choice for intervener.

Additionally the scope of this intervention may be wider than indicated by the eligibility protocol due to nurses carrying out the intervention in a wider population than indicated by inclusion criteria.

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## **Background**

Intimate partner violence (IPV) is a highly prevalent issue worldwide and has been reported by 30% of women (Moreno, *et.al*, 2013). In Mexico, the prevalence is similar, and ranges from 25% (Castro, *et.al*, 2003) to 44% (Romero-Gutierrez, *et. al*, 2011). Often, healthcare providers (HCPs) are the first point of contact and could be a logical point of intervention, but it is likely that individuals experiencing IPV will not spontaneously disclose (Morse, *et.al*, 2012). There are also many associated health risks for victims of IPV. For example, women who are victims of IPV are 16% more likely to have a low-birth-weight baby, more than twice as likely to have an abortion, and almost twice as likely to experience depression (Moreno, *et. al*, 2013). Victims will utilize health services more frequently than individuals who don't experience IPV (Campbell, 2002) and, therefore, HCPs are a logical choice for intervention. Many HCPs, however, have limited training specific to IPV and feel uncomfortable asking questions about IPV (Gutmanis, *et.al*, 2007; Vieira, *et. al*, 2013; Wathen, *et. al*, 2009). Comprehensive and integrative programs for HCPs in clinic settings are important, but few have been evaluated specifically in low and middle income countries. A large randomized controlled trial (RCT) evaluating a nurse-delivered intervention to reduce incidence of IPV and associated adverse health events resulting from IPV took place in Mexico City in 2012-2014 (Falb, *et. al*, 2014). The purpose of this study was to explore the thoughts, beliefs, and knowledge gained by nurses who acted as the HCP interventionists in the Mexico City RCT through qualitative data. There is limited knowledge about implementation issues with large RCTs for IPV in low and middle income countries (Decker, *et.al*, 2012; Goicolea, *et.al*, 2013).

In Mexico City nearly half of the population is uninsured and they receive health care through the federal health care program, Seguro Popular (Knaul, *et. al* 2012). The Ministry of Health (MoH) in Mexico City contains 206 health clinics and 31 hospitals. The health clinics are broken into three divisions. Type III clinics are large and they offer a broad range of services. Type I and II clinics are

considered community clinics and each have one or two doctors and two nurses. The focus of the community clinics is outreach and immunizations. Type III clinics were chosen for the intervention due to higher volume of patients and lack of IPV screening and services (Falb, *et.al*, 2014). In these Type III clinics it is often nurses rather than doctors or other staff who formed the first, and often only, contact with patients who seek care. To our knowledge there is no research on nurses as implementers of interventions in low and middle income countries.

The aims of this study are to learn how the nurse interventionists have changed as a result of participating in an IPV intervention, personally, professionally and in their frame of thinking about IPV.

## **Methodology**

The RCT randomized 42 health clinics in Mexico City as treatment or control clinics. Nurses from each of the control and treatment clinics were invited to participate. Treatment clinics had nurses who received training on screening for IPV, delivering supportive referrals and assessment of health and safety risks. Control clinics had nurses who received standard of care: a one-day training focused on sensitization to IPV as a health issue and were given referral cards to give to women. At both treatment and control clinics, patients were screened for eligibility. This eligibility was based on female sex, age (18 – 44 years), pregnancy status (not pregnant or in the first trimester), and, currently experiencing abuse in a heterosexual relationship as determined by a survey conducted in private spaces by research assistants. Eligible patients who consented then took a baseline survey and received the intervention based on clinic type (treatment – counseling and referral by nurses or control – referral card given to patient). Treatment clinics counseled women twice, once at baseline and at a three-month follow-up. Surveys collecting information from patients on past-year IPV, past-year reproductive coercion, use of community-based resources, safety planning measures, and quality of life (physical and mental) were conducted at baseline, time period 2 (three month follow-up) and time period 3 (15 month follow-up).

Semi-structured qualitative interviews were used to understand subjective experiences, perceptions and motivations of the nurses and to understand the benefits and downfalls of the RCT from the viewpoint of the nurses. The interviews were conducted after time period 2 because that is when their participation in the study had concluded, and experiences were freshest. Nineteen intervention nurses that participated in the RCT were interviewed. Interviews were conducted and recorded by research assistants in Spanish, then translated into English and analyzed using thematic analysis and grounded theory. A coding tree was developed and themes and problems/questions were discussed with the research team as they arose. The interviews were coded in QSR NVivo 10 by one researcher and difficulties and challenges were discussed with the research group as they arose.

Two hundred and seven nurses were trained over the course of three training sessions (October 2012, February 2013, and June 2013). A total of 162 (78%) participated by delivering at least one counseling session/referral to a patient. There was an average of 5 nurses trained per health center. The nurses who participated in the qualitative interviews were selected using purposeful sampling. Nurses were eligible for sampling if they delivered more than one counseling session/referral (n=142). The goal was to maximize diversity by identifying nurses who came from clinics in both high and low income neighborhoods, busy and slow neighborhood clinics (based on observations made by research assistants), gender of nurse, city zone that clinic is located, and number of patients counseled per clinic. Nurses were identified who delivered counseling to patients who reported changes in average numbers of IPV incidence before and after the intervention (decrease and increase), use of safety planning before and after counseling/referral (increase and decrease), and use of community resources before and after counseling/referral (increase). A second aim of the purposeful sampling was to identify nurses who delivered counseling to patients who didn't report any changes in IPV, use of safety planning or use of community resources. Much effort was put into making the 19 nurses selected as different as possible based on all the above criteria.

## **Results**

Table 1 describes the demographics of the 19 nurses who participated in the interviews.

Table 1:

Demographic n=19	Number
Gender	Female: 17 (89.5%) Male: 2 (10.5%)
Age Range (average: 43, SD: 12)	20-25: 2 (10.5%) 26-30: 1 (5.3%) 31-35: 4 (21.0%) 36-40: 2 (10.5%) 41-45: 1 (5.3%) 46-50: 2 (10.5%) 51+: 6 (31.6%) Unknown: 1 (5.3%)
Marital Status	Single: 8 (42.1%) Married: 7 (36.8%) Living with Partner: 3 (15.8%) Unknown: 1 (5.3%)
Highest level of education obtained	Technical Degree: 12 (63.2%) Bachelors Degree: 4 (21.0%) Masters Degree: 2 (10.5%) Unknown: 1 (5.3%)

### **Overview of Themes**

The main themes that will be explored are (1) knowledge of IPV, (2) emotional challenges, (3) scope of intervention, (4) trust and confidence, (5) nurse identification of IPV as a part of their job description and (6) differences between theoretical and practical training.

Knowledge about IPV includes subthemes of previous knowledge regarding IPV, changes in knowledge as a result of the intervention and reasons IPV was avoided previous to the study.

Secondly, emotional challenges will be explored, a number of nurses had mixed feelings about their participation in the study, however, the majority of nurses felt that their work in this study was worthwhile and important. Most nurses had particularly memorable patients and they frequently relayed the important and often difficult stories of these patients.

Next, the scope of the intervention will be discussed. Nurses often brought the intervention with them to



friends and family and to community members who were ineligible due to eligibility criteria of the study.

Trust and confidence will also be discussed as themes. Nurses felt they were seen as trustworthy and their role as nurses allowed them to be both a confidant and a source of encouragement. Several participants also indicated they gained confidence while participating in this intervention.

Nurses also saw IPV prevention and treatment as a part of their job description as a nurse. This drove their desire to not only participate in the intervention but to bring the intervention to anyone who might benefit both now and in the future.

Finally, this study found that nurses discussed the differences between theoretical and practical trainings and felt that intervention, and specifically, the practical training was key in their ability to intervene and counsel about IPV.

### **Knowledge of IPV**

Several questions asked during the qualitative interviews centered around knowledge of IPV, both before and after the intervention. Nurse knowledge before the intervention was considerably varied and ranged from avoiding the issue at all costs to a full understanding of the implications and costs of IPV. Most nurses gained at least some new understanding or knowledge as a result of the study and most nurses had a renewed understanding of IPV after the intervention.

#### *Previous knowledge*

There were variations regarding the nurses' previous knowledge of IPV. The beliefs ranged from lack of awareness and inadequate knowledge regarding the pervasiveness of IPV to having an introductory working knowledge about IPV. One example of this is seen with nurse 13 and her lack of knowledge regarding the pervasiveness of IPV,

Even working as a nurse and with my level of education, I did not know that the level of IPV against women was so high. I saw it as something normal that the women would tell us, today my husband yelled at me.

Another example is seen with nurse 8, who didn't see IPV as a problem he could personally identify,

Before participating in the project, I didn't see it really. I didn't think that there were so many women experiencing IPV, it was like, for real? I mean this lady is saying that she is experiencing IPV. There would have to be punches in order to see that she really is experiencing IPV. We don't realize the magnitude of IPV [and] that so many people in your own population are experiencing IPV.

This nurse also recognized that before the study he participated in victim blaming,

Honestly I used to say, she's stupid, how does she let him do that to her? But I did nothing else. You don't realize what's behind all that. I mean, maybe the woman feels threatened, maybe she thinks that it's his way of loving her or I don't know what she thinks.

Two nurses discussed their lack of knowledge of IPV. "I had heard about it [IPV], I had seen some triptychs from colleagues that went to classes about IPV, but I didn't know anything myself" (Nurse 3). The second nurse, nurse 4, said, "I didn't have all the experience and tools. But, well, I'm a woman, at some point you have the experience to give advice. I just didn't know where to send them to, but now I do".

One nurse (nurse 2) did understand the seriousness of IPV prior to participating in the intervention, however, she had some misconceptions, "well, [my perception was that] men are often violent against women. In fact, most women come to this [health center] because they have been assaulted by their partner". When asked how she came to that conclusion she stated,

We identify from the physical appearance. Actually, from the moment the patient comes in, you can see what's going on with her. And later on, talking to them, we make them feel that they can trust us, and the patient tells us she is an IPV victim.

### *Avoidance Patterns*

Six different nurses talked about their avoidance of discussing IPV with their patients prior to the intervention. Again, there was a range in the ways and reasons nurses avoided the discussion. These included a lack of knowledge about referrals and programs for victims, lack of private space to have the discussion, a fear of reprisal from partners of women experiencing IPV, an inability to recognize IPV and, the belief that IPV is a taboo topic.

One reason for not talking about IPV was due to lack of knowledge on what to do when a patient experienced IPV. This was articulated by Nurse 15,

I didn't know what to tell them. The most I did was sending them to social services or to the psychologist. That was the only help I could give because I didn't know about any other place to refer them to.

Another reason for avoiding the topic was attributed to the lack of a private space to hold the discussion,

We never ask them if they are experiencing IPV, mainly because we don't have a private space. My colleagues work in the hallways, we have no space to ask the women if they are experiencing IPV. There was no project like this until you came along and we noticed the importance of screening the women for IPV (Nurse 19).

Another respondent indicated being fearful to discuss the topic because of the potential negative response of the women's partners, "before the training I did see and know about IPV, but precisely because of how husbands usually respond, we [nurses] often prefer not to get involved" (Nurse 4).

When asked about what the husbands/partners do the nurse cited an incident that happened to a co-worker. The co-worker told a patient that was experiencing IPV that it was not normal and that the husband/partner should stop. The patient went home and told her partner what the nurse said. The partner showed up at the clinic a few days later and threatened the nurse for intervening.

Two nurses reported that IPV just wasn't a concern of theirs as illustrated by the following:

We [health staff] have most of the contact with the women at the health center, but generally the IPV was left undetected, or we didn't want to see it. We didn't do anything about it, we just watched and observed, talked about it and left it like that. (Nurse 16)

and nurse 18 said she, "didn't [pay] much attention to it. Sometimes you can observe this kind of problem among the patients or within the family but you think: I better not barge in. It's not my business".

Nurse 11 explicitly stated that IPV was a taboo topic. She attributed the reason she wasn't seeing IPV in her practice prior to the intervention to the idea that women didn't want to disclose and therefore there was nothing she could do.

Often you think that the women don't want to tell you about it, I mean, they don't want to address this topic out of fear. I thought the women would say, no, I am not going to say

anything. Yes, he hits me, but if I tell this to the nurses maybe they will do something against my partner.

### *Changes in IPV understanding as a result of participating in the intervention*

Most nurses talked about the new knowledge gained by participating in the intervention. Several nurses demonstrated their new understanding as to the prevalence of IPV. Two nurses had a renewed understanding of the negative ramifications of IPV, and the majority of nurses described their current understanding of IPV. In all cases the nurses demonstrated notable knowledge gained through training and participation in the intervention.

Nurses 8 and 9 both discussed their realization about the impact and pervasiveness of IPV,

With this project we achieved to see that there are a lot of people within this health center that are experiencing IPV, young women and older women. So, yes, it's shocking to see that there are still people experiencing IPV. Before the project they didn't say anything, or we didn't believe that there were so many of them or that IPV existed in this way. (Nurse 8)

Nurse 9 indicated, "I think the project increases awareness and you learn how to talk to people and get them to open up to you. So I think you learn to identify [IPV cases] and to get people to open up to you".

The intervention re-affirmed two nurses understanding of the negative ramifications of IPV. Nurse 8's experience,

[IPV] was shocking, isn't it? Because in [this district] there are a lot of women that experience IPV and they think it is normal, as it was something of everyday life, they don't say anything to their husbands or boyfriends, it is something shocking.

Nurse 4 said that the training and intervention,

Reaffirmed that we shouldn't allow IPV to happen, that often oneself, as an external person being part of the health staff, presents IPV at home or is experiencing IPV without being aware of it. One takes it as normal and natural routine. So, I learned how many types of violence there are, that it doesn't necessarily have to be physical but psychological and that there are many other types of violence.

The majority of nurses described their current understanding of IPV. Their descriptions show how much they learned through participation in the intervention. Nurse 8 said,

Before studying my professional career, I thought that [IPV] was something normal, or maybe that they were playing, but after seeing the *Violentómetro* [a thermometer describing the ways in which violence escalates from mild violence to intense violence such as homicide] you can see the level of IPV and you can also say that you are experiencing IPV...I think that we should help us among us so we can change and stop this, I think that beating a woman is a thing of the past, now it is time to leave behind *machismo*.

Nurse 10 felt that IPV should be denounced,

I feel that [IPV] should be denounced. We shouldn't be afraid, we should understand that we are victims of IPV because often we don't understand that but think that we are not loved because [men] beat us, right? So I think we should denounce it.

Another nurse felt that IPV was a systemic problem and one that she felt was important, especially in reference to supporting of victims,

[IPV] is a problem on a global level and it's very...I don't know how to say it, it's a problem that's clear. But women don't have the courage to tell that they are experiencing IPV on a physical and emotional level. So after that training we want to support the women a little, well a lot, in order for them to open up to us and tell us what they are experiencing. (Nurse 17)

#### *Additional Gains*

Three nurses attributed the intervention to personal gains in confidence both with intervention specific activities but also in their lives in general. Nurse 12 said, "the more you practice, the more you feel confident in knowing how to approach the women". Nurse 8 indicated,

I was a little shy, first of all we did a role play with [the research assistants] and I asked them: how do I have to ask women about IPV? because they are the ones who know, and we didn't know what to do or what to ask, and I said to myself: if I am shy here during the role play, imagine when I have to talk with women that experience IPV. But then you get used to it.

And, thirdly, Nurse 3 talked about her gains in confidence, "little by little, yes, I was improving. In the beginning I was afraid, I was embarrassed, I didn't know how to address it or how to tell them, but little by little I let loose". She said that the intervention taught her, "to learn to speak in public, to learn to talk, to find the words, having the words to talk to [the women]". This increase in communication didn't stop with the women who participated, "meeting new people at the training, being able to communicate with [the research staff] and not thinking: oh no, what is she going to say? Now I am able to speak more at ease, but it was difficult for me".

This gain in personal confidence is one example of how the intervention has impacts beyond the identification of women experiencing IPV, counseling and treatment.

### **Emotional Challenges**

All of the nurses discussed moments or issues that were particularly hard emotionally. Some of those challenges were the repetition of sad and disturbing stories. Anger was another emotion that was frequently cited. Nearly all of the nurses discussed a mixture of feelings and at some point every single one of the nurses talked about their feelings of ‘doing good’.

#### *Mixed Feelings*

The feelings that the 19 nurses who participated in the interviews were as varied as the nurses themselves. Nurse 6 discussed her motivations for continuing in the project and her goals of helping at least some of the women who she saw as well as her complicated feelings about her patients,

I asked myself, how is it possible that this woman puts up with so much? I mean, what’s wrong with her, doesn’t she see it? I thought, no there is no way that there are people that mentally messed up, I don’t know, that they allow the men to insult them, to hit them, that’s not right. And I told the women: How can you let him do that? But they are psychologically manipulated by their husbands telling them that they are ugly, that nobody loves them, and whatever, so you put yourself in their position of feeling this sadness, even in their eyes. I remember one woman that came in and I don’t remember if her husband hit her but the point was that we sent her to a community resource and she went there and came back completely changed, with makeup, smiling, she looked happy. She told me: you know what? I decided to leave him, there is no reason to have fear anymore, I know that there are people that can help me. First this sensation of sadness where you say: hopefully they can help her where we are sending her, because what else could I do for her? And later on the joy of seeing her coming back and seeing her so different...if they make a decision, great. Hopefully it’s at least 5 women; then it would be 5 women less, hopefully.

Nurse 19 experienced primarily anger, “first it made me angry because I asked myself: how is it possible that these women are experiencing IPV? As a woman you have to value yourself, you have to put a limit”.

Four nurses described feeling multiple emotions at once. Nurse 18 felt,

On one hand I was thinking that one as a woman keeps a lot of things to herself and I tried to make the women feel that they could trust me. You see them with a face that is crying for help

and sometimes they don't tell you about their problems and I was worried about the situation these girls or women were living. How do they allow for all that to happen? And on the other hand I felt satisfaction about being able to show them other options in the counseling; after that they have to take the decisions on their own. In the end you can counsel them but they have to take their decisions.

Nurse 17 felt both helpful but also upset by the issues her patients were facing, "the women tell you their whole lives and it's ugly and well, we are human, so we also have feelings. But at the same time I felt good because I knew that I could help them and give them information". Another nurse was strongly affected early in the intervention but felt that as time went on she was better able to talk to women experiencing IPV,

In the beginning it was very difficult for me because it affects us a lot too, knowing that [IPV] still exists these times, that there are still women who let that happen and who don't dare to denounce. And now with the practice we also got more aware and could approach the women without fear but with more confidence. And well, it's a great satisfaction to know that one can help people to overcome their problems. (Nurse 10)

Nurse 15 was initially really hesitant to participate, "when I saw the video at the training I asked myself am I really trained to counsel the women? I didn't feel trained because IPV is part of the intimate life and it's really difficult for the women to recognize". However, after gaining confidence and completing the training, she said,

It was a good experience. It gave me a lot of satisfaction to see the women coming back and telling me: you helped me, we are even going to couples counseling, and everything has gotten better. That the women come back with this initiative and being satisfied about the service. Then you think, you did something good, it was worth something to tell them everything in one session. I feel satisfied.

### *Doing good*

Three nurses described that delivering this intervention gave them good, positive feelings. Feelings that made them want to continue doing this type of work. Nurse 1 enjoyed the project because it allowed her to do something for a problem that she thinks is too widespread,

This project was nice for me, I like it, it gets my attention because for me this is a serious problem, I see it every day, women of all ages, every day they come with violence issues...something needs to be done.

Nurse 6 also felt useful and productive,

I felt useful, I felt like contributing to a grain of sand to be able to help women. Because there is also violence among men, so I feel useful helping women to reduce this problem. I really feel happy, I feel that I supported them and helped them. And even though I didn't tell them that I had experienced [IPV] myself, I felt the obligation to help them in order for them to not live with what I had to go through. And I think that there are still many women experiencing IPV within the health ministry, so it's not over, it goes on and on; and I would want the IPV to decrease and not to increase.

### *Memorable Patients*

One of the most influential reasons nurses had such mixed emotions were the patients they worked with, patients with histories that were very challenging. Nurse 6 related a story and her outrage involving a patient whose partner was much older than her. The partner was also a police officer.

A little girl with a 50 year old man, and she was 17 or 18 years old. He was standing there, it was a bad case of IPV, and she says: He controls me; I don't get out of the house, he tells me not this and not that and well: now I can't talk because he is watching me. Horrible controlling man, but what can you do? She says, I don't think I can go to the UAVIF, I don't think I can go to the psychologist. He is a policeman, a public servant, and he had the girl like this, because she's a girl. ... He is one of those horrible controlling men, horrible. And you say and that is a public servant? A policeman? And he is perpetrating violence.

Nurse 8 recalled a house visit she made while conducting a census,

You ask how many children under 8 years of age there are, if there are pregnant women in the household...and one woman told me: yes, I'm pregnant – but like lowering the voice: but my husband shouldn't find out ok? I went with another colleague and said, but why? In which month are you? She said, well in the 6<sup>th</sup>. I asked her, how is that possible? Doesn't he notice the pregnancy or what? She answered, no, I told my husband, my husband told me to abort and I told him I would do it, I even told him that I went to the hospital and that I had done the abortion but I really didn't. And we told her: and what are you going to do now? The baby is going to be born and more noticeable. And she said that her husband was being abusive.

The nurse reported this patient to the research assistants in hopes of being able to provide some support for the patient. However, since the patient was pregnant she wasn't included in the intervention.

Therefore, the nurse took it upon herself to check up on the woman but when she returned to the house she received a very cold welcome. “Well you go to these people, you are doing the effort to make the woman understand that she's in danger and there's no reaction. Like she doesn't even care, so what can you do?”



Nurse 12 related three different stories about memorable patients. The first was a woman she didn't even remember counseling who returned to the health center and indicated that because of the intervention this woman sought counseling and had since separated from her partner and was now happy.

For me that was something. It was very fulfilling for me to see that woman and to know that I had given her a little bit of my time. Because you maybe want to give them all of your time, but it was very good for me to see these women after, at least this one woman who recognized me, and I saw her completely changed from how I remembered her.

The second was of an abusive relationship that involved deadly weapons. The patient told nurse 12 that she slept with a gun beneath her pillow and her husband with a "machete", because they didn't know who would react aggressively at any moment. The partner was enrolled in Alcoholics Anonymous and Narcotics Anonymous, "the woman told me that he came home and threatened her, that he asked her why she was with other men. Really heavy cases where the women say, what do I do? You don't forget these cases". The third patient nurse 12 related a story about was experiencing severe physical violence. The patient showed nurse 12 the numerous bruises in various stages of healing.

She's one of the women I remember the most. She got up and wanted to hug me. I didn't know how to react in that moment, to hug her or not; maybe she was traumatized because every man who hugs her assaults her. Everyone who has touched her has punched her. Violent brothers, boyfriends yelled at her, hit her – she gets together with a man, he hits her, gets her pregnant and leaves her. She gets a new boyfriend and it's the same over and over again.

After relating the story nurse 12 said,

There was a moment when I tried to look in another direction because my eyes were wet and I didn't want her to see that because instead of helping her and going on with the session I would have started to cry.

### **Scope of Intervention**

The scope of the intervention was intended to be all women presenting to local health clinics who screened positive for IPV. There were four different nurses who indicated that they either took the intervention to their family and friends or expanded the intervention beyond the scope of the study.

### *Friends and family*

Nurse 2 and nurse 12 indicated they moved the intervention to their friends and family. This shows that the impact of the intervention may likely be wider than initially indicated. Nurse 2 described her interaction with a friend,

Once my friend came to me, and I, not knowing about her situation, administered the screening tool. She told me: *ay comadrita*, it's very good that you ask those questions because the truth is we never talk about it, not even with you. And I told her: and what do you think about that?, and she said: it's good because a lot of times we experience IPV and we take it as part of the relationship and let it happen. So it is important to administer the screening tool, because it reveals things the patient normally never tells us.

Nurse 12 indicated that no one is immune from IPV,

I liked [the intervention] because it helps you to raise awareness, definitely, just because of getting to know the different types of IPV. It's not the same to learn about these types than perceiving them in other persons. It's very different because you are somehow talking to human beings, even if you don't want to you put yourself in their position and you notice that close family of yours could also be experiencing IPV, so you get more aware. It also makes you a better person, to not exercise violence and not let yourself put up with violence. Because we [nurses, women] have experienced violence with our brother or fathers, etc. So it also helps to know that this is violence too.

Given the international statistics indicating nearly 1 in 3 women will experience IPV in their lifetime it would not be surprising that a number of the nurses interviewed would have a personal history of IPV (Moreno *et. al*, 2013). While personal experiences of IPV in the nurse's lives was not specifically addressed in the interview, there was one nurse who self-disclosed.

My opinion about participating in this is that I had lived it, I experienced IPV, therefore, I want to help people to get out of it, to understand that it is not like we imagine it to be – that the problem is our own, that nobody will help us and that there's nothing we can do. This is what I wanted to express to the community and what I, somehow, wanted to have knowledge about in order to provide counseling and help them. ... My mother experienced it, my mother put up with him, and that scheme should be broken. That cycle shouldn't continue, that is what I wanted to transmit to the women. (Nurse 6)

She related a story about her former partner, she used to tell him to hit her in hopes that the police would see the black eye and finally do something about the violence.

Instead they would tell me, you must have done something to him, because they were men, they would tell me, no, those are marital problems, you did something to him, you cheated on him,

and that's why I think he hit you. Today they would have put him in jail. That's why I asked him to hit me, to go to the borough's office and sue him, but nothing. I got hit for nothing.

This same nurse was also seeing the cycle of violence continue with her daughter.

My big frustration is that my daughter is 20 years old and is experiencing IPV. That's my frustration, so I am left with supporting and helping other women, since I'm not able to do it with my daughter. Hopefully somebody who listened to me remembers my helping voice and doesn't go on like this. It's very sad for you to live it. It's like I told them, this is a pattern that will be dragged on...one lives it and passes it on to the children. The children live it, so it's never too late to help them and contribute with what you have lived and what has helped you to move on. Share, share...That's all I want to tell them. It was upsetting; it was sad, but good. I helped them mostly with my own experiences. I mean, you don't have to wait for a lot of things to happen, for a lot of years to pass and for you to become an old woman in order to leave him or to realize that it was not your partner or that he never changed.

### *All Community Members*

Given the restrictions of the RCT, the individuals who were screened and deemed eligible to participate did not include all individuals experiencing IPV. Two nurses felt it was wrong to limit the scope of the intervention and would counsel patients who did not fit the eligibility criteria but were experiencing IPV.

Nurse 12 indicated that she and her fellow nurses at her clinic felt it was wrong to limit the scope,

There was a time when we said that we thought it was wrong to exclude women who do experience IPV but don't fulfill the criteria of the program from the counseling. Because we thought it was important to include them too. So we addressed these cases too, although they were negative cases within the project.

Nurse 2 was particularly concerned with older patients, "there have been older patients, older than the age limit that is dictated by the screening and I administered [the screening] anyway, because you could tell".

Three nurses indicated that they have continued administering the screening and counseling for their patients even after the intervention has completed.

We [still] administer the mini-screening. Taking the training and applying the mini-screening is how we are able to screen better. I now use the materials for women I see every day, when it is needed, if the woman is aware that she needs help, I give her different options. (Nurse 2)

Nurse 4 indicated the same thing,

Last week a young woman came in and I heard her telling the doctor about the type of IPV she

was experiencing and about how she needed help. So, the doctor asked me and I told her that there were community resources where she could get help, get counseled and get shelter if she needed it, and that she shouldn't think that she's alone. We gave her the address and the phone number so she could go to the SEPAVIGE, and I sent her to the hospital because it was the closest one for her.

A third nurse, 19, indicated that she still gives counseling sessions even though the project has ended. She did express the concern that she has inadequate amount of time to interact with her patients and perform all of her required work as well as screening and counseling, but she is making it work for now. Again, we see the scope of the intervention being wider than initially indicated by the RCT protocol.

### **Trust and Confidence**

One of the most important aspects of the intervention were that the nurses be seen as confidants that could be trusted and relied upon to maintain confidentiality. This came up both as a concept that the nurses brought up as a reason that they hadn't asked patients in the past but also as a natural role for a nurse to hold.

Nurse 7 related the fact that her patients opened up to her, to her role in the health clinic and her age, "they already know me so they open up more easily". She continued,

I think it's due to the fact that I'm the youngest here at the health clinic and it also depends a lot on how you behave yourself, how you break the ice so they can tell you about their personal stuff. It's not easy, honestly, it's really hard to get people to tell you things, even harder if it's about personal things.

Another nurse, 13, indicated that he changed his interactions with the women he counseled,

I lowered the importance of my person, I wanted them to have the same importance, to stop being afraid and talk and dwell about their situation. It's not that difficult for me to express myself. Sometimes I wondered how to quickly make the women feel that they could trust me, because time was running, the women told me that their husbands were waiting for them downstairs or that their children were hungry or that they were waiting in line for the vaccine. I said: don't worry, I will make sure that your child gets the vaccine. So that's what made them trust me, they didn't get stressed anymore, because well: I don't have to wait for another two hours to get the vaccines.

He also noticed that putting a desk between him and the women was a barrier,

I tried to befriend the women, I thought I should stop being the one behind the desk talking to them front to front. I like talking to the women from the side, I don't like talking to them front to

front because I feel like an authority.

Two nurses discussed the issues around confidentiality. Nurse 11 felt that because she was a nurse and many patients felt that health professionals don't have to be confidential that they didn't want to disclose. "One woman told me for example: I don't want to tell you because people are going to find out. I told her, no this is confidential". Nurse 12 agreed and said,

It made me feel very good that the women trusted us. Due to the simple fact that we are nurses most of the population knows us and that they can trust us. I had explained to the women before that everything they told us would be completely confidential, that nothing would leave the room.

Nurses are seen as trustworthy and as a result the nurses interviewed felt that patients could disclose to them in a safe way.

### **Nurses and IPV prevention/treatment as a part of the job description**

Both nurses as individuals and the nursing profession are often seen as trusted advisors and patient advocates. There was much consideration about who the intervener would be in this intervention. The research staff had many conversations among themselves and with various community members about who the intervener in this RCT would be. Nurses were chosen after much thought and discussion. We see that nurses themselves also feel that they are in a position ripe for IPV prevention and treatment.

Four nurses discussed what they thought their 'nurse' status meant for the intervention. Nurse 2 indicated that her patients disclosed to her because she was a nurse,

I think that they felt comfortable because they had already answered the survey. But, when they saw us nurses, as a part of the health center, that's when they felt they could trust us. I think women let go a lot of things during the survey because they don't know [the research assistants]. But, knowing us, they felt they could trust us about the places we referred them to and everything.

Nurse 8 said he felt that screening and counseling, especially after the intervention had completed was just, "part of my nursing activities". Nurse 12 talked about the differences between psychologists and nurses in terms of IPV,

It might be true that [nurses] aren't psychologists and that we don't have this kind of information, but it's also true that we are trained to handle this information. ... Due to the simple fact that we are nurses most of the population know us and know that they can trust us.

Nurse 13 also thought his role as a nurse allowed the women to open up, "this topic is really strong among the population of my health center and it's hard for the women to open up about it. But we, as health staff and nurses, are able to open that door for them". Nurse 10 was asked why she thought nurses were chosen to be the interveners and she replied, "I feel that [nurses] are a little bit more aware of the pain of the people and being aware of that, well, it makes us even more sensitive and conscious". When participants were asked if they would be willing to continue screening and counseling patients without assistance from the research assistants nurse 10 responded, "yes, because I already feel it's part of my job, it's an activity more that we carry out". Similarly, Nurse 1 said, "it comforts me to know that I am doing my job ... it's something that is part of my job, to listen to them, to know that they are going through problems like this".

### **Theoretical versus Practical Training**

Two nurses talked about the differences between theoretical training for IPV that they, or their colleagues, had participated in previously and the practical training that took place during this intervention.

Nurse 8 thought this training would be another theoretical training,

When I take nursing trainings there are things you already know, and it is not that they are unimportant ... this training is 'applied knowledge' because you say to yourself I can do this, I can help these women, I have to screen the women that experience IPV and help them. It is like you get into the job, after the training you feel the need to help them.

Nurse 16 didn't want to participate at first because she thought that this would be the same as all other trainings, theoretical but no concrete things to do to help the population and another few days she had to leave work and try to catch up later. She thought, "oh no, more work!". She talked about a previous program that involved theoretical training, "we have that program about IPV from the ministry of health but we don't carry it out. In the beginning I thought that [about this intervention] but then I saw that the

women were actually responding and I felt satisfied”.

The nurses interviewed felt that IPV screening, counseling and prevention were a part of their job description.

## **Discussion**

This work is qualitative and therefore has limitations specifically related to reporting bias. Every attempt was made to bring the developing themes to the research group at large for feedback and input. The study only included the thoughts and opinions of 19 of the 207 nurses trained to deliver the intervention and while every effort was made to gather a diverse sample of nurses there are voices and opinions that may have missed. This study also did not compare these 19 nurses to the nurses who were a part of the control arm of the RCT which might illuminate more themes and show different understandings of IPV and interventions for IPV as well as additional benefits of this intervention.

Our study found that nurses who work closely with many women who experience IPV do not necessarily understand the pervasiveness of the issue and often have misunderstandings of the best practices to intervene in cases of IPV. These nurses ignore IPV in their patients for a multitude of reasons including their lack of knowledge, perspective that IPV is a taboo topic, their fear of being put in a compromising situation and their inability to provide any real support or relief. Other studies have found similar results; HCPs, including nurses, have varying levels of understanding about gender violence but all have significant misconceptions about prevalence as well as lack of sympathetic views towards women experiencing IPV and broad unpreparedness of HCPs to provide care to individuals experiencing IPV (Gutmanis, *et.al*, 2007; Sundborg, *et.al*, 2012; Vieira *et.al*, 2012; Vieira, *et. al*, 2013; Wathen, *et. al*, 2009).

This intervention and training provided nurses with tools to address IPV, the ability to change their misconceptions about IPV, change their practice, and help facilitate real change in the lives of their

patients. Additionally, several of the nurses who participated in the intervention gained concrete skills like increased confidence in talking with patients about hard subjects. Similar educational training programs about IPV in the United States showed an increase in self-efficacy of providers following training (Gadomski, *et.al*, 2001; Roark, S.V., 2010).

The nurses who participated in the intervention experienced a variety of emotions and attitudes that ranged from outrage to confusion to deep empathy. However, regardless of their feelings the nurses expressed their opinion that this was good and important work frequently and in numerous ways.

Clinically, the implications include the knowledge that nurses feel IPV intervention is part of their scope of practice but they lack the tools to provide such intervention.

Several of the nurses felt it was their responsibility not only to participate in the intervention as dictated by the study, but to apply the intervention to places and people who were initially excluded from the study. These people were friends and family members of the nurses but also the community at large who were excluded from the study due to inclusion and exclusion criteria. We can conclude that this means the scope of the intervention is perhaps broader than initially believed. Several nurses have continued the intervention beyond the conclusion of the study, therefore, showing the sustainability of training HCPs on IPV prevention. This is impressive given the extreme time constraints of these level III clinics. This shows that once trained, nurses will effectively intervene given the appropriate time and resources.

The nurses felt that their position and authority as a nurse was a logical point of intervention. Nurses pointed to their ability to gain trust and confidence from their patients and their increased contact with patients as keys for this intervention. In many clinical settings it is nurses who spend the most time with patients and, therefore, using nurses as the interventionist is a logical choice both for this study and in the future (e.g. James, *et. al*, 2014; Taft, *et.al*, 2012; McFarlane, *et.al*, 2006).



The nurses in this study pointed out that previous training had been theoretical and did not provide them with the specific tools and skills with which to engage patients and rather just provided definitions and frameworks. The training for this intervention, however, did provide them with those tools and skills in addition to the definitions and frameworks and therefore, was much more effective. Therefore, future interventions should incorporate practical tools for training of HCP interventionists.

This work has implications for further IPV interventions and training in Mexico City and around the world. It can inform clinical implementation of IPV screening and counseling sessions as well as demonstrate unintended benefits and consequences of this and future RCTs on the nurses who acted as the interventionists. While initially this RCT seems quite challenging given the large scale, the significant restraints on nurses time and energies, space concerns and the sheer volume of patients that are seen at these Type III clinics it is clear that the nurses who acted as the interveners felt it was successful and that it is feasible to continue screening, counseling and referring women experiencing IPV.

## Sources

- Campbell, J.C. (2002). The health consequences of intimate partner violence. *Lancet*. 359:1331-1336
- Castro, R., Peek-Asa, C., & Ruiz, Agustin. (2003). *Violence against women in Mexico: A study of abuse before and during pregnancy*. *American Journal of Public Health*. 93(7): 1110-1116.
- Decker, M.R., Frattaroli, S., McCaw, B., Coker, A.L., Miller, E., Sharps, P., Lane, W.G., Mandal, M., Hirsch, K., Strobino, D.M., Bennett, W.L., Campbell, J., and Gielen, (2012). *Transforming the Healthcare Response to Intimate Partner Violence and Taking Best Practices to Scale*. *A. Journal of Women's Health*. 21(12): 1222-1229. doi:10.1089/jwh.2012.4058.
- Falb, K.L., Diaz Olavarrieta, C., Campos, P.A., Valades, J., Cardenas, R., Carino, G., Gupta, J. (2014). *Evaluating a health care provider delivered intervention to reduce intimate partner violence and mitigate associated health risks: study protocol for a randomized controlled trial in Mexico City*. *BMC Public Health*. 14:772.
- Gadomski, A.M., Wolff, D., Tripp, M., Lewis, C., and Short, L.M. (2001). *Changes in health care providers' knowledge, attitudes, beliefs, and behaviors regarding domestic violence, following a multifaceted intervention*. *Academic Medicine*. 76.1045-1052.
- Goicolea, I., Vives-Cases, C., Sebastian, M.S., Marchal, B., Kegels, G., and Hurtig, A.K. (2013). *How do primary health care teams learn to integrate intimate partner violence (IPV) management? A realist evaluation protocol*. *Implementation Sciences* 8: 36. doi: 10.1186/1748-5908-8-36
- Gutmanis, I., Beynon, C., Tutty, L., Wathen, C.N. & MacMillan, H.L. (2007). *Factors influencing identification of and response to intimate partner violence: A survey of physicians and nurses*. *BMC Public Health*. 7(12).
- James, J.P., Taft, A., Amir, L.H., Agius, P. (2014). *Does intimate partner violence impact on women's initiation and duration of breastfeeding?*. *Breastfeeding Review*. 22(2).
- Knaul, F.M., Gonzalez, P.E., Gomez, D.O., Garcia, J.D., Arreola, O.H., Barraza, L.M., Sandoval, R., Caballero, F., Hernandez, A.M., Juan, M., Kershenovich, D., Nigenda, G., Ruelas, E., Sepulveda, J., Tapia, R., Soberon, G., Chertorivski, S., Frenk, J. (2012). *The quest for universal health coverage: achieving social protection for all in Mexico*. *Lancet*. 380(9849): 1259-1279.
- McFarlane, J.M., Groff, J.Y., O'Brien, J.A., Watson, K. (2006). *Secondary Prevention of Intimate Partner Violence: A Randomized Controlled Trial*. *Nursing Research*. 55(1): 52-61.
- Moreno, C., Pallitto, C., Devries, K., Stöckl, H., Watts, C., & Abrahams, N. (2013). *Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence*.
- Morse, D.S., Lafleur, R., Fogarty, C.T., Mittal, M., & Cerulli, C. (2012). *"They told me to leave": How health care providers address intimate partner violence*. *Journal of the American Board of Family Medicine*. 25(3): 333-342.
- Roark, S.V. (2010). *Intimate partner violence: Screening and intervention in the health care setting*. *The Journal of Continuing Education in Nursing*. 41(11): 490-495.

- Romero Gutierrez, G., Cruz Arbizu, V.H., Regalado Cedillo, C.A., Ponce Ponce de Leon, A.L. (2011). *Prevalence of violence against pregnant women and associated maternal and neonatal complications in Leon, Mexico*. *Midwifery*. 27: 750-753.
- Sundborg, E.M., Saleh-Statton, N., Wändell, P., and Törnkvist, L. (2012). *Nurses' preparedness to care for women exposed to intimate partner violence: A quantitative study in primary health care*. *BMC Nursing*. 11(1).
- Taft, A.J., Small, R., Humphreys, C., Hegarty, K., Walter, R., Adams, C., & Agius, P. (2012). *Enhanced maternal and child health nurse care for women experiencing intimate partner/family violence: protocol for MOVE, a cluster randomized trial of screening and referral in primary health care*. *BMC Public Health*. 12(811): 1471-2458.
- Vieira, E.M., dos Santos, M.A., and Ford, N.J. (2012). *Seizing an opportunity to help – Knowledge and attitudes of doctors and nurses toward women victimized by intimate partner violence in Brazil*. *Health Care for Women International*. 33(3): 228-249.
- Vieira, E.M., Ford, N.J., De Ferrante, F.G., de Almeida, A.M., Daltoso, D., dos Santos, M.A. (2013). *The response to gender violence among Brazilian health care professionals*. *Ciência & Saúde Coletiva*. 18(3): 681-690.
- Wathen, C.N., Tanaka, M., Catallo, C., Lebner, A.C., Friedman, M.K., Hanson, M.D., Freeman, C., Jack, S.M., Jamieson, E., MacMillan, H.L. (2009). *Are clinicians being prepared to care for abused women? A survey of health professional education in Ontario, Canada*. *BMC Medical Education*. 9(34).