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## Readiness of newly licensed associated degree registered nurses to screen for domestic violence

Theresa Wyatt<sup>a,\*</sup>, Molly L. McClelland<sup>a</sup>, Jo Spangaro<sup>b</sup><sup>a</sup> University of Detroit Mercy, 4001 W. McNichols Rd., Detroit, MI, 48221, USA<sup>b</sup> School of Social Sciences Ground Floor, Morven Brown Building, University of New South Wales, UNSW, Sydney, NSW, 2052, Australia

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## ABSTRACT

Lack of education and training have been identified as common barriers nurses experience in implementing domestic violence screening. The reasons for the barriers are poorly understood. Participants were interviewed to determine if and how they screen for domestic violence, which patients are screened, and how pre-licensure education and current workplace training has influenced this practice. An exploratory qualitative design guided by Constructivist Grounded Theory was used. Eligible participants were contacted via a social media and sixteen agreed to participate in the study. Individual interviews were conducted utilizing an open-ended interview guide. Data collection and analysis were done concurrently exploring factors influencing screening behaviors. Six themes emerged from the interview data: Preparedness, Discomfort, Taboo, Disenchantment, Presumptuous, and Evolving Realizations. These findings suggest nurses are not being taught about screening for domestic violence. Findings also suggested work environment and peers influenced if and how diligently nurses screened. The findings point to an interpersonal or intimate nature to screening for domestic violence that is unique and may require highly interactive training throughout pre-licensure education and work orientation.

## 1. Introduction

Intimate partner violence is a global health concern of pandemic proportion. The World Health Organization (WHO) recognizes that one in three women (35%) across the world will experience some type of physical or sexual violence in their lifetime (2013). An alarming finding is 38% of female homicides globally are committed by an intimate partner (World Health Organization, 2011). In the United States (U.S.), the National Intimate Partner and Sexual Violence (NIPSV) and Victimization of Sexual Orientation survey (VSO) mirrors these findings with one in three women (36%) having experienced intimate partner violence, including physical violence, rape and stalking (Black et al., 2011). One in four men (29%) reported experiences of physical or sexual violence from an intimate partner (Black et al., 2011).

On a global horizon, World Health Organization (2011) and the National Institute for Health and Care Excellence (NICE) (2014) recommend specialized training on intimate partner violence for health care providers on screening. Further, there expectation that healthcare providers will screen when risk factors and health conditions related to abuse are identified (World Health Organization, 2011). However, health care provider intimate partner violence screening rates across medical specialties remain low for women in the U.S. (Alvarez et al.,

2017; Alotaby et al., 2013; DeBoer et al., 2013; McCloskey et al., 2005; Klap et al., 2007; Waalen et al., 2000). Ellis (1999) conducted a foundational study on nurse-based barriers to screening for intimate partner violence that have been consistently replicated (Eustace et al., 2016; Baird et al., 2013, 2015; Sprague et al., 2012). These studies find the most commonly recognized barrier is the lack of education and training (Sprague et al., 2012; Hoke et al., 2008; Ellis, 1999). Specific to the United States, the Centers for Disease Control and Prevention (CDC) (2009), Joint Commission (2010), the American Medical Association (AMA) (1992), and American Nurses Association (ANA) (2000), all advocate screening for intimate partner violence, yet studies conducted with registered nurses suggests that pre-licensure programs rarely include intimate partner violence screening techniques in their curriculum (Connor et al., 2013; Tufts et al., 2009). The low screening rates may be the result of a lack of consistency between pre-licensure education and the expectation to screen once in practice, thus it is necessary to explore the factors that may influence the screening behavior of a registered nurse.

Accreditation standards for pre-licensure nursing education on intimate partner violence should involve specific instruction and training (American Association of Colleges of Nurses (AACN) (1999)), however, based on studies of registered nurses, the majority of U.S. accredited

\* Corresponding author.

E-mail addresses: [wyattr@udmercy.edu](mailto:wyattr@udmercy.edu) (T. Wyatt), [mcclelml@udmercy.edu](mailto:mcclelml@udmercy.edu) (M.L. McClelland), [j.spangaro@unsw.edu.au](mailto:j.spangaro@unsw.edu.au) (J. Spangaro).

schools are slow to integrate intimate partner violence related instruction into their curriculum (Bradbury-Jones and Broadhurst, 2015; Tufts et al., 2009) suggesting a disconnect between pre-licensure education and the expectation to screen once in practice (Connor et al., 2013; Tufts et al., 2009). Due to the interpersonal nature of assessing for intimate partner violence, studies focused on educational interventions for nurses suggest focused multi-layered training is needed beginning with pre-licensure nursing programs that continues once in practice (Hamberger et al., 2015; Miller et al., 2015). However, the findings from these educational intervention programs for intimate partner violence vary in content and delivery method yielding inconsistent outcomes for screening and identification of intimate partner violence indicating more exploration of educational intervention and training programs is warranted (Crombie et al., 2017; Clark et al., 2017; Hamberger et al., 2015; Miller et al., 2015; Yildiz et al., 2014).

### 1.1. Purpose

The purpose of this study was to identify if recently licensed associate degree prepared registered nurses screen for intimate partner violence, how they screen, which patients are screened, and how pre-licensure education and current workplace training has influenced these screening decisions and behaviors.

### 1.2. Background and significance

The NIPSV survey identified that 27% of women and 12% of men have experienced some form of physical violence at some point in their life (Breiding et al., 2011). Approximately 17% of women and 8% of men experienced some type of sexual violence by an intimate partner and 48% of women and 49% of men experienced psychological violence by an intimate partner (Breiding et al., 2011). In another study, 44% lesbian, 61% bisexual and 35% of heterosexual women, as well as 26% of gay men, 37% of bisexual men, and 29% of heterosexual men experienced rape, physical violence, or stalking in their lifetime (Black et al., 2011). In a global study on homicide (United Nations Office on Drugs and Crime, 2013), 38% of females and 5% of male homicides are associated with intimate partner violence. Additionally, 1 in 15 children live in homes where violence occurs between adults with nearly 90% of these children witnessing the violent acts (Black et al., 2011) placing them at high risk for physical and psychological injury (Breiding et al., 2011). Given the high prevalence of intimate partner violence, (Breiding et al., 2011; Black et al., 2011), it is likely that healthcare providers, specifically nurses, will encounter both victims and perpetrators. These individuals may be seeking routine care or treatment for acute or chronic conditions related to the acts of intimate partner violence such as depression, central nervous system symptoms, gastrointestinal symptoms, and anxiety (Bacchus et al., 2018; Dillion et al., 2013; Becker et al., 2010; Woods et al., 2008, 2010; Gerber et al., 2008) providing the ideal opportunity to screen and educate patients (AACN, 2015).

While the World Health Organization (2011), NICE (2014), CDC (2009), Joint Commission (2010), the AMA (1992), and ANA (2000) advocate screening for intimate partner violence, studies have consistently identified numerous barriers to screening women. These barriers include providers' perceived lack of time, lack of knowledge, education, or training, and inadequate resources for follow-up suggesting a disconnect between pre-licensure education and the expectation to screen once in practice (Sprague et al., 2012; Tufts et al., 2009). These barriers are important and foundational in efforts to increase and improve screening education and behaviors (Colarossie et al., 2010; Ellis, 1999). Research on barriers to screening men and same sex relationships are sorely lacking. Specific screening rates of nurses overall, or by specialty, are largely understudied. When evaluating the barriers to screening previously identified, understanding the where the lack of education and training barrier develops needs further

evaluation.

### 1.3. Nursing program accreditation

In the U.S, there are independent agencies responsible for providing accreditation for all levels of nursing instruction. In addition, there are several degree options for entry level nurses. A Licensed Practical Nurse has a limited scope of practice, for example, cannot assess, diagnose, or evaluate patient response to care, or give intravenous medications. There are two options for becoming a Registered Nurse in the U.S. A student can obtain an Associate's Degree in nursing in 2 years or a Bachelor's of Science in Nursing. (BSN) in 4 years. The BSN includes additional science and theory courses such as nursing research with the goal of emerging new leaders in the field of nursing. The Commission on Collegiate Nursing Education (CCNE) through the AACN accredits pre-licensure baccalaureate and above nursing programs while the Accreditation Commission for Education in Nursing (ACEN) accredits pre-licensure programs at the practical and associate's degree levels of nursing programs. While the AACN offers detailed recommendations for weaving intimate partner violence content throughout the curriculum via their website, the ACEN's most recent accreditation standards of 2017 notably lacks clarity on specific expectations for intimate partner violence teaching for associate's degree prepared nurses.

### 1.4. Competencies

The AACN published a comprehensive and progressive position statement on violence in 1999 identifying guidelines and standards for pre-licensure education and training for baccalaureate pre-licensure education on intimate partner violence that has yet to be updated. This statement on violence: *Competencies Necessary for Nurses to Provide High Quality* contains recommendations for training and instruction that includes background on intimate partner violence, assessment skills, interventions, cultural competence, prevention and clinical competency. The AACN guidelines include recommended competencies for each of the five categories, for example, scope of the problem includes prevalence, risk factors, long term consequences and exploration of the student's beliefs and attitudes regarding domestic violence (AACN, 1999). Identification and documentation competencies include education on appropriate screening questions, assessment for physical abuse, child abuse, elder abuse and proper documentation of physical injuries (AACN, 1999). Education for interventions includes knowledge of local, state and national resources, communication techniques, and appropriate referrals. Topics for competencies on ethical, legal and cultural issues comprise of mandatory reporting responsibilities, collecting and documentation of evidence, and exploring ethical principles. Finally, prevention includes increasing public awareness and encourage behavioral change for both victims and perpetrators with a focus on population at risk (AACN, 1999).

Accreditation standards from the ACEN are available via their website covering multiple levels of instruction including associate's and baccalaureate degree programs, recently reviewed and revised for 2017. The ACEN standards are divided into six sections covering topics such as the mission and administrative capacity of the program, faculty and staff, students, student needs and program outcomes, curriculum, financial, physical and learning resources and evaluations. These standards are ambiguous and offer little towards specific curriculum or topic content, however, the 2017 revisions have progressed to include an evaluation of the end of program student learning outcome with an expectation of measurable levels of achievement.

In addition to the ANA and AACN's recommendations, resources are available through a variety of organizations to assist with weaving intimate partner violence training throughout nursing curriculum such as International Association of Forensic Nurses (IAFN), Family Violence Prevention Fund (FVPPF), Institute of Medicine (IOM) NICE (2014) and World Health Organization (World Health Organization, 2011) (Tufts

et al., 2009). However, nurses report lack of training for intimate partner violence in pre-licensure education that suggests accredited schools have yet to intentionally integrate intimate partner violence related instruction into their curriculum (Connor et al., 2013; Tufts et al., 2009). This study focused on newly registered nurses and explored their perception of education and training for intimate partner violence throughout pre-licensure education and initial post-graduation workplace orientation/training and its impact on screening behaviors. Thus, focus of this study was examining when or how the lack of education and training barrier develops.

## 2. Methods

The Medical University of South Carolina's Institutional Review Board approved this qualitative exploratory study. Data collection and analysis were done concurrently exploring factors influencing screening behaviors of registered nurses. Constructivist Grounded Theory (CGT) was chosen because this study focused on communication between patient and nurse and explored the nurse screening, components consistent with CGT constructs (Charmaz, 2014; Lingard et al., 2008). This approach provided the opportunity to understand how participants create meanings during the dialogue. The participants were encouraged to elaborate using prompts such as “why do you think that is” or “what do you mean by that”, to learn how and why they screened for DV.

### 2.1. Design

This qualitative exploratory study designed to understand the education on domestic violence content in pre-licensure programs, utilized open-ended questions to allow exploration of the participants' individual thoughts, experiences, and activities that may influence their decision on screening behaviors. Individual interviews were coded and subsequently analyzed supported by memoing.

### 2.2. Participants

Sixteen participants (n = 16) were included in the study. Specialized websites, including Facebook pages specific for nurses and Allnurses.com, were utilized for recruitment of this purposive sample. A systematic review by Whittaker, Stevelink, and Fear (2017) suggests social media, specifically Facebook, is being used successfully to recruit participants. An Institutional Review Board approved invitation was posted on Facebook to participate in a study to learn more about the various assessments taught during their nursing program education and which assessments they now perform as newly licensed registered nurses. The invite was frequently shared by approximately 30 recently graduated nurses in a large metropolitan area. Potential participants could message through Facebook, call, or email the principal investigator. Participants were limited to English speaking nurses living in the United States with registered nurse licenses granted between January 1, 2015 and March 15, 2016. Verbal consent was obtained prior to conducting interviews. All interviews occurred via telephone. Inclusion in a gift-card drawing was used as an incentive for participation.

The majority of nurses (n = 12) obtained their registered nurse license four months or less with four obtaining their licenses between twelve and sixteen months prior to participating in the study. All of the participants were female, most (n = 12) were white with a mean age of 32. Ten of these nurses were working in specialty areas such as emergency department, stepdown, or intensive care unit.

### 2.3. Data analysis

All interviews were digitally recorded and professionally transcribed. Saturation was achieved at an N = 16 when no new codes and themes were identified, thus further interviews were deemed

unnecessary. All interviews remained anonymous and no identifying information were included to ensure confidentiality of participants. Trustworthiness was demonstrated in several ways. Credibility was achieved through the PI's experience as a registered nurse providing fluency with the nursing language of the participants'. The PI kept in frequent communication with the expert in qualitative methods regarding collection of data, analysis of data and emerging themes and final themes. Dependability was established through reviewers experienced in qualitative analysis confirming the emerging like group, categories as well as core categories. Findings from this study may serve as a foundation for future studies which establishes transferability.

The coding process began with reading the transcripts and coding words and phrases used by the participants. All sixteen interviews were continuously compared using detailed line by line coding. Like groups were then placed into common categories. Continuous analysis occurred producing 16 subcategories emerging from the common categories (Charmaz, 2014). Initially eight themes were identified from the subcategories. After further analysis, 2 themes were combined to create *Preparedness*, and one theme was eliminated as the codes were recognized to belong under existing themes. This process resulted in five themes and one overarching theme that was verified by expert reviewers in qualitative methods.

### 2.4. Findings

Through the interviews, the participants shared their experiences in pre-licensure education for intimate partner violence content as well as any intimate partner violence content covered during hospital orientation. For example, several participants admitted to ‘just checking boxes’ for screening for intimate partner violence in their practice even though a verbal communication had not occurred between the nurse and patient. The practice of *assuming without assessment* was then defended by statements indicating the nurses witnessed their colleagues screening this way, however, the majority of participants also indicated they have never witnessed a preceptor, nurse educator, or colleague screen a patient for intimate partner violence. Many of these nurses implied they would know when to screen and spoke with confidence regarding their instinctive or intuitive abilities to know when a patient will need to be screened for intimate partner violence admitting to only screening when there was a suspicion of abuse present.

A progression of developing themes emerged from the interviews: *Preparedness*, *Discomfort*, *Taboo*, *Disenchantment*, *Presumptuous*, and *Evolving Realizations*. *Preparedness* reflected thoughts on the participant instruction and education from pre-licensure and hospital orientation experiences. *Discomfort* focused specifically on the act of screening for intimate partner violence and participants frequently described the act of screening as uncomfortable. *Taboo* emerged early on as participants identified intimate partner violence as a topic not discussed, specifically described the topic of intimate partner violence and screening as a taboo topic. *Disenchantment* resulted from reality of the actual nursing practice (compared to nursing student experiences) and influences by actions and interactions with experienced colleagues. *Presumptuous* is a theme surrounding a confident intuition of *knowing* when to screen for intimate partner violence despite lack of education or training towards that end. All the preceding led to the overarching theme *Evolving Realizations* defined as developing a ‘truth’ where a gap in knowledge exists and may be the birth of the barrier *lack of education and training*. Table 1 is a sampling of data for each theme.

### 2.5. Preparedness

The nurses had poor recall of the pre-licensure education despite completing their degree within four to sixteen months of the interview. The participants had better recall of which courses intimate partner violence was taught in rather than the specific content taught. Hospital orientation only involved identifying the mandatory field for

**Table 1**  
Sampling of Data per Theme.

Preparedness	Discomfort	Taboo	Disenchanted	Presumptuous	Evolving Realizations
<p>From what I remember, the domestic violence thing was incorporated as a sidebar from the physical act of nursing.</p> <p>I think it could've been incorporated within all of the classes. That way there was a constant flow of information. It was something that wasn't just like, "Today we're going to learn about domestic violence and then done."</p> <p>They told us to look for signs, I can't remember all since I don't work in that population anymore</p> <p>I feel ... I don't know how to go about asking them. And then they sent Me off... open your wings</p> <p>But, I think the best teaching tools are people who have been there and have done that, in that sense. You know, somebody who was a patient, who was a victim of violence. I mean, you know, these were my responses, this is how I reacted to this trauma, and I met other people who reacted this way. And then doing more of a role play for that situation.</p> <p>I think it would've been nice to have been able to learn how to have a conversation with them about domestic violence as opposed to just asking them about it.</p> <p>Nobody's had proper training and nobody gets reeducated on it.</p> <p>Maybe the educators weren't educated about it. So, they didn't feel the need to pass it onto us. Or because it's not part of the curriculum that they need to teach in that amount of time.</p>	<p>You know, just seeing how it's presented, because they are uncomfortable questions. You're probing into someone's life</p> <p>Still feel awkward asking and need to work on.</p> <p>We ask questions but we don't really, those are questions, we aren't really getting eye contact too</p> <p>I think it's when you say sexually it kind of gets a little infinite. So I mean I would still ask it, but I think it's maybe not as likely.</p> <p>it's a touchy subject in people. I know sometimes when I'm asking patients that question you feel like you're crossing that line into very personal.</p> <p>I've been a nurse for what? Since February, March, three months now and I still feel uncomfortable asking those questions. They are very uncomfortable questions to ask I said, I'm sorry I have to ask you these questions. And he was more comfortable answering them than I was giving them.</p> <p>You know because with anything or information it's a matter of practicing it before you get comfortable</p>	<p>I know people want to not acknowledge it's happening or don't know how to do it properly, to be honest with you.</p> <p>It's not what they're initially coming there for it's not talked about</p> <p>But they're just afraid of the repercussions if they open up a can of worms</p> <p>In the hospital it's a very taboo thing to talk about, because it's a small hospital, they do have a lot of times where they know their patients outside of the hospital Clinician-wise, physicians, nurses, case management, social work. I think it needs to change where we're the – the healthcare workers aren't scared to talk about it.</p> <p>I know people want to not acknowledge it's happening or don't know how to do it properly, to be honest with you.</p> <p>But I think it's a topic that is, they stay away from</p> <p>They just give you a card, and a folder along with all the cards and stuff. But they don't talk about it.</p>	<p>You can't fully do your job, and I've actually addressed that with my clinical, my educator and I said you it's just like "you're in and out"</p> <p>I think, I'm just clicking no and I'm, you know, just falling into the regime of the other nurses when I shouldn't be and it's not hard to just ask the initial question 'how safe do you feel in your home'</p> <p>I've seen a couple of patients that when they say something it's almost dismissed. The nurses I've seen aren't really taking it to the next step. I think that needs to be changed.</p> <p>I think they're more focused on the cardiac issue and not the patient as a whole. And I see the patient as a whole.</p> <p>But it's kind of disconcerting that everything we learned in school about background of patients and observing and looking for little signs and things like that isn't – I haven't seen it being done on the floor yet.</p>	<p>Now I don't even make it a part of my assessment anymore because I've, in the routine and I'm just gonna click no because I feel like there's nothing going on, that's just the vibe that I'm getting.</p> <p>I'm always looking and listening and seeing how my patients interact with their family, and people that are visiting them but I'm not asking them questions</p> <p>I remember that and just looking for cues. Maybe they're afraid to say anything.</p> <p>it's kind of more of a feeling for me</p> <p>I really specifically focus on any young woman that comes in, especially if they're alone or they seem anxious or really worried about what's going on at home</p> <p>So most nurses do ask those questions when the patient is able to verbalize. If they're not, we just kinda have to use our judgment.</p> <p>you can kind of tell by a person's demeanor and what's their reaction when they're answering questions and based on how maybe honest they are or how fearful they are.</p> <p>I guess I go with my instinct, too. But I guess it comes to you kind of, like, can tell, too. I don't know. It's, like, you never assume, but you can tell. They've got tension right there, and you feel like something is not right</p>	<p>There's more people that go through the abuse without the marks, but it's harder to find, but we're not asking the right questions.</p> <p>The person on the wrong end that's doing the abuse, they'll probably be more open to expressing they're being abused if they feel like they trust the nurse.</p> <p>Cause some people probably don't seem like they've had domestic violence, but they probably do. I think everybody should be screened for that. Like, routine.</p> <p>If there is fear in the patient is a really big indicator.</p> <p>Usually it's pretty obvious, cause usually it's – the most common thing is a crazy amount of bedsores. That's the most common thing.</p> <p>I always assume it's the demographics, too, that we deal with at the hospital.</p> <p>I have my own rule. My personal rule is to kick everyone out. And I usually put it on IVs and things like that.</p> <p>We do have to screen every patient but mostly through the prenatal forms we get because we get those before they come to the hospital. We look through those before they show up or right when they get there. If there is anything in there that is suspicious like lack of prenatal care or they didn't ever show up to their appointment or always reschedule or if the office</p>

(continued on next page)

Table 1 (continued)

Preparedness	Discomfort	Taboo	Disenchanted	Presumptuous	Evolving Realizations
They're supposed to provide us one to 2 h introduction of how to screen patients, in case we have patients who have experienced domestic violence. I think that would be helpful for us. We never touch on any information about domestic violence	I feel like it's not comfortable to ask my patients – If I'm doing the screening – You know, if I'm meeting patients, I have to still ask them if they are safe at home or are their partners abusing them physically or emotionally.	Talking about it, because we never talked about it and we never brought it up	I think, sometimes the newer nurses will try to – I just think have more compassion	And we also kind of like assess the patient when they answer right away. You know, you kind of, like, look at them and see if they hesitate an answer or if they're giving you – I guess a certain way of answering, you can kind of tell	flagged anything or if they had any concerns, I would go into more. If not I would just do a general assessment on them. Mostly because it's not maybe it's not considered a medical problem that someone comes to the hospital for, I guess, you know. It's not as important as what they're coming in for.

documentation of intimate partner violence screening, not on specific intimate partner violence content or on the act of screening. Considering the abundance of possibilities for mentoring from clinical instructors and preceptors, only one of the sixteen nurses has witnessed another nurse screen for intimate partner violence. Some participant language that led to identification of Preparedness include:

“I think the biggest thing is it's really not touched a lot in school, at least maybe at my level in the associate's field. It's just an associates [degree]”

“I don't know if they talk about it more the further you go on in your nursing career, but I don't feel that it was touched”

“But, I've never heard a preceptor ever ask a patient.”

“I don't recall any questions geared toward training for interviews”

Although, the nurses frequently identified a lack of education and training, they were clear on how intimate partner violence training should occur.

“I feel maybe just doing a mock assessment with your own classmates, just setting a scenario where the patient, quote unquote patient in that scenario where they are being abused or they don't feel safe at home and give someone else a role as the person that is abusing them in the class room setting and go through that and practice ways on how to get the family member out of the room or how to ask the patient, that way you have at least seen it kind of before you go into the real setting.”

“I think it could've been incorporated within all of the classes. That way there was a constant flow of information. It was something that wasn't just like, "Today we're going to learn about domestic violence and then done.”

“But I think the best teaching tools are people who have been there and have done that, in that sense. You know, somebody who was a patient, who was a victim of violence.”

2.6. Discomfort

This theme emerged early on during conversation as well as in the data collection and analysis. There are many skills and assessments taught in pre-licensure education that are uncomfortable in the beginning stages of learning, for example inserting a Foley catheter, but quickly becomes routine with repetition. The act of screening for intimate partner violence was often described as uncomfortable and participants identified that the act of screening does become easier over time, however, still uncomfortable to perform. Participant language the led to the development of *discomfort* include:

“I feel like it's not comfortable to ask my patients – If I'm doing the screening – You know, if I'm meeting patients, I have to still ask them if they are safe at home or are their partners abusing them physically or emotionally.”

“I've never had anybody say yes. I think maybe when you find that one person that needs that help, you'll know you're doing the right thing and put your un- comfort aside and know you're really helping somebody.”

“I feel like it's still an uncomfortable situation.”

2.7. Taboo

Taboo, a theme that emerged early in data collection and analysis and quickly reached saturation. The nurses referred to the topic of intimate partner violence as if it was forbidden, a dark secret, or something that is not discussed. Through conversation, these nurses

explained that intimate partner violence is not taught in school or the workplace, it is an unpleasant subject to talk about and screen for and language used by these participants commonly acknowledged that *no one* is talking about it. Specific language from the participants that lead to the development of taboo includes:

“I know people want to not acknowledge it's happening”

“That's a taboo topic so many people talk don't about it.”

“It's a touchy subject in people. I know sometimes when I'm asking patients that question you feel like you're crossing that line into very personal.”

### 2.8. Disenchantment

These nurses did not receive consistent education or training on intimate partner violence or how to screen. As the nurses enter into the practice, they become overwhelmed with reality, the ‘reality’ of short staffing such as shortened orientations and high nurse to patient ratios, time constraints, inconsistency with multiple preceptors, early ‘charge’ duties, and differences in practice among colleagues. Through the interviews, the nurses revealed they had become disenchanting when the idealism of school is not found in practice. The statements below led to the development of this theme.

“It's actually having the time to ask that question.”

“Maybe the educators weren't educated about it. So, they didn't feel the need to pass it on to us. Or because it's not part of the curriculum that they need to teach in that amount of time”

“Just the personalities in nurses. Some of them are more open to talking to their patients and some of them are just aren't”

“I think that all they care is paperwork. And that's what frustrates me the most.”

### 2.9. Presumptuous

During the interview process, the nurses were asked if they screen every patient.

Most of these participants spoke confidently and used language suggestive of an intuition or instinctive ability to know when to screen patients for intimate partner violence as if victims of abuse is easily identifiable, despite disclosing the absence of education on this phenomenon during the same interview.

“And luckily, I feel like I have good instinct for that, but I have several nurses that I work with who graduated around the same time or after I did, who don't have those instincts”

“I don't know. It's, like, you never assume, but you can tell. They've got tension right there, and you feel like something is not right.”

“Cause some people probably don't seem like they've had domestic violence, but they probably do”

“But my gut instinct has been right every time”

These findings are supported by a study of emergency room nurses who reported using the demeanor of the patient to assist with identifying the need to screen for DV (Robinson, 2010), which may not always be indicative of the presence or absence of abuse.

### 2.10. Overarching theme: Evolving Realizations

The final theme to emerge from the five preceding themes and encompassed the entire Study is *Evolving Realizations*. The nurses shared thoughts and viewpoints as a ‘truth’ that might have been developed in an effort to form knowledge where a gap existed. These statements

seem to be created from snippets of information combined from many different sources, some being accurate such as screen in private, others provided a narrowed or incorrect view of the dynamics of intimate partner violence such as victims are easily identified by presenting with obvious signs or symptoms of abuse. Participants language helping to validate the final overarching theme are as follows:

“Screening for domestic violence is a sidebar to the physical act of nursing”

“If there is fear in the patient is a really big indicator”.

“The stories didn't go with the physical assessment and most of the time when there's a question, case management gets involved or social work gets involved; so it's immediately directed to social work. Then, that's kind of the end of it with us.

“I always assume it's the demographics, too, that we deal with at the hospital.”

“And 90 percent of the people that I admit I don't even ask because they're very – well, I'm just here because I've got cellulitis, I cut my arm while I was at work and now I gotta be here on IV antibiotics, you know”

## 3. Discussion

It's notable that of the six themes, there are two, *Taboo and Discomfort*, dedicated to the general lack of discussion about on intimate partner violence or the difficulty experienced by nurses when attempting to screen patients for intimate partner violence. These themes emerged through the nurse's words more subtly during conversation, for example, when several participants confessed to ‘checking boxes’ when they had not verbally screened the patient. The implications of checking boxes after just observing the patient are concerning for patient safety. Further elaboration by the nurses revealed this may be due, in part, the burden of completing this section of the electronic medical record out of compliance rather than patient safety. This may also provide an inaccurate view of screening activities during chart audits or retrospective reviews for compliance and research, thereby, warranting further exploration.

The theme of *Presumptuous* was an early evolving theme and is heavily influenced by data used to form the *Evolving Realizations* theme. The nurses spoke with confidence regarding their instinctive or intuitive abilities to know when a patient will need to be screened for intimate partner violence based on the ‘truths’ they held firm. The majority of nurses only screen new admissions which aligned with the expectation of their floor or unit. A few admitted to screening outside of the admission process but only when they ‘had a feeling’ something wasn't right. Much has been written in regards to nursing intuition specifically as an advanced skill, requiring education, and years of hands-on experience (Benner, 2001; Rew and Barrow, 2007; Green, 2012). According to Benner (2001), a nurse progresses through five stages of growth. An individual is considered a *novice* while in nursing school progressing to *advanced beginner* as a graduate nurse requiring 2–3 years in a consistent environment to be considered *competent* (Benner, 2001). The next stage is *proficient* requiring 3–5 years of clinical experience followed by *expert* (Benner, 2001). It is at the expert level where the nurse has an “intuitive grasp” (Benner, 2001, p 32) of a situation that is based on years of experience. By the very nature of Benner's (2001) definition, it is not possible for these nurses to be intuitive, in particular, just after describing the lack of education and training received on intimate partner violence or how to screen. Further research is needed to explore this phenomenon and its influence on screening behaviors and barrier development.

The overarching theme, *Evolving Realization* was heavily influenced by the five preceding themes and impacted the screening behaviors of the participants. Some participants noted that intimate partner violence

was “briefly touched on in education” which technically meets the ACEN guidelines, however, the instruction was likely minimal and ineffective based on the poor recall of content which is consistent with earlier studies (Bradbury-Jones and Broadhurst, 2015; Tufts et al., 2009) suggestive that further research and guidelines are needed. As a result of their perceived lack of education and training, this small sample of nurses essentially became products of their work environment. These participants commonly acknowledged that screening is an expectation of their job, however, if and how diligently they screened was greatly influenced by their peers and the *Evolving Realizations* professed during the interviews, although further exploration of this phenomenon is needed.

Every participant had specific and strong recommendations on how to better prepare nurses for screening for intimate partner violence that centered on one premise: hands on learning. As the participants made specific recommendations, these were often associated with the *Discomfort* theme suggestive of a connection between actively performing this very interpersonal task and an increased comfort level. Many of the recommendations included role play, simulation, mentored learning in the clinical setting, and learn to screen with previous victims of intimate partner violence. Several participants questioned the possible lack of knowledge and skill level of faculty and its direct impact on their learning that has been identified in previous studies (Tufts et al., 2009). These recommendations are suggestive that pre-licensure education on intimate partner violence is unique and interpersonal in nature and likely needs to be included throughout their pre-licensure education and highly be interactive. This also requires nurse educators to be well prepared and comfortable teaching intimate partner violence which is an area of study that requires further exploration.

Existing studies recognize the need for improved and increased education and training across the nursing profession, beginning with nursing faculty teaching at pre-licensure level (Connor et al., 2013; Beccaria et al., 2013; Tufts et al., 2009), as well as currently active registered nurses and in pre-licensure education. According to the AACN (2015), the age range of doctorally prepared faculty is 51–62 years of age and for master's prepared faculty is 51–57 years of age. It is likely this group of faculty completed their baccalaureate education well before the AACN's guidelines on violence were published in 1999. This places responsibility on the individual nurse educator to obtain intimate partner violence instruction. With the strong recommendations of interactive and hands on learning by nurses and the lack of discussion on this topic, where nursing faculty obtain education and training on intimate partner violence needs to be considered and researched.

### 3.1. Limitations

Several limitations are identified. A geographical limitation with a small sample ( $n = 16$ ) from one large metropolitan area limits the findings from being generalized to nurses in other states. The sample was 100% female and 70% white, which may not represent the new licensed nurses as a group. In addition, the sample was 100% Associated Degree prepared thus preventing findings from being generalized to BSN graduates who have more training. Finally, the use of social media may have biased the sampling to those who specifically use and trust this media to share contact information.

## 4. Conclusion

Acknowledging the limitations of the small study within one large metropolitan area, this data reveals a possible gap in current nursing education practice regarding the implementation of both screening and intervention guidelines in the area of intimate partner violence for pre-licensure nursing students. Further, it is suggestive of the need to examine healthcare workplace education regarding the need for screening for intimate partner violence among all patients, including males and

individuals in same sex relationships. Clearly, further research is needed in this critical area.

In order to improve the educational presentation of intimate partner violence in pre-licensure programs, there is a need to review current national guidelines alongside accreditation requirements and develop standard coursework, possibly with the use of a layered simulation experience, to embed intimate partner violence content within other scenarios so that student's or practicing nurses' assumptions that they can intuitively identify victims of intimate partner violence can be confronted. In a professional nursing course or through orientation and yearly in-service, students' and practicing nurses could develop strategies to confront colleagues or managers who do not support taking the time to screen for intimate partner violence. Further research is needed in this area to design the best way to present this content, as well as to verify the results of this study through a national survey of practicing nurses by a national nursing organization such as American Nurses Association. With the staggering increase in intimate partner violence and its effects on the health of individuals, families, communities and our nation, nursing and health educators need to begin these initiatives and research now.

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