


**ORIGINAL RESEARCH:
EMPIRICAL RESEARCH - QUALITATIVE**

A qualitative content analysis of nurses' perceptions about readiness to manage intimate partner violence

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Abstract

Aims: To explore the perceptions of nurses on the factors that influence their readiness to manage intimate partner violence (IPV) in Spain.

Design: Qualitative content analysis based on data from six different regions in Spain (Murcia, Region of Valencia, Castile and Leon, Cantabria, Catalonia, Aragon) collected between 2014 and 2016.

Methods: 37 personal interviews were carried out with nurses from 27 primary health care (PHC) centres and 10 hospitals. We followed the consolidated criteria for reporting qualitative research guidelines. Qualitative content analysis was supported by Atlas.ti and OpenCode.

Results: The results are organised into four categories corresponding to (1) acknowledging IPV as a health issue. An ongoing process; (2) the Spanish healthcare system and PHC service: a favourable space to address IPV although with some limitations; (3) nurses as a key figure for IPV in coordinated care and (4) factors involved in nurses' autonomy in their response to IPV, with their respective subcategories.

Conclusion: In practice, nurses perceive responding to IPV as a personal choice, despite the institutional mandate to address IPV as a health issue. There is a need to increase continuous training and ensure IPV is included in the curriculum in university nursing undergraduate degrees, by disseminating the existing IPV protocols. Furthermore, coordination between healthcare professionals needs to be improved in terms of all levels of care and with other institutions.

KEYWORDS

intimate partner violence, nursing, primary health care, qualitative research, Spain

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1 | INTRODUCTION

Intimate partner violence (IPV) is defined as any conduct by current or former intimate partners that results in physical, sexual or psychological trauma, including physical aggression, sexual coercion, psychological abuse and controlling behaviour (World Health Organization, 2010). In heterosexual relationships, women are more frequently exposed to IPV and the abuse tends to be more severe, placing them at a higher risk of being killed by their male partners. This affects all demographic, ethnic, cultural and economic groups (Keeling & Mason, 2008). Worldwide it is estimated that around 30% of women will be victims of IPV in their lifetime (World Health Organization, 2013a, 2013b).

Intimate partner violence is a global public health problem due to its magnitude, health risk and impact on health services (World Health Organization, 2013a, 2013b). IPV not only results in acute physical injuries and chronic physical problems but also significantly impacts victims' psychological and emotional well-being. This can lead to problems such as post-traumatic stress disorder, depression, smoking, substance abuse and even suicide (Humphreys & Campbell, 2010). Many afflictions associated with stress are highly reported among IPV victims. These can include headaches, sleeping disorders, neuromuscular pain, hypertension and a compromised immune system resulting in more viral and bacterial infections, including those of a sexual nature (Humphreys & Campbell, 2010). Women suffering IPV are also more probably to experience unwanted pregnancies compared with women who do not experience IPV (World Health Organization, 2013a, 2013b). IPV does not only affect the victim but also their children. Children who witness IPV at home are more probably to suffer from psychological, emotional and behavioural problems, as well as being at a higher risk of becoming victims of child abuse, and when they are adults they are more probably to become perpetrators or victims of IPV (Geffner et al., 2003; Humphreys & Campbell, 2010).

As a result of all the long-term health consequences, women suffering IPV tend to use health services more when compared with women not suffering IPV especially Primary Health Care (PHC), Mental Health, and Emergency services (Black, 2011). Nurses could contribute to identifying cases of IPV since PHC centres and emergency services are often the first and only service where victims go (Alshammari et al., 2018; Garcia-Moreno et al., 2014; World Health Organization, 2013a, 2013b). PHC centres are the point of entry to health services and are run by multidisciplinary teams including doctors, paediatricians, midwives, social workers and nurses (OECD/European Observatory on Health Systems & Policies, 2019). PHC nurses could also prevent IPV through educational or community interventions (Ellsberg et al., 2015; Pérez García & Manzano Felipe, 2014).

Since 2004, there is a specific regulation in Spain against gender-based violence, including IPV. It includes multi-sectorial comprehensive measures intended to protect and care for female victims of IPV and their children, increasing the scope from legal and judicial sectors to health, education and civil society. Spanish Law reflects the need

Impact statement

- **What problem did the study address?** Intimate partner violence (IPV) is a public health problem. The position nurses have in health care make them the ideal candidates to support women exposed to IPV. They have the opportunity to respond to IPV, whether in routine checks, treating injuries or caring for chronic health problems due to exposure to constant violence.
- **What were the main findings?** In practice, nurses perceive responding to IPV as a personal choice, despite the institutional mandate to address IPV as a health issue. Motivation and suitable working conditions are essential to develop better responses for women suffering IPV.
- **Where and on whom will the research have impact?** Training in IPV would increase nurses' sense of self-efficacy, screening frequency and detection rates. Motivation and determination are essential to develop better responses to women suffering IPV.

to train health professionals to respond to IPV, including prevention, early detection and intervention in coordination (Organic Law 1/2004, of 28th December, on Comprehensive Protection Measures against Gender-based Violence, 2004). Steps taken towards this included developing IPV protocols and guidelines, providing IPV training for health professionals and introducing systems for IPV monitoring and assessment. The National Health System Portfolio of Common Services (regulated by Royal Decree 1030/2006) includes detecting and assisting IPV victims as part of health professionals' responsibility (Official Bulletin of the State, 2006). Since 2007, a common protocol for action against gender-based violence offers a standardised guideline for health professionals to respond to IPV (updated in 2012; Ministry of Health, Social Services, & Equality, 2012).

1.1 | Background

Spain has introduced several high-level interventions to identify IPV in the health context. These include the Spanish law, comprehensive protection measures against gender-based violence, the national health system portfolio of common services and a common protocol for health action against gender-based violence. Unfortunately, the number of identified IPV cases in health facilities is still low (Rodríguez-Blanes et al., 2017). Several studies have analysed the different aspects of the Spanish health system's response to IPV (Goicolea, Briones-Vozmediano, et al., 2013; Goicolea, Vives-Cases, et al., 2013; Murillo et al., 2018; Rodríguez-Blanes, 2017). These studies indicated that IPV is not considered a health problem by all health professionals, neither is it a priority

TABLE 1 Description of participants and data collection

	Regions	Year	Interviews	Hospital	PHC	Women	Men
	Murcia, Cantabria, Castile and Leon, Valencian region	2014	12	0	12	9	3
	Catalonia, Aragon	2016	25	10	15	23	2
Total	6		44	10	27	37	7

to identify and treat victims in their daily routines. This reality worsened with the economic crisis and the reduction of investment in health professional training. Research shows that health professionals often fail to identify IPV and when they do, their response can be negative, inappropriate or even harmful (Humphreys & Campbell, 2010; Liebschutz et al., 2008). An emotional burden to support and protect IPV victims could lead nurses to distance themselves from them as a means of emotional self-protection (Christensen et al., 2021).

Nurses' competencies, attitudes, beliefs, and behaviours towards IPV influence how they respond to IPV (Jakovenko, 2021; Li et al., 2021). Their position makes them the ideal candidates to support women exposed to IPV. They have the opportunity to respond to IPV, whether through routine checks, treating IPV injuries or caring for chronic health problems due to constant violence (Alshammari et al., 2018; Beccaria et al., 2013; Humphreys & Campbell, 2010; Tufts et al., 2009). Nevertheless, studies conducted in other countries indicate that despite a growing awareness of IPV, there is a low level of knowledge and preparation to respond to IPV among nurses (Li et al., 2021). They do not usually feel they have received sufficient training or have enough time to address the needs of women IPV victims (Beccaria et al., 2013; Visentin et al., 2015). Literature indicates that nurses receive limited undergraduate and professional training to identify and deal with IPV in practice, for example, related to communication skills (Alshammari et al., 2018; Silva et al., 2021). In particular, not knowing how to ask women about the situation, how to act and what are the existing resources with which to coordinate. An effective solution to support IPV victims cannot be achieved without knowledge and practice from different disciplines and sectors such as the police, NGOs, shelters, psychology, public health, social work, and/or criminology (Li et al., 2021; Garcia-Moreno et al., 2014). However, there is an evident connection between the training and preparation nurses receive, and recent IPV training reported increased confidence to address IPV in a clinical environment (Hooker et al., 2021; Jack et al., 2021). A deeper understanding of Spanish nurses' perceived readiness to respond to IPV may help to identify the measures needed to improve the amount of IPV cases being handled.

2 | THE STUDY

2.1 | Aims

The aim of this study was to explore the perceptions of nurses on factors that influence their readiness to manage IPV in Spain.

2.2 | Setting

This research was set in 27 PHC centres and 10 hospitals across six regions of Spain. The Spanish national health system is decentralised in 17 regions.

2.3 | Design

A qualitative study was conducted with 37 interviews with nurses working in 27 PHC centres and 10 hospitals, in six Spanish regions between 2014 and 2016 (Table 1). The first 12 interviews were conducted in 2014 in four Spanish regions, as part of a wider research project exploring the process of integration of the response to IPV in PHC with different health professionals (physicians, social workers, nurses, midwives, paediatricians, etc.; Goicolea et al., 2015). Nurses' response was not the primary focus of the data collection process, nor the analysis. To gain more insight into their experiences and perceptions, 25 additional interviews were conducted with PHC and specialised care nurses following the same interview guide. Two additional regions were added to the scope in 2016.

2.4 | Participants

A total of 37 interviews were held with nurses (Table 1). In the first phase (2014), professionals with different backgrounds from 12 PHC centres in four different regions were invited to participate in meetings held in each PHC centre to introduce the project. Health professionals were encouraged to participate as volunteers in the interviews. 12 interviews with nurses were analysed for this phase.

In the second phase in 2016, 25 additional nurses were interviewed. They worked in 15 PHC centres and 10 hospitals in two other regions. Firstly, four nurses (two working in PHC centres and two in hospitals, two per region) were purposely selected as key informants due to their role as IPV coordinators in their centres. They were invited to participate in face-to-face interviews. Other potential participants were recommended by means of the snowball technique and their contact details (email or telephone number) were provided to the authors who invited them to take part. This process was repeated with each of the interviewees until data saturation was reached. In both data collection phases, the only inclusion criteria were being a nurse in the public Spanish national health system.

2.5 | Data collection

Data were collected using a semi-structured interview technique to guide the interviews, allowing new aspects to emerge during the interviews. The interview guide of the first project included questions on the perceptions of the PHC team's response to IPV, how IPV had been included in teamwork, relationships in teams, the different degrees of individual involvement in IPV, academic training received on IPV, their reflections on possible barriers and proposals for improvement to generate an adequate response. This guide was applied to the interviews conducted in the second phase and only one new question related to the role of the nurse in IPV response was added. Between 2014 and 2016, four of the authors (EBV, LOG, MGQ and MGS) held face-to-face interviews in Spanish in clinical settings (in private). Interviews lasted between 30 and 60 min and were recorded and transcribed verbatim.

2.6 | Ethical considerations

Ethics approval for the original research project was granted by the Ethical Committee of the University of Alicante in Spain. Prior to each interview, signed informed consent was obtained. They were also advised that their participation was anonymous and voluntary and that they could withdraw at any stage. Authors followed the COREQ guideline to conduct qualitative research.

2.7 | Data analysis

Interviews with nurses conducted during the first phase of data collection were previously analysed together with the rest of the interviews held with health professionals to explore the mechanisms that trigger an appropriate IPV response (Goicolea et al., 2015), PHC attributes and (Goicolea et al., 2017) the response during the economic crisis (Otero-García et al., 2018). A new qualitative content analysis of all the interviews conducted during the first and second phases was conducted following the Graneheim and Lundman method (2004), focusing specifically on nurses. By using Open Code 4.03 and Atlas-ti.8, four researchers (EBV, LOG, SDF and MGS) read each interview thoroughly and open coded data extracts. The codes were then grouped into categories according to their similarity. The next step involved comparing similarities and differences in the analysis to reach consensus on the final identified categories. They were refined, discussed and negotiated among the research team until the final categories were decided. Representative quotes were chosen and translated into English.

2.8 | Rigour

This study explored Spanish nurses' perceptions on responding to IPV using data collected at two different moments. The second data collection was specifically developed from the experience of

the first one to delve into aspects that might have been missed in the first project. Data of more health professionals were analysed altogether and data of PHC nurses were triangulated with nurses working in hospital settings. Data saturation was reached and this increased the transferability and trustworthiness of the findings (Lincoln & Guba, 1985).

To assure trustworthiness in qualitative research, triangulation took place through peer debriefings among the research team and by including different profiles and perspectives (insider and outsider) in the research process. Five of the authors participated in the original data collection process, all of which had broad experience in qualitative research. All the authors also had experience participating in research projects on IPV.

An inductive and emergent design characterised the research process. This allowed categories to emerge from the phenomenon as opposed to making the data fit into pre-established themes or theoretical models. The categories themselves went through a process of constant refinement based on what emerged in the transcripts and as a result of peer debriefings. Finally, quotes extracted from the interviews were used to illustrate our conclusions to ensure that the results stem from the data and not from our preconceptions (Dahlgren et al., 2007).

3 | FINDINGS

The 37 study participants (32 women and five men) work at 27 PHC centres and 10 hospitals in six different regions in Spain. The results are organised into four categories corresponding to: (1) acknowledging IPV as a health issue. An ongoing process; (2) the Spanish healthcare system and PHC service: a favourable space to address IPV although with some limitations; (3) nurses as a key figure for IPV in coordinated care and (4) factors involved in nurses' autonomy in their response to IPV,

3.1 | Acknowledging IPV as a health issue. An ongoing process

The nurses perceived that society's view of IPV in Spain has changed from a private problem to a public health problem and a crime. The participants expressed that policies, institutions (including the public health system) and civil society are raising awareness on IPV as a public health problem (in society as a whole and among nursing professionals). They also highlighted the 2004 law on comprehensive care for IPV in Spain, which involves the health sector as a turning point in raising awareness for IPV care (Table 2).

Even so, many nurses were trained in earlier times, when IPV was socially invisible or even naturalised and there was no awareness of the need for professional involvement. IPV was so normalised that, as one interviewee stated, it was common to listen to judging comments or jokes about IPV in PHC centres. The nurses acknowledged that a tolerant social attitude towards IPV still exists and there are still nurses with more conservative ideologies and situations who

TABLE 2 Codes and quotes for the category 'Acknowledging IPV as a health issue, an ongoing process'

Codes	Quotes
Social sensitization	<p>'We are more sensitised because the issue of gender-based violence has developed a lot at the political level. At the institutional level things have also advanced a lot, I also believe that society as a whole is more sensitised...' (Interview 11)</p> <p>'We all have our most vulnerable moments in life and it could happen to anyone and at the most unexpected time in our lives... pregnancy, dating, separation, family and social isolation, migration, physical and economic dependence, situations of social exclusion, prostitutes...' (Interview 15)</p> <p>'...one day her friends caught up with her and told her that this could not be, that this was not normal, that it could not be that she always kept quiet and she decided to leave him' (Interview 29)</p>
Comprehensive law of IPV as a turning point	'Society is coming to the realisation that IPV needs to be taken seriously, because until now it hasn't been tackled with determination ... situations of violence have always existed, but now political parties of all different colours, everyone talk about situations of gender-based violence in a serious way, it's taken seriously now' (Interview 6)
Judging comments and jokes	'Many years ago, making jokes about IPV used to be socially acceptable, but those jokes have disappeared from the workplace... He hit her, well, she must have done something I heard it a million times before' (Interview 16)
Normalization of IPV in the society	<p>'The children don't help either, they always say, "Mother, where are you going now if you split up?"' (Interview 31)</p> <p>'Victimised women from small villages are unlikely to disclose because it's harder to change ideologies, it's a very embarrassing issue, so it also has to do with the context, not just the health professional' (Interview 5)</p>
Normalization of IPV among nurses	<p>'.../because you can't prevent, for example, that tomorrow it will rain' (Interview 14)</p> <p>'Many people know someone, a sister, or a sister-in-law, a cousin, who was beaten up by their husbands, did anybody do anything about it? We have never done anything about it. I have never done anything about it' (Interview 6)</p>
Blaming attitudes	<p>'When we discuss a case sometimes even among those of us who are more motivated with the topic of IPV, people still say "she has been a bad mother"' (Interview 6)</p> <p>"She must have done something," you hear those comments. If a woman goes and tells this type of nurse what she is going through she will never open her mouth again' (Interview 9)</p> <p>'When there are cases of women who go back to their partners, it's hard for us to digest, with all that it implies and all that we have done, it's hard to accept the woman's decision...knowing my colleagues the patient will lose credibility and they will say "that dumb girl went back to the scoundrel"' (Interview 9)</p>

distrust the testimony of IPV victims, blaming them for returning to the abuser or judging them if they do not leave.

3.2 | The Spanish healthcare system and PHC service: A favourable space to address IPV although with some limitations

The interviewed nurses highlighted how easy it is to access the public health system in Spain, especially to PHC consultations, as a facilitator to detect cases of IPV. On the one hand, the holistic and biopsychosocial approach of PHC favours providing comprehensive and personalised care, taking into account the physical, psychological

and social problems that affect patients' health. In turn, this makes it easier to detect complex situations, such as IPV, and to offer comprehensive care to victims (Table 3).

On the other hand, nurses at PHC centres work with a specific quota of patients who they know and with whom they can establish a relationship of trust due to frequent visits. The participants considered that nursing consultations are an optimal place to detect warning signs that indicate possible abuse due to the proximity nurses have with their patients, as well as having longer to spend with them than doctors. This encourages women to trust them talk about their problems and for nurses to get to know them.

Furthermore, the nurses described that during the consultation, the ideal conditions, such as being able to ensure privacy, creating a

TABLE 3 Codes and quotes for the category 'the Spanish healthcare system and primary health care service: A favourable space to address intimate partner violence although with some limitations'

Codes	Quotes
Holistic and biopsychosocial approach in PHC	'In health centres, patients receive personalised attention. The biomedical perspective is complemented by social aspects, all dimensions of the patients are considered' (Interview 2) 'biological matters are not the be-all and end-all in life.... we need to treat IPV like we treat diabetes' (Interview 18)
Closeness in the nurse-patient relation	'From primary health care we have an ideal setting to get to know our patients, so that we can anticipate any signs of violence and act quickly'. (Interview 23) 'Once a 55-year-old lady we knew personally from the village came to us and ended up exploding in a scheduled consultation that she had been suffering for 25 years that her husband was pressuring her psychologically' (Interview 14)
Challenges to address IPV in nursing consults	'/.../a woman comes to talk about the problems she is having with her partner, in an anxiety crisis, and there are many things that [the nurse] has to do in parallel' (Interview 21)
Limitations of Specialized care	'In hospitals, follow-up is very complicated since admissions are usually short-lived, and also they are people who come for a specific process and do not return. Nursing in PHC achieves better follow-up than hospital nursing' (Interview 35)

space of trust and taking care of verbal and non-verbal communication, showing respect and empathy at all times, should be enabled. Ideally, it would be best to be alone with women suspected of suffering IPV. However, in reality, it is not always possible. In this sense, the participants complained that the health system does not provide the necessary conditions to effectively respond to IPV in health centres. For example, they felt that the workload hinders detecting cases based on suspicion and/or giving women IPV victims the attention they need (e.g. listening to them requires time which they do not always have).

3.3 | Nurses as a key figure for IPV in coordinated care

3.3.1 | Detection and prevention

The nurses felt that their primary role in responding to IPV is detecting and attending to cases, which could include physical examinations, treating injuries and bruises if necessary, giving information on available resources, offering emotional support and referring patients to the most appropriate professional according to the case. The participants identified nurses' function of giving information and empowering patients as one of their potential roles to prevent IPV, both on an individual level from PHC consultations and on a group level as part of school or community health interventions (Table 4).

3.3.2 | Internal team coordination

The nurses believed that collaboration between PHC interdisciplinary team members is essential when dealing with IPV cases to provide comprehensive, personalised care to each female IPV victim. Nevertheless, the need to replace the automatic referral to other health professionals (such as doctors or social workers) that often occurs is considered (in the first instance, between

nurses and doctors). Some PHC centres are structured around 'mini teams' made up of doctors and nurses who always work together with a group of patients assigned to them. According to the nurses, doctors and nurses in the 'mini teams' collaborate by sharing information that the patient has given to each of them and by discussing the details together. This collaboration leads to a better understanding of each situation and allows them to provide personalised care. The next step is to share information with the rest of the team. In some PHC centres, clinical sessions are held during working hours where nurses and other health professionals can actively participate. These sessions are useful for them to discuss cases they have attended and to improve their practice by learning from and supporting each other. However, the sessions usually have a biomedical approach. In some cases, a health professional is in charge of or coordinates IPV to facilitate care and coordination of cases with other professionals. However, this person is often not sufficiently aware to offer guidelines to other health professionals who at a given moment do not know how to deal with a case of this nature.

3.3.3 | Coordination with other levels of care

The nurses pointed out the need for better coordination between PHC and specialised care services. For instance, if a woman suffering IPV goes to the emergency services department, her follow-up must be done at a PHC centre. In addition, mental health services in Spain are usually included in this specialised care service, although some PHC centres have a psychologist. Therefore, communication between PHC and specialised care is required.

3.3.4 | Coordination with external resources

The nurses expressed the need for greater and better coordination and communication between the different institutions involved in the

TABLE 4 Codes and quotes for the category 'Nurses as a key figure for IPV in coordinated care'

Codes	Quotes
Providing information to women	'Most women are aware of the measures they can take against abuse, but not of the resources available to them...' (Interview 31) 'Together with the social worker, they are informed about how to obtain professional lawyers, their rights, how to complain. They are introduced to a work reintegration programme, they are provided with transport...' (Interview 34)
IPV detection	'We have to take into account that the nursing staff is part of bigger team of health personnel. Therefore, our main role is the detection of cases and the action has to be joint with others' (Interview 23) '.../we are not the front line of battle in terms of acting. We take notes of what has happened, the doctor will come and do an examination, write a report of the injuries and it will be reflected there' (Interview 31)
IPV prevention	'If he controls you, if he dominates you, if he is jealous, is it positive? For them it means that this guy loves them, that he cares about them. This has to be dealt with socially, these clichés are social, an element for which education would be useful, and which could be dealt with since primary school and by giving talks' (Interview 18)
Need of nurses' involvement in the coordination	'There is a group that is held to help women, who feel sadness and pain somewhere in their body every day, with their self-esteem' (Interview 3)
Internal team coordination	'The first step is to share any information with the doctor. You begin to analyse what happened based on how each of us has perceived it, and together you come up with the story... they tell us different things, not contradictory, but sometimes they share things with us, nurses, that they don't share with the doctor, because nurses are more accessible, and then together with the Dr. we gather all the information... to try to find a solution' (Interview 9) 'Our social worker is in charge of sending us the updates of the protocol' (Interview 31) 'I asked her some questions. Then I told the nursing coordinator and we decided what to do next' (Interview 25)
Clinical sessions in PHC centres	'Simply by having that space to discuss cases, obtain the opinions of other people,... and see other ways of doing things, and learn from each other... what we discuss in the group is to improve ourselves, and it also works as a therapy for us' (Interview 1)
Coordination with other levels of care	'This is an issue that the professionals have to address with the same protocol, to have unity and facilitate action, since, if for some reason we have to refer the patient to another centre, this centre will have to carry out the follow-up and provide our patient with the same actions that we were carrying out, to attend to the patient in the same way' (Interview 33)
Coordination with other resources	'Even if you do respond, the area in which you work plays a big role (in the woman's outcome), this area is very socially depressed, so here the resources, the knowledge, and the information women have are very limited, they are very restricted in terms of getting out of their relationships because of that when compared to other areas' (Interview 11) 'In our PHC centre there is a nurse who is specialising in IPV, and who transmits it to the educational centres from an early age to both parents and children' (Interview 34)

response of IPV (health system, specialised resources, social services, security and judicial bodies). As a result, the participants proposed using new communication technologies and working with existing associations at a community level to reach women in the population who would otherwise be much more difficult to help, such as immigrants.

3.4 | Factors involved in nurses' autonomy in their response to IPV

3.4.1 | Training received

It was not common for nurses to have received IPV training in their university studies. Even if some training was received in the workplace, they felt that attending a talk or reading a protocol was insufficient to deal with IPV cases. They remembered that it is not common to talk about specific health protocols to respond to IPV

when they entered a new service unless universal screening is institutionalised in the region. Consequently, they felt unsure of being able to detect and effectively respond to IPV. To improve the confidence required to deal with IPV cases, they expressed that it is necessary to offer continuous specific training on IPV in PHC centres and hospitals. Including specific subjects or contents on IPV prevention and intervention in undergraduate degrees is also deemed essential (Table 5).

3.4.2 | Gender awareness

The interviewed nurses acknowledged that their ideology conditions both the response to IPV and their attitudes towards IPV patients. For example, if nurses justify violence, there is a risk that women will not get the support they need and may never try to seek help again. On the contrary, being aware of women's

TABLE 5 Quotes for the category 'Factors involved in nurses' autonomy in their response to IPV'

Factors	Yes	No
Training received		<p>'We lack the training to know how to detect it, how to deal with it. We are not sensitised enough' (Interview 34)</p> <p>'I'm a bit scared, it's such a delicate matter... if you do something wrong it could lead to serious consequences, so I don't feel comfortable dealing with IPV like I do with other issues /.../because us scientists, we who have had a scientific education are very used to everything being more mathematical; when this happens you do this, cause and effect.... But when things like this happen (IPV), then what do I do?' (Interview 7)</p> <p>'When I faced the first case, I was very afraid because I did not know what to do. I tried to relax so as not to transmit the fear to the patient' (Interview 25)</p>
Gender awareness	'You can also see it when you enter a room and see the behavior of couples. Perhaps the women are just shy and the men have the upper hand, they answer your questions, they are authoritarian...' (Interview 14)	'I consider that children and old people are more vulnerable than women. There isn't much difference between a man and a woman, a woman can defend herself' (Interview 5)
Screening question	<p>'...routinely, I ask all women who come to the surgery about this subject' (Interview 28)</p> <p>'Asking one of your 60-year-old patients if she has had problems with violence with her husband and then finding out that in fact she does because you asked, but if you hadn't asked you wouldn't have known, OMI [software to screen] is good for detection' (Interview 10)</p> <p>'They put a new program on our computer to ask all women about IPV, also to sensitize us and to make us find a case... you know your patients, you think you know it all, but you don't. OMI [software to screen] has been good for that' (Interview 7)</p>	<p>'The truth is that I don't know anything about the detection of abuse, so I don't know if there is any kind of screening' (Interview 30)</p> <p>'I think we should be more aware of IPV, not ignore it. We should introduce it as another form of screening. Surely, if we asked more, we would detect more cases of IPV' (Interview 34)</p>
Questioning women if there is an IPV suspicion	'I would ask what is going on, if she could open up to me just to have a conversation, that I do not want to interfere with her life, I just think that she might feel better getting things off her chest and maybe with the information she gives me I might be able to help, because many times seeing things from the outside gives more perspective, I would give her pamphlets and I would probably talk to the social worker' (Interview 8)	<p>'Some people refuse to ask about IPV, because, of course, it is like opening a Pandora's box' (Interview 2)</p> <p>'I don't know how to approach patients to make them feel they can open up to me and share what they are going through, maybe we have had IPV patients but we just didn't detect them' (Interview 8)</p>
Ability to see beyond	<p>'What happens is that, of course, you see in a particular case, in someone's clinical history that she fell and that later within fifteen days she has fallen again' (Interview 29)</p> <p>'Many people somatise, depending on the degree of stress you can have anything from gastritis... there are many illnesses and they manifest themselves through the digestive system, through the skin, headaches...' (Interview 31)</p> <p>'discomfort, embarrassment, difficult communication and avoidance of gazing, anxiety' (Interview 28)</p> <p>'Women who are victims of abuse attend health services more often and undergo more surgery, extend their hospital stay longer and take more drugs than others' (Interview 35)</p> <p>'You can also see it when you walk into a room and you see the behaviour of the male partner, they might be self-conscious and they might be in charge, they might answer your questions, they might be authoritarian...' (Interview 13)</p>	<p>' /.../some patients have probably come and kept quiet' (Interview 5)</p> <p>'I haven't had any cases, no one has verbalised [being victims of IPV]' (Interview 7)</p>

TABLE 5 (Continued)

Factors	Yes	No
Institutional barriers: Work overload and lack of time	<p>'Not having time is the excuse that people have always used for as long as I can remember. There is time, if you are willing to do things' (Interview 13)</p> <p>'/.../diabetes must be controlled, they must follow the diet well... but how about the issue of social and psychological well-being? Since we don't have time... but this is also part of health' (Interview 31)</p>	<p>'I have never detected a case of IPV, ever, with our workload there is no time to pay attention to that...' (Interview 5)</p> <p>'A woman comes to talk about the problems she is having with her partner, in an anxiety crisis, and there are many things you have to do in parallel. I think that daily dynamics are not conducive to being able to deal with IPV' (Interview 9)</p> <p>'We pay attention to ensuring that the diabetes is under control, that they get their diet right... and what about social and psychological well-being? As we don't have time... but this is also part of general health' (Interview 31)</p>
Empathy	'There are nurses who are very dry, there are nurses who are more approachable, there are people who are better at building rapport, there are people who empathise more, and those who empathise less' (Interview 14)	'Sometimes, nurses don't act professionally. If you are against something you cannot force that upon your patient, you cannot influence them, you just need to provide information objectively, you cannot tell patients what to do, this, however, happens sometimes' (Interview 1)
Proactive attitude of nurses	'I don't know if I'm qualified, but I take care of them anyway' (Interview 33)	'I think we are not prepared. I believe that there are other professionals more prepared and more suitable to act in these cases' (Interview 27)
Motivation related to institutional barriers	'I had no choice but to accommodate her because she was in a bad shape, but at the same time I was saying to myself, there is nothing I can do here, but listen to her because she has been in this situation many times before' (Interview 6, dataset 1)	<p>'After the training session I attended about 8 years ago I was very motivated with the topic, but that motivation has faded because they never insisted on the subject' (Interview 10)</p> <p>'... in the end people say 'I am going to come in and do my job... but I am not going to go the extra mile' (Interview 7)</p> <p>'When you are subject to institutional mistreatment people say: "I'm not going to do anything more than I need to, the way things are these days I may find out that I've lost my job any minute now"' (Interview 6)</p>

vulnerability to IPV leads to getting involved in optional training sessions.

3.4.3 | Screening question or based on suspicion

In regions where IPV screening has been introduced, the participants felt that it helped to raise visibility of the problem among health professionals. In the regions where it is not mandatory, nurses who believe that screening is useful affirmed to directly asking their patients about IPV if suspected. In contrast, other nurses chose not to ask because they feel uncomfortable and unsure about what to do if a case were detected, they believed that the woman should

disclose it, or that asking a woman directly if she is suffering IPV is counterproductive since it would generate a defence mechanism.

3.4.4 | Professional approach

While there are nurses who focus on the symptoms reported by women, others were aware of certain risk symptoms, such as unexplained falls, consumption of anxiolytics, changes in behaviour or low self-esteem, among others. Nurses who have dealt with women suffering IPV reported that it is not common for women to directly confess their situation, but that they tend to frequent health services for other reasons.

3.4.5 | Proactive attitude linked to motivation

While there were nurses who justified not responding to IPV because of a lack of time or a heavy workload, there were also those who respond to IPV despite challenges, such as time pressure, inability to solve the problem on their own and the emotional impact that cases have on them. For instance, deciding to spend more time with a patient instead of finishing the consultation. These nurses identified that there is a lack of understanding, involvement and commitment by nurses and other health staff which creates a barrier to effectively respond to IPV.

3.4.6 | Empathy

To create a climate of trust where women feel comfortable, supported and safe to share their experiences of IPV, the nurses were aware that they must maintain a non-judgmental attitude, be empathetic, kind, sensitive, actively listen, show an interest in women's issues and respect their time. Nevertheless, the participating nurses were aware that not all nurses respect this autonomy and try to force women to make decisions (report to authorities, leave home) without taking into account that they usually need time to decide.

3.4.7 | Motivation

On the one hand, a proactive attitude is linked to personal motivation. On the other hand, the nurses complained that when they feel overloaded with trying to cope with a heavier workload due to staff reductions, their motivation to improve IPV response (and in general) is reduced. Furthermore, it was common among the nurses to not have received training sessions for many years due to budget cuts, leading to a loss of skills and motivation to respond to IPV.

4 | DISCUSSION

This study shows whether or not responding to IPV is at the discretion of individual nurses. The participating nurses considered that responding to IPV was seen as a personal choice, indicating that there is a gap between health policy recommendations (Ministry of Health, Social Services, and Equality, 2012) and clinical practice. In the interviewees' discourses, several functions related to IPV arose, such as detecting and notifying cases and providing information to women, among others. However, the reality is that they do not always carry them out because: (i) they do not feel capable of dealing with IPV; (ii) they have a lack of awareness, commitment and motivation or (iii) due to institutional barriers, such as work overload and the limited time they have with patients.

The first two factors are mainly due to the lack of training received in IPV and the consequent lack of knowledge about existing

resources to offer women suffering IPV (Alshammari et al., 2018; Hooker et al., 2021; Jack et al., 2021). On the one hand, health professionals mainly receive biomedical training focused on pathology and physical conditions and, therefore, they are not prepared to deal with issues with a strong social and emotional component, such as IPV. Thus, it is necessary to replace this with a holistic approach towards patient care where nurses can assess patients as a social being (Briones-Vozmediano et al., 2015; Goicolea et al., 2015; Rodríguez-Blanes et al., 2017).

On the other hand, as the results showed, nurses have not received specific and sufficient IPV training in their university studies. They also do not receive further training at their workplace (Alhalal, 2020; Ambikile et al., 2020; Gómez-Fernández et al., 2017; Sundborg et al., 2012; Visentin et al., 2015; Zaher et al., 2014). Although IPV is included in the university nursing degree curriculum in Spain since 2008 (Order CIN/2134/2008, by which the requirements for the verification of official university degrees that enable the exercise of the profession of Nursing were obtained, 2008), a study published in 2019 found that 20% of the nursing training programmes in the country had not included this subject (Maquibar et al., 2019). If there is an IPV module included in the degree, new graduates will be more probably to enter the workforce with the necessary skills to approach and care for women suffering IPV (Wong et al., 2006). Training received will shape each nurse's professional style, which in turn will affect the response to IPV. Nevertheless, even if training increased awareness, it might have little impact in addressing myths around IPV that became barriers to develop a response from healthcare services (Maquibar et al., 2018).

Nonetheless, each nurse has their own personal ideology that, in turn, is influenced by the surrounding social values. Certain ideologies could be conducive to responding to IPV and some not, influencing whether a nurse views IPV as just or unjust. Thus, for example, professionals who do not view psychological abuse as a type of IPV or consider IPV as a private and intimate household issue will not take a stand on the matter. Nevertheless, the way the health system organises service delivery can either promote or hinder IPV response. Creating environments that promote a positive healthcare response to IPV is also part of the health system's obligations. In this sense, training in IPV screening increases professionals' sense of self-efficacy of the intervention and increases screening frequency and detection rates (Ahmad et al., 2009; Garcia-Moreno et al., 2014; Ministry of Health, Social Services, and Equality, 2012).

A good healthcare response to IPV is one in which providers can identify IPV cases, provide a supportive response to disclosure or detection, provide clinical care, offer continuity of care and refer appropriately (World Health Organization & London School of Hygiene & Tropical Medicine, 2010). The health system needs to create the necessary conditions to improve its response to IPV by fostering good coordination and referral systems, protocols and capacity building. However, this cannot be done if IPV is not prioritised sufficiently in health policies, budget allocations and when training professionals (Garcia-Moreno et al., 2014). The financial crisis in Spain starting in 2008 resulted in a healthcare budget cut that led to a

shortage in human resources. This then led to a demanding workload that put nurses under pressure and still continues, as seen with the recent COVID-19 crisis (Lamata Cotanda, 2017). The findings from this research suggest that nurses who feel this pressure are less probably to take on additional roles, including those related to IPV. Therefore, the health system must aim to allocate existing funds in a way that supports nurses and their ability to provide comprehensive care. Moreover, a specific budget allocation towards IPV services is recommended to ensure that funds are available for adequate training, equipment, supplies and support for nurses (Garcia-Moreno et al., 2014).

4.1 | Limitations

This study followed an emergent design. The second phase of data collection was not initially planned. We collected data with a 2-year difference to triangulate and reach saturation. The project in which the interviews of the first phase were conducted explored the response to IPV among several PHC professionals, thus, this did not specifically focus on nurses. To reach dependability, we used the same interview guide. Nevertheless, in the second phase, the interviewed nurses knew they were participating in a nurse-specific sub-study, so their answers could have been more specific on the role of nurses towards IPV response than the participants in the first phase of data collection. By broadening the initial sample and combining the perspectives of PHC and specialised care nurses, we were able to reach a broader picture of the phenomenon.

As a result, the final sample is heterogeneous in terms of time, meaning that their context was not exactly the same. In 2014, the effects of the economic crisis were harder than in 2016, which explains that in the first set of data, the influence of the economic crisis emerged in the interviews as one of the causes of the lack of institutional efforts to train health professionals (Otero-García et al., 2018). Two years later, interviews indicated that the situation had not improved, since the lack of specific and continuous training on IPV was always commented by the participants interviewed in 2016. Another limitation was that we were not able to compare between men and women, or between PHC and specialised care nurses. As a consideration for future research, it would be of interest to delve into the perspectives of specialised care nurses, as well as to know how victims of IPV perceive the services offered in response to IPV, as well as to identify areas that could be improved and what has been successful. This is especially relevant taking into account the current COVID-19 context which could prevent women from attending health services.

Different methods of sampling between phase one and two could have produced a higher predisposition of participating nurses in the second phase of data collection. They were invited to participate days in advance to conduct the interview, while the nurses interviewed in the first phase were recruited opportunistically by directly visiting the PHC centres and inviting them to participate during their work breaks.

5 | CONCLUSION

In practice, nurses perceive responding to IPV as a personal choice, despite the institutional mandate to address IPV as a health issue. Therefore, nurses' motivation and determination are essential to develop better responses to IPV. To enhance both, it is necessary to increase IPV training in university degrees and during their working years, ensuring access for all nurses, as well as improving their working conditions.

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CONFLICT OF INTEREST

No conflict of interest has been declared by the authors.

AUTHOR CONTRIBUTION

All authors have agreed on the final version and meet at least one of the following criteria: (1) substantial contributions to conception and design, acquisition of data or analysis and interpretation of data; (2) drafting the article or revising it critically for important intellectual content.

ETHICAL STATEMENT

This study received the approval of the Research Ethics Committees of the University of Alicante (2013-0012) and the Faculty of Nursing and Physiotherapy of the University of Lleida (2016-03-01).


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DATA AVAILABILITY STATEMENT

Data available on request from the authors.

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