EMPIRICAL RESEARCH - QUALITATIVE

WILEY

# Primary healthcare nurses' experiences of addressing intimate partner violence in supportive legal and health system contexts

Amaia Maquibar[1] | Itziar Estalella[1] | Rocío Romero-Serrano[2] |
Juana Macías-Seda[3] | Eugenia Gil-García[3] | Inmaculada Lancharro-Tavero[2]

[1]Department of Nursing I, Faculty of Medicine and Nursing, University of the Basque Country UPV/EHU, Leioa, Spain

[2]Department of Nursing, San Juan de Dios University Nursing Center. Seville University, Bormujos, Spain

[3]Department of Nursing, Faculty of Nursing, Physiotherapy and Podiatry, Seville University, Seville, Spain

**Correspondence**
Amaia Maquibar, Department of Nursing I, Faculty of Medicine and Nursing, University of the Basque Country UPV/EHU, Bizkaia, Spain.
Email: amaia.maquibar@ehu.eus

## Abstract

**Aim:** To explore the experiences of primary healthcare (PHC) nurses caring for women experiencing intimate partner violence (IPV) in a context of institutional support for the management of this health issue.

**Design:** Secondary qualitative analysis.

**Methods:** A purposeful sample (*n* = 19) of registered nurses, working in a PHC setting, with experience providing care to women who had disclosed intimate partner violence completed an in-depth interview. Thematic analysis was used to code, categorize and synthesize the data.

**Results:** Four themes were developed from the analysis of the interview transcripts. The first two themes address the characteristics of the type of violence most frequently encountered by participants, and how these characteristics shape the needs of women and the care nurses provide them. The third theme encompasses uncertainties and strategies developed to deal with the aggressor during the consultations as the woman's companion or as the patient himself. Finally, the fourth theme reflects the positive and negative consequences of caring for women exposed to intimate partner violence.

**Conclusion:** When there is a supportive legal framework and health system to address IPV, nurses are able to implement evidence-based best practices in caring for women experiencing intimate partner violence. The predominant type of violence experienced by women at the time they enter the healthcare system shapes their needs and the service/unit they reach. These varying needs should be considered in the development of training programmes for nurses and should be adapted for different healthcare services. Caring for women experiencing intimate partner violence implies an emotional burden even in an institutional supportive context. Therefore, actions to prevent nurses' burnout should be considered and implemented.

**Impact:** Lack of institutional support usually hinders the potential role nurses can play in the care provided to women who have experienced intimate partner violence. Findings

from this study demonstrated that primary healthcare nurses are able to implement evidence-based best practices in the care for women experiencing intimate partner violence when there is a supportive legal framework and the health system context is openly favourable to addressing intimate partner violence. Findings from this study could inform the design and implementation of programmes and/or policies to improve nurses' responses to intimate partner violence in primary healthcare services.

**KEYWORDS**
intimate partner violence, nurses, primary healthcare, qualitative research, Spain, thematic analysis

## 1 | INTRODUCTION

Intimate partner violence (IPV) is globally the most widespread form of violence against women (World Health Organization, 2021). IPV can be defined as any behaviour by a current or former intimate partner in the context of marriage, cohabitation or any other formal or informal union that causes physical, sexual or psychological harm (Breiding et al., 2015). According to the World Health Organization's estimates, 26% of ever-married/partnered women aged 15 years and older have been subjected to physical and/or sexual violence from a current or former husband or male intimate partner at least once in their lifetime and 10% in the past 12 months (World Health Organization, 2021).

The detrimental impact that exposure to IPV has on women's health and well-being has been widely reported during the last decades (Campbell, 2002; World Health Organization, 2013). In Spain, more than 46% of women who had experienced physical violence and/or sexual violence have suffered physical injuries as a consequence and up to 70% have experienced mental health issues such as anxiety and depression (Spanish Government Delegation Against Gender Violence, 2021). Therefore, women living in a violent relationship are more frequent users of healthcare services than those who are not (World Health Organization, 2013), making the health system a key actor in the development of responses to this health issue. Healthcare facilities, especially primary healthcare (PHC) services are crucial to identify cases, provide non-judgmental and confidential support, orientation and referral for women (d'Oliveira et al., 2022). Furthermore, accessibility, a longitudinal approach and person-centred care are core features of PHC which makes this level of attention one of the most suitable to provide quality responses to IPV (d'Oliveira et al., 2022; Goicolea et al., 2017).

Among healthcare professionals, nurses are in a privileged position to identify and develop responses to IPV. Nurses are often the first healthcare professional patients encounter when accessing healthcare services (Mphephu & Du Plessis, 2021). However, to successfully manage IPV, nurses need specific training in the topic, clinical guidelines that define the courses of action, referral systems and positive attitudes towards this health issue (Alhalal, 2020; Mphephu & Du Plessis, 2021).

## 1.1 | Background

The Spanish public healthcare system is composed of 17 regional healthcare systems—one in each of the Autonomous Regions in which the country is politically divided—which work independently but are coordinated by a national commission. The Spanish Government enacted in 2004 one of the most comprehensive laws worldwide to address IPV as it included specific actions in the areas of health, education, social services, the legal system, police, media and women's groups (Vives-Cases et al., 2010).

The available evidence (Colombini et al., 2012) points out that the necessary elements for the implementation of a nationwide health sector IPV response include specific policies in IPV, enough funds and appropriate infrastructures, clear guidance for health providers on how to act through guidelines and protocols, good internal and external referral systems and well-prepared human resources, that is, trained, sensitized and non-judgmental. Along with training, a woman-centred approach that respects each woman's needs and preferences has been recommended (Colombini et al., 2012; World Health Organization, 2013).

Implementation of the actions stated in the law as well as international evidence-based recommendations have been uneven in Spain. Among the Autonomous Regions, Andalucía stands out for being one of the leading regions in the country in the number of actions implemented in its regional healthcare system to address IPV (Table 1) (Goicolea et al., 2013). Training in IPV for registered nurses was first implemented in 2008 and has been maintained to date. In addition, the 'Andalusian Protocol for Healthcare Response to Gender Based Violence' was first published in 2008 and a third edition incorporating updated data and evidence was published in 2020 for the purpose of supporting and unifying healthcare professionals' responses to IPV, especially for those working in PHC (de Andalucia, 2020). Following WHO recommendations (World Health Organization, 2013), universal screening is not recommended in the protocol, but instead selected screening of women who present a range of signs, symptoms, attitudes and/or behaviours that might raise the suspicion of exposure to IPV.

The relevance of nurses in the development of responses to IPV in the healthcare sector is reflected in the large number of studies published in the last decades about the knowledge, attitudes,

**TABLE 1** Actions implemented by 2013 in the Andalusian regional healthcare system to address intimate partner violence (IPV) (Goicolea et al., 2013)

| |
|---|
| Autonomic law enacted against IPV than explicitly mentioned health sector response |
| IPV included as a health problem in its autonomic health plan |
| IPV management included in the portfolio of services offered in primary healthcare |
| IPV included in the indicators of management in primary healthcare contracts |
| A team of people working in coordinating IPV activities in the health system |
| Protocol published for inter-sectoral response to IPV that included the health sector |
| Inter-sectoral body formed for dealing with IPV in which health sector was included |

perceptions, facilitators, challenges and/or readiness of nurses to address IPV (Adams et al., 2022; Alhalal, 2020; Alshammari et al., 2018; Christensen et al., 2021). However, literature about nurses' experiences in caring for women who have experienced IPV is scarcer (Christensen et al., 2021; García-Moreno, 2015). Previous studies conducted with nurses working in emergency departments, maternal and child clinics and PHC services have highlighted the relevance of the context on the experiences of nurses. Among the most frequently cited elements that have been found to have a greater impact are training in IPV, the support of multidisciplinary teams, referral systems and clinical guidelines (Anderzén et al., 2021; Burnett et al., 2021; Christensen et al., 2021; Mphephu & Du Plessis, 2021). None of the previous studies was conducted in a context in which all these factors had been implemented. Thus, this study sought to answer the research question 'What are the experiences of primary health care nurses when providing care to women experiencing IPV within this supportive legal and health system context?'

By doing this study in a context in which most recommendations for successful IPV management have been implemented, the knowledge generated could both confirm that those are the required elements to facilitate a successful response to IPV by nurses and/or identify challenges or unforeseen elements that influence nurses' responses. Thus, the conclusions could inform future implementation of programmes or policies to foster nurses' responses to IPV.

## 2 | THE STUDY

### 2.1 | Aims

The aim of this secondary qualitative analysis was to explore the experiences of PHC nurses caring for women experiencing IPV in a context of institutional support for the management of this health issue.

The aim of the primary study for which the data were originally collected was to analyse PHC nurses' perceptions about IPV, their knowledge about the 'Andalusian Protocol for Healthcare Response to Gender Based Violence' and the challenges/opportunities they perceived in its application.

### 2.2 | Design

The present study is a secondary qualitative analysis of a subset of data from a previous phenomenological study.

### 2.3 | Setting and participants

The research took place in the public Aljarafe-Sierra Norte and Sevilla PHC centres of the province of Sevilla in the Andalusian Autonomous Region. For the original study, 26 nurses working in the province of Sevilla were selected. The selection of participants was intentional and followed a snowball technique. Selection criteria were to be a nurse working at a PHC centre and to have attended at least one sensitization training about IPV organized by the regional health system. None of the nurses invited to take part in the study rejected the invitation.

As a secondary qualitative analysis, we report on a subset of data from this original study. Only those interviews of nurses who stated that they had met at least one woman experiencing IPV during their work were selected for this study, resulting in a sample of 19 interviews.

### 2.4 | Data collection

Data were collected between March and November 2017 through semi-structured interviews. All the interviews were conducted by ILT, a nurse and an anthropologist with previous experience in qualitative research. Interviews took place in offices at the PHC centres where the nurses were working. The mean length of the interviews was 37 minutes (range 16–75 min). Data about participants' age, years of experience as a PHC nurse and educational level were collected before each interview. A semi-structured interview guide was developed which included questions that allowed for the exploration of nurses' perceptions of IPV, their values related to this health issue and the healthcare protocol, their knowledge of the protocol and the challenges/opportunities they perceived in its application. A specific question on whether they had ever met a woman exposed to IPV was included in the guide. If the answer was affirmative, an open question about their experience was asked. For the present study, only interviews with a positive answer to this question were analysed.

### 2.5 | Ethical considerations

The study was approved by the 'Andalusian Ethical Committee for biomedical research' (PEIBA 0303-N-14). Every participant received

oral and written information about the project. Written informed consent was signed by each participant in the study.

## 2.6 | Data analysis

Interviews were recorded and transcribed verbatim. Transcripts were analysed with the support of the Atlast.ti9 software following thematic analysis as described by Braun et al. (2016) in their six-step methodological guide. Data analysis was inductive, thus thematic construction was data-driven; no initial hypothesis guided the preliminary coding and subsequent thematic development.

Two authors, AM and IE, performed an initial line-by-line coding of the sections of the interview transcripts related to the study objective and ensured that each interview had at least been coded by the two of them independently to develop a robust and consistent code set. All the codes were then discussed and refined by the same two researchers. The resulting codes were then sorted into potential themes. Thematic maps were used at this stage to help with theme grouping and the analysis of relationships between developed themes and codes.

The elaborated themes were refined using the three stages proposed by Braun et al. (2016) for this part of the analysis with the participation of four authors (AM, IE, RRS and ILT). First, all the coded extracts for each theme were thoroughly read to check coherence in the pattern that led to that theme definition. Once necessary adjustments had been made, the preliminary thematic map was confronted with the whole data set, refining themes. Finally, a detailed analysis of each theme, which included its meaning and scope, as well as relations with the other themes was conducted.

## 2.7 | Rigour

In relation to credibility, four of the authors are female nurses who live and have worked in the context in which the study took place. Therefore, they have a vast knowledge of the regional health system and its context. In contrast, the remaining two authors are also female nurses who work in a very different region of the country. This difference allowed triangulation during the process of data analysis and manuscript elaboration as well as debriefing among the authors.

In the Background section, we provided a thick description of the general context of Spain as well as the regional health system in relation to IPV. We believe that the information provided can help the readers to assess the transferability of the findings and conclusions of the present study to other settings of their interest.

To achieve dependability, we provided clear information on how these steps have been followed in the present study, in addition to providing a reference of a methodological paper that describes in detail the data analysis conducted. Furthermore, two researchers independently coded each interview and the resulting codes were discussed among the researchers to enhance the consistency of the developed codes and themes with raw data.

Finally, quotations from participants along with the codes elaborated and the theme to which they were sorted are provided in Section 3 to enhance confirmability (Nowell et al., 2017).

## 3 | FINDINGS

The 19 study participants (13 women and 6 men) ranged in age from 41 to 60 years and 84% had more than 10 years of experience as PHC nurses (Table 2).

Four themes were developed from the analysis of the transcriptions: (a) *It is not just the identification, but the process of the women in identifying it*, (b) *ending a violent relationship is a complex and nonlinear journey*, (c) *the elephant in the room* and (d) *nurses are used to dealing with overwhelming situations and yet....* The first two themes address the characteristics of the violence most frequently encountered by participants and how these characteristics shape the needs of women and the care provided to them. The third theme encompasses uncertainties and strategies to deal with the aggressor during the consultations as the companion of the woman and as a patient himself. Finally, the fourth theme reflects the positive and negative consequences of caring for women exposed to IPV.

## 3.1 | It is not just the identification but the process of the women in identifying it

This first theme encompasses all the codes that describe the type of IPV that reaches PHC nurses according to participants' experiences and the implications it has for the care provided. According to participants, the type of violence that reaches their consultations is mainly psychological violence. Episodes of physical violence usually reach emergency services and in those cases, the procedure is mainly led by the physician who is responsible for filling out the injury report with less participation from the nurses (Table 3).

TABLE 2 Demographic data of participants (*N* = 19)

| | Mean (SD), *n* (%) |
|---|---|
| Age | 49.21 ± 5.36 |
| Gender | |
|   Female | 13 (68) |
|   Male | 6 (32) |
| Years of experience as primary healthcare nurses | |
|   >10 years | 16 (84) |
|   <10 years | 3 (16) |
| Academic degree | |
|   Bachelor's degree | 12 (64) |
|   Master's degree | 5 (26) |
|   Mental health nurse specialist | 1 (5) |
|   PhD | 1 (5) |

WILEY |

**TABLE 3** Codes and quotes for the theme 'It's not just the identification, but the process for the women to identify it'

| Codes | Quotes |
|---|---|
| It is not just the identification, but the process for the women to identify it | 'Before she recognizes that she is a victim of a situation of abuse she is like in absolute denial of everything around her. Until she is not able to see that she is really being a victim of a situation of abuse, that her partner does not treat her in an appropriate way, until she is not able to see that this situation is not normal, that it is not the normality of the whole society …' (Patricia)<br>'More than anything it is that: to make her see the problem' (Ángel)<br>'She was an old lady; psychologically she was wretched and was not aware of it.' (Maribel) |
| Physical violence cases in emergency services | 'In the emergency room, many cases are seen. What do you do? Parts of injuries, parts of injuries that are referred to the hospital.' (Begoña)<br>'It seems that doctors, and I say doctors because they are the ones who usually do the injury parts, are quite aware of what they have to do, of the required documentation' (Marina) |
| PHC nurses find more psychological violence | 'When we were at home alone with her she verbalized that long time ago there had been physical abuse. At that time it was only psychological, but it is true that when the husband arrived and saw us there, the woman would drop and even tell us not to leave.' (Maribel)<br>'Because, when they go to the emergency room with an injury that is no longer just a verbal aggression, which is a push, when there are more important physical injuries, they go to the doctor.' (Lidia) |
| Lifelong violence | 'Usually the abuser in the area, or the one I perceive and care for, are abusers of many years, almost since they got married. And now that they are in their 70s, they continue to mistreat their women, from bed.' (Marcos) |
| It is unusual to begin with a plain disclosure | 'Many times it is not that the woman discloses [the violence] that you say "how clear it is"'(Ángel)<br>'When you start talking to a person, you say here's something hidden. Now, what is behind? There are people who tell you and people who don't. You have to keep working with them.' (Begoña)<br>'We [nurses] have to earn the trust of the user, that is, they do not come fully trusting the professional they have in front at first. Then, it is necessary another interview or two more interviews – at least in my experience – so that that person is able to let everything go and relax and know, well, that you are a health professional, that you are going to respect their privacy and that nothing will come out of here, and then, when they already feel confident enough, they tell you.' (Patricia)<br>'The case of this lady, with hypertensive crises, for example, and what was behind it was an issue of violence, of an alcoholic husband, with whom she had to stay alone.' (Juan José) |
| Relevance of continuity | 'They know the neighbourhood, because they are nurses who have been here for 17 years, 18, 20 … Many… They have vaccinated girls who are vaccinating their children now. The degree of knowledge of their neighbourhood is mind-boggling.' (Marcos)<br>'Usually, the nurse knows woman's family environment. I know if she lives with dependent people, maybe that anxiety crisis does not come from gender violence, it comes from the fact that you are an informal caregiver and are overwhelmed, having to be with a dependent person, maybe, this anxiety is from that. But if you know her husband, you know more or less the profile of her husband and you know the situation of her family environment you can investigate.' (Carmen) |
| The home is the ideal place to detect | 'Yes, and of course, it is possible… follow up, I do not know if at home level, or at such a level … of course, that would be ideal.' (Manuela)<br>'Of course, either I go to see her at her house or I stay with her to see her life context, to see the possible abuser or, to see a little bit of where she is moving around.' (Patricia) |
| Alert for signs | 'Because under that low self-esteem that she has, that cry or that anguish, that she starts crying for no reason in the consultation, that you may think can be because of an illness of her or a relative, what is behind, it can be a case of violence.' (Juan José)<br>'You do a motivational interview when you already detect that the husband is always present, that there is something that does not fit, the symptoms that she expresses, they are usually depressive, crying, but the one who answers is always he. You realize of many details.' (Begoña) |
| Detection, a learning process | 'So I, perhaps, up to 2010, I knew that it could exist, but I was not so aware of it, it may be that in some patients I had treated, that either a child or an adolescent or a woman has arrived at the nursing consultation of common services or emergencies with an injury possibly because of that, but I have not been aware that there could be gender violence behind it. Not now. Now, I catch it… there is more awareness, more training.' (Juan José)<br>'It has changed that I at first, when I was a young girl and started [working as a burse] I thought "here she is again, the annoying woman of the *Dogmatil*, asking for *Dogmatil* again, how tiresome she is, and they have already done all the tests…" […] she did not express anything else, that she was dizzy, it was the only thing she expressed, until, of course, with time, I talk about years, until you realize that she is a victim, she is a victim [of IPV].' (Begoña) |
| Screening universal would be burdensome | 'Yes, it would be a burden to make you ask all women, fill out a questionnaire to see if they are potential victims or not, that would be a burden because well, it would be to do a 'screening', it would be a …' (Ángel) |

(Continues)

**TABLE 3** (Continued)

| Codes | Quotes |
|---|---|
| Listening more than talking | 'Well, look, in relation with care I think that nursing professionals have in our favour active listening. So I think that's the fundamental tool in one case or another. I believe that with active listening many more things could be solved and, above all, the person becomes aware and reinforcing her when she tells you something, in new consultations or in new interviews to ask her again about that topic that came out.' (Marina) <br> 'And listen a lot and talk little, because, of course, many times the gestures, certain comments what can give you clues.' (Jose Luis) <br> 'Let's see, there, the first care is the active listening on our part. Let them be the ones who expose, those who say and so on.' (Montserrat) <br> 'The main care provided, it would be the listening.' (Alberto) |
| Nurses' easiness to talk about IPV | 'But, for me, personally, it is not difficult to talk about that topic [IPV].' (Elena) <br> '…the lack of shyness to speak [about IPV] is very healthy.' (Marcos) <br> 'I also have no trouble saying: "hey, if your husband bothers you, you can leave him or you can report him"'. (Angel) |
| It is a time-consuming process for nurses | 'The way to retain her is to give her a date again, but the next appointment is for something else, never for what it really is, but we will trick the system. "Yes, right. We are going to go, look, I am going to give you an appointment because, as I have told you, because I have to give you an explanation on" another different topic that has nothing to do with gender violence, and once you are putting things to her and you are making her reflect, she is coming and you are giving her appointments […]. For nurses it's really time consuming and it is a shame because in that time something can happen [to the woman]. (Begoña) |
| Leaving an open door | 'And then there are techniques of asking in the interview, like, "I see there's something that worries you, do you want to talk about it?" It is not to force her to say anything, but it is to leave the door open, and above all that they leave knowing that they can come back whenever they want and that they can call me and enter here and make me a signal and at the moment they want, we'll talk.' (Mónica) <br> 'Then you can leave the suggestion that if there is something wrong you can comment on it, that my office is open, that if you feel more comfortable with another professional you can talk directly with that person' (Jose Luis) |
| You have to earn their trust | '…because that person has to vent, the first thing that happens is that she explores you, she has to trust you, because she wants to know if you are a person who can help her or not, because you are not going to tell intimacies to a stranger, to a stranger who then on top of that will not give you confidence, no empathy, no help of any kind.' (Mónica) |
| Women with negative experiences with the health system | 'I asked her: "have you told your doctor the same thing you are telling me, that you know your doctor for more years than me? Have you told him?" She said yes, he knows it, but no, he does nothing, there is nothing to do.' (Begoña) |
| Maybe undetected cases | 'Well, possibly, daily or weekly women who are suffering from this can go to consultation. What happens is that it is not, perhaps, an issue of awareness on my part but, as it is a little hidden thing, I mean you do not go with a sign saying I am a battered person, then some cases can go undetected.' (Juan José) |

The cases of IPV the participants most frequently addressed most were long-term (lifelong) stories of violence in adult women. One of the participants even described a case of violence 'beyond death', referring to a woman who even after the death of her husband continued to live in fear and according to the rules he had set up while living together. This type of violence was usually subtle and continuous psychological violence. Participants perceived that it was common for the violence to increase with ageing, dependency and disability and, in some cases, these circumstances were the reason that women who had ended the relationship in the past went back to the aggressor.

Due to these characteristics of the violence, participants stated it was very unlikely that the process began with an overt acknowledgement of the situation by the women. Instead, it was nurses' awareness of the signs of IPV that triggered suspicions about the opportunity of exposure to IPV, such as the woman being very shy, always coming with the partner to consultations, the partner as the one answering the questions and coming too frequently to consultations with vague motives. In this sense, participants described home visits that are part of the routine work done by PHC nurses as the best scenario for detection of these kinds of signs. Continuity in attention that is characteristic of PHC in Spain was also cited by participants as essential to allow this identification.

Acquisition of the required knowledge about alert signs was described as a learning process and some of the participants acknowledged being blind in the past to all these signs. Once these were internalized participants stated that keeping them in mind and being alert did not imply a burden. However, the opportunity of doing a universal screening was considered a burden by one of the participants.

If there was a suspicion that a woman was experiencing IPV, participants described how they started the process with the aim of helping the woman become aware of her situation or giving her the chance to disclose it to the professionals. The approach was very tactful and consisted of more listening than talking. Participants stated that it was easy for them to bring this topic into the conversation and frequently their strategy was pointing out that other types of relationships in life are possible as a way to raise awareness among women.

This process was seen as very time-consuming for the nurse because it could take many consultations to gain a woman's confidence,

especially in the case of women who had previous negative experiences with healthcare professionals. Nurses stated that it was important to make clear to the woman that their door was always open and to ensure a follow-up, whether she had disclosed a situation of IPV or had failed to acknowledge she was in a violent relationship even though clear evidence had been found. Participants thought some cases had not been detected despite all the awareness they showed.

## 3.2 | Ending a violent relationship is a complex and non-linear journey

In their narratives about their experiences in taking care of women experiencing IPV one of the most frequently repeated messages in the interviews was how difficult it is to leave a violent intimate partner relationship. Participants repeatedly brought up this idea as key to understanding the needs of these women and consequently the care that was provided. In the participants' view, at the base of the difficulty to end up these relationships was the extremely undermined self-esteem of the women who had experienced IPV for a long time. Thus, much of the care that was provided focused on trying to rebuild the women's self-esteem and give them tools and resources to be able to make decisions on their own. This objective was considered ambitious, difficult to achieve and one that requires time, patience and perseverance (Table 4).

In any case, the care provided was always from a non-judgemental approach, giving priority to the women's wishes, giving women autonomy, always respecting their decisions or lack of decisions, and respecting their process and timing. In other words, the nurse's role was seen as providing women company during each individual process, thereby highlighting the relevance of 'presence'.

In this whole process, there was a strong feeling that this task required the involvement of an interdisciplinary team. If the physician with whom they shared an assigned population was the first in being notified of the case, the participation and support provided by the social worker of the PHC was described as essential.

Besides inter-professional collaboration, interviewees thought it was very important for nurses to have an updated knowledge of available resources and maybe a referent nurse in IPV.

Socio-economic conditions of women were frequently mentioned as an added difficulty in leaving a violent relationship. Participants stated that women continue to be somehow defenceless as the resources available are not enough to start a new life from scratch and more importantly, that it is almost impossible with current resources to ensure they will be kept safe and protected.

One unsolved concern for these professionals was the care of the children of these women. However, there was no mention of collaboration or networking with paediatric nurses in any of the interviews.

## 3.3 | The elephant in the room

Aggressors and different approaches to dealing with them were present in nurses' discourses. Issues in relation to aggressors were two-fold. First, there were issues related to the aggressor being present in the consultation with the woman. Problems derived from his presence related to preventing the woman from overtly talking about the situation, concerns about maintaining the confidentiality to protect the woman and also how to act during the consultation if any sign of violence was witnessed. Second, participants brought up the professional (mainly ethical) issues related to knowing that the man, who was also their patient, was exerting violence against his partner (Table 5).

The first step taken by the interviewees when there was awareness of a woman's fear of her partner and its implications for her security was to ensure that the woman was given the opportunity to stay alone with the nurse. To achieve this, participants described a range of strategies from gaining the confidence of the aggressor so that he would feel they were not at all aware of the situation and let her come alone to inventing excuses or medical reasons for a consultation that only she could attend. One new concern in relation to confidentiality and security of the woman is the newly implemented online access to medical records for all individuals in Spain. The concern was related to the aggressor being able to get his partner's passwords and gain the ability to read any diagnosis or alert included in her medical records. Although there are ways to block access to this information for anyone other than professionals, not all professionals know about this option or how to put it into practice since it is new.

What to do if they witnessed any type of verbal violence during the consultation was controversial, and there was no agreement among participants. For some, confrontation with the aggressor might increase the risk to the woman once the consultation was over. In some other cases, confrontation was avoided due to fear of the aggressor. For other nurses, it was felt as if they must stand up and make him consider the way he was talking to his partner.

The second issue in relation to aggressors was knowing that your patient exerts violence against his partner, which raises concerns and ethical considerations for nurses. While there was unanimity on the need to work on prevention programmes with young girls and boys, more diversity in opinions was expressed in the interviews on what or whether anything should be done with adult men that are violent.

## 3.4 | Nurses are used to dealing with overwhelming situations and yet...

When asked about the consequences of caring for women experiencing IPV some interviewees highlighted that nurses are used to dealing with circumstances with a high emotional burden and gave as an example their work in palliative care. Some of them attributed higher emotional burdens to PHC compared with hospital-based work in the sense that when finishing your shift

**TABLE 4** Codes and quotes for the theme 'Ending a violent relationship is complex and non-linear journey'

| Codes | Quotes |
|---|---|
| Non-linear process | 'They are also women who, as I always say, two steps forward and one step back. That it's normal, or one step forward and two steps back. Then you have to pick them up, and you have to go back and work with them, call them back and get them back.' (Carmen) |
| Rebuilding self-esteem | '…in this point her self-esteem is so low, we work with the self-esteem and I try to overcome it. I tell her that this is the tool he has to make her submissive for whatever he wants. So I try to strengthen her.' (Begoña) |
| | 'To show herself that she is capable, that she is worth. And with small consecutive achievements, low self-esteem and depression can be overcome…' (Elena) |
| | 'A low self-esteem implies that in the end you rarely visualize that they have applied the tools you have given them. They continue to assume it as something natural and this is so, what else can you do?' (Angel) |
| Empowering women | 'So my strategy is to empower women and make them identify their situation of oppression and seek strategies from their environment and from their families.' (Marina) |
| | 'Who takes him out of his apartment? His wife got him out. Empowered by a social worker, encouraged by me and by her doctor. But there is no police report saying this man is abusing his wife.' (Marcos) |
| Act in a non-paternalistic way | '…and then the accompaniment and help in making decisions, I don't mean making decisions, but help in decision making.' (Mónica) |
| | 'Because even in health we have the defect of being paternalistic. And that doesn't help.' (Montserrat) |
| Provide tools for decision-making | 'Above all, it is to make her see the problem […] Well, it is not if you tell her: "Hey, you have to see […] that he is exploiting you, don't fool yourself", but to give her the tools: "Hey, think, when he tells you this, how do you react, do you feel bad?"' (Angel) |
| | 'In the motivational interview, in the action plan, they are given the resources to be able to take the step, such as: open a bank account in the name of your mother, your father, that you will be able to pass money, without him knowing; always have a suitcase prepared at the house of a neighbour, a friend, someone you trust in case you have to run away. All the guidelines are given until she takes the plunge.' (Begoña) |
| | '…give them the tools they need. Contact with social services, contact with the police, provide telephones if necessary. Make a family assessment, too … Other needs that may exist in the environment, or in the family, that perhaps we do not see directly in the consultation' (Juan) |
| | 'We have to open up the world of possibilities, because they are women who have hardly ever left their homes. They do not know that there are shelters, that they can seek legal separation. Many women are even unaware that they can legally separate if the husband does not authorize it. That is, the misinformation is total.' (Marcos) |
| Accompany respecting their process | 'Support and advice will continue to be provided. If they do not recognize it, well, we are going to continue informing them, we are going to continue advising them. We can include them in the groups, so that they can see other women who have the same circumstances as them, who may or may not have acknowledged it.' (Magdalena) |
| | 'It is true that, when the woman does not perceive that she has been or is being mistreated, it is a shock to accept this reality, there are women who collapse and you have to give her some time. Because if not, they can feel manipulated by the professional, and you have to give them that time. And there are times when they come. And, they usually never take drastic measures. But they begin to impose their criteria: well, no, because I'm going to go out today, I'm going to go for a walk, I'm going to see the neighbour … These are small changes. In this, the "all or nothing" is very complicated. Except for the flagrant cases of abuse in which we try to make it an "all or nothing" to get it out' (Marcos) |
| | 'When health care providers say "but they themselves do not recognize it and see it as normal" or "it is not only that the victim does not recognize it, but also that it is difficult for us to take the step, it is as if we were taking the step for her, and if she does not want to, who am I to", then there is a lot of work to be done here.' (Manuela) |
| Women's wishes priority | 'Of course, there we already have respect for women, respect for her own decision. No action can be taken unless we see that there is an imminent danger of death, because the woman's decision must be respected and preserved.' (Magdalena) |
| | 'I do not take a step without the user knowing the step, of course. I ask my users for permission for everything, that is, if I need to contact an association to carry out whichever action, they (the patients) know it first. Therefore, women who are potential victims or actual victims of abuse cannot be less. They are aware of all the steps I follow. So my constraint is as far as the woman allows me to go. If she gives me carte blanche, I get entirely involved, even going to social services.' (Patricia) |
| A process that takes time | '…and women are not always prepared to report [to the police], there are some stages that you have to work with them, but that cannot be done in five minutes in a consultation with three waiting for you and knocking on your door.' (Luz) |
| Relevance of nursing presence | '"And here I am, this is my phone and this is my office. If you ever want to go further, then, count on me, and we'll see how we do it"'. (Angel) |
| | 'The presence is an intervention that when I started with the NICs seemed like a joke and now it seems increasingly relevant to me. So, to make ourselves visible, to let them know that we are here.' (Monica) |
| | 'Knowing that you are present for everything she needs and knowing that they have support and can count on us at any time, and at any time they need, that we are going to help her.' (Carmen) |

**TABLE 4** (Continued)

| Codes | Quotes |
|---|---|
| Awareness of group work | '…that this is a multidisciplinary job, that it does not have to be the nurse alone. So, when I have detected something, whom do I go to? Well, to all those professionals who intervene with that patient, because you alone will not be able to act, so it has to be a joint effort.' (Marta)<br><br>'Yes, usually yes, I mean, when you already talk with colleagues it is like… "Hey, look, this is happening", and so; "well, I'm going to be aware", for example, especially when there are children '(Jose Luis)<br><br>'We always meet maybe every 15 days, every 20 days, if there has been any case, we address the patient, we ask. Have you had any contact, any relationship? I think that talking about it, people become a little more sensitized. Both men and women.' (Magdalena) |
| Fearless for inter-professional collaboration | 'We speak in the team. The first thing is telling her physician "be aware that there is something here", and the doctor who also knows her is very attentive, is very alert, does not suppose a burden at all, because in addition those people seek refuge in us and are very demanding and come and want to be listened to.' (Begoña)<br><br>'To me, for example, what I have found very good lately, is the coordination of the different groups when facing this issue, in the sense that we in the commission for example, the meeting is: City Council, information point for women, national and Local Police, social workers and healthcare centres and nursing. So all that, we get together and discuss the cases that are more difficult, those that have been resolved, those that have not been resolved. That didn't exist before, did it? that didn't exist before.' (Carmen) |
| Collaboration with social workers is essential | 'Usually the social worker is the one most updated, the one who usually knows and manages the protocol better and the one who is usually assigned with these cases, usually has that function assigned in a health centre like this, with many people.' (Angel)<br><br>'In that sense, too, our social worker is very much of: "I'm going to facilitate you… Let's go next door, to the police, to the registry, where necessary." In that sense, we are very supported by a multidisciplinary team. If the multi team works, much better.' (Marcos)<br><br>'Social workers handle it incredibly, but back to the same, they are not always present, and the problem comes when there is a suspicion of violence and they are not here' (Manuela)<br><br>'There we help each other a lot. Personally, I look a lot for the help of the social worker…I, personally, have long been aware that I work within a multidisciplinary team and for me, a social worker, or in my case, a social worker, for me it is a very important tool in my centre.' (Juan José) |
| Knowing the resources/ updated knowledge | 'Advice. Fundamental. That every registered nurse, doctors, everyone knows what resources we have at the level of our basic area as a health institution and at the local level. And that. Not long ago we had a training and throughout the year, trainings are organized.' (Magdalena) |
| Aware of the impact of social determinants | 'The one who is wealthy fine, but the one who is not… and many don't take the step because they say "and what next? What I'm going to do?" […] So I know that it's not the same, that you have to take the step, but you need money to leave from where you live, to leave and change everything, as in the movies, don't they even change their name [in the movies]?' (Begoña)<br><br>'Lack of economic resources… and also lack of knowledge of social resources' (Lidia)<br><br>'It really moves me a lot, and I come out [of the consultation] feeling terrible, it is very difficult to get it out of your mind. Put yourself in that person's place, depressed, without resources, in a phase of humiliation, that is, it is so…these situations are tremendous. People without resources, depressed and so submissive and vulnerable, who are also unable of making decisions.' (Mónica) |
| Women are still defenceless | 'They are afraid, behind the decision of now I am going to report him to the police, I am going to testify against him, there are the fears of "but who will watch my back, and my children's? Who will? No, therefore…"' (Begoña)<br><br>'Many deny it out of shame or fear, and because they think that justice does not act afterwards.' (Jose Luis) |

at the hospital you know another team of nurses will take care of patients, while at PHC patients are left on their own once the consultation time is over. Despite being used to highly emotional situations, cases of IPV were described by most of the participants as 'cases that hurt' (Table 6).

In certain cases, serious negative consequences for the participant's personal life were described. One participant narrated how she encouraged a woman to leave her husband in a situation in which the life of the woman was considered to be at severe risk. The woman followed the advice and left the home. In the following weeks, she was living alone, struggling to find a job and in a legal nightmare to get custody of her children, and she blamed the nurse for her miserable situation. This was totally devastating for the nurse, even if things

improved for the woman and the story had a happy ending. Although not as extreme, other participants also talked about the emotional burden getting involved in caring for these women implies. Negative implications could be worsened by a lack of support from colleagues in some cases.

There were positive consequences of dealing with IPV as well. Success in any of these women leaving the violent relationship behind and beginning a new life was described as fulfilling for nurses and as compensating for the frustration when things went wrong. Moreover, some participants expressed that dealing with IPV requires nurses to compulsorily adopt a holistic approach to their patients and described this as the core of nursing practice, much more challenging than the mainstream biomedicalized approach but also

**TABLE 5** Codes and quotes for the theme 'The elephant in the room'

| Codes | Quotes |
|---|---|
| Aggressor present at the consultation | 'She used to come with her husband and then we had to manage to get the husband out of the consultation or take her to another consultation and talk to her in peace.' (Maribel) |
| Gain his confidence | 'First I try to gain his confidence. I empathise with the husband as the one who knows absolutely nothing. And then, once you see that the husband is talking and empathising and so on… "well, I'm going to talk to your wife about" any other issue "about the analysis because she is not doing ok or— I'm making this up, right?— I am going to talk to her about…you don't need to come." And that's it, they don't come, eh, they don't come. First I have to bring them to my land so that they trust me, then I separate them and then they talk…'(Begoña) |
| New risk with access to online history | 'We write it down in the histories. Patients who come accompanied by their husbands… "I indicate that I would like her to answer the questions, because he answers all the time…" That is, there are colleagues who are already leaving you a record that, in the long-term, is very beneficial, even if you are not saying anything… Because everyone can have a copy of her health history, which was a problem that we know could happen, which is where we write… And that remains a void that the transparency of information prevents, it plays against the visualization of mistreatment.' (Marcos) |
| | 'So if he can access with her health card and see that she is being monitored for abuse, we are already putting her in danger.' (Begoña) |
| | '…because when things of this type or sexual things or anything that I consider to be intimate and the person wants to keep them private, then I block them with the padlock, which is an option of the digital record, to block what you write with the padlock. And this, for example, many colleagues don't know about it […]It seems to me that the professionals have to know it, and then when a judge comes or when a professional comes and asks us for it, then it opens up.' (Mónica) |
| Confront the aggressor if necessary | 'In my practice, no one speaks as one pleases; I mean in those terms … Here we are for health reasons.' (Marcos) |
| | 'So I'm able to say something to someone because I'm paid for it. As a professional I see myself capable of undoing him.' (Alberto) |
| | 'It may be direct confrontations with the male. With the man. When I tell him: "no, let her speak". He says "no", or "don't talk to her like that.", "I speak to her as I please." In other words, he doesn't assume another man or another woman - my female colleagues even more so - will stop him.' (Manuela) |
| | 'I don't have that problem because I am a woman. If the man is mistreating the woman and I have to tell him something, I tell him, I am not going to stop doing it because I am a woman.' (Magdalena) |
| | 'But, normally, men of violent profile, violent towards his wife, tend to take it very badly when another woman or another man tries to position him on levels of equality with his wife. It's like it beats him. So much that he is able to break his protocol of kindness or false kindness in consultation. It has not been the case of having to say openly to anyone: you are mistreating your wife, except "you are speaking badly", because the word mistreatment, when it comes out, it is as if the abusers' own alarms are raised.' (Marcos) |
| No confrontation | 'You can't… Confrontation with the aggressor I think would be absurd, come on. No, no. I don't see that as a way out at all.' (Ángel) |
| | 'So, sometimes, I don't know if they are euphemisms or ways of saying: "Don't you see that your wife suffers when you talk to her like that? Do you think that you can say things or talk to your wife in a different way? That she is capable of talking, saying or deciding by herself?"' (Monica) |
| | 'You can't solve the problem for the person; they have to solve it themselves. You can help them to find a solution, a way out, but you are not going to be the one to say "hey, don't hit her any more". Neither being a [female] nurse nor being a [male] nurse, come on, or "don't treat her like that". No. "Look, do you realise that you are treating her badly? Don't you realise that when you do this he says…? Do you realise…?"' (Angel) |
| Fear of the aggressor | 'Many professionals say: "I can raise the alarm, but this man is going to come to the health centre every day…" There are people who feel that they are also going to be a victim of the aggressor.' (Marcos) |
| | 'My role would be to try to see the woman alone, to encourage her to explain to me, to encourage her to take the step, to recognise that it is gender-based violence and if she tells me that it really is gender-based violence and that it has to be reported, I will support her because you she told me about it. But of course, for health professional that is a complication. Tomorrow the husband comes to the consultation.' (Magdalena) |
| It implies changing vision about aggressor | 'It is a shock; it has happened to me, that I have seen the couple and I have seen him with less affection, my feeling. But, he is still a person, right?' (Alberto) |
| Close relationship with the aggressor | 'Recently, a week ago, we had a case […] and all the… the channels and the algorithm were established and set in motion, according to the protocol, which has resulted in such a problem because in the end, well, the problem was that the social workers had a personal relationship with the alleged aggressor, and well, this is a very complex issue, but it is true that it happens, it happens, in many cases and they are very complex issues.' (Manuela) |

**TABLE 6** Codes and quotes for the theme 'Nurses are used to deal with overwhelming situations and yet…'

| Codes | Quotes |
| --- | --- |
| Nurses work on the edge of sensitivity | 'We are working totally on the edge of sensitivity. My work is with palliative patients; my work is with children in high need of care, and I am a mother; my work is with people with greater need of care and with situations of maximum stress for caregivers.' (Marina) |
| In primary healthcare you take everything home | 'Sometimes what you feel is the uncertainty of whether I'm doing it right or I'm doing it wrong, or how far I could have gone. To some extent, you take it home with you. You carry these cases with you. Just like when my palliative care patients die… I remember them, I am very sorry, but, I have learned a lot that a good death is a success for the patient, for me, for the family, it is a topic that I have worked much more, but by exposure, because the number of palliative patients in relation to women exposed to violence is greater.' (Marcos) |
| Nurses work on the edge of sensitivity | 'You can't go home with that problem with you. But sometimes it's hard. And with this problem [IPV] it is. Not all cases are the same and with this problem [IPV], although you close the door, as it is that the life of a person is in danger, sooner rather than later, possibly, you cannot get into bed with the same tranquillity. You don't get into bed with the same peace of mind.' (Juan José) |
| They make me nervous | 'But it involves me getting nervous in the sense that I am in a situation of great risk for that person and to make sure I do not have the guilt of not having done something well and protecting that person. On the issue of confidentiality and privacy, the issue of cases that have to be referred to police groups, or to the women's institute, or to whatever has a circuit, or to protected houses, or all that kind of thing.' (Mónica) |
| 'These cases hurt' | 'They [IPV cases] annoy me a lot, on a personal level, as a woman…' (Montserrat)<br>'For me it's tremendous, it's devastating. When I ask, because I am one of the heavy nurses, of those who get into the kitchen, open the refrigerator. When I ask if they have suffered from their husbands some kind of violence and they tell me, because most of them tell me that yes, their husbands have beaten them when they were young, or not, my husband has been very good told me a woman once, my husband has been very good, my husband came from the field and didn't kick me, you say, my God!' (Patricia)<br>'…because with every dead woman [by IPV], dies a part of me. Look, the last woman killed by violence, I felt her as a part of my family, you see?' (Patricia)<br>'And having to run out with a woman, well, too. Once. That one hurt me a lot because you could see the imminent risk.' (Magdalena)<br>'Yes, caring in these cases hurts, it hurts just as it hurts them. Well, it's not the same, but it hurts, so…' (Begoña) |
| Negative consequences for personal life/ nurse blamed of new situation | '…but the situation for me was quite devastating. When she told me that because of me she could no longer see her children, that because of me she had had to leave her house, for me it was tremendous. I wasn't prepared at the time to take that blame.' (Patricia)<br>'Things can be done well or not, everything can be improved, but even doing things well, in the end, there is always, I don't know, it is how things turn against you, against the health professional and they [women exposed to IPV] are tremendously complex and it's a sensitive issue and they themselves are complex, they have such a complex life that the approach is very complex, and whatever we do, there is a thin red line between, doing things right and doing things wrong.' (Manuela)<br>'It does wear me down. I, in fact, have to recognize that, when I go to make the regulated home visits, I leave them for the end, because I have a feeling that I use a lot of energy, a lot of effort, because, as a professional, you have to treat this very professionally, and it generates a burden to see situations of violence or pseudo violence in which your scope of intervention is what it is' (Marcos)<br>'…but this ripped my soul inside.' (Mónica) |
| Rejection of this issue by colleagues | 'In addition, in reality, on many occasions, the same colleagues say "Well, she has looked for it", "Well, there she is, let her fix it, I'm not going to get into her life."' (Elena)<br>'I have found centres with great colleagues, and I have found centres in which they have looked at me as if to say: she is crazy or this is a feminazi or this is a… That it's not our responsibility, why do you get involved or complicate your life in this type of situation? Then that rejection, because over the years you learn not to be afraid of rejection, and don't stop working.' (Marina) |
| Successful cases compensate frustration | 'But what happens is that others that go well and that you manage to move forward compensate you. That you catch the cases on time, so that compensates you, doesn't it?' (Carmen) |
| Doing the difficult/I am more nurse than before | 'I say that now I am more a nurse than before, okay, I am much more a nurse than before because, when the problem is physical, it is physical, but everything physical has something emotional … The emotional approach is much more difficult.' (Manuela)<br>'But it is much easier to make a prescription and send them home, than to address [other dimensions] that requires much more time. That is why these interventions that are in the field of the emotional, the spiritual and the psychological, are much more complex, because we are used to, we put a pill and we see that there is a change, oops that's easy!, but everything else, is very complex, but it is our work, it is the most complicated … when you start it again and again and again and you make mistakes and you learn about the mistakes you make and you know that next time, you don't come in here, you go in, these interventions hook you, you get hooked […] Yes. Then, obviously, it makes you grow a lot' (Manuela) |

(Continues)

**TABLE 6** (Continued)

| Codes | Quotes |
|---|---|
| Everything new comes for nursing | 'I'll be honest with you. Nurses, in general, we'll say, something else for us. Because everything new that appears comes for nursing. But absolutely everything, huh? I mean, we've offloaded a lot of work off the doctors. I am not against doctors, of course, but it is true that we have downloaded a lot of work. We have taken care of residency, prescription, a lot of things that they used to do. And, every time a story comes out, nursing is involved, not because we want to, but because it is imposed by the district…' (Lidia) |
| It is easier if you can handle your agenda | 'Or, even if your job is vocational, you can't afford to spend 20, 30, 40 minutes doing what you feel right about, or what you want. Because I think even the professional feels more rewarded when they can work properly. And we don't have it. We have lost that. The system is like this and we have to accept it, but…' (Elena)<br><br>'That the case manager [Advance practice nurse] owns her agenda. So I have the freedom to say well, because today I'm going to do this interview and I'm going to take as long as it takes. That's the advantage of case management. Then I can devote time to this person.' (Patricia) |

more rewarding. Therefore, in the words of one participant, dealing with IPV had made her 'become more nurse than previously'.

In relation to professional consequences, there was a claim about nurses' scope of action being widened and, consequently, the workload is being increased in recent years but without a pertinent reduction in patient ratios and increments of nurses on the teams. Given the time that IPV cases require, some participants were of the view that this was possible only when the nurse was able to manage his or her agenda, which is only the case for PHC advance practice nurses and not for the majority of nurses.

## 4 | DISCUSSION

This paper aimed to explore the experiences of PHC nurses dealing with intimate partner violence against women in a supportive institutional context for IPV management. The main finding of this study is that when there is favourable institutional support for IPV management, even if it is not perfect, nurses are able to identify the subtlest and hidden cases of violence and implement all the recommendations stated in the literature to provide the best quality of care to women experiencing IPV. Thus, participants in this study described how they identified all the signs that might raise suspicion about IPV exposure, asked questions in a non-judgemental way, provided woman-centred care, managed referral systems and implemented all these actions from an inter-professional approach as recommended in the WHO guidelines and regional protocol based on the available evidence (de Andalucia, 2020; World Health Organization, 2013). A big question for future research is whether this achievement can be sustained over time given that PHC systems have been experiencing ongoing budget cuts since the economic crisis of 2009 and given the stress generated by the COVID-19 pandemic for nurses (Gea-Sánchez et al., 2021; Goicolea et al., 2017; Manzano García & Ayala Calvo, 2021).

Identification of IPV by nurses and other healthcare professionals is at the base of all the recommendations and guidelines to manage IPV (de Andalucia, 2020; World Health Organization, 2013). There is an open debate about which is the most effective way to identify women experiencing IPV.

Accordingly, different recommendations have been included in international and national guidelines about which women, what and how to ask for information that can disclose a situation of IPV through screening programmes or other approaches (Burnett et al., 2021; de Andalucia, 2020). The findings of this study suggest that identification in the case of long-term IPV relationships in which psychological violence is predominant is frequently a process not only for professionals but for women themselves. Similar to the experiences of nurses in other settings, identification itself thus becomes something much bigger and more complex than a discrete action or one consultation (Anderzén et al., 2021; Burnett et al., 2021; Mphephu & Du Plessis, 2021).

In this study, participants expressed that the process of identification from the raising of suspicions to whatever outcome required important nursing care, such as nursing presence, actions aimed at rebuilding women's self-esteem and building a strong therapeutic relationship. Nursing presence is included in the NIC taxonomy as a nursing intervention, but it has also been defined as 'co-constructed interaction established through deliberate focus, task-oriented/patient oriented relationship, clarification of meanings, ubiquitous participation, and accountability' (Mohammadipour et al., 2017). This definition incorporates the patient as 'someone who has a unique experience and is involved in an interaction with a nurse who has both personal and clinical competence and desires to accompany the patient in finding the meaning attached to various dimensions of his experience and who does not consider the technical dimension of care and performing care duties as the only important affairs' (Mohammadipour et al., 2017). This definition of 'nursing presence', including the patient as described, accurately fits participants' narratives about their experience and relationship caring for women experiencing IPV. Although at the core of the nursing practice, nursing presence and the other competencies nurses put in practice to care for women experiencing IPV were described by some participants as doing 'the difficult' because, in their view, the biomedical approach is mainstream in healthcare system. However, caring for women in a situation of IPV somehow 'obliged' nurses to go back to the core of nursing, and in the words of one participant, to 'be more nurse'. Thus, lessons learnt in the management of IPV could challenge the mainstream biomedical reductionist approach and shed light on how

to better address other health issues strongly related to social determinants of health that represent a high percentage of consultations in PHC services (Dowrick, 2010).

One topic our findings bring-up is what to do with the aggressor when he is not only coming as the women's companion but also as the patient himself. This happens in the Spanish healthcare system in which PHC nurses and physicians work with an assigned number of households geographically close to the PHC centre. Despite the right to change the assigned healthcare professional team, it seems unlikely that aggressors would allow women to do so, which means both will probably have the same physician and nurse assigned to them. There was already a call for the implementation of evidence-based programmes with men and boys to reduce gender-based violence in a special series about violence against women and girls published in the Lancet in 2015 (Jewkes et al., 2015), but the evidence on the topic is still limited (Graham et al., 2021). According to findings from a recent systematic review, the small number of interventions evaluated, the heterogeneity of their approaches and the variety of the measured outcomes do not allow conclusions to be drawn on what works best to prevent IPV perpetration (Graham et al., 2021). Since 2016 in the setting in which this study was conducted, there has been a socio-sanitary intervention led by PHC to work with men in the prevention of suicide. The intervention consists of a group intervention of eight sessions facilitated by a social worker. The content of the sessions includes the challenge of traditional gender norms and the acquisition by participants of better communication skills, both related to a delay in seeking help in situations of poor mental health among men. Given that traditional gender norms are also at the root of IPV (Fine et al., 2021), future research that follows recommendations derived from the revision of previous interventions with this same aim (Graham et al., 2021) could assess whether derivation and participation of men who are exerting violence against their partners in that or similar interventions could reduce that violent behaviour.

A good understanding of the complexity of leaving a violent relationship can reduce some of the negative impacts that caring for women experiencing IPV might cause. Participants in this study showed a good awareness of the difficulties women have in leaving their relationships, and they manifested less severe emotional burdens than have been found in previous studies (Christensen et al., 2021). Yet as described in the fourth theme, it still has an important emotional impact on nurses. Therefore, debriefing sessions and better support should be provided for them beyond the self-care that is recommended in the regional protocol (de Andalucia, 2020).

## 4.1 | Limitations

One potential limitation derived from qualitative secondary analysis design is that the data might not fit the purpose of the secondary study (Heaton, 2008). However, the question about experiences taking care of women experiencing IPV was included in the primary study's interview guide. Therefore, the data were rich and deep enough to answer the purpose of the present study. A second potential limitation is related to researchers not having been involved in the data collection (Heaton, 2008). To address this limitation, the research team included three researchers from the primary study along with three new researchers with experience in IPV research in different settings.

## 5 | CONCLUSION

When there is a supportive legal framework and the health system context is openly favourable to addressing IPV by elaborating protocols, providing training and enabling inter-professional collaboration, nurses are able to implement evidence-based good practices in the care for women exposed to IPV.

The predominant type of violence women are experiencing when they enter the healthcare system shapes their needs and the service/unit they will more likely reach. In the case of PHC, long-time psychological violence might be the most frequent type of IPV. This implies that guidelines and training on IPV for PHC nurses should take this into account and reinforce knowledge and skills related to 'nursing presence' for the identification process while women decide whether and how to act in relation to their situation.

In healthcare systems in which the aggressor is also the patient of the same healthcare providers, it is urgent to implement and evaluate interventions that guide recommendations for nurses' professional and ethical actions towards them.

The emotional burden that is generated by caring for women experiencing IPV is still an issue in an institutionally supportive context, and the prevention of nurses' burnout should be carefully taken into account, especially in the current situation of maximum stress for PHC due to budget limitations and enhanced workload due to the COVID-19 pandemic.

## CONFLICT OF INTEREST

The authors declare no conflict of interest.

## PEER REVIEW

The peer review history for this article is available at https://publons.com/publon/10.1111/jan.15406.

## DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

## ORCID

*Amaia Maquibar* https://orcid.org/0000-0002-8256-5771
*Itziar Estalella* https://orcid.org/0000-0001-9812-9299
*Rocío Romero-Serrano* https://orcid.org/0000-0002-2973-4919
*Juana Macías-Seda* https://orcid.org/0000-0001-6739-0312
*Eugenia Gil-García* https://orcid.org/0000-0003-3862-6845
*Inmaculada Lancharro-Tavero* https://orcid.org/0000-0001-7532-9677

## REFERENCES

Adams, C., Hooker, L., & Taft, A. (2022). A systematic review and qualitative meta-synthesis of the roles of home-visiting nurses working with women experiencing family violence. *Journal of Advanced Nursing*, 1–22. https://doi.org/10.1111/jan.15224

Alhalal, E. (2020). Nurses' knowledge, attitudes and preparedness to manage women with intimate partner violence. *International Nursing Review*, 67(2), 265–274. https://doi.org/10.1111/inr.12584

Alshammari, K. F., Mcgarry, J., & Higginbottom, G. M. A. (2018). Nurse education and understanding related to domestic violence and abuse against women: An integrative review of the literature. *Nursing Open*, 5(3), 237–253. https://doi.org/10.1002/nop2.133

Anderzén, A., Bäccman, C., & Almqvist, K. (2021). The professional relationship forms the base: Swedish child health care nurses' experiences of encountering mothers exposed to intimate partner violence. *International Journal of Qualitative Studies on Health and Well-Being*, 16(1), 1988043. https://doi.org/10.1080/17482631.2021.1988043

Braun, V., Clarke, V., & Weate, P. (2016). Using thematic analysis in sport and exercise research. In B. Smith & A. C. Sparkes (Eds.), *Routledge handbook of qualitative research in sport and exercise* (Vol. 3, pp. 191–205). Routledge. https://doi.org/10.1191/1478088706qp063oa

Breiding, M. J., Basile, K. C., Smith, S. G., Black, M. C., & Mahendra, R. (2015). *Intimate partner violence surveillance: Uniform definitions and recommended data elements*, Version 2.0. Atlanta (GA): National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Retrieved from https://www.cdc.gov/violenceprevention/pdf/ipv/intimatepartnerviolence.pdf

Burnett, C., Crowder, J., Bacchus, L. J., Schminkey, D., Bullock, L., Sharps, P., & Campbell, J. (2021). "It doesn't freak us out the way it used to": An evaluation of the domestic violence enhanced home visitation program to inform practice and policy screening for IPV. *Journal of Interpersonal Violence*, 36(13–14), NP7488-NP7515. https://doi.org/10.1177/0886260519827161

Campbell, J. C. (2002). Health consequences of intimate partner violence. *The Lancet*, 359(9314), 1331–1336. https://doi.org/10.1016/S0140-6736(02)08336-8

Christensen, M., Metcalfe, L., & O'Reilly, R. (2021). Emergency department nurses experiences of female domestic violence presentations: A review of the qualitative literature. *Nursing Forum*, 56, 925–937. https://doi.org/10.1111/nuf.12632

Colombini, M., Mayhew, S. H., Ali, S. H., Shuib, R., & Watts, C. (2012). An integrated health sector response to violence against women in Malaysia: lessons for supporting scale up. *BMC Public Health*, 12(1), 548. https://doi.org/10.1186/1471-2458-12-548

d'Oliveira, A. F. P. L., Pereira, S., Bacchus, L. J., Feder, G., Schraiber, L. B., Aguiar, J. M., Bonin, R. G., Vieira Graglia, C. G., & Colombini, M. (2022). Are we asking too much of the health sector? Exploring the readiness of Brazilian primary healthcare to respond to domestic violence against women. *International Journal of Health Policy and Management*, 11(7), 961–972. https://doi.org/10.34172/ijhpm.2020.237

Dowrick, C. (2010). Medically unexplained symptoms in primary care: How can doctors help, not hinder? *Mental Health in Family Medicine*, 7, 191–192. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3083255/

Fine, S. L., Kane, J. C., Murray, S. M., Skavenski, S., Munthali, S., Mwenge, M., Paul, R., Mayeya, J., & Murray, L. K. (2021). The role of violence acceptance and inequitable gender norms in intimate partner violence severity among couples in Zambia. *Journal of Interpersonal Violence*, 36(19–20), NP10744–NP10765. https://doi.org/10.1177/0886260519876722

García-Moreno, C. (2015). The health-systems response to violence against women. *International Encyclopedia of Public Health*, 385, 491–500. https://doi.org/10.1016/B978-012373960-5.00477-9

Gea-Sánchez, M., Briones-Vozmediano, E., Legido-Quigley, H., Muntaner, C., Rocaspana, M., & Blanco-Blanco, J. (2021). The resistance of nurses to austerity measures in the health sector during the financial crisis in Spain. *Gaceta Sanitaria*, 35(1), 42–47. https://doi.org/10.1016/j.gaceta.2019.08.009

Goicolea, I., Briones-Vozmediano, E., Ohman, A., Edin, K., Minvielle, F., & Vives-Cases, C. (2013). Mapping and exploring health systems' response to intimate partner violence in Spain. *BMC Public Health*, 13(1), 1162. https://doi.org/10.1186/1471-2458-13-1162

Goicolea, I., Mosquera, P., Briones-Vozmediano, E., Otero-García, L., García-Quinto, M., & Vives-Cases, C. (2017). Primary health care attributes and responses to intimate partner violence in Spain. *Gaceta Sanitaria*, 31(3), 187–193. https://doi.org/10.1016/j.gaceta.2016.11.012

Graham, L. M., Embry, V., Young, B., Macy, R. J., Moracco, K. E., Reyes, H. L. M., & Martin, S. L. (2021). Evaluations of prevention programs for sexual, dating, and intimate partner violence for boys and men: A systematic review. *Trauma Violence Abuse*, 22(3), 439–465. https://doi.org/10.1177/1524838019851158

Heaton, J. (2008). Secondary analysis of qualitative data: an overview. *Historical Social Research*, 33(3), 33–45. https://doi.org/10.12759/hsr.33.2008.3.33-45

Jewkes, R., Flood, M., & Lang, J. (2015). From work with men and boys to changes of social norms and reduction of inequities in gender relations: a conceptual shift in prevention of violence against women and girls. *The Lancet*, 385(9977), 1580–1589. https://doi.org/10.1016/S0140-6736

Junta de Andalucia. (2020). *Andalusian protocol for health system responses to gender-based violence*. Department of Health and Families, Board of Governors of Andalucia. Retrieved from https://www.juntadeandalucia.es/export/drupaljda/Protocolo_Andaluz_para_Actuacion_Sanitaria_2020.pdf

Manzano García, G., & Ayala Calvo, J. C. (2021). The threat of COVID-19 and its influence on nursing staff burnout. *Journal of Advanced Nursing*, 77(2), 832–844. https://doi.org/10.1111/jan.14642

Mohammadipour, F., Atashzadeh-Shoorideh, F., Parvizy, S., & Hosseini, M. (2017). Concept development of nursing presence: Application of Schwartz-Barcott and Kim's Hybrid Model. *Asian Nursing Research*, 11(1), 19–29. https://doi.org/10.1016/j.anr.2017.01.004

Mphephu, A., & Du Plessis, E. (2021). Professional nurses' experience in providing nursing care to women experiencing gender-based violence: A caring presence study. *Health SA Gesondheid*, 26, 1658. https://doi.org/10.4102/hsag.v26i0.1658

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis. *International Journal of Qualitative Methods*, *16*(1), 1–13. https://doi.org/10.1177/1609406917733847

Spanish Government Delegation Against Gender Violence. (2021). *Executive summary of the 2019 macro- survey on violence against women.* Secretary of State for Equality and against Gender Violence, Ministry of Equality. Retrieved from https://violenciag enero.igualdad.gob.es/violenciaEnCifras/macroencuesta2015/pdf/RE__Macroencuesta2019__EN.pdf

Vives-Cases, C., Ortiz-Barreda, G., & Gil-González, D. (2010). Mapping violence against women laws in the world: An overview of state commitments. *Journal of Epidemiology & Community Health*, *64*(6), 474–475. https://doi.org/10.1136/jech.2009.090365

World Health Organization. (2013). *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines.* World Health Organization. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/85240/9789241548595_eng.pdf

World Health Organization. (2021). *Violence against women prevalence estimates, 2018: Global, regional and national prevalence estimates for intimate partner violence against women and global and regional prevalence estimates for non-partner sexual violence against women.* World Health Organization. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/341338/9789240026681-eng.pdf