DISCLOSURE OF INTIMATE PARTNER VIOLENCE: A MIXED METHODS STUDY

DISCLOSURE OF INTIMATE PARTNER VIOLENCE IN URBAN EMERGENCY DEPARTMENT SETTINGS: A MIXED METHODS STUDY

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ABSTRACT

This mixed methods study seeks to explain women's decision making regarding intimate partner violence disclosure in urban emergency departments. It contributed to an overall program of research led by Dr. H.L. MacMillan examining the effectiveness of screening in health care settings to reduce violence and improve the quality of women's lives.

The study included a randomized, controlled trial with a quantitative sub-analysis and a grounded theory approach. The trial goal was to evaluate whether routine screening for IPV in health care settings, as compared to usual care, does more good than harm. The quantitative sub-analysis included 1,182 participants from three trial emergency departments. In the sample, 1.9% were exposed to intimate partner violence disclosed to the health care provider. Of those who disclosed, 62.9% were positive on both the screening tool and criterion standard. The grounded theory phase involved 19 participants and sought to examine the problems that trial participants associated with intimate partner violence disclosure and the processes they used to resolve them.

"Being found out" was the basic social psychological problem that influenced women's decisions against disclosure. This led to a three-phase process where participants attempted to "minimize their risks." The basic social psychological process

included: (a) deciding to seek health care, (b) evaluating trust in the clinician, and (c) establishing internal readiness for disclosure. Participants stated that the emergency department was not an ideal place to disclose violence due to overcrowding, chaos, long wait times, and a lack of privacy. Results indicated that abused women wanted clinicians to offer empathy and support, and to minimize the intrusion caused by assessment. Clinician education is required to improve communication, client engagement and comfort discussing intimate partner violence. Future research could explore the barriers and facilitators to care quality and patient satisfaction among abused women seeking emergency care.

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Moreover, I feel deep gratitude to the women who shared their experiences of intimate partner violence for the purposes of my research. Throughout the course of this study, I developed a greater respect and appreciation for the challenging realities that this vulnerable segment of the population experiences. It is my sincere hope that this work will be used to expand the knowledge of health care providers when working with women exposed to IPV.

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CHAPTER 1

Introduction

This dissertation consists of three manuscripts that will be prepared for publication. They detail the overall findings from a mixed methods study regarding the disclosure of intimate partner violence (IPV) by women to health care professionals in urban emergency departments. The purpose of this chapter is to review current literature related to IPV disclosure within urban emergency departments. This includes: an examination of the prevalence of IPV among women seeking health care at emergency departments; health outcomes related to IPV; issues related to emergency department use among women exposed to IPV; and factors related to the disclosure of IPV. The chapter will also discuss the gaps identified by the literature and how this mixed methods study attempts to address them. Finally, the methods will be presented.

Intimate Partner Violence Defined

"Wife beating," "spousal abuse," "domestic violence," and "intimate partner violence"– these phrases have evolved over the past two decades to describe the physical, sexual, psychological, and financial abuse within adult human relationships. This research relies on the definition that IPV encompasses a set of behaviours including

physical abuse, sexual abuse and exploitation, emotional abuse, spiritual abuse, and financial or economic abuse (Department of Justice Canada, 2004; Gordon, 2000; Hegarty, Sheehan, & Schonfeld, 1999). While the majority of the literature focuses on heterosexual couples, IPV also occurs in same sex relationships (Krug, Dahlberg, Zwi, & Lozano, 2002). IPV has often been studied in the context of the male partner as the perpetrator and the female partner as the victim. However, IPV includes perpetrators and victims of either sex (Krug et al., 2002). According to the World Health Organization, violence is multifaceted and includes individual, relationship, community and societal determinants (Krug et al.).

Literature Review

This review presents key issues from the literature related to IPV disclosure in urban emergency departments. They include IPV prevalence, associated health and economic costs, the use of acute care services, and aspects related to the disclosure of IPV within acute care settings. The following databases were searched from 1990–2008: CINAHL, Nursing and Health Sciences (SAGE), PsycINFO, Psychology (SAGE), Sociological Abstracts, Social Sciences Citation Index, Violence and Abuse Abstracts, HealthSTAR, ERIC, and PubMed. The search strategy was developed with the assistance of a health sciences librarian and included several search terms to represent IPV: "intimate partner violence," "domestic violence," "wife battering," "violence against women," and "assault." These terms were searched in conjunction with the terms "nursing" and "health care professionals" in order to identify relevant articles of interest.

Over 3,200 titles were identified and were further assessed if they: (a) pertained to nursing, (b) related to the emergency department, (c) provided insight into the health consequences among women exposed to IPV who sought acute care, and/or (d) discussed disclosure of IPV. Excluded were articles that did not relate to the population of this mixed methods study. Articles were excluded if they discussed batterer treatment and interventions; were related to social assistance use and uptake (e.g. welfare); focused on immigrant women and pregnant women; or were commentary pieces. These criteria reduced the count to 469 abstracts and full articles were retrieved. Upon further review of the full articles, 413 were excluded because they related to instrument validation; tested interventions related to IPV after disclosure but did not focus on disclosure; articulated health consequences of IPV; discussed interventions in women's shelters; focused on health care settings not applicable to emergency departments; or were opinion pieces. Fifty-six articles that were deemed potentially relevant to IPV disclosure among women attending emergency department settings were appraised for quality. Quantitative literature was assessed by the author using two instruments from the "users' guides to the medical literature" series, one for systematic reviews (Oxman, Cook, & Guyatt, 1994) (Appendix A) and one for primary studies (Guyatt, Sackett, & Cook, 1993) (Appendix B). Both tools provide criteria for the evaluation of a study or review's validity, such as participant randomization, occurrence of blinding, nature of the intervention and effect, analysis of results, follow-up procedures, and relevance of the results. A study was identified as "strong" in quality if it met all criteria, "moderate" in quality if two or three significant design flaws were evident, and "weak" in quality if multiple design flaws

were determined. An additional criterion that was considered was the article's relevance to disclosure decision making among women attending urban emergency department settings. For qualitative research, Mays and Pope's (2000) quality criteria were used (Appendix C). No quality criteria were found for qualitative meta-synthesis, so Mays and Pope's criteria were applied to qualitative meta-syntheses. A strong qualitative study would: adhere to the methodologic design, sampling, data collection and analysis principles of the qualitative approach; discuss procedures used to attain rigour including triangulation, participant validation, audit trail; outline context and reflexivity; and present relevance of the study. A moderate qualitative study would adhere to methodologic principles but might omit thorough discussions of rigour, context, or reflexivity. A weak qualitative study would involve method slurring or fatal flaws regarding carrying out the qualitative approach, and would omit major details related to rigour, context, and/or reflexivity.

The majority of the literature related to screening for IPV in the acute care setting, prevalence studies related to IPV, health care provider attitudes toward IPV inquiry, and health care provider education. Of the eight systematic reviews related to screening, three were rated as strong, one as moderate, and four as weak. Of the 32 primary studies, one rated as strong (MacMillan et al., 2006), two rated as moderate (Cox et al., 2004; Dearwater et al., 1998), and 29 rated as weak quality. While these studies focused on a number of different issues related to IPV, for instance, screening in health care settings, provision of interventions and education of health care providers, they did not thoroughly

address the process of IPV disclosure or women's decision making regarding disclosure in an urban emergency department setting.

Only three reviews related to IPV disclosure. One was a strong qualitative meta-synthesis (Feder, Hutson, Ramsay, & Taket, 2006), one was a systematic review of moderate quality (Robinson & Spilsbury, 2008), and one was a systematic review of weak quality (Olive, 2007). Among the 16 primary studies retrieved that related to IPV disclosure, one was strong (Varcoe, 2001), two were moderate (Hathaway, Willis, & Zimmer, 2002; Tower & McMurray, 2006), eight were rated as weak and five related more to application of a theory. Articles of all quality ratings will be discussed as they represent the best of what is available in the literature, or provide greater insight into the issues encountered in this study.

Intimate Partner Violence Population Prevalence

In Canada, the prevalence of IPV was estimated by the 1999 General Social Survey, a population-based telephone survey (Pottie Bunge & Locke, 2000). The General Social Survey relied on a national population sample of 26,000 individuals randomly selected to participate (Johnson & Pottie Bunge, 2001). Approximately 8.7% (n=8450) of women who were married or living in common-law relationships or who were in contact with a previous spouse during the five-year period preceding the survey reported having experienced some form of violence by a partner (Johnson & Pottie Bunge). The overall response rate of this survey was high at 81.3% with non-response occurring due to language barriers and inability of those completing the survey to reach the appropriate household member for participation. Results of the General Social Survey indicated that

the relative risk of IPV for women was 1.2 for both the 12-month and five-year period (Johnson & Pottie Bunge).

The ten General Social Survey questions used to calculate IPV prevalence were modified and adapted from the Conflict Tactics Scales 1 and 2 (Straus, 1979; Straus, Hamby, Boney-McCoy, & Sugarman, 1996). These instruments were selected for the General Social Survey to measure IPV since they were used in previous research studies in the United States and were considered to be the "best available" instruments for IPV research (Hegarty, Sheehan, & Schonfeld, 1999; Johnson, 1996; Straus et al., 1996). The Conflict Tactics Scales are the basis for the instruments used in this doctoral work to measure IPV exposure. Prior to the Conflict Tactics Scales 1 and 2, no instrument existed that measured severity and frequency of "acts" associated with IPV (Straus, 1979). Created in the early 1970s as a self-report instrument for survey research, the Conflict Tactics Scale 1 (20 items) assesses "acts" of conflict between intimate partners as opposed to opinions, attitudes or beliefs (Straus, 1990). The Conflict Tactics Scale 2 (39 items) was developed to augment the original Conflict Tactics Scale 1 (20 items) as well as to introduce the new scales of sexual coercion and physical injury (Straus et al., 1996).

The Conflict Tactics Scales 1 and 2 have been evaluated for internal consistency reliability (using Cronbach's alpha) and produced the following scores: α=0.83 Physical Aggression (Straus 1990a, 1990b) for Conflict Tactics Scale 1; and α=0.86 Physical Assault, α=0.87 Sexual Coercion and α=0.95 Injury for Conflict Tactics Scales 2 (Straus, Hamby, Boney-McCoy, & Sugarman, 1996).

Validity testing was performed using the Conflict Tactics Scales 1 and 2 by its authors to assess criterion (Straus, 1990a, p.41; Straus 1990b, p.65; Straus et al., 1996, p.307) and construct validity (Stets & Straus, 1990; Straus, 1990a, p.41-43; Straus 1990b, p.69-71; Straus & Douglas, 2004; Straus et al., 1996, p. 307). No evidence for face and content validity were provided by the authors of the Conflict Tactics Scales 1 and 2 (Straus, 1979; Straus, 1990a, p.42; Straus et al., 1996, p.291-2). Because the General Social Survey used a modified version of the Conflict Tactics Scales 1 and 2, the results from the psychometric testing of these instruments may not apply. Furthermore, no evidence of psychometric evaluation was found for the General Social Survey questions that were used to determine IPV prevalence.

Despite a lack of psychometric evaluation, the authors do highlight some key limitations with the General Social Survey methods including sampling error and bias. Non-sampling error can occur in both census and population-based surveys (Besserer & Trainor, 2000). Such errors may be due to coverage (e.g. the General Social Survey excluded households without a telephone even though the target population was all households), processing (e.g. errors introduced while capturing and processing the General Social Survey results), and non-response (e.g. the chosen respondent does not answer some or all of the questions) (Besserer et al., 2000). A significant potential for error is the exclusion of residents in the Yukon, Northwest Territories, and Nunavut and full-time residents in institutions (Statistics Canada, 2000). While it is difficult to determine the impact of such exclusions from the sample, one could argue that these

exclusions might affect the ability of the sample to be nationally representative as well as generalizable overall.

Bias, in contrast to random error, leads to systematic deviations from the underlying truth, including overestimates or underestimates of the outcome (Guyatt, 2002). The General Social Survey methodology allows for the potential introduction of bias through its reliance on the subject to disclose his or her experiences with violence, as well as characteristics related to his or her partner. While it is more likely that a victim would remember violence exposure, a potential source of bias relates to retrospective recall whereby individuals have greater difficulty remembering specific details or events that occurred in the past particularly over a longer period of time (e.g. five years). Another potential source of bias is self-report bias, whereby subjects fail to report incidents of violence to strangers over the telephone in reaction to overly invasive questioning, or even fear of reporting information to a government affiliated agency (e.g. Statistics Canada) (Besserer & Trainor, 2000). While Statistics Canada representatives received extensive training, possibilities existed whereby the interviewer might have influenced the respondent's answer through greater probing, known as interviewer bias (Guyatt et al., 2002). Social desirability bias, where respondents only answer what they perceive to be socially acceptable, is also a possible occurrence particularly in regard to the often-taboo subject of violence (Fisher, 1993). Despite the potential design flaws described above, this study differs from other studies that have reported prevalence exclusively from clinical samples. A large, population-based assessment of IPV may be

arguably one of the most valid ways of estimating the prevalence of IPV in the population.

Burden of Intimate Partner Violence in Emergency Departments

Emergency departments provide health care to a disproportionate number of women seeking treatment for injuries related to IPV (El-Bassel et al., 2003). Studies involving women exposed to IPV who attended acute care settings, such as emergency departments, reported varied prevalence rates. For example, one-year IPV prevalence rates range from 1% to approximately 54% (Anglin & Sachs, 2003; Dearwater et al., 1998; Ernst & Weiss, 2002; Kramer, Lorenzon, & Mueller, 2004). Lifetime prevalence rates range from 22% to 55% among women exposed to violence who seek medical care within an emergency department (El-Bassel et al.). Prevalence for an acute episode of IPV accounts for approximately 1–7% of patient encounters among studies included for review (Anglin & Sachs; Lipsky, Caetano, Field, & Bazargan, 2004). Among all female patient encounters, 14–22% acknowledged IPV exposure in the past 12 months (Anglin & Sachs). In Lipsky et al.'s (2004) cross-sectional survey of male and female clients who attended urban emergency departments, participants arrived at the emergency department for health care with pain and physical discomfort as chief complaint. Of these, approximately 15% of men and 10% of women were found to be positive for IPV exposure in the past 12 months. The differences in prevalence between males and females were not statistically significant ($p<0.10$). When results were combined across men and women, however, the odds of a violence-related injury were three times higher for those who reported past victimization when compared with those who did not report past

victimization (AOR 2.87; CI 1.23, 6.71) (Lipsky). One challenge with this article is the lack of a separate examination of women's risk indicators related to IPV exposure. Kramer et al. (2004) also studied women seeking care for IPV in emergency departments and found one-year rates to be 28% for emotional abuse, 12% for physical abuse, 6% for severe physical abuse, and 4% for sexual abuse. Studies in Ontario, Canada using acute care samples have estimated one year prevalence to be 26% (Cox, Bota, Carter, Bretzlaff-Michaud, & Sahai, 2004) and 13.9% (MacMillan et al., 2006; Wathen et al., 2007).

Reasons for Diverse Estimates of IPV Prevalence

Many factors contribute to these diverse estimates of burden due to IPV. Because a great deal of IPV research relies on clinical samples, such as participants from the acute care setting, it is possible that estimates are higher due to the nature of the population attending the emergency department. According to Glass, Dearwater, and Campbell (2001) emergency department screening led to a higher use of emergency department services for those women reporting trauma related to IPV in the past year (39%) than for those reporting IPV without trauma (13%). Screening initiatives undertaken in the emergency department may lead to increased identification of women when more health care providers actively ask about IPV. Acute care estimates of prevalence were derived from screening interventions. This creates a higher estimate of burden among abused women seeking care in urban emergency departments than if prevalence was calculated using the broader population.

Impairment Associated with Intimate Partner Violence

Current evidence suggests that there are differences between men and women who experience IPV in terms of their risk for physical and mental impairment associated with violence (Rodriguez, Lasch, Chandra, & Lee, 2000). While violence against men occurs, the prevalence and potential consequences of IPV have greater impact on the health and well-being of women (Centers for Disease Control, 2004; Pottie Bunge & Locke, 2000; Rodriguez et al.). In a Canadian study, women were more likely to be injured, utilize medical services and social services and take time off from paid or unpaid work as a result of the violence that they experienced (Pottie Bunge & Locke). In a US study, women exposed to IPV were more likely to rate their general health as poor as compared with non-exposed women. Approximately 26% of abused women reported that their health was excellent compared with 35% of non-abused women. Similarly, 12% of abused women rated their health as fair to poor compared with 6% of non-abused women (Campbell et al., 2002).

Campbell et al. (2002) used a case-control study involving HMO enrolees in the age range of 25–55 years to identify the physical health problems of women exposed to IPV compared to those who reported no exposure to IPV. Women were asked to complete various measures, using tools with known psychometric properties, including the Abuse Assessment Screen (Soeken, McFarlane, Parker, & Lominack, 1998) and the Miller Abuse Physical Symptom and Injury Scale (Miller & Campbell, 1993). Cases and a random sample of controls were involved in an additional in-depth interview where women described their health conditions and experiences of IPV.

Women exposed to IPV were found to have long-term health problems regardless of whether IPV stopped or persisted and frequently reported one to three problems per health care visit (Campbell et al., 2002). These included gastrointestinal disorders, viral infections and cardiovascular problems like chest pain and hypertension (Campbell et al.). In addition these authors found gynaecological problems like sexually transmitted infections (STIs), vaginal bleeding, fibroids, pelvic pain, and urinary tract infections (UTIs). Finally, women exposed to IPV had central nervous system problems like headaches, back pain, fainting, and seizures (Campbell et al.). There was a statistically significant difference ($p<0.05$) in reported health problems among abused women compared with non-abused women. These health problems included headache, back pain, vaginal infection, and digestive disorders. In support of Campbell et al.'s results, Plichta (2004) found that women exposed to IPV reported numerous physical injuries, especially to the face, neck, upper torso, breasts, and abdomen (Plichta, 2004). Furthermore, abused women experienced long-term sexual health problems like sexually transmitted infections and vaginal injuries (Plichta, 2007).

While the methodological strength of Campbell et al.'s (2002) case control study could have been improved with a stronger design (e.g. cohort analytic study), the article is unique in that it presents a comprehensive summary of the numerous physical conditions associated with IPV. Because study recruitment occurred through HMO sites, it is difficult to know if similar results would be found in the general population, which limits the generalizability of the results.

Psychiatric impairment is also associated with IPV exposure. Carlson, McNutt, Choi, and Rose (2002) found that as women reported multiple types of IPV (e.g. physical, emotional, and sexual), symptoms characteristic of depression, anxiety and somatization increased. In their study, 14% of women exposed to IPV reported depression symptoms and 26% of women reported anxiety symptoms. The presence of these mental health problems were found to be related to a number of issues like poor self-esteem, economic hardship, unemployment, and social isolation from professional support services and informal connections like family and friends (Carlson et al., 2002). Other mental health issues related to IPV include stress and coping responses like substance use. Alcohol consumption before a violent event was associated with IPV-related injury (Ernst & Weiss, 2002; Lipsky, Caetano, Field, & Bazargan, 2004). Authors have found a relationship between somatic complaints, like pain, and exposure to IPV (Glass et al., 2001; Olson et al. 1996; Wathen et al. 2007).

Among women presenting to the emergency department, approximately 33% of the sample exposed to IPV sought care between 11 p.m. and 7 a.m., with the chief complaints ranging from assault (54%), trauma (8%), and abdominal pain (7%) (Olson et al.). Wathen et al. (2007) found that depression was a risk indicator associated with IPV. They suggested that women with suspected depression be asked about IPV as part of their diagnostic assessment. These results provide some support for "case finding" where clinicians, regardless of the practice setting, ask questions related to IPV when certain risk indicators are present.

Economic Costs Related to Intimate Partner Violence

Violence reported by women, when compared with men, is more frequent and results in more serious consequences and outcomes (Pottie Bunge & Locke, 2000). In the United States, medical costs related to IPV are estimated at over $4 billion annually (Plichta, 2004; 2007). The first Canadian study to estimate the costs of various forms of violence against women, including intimate relationships, found that violence costs Canadian society approximately $4.2 billion per year in social services, education, criminal justice, labour, employment, health, and medical costs. Canadian criminal justice costs alone totalled an estimated $871,908,583 per year (Greaves, Hankivsky, & Kingston-Riechers, 1995). Estimates of violence-specific health care costs are in the range of $1.5 billion annually (Day, 1995; Department of Justice Canada, 2004). Greaves et al. (1995) compiled estimates of Canadian costs attributed to IPV based on information from approximately 30 surveys, reports, and studies, including the Statistics Canada survey "Violence Against Women, 1994." While these are the most recent estimates, there is a lack of data on costs attributed to violence in the health, criminal justice and social systems. IPV poses a significant economic burden when one considers such issues as the cost of health care services, social services and time lost from work.

Universal Screening Interventions

Due to the prevalence and burden of suffering associated with IPV, universal screening has been recommended by numerous professional bodies including the Registered Nurses Association of Ontario (Registered Nurses Association of Ontario, 2005), the American Medical Association (American Medical Association, 1992; Bair-

Merritt, Mollen, Yau, & Fein, 2006; Bauer & Shadigian, 2002), by advocacy groups (Family Violence Prevention Fund, 2004; Middlesex London Health Unit, 1995), and by some government organizations (New Zealand Ministry Of Health, 2002; United Kingdom Department of Health, 2000). Often these recommendations overlook the paucity of evidence examining the potential benefits and/or harm associated with universal screening.

Three strong systematic reviews were found that discussed the effectiveness of screening in health care settings (Nelson, Nygren, McInerney, & Klein, 2004; Ramsay, Richardson, Carter, Davidson, & Feder, 2002; Wathen & MacMillan, 2003). Ramsay, Richardson, Carter, Davidson, and Feder (2002) carried out a systematic review to assess the acceptability and effectiveness of screening for IPV in health care settings. The search strategy involved three electronic databases searched up to 2001. Included studies were those that measured IPV screening compared with no screening; health care provider and women's attitudes towards IPV screening; and intervention studies where abused women receiving an intervention were compared against no intervention. Very few good quality studies were found that met Ramsey et al's (2002) inclusion criteria. Most had serious design flaws such as a lack of comparability between groups; a lack of quality monitoring for chart abstraction studies; or poorly detailed sampling strategies, intervention methods and results.

Of the 20 papers that met the authors' inclusion criteria, five were cross-sectional surveys that discussed attitudes toward IPV screening (Ramsay, Richardson, Carter, Davidson, & Feder, 2002). Results indicated great variation among women's attitudes

toward screening with 43–85% stating that routine IPV screening was acceptable. Attitudes of health care providers were also varied with 33% in primary care and 53% in emergency departments finding routine IPV screening to be acceptable (Ramsay et al., 2002). Ten papers were identified that examined the application of a screening protocol for all women who attended health care settings like emergency departments, primary care or antenatal clinics (Ramsay et al.). The strongest study from this group was a cluster randomized, controlled trial that found no statistically significant difference in screening rates between primary care clinics that used a screening protocol and those who that did not. The remaining studies were of weaker design but did show an increase in the identification of women using routine IPV screening versus no screening. One important methodological challenge with the included screening studies was that none included adequate follow-up after implementation of the routine screening protocol.

Six studies were found that examined interventions for women exposed to IPV compared against women exposed to IPV who received no interventions (Ramsay, Richardson, Carter, Davidson, & Feder, 2002). No study was a randomized, controlled trial and no relationship was found between intervention effectiveness on measured outcomes related to IPV (Ramsay et al., 2004). Ramsay et al. concluded that introduction of a routine IPV screening protocol in a health care setting was premature based on evidence reviewed. Furthermore, better designed research is required that tests the effectiveness of interventions and identifies issues related to harm is required.

The US Preventive Services Task Force conducted a systematic review that examined evidence on the benefits and harms of routine screening for IPV and family

violence in health care settings among adult and older adult women (Nelson, Nygren, McInerney, & Klein, 2004). Six bibliographic databases were searched from the database start date until 2002. Over eight hundred abstracts were reviewed with 14 studies that met inclusion criteria related to screening and two met criteria related to interventions. No studies were found that examined the effectiveness of screening for reducing harm related to family violence (Nelson et al., 2004). The two intervention studies were deemed fair quality because they did not include a non-intervention control group. These studies focused on pregnant women and the provision of information resource cards as an intervention. Overall results indicated that there was no study of high quality to guide clinicians in the care and management of IPV (Nelson et al.)

Wathen and MacMillan (2003) conducted a systematic review that examined evidence for interventions aimed at the prevention of IPV relevant to the primary care setting. Five bibliographic databases from start date to 2001 were searched with an update completed in 2002. Over 2,185 titles and abstracts were reviewed with 22 articles retrieved for critical appraisal. Results indicated that while screening instruments can identify women exposed to IPV, the majority of these studies focus on the outcome of detection. No study was found that examined screening effectiveness for improved outcomes among abused women. Wathen and MacMillan argued the need for a high quality study that incorporated an experimental and control group to investigate the effectiveness of screening on health outcomes for women. Further, Wathen and MacMillan found no high quality evidence for the effectiveness of women's shelters as an intervention for women exposed to IPV. Fair quality evidence was found indicating

that women who had used shelters and undertook the interventions of specific advocacy programs and counselling reported a reduction in re-abuse and improved quality of life.

As a result of these systematic reviews, the Canadian Task Force on Preventive Health Care and the United States Preventive Services Task Force have concluded that there is insufficient evidence to recommend for or against universal screening for IPV (MacMillan & Wathen, 2001; Nelson, Nygren, McInerney, & Klein, 2004; United States Preventive Services Task Force, 2004; Wathen & MacMillan, 2003). This literature review does not debate the issue of universal screening for IPV, but it does acknowledge the divided thinking among researchers and clinicians regarding how to appropriately identify women exposed to IPV. Screening interventions have implications for women's decisions to disclose or not disclose IPV and these implications vary across studies.

Amongst the remaining weak primary studies related to screening, 13 related to prevalence, 11 related to IPV detection, and 12 related to facilitators and barriers to screening. Prevalence studies occurring in emergency department settings focused on the identification of IPV prevalence over a 12-month period or over a lifetime. They also looked at the prevalence of injury among abused women using various methods. These studies used some form of IPV screening as an instrument but may not have included additional interventions such as referral. Some examples included prospective cohort designs with random selection of participants (Cox et al. 2004); cross-sectional surveys (Heinzer & Krimm, 2002; Johnson & Pottie Bunge, 2001; Kramer, Lorenzon, & Mueller, 2004; Lipsky, Caetano, Field, & Bazargon, 2004); retrospective record reviews (Husni, Linden, & Tibbles, 2000; Kothari & Rhodes, 2006; Larkin, Hyman, Mathias, D'Amico,

& MacLeod, 1999; Morrison, Allan, & Grunfeld, 2000; Olson et al., 1996); a combination of survey and record reviews for validation of the survey responses (Dearwater et al., 1998; Roberts, Lawrence, O'Toole, & Raphael, 1997a; Roberts, Lawrence, O'Toole, & Raphael, 1997b); or an examination of risk indicators associated with IPV among women seeking care in emergency department settings (Wathen et al., 2007).

Studies related to the detection of IPV often used a screening protocol alongside an intervention. Examples of this included the screening and provision of information regarding community resources (Houry et al., 2008; Ramsden & Bonner, 2002; Trautman, McCarthy, Miller, Campbell, & Kelen, 2007); screening and direct referral to a social service agency (McFarlane, Soeken, Reel, Parker, & Silva, 1997; Zun, Downey, & Rosen, 2003); and screening and provision of an education intervention for health care providers related to IPV detection and referral (Campbell et al., 2001; Dienemann et al., 1999; Fanslow, Norton, & Robinson, 1999; Fanslow, Norton, Robinson, & Spinola, 1998; Loughlin, Spinola, Stewart, Fanslow, & Norton, 2000; Zachary, Mulvhill, Burton, & Goldfrank, 2001). Many of these studies were of weak quality with serious design flaws, including quasi-experimental design (Trautman et al., 2007), lack of adequate follow-up regarding the effect of the intervention (Ramsden & Bonner), and high rates of attrition (Houry et al.).

Articles that examined the facilitators and barriers to detecting women exposed to IPV included studies of health care provider attitudes (Corbally, 2001; Ellis, 1999; Gutmanis, Beynon, Tutty, Wathen, & MacMillan, 2007; Haggblom & Moller, 2006;

Inoue & Armitage, 2006); abused and non-abused women's opinions regarding screening (Dowd, Kennedy, Knapp, & Stallbaumer-Rouyer, 2002; Gielen et al., 2000; Lutenbacher, Cohen, & Mitzel, 2003; Webster, Stratigos, & Grimes, 2001); and the assessment of other emergency department specific barriers like screening environment (Thackery, Stelzner, Downs, & Miller, 2007).

Universal Screening versus Case-Finding

It is important to note the difference between universal screening, where a health care provider regularly asks every woman who enters a health care setting about IPV exposure, regardless of her reasons for attending the health care setting (Kimberg, 2001; Malecha, 2003; Poirier, 1997), and "case finding" or a "diagnostic approach" where a woman is asked about IPV when a health care provider identifies risk indicators, or signs suggestive of IPV (Nelson, Nygren, McInerney, & Klein, 2004; Taft & Hegarty, 2002). Case finding is part of prudent clinical assessment (e.g. during a diagnostic assessment for an injury) where clinicians identify and respond to the signs and symptoms of IPV arising from physical injury patterns, mental health concerns or unexplained complaints (e.g. pain and/or depression) (Tacket, Wathen, & MacMillan, 2004). When key risk indicators or symptoms for IPV are identified during an assessment but are not further explored, problems can be missed, inappropriate diagnoses made, and/or potentially unsuitable investigations or treatments suggested (Cole 2000; Tacket et al.; Wathen & MacMillan, 2003).

Literature Related to the Disclosure of Intimate Partner Violence in Emergency Department Settings

Use of Emergency Department Services

Taket et al. (2003) have argued that women exposed to IPV use a multitude of services and frequent acute settings three times more often than non-exposed women. Plichta (2004; 2007) undertook an integrative review using literature from 1996–2006 that examined abused women's use of acute care services and their interactions with health care providers. Formalized review methods were not described including: (a) the search strategy and methods for relevant article identification, (b) the methods for obtaining and appraising retrieved articles, and (c) the quality of the resulting articles. Plichta (2004; 2007) found that women exposed to IPV are as likely as other non-exposed women to enter the health care system and use services. Plichta argued that inefficient use of health care services led to inappropriate receipt of services for abused women. Unlike other women, those exposed to IPV report having unmet health care needs related to either their refusal to seek care from the health care providers' failure to detect IPV (Plichta, 2007). After controlling for access to care and demographic characteristics, women experiencing IPV were twice as likely to report unmet health care needs (Plichta & Falik, 2001).

According to the United States Centers for Disease Control and Prevention (2003), approximately 486,000 emergency department visits and 95,000 calls to ambulance services are made annually related to IPV. Women affected by IPV seek acute care for various health issues not related to IPV (Plichta, 2007); however, various authors

suggest that these women will return to the emergency department for issues related to IPV (Glass, Dearwater, & Campbell, 2001; Muelleman & Liewer, 1998; Zachary, Mulvihill, Burton, & Goldfrank, 2001). Approximately 64% of women exposed to IPV had at least one visit to the emergency department in the past 12 months, with the majority of visits occurring during the month of the assault (Kothari & Rhodes, 2006). Many factors contributed to a woman's decision to seek care in an emergency department including limited access to primary care, or embarrassment about discussing the topic with a family physician or other social services (Ernst & Weiss, 2002).

Refusal to Use Emergency Services

There is evidence that abused women did not seek timely medical care. Plichta (2004) found that only 39% of women who were strangled multiple times by an intimate partner sought medical care for injuries. According to Husni, Linden, and Tibbles (2000), over 23% of women exposed to IPV refused to be taken to the hospital when an ambulance arrived at their homes. This posed challenges for women who require assistance yet refuse to rely on emergency services (i.e. ambulance) for transport to hospital. This is of great concern for women whose injuries are severe and life-threatening.

Disclosure within the Emergency Department Setting

Feder, Hutson, Ramsay, and Taket (2006) provide an example of a strong meta-synthesis that explored the appropriate response by health care providers to a disclosure of IPV. Five bibliographic databases were searched from their start dates until 2004 for articles that used qualitative research design and investigated women's views of health

care professionals related to IPV disclosure. Twenty-five studies met criteria and results produced three levels of constructs which were themes identified by the literature reviewed (Feder et al., 2006). Among first-order constructs, abused women wanted health care providers who were non-judgmental, compassionate, sensitive, and could maintain confidentiality (Catallo, 2006; Feder et al.). Second-order constructs identified inconsistencies in the literature and were resolved through the creation of a third order construct. Third-order constructs recommended that health care providers assure abused women about safety, privacy and confidentiality; place information about abuse in public waiting areas; create a non-threatening and supportive clinical environment; and respond to disclosure with belief, compassion and support (Feder et al.).

A moderate quality review by Robinson and Spilsbury (2008) sought to determine factors that enabled or discouraged IPV disclosure to health care providers. This review searched 12 bibliographic databases up to 2005 and retrieved 162 potentially relevant abstracts. After inclusion screening, 10 qualitative papers related to IPV disclosure were included for review and were critically appraised using criteria by Mays and Pope (2000). Of the five studies that directly pertained to disclosure of IPV two were of strong quality, two were of moderate quality, and one was rated as weak. Results indicated that women exposed to IPV wanted health care providers to routinely ask about IPV but were concerned that the health care provider's response might not be helpful (Robinson & Spilsbury). Further participants suggested the health care environment, especially the emergency department, might not be the best place for IPV disclosure due to the lack of

privacy, time constraints, and challenges building trust with the health care provider (Robinson & Spilsbury).

Consistent with these reviews are other sources from the literature that examine disclosure from the perspective of the woman exposed to IPV. Abused women described key desirable characteristics of health care providers that they felt would promote IPV disclosure. These included a non-judgmental attitude, compassion, sensitivity, and the ability to maintain confidentiality (Chang et al., 2005; Feder, Hutson, Ramsay, & Taket, 2006; Lipsky, Caetano, Field, & Bazargan, 2004). Women exposed to IPV wanted health care providers to value their experiences and not blame them for their involvement in a violent relationship (Feder et al. 2006). Women described wanting health care providers to help them by providing more information about IPV and by offering referrals (Peterson, Moracco, Goldstein, & Andersen, 2003). Professional competency and the ability to establish a professional relationship with the woman was also important to those exposed to IPV (Battaglia, Finlay, & Liebschutz, 2003).

Finally, women cited other barriers that influence their decision making about seeking care in the emergency department for IPV. These included the need to protect their partner and preserve their relationships (Battaglia, Finlay, & Liebschutz, 2003; Fugate, Landis, Riordan, Naureckas, & Engel, 2005); the need to protect their privacy (Fugate et al., 2005); fears of losing their children after disclosure of IPV (Chang et al., 2003; Chang et al., 2005); and police involvement after disclosure (Chang et al., 2003; Chang et al., 2005).

Other literature discussed facilitators and barriers among health care providers related to discussing IPV. There were a number of factors related to the health care provider that influenced whether or not a woman discloses IPV. Key barriers cited by health care providers included their own lack of education, the belief that IPV is not apparent or existent in their practice setting, and the frustration of not being able to help change women's situations (Ernst & Weiss, 2002; Moore & Zaccaro, 1998). In one study of nurses, attitudinal barriers were in existence, such as their perceptions of a lack of time and training (Moore & Zaccaro). Other authors have also found such barriers (Heinzer & Krimm, 2002). Nurses who worked in the hospital setting, including emergency department, were less likely to acknowledge presence of IPV among women seeking care and least likely to report having the education to assess and intervene with IPV compared with nurses in other settings (Moore & Zaccaro). In a study by Heinzer and Krimm, only acute care triage nurses participated in a screening study. All other emergency personnel, including other nurses, refused to participate due to their immense discomfort with inquiring about IPV. Ellis (1999) stated that hospital nurses are the least likely to inquire about IPV with the top three barriers being a lack of privacy in the emergency department, lack of time to assess for IPV, and a lack of confidence to ask about IPV.

Gutmanis, Beynon, Tutty, Wathen, and MacMillan (2007) randomly selected 1,000 nurses and 1,000 physicians from family practice, obstetrics and gynecology, emergency care, maternal/newborn care and public health areas of practice in Ontario, Canada. Participants received a mailed 43-item questionnaire that examined the facilitators and barriers to their current practices regarding IPV screening. Two open-

ended questions asked participants to describe barriers to screening for IPV and facilitators that would make routine abuse inquiry easier (Gutmanis et al., 2007). The response rate for completed surveys among nurses was 59.7% (n=931) and 32.8% (n=328) for physicians. Results indicated that acute care physicians (52.9%) were more likely than nurses (24%) to initiate discussions of IPV ($p<0.002$) (Gutmanis et al.). This study used principal components analysis in order to identify constructs related to the identification and response to IPV. Principal components analysis, often a first step in factor analysis, can help to reduce the number of overall variables as well as isolate variables for the purposes of discerning their effect on the dependent variable (Pedhazur, 1997). Gutmanis et al. found that the key variables which influenced health care provider identification of and response to IPV included: (a) preparedness, (b) self-confidence, (c) professional supports, (d) abuse inquiry, (e) consequences of asking, (f) comfort following disclosure, (g) clinician lack of control, and (h) practice pressures. Overall, preparedness emerged as a key concept and was impacted by the health care provider's past experiences with IPV or his/her having known someone on a personal level who experienced IPV (Gutmanis et al.).

Some authors have studied how nurses view women who were exposed to IPV. Corbally (2001) argued that the personal values and beliefs of nurses influenced how they viewed clients who sought care at the emergency department. Nurses often made moral judgments regarding clients and ranked them according to their illnesses and injuries. These judgments led to a response of dislike, anger and frustration among nurses for caring for clients who regularly sought acute care, such as women exposed to IPV

(Corbally). Varcoe (2001) completed an ethnographic study where data were collected by the author for over two years in two urban emergency department settings. In this well-conducted ethnography, data collection included 200 hours of observation, 30 in-depth interviews with health care providers, and 5 in-depth interviews with women exposed to IPV. Varcoe described the ethnographic traditions that she followed for data collection and analysis. Using critical ethnography, her goal was to seek competing, contradictory perspectives for analysis and involve participants in the analysis whenever possible. Results indicated that nursing practice in the emergency department was influenced by stereotypes and focused on solving immediate physical problems as a means to maintain department efficiency and patient flow. In her study, Varcoe found that IPV largely went unrecognized as a problem not encountered in the setting. Further, nurses decided what type of care women deserved to receive which ranged from the nurse "doing nothing" to providing greater interventions for women perceived to be deserving of nursing care. Women who deserved "nothing" were perceived as seeking care regularly at the emergency department, abusing substances or were seen as not committed to making changes to their relationships. Women who were "deserving of care" had obvious or severe physical injuries and/or appeared to be of higher social status (Varcoe).

For women seeking health care, provider gender may affect their comfort when it comes to discussing sensitive issues like IPV. In a study of how physician gender impacted visits to primary care settings, Bertakis, Franks, and Azari (2003) found that clients of female physicians were more satisfied with the interaction and that women physicians focused more of their visit on prevention and counselling. According to

Thackeray, Stelzner, Downs, and Miller (2007) Caucasian and African American women exposed to IPV were both statistically significantly more comfortable with a female clinician to screen them for IPV rather than a male clinician. The participants from this study were recruited from a large shelter in the United States and all had left their abusive relationship. Participants (N=134) were between the ages of 20 and 40 years (76.1%) and indicated that they felt greater comfort when a health care provider of their respective race asked about IPV. The sample was composed predominantly of African-American participants (55.1%) and Caucasian participants (33.3%). The remaining sample was too small to draw any conclusions about other ethnic backgrounds. While the results suggest that female clinicians are preferred by women exposed to IPV, it is difficult to know if the results would have been different if the sample population included women recruited from a health care setting and a comparison was made between abused and non-abused women. Potentially, one could argue that the preferences of women who have left an abusive relationship and entered a shelter may be different than those women who may be seeking care in an emergency department and who have not yet disclosed IPV. In a meta-synthesis of 29 qualitative articles, Feder, Hutson, Ramsay, and Taket (2006) determined that clinician gender preference was an issue that remained unresolved. These authors did not find any qualitative studies in their review that provided adequate explanation to support health care provider gender preference by women exposed to IPV. It is not clear from the literature whether or not there would be a difference in women's gender preference if they were to initiate IPV disclosure rather than the provider. Potentially, women could view these two types of events as different; something that

could be examined separately in research. It is still not clear whether or not gender impacts either women's willingness to disclose IPV or their comfort discussing IPV after being asked by a health care provider.

According to Ernst and Weiss (2002) barriers that prevented women from disclosing IPV in an emergency department included concerns about confidentiality, lack of awareness of the role that clinicians can play, ability to hide the signs of IPV, and a reluctance to discuss the issue within the emergency department. Other authors have also found that a negative experience in the emergency department influenced their decisions about disclosure of IPV (Ellis, 1999). Women exposed to IPV and who were admitted to hospital experienced stigma and social isolation, and disengagement by staff (Varcoe, 2001). These women experienced health care providers as judgmental and as blaming for their relationship choices and were made to feel unworthy (Varcoe). Gielen et al. (2000) found that 48% of all women recruited from an HMO agreed that clinicians should routinely screen all women for IPV. The sample included 202 women identified as abused and 240 women randomly selected as non-abused. While women agreed with routine screening as a policy within the emergency department, they expressed concern about retaliatory violence from abusive partners from emergency department policies supporting routine screening (43%) and the mandatory reporting of abuse to the police (52%). Over 66% of the sample indicated that mandatory reporting of IPV to police would be a significant barrier to disclosure of IPV. These results indicate that department wide policies should be carefully reviewed for their impact on self-initiated disclosure of IPV by women. Additionally, other barriers like the experience of shame and stigma can

impact women's ability to disclose IPV in health care settings like the emergency department.

Harms

There are potential harms for women who disclosed in health care settings like the emergency department. When a health care provider intervenes beyond what a woman is ready for at the time, the provider may alienate her, potentially impacting the woman's future desire and readiness to seek help (Zink, Elder, Jacobson, & Klosterman, 2004.

While the harms are not well documented, some authors have discussed potential negative outcomes for women as a result of IPV screening:

1. Generating psychological distress by asking a woman to disclose IPV when she is not ready;
2. Creating false security that IPV screening can help when it may not;
3. Instilling fear that screening will lead to the involvement of child protection services;
4. Potentially exposing a women to further violence; and:
5. Inhibiting a woman from future discussions about IPV if the interaction with the health care provider was negative (Feder, Hutson, Ramsay, & Tacket, 2006; MacMillan & Wathen, 2004; Taft & Hegarty, 2002).

Gaps in the Literature

This literature review highlighted key gaps in the literature related to IPV disclosure in urban emergency department settings. No review related exclusively to IPV disclosure in emergency departments was found. A review that exclusively examines IPV

dislcosure in the emergency department setting is crucial to understand the complex relationship between abused women seeking care, characteristics of emergency department health care providers and the overall impact of the health care setting as facilitators and inhibitors of IPV disclosure. Among the primary studies found, most incorporated qualitative methods but were of weak quality because of omission of qualitative design specification, did not adhere to the methodologic criteria of the chosen approach, and/or lacked description of the processes used for maintaining rigour and reflexivity. As a result, very little is answered by the literature such as characteristics that promote or discourage IPV disclosure in urban emergency departments, specific processes that abused women undertake when deciding whether or not to disclose, and how health care providers can respond to disclosure of IPV. While research has shown that women exposed to IPV do attend emergency department settings (Kothari & Rhodes, 2006), little is known about specific problems women identify with disclosure and strategies used when deciding to disclose IPV. These are important areas of research since there is a strong likelihood that women who continue to be exposed to violence may be at risk for injury, long-term physical and mental health sequelae, and potential mortality.

Statement of the Problem Based on the Literature Review

Based on the literature review, it was clear that there was considerable variability in the prevalence of IPV across acute care settings. In addition, many factors–including the use of urban versus rural emergency department settings, variation in the assessment, and documentation of IPV, and the willingness of abused women to disclose IPV--can

influence the prevalence estimate, making it challenging to estimate the burden of IPV in emergency department settings. The rate of IPV documentation was low among emergency department clinicians (Kothari & Rhodes, 2006). Rhodes et al. (2007) found that clinicians struggle with discussion of IPV making it challenging for women to disclose IPV.

Numerous factors like embarrassment, fear, and helplessness influenced women's decisions to disclose IPV within the emergency department setting (McCauley, Yurk, Jenckes, & Ford, 1998; Sankar & Jones, 2005). When IPV disclosure was not validated by health care providers, many women refrained from discussing the issue (Fugate, Landis, Riordan, Naureckas, & Engel, 2005). Women exposed to IPV were at risk for marginalization due to the complexity of their physical and mental health needs (Campbell et al., 2002; Mechanic, 2004). This was further complicated by the fact that these women were found to utilize more health care services compared with those women not exposed to IPV (Ramsay, Richardson, Carter, Davidson, & Feder, 2002) and were perceived as misusing health services (Lutenbacher, Cohen, & Mitzel, 2003).

Women sought treatment on numerous occasions from the same or multiple health care providers before deciding to disclose violence and identified barriers to disclosure (Lutenbacher, Cohen, & Mitzel, 2003). In addition, past negative experiences or the perception of indifferent reactions from health care providers prevented IPV disclosure (McCauley, 1998; Fugate et al., 2005). A woman's decision to disclose IPV to a health care provider depended on having a safe, inviting environment for her to reveal her experiences (Dienemann, Glass, & Hyman, 2005). Moreover, past experiences and

expectations surrounding disclosure of IPV impacted her willingness to do so (Dienemann et al.). Upon disclosure of violence, women expressed specific needs from the health care provider: the desire to be treated with respect, the need for protection from the abuser, the wish for self-control, and the provision of options and clinician documentation of the situation (Dienemann et al.). Study Purpose

The purpose of this mixed methods study was to understand and explain women's decision making related to IPV disclosure in urban emergency department settings. Results will provide further explanation to findings arising from the acute care component of a randomized, controlled trial assessing the effectiveness of screening versus usual care across health care settings in Ontario, Canada. An additional goal for this study was to identify what encouraged and/or discouraged IPV disclosure in urban emergency departments by way of identifying participant's central problem(s) related to disclosure. Further, once the central problem(s) related to IPV disclosure in urban emergency departments emerged, this study sought to identify the process by which women undertook to resolve the/these problem(s).

Relevance to Nursing

Developing a perspective on the process of disclosure among women exposed to IPV is important for nursing. The results of this mixed methods study will contribute to nursing knowledge through the understanding of women's decision making regarding IPV disclosure. Nurses are among the first health care providers that women exposed to violence encounter upon entering the health care system (Ross, Hoff, & Coutu-Wakulcyzyk, 1998; Short, Johnson, & Osattin, 1998; Malecha, 2003). Ross et al. (1998)

argued that nurses had difficulty problem-solving and making decisions during situations where there was a potential concern for the well-being of women and children. As mentioned earlier, health care providers cited their own lack of education as a barrier for inquiry about IPV in the health care setting. The findings from the literature review suggest that nurses need greater skill support for assessment and intervention among women exposed to IPV. This study can help to address this gap by outlining from the abused woman's perspective, the process of decision making undertaken before disclosure in an urban emergency department. Additionally, results from this mixed methods study can inform the assessment and intervention among women attending emergency department settings.

Methods

Background

This dissertation research was part of an overall research program related to IPV led by Dr. Harriet MacMillan, Professor of Pediatrics and Psychiatry and Behavioural Neurosciences at McMaster University, Hamilton, Ontario. The title of the research program was "If, When, and How to Ask the Questions: Assessing Screening Approaches to Identifying Woman Abuse in Health Care Settings," with more information available at http://fhs.mcmaster.ca/vaw/index.html. The program of research was multi-disciplinary and examined the effectiveness of screening on reducing violence and improving the quality of life for women and their children. Many individual projects attempted to address these issues including studies population attitudes to screening, a meta-analysis of risk indicators, a trial to test effectiveness of screening methods, and an overall

screening trial to examine the effectiveness of screening versus usual care in various health care settings. This program of research was funded by the Ontario Women's Health Council, Ontario Ministry of Health and Long-Term Care beginning in March 2003. Funding for the dissertation research came from a Doctoral Scholars Award in Women's Health (2006–2007) from the Ontario Council on Graduate Studies and the Ontario Women's Health Council, Ontario Ministry of Health and Long-Term Care.

Brief Outline of Mixed Methods Study

This mixed methods study occurred over two phases beginning with a subsample recruited from a multi-site randomized, controlled trial; a quantitative sub-analysis using data from the trial and a grounded theory approach. Figure 1 outlines both phases and the research undertaken as part of this dissertation:

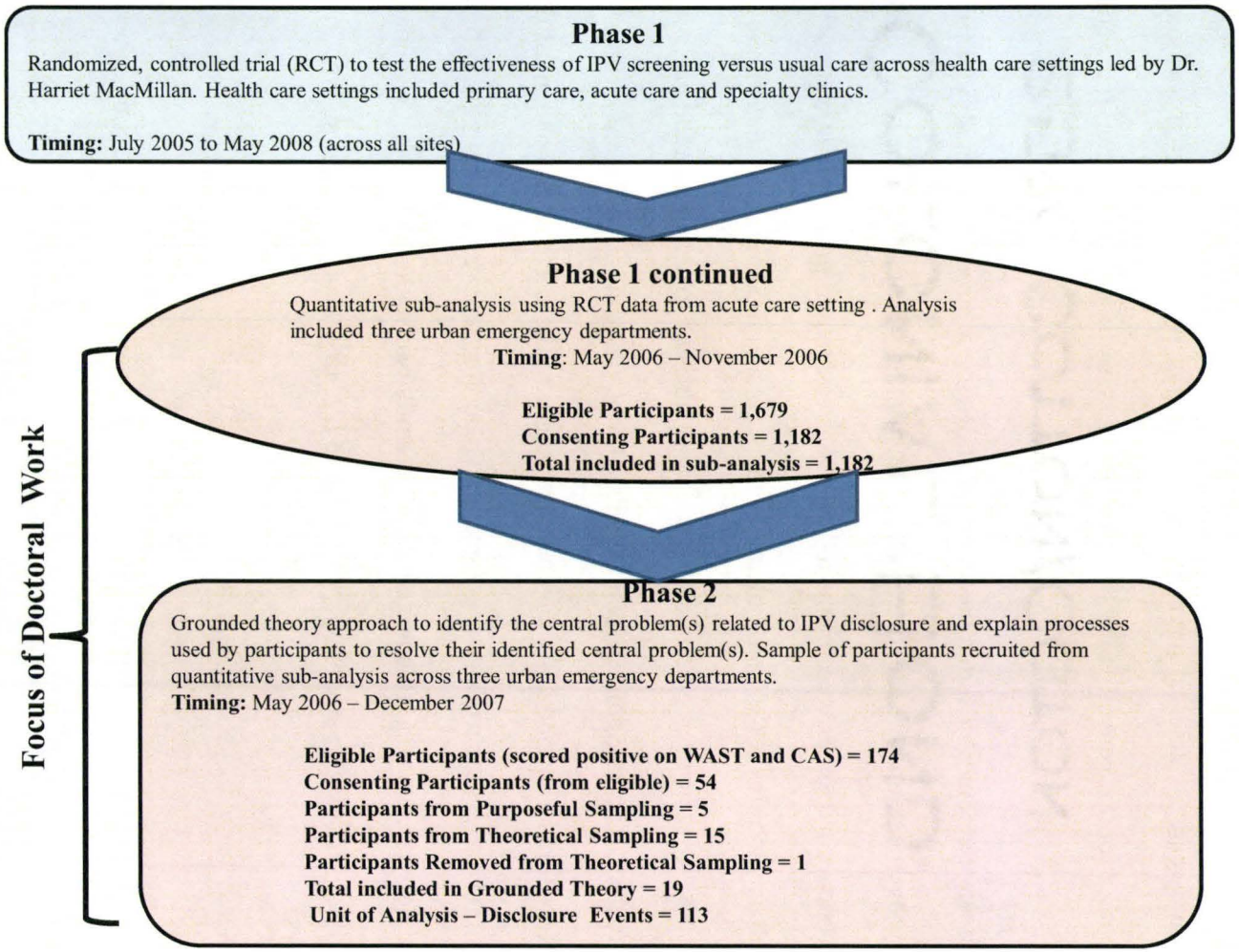

Figure 1. Brief outline of focus of doctoral work

Phase 1: Quantitative Phase

The randomized, controlled trial was conducted across Ontario, Canada led by Dr. MacMillan (Principal Investigator) and involved three types of health care settings: primary care, acute care, and specialty clinics. The purpose of the trial was to evaluate whether routine screening for IPV in health care settings, as compared to usual care, does more good than harm. Various outcomes were assessed as part of the randomized trial. Primary outcomes included the assessment of violence reduction, quality of life improvement, and the identification of potential harms of screening. A number of secondary outcomes were evaluated, like depression and post-traumatic stress disorder, as well as variables considered potential mediators and moderators to understanding the process by which screening and usual care might lead to changes in the primary outcomes. The randomized, controlled trial took place across different settings with a follow-up of 18 months. At the commencement of the doctoral component of this mixed methods study, the trial was ongoing, so data collection was continuing and final analysis had not yet occurred. This mixed methods study was undertaken to better understand early observations pertaining specifically to IPV disclosure decision making in the acute care setting type.

Setting

Participants for this dissertation research were recruited across three urban emergency departments in the greater horseshoe area of Southern Ontario. Two of the three emergency department settings that participated in this study are part of one of Ontario's largest multi-site hospital amalgamation and serves over 434,000 residents.

This site has over 747 acute care beds and it employs 4,200 employees across the amalgamated hospital settings. From April 2006 to March 2007, there were 200,250 visits to the emergency department according to the hospital website. The third emergency department setting where participants were recruited is part of a multi-centre hospital with more than 4,000 staff, 650 beds and 100,000 emergency department visits annually. Further information regarding the patient flow for these three emergency department sites was sought, but not provided the administrators of these sites.

The quantitative sub-analysis (May–November 2006) involved data obtained from three urban emergency department sites participating in the randomized, controlled trial. The emergency department sites were randomized into "screening" and "non-screening" shifts of eight hours in length: one shift per day at specific times of the day (i.e. morning, afternoon, evening, night). Women who were recruited on a "screening" shift made up the screen group. Upon entering the emergency setting, women were approached by a research assistant to participate in a women's health study. Those who provided verbal consent were invited into a private area where they were assessed for study eligibility (Appendix D).

According to MacMillan et al. (2006), an annual IPV prevalence rate of 13.9% was found for Ontario acute care settings with women reporting a preference for self-report strategies (including written and computer-based). Face-to-face encounters were the least preferred option. After informed consent was sought for eligible women, participants completed questionnaires as part of the randomized, controlled trial including

a demographic questionnaire, two questionnaires to assess IPV exposure and the clinical interactions questionnaires both for the participant and for the health care provider.

Intimate Partner Violence Screening Instruments

In order to assess IPV exposure, the randomized controlled trial utilized two instruments including a screening tool and a criterion standard. The chosen screening tool was the Woman Abuse Screening Tool (WAST) (Appendix E) (Brown, Lent, Schmidt, & Sas, 2000; Brown, Lent, Brett, Sas, & Pederson, 1996). A previous study that utilized a comparable participant population to this study found that the WAST administered as a self-completed written approach resulted in less missing data than the other screening instrument and methods tested (MacMillan et al., 2006). The sensitivity and specificity of the WAST was found to be 47% and 95.6% respectively (MacMillan et al.).

The WAST is an 8-item instrument developed for primary care settings that asks about all forms of abuse (physical, sexual, emotional) in the previous 12-month period. Scoring ranges from 0 to 2 with a total possible score of 16 points with 0 = never, 1 = sometimes, and 2 = often. A score of $\geq$4 on the WAST indicated exposure to IPV which was determined from results of an earlier study that found this score increased the instruments sensitivity (72%) and specificity (90%) among comparable populations (MacMillan et al., 2006; Wathen, Jamieson, & MacMillan, 2008).

Early validation studies of the WAST indicated acceptable internal consistency reliability scores, with Cronbach's alpha ranging from 0.75 to 0.95 (Brown, Lent, Brett, Sass, & Pederson, 1996; Brown, Lent, Schmidt, & Sas, 2000). Other assessments of reliability, like test-retest reliability, were not performed. Preliminary construct and

discriminant validity was assessed, with results indicating the ability of the instrument to detect abused women and discern from non-abused women (Brown et al., 1996).

A second instrument was chosen to be the criterion standard for IPV identification for the randomized, controlled trial. The Composite Abuse Scale (CAS) (Appendix F) is a 30-item instrument with two published studies detailing its psychometric properties (Hegarty, Bush, & Sheehan, 2005; Hegarty, Sheehan, & Schonfield, 1999). The CAS contains four subscales, including physical abuse, emotional abuse, severe combined abuse and harassment. Questions related to abuse behaviours over the last 12 months are scored according to frequency of occurrence, with 0 = never to 5 = daily for a total possible score of 150 points (Hegarty et al., 1999; Hegarty & Roberts, 1998). For this study a score of ≥ 7 on the CAS indicated positive IPV exposure (Wathen, Jamieson, & MacMillan, 2008).

Early validation studies using the CAS found acceptable internal consistency reliability across all four subscales with Cronbach's alpha score > 0.75 (Hegarty, Bush, & Sheehan, 2005; Hegarty, Sheehan, & Schonfield, 1999). Other assessments of reliability, including test-retest reliability were not performed. Validation assessment included acceptable face and content validity (Hegarty et al., 1999), and preliminary criterion and construct validity (Hegarty et al., 2005; Hegarty et al., 1999).

Wathen, Jamieson and MacMillan (2008) assessed the agreement of the WAST and CAS utilizing results from the randomized, controlled trial across 26 health care settings from August 2005 to December 2006. The 12-month IPV prevalence was found to be 22.1% for the WAST and 14.4% for the CAS (Wathen et al., 2008). The overall

agreement between the two instruments was found to be moderate with Kappa (κ) = 0.63. Overall sensitivity and specificity of the WAST was found to be 88% and 89% respectively (Wathen et al.).

Administration of Intimate Partner Violence Screening Instruments

During a "screening shift" women received the IPV screening instrument (WAST), then proceeded to see the health care provider. Before leaving the acute care setting, participants completed the criterion standard (CAS). Participants were not informed of their screening score on either the WAST or CAS. When a participant scored positive for IPV using the WAST, health care providers were notified of a positive screen result on the participant's medical chart. On a "non-screening" shift, women completed both the WAST and the CAS after their visit with the acute care health care provider for research purposes only; this information was not shared with the health care provider.

Data Sources for Quantitative Sub-Analysis

Demographic data including age, marital status, pregnancy status, education level, household income and place of residence (e.g. rural or urban) were collected. Participants completed a clinical interactions questionnaire (Appendix G) which asked them the following question: "Did you discuss the issue of partner violence during your visit with the health care provider (e.g. doctor, nurse) today?" If participants answered "yes" they continued to answer questions regarding the interventions, including information and referral, provided by the clinician. Likewise, health care providers completed a similar clinical actions questionnaire that asked the clinician to report on the interventions they provided abused women. These included: verbal information or education on IPV; IPV

disclosure acknowledgement, validation of women's feelings, referrals and written information, and offering problem-solving strategies for immediate assistance.

Phase 2: Qualitative Phase

An explanatory qualitative phase was chosen to explain decision making by participants in the screen group regarding their avoidance of personally disclosing their IPV exposure to the attending health care provider despite obtaining a score ≥4 on the WAST. Many factors may have contributed participants decisions related to disclosure of IPV within the emergency department. Various hypotheses generated after the completion of Phase 1 can be found in Appendix H. Participants were not provided with their IPV screening results at any point in the screening trial.

This called for a method that could explore what was contributing to women's decision making related to the disclosure of IPV. The principles of traditional grounded theory (Glaser & Straus, 1967; Glaser, 1978; Glaser, 1998) guided this study. Grounded theory, a method that studies human interaction, permits the identification of the central problem(s) that prevented participants from disclosing IPV during their visit to the emergency department. Further, grounded theory was chosen because it explored a process that participants utilized to resolve problems related to IPV disclosure. A secondary purpose for the use of grounded theory was to build a mid-range, substantive theory to portray the central problem, its antecedent characteristics, the contributing factors affecting the strategies to resolve the problem and the consequences if the problem was not resolved (Glaser & Straus). The new questions developed to drive the grounded theory explanatory phase included:

1. What is the basic social psychological problem that women exposed to IPV encounter when deciding to disclose IPV in urban emergency departments?

2. What social psychological process do women exposed to IPV use to resolve this problem?

Initial Purposeful Sampling

Recruitment for Phase two of this study is shown in Figure 2. Phase two of this study began with a sample derived from the screening trial across three emergency department settings and lasted for a 16-month period from June 2006 to December 2007. The following inclusion criteria were used to identify an initial five participants for purposeful sampling. Participants needed to be:

1. 18 years or older and were enrolled in the randomized, controlled trial at one of the three recruitment emergency departments;

2. Recruited into the randomized, controlled trial on a "screen" day and scored positive for IPV (e.g. $\geq$4 on the WAST and $\geq$7 on the CAS);

3. Able to disclose IPV to a health care provider during their emergency department visit according to the Clinical Interactions instrument used in the randomized trial;

4. Healthy enough to participate in a 60–90 minute interview; and

5. Able to speak, read, and write in English.

Recruitment for this study began in May 2006. By the end of June 2006 no participants had responded "yes" to the question, "Did you discuss the issue of partner violence during your visit with the health care provider (e.g. doctor, nurse) today?" Recruitment

data were reviewed back to the screening trial start date for the emergency department settings and it was found that only five out of a potential 251 participants who had scored positive for IPV using the WAST and CAS responded "yes" to this question. However, these participants were recruited into the screening trial prior to the start date for this mixed methods study and could not be included. In order to understand the disclosure experiences of women who scored positive for IPV on the screening instruments the third inclusion criterion was revised to include women who also responded "no" to the question regarding discussion of IPV with the clinician. Five participants were obtained for initial purposeful sampling to test and modify the interview guide (Appendix J) and develop preliminary codes and categories for further testing. These five participants provided data for initial coding and new criteria to drive theoretical sampling.

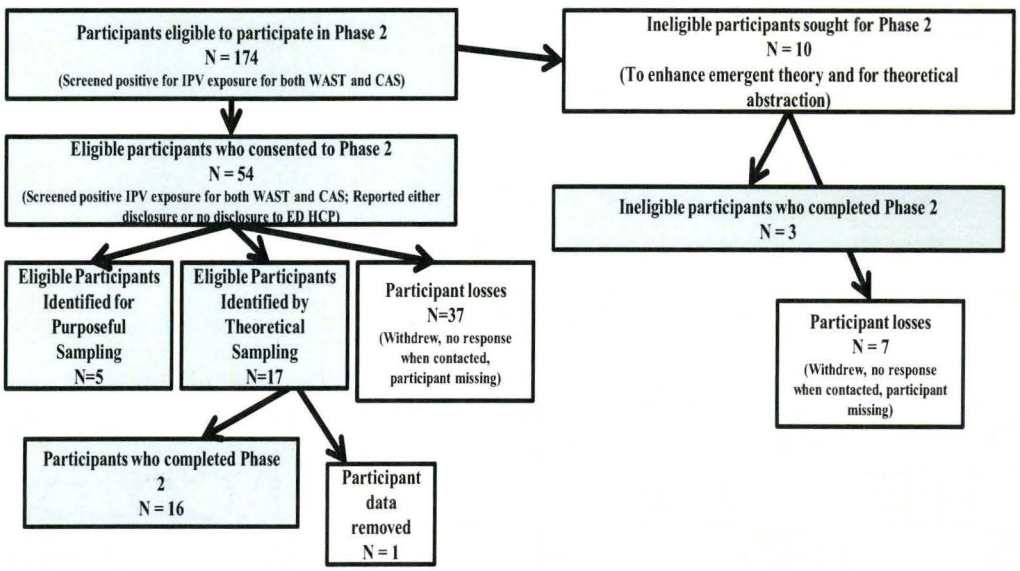

Figure 2. Recruitment for Phase 2.

Theoretical Sampling Methods

After purposeful sampling was completed, adapted forms of theoretical sampling, maximum variation sampling and negative case sampling were used. Adaptations were required in order to preserve the overall integrity of the mixed methods design and to maintain the integrity of the grounded theory component, which will be discussed in this dissertation. When undertaking the process of theoretical sampling, themes related to IPV disclosure arose that required the inclusion of participants who did not indicate a true positive score for IPV exposure (i.e. WAST $\geq$4 and a CAS score $\geq$7). As a result, additional participants from Phase 1 with either a mixed screening score or a negative screening score were sought.

Recruitment

All participants for the qualitative component were contacted by phone approximately seven days post recruitment into the screening trial. A recruitment script for the qualitative component of the study was created (Appendix K). Women were told that the qualitative component was an additional study involving an open discussion regarding their experiences speaking with an emergency department clinician about IPV. For both components, as with Phase 1, women were informed that they could refuse participation or withdraw at any time during the course of the study. All women were provided with a $25 honorarium upon completion of each interview for the quantitative and qualitative components.

Participants completed consent forms indicating that they would be audio recorded during the interview. Interviews with participants were conducted using a

structured interview guide which was modified over time to permit saturation of themes and testing of developing categories and theoretical relationships. All interviews lasted between 60–90 minutes and were audio recorded. After consultation with the research team, one participant's data was removed from the study after the first qualitative interview due to concerns regarding her mental health status and the validity of data provided. In the quantitative phase, participants completed questionnaires during their visit to the acute care setting. However in the qualitative phase, the majority of interviews occurred in a public setting, such as the public library. Prior to the third interview, three women expressed concern with discussing personal information in a public place and requested that the remaining interviews occur in their homes. After assessing the women's and the researcher's safeties in the home, the remaining interviews for these women were conducted in their home setting.

Data Analysis

Data analysis methods for grounded theory were followed as recommended by Glaser (1978) and expanded upon by Charmaz (2006). The constant comparative method was followed using the technique of constantly comparing data to create categories and then to compare emerging categories to identify relationships supporting an emerging theory (Glaser; Glaser, & Straus, 1967). Data for the explanatory phase included interview transcripts, field notes and memos and were organized and coded using NVIVO 7.0 software. Both substantive and theoretical coding was conducted for Phase 2 of this mixed methods study. During substantive coding, both open and selective coding strategies were used. Open coding was performed where data were broken down into

incidents in order to examine similarities and differences. All data were examined in order to create substantive and theoretical codes (Glaser, 1978). Coding was completed in levels beginning with substantive coding, also known as "in vivo" coding (Level 1) (Schreiber, 2001). During this coding stage, substantive codes can involve one word and, more often, incorporate the terms used by the participants (Glaser). These initial "in vivo" codes were reviewed and categories were developed to capture groupings of similar codes under a shared phrase called a category (Level 2) (Schreiber). Theoretical codes were more abstract and involved developing a theoretical construct. Level 3 coding involved identifying possible relationships between the emerging categories and creating constructs to generating meaning for a developing theory (Tatano-Beck, 2002). After the core variable and basic social process (BSP) was discovered, selective coding strategies were used. Selective coding used coding families to identify relationships among the substantive codes (Glaser). Elements from the coding families used included "process," "strategy," and the "six C's" (Glaser). These coding families were developed by Glaser to help researchers in the coding process towards identification of a basic social psychological problem and process. The "six Cs" included causes of the phenomenon, context, contingencies, consequences, covariances, and conditions (Glaser).

In addition to the coding techniques described above, the sorting and integration of memos was used as part of the process of theoretical sampling. Memos were created during data collection and in the analytic phase in order to help with initial category development and with obtaining theoretical abstraction during theory development (Charmaz, 2006). Sorting of memos by hand and using coding trees with NVIVO 7.0

software were undertaken in order to identify significant events or categories, expand theoretical integration of defined categories and the comparison of categories at an abstract level (Charmaz). During the process of sorting memos categories were compared and refinements were made to categories and relationships between categories. One strategy used to help with defining the relationships between categories was diagramming, such as creating maps and matrices (Charmaz). When trying to determine processes and strategies that women use during IPV disclosure decision making, concept mapping using diagrams was an essential strategy to view the sequence of events and establish hypotheses around women's decisions and behaviours.

In addition to sorting and comparing memos, integration strategies were used in order to determine the order of categories and processes and to define the logic and hypothesized nature of the relationships between components of the grounded theory. Charmaz (2006) recommends that several categories be considered during the integration phase of analysis as opposed to writing about a single category. Newer adaptations to Glaser's method were followed, which suggest that the researcher should look for interpretive understandings grounded in context as opposed to causal relationships between categories (Charmaz). Following these analysis strategies permitted identification of theoretical relationships between categories.

Results

Results of the Quantitative Sub-Analysis

Demographic results for the quantitative sub-analysis of both screen and non-screen groups are found in Appendix L. Approximately 14.7% scored positive for IPV

(i.e. ≥4 WAST and ≥7 CAS) and 73.6% scored negative for IPV (Appendix L). For screen group participants, 12.6% indicated a positive IPV exposure (Appendix M). The rate of mixed IPV exposure status (i.e. false positive or false negative score) remained consistent across both groups. Across the total sample of participants, 1.9% had a true positive score and stated that they had disclosed IPV to the health care provider in the emergency department (Appendix N). Among those who disclosed IPV, 62.9% scored positive for IPV on both the WAST and CAS (N=22) (Appendix O). Among those participants who stated that they did not disclose IPV to the health care provider in the emergency department, 13.3% scored positive for IPV on both the WAST and CAS (Appendix O). These results indicated a need to generate further insight into the process related of IPV disclosure in urban emergency departments. Results for the clinical interactions questionnaire among screen group participants and health care providers are found in (Appendix O). For the screen group, 3.6% of participants who scored positive for IPV exposure (i.e. ≥4 WAST and ≥7 CAS) reported disclosure of IPV to an acute care clinician. Only 48 clinicians completed the clinical interactions instrument for the 563 participants in the screen group for a response rate of 8.5%. Among the 48 questionnaires completed, 26 health care providers stated that they acknowledged the participant's IPV disclosure among screen group participants. (Appendix P) shows the types of clinical interactions offered to participants in the screen group according to both participants and clinicians. Response rate regarding interventions was 6.4% among participants and 8.5% among health care providers. Due to large amounts of missing data from participants and

health care providers, further assessment of disclosure using qualitative methods was required.

Chapters 2 to 5 will provide the description of methods, study implementation and presentation of key results, and the implications and conclusions. Chapter 2: *"Mixing a Grounded Theory Approach With a Randomized Controlled Trial Related to Intimate Partner Violence: What Challenges Arise for Mixed Methods Research?"* describes the adaptations undertaken to incorporate a grounded theory approach with a randomized, controlled trial as part of a mixed methods study. Further, this chapter examines the strengths and limitations of these design adaptations and provides recommendations for the incorporation of a grounded theory approach with a randomized trial.
Chapter 3: *"Being Found Out--A Grounded Theory Explaining Intimate Partner Violence Disclosure Processes by Women in Urban Emergency Department Settings,"* presents the findings from the grounded theory component of this mixed methods study. This chapter presents the overall grounded theory with a discussion of the strategies women use related to IPV disclosure, the consequences of disclosure, and other factors related to disclosure such as intervening conditions and the context of the emergency department setting. Finally, implications for nursing and health care provider practice are provided.

Chapter 4: "*'I'll Tell You When I am Ready'--Description of Steps Towards Intimate Partner Violence Disclosure in Emergency Departments: Application to the Transtheoretical Model of Change*," discusses change theory and its application to the decision making processes of women exposed to IPV. It describes a unique mapping exercise used to understand decisions and behaviours based on the various stages of

change. Implications of women's behaviours related to change theory are also discussed in relation to how women choose to disclose or not disclose IPV.

Chapter 5: *"Discussion of Findings, Limitations, and Future Implications"* discusses the final conclusions arising from this mixed methods study and the implications of the research. Recommendations for nursing clinical practice, future research endeavours, and considerations for nursing education are provided. This chapter will discuss how the dissertation papers form a coherent, substantial body of work.

References

American Educational Research Association (1999). *The standards for educational and psychological testing.* Washington, DC: American Psychological Association.

American Medical Association (AMA). (1992). Violence against women: Relevance for medical practitioners. *Journal of the American Medical Association, 267*, 3184–3189.

Anglin, D., & Sachs, C. (2003). Preventive care in the emergency department: Screening for domestic violence in the emergency department. *Academic Emergency Medicine, 10*, 1118–1127.

Asher, J., Crespo, E.I., & Sugg, N. K. (2001). Detection and treatment of domestic violence. *Contemporary Obstetrics and Gynecology, 9*, 62-72.

Bair-Merritt, M.H., Mollen, C.J., Yau, P.L., & Fein, J.A. (2006). Health care providers' opinions on intimate partner violence resources and screening in a pediatric emergency department. *Pediatric Emergency Care, 22*, 150–153.

Battaglia, T.A., Finley, E., & Liebschutz, J.M. (2003). Survivors of intimate partner violence speak out. Trust in the patient-provider relationship. *Journal of General Internal Medicine, 18*, 617–623.

Bauer, S., & Shadigian, E.M. (2002). Screening for partner violence makes a difference and saves lives. *British Medical Journal, 325*, 1417.

Bertakis, K.D., Franks, P., & Azari, R. (2003). Effects of physician gender on patient satisfaction. *Journal of American Medical Women's Association, 58*, 68–75.

Besserer, S., & Trainor, C. (2000). Criminal victimization in Canada, 1999. *Juristat, 20*(10), 1–27.

Brown J.B., Lent, B., Brett, P.J., Sas, G., & Pederson, L.L. (1996). Development of the Woman Abuse Screening Tool for use in family practice. *Family Medicine, 28*(6), 422–428.

Brown, J.B., Lent, B., Schmidt, G., & Sas, G. (2000). Application of the woman abuse screening tool (WAST) and the WAST-short in the family practice setting. *Journal of Family Practice, 49*(10), 896–903.

Campbell. J.C., Coben, J.H., McLoughlin, E., Dearwater, S., Nah, G., Glass, N., Lee, D., Durborow, N. (2001). An evaluation of a system-change training model to improve emergency department response to battered women. *Academic Emergency Medicine, 8*(2), 131–138.

Campbell, J., Snow Jones, A., Dienemann, J., Kub, J., Schollenberger, J., O'Campo, P., Carlson Gielen, A., & Wynne, C. (2002). Intimate partner violence and physical health consequences. *Archives of Internal Medicine, 162*, 1157–1163.

Carlson, B.E., McNutt, L.A., Choi, D.Y., & Rose, I.M. (2002). Intimate partner abuse and mental health. *Violence Against Women, 8*(6), 720–745.

Catallo, C. (2006). Commentary. Review: Meta-analysis of qualitative studies generated recommendations for healthcare professionals meeting with women who had experienced intimate partner violence. *Evidence-Based Nursing, 9*(4), 125.

Centers for Disease Control. (2003). *Costs of intimate partner violence against women in the United States*. Atlanta, GA: Centers for Disease Control. Retrieved November 27 2008 from http://www.cdc.gov/ncipc/pub-res/ipv_cost/ipv.htm

Centers for Disease Control. (2004). *What is the burden of intimate partner violence in the United States*? Atlanta, GA: Centers for Disease Control. Retrieved August 2005, from http://www.cdc.gov/omh/Highlights/2004/HOct04.htm

Chang, J.C., Decker, M.R., Moracco, K.E., Martin, S.L., Peterson, R., & Frasier, P.Y. (2005). Asking about intimate partner violence: Advice from female survivors to health care providers. *Patient Education and Counseling, 59*, 141–147.

Chang, J.C., Decker, M.R., Moracco, K.E., Martin, S.L., Peterson, R., & Frasier, P.Y. (2003). What happens when health care providers ask about intimate partner violence? A description of the consequences from the perspectives of female survivors. *Journal of the American Medical Women's Association, 58*, 76–81.

Charmaz, K. (2006). *Constructing grounded theory. A practical guide through qualitative analysis*. London, UK: Sage Publication.

Coker, A.L., Bethea, L., Smith, P.H., Fadden, M.K., & Brandt, H.M. (2002). Missed opportunities: Intimate partner violence in family practice settings. *Preventive Medicine, 34*, 445–454.

Cole, T. (2000). Is domestic violence screening helpful? *Journal of the American Medical Association, 284*(5), 551–553.

Corbally, M.A. (2001). Factors affecting nurses' attitudes towards the screening and care of battered women in Dublin A&E departments: A literature review. *Accident and Emergency Nursing, 9*, 27–37.

Cox, J., Bota, G.W., Carter, M., Bretzlaff-Michaud, J.A., Sahai, V., & Rowe, B.H. (2004). Domestic violence. Incidence and prevalence in a northern emergency department. *Canadian Family Physician, 50*, 90–97.

Day, T. (1995). *The health-related costs of violence against women in Canada: The tip of the iceberg.* London, ON: Centre for Research on Violence Against Women and Children.

Dearwater, S.R., Coben, J.H., Campbell, J.C., Nah, G., Glass, N., McLoughlin, E., & Bekemeir, B. (1998). Prevalence of intimate partner abuse in women treated at community hospital emergency departments. *JAMA, 280*(5), 433–8.

Department of Health. (2000). *Domestic violence: A resource manual for health care professionals.* London, UK: Department of Health. Retrieved September 14, 2006, from www.doh.gov.uk/domestic.htm

Department of Justice Canada. (2004). *Spousal abuse: A fact sheet from the department of justice.* Ottawa, ON: Department of Justice Canada.

Dienemann, J., Campbell, J.C., Landenburger, K., Curry, M.A. (2002). The domestic violence survivor assessment: A tool for counseling women in intimate partner violence relationships. *Patient Education and Counseling, 46*, 221–228.

Dienemann, J., Glass, N., & Hyman, R. (2005). Survivor preferences for response to IPV disclosure. *Clinical Nursing Research, 14*(3), 215–33.

Dienemann, J., Trautman, D., Shahan, J.B., Pinnella, K., Krishnan, P., Whyne, D., Bekemeier, B., Campbell, J.C. (1999). Developing a domestic violence program in an innercity academic health center emergency department: The first 3 years. *Journal of Emergency Nursing, 25*, 110–115.

Dowd, M.D., Kennedy, C., Knapp, J.F., & Stallbaumer-Rouyer, J. (2002). Mothers'and health care providers' perspectives on screening for intimate partner violence in a pediatric emergency department. *Archives of Pediatric Adolescent Medicine, 156*, 792–799.

El-Bassel, N., Gilbert, L., Witte, S., Wu, E., Gaeta, T., Schilling, R., & Wada, T. (2003). Intimate partner violence and substance abuse among minority women receiving care from an inner-city emergency department. *Women's Health Issues, 13*, 16–22.

Ellis, J.M. (1999). Barriers to effective screening for domestic violence by registered nurses in the emergency department. *Critical Care Nursing Quarterly, 22*(1), 27–41.

Ernst, A.A., & Weiss, S.J. (2002). Intimate partner violence from the emergency medicine perspective. *Women & Health, 35*(2/3), 71–81.

Family Violence Prevention Fund. (2004). *National consensus guidelines on identifying and responding to domestic violence victimization in health care settings*. San Francisco, CA: Family Violence Prevention Fund. Retrieved September 14, 2006, from http://www.endabuse.org/health

Fanslow, J.L., Norton, R.N., & Robinson, E.M. (1999). One year follow-up of an emergency department protocol for abused women. *Australian and New Zealand Journal of Public Health, 23*(4), 418–420.

Fanslow, J.L., Norton, R.N., Robinson, E.M., & Spinola, C.G. (1998). Outcome evaluation of an emergency department protocol of care on partner abuse. *Australian and New Zealand Journal of Public Health, 22*(5), 598–603.

Feldhaus, K.M., Koziol-McLain, J., Amsbury, H.L., Norton, I.M., Lowenstein, S.R., & Abbott, J.T. (1997). Accuracy of three brief screening questions for detecting partner violence in the emergency department. *Journal of the American Medical Association, 277*(17), 1357–1361.

Feder, G.S., Hutson, M., Ramsay, J., & Taket, A.R. (2006). Women exposed to intimate partner violence. Expectations and experiences when they encounter health care professionals: A meta-analysis of qualitative studies. *Archives of Internal Medicine, 166*, 22–37.

Fugate, M., Landis, L., Riordan, K., Naureckas, S., & Engel, B. (2005). Barriers to domestic violence help seeking. *Violence Against Women, 11*(3), 290–310.

Gielen, A.C., O'Campo, P.J., Campbell, J.C., Schollenerger, J., Woods, A.B., Jones, A.S., Dienemann, J.A., Kub, J., & Wynne, C. (2000). Women's opinions about domestic violence screening and mandatory reporting. *American Journal of Preventive Medicine, 19*(4), 279–285.

Glaser, B. (1978). *Advances in the methodology of grounded theory. Theoretical sensitivity.* Mill Valley, CA: Sociology Press.

Glaser, B. (1998). *Doing grounded theory – Issues and discussions.* Mill Valley, CA: Sociology Press.

Glaser, B., & Strauss, A. (1967). *Discovery of grounded theory. Strategies for qualitative research.* Mill Valley, CA: Sociology Press.

Glass, N., Dearwater, S., & Campbell, J. (2001). Intimate partner violence screening and intervention: Data from eleven Pennsylvania and California community hospital emergency departments. *Journal of Emergency Nursing, 27*(2), 141–149.

Gordon, M. (2000). Definitional issues in violence against women. *Violence Against Women, 6*(7), 747–783.

Greaves, L.,Hankivsky, O., & Kingston-Riechers, J (1995). *Selected estimates of the costs of violence against women.* London, ON: Centre for Research on Violence Against Women and Children.

Gutmanis, I., Beynon, C., Tutty, L., Wathen, C.N., & MacMillan, H.L. (2007). Factors influencing identification and response to intimate partner violence: A survey of physicians and nurses. *BMC Public Health, 7*(12), e1–e11.

Guyatt, G.H. (2002). Therapy and harm. Why study results mislead – Bias and random error. In G. Guyatt, & D. Rennie (EDs.), *Users' guides to the medical literature. A manual for evidence-based practice* (p.223-232). Chicago, IL: American Medical Association.

Guyatt, G.H., Sackett, D.L., & Cook, D.J. (1993). Users' guides to the medical literature. II. How to use an article about therapy or prevention. *Journal of the American Medical Association, 270*(21), 2598–2601.

Haggblom, A.M.E., & Moller, A.R. (2006). On a life-saving mission: Nurses' willingness to encounter with intimate partner abuse. *Qualitative Health Research, 16*(8), 1075–1090.

Hathaway, J.E., Willis, G., Zimmer, B. (2002). Listening to survivor's voices. Addressing partner abuse in the health care setting. *Violence Against Women, 8*(6), 687–719.

Hegarty, K., Bush, R., & Sheehan, M. (2005). The composite abuse scale: Further development and assessment of reliability and validity of a multidimensional partner abuse measure in clinical settings. *Violence and Victims, 20*(5), 529–547.

Hegarty, K., & Roberts, G. (1998). How common is domestic violence against women? The definition of partner abuse in prevalence studies. *Australian and New Zealand Journal of Public Health, 22*(1), 49–54.

Hegarty, K., Sheehan, M., & Schonfield, D. (1999). A multidimensional definition of partner abuse: Development and preliminary validation of the composite abuse scale. *Journal of Family Violence, 14*(4), 399–415.

Heinzer, M.M.V., & Krimm, J.R. (2002). Barriers to screening for domestic violence in the emergency department. *Holistic Nursing Practice, 16*(3), 24–34.

Houry, D., Kaslow, N.J., Kemball, R.S., McNutt, L.A., Cerulli, C., Straus, H., Rosenberg, E., Lu, C., & Rhodes, K.V. (2008). Does screening in the emergency department hurt or help victims of intimate partner violence? *Annals of Emergency Medicine, 51*(4), 433–442.

Husni, M.E., Linden, J.A., & Tibbles, C. (2000). Domestic violence and out-of-hospital providers: A potential resource to protect battered women. *Academic Emergency Medicine, 7*(3), 243–248.

Inoue, K., & Armitage, S. (2006). Nurses' understanding of domestic violence. *Contemporary Nurse, 21*, 311–323.

Johnson, H. (1996). *Dangerous domains. Violence against women in Canada.* Toronto, ON: Nelson Canada.

Johnson, J., & Pottie Bunge, V. (2001). Prevalence and consequences of spousal assault in Canada. *Canadian Journal of Criminology, 43*(1), 27–45.

Jones, C., & Bonner, M. (2002). Screening for domestic violence in an antenatal clinic. *Australian Journal of Midwifery, 15*(1), 14–20.

Kramer, A., Lorenzon, D., & Mueller, G. (2004). Prevalence of intimate partner violence and health implications for women using emergency departments and primary care clinics. *Women's Health Issues, 14*, 19–29.

Kimberg, L. (2001). Addressing intimate partner violence in primary care practice. *Medscape General Medicine, 3*(1), 1–15.

Kothari, C.L., & Rhodes, K.V. (2006). Missed opportunities: Emergency department visits by police-identified victims of intimate partner violence. *Annals of Emergency Medicine, 47*, 190–199.

Krug, E.G., Dahlberg, L.L., Mercy, J.A., Zwi, A.B., & Lozano, R. (2002). *World report on violence and health.* Geneva, Switzerland: World Health Organization.

Larkin, G.L., Hyman, K.B., Mathias, S.R., D'Amico, F., & MacLeod, B.A. (1999). Universal screening for intimate partner violence in the emergency department: Importance of patient and provider factors. *Annals of Emergency Medicine, 33*(6), 669–675.

Lesserman, J., Drossman, D.A., Zhiming, L., Toomey, T.C., Nachman, G., & Glogau, L. (1996). Sexual and physical abuse history in gastroenterology practice: How types of abuse impact health status. *Psychosomatic Medicine, 58*, 5–15.

Lipsky, S., Caetano, R., Field, C.A., & Bazargan, S. (2004). Violence-related injury and intimate partner violence in a urban emergency department. *Journal Trauma, 57*, 352–359.

Loughlin, S., Spinola, C., Stewart, L., Fanslow, J., & Norton, R. (2000). Emergency department staff responses to a protocol to care for abused women. *Health Education and Behaviour, 27*(5), 572–590.

Lutenbacher, M., Cohen, A., & Mitzel, J. (2003). Do we really help? Perspectives of abused women. *Public Health Nursing, 20*(1), 56–64.

MacMillan, H.L., & Wathen, C.N. (2001). *Canadian task force on preventive health care. Prevention and treatment of violence against women: Systematic review and recommendations*. Retrieved September 14, 2006, from http://www.ctfphc.org/Full_Test/CTF_DV_TR_final.pdf.

MacMillan, H.L., Wathen, C.N., Jamieson, E., Boyle, M., McNutt, L.A., Worster, A., Lent, B., & Webb, M. (2006). Approaches to screening for violence against

women in health care settings: A randomized trial. *Journal of American Medical Association, 296*, 530–536.

MacMillan, H.L., & Wathen, C.N. (2004). Practising sound medicine in the absence of evidence. *Canadian Medical Association Journal, 170*(5), 767.

Malecha, A. (2003). Screening and treating intimate partner violence in the workplace. *American Association of Occupational Health Nurses, 51*(7), 310–316.

Mays, N., & Pope, C. (2000). Qualitative research in health care: Assessing quality in qualitative research. *British Medical Journal, 320*, 50–52.

McCauley, J., Yurk, R.A., Jenckes, M.W., & Ford, D.E. (1998). Inside 'Pandora's box': Abused women's experiences with clinicians and health services. *Journal of General Internal Medicine, 13*, 549–555.

McFarlane, J., Hughes, R.B., Nosek, M.A., Groff, J.Y., Swedlend, N., & Dolan Mullen, P. (2001). Abuse assessment screen-disability (AAS-D): Measuring frequency, type, and perpetrator of abuse toward women with physical disabilities. *Journal of Women's Health & Gender-Based Medicine, 10*(9), 861–866.

Mechanic, M.B. (2004). Beyond PTSD: Mental health consequences of violence against women. *Journal of Interpersonal violence, 19*(11), 1283–1289.

Middlesex-London Health Unit (1995). *Task force on the health effects of woman abuse final report*. London, ON: Middlesex-London Health Unit.

Miller, C.D., & Campbell, J. C. (1993). *Reliability and validity of the the miller abuse physical symptom and injury scale (MAPSAIS)*. Chicago, IL: Midwest Research Society.

Moore, M. L., Zaccaro, D., & Parsons, L. H. (1998). Attitudes and practices of registered nurses toward women who have experienced abuse/domestic violence. *Journal of Obstetric, Gynecologic and Neonatal Nursing, 27*, 175–182.

Morrison, L.J., Allan, R., & Grunfeld, A. (2000). Improving the emergency department detection rate of domestic violence using direct questioning. *The Journal of Emergency Medicine, 19*(2), 117–124.

Muelleman, R.L., & Liewer, J.D. (1998). How often do women in the emergency department with intimate partner violence injuries return with such injuries? *Academic Emergency Medicine, 5*(10), 982–5.

Nelson, H.D., Nygren, P., McInerney, Y., & Klein, J. (2004). Screening women and elderly adults for family and intimate partner violence: A review of the evidence for the U.S. preventive services task force. *Annals of Internal Medicine, 140*, 387–396.

New Zealand Ministry of Health. (2002). *Family violence intervention guidelines: Child and partner abuse*. Retrieved September 14, 2006, from http://www.moh.govt.nz/moh.nsf

Olive, P. (2007). Care for emergency department patients who have experienced domestic violence: A review of the evidence base. *Journal of Clinical Nursing, 16*, 1736–1748.

Olson, L., Aactil, C., Fullerton, L., Brillman, J., Arbuckle, J., & Sklar, D. (1996). Increasing emergency physician recognition of domestic violence. *Annals of Emergency Medicine, 27*(6), 741–746.

Oxman, A.D., Cook, D.J., & Guyatt, G.H. (1994). Users' guides to the medical literature. VI. How to use an overview. *Journal of the American Medical Association, 272*(17), 1367–1371.

Petersen, R., Moracco, K.E., Goldstein, K.M., Clark, K.A. (2003). Women's perspectives on intimate partner violence services: The hope in Pandora's box. *Journal of American Medical Women's Association, 58*, 185–190.

Plichta, S.B. (2004). Intimate partner violence and physical health consequences. Policy and practice implications. *Journal of Intimate Partner Violence, 19*(11), 1296–1323.

Plichta, S.B. (2007). Interactions between victims of intimate partner violence against women and the health care system. *Trauma, Violence & Abuse, 8*(2), 226-239.

Plichta, S.B., & Falik, M. (2001). Prevalence of violence and its implications for women's health. *Women's Health Issues, 11*(3), 244–258.

Poirier, L. (1997). The importance of screening for domestic violence in all women. *The Nurse Practitioner, 22*(5), 105–122.

Pottie Bunge, V., & Locke, D. (2000). *Family violence in Canada: A statistical profile 2000* (Statistics Canada Catalogue no. 85224XIE). Ottawa, ON: Canadian Centre for Justice Statistics, Statistics Canada.

Ramsden, C., & Bonner, M. (2002). A realistic view of domestic violence screening in an emergency department. *Accident and Emergency Nursing, 10*, 31–39.

Ramsay, J., Richardson, J., Carter, Y.H., Davidson, L.L., & Feder, G. (2002). Should health care professionals screen for domestic violence? Systematic review. *British Medical Journal, 325*, 314–327.

Registered Nurses Association of Ontario. (2005). *Woman abuse: Screening, identification and initial response. Nursing Best Practice Guidelines*. Retrieved September 14, 2006, from http://www.rnao.org/bestpractices

Roberts, G.L., Lawrence, J.M., O'Toole, B.I., & Raphael, B. (1997)a. Domestic violence in the emergency department: Two case-control studies of victims. *General Hospital Psychiatry, 19*, 5–11.

Roberts, G.L., Lawrence, J.M., O'Toole, B.I., & Raphael, B. (1997)b. Domestic violence in the emergency department: 2 detection by doctors and nurses. *General Hospital Psychiatry, 19*, 12–15.

Robinson, L., & Spilsbury, K. (2008). Systematic review of the perceptions and experiences of accessing health services by adult victims of domestic violence. *Health and Social Care in the Community, 16*(1), 16–30.

Rodriguez, M.A., Bauer, H.M., McLoughlin, E., & Grumbach, K. (1999). Screening and intervention for intimate partner abuse. Practices and attitudes of primary care physicians. *Journal of American Medical Association, 281*(5), 468–474.

Rodriguez, E., Lasch, K.E, Chandra, P., & Lee, J. (2000). Family violence, employment status, welfare benefits, and alcohol drinking in the United States: What is the relation? *Journal of Epidemiology and Community Health, 55*, 172–178.

Ross, M.M., Hoff, L., & Coutu-Wakulczyk, G. (1998). Nursing curricula and violence issues. *Journal of Nursing Education, 37*(2), 52–60.

Sankar, P., & Jones, N. (2005). To tell or not to tell. *Archives of Internal Medicine, 165*, 2378–2383.

Schrieber, R.S. (2001). The "how to" of grounded theory: Avoiding the pitfalls. In R.S. Schreiber & P.N. Stern (Eds.). *Using grounded theory in nursing* (pp. 55–83). New York: Springer.

Short, L.M., Johnson, D., & Osattin, A. (1998). Recommended components of health care provider training programs on intimate partner violence. *American Journal of Preventive Medicine, 14*(4), 283–288.

Soeken, K.L., McFarlane, J., Parker, B., & Lominack, M.C. (1998). The abuse assessment screen: A clinical instrument to measure frequency, severity and perpetration of abuse against women. In: Jacquelyn Campbell (Ed.). *Empowering survivors of abuse: Health care for battered women and their children* (pp. 195–203). Thousand Oaks, California, Sage Publications.

Statistics Canada. (2000). *The 1999 general social survey – cycle 13 victimization user's guide* (Statistics Canada Catalogue no 12M0013GPE). Ottawa, ON: Centre for Justice Statistics, Statistics Canada.

Stets, J.A., & Straus, M.A. (1990). Gender differences in reporting marital violence and its medical and psychological consequences. In M.A. Straus & R.J. Gelles (Eds.). *Physical violence in American families. Risk factors and adaptations to violence in 8,145 families* (pp. 151–166). New Brunswick, NJ: Transaction Publishers.

Straus, M.A. (1979). Measuring intrafamily conflict and violence: The conflict tactics (CT) scales. *Journal of Marriage and the Family, 41*(1), 75–88.

Straus, M.A. (1990)a. Chapter 3. Measuring intrafamily conflict and violence: The conflict tactics (CT) scales. In M.A. Straus & R.J. Gelles (Eds.). *Physical violence in American families: Risk factors and adaptations to violence in 8,145 families* (pp. 29–47). New Brunswick, WJ: Transactions Publishers.

Straus, M.A. (1990)b. Chapter 4. The conflict tactics scales and its critics: An evaluation and new data on validity and reliability.In M.A. Straus & R.J. Gelles (Eds.). *Physical violence in American families: Risk factors and adaptations to violence in 8,145 families* (pp. 49–73). New Brunswick, WJ: Transactions Publishers.

Straus, M.A., Hamby, S.L., Boney-McCoy, S., & Sugarman, D.B. (1996).The revised conflict tactics scale (CTS2): Development and preliminary psychometric data. *Journal of Family Issues, 17*(3), 283–316.

Straus, M.A., & Douglas, E.M. (2004). A short form of the revised conflict tactics scales, and typologies for severity and mutuality. *Violence and Victims 19*(5), 507–520.

Streiner, D.L., & Norman, G. (2003). *Health measurement scales. A practical guide to their development and use* (3rd ed.). Oxford, UK: Oxford University Press.

Taft, A., & Hegarty, K. (2002). Safe healthcare system needs to be in place. *British Medical Journal, 325*, 1418.

Taket, A., Wathen, C.N., & MacMillan, H.L. (2004). Should health care professionals screen all women for domestic violence? *PLoS Medicine, 1*(1), e4–e9.

Taket, A., Nurse, J., Smith, K., Watson, J., Shakespeare, J., Lavis, V., Cosgrove, K.M., & Feder, G. (2003). Routinely asking women about domestic violence in health settings. *British Medical Journal, 327*, 673–676.

Tatano-Beck, C. (2002). Releasing the pause button: Mothering twins in the first year of life. *Qualitative Health Research, 12*(5), 593–608.

Thackeray, J., Stelzner, S., Downs, S.M., & Miller, C. (2007). Screening for intimate partner violence. The impact of screener and screening environment on victim comfort. *Journal of Interpersonal Violence, 22*(6), 659–670.

Tower, M., & McMurray, A. (2006). Domestic violence, health and health care: Women's accounts of their experiences. *Contemporary Nurse, 21*(2), 186–198.

Trautman, D.E., McCarthy, M.L., Miller, N., Campbell, J.C., & Kelen, G.D. (2007). Intimate partner violence and emergency department screening: Computerized screening versus usual care. *Annals of Emergency Medicine, 49*(4), 526–534.

United States Preventive Services Task Force (USPSTF). (2004). Screening for family and intimate partner violence: Recommendation statement. *American Family Physician, 70*(4), 747–51.

Varcoe C. (2001). Abuse obscured: an ethnographic account of emergency nursing in relation to violence against women. *Canadian Journal of Nursing Research, 32*, 95–115.

Wathen, C.N., & MacMillan, H.L. (2003). Interventions for violence against women: Scientific review. *Journal of American Medical Association, 289*, 589–600.

Wathen, C.N., Jamieson, E., Wilson, M., Daly, M., Worster, A., & MacMillan, H.L. (2007). Risk indicators to identify intimate partner violence in the emergency department. *Open Medicine, 1*(2), e113–22.

Wathen, C.N., Jamieson, E.J., MacMillan, H.L., & the McMaster Violence Against Women Research Group (2008).Who is identified by screening for intimate partner violence? *Women's Health Issues, 18*, 423–432.

Wathen, C.N., Tanaka, M., Catallo, C., Lebner, A.C., Friedman, M.K., Hanson, M.D., Freeman, C., Jack, S.M., Jamieson, E., MacMillan, H.L. and the McMaster IPV Education Research Team. (2009). Are clinicians being prepared to care for abused women? A survey of health professional education in Ontario, Canada. *BMC Medical Education, 9:34.*

Webster, J., Stratigos, S.M., & Grimes, K.M. (2001). Women's responses to screening for domestic violence in a health care setting. *Midwifery, 17*, 289–294.

Zachary, M.J., Mulvihill, M.N., Burton, W.B., & Goldfrank, L.R. (2001). Domestic abuse in the emergency department: Can a risk profile be identified? *Academic Emergency Medicine, 8*, 796–803.

Zink, T., Elder, N., Jacobson, J., & Klosterman, B. (2004). Medical management of intimate partner violence considering the stages of change: Precontemplation and contemplation. *Annals of Family Medicine, 2*, 231–239.

Zun, L.S., Downey, L., & Rosen, J. (2003). Violence prevention in the ED: Linkage of ED to a social service agency. *American Journal of Emergency Medicine, 21*, 454–457.

CHAPTER 2

Mixing a Grounded Theory Approach With a Randomized Controlled Trial Related to Intimate Partner Violence: What Challenges Arise for Mixed Methods Research?

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Mixing a Grounded Theory Approach With a Randomized Controlled Trial Related to Intimate Partner Violence: What Challenges Arise for Mixed Methods Research?

Abstract[1]

Incorporating a grounded theory approach with a randomized, controlled trial requires methodological modifications to maintain the overall rigour of a sequential, explanatory mixed methods study. The aim of this two-phase mixed methods study was to explore women's decision making related to the disclosure of intimate partner violence in urban emergency department settings. Both phases were equally weighted and mixing involved both embedding and connecting quantitative and qualitative data. This paper discusses the design and analytic modifications made to incorporate a grounded theory approach with a randomized trial related to intimate partner violence. Strengths and challenges arising from these modifications are presented. Recommendations for future studies that incorporate a grounded theory approach with a randomized, controlled trial are offered.

Key words

Randomized controlled trial; grounded theory; intimate partner violence

[1]Designed to meet manuscript requirements for the *Journal of Mixed Methods* research. Submission requirements dictate an abstract of 120 words with 3–5 key words and 8,000 words for methodological papers. For thesis dissertation purposes the overall manuscript will be longer than 8,000 words.

Mixing a Grounded Theory Approach With a Randomized Controlled Trial Related to Intimate Partner Violence: What Challenges Arise for Mixed Methods Research?

Background

Mixed methods studies pose challenges for researchers in both planning and implementation due to their design complexity, poor description of methods used and difficulties related to appropriate integration of data and results (Hanson, Creswell, Plano Clark, Petska, & Creswell, 2005; Ivancova, Creswell, & Stick, 2006; Wilkins & Woodgate, 2008). This paper will describe the process of implementing a mixed methods study among women exposed to IPV who sought care at urban emergency department settings. This sequential explanatory mixed methods study included a randomized, controlled trial [QUAN] with a sub-analysis of the data pertaining to three urban emergency departments from the randomized, controlled trial [quan] followed by a grounded theory approach [QUAL]. The focus of this paper will be on the methodological modifications to the grounded theory approach when used as an explanatory component for a randomized, controlled trial. Strengths and challenges of incorporating a grounded theory approach with a randomized trial will be discussed. Finally, this paper will recommend design and analytic considerations when incorporating a grounded theory approach with a randomized trial as part of a sequential explanatory mixed methods study.

Incorporating Qualitative Approaches with Randomized, Controlled Trials

Debates continue regarding the paradigmatic assumptions that arise when combining quantitative and qualitative methods as part of a mixed methods study. Purists

have argued that opposing paradigms especially those underlying the randomized, controlled trial (post-positivist paradigm) and grounded theory approach (constructivist paradigm) (Jang, McDougall, Pollon, Herbert, & Russell, 2008) were incompatible. Teddlie and Tashakkori (2003) stated that a focus on paradigmatic differences can halt the productivity of innovations in mixed methods research. Others have argued that a mixed method design can offer resolution to the paradigm debate through its philosophical grounding in pragmatism which offers a utilitarian approach to research (Mark, Feller, & Button, 1997; Teddlie & Tashakkori). Mixed methods permit a deeper and richer understanding of the phenomenon under study through its emphasis on plurality--of philosophical paradigms, theoretical assumptions, and methodological techniques (Greene, 2007). Many authors recognize the multiplicity of paradigms which can compete and give rise to contradictions, but which is a normative component of mixed methods research (Greene). This means that methods are combined, regardless of their individual philosophies, in order to meet the goals of the overall research project. Because it does not simply fit into a taxonomic framework (Maxwell & Loomis, 2003), mixed methods research is complicated and requires a flexible approach. While the purpose of this paper is not to debate the philosophical issues underlying the selected methods chosen for this mixed methods study, they were considered. The methods used were compatible, not so much for their philosophical underpinnings but rather for their ability to address the underlying research questions and goals.

The randomized, controlled trial is the gold standard in the evaluation of the effectiveness of an intervention and pre-identified health outcomes (Heaven, Murtagh,

Rapley, May, Graham, Kaner, & Thomson, 2005; Kinn & Curzio, 2005; O'Cathain, 2009; Stange, Crabtree, & Miller, 2006; Verhoef, Casebeer, & Hilsden, 2002; Vuckovic, 2002). However, for research questions requiring greater depth and exploration--including the study of processes, perceptions and experiences--the randomized trial is not the strongest method (Verhoef et al., 2002). Incorporating a qualitative approach with a randomized, controlled trial can address unexpected phenomena that emerged throughout the course of the trial, such as a better understanding of the effects of an intervention (Verhoef et al.; O'Cathain). Qualitative research used within a randomized trial can explore the meaning that participants attributed to the intervention that might serve to maximize its efficacy through greater contextual understanding. Finally, using a qualitative approach to better understand the process of events and actions could add insight into the feasibility of the trial (Verhoef). Researchers have combined qualitative research with a randomized trial so that the shortcomings of either method could be overcome while comprehensively examining a research problem, such as complex interventions (Kinn & Curzio).

According to Lewin, Glenton, and Oxman (2006) very little research has evaluated the use of qualitative approaches in randomized, controlled trials. In their systematic review, Lewin et al. (2006) investigated a random sample of 106 articles detailing randomized controlled trials obtained from the Cochrane Effective Practice and Organization of Care Review Group Registry from 2001 to 2003. From this sample, 23 articles included formal qualitative approaches used with randomized trials before, during or after the trial. These mixed methods studies examined issues like mental health, sexual

health and appropriate use of medication (Lewin et al.). Results of this systematic review indicated that randomized, controlled trials that involved formal qualitative approaches did not describe the rationale for mixing methods, failed to discuss the integration of methods and neglected to discuss how both quantitative and qualitative methods contributed to the overall study interpretations (Lewin et al.). Additionally, review results indicated that studies did not discuss sampling methods used in the qualitative component, modifications to the study for data collection and methods for qualitative data analysis or thematic development (Lewin et al.).

Kinn and Curzio (2005) conducted a systematic review that assessed the incorporation of quantitative and qualitative methods. The authors searched MEDLINE, CINAHL and PscyhInfo bibliographic databases from 1982 to 2000. Initially, 2,382 citations were reviewed for relevance. Ninety-one citations were downloaded with 14 randomly selected for appraisal. Those appraised were mixed methods studies that reported a randomized trial. Findings indicated that qualitative approaches were used for different purposes, ranging from preliminary exploratory work to validation of quantitative findings (Kinn & Curzio). An important gap found by this review was the lack of discussion of methods used for the qualitative components and the impact of this on overall study rigour. Other areas of weakness included a lack of discussion of the qualitative approach such as the interview guide development, sampling procedures, coding and analysis techniques, and methods for the integration of both quantitative and qualitative findings (Kinn & Curzio).

Other authors have confirmed these systematic review results and argued the need for greater cohesion of methods when incorporating qualitative approaches with a randomized, controlled trial (Hall & Howard, 2008; Vukovic, 2002). Combining methods in a transparent manner can help overcome methodological weaknesses in both approaches and provide a comprehensive examination of the research issue (Stange, Crabtree, & Miller, 2006). The most advantageous use of qualitative approaches with the randomized trial occurs when both hold equal importance and weighting and are not considered subservient to one another (Hall & Howard; Vukovic).

Sequential Mixed Methods Designs

There are two types of sequential mixed methods designs--exploratory and explanatory. The sequential exploratory design is conducted over two phases so that the first method (either quantitative or qualitative) helps to inform the second phase (Creswell & Plano Clark, 2007). Typically, studies using this design begin with qualitative data collection and analysis followed by a phase of quantitative data collection and analysis. Integration of both phases occurs during the interpretation phase (Creswell, Plano Clark, Gutman, & Hanson, 2003). The goal of this design is to explore a phenomenon--usually qualitatively--and then develop categories, themes, relationships or findings that drive the second, quantitative phase (Creswell & Plano Clark; Creswell et al.). Other reasons for use of this design include an initial qualitative phase to identify indicators for instrument development followed by a quantitative phase to test the new instrument (Creswell et al.), or to determine the distribution of a phenomenon within a specific population (Morse, 1991).

Like the exploratory design, the sequential explanatory design is also carried out over two phases. Creswell & Plano Clark (2007) suggested that the sequential explanatory design begins with a quantitative phase followed by a qualitative phase. In keeping with the sequential exploratory design, the explanatory variant answers one type of question by collecting and analyzing two types of data (qualitative and quantitative) and draws inferences using both data types usually during the interpretation stage of the study (Creswell & Plano Clark; Creswell, Plano Clark, Gutman, & Hanson, 2003). The purpose is to explain and expand upon unusual or unexpected findings that occurred during the first phase of the study (Creswell & Plano Clark; Tashakkori & Creswell, 2007). The need to explain the results drives the qualitative component of the second phase (Ivancova, Creswell, & Stick, 2006). While both sequential designs provide clear separation of phases making it a straight forward mixed methods design to implement, sequential designs can pose challenges at each phase and may involve a great deal of time before overall completion of the study (Creswell et al., 2003).

Example Mixed Methods Study

The example mixed methods study related to decision making regarding intimate partner violence (IPV) disclosure in urban emergency department settings in Ontario, Canada. Previous research demonstrated that women exposed to IPV seek health care for physical and mental health impairment (Campbell et al., 2002; Carlson, McNutt, Choi, & Rose, 2002; Plichta, 2007; Wathen et al., 2007). In a recent Ontario study, Wathen et al., (2007) found the 12-month prevalence of IPV to be 13.9% in emergency department settings. This corresponds with findings across United States emergency department

settings where 12-month prevalence rates were between 14% (Dearwater et al., 1998) and 22% (Anglin and Sachs, 2003). While the literature discussed many factors related to IPV disclosure in emergency department settings such as communication with the health care provider (Battaglia, Finley, & Liebschutz, 2003; Rhodes et al., 2007) and past experiences among abused women receiving care in the emergency department (Chang et al., 2003; Liebschutz, Battaglia, Finley, & Averbuch, 2008; Tower & McMurray, 2006), little is known about the decisions women undertake that facilitate or inhibit disclosure (Battaglia et al., 2003). Further, little is known regarding the behavioural processes that women undertake when deciding to disclose IPV to an emergency department health care provider.

This mixed methods study arose out of a randomized, controlled trial that evaluated whether routine screening for IPV versus no screening or usual care, does more good than harm. The randomized, controlled trial was a multi-site trial across Ontario involving primary care, acute care, and specialty clinics. For the overall randomized, controlled trial, various outcomes were assessed. Primary outcomes included the assessment of violence reduction, quality of life improvement, and the identification of potential harms of screening. A number of secondary outcomes were evaluated, including depression and posttraumatic stress disorder, as well as variables considered potential mediators and moderators to help understand the process by which screening and usual care might lead to changes in the primary outcomes. The overall randomized, controlled trial occurred across different settings with a follow-up of 18 months.

Phase 1 of this sequential mixed methods study involved a sub-analysis of data obtained from the randomized, controlled trial [QUAN] as shown in Figure 1. This sub-analysis of quantitative data occurred across three emergency departments [quan] and resulted in unexpected findings that required further examination. Phase 2 involved a grounded theory approach [QUAL] which sought to explain unexpected results from the smaller quantitative analysis and help inform the randomized, controlled trial [QUAN]. At the point of the commencement of this mixed methods study, the randomized controlled trial was ongoing, so data collection was continuing and final analysis had not yet occurred.

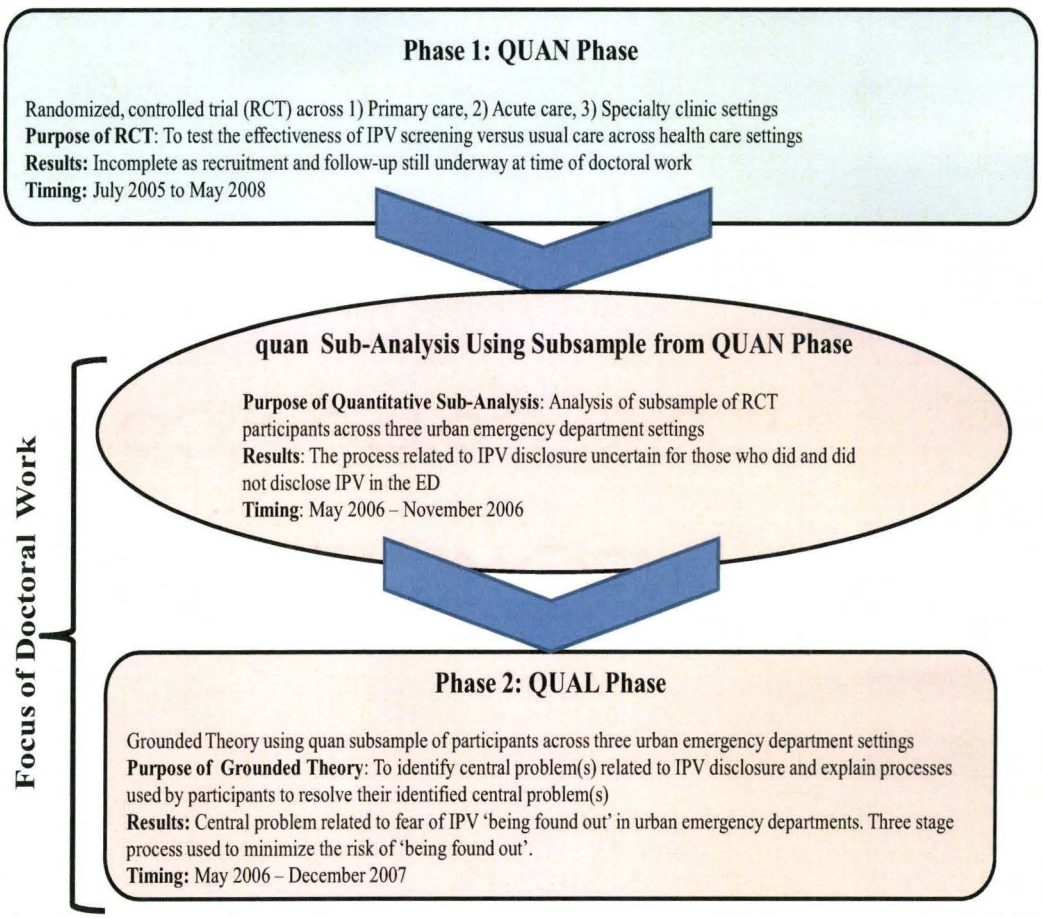

Figure 1. Diagram of two-phase sequential explanatory mixed methods study

The purpose of the sub-analysis of quantitative data from the randomized trial [quan] was to examine IPV exposure and disclosure among participants recruited across three urban emergency department settings from May to November 2006. IPV exposure was evaluated using a screening instrument, the Woman Abuse Screening Tool (WAST) (Appendix E) (Brown, Lent, Brett, Sas, & Pederson, 1996; Brown, Lent, Schmidt, & Sas, 2000) and a criterion standard, the Composite Abuse Scale (CAS) (Appendix F) (Hegarty, Bush, & Sheehan, 2005; Hegarty, Sheehan, & Schonfield, 1999). Both instruments were evaluated for their psychometric properties, including reliability and validity, which were found to be acceptable with a Cronbach's alpha coefficient score of >.90 for both instruments (Brown et al., 1996; Hegarty et al., 2005; Hegarty et al., 1999). Further, both the WAST and the CAS received evaluation of face and content validity (Brown et al.; Hegarty, Bush et al.; Hegarty, Sheehan et al.), and the CAS was evaluated for criterion and construct validity (Hegarty, Bush et al.; Hegarty, Sheehan et al.).

In the emergency department setting, participants were recruited into the randomized, controlled trial on either a "screen" day or a "non-screen" day predetermined through a randomization process. On a "screen" day participants received the WAST, proceeded to their health care provider visit, and then completed the CAS before leaving the emergency department. Those participants recruited on a "non-screen" day, received both the WAST and the CAS after the visit with the health care provider. A score of $\geq$4 on the WAST indicated exposure to IPV, which was determined from results of an earlier study which found that this score increased the instrument's sensitivity (72%) and specificity (90%) among comparable populations (MacMillan et al., 2006;

Wathen, Jamieson, & MacMillan, 2008). A score of ≥7 on the CAS indicated positive IPV exposure (Wathen et al., 2008). Demographic data on age, marital status, pregnancy status, education level, household income, and place of residence (e.g. rural or urban) was collected. Women completed a clinical interactions questionnaire asking the following question: "Did you discuss the issue of partner violence during your visit with the health care provider (e.g. doctor, nurse) today?" Women who replied, "yes" continued to answer questions regarding the interventions, including whether or not they received information and referral, provided by the clinician. Likewise, health care providers completed a similar clinical actions questionnaire which asked the clinician to report on the actions taken during the emergency department visit including: providing verbal information or education on IPV, acknowledging disclosure of IPV, validation of woman's feelings, providing referrals and written information, and offering problem-solving strategies for immediate assistance.

Results from the quantitative sub-analysis indicated 14.7% (n=174) of total participants scored positive for IPV exposure (i.e. ≥4 WAST and ≥7 CAS) across both screen and non-screen groups. Only 1.9% (n=22) of the total sample indicated that they had disclosed IPV to an emergency department health care provider during their visit. Of those who stated that they disclosed IPV, approximately 63% had a positive score for IPV using the WAST and the CAS (Appendix O). While both participants and health care providers completed the clinical interactions questionnaire, 94% of participants (n=563) and 91% of health care providers (n=515) did not complete this questionnaire. There was a large amount of missing data among both participant and health care provider

respondents. As a result, the clinical interactions questionnaire did not provide explanation for decision making related to IPV disclosure. Participants may have been uncomfortable answering questions regarding the care that they received for IPV. Further, participants were possibly unaware that they had received an intervention from the health care provider. This suggested that the quantitative instrument may not be the best means of learning about the complexities of women's decision making regarding IPV disclosure. As a result, these results provided rationale for further explanation, using a qualitative approach, of participant decision making related to IPV disclosure in acute care setting.

Phase 2, a qualitative phase [QUAL], was implemented to further understand what women considered to be problematic regarding the disclosure of IPV in the urban, emergency department setting. In order to further explain the results from the quantitative sub-analysis and inform the randomized, controlled trial, it was necessary to identify and describe the processes that participants used to address their identified problems related to IPV disclosure. Using the principles of traditional grounded theory (Glaser, 1978; Glaser & Straus, 1968) permitted a complementary perspective for explaining ambiguous results or analyses that would otherwise not be explored if researchers relied on the quantitative results alone (Bryman, 2006; Collins, Onwuegbuzie, & Jiao, 2006). Grounded theory, a qualitative approach, was chosen for its ability to both describe and explain a system of behaviour and seek, as an end result, a substantive mid-range theory grounded in the data (Cutcliffe, 2000). The combination of these factors made it the best choice to explain women's behaviours and decision making regarding IPV disclosure in

urban emergency departments. The goal of the qualitative component was (a) to identify the basic social psychological problem(s) that women identified with the disclosure of IPV in urban emergency departments, and (b) to define processes and strategies that women used to resolve their identified problem(s). The qualitative phase recruited participants from the quantitative sub-analysis across three urban emergency department settings and took place over a 16-month period from June 2006 to December 2007.

Ethics

Ethics approval for this study was obtained from the McMaster University/Hamilton Health Sciences Research and Ethics Board in Hamilton, Ontario, Canada (Appendix R). Ethics approval was also sought and obtained from the three Ontario hospital sites where recruitment occurred (Appendices S and T). Initial approval was obtained for the overall randomized, controlled trial. Approval for the mixed methods study occurred afterwards with subsequent amendments made in order to include the use of the data obtained from the screening trial such as demographic data, IPV exposure scores and the clinical actions questionnaires. A second amendment was submitted to increase the number of interviews per participant from two to four in order to accommodate a highly transient and high-risk population. Formal written consent was obtained during recruitment into the randomized trial and before each face-to-face interview in the grounded theory phase (Appendices U and V). Participants were informed that confidentiality would be maintained unless disclosure was made indicating that a child was at risk of harm. Throughout the mixed methods study, women were provided with a resource card listing local area organizations that they could contact for

further support after each interview. A formal safety protocol was followed for this study (Appendix W).

Timing, Weighting, and Mixing Decisions

According to Creswell, Fetters, and Ivankova (2004), a well-written mixed methods study should provide a rationale for the mixing of both quantitative and qualitative techniques and must define the timing, weighting and mixing decisions made during the course of the study. Creswell and Plano Clark (2007) stated that the sequencing of a mixed methods design depends on the temporal relationship between the quantitative and qualitative components. For this mixed methods study, the timing was sequential in that data collection and analysis occurred during different phases (Creswell & Plano Clark). The focus for the quantitative sub-analysis focused on emergency departments since the recruitment of this setting type as part of the randomized, controlled trial had just begun and would continue for at least six months. Once ethics approval for the mixed methods study was obtained in April 2006, the quantitative subgroup analysis [quan] was undertaken from May to November, 2006. The results of this quantitative analysis drove the initial rationale and design of the qualitative explanatory phase [QUAL] which continued until December 2007.

In addition to timing, weighting of the mixed methods study is important because it influences the priority of the quantitative and qualitative methods used (Creswell & Plano Clark, 2007). In this study, equal emphasis was placed on Phase 1, the randomized, controlled trial and Phase 2, the grounded theory approach. A smaller quantitative sub-

analysis during Phase 1 had less emphasis and would serve to inform the randomized, trial.

Usually a sequential explanatory design involves establishing unequal emphasis on one method (e.g. qualitative or quantitative) over another. For this type of mixed method design Creswell and Plano Clark (2007) stated that investigators generally place more emphasis on quantitative methods over qualitative methods. Creswell, Fetters and Ivankova (2004) found many sequential studies emphasized quantitative data but the qualitative methods used were not sophisticated. An equally weighted qualitative approach was chosen to provide deeper explanation for this current study's quantitative findings. By selecting grounded theory, the goal was to overcome the perceived weaknesses of other sequential studies that relied on less sophisticated qualitative methods to address the research questions and goals. Further, an equal weighting between quantitative and qualitative phases meant that results could better inform the randomized trial. Another factor in the weighting decision involved the theoretical drive of the mixed methods study. According to Morse (2003) the theoretical drive or overall direction of the project should be defined for mixed methods studies. This can have significant philosophical implications if the study incorporates methods that contradict the overall theoretical drive, like a mixed method study with a deductive theoretical drive that relies primarily on inductive approaches. For this study, the goal was to explain findings from the sub-analysis of the randomized, controlled trial: namely, that few women exposed to IPV chose to disclose IPV to the emergency department clinician. Because the goal

involved exploration of these findings, the overall drive for this mixed methods study was inductive but incorporated equal use of deductive and inductive thinking.

Deductive thinking was used in the quantitative sub-analysis to determine the rate of IPV exposure among women completing the IPV screening instruments and when identifying clinical actions associated with IPV exposure. Deductive thinking was also used in the second phase of the mixed methods study when coding qualitative data. This was done for an improved understanding of the properties and dimensions that created the categories and for verifying hypotheses and testing the theory related to IPV disclosure decision making at varying levels of abstraction. Because the overall drive of the mixed methods study was inductive, it was important to select an approach for the explanatory phase of the study that could also support inductive thinking. Incorporating a grounded theory approach was appropriate because it permitted both inductive and deductive thinking (Glaser, 1978). Inductive thinking was used during the process of identifying the core problem(s) and the strategies that participants utilized to resolve this/these problem(s). Inductive thinking occurred during analysis of specific IPV disclosure incidents for category development and for the definition of the relationships forming the emergent theory. Grounded theory was a versatile qualitative approach that incorporated both deductive and inductive thinking to address the overall theoretical drive of this mixed methods study.

Creswell and Plano Clark (2007) stated that a mixed methods study needs to identify how quantitative and qualitative data are mixed through merging, embedding or connecting data. This mixed methods study involved both the embedding and connecting

of quantitative and qualitative data. Embedding data can involve mixing at the design level where one form of data is embedded in another form and can occur sequentially (Creswell & Plano Clark). One example of how data from the quantitative sub-analysis was embedded into the grounded theory approach occurred through an analysis of types of IPV exposure as defined by the Composite Abuse Scale (CAS) (Hegarty, Sheehan, & Schonfield, 1999) to further examine developing categories and relationships related to IPV disclosure. Connecting data involves the analysis of one type leading to the need for another type of data (Creswell & Plano Clark). An example of this occurred as a result of the quantitative sub-analysis where the results led to the subsequent need for the collection and analysis of qualitative data. Connection occurred through participant selection, initial research questions, and the development of original interview guide.

Modifications to the Qualitative Component

In order to incorporate grounded theory with a randomized, controlled trial for the purposes of explaining findings, a number of key modifications were required in order to carry out the mixed methods study. These included modifications to the sampling, data collection, and analysis methods used in the grounded theory approach.

Sampling Decisions

Sampling for mixed methods studies follow the general rules governing both quantitative methods and qualitative methods and involve selecting participants using both probability and purposive sampling techniques (Teddlie & Yu, 2007). According to Collins, Onwuegbuzie, and Jiao (2007), determining an appropriate sampling scheme is pivotal to the preservation of rigour and the overall integration of results for a mixed

methods study. In the sequential explanatory design, the purpose of the qualitative phase is to provide greater depth and understanding of the results arising from the initial quantitative phase (Collins et al.; Creswell & Plano Clark, 2007). As a result, the participants in the qualitative phase are selected to provide in-depth details regarding the phenomenon under study. In this current study, all participants for the grounded theory phase were derived from those previously enrolled in the randomized, controlled trial from three emergency department settings. These participants also formed the sample for quantitative sub-analysis from May to November 2006. This sampling decision posed unique challenges for a grounded theory approach. Because participants from the randomized, controlled trial were utilized for the grounded theory phase, it can be argued that the sampling strategy was convenience sampling. Convenience sampling is a type of purposive sampling that relies on obtaining participants through ease of access, which may or may not be reflective of phenomena generalizable to the population (Kemper, Stringfield, & Teddlie, 2003). This can challenge the rigour of a study and lead to derivation of spurious conclusions.

While authors support the mixing of sampling strategies in order to obtain participants who can provide rich detail to address research problems, it is recommended that the same individuals for each of the quantitative and qualitative components be used to enable greater opportunity for explanation of the issues under study (Creswell & Plano Clark, 2007; Teddlie & Yu, 2007; Wilkins & Woodgate, 2008). It was essential to use a sample bounded by the trial in order to understand the processes related to IPV disclosure and to inform results arising from the randomized, controlled trial. Because the problem

relating to IPV disclosure may have been closely attached to the meaning that participants derived from the experience of participating in the randomized, controlled trial, it was essential that the sample be bounded for both phases of the mixed methods study. Convenience sampling methods which recruit participants who are easy to access or who volunteer for the study were not used for this study. This sample was generated from strict principles governing a randomized, controlled trial, namely, randomization with predetermined inclusion and exclusion criteria. As a result, participants had an equal and unbiased opportunity to be randomly allocated to either the experimental group (i.e. routine screening) or the control group (i.e. usual care). This added strength to the recruitment strategy for the study as random selection and allocation are the strongest choice to reduce error and selection bias and also contribute to the internal validity of study design (Kemper, Stringfield, & Teddlie, 2003).

With many qualitative techniques, it is difficult to determine an exact sample size prior to initiation of the study, however, a goal of 20–50 interviews was set based on similar grounded theory studies in order to reach saturation (Collins, Onwuegbuzie, & Jiao, 2006; Sandelowski, 1995). Sampling decisions were made for the purpose of identifying participants who would be able to provide data to develop or test concepts of the emerging grounded theory. Sample size was determined by the data generated in the analysis with data collection occurring until saturation of conceptual information was achieved (Glaser & Straus, 1967; Streubert-Speziale & Carpenter, 2003). Saturation means that no additional data are found and the researcher can stop data collection (Glaser & Straus). For this component of the mixed methods study, an estimated goal to

sample 20–27 women was identified in keeping with other grounded theory studies involving participants who were either deemed vulnerable or who attended acute care settings (Jack, DiCenso, & Lohfeld, 2005; Lutz, 2005; Rittmayer, 2000; Wuest & Merritt-Gray, 2008).

Glaser (1978) stated that selective sampling methods were not appropriate for grounded theory. Glaser defined selective sampling as deliberately identifying participants or characteristics of participants prior to beginning the study. Participants were selected as needed through the simultaneous process of data collection, coding, and analysis for the purposes of theory generation known as theoretical sampling (Schreiber, 2001). The goal of theoretical sampling was to identify participants who provided greater information and detail about the basic social process and core problem under study; the emerging theory; and the dimensions and the properties of categories (Schreiber). Glaser (1978) argued that an overall sample of participants should not be determined prior to beginning a grounded theory approach as the researcher cannot know what criteria to explore and who to sample. Authors like Cutcliffe (2000), have modified the original principles set out by Glaser and argued that it is acceptable for purposeful sampling to be used in the beginning stages of grounded theory. Approximately 174 participants were eligible to participate in the qualitative phase. Fifty-four participants consented to participate in the grounded theory phase. Initial criteria were created to identify variation among participants and build codes that would drive future interviews prior to entering the theoretical sampling phase of the study (Cutcliffe). Using the criteria below, five

participants were purposefully sought for the initial grounded theory phase (Appendix I). Participants needed to be:

1. 18 years or older and were enrolled in the randomized, controlled trial at one of the three recruitment emergency departments;
2. Recruited into the randomized, controlled trial on a "screen" day and scored positive for IPV (e.g. $\geq$4 on the WAST and $\geq$7 on the CAS);
3. Able to disclose IPV to a health care provider during their emergency department visit according to the Clinical Interactions instrument used in the randomized trial;
4. Healthy enough to participate in a 60–90 minute interview; and
5. Able to speak, read, and write in English.

These five participants provided data for initial coding so that potential categories could be developed and tested in future interviews. The interview guide was also refined and developed through these selected participants. Initial purposeful sampling also identified new criteria for future sampling such as including participants from the randomized, controlled trial who scored negative for IPV exposure, those who had a mixed IPV exposure score (i.e. false positive or false negative) and those participants who did not disclose IPV during the emergency department visit.

After completion of purposeful sampling, theoretical sampling began and sought to identify participants from the consenting participants. Throughout the course of theoretical sampling, 37 participants withdrew, refused participation or were lost to follow-up. A final sample of 19 participants was obtained in the grounded theory phase.

During the theoretical sampling phase, key adaptations were required in order to maintain the expectations for a sequential explanatory design, yet preserve the underlying principles driving Glaserian methods. This included (a) modifying theoretical sampling to include a "unit of analysis" approach, (b) using the unit of analysis as part of maximum variation sampling and (c) conducting negative case analysis during the development of the grounded theory. Theoretical sampling is the hallmark of grounded theory methods and provides an overall process for conducting a grounded theory study, not just a means to recruit participants. Beyond recruitment, theoretical sampling permits the researcher to: (a) understand what participants define as their basic problem, (b) to explore the full depth of the properties/dimensions of the core variable and all emerging themes, and (c) to develop and test relationships related to the emerging theory (Glaser, 1978). Typically, theoretical sampling is conducted through the identification of *new* participants who meet specific criteria and who can provide more information regarding the concepts forming a category and, ultimately, the core problem (Draucker, Martsolf, Ross, & Rusk, 2007; Glaser, 1978). Since new participants were not obtained, a key adaptation was made in order to preserve the principles of theoretical sampling within the confines of this study.

According to Schwandt (2001), theoretical sampling includes collecting data on activities and events as dictated by the evolving theory. Continuous comparison is an essential feature of grounded theory where comparisons are made between the developing theory and the raw data until no new findings or views emerge regarding a concept or category--a key feature of saturation (Schwandt). In this study, to obtain conceptual density and a theory grounded in the data, despite a bounded sample of

participants, constant comparison of findings was undertaken based on the incidents, events, or situations related to the disclosure of IPV in urban emergency departments. To maximize the potential for theoretical density, constant comparison was made by incorporating a "unit of analysis" approach. This meant that different IPV disclosure stories were analyzed in order to identify features and components for developing concepts and categories (Schreiber, 2001). The unit of analysis did not represent actual participants but rather events, incidents, or examples. In this case, each "unit" was an "IPV disclosure event" (Schreiber). While the final sample of participants for the grounded theory phase totalled 19, each was interviewed up to four times. This resulted in 113 individual IPV disclosure events among participants to the following types of professional and non-professional individuals: physicians, registered nurses, police officers, counselling professionals, family members, and friends.

The unit of analysis approach enabled the generation of a larger sample for data collection and analysis. It preserved the principles of theoretical sampling in that there were multiple and new disclosure stories or units from which to draw for identification of the core variable, saturation of themes, and building of an overall theory. As units of analysis were identified, sampling, data collection, and analysis decisions were made to guide joint data collection, coding, and analysis. An inductive process was followed to guide the selection of participants to develop and test the emerging grounded theory (Becker, 1993).

Once the core variable was defined and relationship linkages developed, two other sampling methods were adapted to further assess the developed categories and to raise

the description of the theory to a higher level of abstraction (Schreiber, 2001). Maximum variation sampling, sometimes referred to as extreme case sampling, involves interviewing participants who hold different perspectives, sometimes at "opposite ends of the spectrum" in order to obtain a full understanding of the phenomenon under study (Creswell & Plano Clark, 2007; Teddlie & Yu, 2007). Typically, this involves locating and recruiting new participants into the grounded theory study (Schreiber). The principal intent of maximum variation sampling was maintained, namely, to explore the full spectrum of a category's properties and dimensions, including that of the core variable as well as the developing relationship between categories. However, an adaptation was required to conduct maximum variation sampling for this mixed methods study, as no new participants were recruited for the grounded theory phase. Disclosure events, known as units of analysis, were used in order to look for variants at opposing spectrums. This was used when identifying the properties and dimensions of a concept, testing developing relationships and theoretical hypotheses. This included recruiting participants from the non-screen group who scored positive for IPV exposure, those with mixed screening scores and those with negative screening scores. Incorporating these participants' disclosure events was essential to determine sub-categories and theoretical relationships. One example of maximum variation sampling was used in this study to identify the dimensions of the category "building trust with a health a care provider." As a result, disclosure events describing a participant's ability to trust health care providers with extreme ease were compared against disclosure events describing participant's with extreme difficulty with trusting health care providers. Studying these units of analysis,

allowed further development of the category through identifying sub-categories and relationships. One example was to examine the units of analysis for participants who could immediately trust health care providers (implicit trust), participants who trusted clinicians after a demonstration of trustworthiness (distrust), and those participants having extreme difficulty trusting health care providers (mistrust). When more information was required, the unit of analysis was linked back to the original participant and that participant was sought for further interviews.

In addition to modifying maximum variation sampling techniques, adaptations were required to implement another grounded theory sampling technique: negative case sampling. The goal of negative case sampling is to test emerging theoretical hypotheses in order to achieve a higher level of theoretical abstraction beyond a description of relationships between concepts (Schreiber, 2001). This type of sampling is typically performed after the development of the grounded theory in order to identify new participants whose experiences refute or deviate from the developing theory (Schreiber, 2001; Teddlie & Yu, 2007). Deviant cases offer opportunity for comparison across other categories and are often selected outside of the sample used to generate the grounded theory (Schreiber, 2001).

Because new participants were not sought, negative case sampling could not occur. As a result, negative case sampling was modified for use with the unit of analysis approach. Instead of sampling for negative cases, disconfirming evidence related to IPV disclosure events was sought from the data. Disclosure events were reviewed when theoretical hypotheses were generated in order to determine potential contradictory

relationships that could test or challenge the developing theoretical hypotheses. This is referred to as "negative case analysis" and was deliberately completed during the different stages of coding and analysis, not just after a full theory was developed (Loiselle, Profetto-McGrath, Polit, & Beck, 2007). Because many diverse units of analysis were available for review, negative case analysis could be conducted. When more information was required, the unit of analysis was linked back to the participant and she was further interviewed to provide greater insight. However, this approach would not have been possible had there been a small sample of disclosure events or if the events from which to draw on had been very similar in nature. While negative case sampling--which in its truest form tests the full theory after completion among new participants--could not be performed, the principles underlying this approach were maintained. Negative case analysis using disclosure events as the unit of analysis provided the researcher with an opportunity to evaluate contradictory developments as the grounded theory was developed and refined.

In order to conduct the sampling techniques discussed above, key variations were required. Careful review of coding families and methods for finding the most appropriate sources of data to reflect the broadest range of experiences must be considered when using all sampling techniques (Schreiber, 2001). The unit of analysis approach was one such adaptation required in order to conduct various sampling techniques. However, this adaptation requires a large and varied number of units to draw from in order to carry out sampling techniques for grounded theory. This meant that participants were followed for longer periods of time and data was collected over multiple interviews in order to obtain

adequate information to support the unit of analysis and satisfy the principles of the sampling technique used. Further, participants' IPV disclosures to different types of professionals were examined when undertaking maximum variation and negative case sampling in order to ensure that adequate variation and disconfirming experiences were found that could apply to the developing grounded theory. When using a bounded sample, it is impossible to undertake both maximum variation sampling and negative case sampling in the strictest sense. In negative case sampling, if the bounded sample does not contain informants whose experiences refute or disconfirm the emerging hypothesis, then it is impossible to undertake. Because the bounded sample included participants with various experiences related to IPV disclosure to clinicians, the adapted form of negative case analysis was used. As a result, while some of the methods relating to participant recruitment for Glaserian grounded theory were adapted, the principles and underlying rationale for the techniques were maintained. This, along with adherence to various attempts to ensure the trustworthiness of the grounded theory phase, aided in building the rigour of this phase.

Data Collection Decisions

Unique data collection decisions were made in this mixed methods study when incorporating a grounded theory approach with a randomized, controlled trial. Both the quantitative sub-analysis and the grounded theory phase were part of the author's (CC) doctoral work. At the time of ethics approval, initial recruitment for the randomized, controlled trial had been completed or was near completion for certain settings (e.g. primary care and specialty clinics). Recruitment among the acute care settings for the

randomized trial was still at an early stage. This was conducive for the mixed methods study as it allowed the most time for ongoing analysis and data collection for both the quantitative sub-analysis and the qualitative explanatory phase.

Because the grounded theory phase involved the same participants as the randomized trial, the potential for response burden was a concern. Participants who were recruited into the randomized trial across the three emergency departments continued to participate in follow-up interviews where they completed surveys at 7 days, 6 months, 12 months, and 18 months after initial recruitment. These participants also participated in a brief phone interview where they discussed any concerns they had with participating in the trial at 3 months, 9 months, and 15 months. For the grounded theory phase, participants would be involved in up to four interviews lasting 60 to 90 minutes where they would be engaging in discussion with the interviewer as opposed to completing surveys. Attempts were made to stagger interviews for the grounded theory phase around the schedule of interviews for the randomized, controlled trial in order to reduce the potential for response burden. In addition, the author (CC) maintained contact with the research centre for the randomized trial regarding when qualitative interviews took place. If a participant suddenly discontinued participation in the randomized, controlled trial after a qualitative interview, the trial interviewer could then ask if the participant wanted to voluntarily share reasons for refusal during a scheduled contact. Among the final sample of 19 participants for Phase 2, four participants were lost to both the randomized trial and the grounded theory phase for a period of time, with two returning to both studies at a later date. One participant refused to continue in the grounded theory phase

after completing two interviews yet continued to participate in the randomized trial. This participant stated that her change in participation was not due to either study but due to a change in the location of her job made it difficult for her to meet for interviews. Data from one participant was removed when her responses raised concerns about the validity of the information. This occurred after one interview had been completed and following consultation with the author's (CC) thesis committee. All remaining participants continued in both the randomized, controlled trial and the grounded theory component, suggesting that participating in both the quantitative and qualitative phases did not induce excessive burden.

In addition to response burden, the potential for emotional distress caused from discussing sensitive issues related to IPV during Phase 2 was a concern. According to Becker-Blease and Freyd (2006), discussing abuse or upsetting experiences did not encourage participants to withdraw from studies. Further, research questions about traumatic events were not found to trigger further trauma for abuse survivors, but rather, were perceived to be helpful (Becker-Blease and Freyd). In order to address any potential concerns with emotional stress as a result of participating in the grounded theory interviews, a locally-specific community resource card was provided to all participants to seek emotional support when needed. In order to protect the participant's and interviewer's safety during interviews, a safety protocol was created for the randomized trial and used throughout the grounded theory phase. The safety protocol outlined ways to discuss the study should a participant's partner arrive unexpectedly, including discontinuing the interview, or establishing code words when the participant no longer

felt safe. This protocol protected the participant but also served to protect the interviewer from the volatile and unpredictable nature of abusive intimate relationships.

One issue that was unexpected and required modification to data collection involved establishing trust and engagement with the research participants during the grounded theory phase. Collecting data from participants over two interviews had been planned. However, for most participants, the grounded theory phase was one of the first opportunities for them to tell their personal stories regarding IPV. During scheduled telephone contacts that were part of the randomized trial, participants regularly expressed appreciation for having the opportunity to discuss IPV. Many found the experience of telling their story to be helpful and offer some relief. On more than one occasion, the first meeting with the participant occurred after a stressful event such as an abusive episode, entering a shelter, or having an abusive partner arrested. In order to build trust with the participant, it was important to give enough time for her to describe her concerns before focusing on the questions pertaining to the study. As a result, an ethics amendment was submitted that permitted up to four interviews per participant so that the focus of the first two interviews could relate to developing trust. The remaining interviews allowed the interviewer to focus questions related to the needs of the grounded theory component. In some cases, trust was established after the first interview and enough data could be collected prior to completion of four interviews. Permission for four possible interviews was an important data collection strategy to balance the needs of the participant with those of the researcher to collect data.

One challenge that arose during the course of data collection was how to maintain contact with participants who lived highly vulnerable, chaotic, and transient lifestyles. In order to maintain contact with participants involved in the grounded theory phase, the author (CC) established a toll-free phone number so that participants could call from any part of the province free of charge. As part of the randomized, controlled trial, participants provided their phone number, mailing address, and a second contact person should it be needed. Over the course of the study, participants often moved, no longer had a working phone line or were not in communication with the second contact person. On multiple occasions, participants made contact with the author with the use of the toll-free number which they stated was the only way they could reconnect with the study. Interviewers from the randomized, controlled trial and the grounded theory approach (CC) would update the research centre when participants changed their contact information or resurfaced after a long absence. The resources offered by the randomized, controlled trial allowed for ongoing tracking of participants, which was often time consuming and complex.

However, there were occasions when participants were sought for the grounded theory phase but were no longer being followed by the randomized, controlled trial. During the process of theoretical sampling, it became necessary to explore the disclosure experiences of women with mixed and negative IPV exposure scores. Recruitment of these participants was essential for relationship exploration and theoretical abstraction. When this sampling need was identified, the acute care recruitment was completed for the randomized, controlled trial. The trial had additionally completed its follow-up for

participants with a mixed IPV exposure status (six months) and for those with a negative IPV exposure in the screen group (seven days after initial recruitment). As a result, these participants were no longer being followed as part of the randomized, controlled trial and many of the participants contacted either refused participation or did not respond to recruitment invitations. As a result, only three participants from the desired 10 were obtained. While these participants added greatly to the development of the emergent grounded theory, it is difficult to discern whether more participants with this type of IPV exposure status could have further contributed to the developing theory.

Data Analysis Decisions

A number of analytic strategies were used in order to embed and connect data collected from both phases of the mixed methods study. Analysis from the quantitative sub-analysis provided rationale for the incorporation of a qualitative component. The results from this analysis also confirmed that grounded theory was the most appropriate design choice for the qualitative component and initial research questions were generated based on these results. Data analysis from Phase 1 contributed to the development of an initial qualitative interview guide with questions that attempted to expand upon and further explain IPV disclosure in the emergency department setting. During the grounded theory analysis, methods recommended by Glaser (1978) and expanded upon by Charmaz (2006) were followed. Constant comparison is an essential component of analysis and was used during substantive and theoretical coding (Glaser, 1978; Schreiber, 2001). During initial substantive coding, "in vivo" codes were created using single words or the terms used by the participants (Schreiber). Results from the quantitative sub-analysis

helped to inform this initial coding by reviewing the responses participants provided on the clinical interactions questionnaire related to health care interventions offered after disclosure of IPV. Some in vivo codes included were "validation of IPV," "support," "providing information," and/or "offering referrals." Because the quantitative data related to IPV disclosure was limited, greater emphasis was placed on the information provided by the participants across a range of issues related to IPV disclosure while seeking care in an emergency department setting. Using this quantitative data to connect to preliminary qualitative coding allowed for mixing to occur during analysis.

In addition to connecting the quantitative data obtained from the randomized, controlled trial with the grounded theory phase, the analysis strategy involved embedding quantitative data during theoretical coding. After development of substantive codes grouped according to relationship or shared phrasing, theoretical coding begins (Schreiber & Stern). Again, constant comparison is used during theoretical coding to identify potential relationships between emerging categories and to create constructs in order to generate meaning for the developing theory (Tatano-Beck, 2002). As part of the quantitative sub-analysis phase, participants completed the Woman Abuse Screening Tool (WAST) (Brown, Lent, Schmidt, & Sas, 2000) and the Composite Abuse Scale (CAS) (Hegarty, Bush, & Sheehan, 2005; Hegarty, Sheehan, & Schonfield, 1999). The quantitative results from the WAST and CAS were used in the qualitative analysis in two ways: (a) to compare participants according to low, medium and high scores for IPV exposure, and (b) to compare participants according to different types of IPV using the CAS sub scales. Participants were grouped according to their WAST and CAS scores:

1. Low (0–4 points WAST, 0–29 points CAS).
2. Moderate (5–9 points WAST, 30–59 points CAS).
3. High (10–16 points WAST, 60–150 CAS).

Grouping participants according to severity of IPV exposure aided in initial analysis when identifying preliminary codes and potential categories. A result from this analysis found that participants with high CAS and WAST scores were most concerned with being judged by health care providers for remaining in an abusive relationship. This subgroup was later assessed for unique features that could enhance the understanding of the properties of the developing categories, including the BSP and core variable. After identification of the BSP, "being found out," participants were compared across low, moderate, and high severity to verify existing categories and relationships or identify any new features or conditions not seen previously. In the second mixing strategy, CAS results were used to organize qualitative participants according to the type of abuse including combined, severe abuse, physical abuse, emotional abuse, and harassment. This was completed to identify or confirm emerging or developing relationships. For example, the CAS scores showed that participants with high scores for emotional abuse had more difficulty identifying their relationship as abusive and seeking care for IPV, unless it was for an immediate physical injury. Participants who scored high for more than one type of abuse, like severe combined and emotional abuse, avoided health care as this group perceived the risks of "being found out" too great. Embedding the quantitative data during qualitative analysis permitted exploration of these relationships and categories to provide additional explanation.

Finally, the quantitative data were used during analytic memoing to support category development and to obtain theoretical abstraction during theory generation (Charmaz, 2006). Writing analytic memos permitted examination of interpretive understandings grounded in context, as opposed to causal relationships between categories (Charmaz). For example, memos explored the impact of abuse type obtained from the quantitative data on the decision of women to seek health care related to IPV as well as for disclosure of IPV.

Incorporating quantitative data from the randomized, controlled trial was useful for initial analysis and preliminary theoretical abstraction. However, due to the limited quantitative data collection methods utilized for this mixed methods study related to IPV disclosure, greater emphasis on the information provided by the participant was essential for category generation and development of the emergent theory.

Maintaining Rigour

When incorporating a grounded theory approach with a randomized, controlled trial it is important to maintain the integrity of both methods. In this case, a sequential explanatory design with equal weighting between quantitative and qualitative phases made it possible to address any potential threats to the rigour of the grounded theory phase. Considerations were made to address credibility, confirmability, dependability, and transferability when incorporating grounded theory with a randomized, controlled trial. According to Tobin and Begley (2004), credibility relates to the comparability or fit between the realities described by the participants and their representation by the researcher. Credibility for qualitative inquiry is the counterpart of internal validity in

quantitative research (Tobin & Begley). In order to address credibility, prolonged engagement, peer debriefing, and member checking were used. In order to develop trust and engagement with participants, research for the grounded theory phase occurred over 16 months so that there was sufficient time for data collection and an in-depth understanding of participant views. Member checking was completed at various points to confirm with participants that what they reported was being captured in the research. This was completed after identification of the core category and basic social psychological problem, the process used to address this problem, and during the development of the emergent theory. Having the human resources offered by a randomized, controlled trial permitted peer debriefing where the research team and experts studying IPV could comment on emerging interpretations.

Confirmability relates to establishing that interpretations are derived from data and not the researcher's imagination (Tobin & Begley, 2004). The nature of mixing both quantitative and qualitative data helps to address confirmability. From the quantitative sub-analysis, participants exposed to IPV decided against disclosing IPV in the emergency department. This resulted in the need for qualitative research to understand why participants chose for and against disclosure of IPV. The quantitative findings left a number of unanswered questions related to disclosure. Many of these unanswered questions were incorporated into the initial qualitative interview guide. During the grounded theory phase, a master's student with content expertise in IPV acted as a second person to code, analyze, and interpret the data. This enabled opportunity to verify that the developing categories and relationships were grounded in the data as opposed to the

author's (CC) interpretations. Further, a reflexive journal was maintained by the author (CC) to consider and challenge opportunities when the researcher might have influenced interpretation of the results as opposed to participants.

Reflexivity is another strategy to build qualitative rigour to capture reflection of how the researcher and the research process have shaped data collection and analysis (Mays & Pope, 2000). This was important since the interviewer had past experience as a nurse working with women exposed to IPV and was familiar with the literature related to IPV. This method was helpful to evaluate and distinguish whether the developing analysis was grounded in the data or flavoured by past clinical and educational experience. All participants were informed that the interviewer (CC) was a nurse on the participant information and consent form. Potentially this awareness may have contributed to initial resistance or reluctance to discuss IPV disclosure. As a result, the interviewer (CC) explained to the participant that she was present as a researcher and not as a health care provider. At times this posed challenges when participants requested medical attention or further help with their situation. When this occurred, the interviewer (CC) listened to participants concerns but clearly informed them that they were there to experience their story for research purposes. Additional social support resource contact information was provided to those participants requesting assistance. During the course of data collection, a break from data collection and analysis was taken when a friend of the interviewer (CC) experienced a tragedy related to IPV. During this time, the interviewer continued to explore perceptions and challenged assumptions that could potentially flavour data analysis through the use of the reflexive journal.

Dependability relates to how well the research process and methodological changes are documented and how traceable they are (Tobin & Begley, 2004). The counterpart in quantitative research is reliability (Tobin & Begley). Strategies to maintain dependability included documenting changes to method, such as adaptations to sampling, data collection, and analysis for the grounded theory phase. Transferability, which is often compared with external validity in quantitative methods, refers to how well findings can be "transferred" to other settings or further generalized. The nature of this mixed methods study meant that a grounded theory was developed to inform unexplained findings from a randomized, controlled trial, results. Further, because of the setting type, results may not be transferable beyond the context of urban emergency departments. Attention to transferability involved preparing a description of the emergency department settings used for recruitment into the study. This included participant reports on the nature of the setting, the interaction between emergency department health care providers and observations made by participants when health care providers inquired about IPV. Five health care providers who worked in various emergency department sites that were not involved in the study were sought by the author during a nursing course taught at a university in a large urban centre and after a presentation to grand rounds in a large urban hospital. The description exercise was shared with the participating health care providers for congruency regarding emergency department settings and their own practice experiences. This exercise was helpful in terms of exploring whether or not the nature of the emergency department settings in the mixed methods study were comparable with other emergency departments in Ontario.

Strengths and Limitations of this Mixed Methods Study

There are a number of key strengths and limitations to consider when incorporating a qualitative approach with a randomized, controlled trial. One strength of this mixed methods study was the "unit of analysis" approach during Phase 2 that maintained the principles of theoretical sampling, maximum variation, and negative case sampling despite the fact that no new participants were recruited into the study. Designing a mixed methods study that adheres to the principles of the grounded theory method is especially important when incorporating a qualitative approach such as grounded theory. These adaptations made it possible to explore IPV disclosure decision making within the context of women who participated in the randomized, controlled trial. This provided better explanation that would add to information arising from the screening trial but also provide new insights regarding IPV disclosure in emergency departments.

An important strength for the data collection process of Phase 2 was the access to available resources made possible through participation in a randomized, controlled trial. The most obvious resource was access to human resources essential for the initial recruitment of participants for the grounded theory phase as well as for assistance with the ongoing tracking of participants. Relying on the staff involved with the randomized, controlled trial also enabled ongoing communication so that qualitative interviews could be staggered around the trial interview schedule and helped to prevent attrition. Human resources support was also essential to help with tracking and monitoring of participants, crucial elements to working with a highly vulnerable and transient sector of the population like women exposed to IPV.

Finally, having access to quantitative data during qualitative data analysis served as an important strength. Data from the quantitative sub-analysis was used to develop initial qualitative interview guides during the purposeful sampling phase of the grounded theory phase. Quantitative data was also used for initial in vivo coding which was then tested during qualitative interviews to help define the dimensions and properties of early categories. During later qualitative analysis, the quantitative data was used to help explore established categories and test developing hypothesis to support generation of the grounded theory. Having quantitative data available for use in Phase 2 enhanced the ability of the qualitative phase to inform the randomized, controlled trial.

Key limitations arose from the incorporation of a grounded theory approach with a randomized controlled trial. The most significant limitation of this study was beginning this mixed methods study after the overall screening trial was underway. Creswell and Plano Clark (2007) recommended deliberately planning a mixed methods study as study in and of itself. The screening trial was highly complex and one of the first of its kind in North America. Further, because a randomized, controlled trial investigating the effectiveness of routine IPV screening versus usual care across health care settings had not been previously studied, it was impossible to estimate the types of mixed methods research questions that would arise. As a result, it was impossible to predict the need for a mixed methods study at the outset of the randomized, controlled trial. The pragmatic approach, in keeping with the philosophical principles of mixed methods design, was to incorporate a mixed methods study into this developing research program. This enabled

the identification of unique research opportunities and possibilities to add insight that would have otherwise been missed had this mixed methods study not occurred.

An additional challenge that arises when incorporating a qualitative approach with a randomized, controlled trial is the large amount of time needed in order to complete both phases of the study. During the grounded theory phase it was necessary to recruit participants who had previously completed the randomized, controlled trial. Because these participants were no longer involved, it was more difficult to re-engage their interest for the qualitative component. As a result, it is uncertain what the overall impact is of having fewer participants from the group who were no longer followed by the randomized, controlled trial on the developed grounded theory.

Future Recommendations

The following recommendations should be considered when incorporating a qualitative approach like grounded theory with a randomized, controlled trial as part of a mixed methods study.

Equal Emphasis on Approach

Future studies incorporating a grounded theory approach with a randomized trial should place equal emphasis on both methods. This will ensure that both are valued by the research team for their unique contributions to the research purpose, questions, and overall study goals. Further, equal emphasis can aid in the provision of human resources support essential for carrying out both components. Choosing a qualitative approach adds to the overall rigour of the study and permits a sophisticated and thorough means of addressing multiple research questions.

Provision of Adequate Human Resources to Support Phases

The implementation of both phases of this mixed methods study was enabled by the availability of adequate human resources. The randomized, controlled trial included a research coordinator, multiple interviewers who followed participants for 18 months post-recruitment, research assistants involved with data entry, data cleaning participant tracking, and research associates. The grounded theory phase involved one interviewer who collected and analyzed the qualitative data and one individual who transcribed each interview. It was necessary to rely on the staff involved with the implementation of the randomized trial for the grounded theory phases to aid with initial invitation for recruitment, tracking of participants, and the preparation of quantitative data for sub-analysis. Implementing a grounded theory with a randomized, controlled trial requires human support, especially when studying a highly vulnerable and transient sector of the population. Planning for a mixed methods study should take into consideration the human resources need to carry out both the quantitative and qualitative components of the study.

Timing of Quantitative and Qualitative Phases

This study found that the timing of both the quantitative phase and the qualitative phase was crucial in terms of recruitment, prevention of attrition, and analysis. When incorporating a grounded theory approach with a randomized, controlled trial, adequate time should be allotted so that the initial interviews for the grounded theory approach can be completed during the data collection phase of the trial. This includes the potential for interviewing participants in the qualitative phase who were either not eligible for the quantitative phase or who had previously completed the quantitative phase. Potential

participants should be identified as early as possible to increase the chances that they may agree to participate in the qualitative phase. Interviews for the qualitative component should also be staggered around the schedule of interviews for the randomized, controlled trial so as not to impose a further burden on participants. Providing intervals of one month or more between interviews may prevent participants from withdrawing from either phase of the mixed methods study. If the qualitative approach could begin early in the recruitment of the randomized, controlled trial, it may be possible to incorporate theoretical sampling with fewer modifications. This would help identify participants from the trial using criteria derived during grounded theory analysis.

Planning for Potential Data Mixing Opportunities

While this study involved both the embedding and connection of quantitative and qualitative data as mixing strategies, future mixed methods studies should seek and incorporate opportunities for data mixing. This study could have been enhanced by either the development or utilization of an existing quantitative questionnaire that explored IPV disclosure for participants recruited across emergency departments. This quantitative data could then have been used to connect to the initial stages of grounded theory for the development of the interview guide as part of purposeful sampling and for early qualitative coding and analysis. Incorporating quantitative data collection opportunities that could later be embedded during the qualitative data analysis would also add to the overall rigour of a mixed methods study. Embedding quantitative data during the qualitative explanatory phase served to better inform the randomized, controlled trial and original purpose for this mixed methods study.

In conclusion, this sequential explanatory mixed methods study combined two distinct research approaches to explain women's decision making regarding IPV disclosure in urban emergency department settings. The grounded theory phase addressed gaps that arose from a quantitative sub-analysis and provided a comprehensive examination of the problems that women identify with IPV disclosure and the strategies that they use to address these problems. In order to incorporate a grounded theory approach with a randomized, controlled trial, key modifications to sampling, data collection, and data analysis were required. Incorporating a qualitative approach with a randomized trial can enhance the study's overall findings and provide better explanations regarding incongruent findings. Key recommendations for including a qualitative approach with a randomized trial include attention to timing, weighting, mixing, and the incorporation of adequate resources to carry out both approaches.

References

Anglin, D., & Sachs, C. (2003). Preventive care in the emergency department: Screening for domestic violence in the emergency department. *Academic Emergency Medicine, 10*, 1118–1127.

Battaglia, T.A., Finley, E., & Liebschutz, J.M. (2003). Survivors of intimate partner violence speak out. Trust in the patient-provider relationship. *Journal of General Internal Medicine, 18*, 617–623.

Becker, P.H. (1993). Comixed methodson pitfalls in published grounded theory research. *Qualitative Health Research, 3*(2), 254–260.

Becker-Blease, K.A., & Freyd, J.J. (2006). Research participants telling the truth about their lives. The ethics of asking and not asking about abuse. *American Psychologist, 61*(3), 218–226.

Brown J.B., Lent, B., Brett, P.J., Sas, G., & Pederson, L.L. (1996). Development of the Woman Abuse Screening Tool for use in family practice. *Family Medicine, 28*(6), 422–428.

Brown, J.B., Lent, B., Schmidt, G., & Sas, G. (2000). Application of the woman abuse screening tool (WAST) and the WAST-short in the family practice setting. *Journal of Family Practice, 49*(10), 896–903.

Bryman, A. (2006). Integrating quantitative and qualitative research: How is it done? *Qualitative Research, 6*(1), 97–113.

Campbell, J., Snow Jones, A., Dienemann, J., Kub, J., Schollenberger, J., O'Campo, P., Carlson Gielen, A., & Wynne, C. (2002). Intimate partner violence and physical health consequences. *Archives of Internal Medicine, 162*, 1157–1163.

Carlson, B.E., McNutt, L., Choi, D.Y., & Rose, I.M. (2002). Intimate partner abuse and mental health. *Violence Against Women 8*(6), 720–745.

Chang, J.C., Decker, M.R., Moracco, K.E., Martin, S.L., Peterson, R., & Frasier, P.Y. (2003). What happens when health care providers ask about intimate partner violence? A description of the consequences from the perspectives of female survivors. *Journal of the American Medical Women's Association, 58*, 76–81.

Charmaz, K. (2006). Constructing Grounded Theory. *A practical guide through qualitative analysis*. London, UK: Sage Publication.

Collins, K.M.T., Onwuegbuzie, A.J., & Jiao, Q.G. (2006). Prevalence of mixed methods sampling designs in social science research. *Evaluation and Research in Education, 19*(2), 83–101.

Collins, K.M.T., Onwuegbuzie, A.J., & Jiao, Q.G. (2007). A mixed methods investigation of mixed methods sampling designs in social and health sciences research. *Journal of Mixed Methods Research, 1*, 267–294.

Creswell, J.W., Fetters, M.D., & Ivankova, N.V. (2004). Designing an mixed methods study in primary care. *Annals of Family Medicine, 2*(1), 7–12.

Creswell, J.W., & Plano Clark, V.L. (2007). *Designing and conducting mixed methods research*. Thousand Oaks, CA: Sage Publications.

Creswell, J.W., Plano Clark, V.L., Gutmann, M.L., & Hanson, W.E. (2003). Advanced mixed methods research designs. In A. Tashakkori & C. Teddlie (Eds.). *Handbook of mixed methods in social and behavioural research* (pp. 209–240). Thousand Oaks, CA: Sage Publications.

Cutcliffe, J.R. (2000). Methodological issues in grounded theory. *Journal of Advanced Nursing, 31*(6), 1476–1484.

Davila, Y.R. (2006). Increasing nurses' knowledge and skills for enhanced response to intimate partner violence. *The Journal of Continuing Education in Nursing, 37*(4), 171–177.

Dearwater, S.R., Coben, J.H., Campbell, J.C., Nah, G., Glass, N., McLoughin, E., & Bekemeier, B. (1998). Prevalence of intimate partner abuse in women treated in comixed methodsunity hospital emergency departments. *JAMA, 280*(5), 433-438.

Draucker, C.B., Martsolf, D.S., Ross, R., & Rusk, T.B. (2007). Theoretical sampling and category development in grounded theory. *Qualitative Health Research, 17*(8), 1137–1148.

Glaser, B. (1978). *Advances in the methodology of grounded theory. Theoretical sensitivity.* Mill Valley, CA: Sociology Press.

Glaser, B., & Strauss, A. (1967). *Discovery of grounded theory. Strategies for qualitative research.* Mill Valley, CA: Sociology Press.

Greene, J.C. (2007). *Mixed methods in social inquiry*. San Francisco, CA: John Wiley & Sons, Inc.

Hall, B., & Howard, K. (2008). A synergistic approach: Conducting mixed methods research with typological and systemic design considerations. *Journal of Mixed Methods Research, 2*(3), 248–269.

Hanson, W.E., Creswell, J.W., Plano Clark, V.L., Petska, K.S., & Creswell, J.D. (2005). Mixed methods research designs in counseling psychology. *Journal of Counseling Pyschology, 52*(2), 224–235.

Heaven, B., Murtagh, M., Rapley, T., May, C., Graham, R., Kaner, E., & Thomson, R. (2006). Patients or research subjects? A qualitative study of participation in a randomized controlled trial of a complex intervention. *Patient Education and Counseling, 62*, 260–270.

Hegarty, K., Sheehan, M., & Schonfield, D. (1999). A multidimensional definition of partner abuse: Development and preliminary validation of the composite abuse scale. *Journal of Family Violence, 14*(4), 399–415.

Hegarty, K., Bush, R., & Sheehan, M. (2005). The composite abuse scale: Further development and assessment of reliability and validity of a multidimensional partner abuse measure in clinical settings. *Violence and Victims, 20*(5), 529–547.

Ivancova, N.V., Creswell, J.W., & Stick, S.L. (2006). Using mixed methods sequential explanatory design: From theory to practice. *Field Methods, 18*(1), 3–20.

Jack, S.M., DiCenso, A., & Lofeld, L. (2005). A theory of maternal engagement with public health nurses and family home visitors. *Journal of Advanced Nursing, 49*(2), 182–190.

Jang, E.E., McDougall, D.E., Pollon, D., Herbert, M., & Russell, P. (2008). Integrating mixed methods data analytic strategies in research on school success in challenging circumstances. *Journal of Mixed Methods Research, 2*(3), 221–247.

Kemper, E.A., Stringfield, S., & Teddlie, C. (2003). Mixed methods sampling strategies in social science research. In A. Tashakkori & C. Teddlie (Eds.). *Handbook of Mixed Methods in Social and Behavioural Research* (pp. 273–296). Thousand Oaks, CA: Sage Publications.

Kinn, S., & Curzio, J. (2005). Integrating qualitative and quantitative research methods. *Journal of Research in Nursing, 10*(3), 317–336.

Lewin, S., Glenton, C., & Oxman, A. (2006). How are qualitative methods being used alongside complex helath service randomized controlled trials? A systematic review. Paper presented at the meeting of the Cochrane Colloquium, 2006, Freiburg, Germany. Retrieved March 4, 2009, from www.imbi.uni-freibuge.de/OJS/cca/index.php/cca/article/viewArticle/5372

Liebschutz, J., Battaglia, T., Finley, E., & Averbuch, T. (2008). Disclosing intimate partner violence to health care clinicians – What a different the setting makes: A qualitative study. *BMC Public Health, 8*, e229–e236.

Loiselle, C.G., Profetto-McGrath, J., Polit, D.F., & Tatano Beck, C. (2007). *Canadian essentials of nursing research* (2nd ed.). Philadelphia, PA: Lippincott Williams & Wilkins.

Lutz, K.F. (2005). Abused pregnant women's interactions with health care providers during the childbearing years. Journal *of Obstetric, Gynecologic, and Neonatal Nursing, 34*(2), 151–162.

MacMillan, H.L., Wathen, C.N., Jamieson, E., Boyle, M., McNutt, L., Worster, A., Lent, B., & Webb, M. (2006). Approaches to screening for intimate partner violence in health care settings. A randomized trial. *Journal of the American Medical Association, 296*(5), 530–536.

Mark, M.M., Feller, I., & Button, S.B. (1997). Integrating qualitative methods in a predominantly quantitative evaluation: A case study and some reflections. *New Directions for Evaluation, 74*(2), 47–59.

Maxwell, J.A., & Loomis, D.M. (2003). Mixed methods design: An alternative approach. In A. Tashakkori & C. Teddlie (Eds.). *Handbook of mixed methods in social and behavioural research* (pp. 241–271). Thousand Oaks, CA: Sage Publications.

Morse, J.M. (1991). Approaches to qualitative-quantitative methodological triangulation. *Nursing Research, 40*, 120–123.

Morse, J.M. (2003). Principles of mixed methods and multimethod research design. In A. Tashakkori & C. Teddlie (Eds.). *Handbook of mixed methods in social and behavioural research* (pp. 189–208). Thousand Oaks, CA: Sage Publications.

O'Cathain, A. (2009). Editorial: Mixed methods research in the health sciences: A quiet revolution. *Journal of Mixed Methods Research, 3*(1), 3–6.

Plichta, S.B. (2007). Interactions between victims of intimate partner violence against women and the health care system. *Trauma, Violence & Abuse, 8*(2), 226–239.

Rhodes, K.V., Frankel, R.M., Levinthal, N., Prenoveau, E., Bailey, J., & Levinson, W. (2007). "You're not a victim of domestic violence, are you?" Provider patient communication about domestic violence. *Annals of Internal Medicine, 147*(9), 620–627.

Rittmayer, J. (2000). Creating comfort: A grounded theory of intimate partner abuse survivors' perspective of primary health care visits. (Doctoral Dissertation, Texas Women's University, 2000). *Dissertation Abstracts International.* (UMI No. AAI9993960).

Sandelowski, M. (1995). Sample size in qualitative research. *Research in Nursing and Health, 18*, 179–183.

Schrieber, R.S. (2001). The "how to" of grounded theory: Avoiding the pitfalls. In R.S. Schreiber & P.N. Stern (Eds.). *Using grounded theory in nursing* (pp. 55–83). New York: Springer.

Schwandt, T. (2001). *Dictionary of qualitative inquiry* (2nd ed.). Thousand Oaks, CA: Sage Publications.

Stange, K.C., Crabtree, B.F., & Miller, W.L. (2006). Publishing multimethod research. *Annals of Family Medicine, 4*(4), 292–294.

Streubert-Speziale, H.J., & Carpenter, D.R. (2003). Chapter 7: Grounded theory as method. *Qualitative research in nursing: Advancing the humanistic imperative* (3rd ed., pp. 107–22). New York: Lippincott, Williams & Wilkins.

Tashakkori, A., & Creswell, J.W. (2007). Editorial: Exploring the nature of research questions in mixed methods research. *Journal of Mixed Methods Research, 1*, 207–211.

Teddlie, C., & Tashakkori, A. (2003). Major issues and controversies in the use of mixed methods in the social and behavioural sciences. In A. Tashakkori & C. Teddlie (Eds.). *Handbook of mixed methods in social and behavioural research* (pp. 3–50). Thousand Oaks, CA: Sage Publications.

Tatano-Beck, C. (2002). Releasing the pause button: Mothering twins in the first year of life. *Qualitative Health Research, 12*(5), 593–608.

Teddlie, C., & Yu, F. (2007). Mixed methods sampling: A typology with examples. *Journal of Mixed Methods Research, 1*, 77–100.

Tobin, G.A., & Begley, C.M. (2004). Methodological rigour within a qualitative framework. *Journal of Advanced Nursing, 48*(4), 388–396.

Tower, M., & McMurray, A. (2006). Domestic violence, health and health care: Women's accounts of their experiences. *Contemporary Nurse, 21*(2), 186–198.

Verhoef, M.J., Casebeer, A.L., & Hilsden, R.J. (2002). Assessing efficacy of complementary medicine: Adding qualitative research methods to the "gold standard". *The Journal of Alternate and Complementary Medicine, 8*(3), 275–281.

Vuckovic, N. (2002). Integrating qualitative methods in randomized controlled trials: The experience of the Oregon centre for complementary and alternative medicine. *The Journal of Alternate and Complementary Medicine, 8*(3), 225–227.

Wathen, C.N., Jamieson, E.J., MacMillan, H.L., & the McMaster Violence Against Women Research Group (2008).Who is identified by screening for intimate partner violence? *Women's Health Issues, 18*, 423–432.

Wathen, C.N., Jamieson, E., Wilson, M., Daly, M., Worster, A., & MacMillan, H.L. (2007). Risk indicators to identify intimate partner violence in the emergency department. *Open Medicine, 1*(2), e113–22.

Wilkins, K., & Woodgate, R. (2008). Designing a mixed methods study in pediatric oncology nursing research. *Journal of Pediatric Oncology, 25*(1), 24–33.

Wuest, J., & Merritt-Gray, M. (2008). A theoretical understanding of abusive intimate partner violence relationships that became non-violent: Shifting the pattern of abusive control. *Journal of Family Violence, 4*, 281–294.

CHAPTER 3

"Being Found Out"--A Grounded Theory Explaining Intimate Partner Violence Disclosure Processes by Women in Urban Emergency Department Settings

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"Being Found Out"--A Grounded Theory Explaining Intimate Partner Violence Disclosure Processes by Women in Urban Emergency Department Settings

Abstract

Background

Women regularly seek care in urban emergency departments for mental and physical impairment related to intimate partner violence. A lack of high quality evidence identifying effective health care interventions makes it difficult to recommend an ideal health care provider response for abused women. Women value providers who are non-judgmental, empathetic, supportive, and who are protective of their clients' privacy and confidentiality. Health care providers face many challenges and barriers related to clients exposed to IPV including their own lack of time and education when dealing with this complex social issue. This paper reports the qualitative findings from a mixed methods study that sought to understand and explain women's decisions related to the disclosure of intimate partner violence in urban emergency department settings.

Methods

A sequential explanatory mixed methods study was carried out from May 2006 to December 2007. Phase 1 involved a randomized, controlled trial with a quantitative sub-analysis of data obtained across three emergency departments in Ontario, Canada. At the point of the commencement of the quantitative sub-analysis, the randomized, controlled trial was already underway, so data collection was ongoing and final analysis had not yet occurred. Sub-analysis results indicated that women reported exposure to IPV but did not disclose IPV in the emergency department setting. This finding led to the development of Phase 2 using a grounded theory approach (Glaser & Straus, 1967; Glaser, 1978). The goal of this phase was to identify and explain women's basic social problems and processes related to disclosure of violence in urban emergency department settings.

Results and Discussion

"Being found out" was the basic social psychological problem that women stated influenced their decisions to disclose violence in the emergency department setting. Women exposed to IPV undertook a three phase process related to decision making about intimate partner violence disclosure including: (a) deciding whether to seek care, (b) evaluating level of trust, and (c) establishing readiness to disclose. Women indicated that the chaos and lack of privacy of the emergency department made it difficult to disclose violence. For a positive disclosure outcome, they needed to first establish their health care provider's trustworthiness and also determine their own internal readiness.

Conclusion

Health care providers can assist in supporting women and developing women's readiness for disclosure of IPV by initiating a non-judgmental and supportive interaction with the client. Basic communication principles like provider-initiated introductions, maintenance of eye contact, provision of active listening, and offering of verbal support can create a comfortable environment for women exposed to intimate partner violence.

"Being Found Out"--A Grounded Theory Explaining Intimate Partner Violence Disclosure Processes by Women in Urban Emergency Department Settings

Background

Intimate partner violence (IPV) is a significant problem encountered by health care providers working in emergency departments. It is no longer a debate that IPV causes women to suffer ongoing physical and mental impairment (Feder et al., 2009). IPV exposure alters women's interpretation of their health status (Campbell et al, 2002; Plichta, 2004) with many reporting health deterioration (Tower & McMurray, 2006).

In some cases, health care providers exacerbate women's health impairment through secondary victimization (Inoue & Armitage, 2006). Women described a range of responses from clinicians: a failure to fully investigate their concerns; being treated only for obvious physical injuries; being judged for relationship choices; and feeling punished for seeking health care (Chang et al., 2003; Liebschutz, Battaglia, Finley, & Averbuch, 2008; Tower & McMurray, 2006). Despite negative responses from health care providers that frequently led to an increased sense of victimization, some women continued to disclose IPV. A negative communication experience with a health care provider where a woman felt judged or ignored, impacted future disclosures and contributed to their view that health care provider interactions are not helpful or beneficial (Liebschutz et al., 2008).

The ideal health care response for abused women depends on both a woman's perception of the clinician and her own personal preferences. Feder, Hutson, Ramsay, and

Taket (2006) found that women wanted health care providers who were non-judgmental, non-directive, and who understood their circumstances. The nature of the client-provider relationship, a woman's readiness to discuss IPV, and the overall context during the discussion of IPV influenced women's perceptions and their satisfaction with the interaction (Feder et al). These results were consistent with other primary studies which found that women exposed to IPV valued several key provider characteristics: empathy and caring, open communication, active listening, permission for women to control their own situation and decision making, confidentiality, and competency in care related to IPV (Battaglia, Finley, & Liebschutz, 2003; Liebschutz, Battaglia, Finley, & Averbuch, 2008; Rhodes et al., 2007).

While research has shown that abused women attend emergency department settings, little is known about the problems that facilitate or inhibit disclosure of IPV in such a setting. Furthermore, little is known of the process(es) that women undertake to resolve identified problem(s) related to disclosure. This study reports on the qualitative phase of a sequential explanatory mixed methods study. This grounded theory study (Glaser, 1978; Glaser & Straus, 1967) aims to identify women's basic social psychological problem with IPV disclosure in urban emergency departments and the basic social process(es) that women use to resolve this (these) problem(s).

Methods

Background on Mixed Methods Study

Grounded theory (Glaser & Straus, 1967; Glaser, 1978) was used in this mixed methods study to explain results arising from an initial quantitative sub-analysis from a

randomized, controlled trial. The purpose of the randomized, controlled trial was to evaluate whether routine screening for IPV in health care settings, as compared to usual care, does more good than harm. A quantitative sub-analysis was conducted using data obtained across three urban emergency departments participating in the trial. At the time of this quantitative sub-analysis, the randomized, controlled trial was ongoing and final analysis of data had not yet occurred.

In order to identify IPV exposure in women two instruments were used as part of the trial. In the emergency department, randomization occurred by eight-hour shifts throughout the day into "screening" and "non-screening" groups. Screen group recruits completed the Woman Abuse Screening Tool (WAST) (Brown, Lent, Schmidt, & Sas, 2000) (Appendix E) then proceeded to their visit with the emergency department clinician. After this visit, screen group participants completed the Composite Abuse Scale (CAS), a criterion standard to assess IPV exposure (Hegarty, Sheehan, & Schonfield, 1999) (Appendix F). These participants also completed a clinical actions questionnaire regarding IPV disclosure to the health care provider and received interventions. Non-screen participants proceeded to their health care visit and, before leaving, completed the WAST, the CAS, and the clinical interactions questionnaire. Demographic data for both groups were collected during this recruitment visit. Emergency department clinicians for the screen group participants completed a clinical actions instrument where they detailed what interventions they provided for those who had disclosed IPV.

A quantitative sub-analysis was completed from May to November, 2006. Results revealed that for both the screen and non-screen groups, approximately 14.7% scored

positive for IPV (i.e. ≥4 WAST and ≥7 CAS) with only 1.9% of the total participants reporting disclosure of IPV. Among participants who disclosed IPV, approximately 63% had a positive score on both the WAST and CAS (Appendix O). On the clinical interactions questionnaire, a large amount of missing data from participants and health care providers prevented further explanation of decision making related to IPV disclosure. This suggested that the quantitative instrument may not have been the best means of learning about the complexities of women's decision making regarding IPV disclosure. The low disclosure rates among participants who scored positive for IPV suggested that other factors may have contributed to their decision to disclose. As a result, a grounded theory study was conducted to provide further explanation of these quantitative findings.

Participant Recruitment

A grounded theory study was carried out from May 2006 to December 2007. Because the goal of the grounded theory approach was to help explain the IPV disclosure results, all participants were recruited from the three urban emergency departments used in the quantitative sub-analysis. The three urban emergency departments used for recruitment were in the greater horseshoe area of Southern Ontario. Two emergency departments were part of a large multi-site hospital amalgamation serving 434,000 Ontario residents. The third emergency department was part of a multi-centre teaching hospital with more than 100,000 annual emergency department visits.

Initial eligibility criteria were established in order to identify a purposeful sample of five participants from the quantitative sub-analysis of the randomized, controlled trial

data (Appendix I). The goal with these preliminary five participants was to develop and modify the initial interview guide and identify initial codes and potential categories for further analysis. When this was completed, theoretical sampling began and participants were sought from either the screen or non-screen groups with a positive IPV exposure score and who reported disclosing IPV at the emergency department setting, participants from the screen and non-screen group who did not disclose IPV at the emergency department setting, and those participants with negative scores and mixed scores (e.g. false positive and false negative) for IPV exposure status. An estimated goal to sample 20–27 women was identified in keeping with other grounded theory studies involving vulnerable women or women attending acute care settings (Jack, DiCenso, & Lohfeld, 2005; Lutz, 2005; Rittmayer, 2000; Wuest & Merritt-Gray, 2008).

Theoretical sampling was modified to accommodate the recruitment of participants from the randomized, controlled trial. The principles of theoretical sampling were used including simultaneous collection, coding and analysis of data on activities and events to saturate the evolving theory and increase its level of abstraction (Schwant, 2001). The constant comparative method was used throughout sampling and analysis and examined incidents, events, or situations related to the disclosure of IPV in urban emergency departments (Eaves, 2001; Glaser, 1978). The "unit of analysis" did not represent actual participants but rather events, incidents or examples. For this study, each "unit" was an "IPV disclosure event" (Schreiber, 2001). This approach permitted multiple, new disclosure stories, or "units" from which to draw on for identification of the core variable, saturation of themes, and building of an overall theory. As new "units

of analysis" were identified, sampling, data collection and analysis decisions were made to guide joint data collection, coding and analysis so that an inductive process was followed to guide the selection of participants to develop and test the emerging grounded theory (Becker, 1993).

Two other sampling methods were adapted for use in this grounded theory study since no new participants were recruited outside of the randomized, controlled trial. After identification of the core variable and initial relationship linkages were developed, a modified form of maximum variation sampling and negative case sampling were undertaken. The "unit of analysis" approach was used for maximum variation to identify IPV disclosure events at "opposite ends of the spectrum" so that a category's properties and dimensions could be compared and examined.

Negative case sampling, used upon emergence of a theory grounded in the data, can increase theoretical abstraction by examining perspectives from new participants that refute or deviate from the developing theory (Schreiber, 2001; Teddlie & Yu, 2007). Because new cases outside of the randomized trial were not sought, negative case sampling was modified for this study to examine disconfirming evidence and potential contradictions among "units of analysis" throughout the different stages of coding and analysis (Loiselle, Profetto-McGrath, Polit, & Beck, 2007).

Ethics

Ethics approval for this study was obtained from the McMaster University/Hamilton Health Sciences Research and Ethics Board, Hamilton, Ontario, Canada from the three Ontario Hospital sites where recruitment occurred (Appendix R, S,

and T). Participants provided written consent prior to each face-to-face interview (Appendix U and V). While it was not anticipated that participating in interviews would cause emotional distress, all participants were provided with a resource card listing local area organizations for further support. A formal safety protocol was followed for this study (Appendix W).

Data Collection

Up to four interviews were conducted per participant to ensure sufficient data for category saturation and theory development. Because of the transient, high-risk nature of participants' lives, the first interview was conducted largely for the purposes of developing trust with the interviewee and for allowing her to tell her story. Interview guides evolved over time and initial questions focused on the collection of participant and family background, descriptions and experiences of abuse, and the conditions that promoted a positive and negative interaction with a health care provider. Subsequent interview guides explored IPV disclosure, including its features, its consequences, and recommendations for the health care provider (Appendix J). The majority of interviews took place in a public location or, when accessibility demanded, in a participant's home. All participants were provided with $25 per 60–90 minute interview.

Data Analysis

Three levels of coding were used, including "in vivo," substantive and theoretical coding. Throughout the coding process, the constant comparison method (Glaser & Straus, 1967) was used to review data for fit and relevance, to evaluate codes with one another to generate categories, and to identify relationships between categories for the

ultimate generation of a theory grounded in the data (Charmaz, 2006; Glaser, 1978; Glaser, 1992). During "in vivo" coding, codes were labelled, separated, and compiled to capture the main idea of the participant (Level 1) (Schreiber, 2001). These codes were then grouped together to create clusters or families which were then classified under a label as "concepts." These concepts were then organized together to form categories (Level 2) (Eaves, 2001; Schreiber). Constant comparison identified relationships among codes and categories (Level 3), properties and dimensions of the categories, and conceptual linkages within the data (Charmaz; Glaser, 1978). After the core variable and basic social psychological problem (BSP) were discovered, selective coding strategies were used. These included elements from the following coding families like "process," "strategy," and the "six C's" to identify relationships and substantive codes (Glaser). Memos were created for initial category development and assisted to advance theoretical abstraction during theory development (Charmaz). Diagramming, including the creation of concept maps and matrices, helped refine and define the relationships between categories (Charmaz). These strategies were essential for viewing the sequence of events and establishing hypotheses around women's decisions and behaviours.

Rigour

Trustworthiness was established by promoting credibility through prolonged engagement with participants, member checking, and peer debriefing with emergency department health care providers outside of this study. These health care providers commented on the nature of the emergency department and compared the context of this study for consistency and transferability to other emergency departments. Strategies for

confirmability included involvement of a master's student to double code transcripts and develop categories to verify author (CC) findings. Informal inquiry audits were undertaken and stored on computer regarding the processes and adaptations to method, data collection, and analysis with thesis committee members. Reflexive journaling was used by the author to examine the impact of her role as a health care provider, her past experience working with victims of violence, and her awareness of the IPV literature.

Results

A final sample of 19 women completed up to four face-to-face interviews. A total of 50 interviews were completed. Seven participants each completed four interviews for a total of 28 interviews. Two participants each completed three interviews, six participants each completed two interviews and four participants each completed one interview. After the completion of one interview, data from one participant was removed when her responses raised concerns about the validity of the information. Demographic data for these participants were collected as part of the randomized, controlled trial.

Among the 19 participants, 16 scored positive for IPV exposure on both the WAST and the CAS. Two participants had a mixed screen score (e.g. false negative) and one participant had a negative score on both instruments as seen in Table 1.

Table 1

Intimate Partner Violence Exposure Scores Among Participants Using the WAST and CAS Instruments

Intimate Partner Violence Exposure Status	Number of Participants (N=19)
True Positive Score (WAST ≥4, CAS ≥7)	16
True Negative Score (WAST <4, CAS <7)	1
False Positive Score (WAST ≥4, CAS <7)	0
False Negative Score (WAST <4, CAS ≥7)	2

Intimate Partner Violence Exposure

Using the WAST, 16 participants scored positive for IPV exposure (≥4) and three scored negative for IPV exposure (<4). The mean score value across all participants was 8.03. Eighteen participants scored positive for IPV exposure using the CAS (≥7). The mean score value was 31.9 and the full range of scores from 0–150 points.

Nature of Intimate Partner Violence Experienced

Using the subscales of the CAS, 10 participants reported combined severe abuse (mean=4.12); 13 reported physical abuse (mean=5.80); 18 reported emotional abuse

(mean=17.68); and 11 reported harassment (mean=4.33). Figure 1 depicts a comparison of CAS subscale scores across participants with abuse type in percentage per participant. For 15 participants the prevalence of emotional abuse was higher than other forms of abuse.

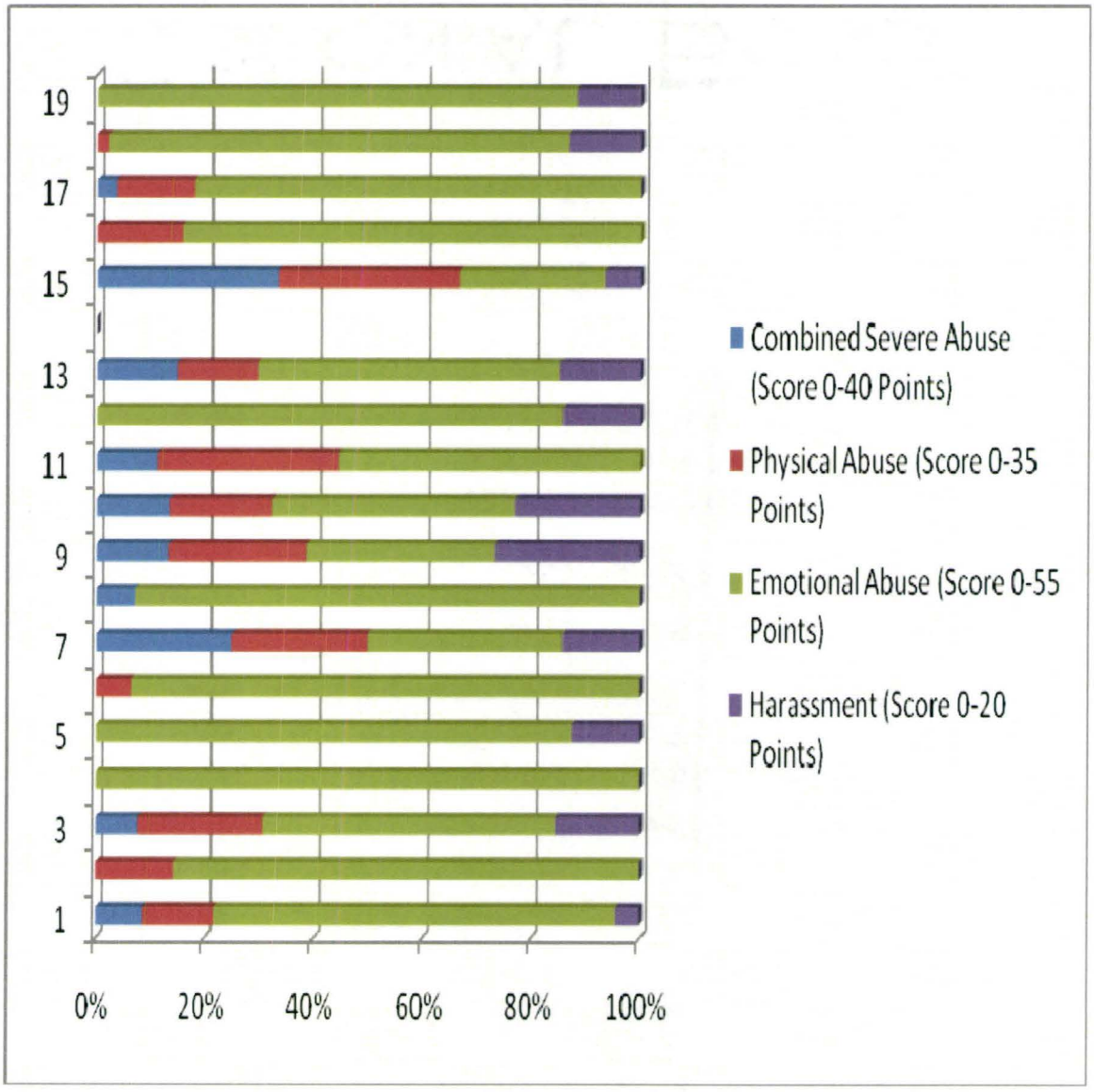

Figure 1. The rate of abuse across the Composite Abuse Scale Subscales

Intimate Partner Violence Disclosure Events

When participants were asked their thoughts about providing a health care provider notice of their positive IPV screen result, seven women stated that they would not report the truth about their relationship, four women stated that this would not affect their decisions to report violence in their relationships, and eight participants stated that they did not know. Participants were asked about past IPV disclosures to health and social service providers. Twelve participants disclosed IPV to a health care provider. Seven of these disclosed to an emergency department clinician, four to a family physician, and one to a public health nurse. The remaining seven women stated that they had not yet disclosed IPV to a health care provider. As one woman stated, "I haven't done it yet, but that doesn't mean I haven't thought about it." Twelve participants disclosed IPV to other types of providers including police, social workers or family and friends. Among the 19 participants, 113 individual IPV disclosure "units of analysis" were sampled involving physicians, registered nurses, police officers, counselling professionals, family members, and friends as seen in Table 2.

Table 2

Disclosure Events Among Women Attending Urban Emergency Departments and Exposed to Intimate Partner Violence

Unit of Analysis – IPV Disclosure Events	Number of Disclosure Events
Emergency Department Physician	9
Emergency Department Nurse	14
Other Types of Physicians (e.g. Primary Care)	18
Other Types of Nurses (e.g. Public Health)	3
Police Officers	19
Counselling Professionals (e.g. Social Workers, Child Protection Workers)	15
Family Members	14
Friends	21
Total Number of Disclosure Events	113

Basic Social Psychological Problem

"Being found out" was the basic social psychological problem (BSP) that influenced decisions regarding IPV disclosure in the emergency department setting. For participants exposed to IPV, telling a health care provider about violence might lead to

positive supports but could also result in greater vulnerability and powerlessness. As one woman explained:

> I was angry at myself, and you know, traumatized. I was already embarrassed about coming all the time [to the emergency department] with abuse problems--to have to talk about it makes it harder for me to look at myself.

Participants described feeling embarrassed and ashamed about being in a violent relationship and feared judgment for remaining in an abusive situation. One participant described this:

> It's embarrassing to have been a victim over and over. How could I be so stupid, and be in there? I was embarrassed. The doctors and nurses start to be judgmental and stuff. They go, "What are you doing?" You know, "how come you're not doing anything about this?" You don't know if [the doctor or nurse] is going to get mad at you so why tell them?

"Being found out" in the emergency department was perceived as risky. Participants described the potential of being viewed by the health care provider as a "misuser of the system":

> … in front of every person that was in the emerg waiting room and the doctors and nurses, everybody, [the doctor] yelled at me and swore at me because I wanted help for pain after being beat up. [The doctor] said I was a no good for nothing drug addict and he wasn't "f'in' giving me anything"--and told me to get out. So I've never been back there and I probably will never go back there. I wouldn't. Or I will travel to a different city to go to a hospital.

Women in violent intimate relationships attempted to achieve normalcy in their chaotic lives and feared further disruption from the involvement of health and social service providers. Disclosing IPV was seen as an invitation to further intrusion from health care providers and other agencies like police, social services, and child protection.

"Managing the risks" was the basic social psychological process related to decisions women made regarding IPV disclosure in the emergency department. A three-phase process related to decision making about IPV disclosure included: (a) deciding whether to seek care, (b) evaluating the level health care provider trustworthiness, and (c) establishing readiness to disclose IPV. This is outlined in Figure 2.

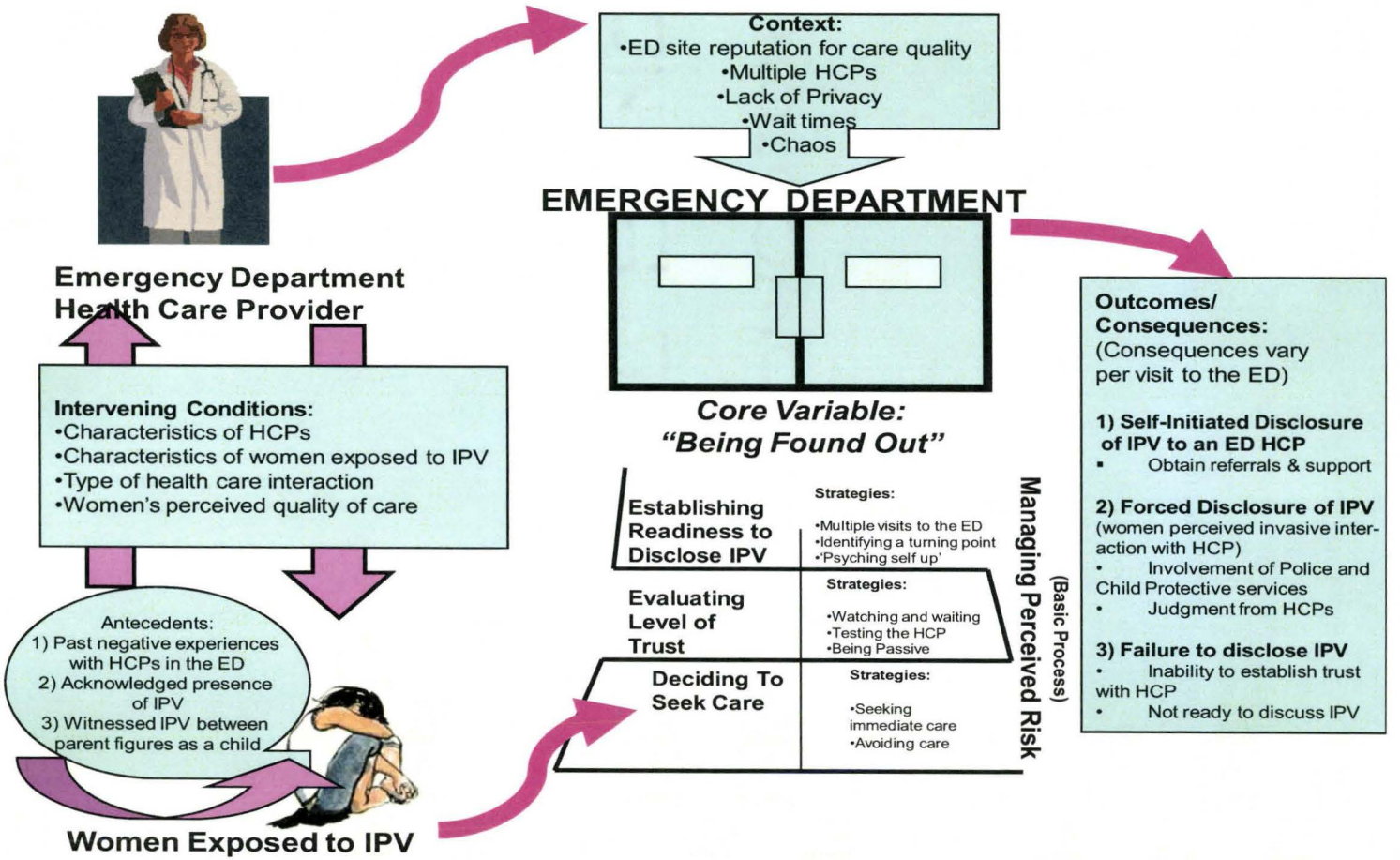

Figure 2. Grounded Theory of Intimate Partner Violence Disclosure Decision Making

From the figure, each phase is a sub-process and involves ongoing evaluation and decision making by the woman before a self-initiated disclosure. Participants entered the emergency department fearing change and life disruption if the violence in their relationship was revealed to the health care provider. For each phase, women weighed the potential benefits of disclosure against their own perceived risks. How women negotiated each phase of the process was influenced by evaluated the perceived risks of disclosing IPV with their need to obtain health care. Progression through the phases of "managing risk" could occur linearly from deciding to seek care, then evaluating the health care provider's trustworthiness, to establishing internal readiness for IPV disclosure. Movement through each phase occurred at different rates with women finding some phases easier to negotiate than others. Not all participants in this study completed the three phases of "managing risk" in a linear fashion. Women sometimes became stuck or fixed in a phase when abuse was recognized by the clinician before disclosure, when the health care interaction was perceived by the woman as negative, or when participants were not ready to disclose IPV. Central to the process of "managing risk" were intervening factors like the personal qualities of both the health care provider and the woman, the nature of the interaction with the provider, and women's overall perceptions of care quality.

Antecedents

Poor interactions with health care providers, the inability to see the intimate relationship as abusive, and a history of child maltreatment were antecedents that influenced participant progression through the process of "managing risk." A multitude

of negative interactions with clinicians resulted in greater difficulty building trust with emergency department clinicians. Participant satisfaction was influenced by expectations prior to receiving health care and the perceived outcome after receipt of health care. When prior expectations were not met, the outcome, and ultimately the health care interaction, was deemed negative. Participants were dissatisfied when the clinician demonstrated a lack of empathy or concern, did not actively listen to concerns, betrayed privacy or confidentiality, or judged participants for failure to leave an abusive relationship. Alternatively, some women expected poor treatment and left the health care interaction satisfied when they received health care that surpassed their expectations.

The inability to acknowledge IPV as a problem was an antecedent. In this sample, women who openly defined their relationship as abusive were more likely to seek health care for their own health needs and engaged in the phases of "managing risk." Those not ready to openly identify their relationships as abusive did not view injuries or concerns as requiring health care. Seven participants in this study stated that physical abuse was IPV, but not other types of abuse like emotional abuse or harassment. For example, one participant scored positive for IPV exposure using the WAST and the CAS, but stated that her relationship was not abusive because there was no physical abuse:

> We have our issues though, you know. My husband has a nasty temper so he, but he's working on it, you know, so I think it's better. He's not abusive. He's never hit me or anything like that. But he gets very angry, very hot under the collar... I don't think it's always appropriate... it can make me uncomfortable... you know his anger. But he's never, never hit me, never hit the kids, never done anything

> that would, uh, lead me to believe that he would abuse me either. It's only abuse if he hits you.

The third antecedent that arose from these data related to past exposure to child maltreatment--specifically child exposure to IPV between parent figures. Participants who had witnessed IPV as children had one of two types of responses in their own relationships: (a) some women viewed IPV as a normal element of adult intimate relationships, or (b) some women recognized IPV and attempted to seek healthier relationships. Abusive relationships were viewed as "normal" for these participants and the consequence was greater difficulty acknowledging and accepting that their relationship was violent: "When you grow up with it, [abuse] gets normal. How do you know the difference anymore?" These participants felt stuck in a pattern of choosing abusive relationships and strived to avoid "being found out."

For four women who were exposed to child maltreatment, "being found out" was especially embarrassing since they felt that they repeated the relationship choices of their own mothers: "I should have known better than get involved with someone like [my father or male parent figure]." One participant who reported negative exposure to IPV in the past 12 months using the WAST and the CAS, decided as an adult to choose healthy relationships after having to explain her mother's situation with IPV:

> When I was a kid, doctors did talk to me about my mom being abused. My mom would go into the hospital and they would, like, talk to me. I was little, like, I was ten and [the doctors and nurses] tried to find out what happened because my mom would not be able to say anything. She wouldn't say anything so they come to me

> and my little sister and try to, like, figure out what was going on. She never admitted to any of it and stayed in it for years. And finally she got out of it, but that was when her life was in danger. She got out of it and so I just don't tolerate it.

Managing Risk: The Process Related to Intimate Partner Violence Disclosure

Managing risks was the core variable with three phases: (a) deciding to seek care, (b) evaluating level of trust with the presenting health care provider; and (c) establishing personal readiness to disclose.

Deciding to Seek Care

In this initial phase, decisions related to whether or not to seek health care for physical injuries or emotional concerns related to IPV. Three strategies arose during this phase: weighing options, seeking immediate care, and avoiding care.

Weighing Options

Initiating treatment in an emergency department was perceived as a threatening activity requiring a "weighing of options." In order to seek care, the need for treatment had to outweigh fears of public exposure of IPV. Nine women described past experiences where health care providers made them feel powerless after IPV disclosure. Weighing options allowed participants to regain control over their situations, and to decide whether or not to seek health care for problems related to IPV. Throughout this phase, women managed perceived risks by withholding information about their relationships until they determined the clinician was trustworthy. As one participant stated, "I'm not a cop caller, right, so I didn't want to talk about [IPV] and aggravate the situation. You have to really

think carefully before you blurt it out… The guy's gonna find out and be [angry]." When women thought they were under suspicion by the clinician, they might lie about IPV in order to avoid further public exposure from disclosure.

Seeking immediate care

Participants sought care in the emergency department when immediate health care needs outweighed the perceived risks related to IPV disclosure. The types of health care women sought at this point were for treatment of physical injuries, especially those of a severe nature, and emotional issues, for example, feeling suicidal, depressed, anxious, panicked, or overwhelmed. During this time, women were cautious and trust in the health care provider occurred slowly over multiple visits to the emergency department. Participants were preoccupied with gaining entry into the system and described: (a) being overwhelmed with the busy nature of the emergency department environment, (b) feeling lost and ignored upon entry into the setting, and (c) passing through different stages of waiting until they met a health care provider. Women experienced "feeling isolated" and had to "fight to get heard" in order to be acknowledged by triage staff. Triage health care providers were seen to be "shuffling papers" as opposed to providing care. One woman reported her experience waiting to be admitted by the triage staff:

> I went over to the desk and kind of waited for one of the nurses to look up and then [the nurse] was like, "Why are you standing here?" and then tried to shuffle the papers or something. So I was like, "Ok, well I can't wait any longer, is anybody going to see me?" And I was a little bit, you know, short with [the nurse]

> because she had been so rude. So she just looked at me, grabbed her papers and, like, walked away.

Other participants stated that they felt "invisible" and "forgotten" as they were moved from one waiting area to the next in anticipation of meeting the clinician for the first time. A woman's need to hide IPV decreased when the triage health care providers: (a) acknowledged their presence, making them feel deserving of care, (b) provided them with information regarding the potential wait time before receiving care, and (c) gave them an update after a number of hours of waiting had passed.

Five participants who scored positive for IPV and who had high emotional and physical abuse scores on the CAS sought health care for physical injuries and/or emotional needs but subsequently left the emergency department. These participants avoided engagement with the clinician and opportunities to build trust needed for IPV disclosure. This allowed these women to exercise a degree of autonomy over their situations. Often women who utilized this strategy were not yet ready to discuss IPV:

> ...definitely I have gone to the emergency room to get fixed up and turned around and left. I've done it. Sometimes, I tell the [doctor or nurse] "Oh I want to talk to you, but I don't want to talk to you." Again it's that trust issue. You know just by looking at the [doctor or nurse], how [s/he] talks to you, how [s/he] reacts. I've done it, just to test the [doctor or nurse] to see if I want to talk to [him/her] and if I don't, I don't.

Avoiding care

Among participants with a positive score for IPV and a score of ≥10 on the severe, combined abuse scale of the CAS, avoiding health care was a strategy used to prevent IPV disclosure. Despite severe injuries from IPV, these participants described being "forced" to seek health care when they were transported by emergency services like police or ambulance. The fear of "being found out" led this group of women to deny abuse and conceal their injuries as a further strategy to avoid care and the potential judgment and invasion by health care providers. As one woman stated: "They wouldn't go see a doctor. They would be trapped at home. A lot of people won't tell the truth; they'll lie." Outcomes for these women included chronic pain; improper healing of fractures; facial and body disfigurement; gynaecologic problems; unresolved dental trauma including edentulism; and, in one case, loss of hearing and vision.

A condition of the category "avoiding care" was the perception that health care providers were invasive and receipt of health care meant a lack of privacy, exposure to multiple, often anonymous providers and being forced to relive trauma. By being "forced to seek care" women felt powerless and uncertain when passing through the emergency department system. Transport by police and/or ambulance, caused women to feel vulnerable as their lives were "uprooted." The perceived consequences of being brought to the emergency department for immediate treatment included: intrusion to collect evidence and obtain photographs, partner betrayal from pressing criminal charges, and potential retaliatory violence from the perpetrator. Unlike the women who entered the emergency department of their own accord and then felt ignored, these participants felt

invaded and singled-out for treatment from various health and social service providers. As one woman described the experiences: "It's intrusive. I feel it's nobody's business if I want to be in this situation, it's my choice. I'm a big girl, and it's all I know and they can't just turn around and uproar my whole life."

What participants perceived as "increased medical attention" interfered with their ability to build trust with a health care provider and establish readiness for IPV disclosure. Women repeated their stories to each provider and were unable to exercise control over their own situations. One woman described "feeling traumatized" and did not want to interact with the various health care providers entering and leaving her room as it caused her to relive an abusive episode. This participant stated, "You really do want to be alone, at least I did… I definitely don't want the cleaning lady to keep coming in. That can wait, you know, because you don't trust anyone at that point." "Feeling powerless" caused a dilemma for abused women who wanted help but feared excessive intrusion from health care providers. As a result, strategies of severely abused women were to: (a) remain passive so health care providers could complete their investigations, and (b) avoid engagement with health care providers. Through these strategies, women reclaimed autonomy by deciding when to share information regarding IPV.

Evaluating Levels of Trust

Evaluation of the health care provider's trustworthiness was the second phase of the process of "managing risk." The "unit of analysis" approach identified the following conditions of trust between the participant and the health care provider: implicit trust, distrust, and mistrust. Women used the following strategies to evaluate their level of trust

in the health care provider: watching and waiting; testing the health care provider regarding a chief complaint not related to IPV; and being passive and complying with health care provider requests. The evaluation process women undertook was an important precondition before women could explore their readiness for disclosure.

Trusting Health Care Providers Implicitly

Five women had the tendency to implicitly trust others and were able to quickly evaluate their ability to trust their health care provider. These participants reported IPV exposure with scores ≥9 WAST and ≥19 CAS. The highest scores for this group were 12 points WAST and 75 points CAS. These participants experienced positive interactions with health care providers of all types in the past. For the interaction with a health care provider to be positive, women needed to feel that their primary concerns were acknowledged and addressed by the health care provider in a respectful and non-judgmental manner. A positive health care interaction helped to establish trust in the health care provider and facilitated readiness for disclosure:

> The doctor came in asked me if I was afraid to go home and if I was afraid that [my husband] would come home and cause any more damage. The doctors and nurses did ask and they did suggest that if I ever was worried that I could call these numbers for help… I felt safe so I did the abuse thing after I got my staple put in.

In order for a health care provider to be deemed trustworthy, s/he must have met the following criteria: (a) given assurance that a woman's confidentiality and privacy would be maintained throughout the health care interaction, (b) demonstrated caring and

empathy, (c) refrained from judging the woman for her relationship choices, and (d) sought the woman's opinion regarding whether or not the proposed interventions were feasible and appropriate. Women who trusted health care providers implicitly viewed members of the health care profession (e.g. physicians and nurses) as trustworthy because of the nature of their roles and responsibilities. Equal levels of trust were assigned to nurses and physicians and the practice setting where a health care provider is employed. For these women, it was a societal expectation that a health care provider be trusted. As one woman explained, "If you can't trust a doctor or nurse, who can you trust?" When a health care provider betrayed one or more of the criteria for trust, women were no longer able to build a trusting relationship with that particular provider. The consequences that resulted from a woman's ability to trust included opening up and sharing more personal information, reviewing potential readiness for disclosure of IPV and identifying health care providers that were trustworthy.

Distrusting Health Care Providers

For seven women who distrusted health care providers, the ability to evaluate their trust in the emergency department clinician was very important. IPV exposure scores ranged from $\geq$2 and $\leq$12 points (WAST) and $\leq$45 (CAS). One participant scored negative for IPV exposure in the past 12 months but described challenges in developing trust with the clinician related to IPV disclosure. This group of women believed that the provider must "prove" that s/he is trustworthy:

> They have to be able to prove to me... I guess they have to show me trust first before I can trust them. It has to be easy--you can see it in their eyes. But first I need proof. Don't think you will get my trust, you need to earn it...

This group undertook a complex evaluation process and identified criteria for a health care provider to meet in order to establish trust. Health care providers were considered trustworthy if they were comfortable discussing IPV, presented themselves as approachable, used facilitative body language, and demonstrated active listening in an empathic manner. Further, confirmation of trustworthiness occurred when the health care providers were competent and experienced in working with women exposed to IPV. Gender was an important consideration for this group as female health care providers were considered to be more trustworthy than male health care providers.

Women identified characteristics of health care providers that would make him/her "untrustworthy," including a failure to do the following: listen to concerns, be sympathetic, provide competent care, and offer support and interventions. As one participant recounted:

> It was not good. [The doctor] barely looked up at all, you know. He asked me did someone hurt me or did I do anything that could have hurt myself. The whole time he had his head down when I was talking and he wasn't looking at me. He told me to take aspirin. It was really quick and so it wasn't good. He wasn't very personal at all.

Women who cited difficulty trusting a health care provider had experienced a mix of both positive and negative interactions with past health care providers. Women

described negative experiences including: being labelled as manipulative or misusing the health care system, having the health care provider betray confidence and/or privacy, and the health care provider failing to address what women perceived to be their health care needs. These participants required numerous interactions with clinicians in order to feel comfortable discussing private issues. Because women in this group identified at least one family member or friend in whom they trusted, it was possible to develop a trusting relationship with a health care provider over time. These women could not trust anyone implicitly due to a multitude of experiences where trust was betrayed by a significant person in their lives. When women perceived the health care providers as having betrayed their trust, consequences included: (a) a greater guarding of sensitive information, and (b) the need for a safe, engaged relationship to be established before trust could be restored.

Mistrusting Health Care Providers

Six participants formed the group with the greatest difficulty developing trust with the health care provider at the emergency department. Two of these participants had a false negative score for IPV exposure ($\leq$ 2points WAST, $\geq$7$\leq$140 points CAS). The remaining participants scored positive for IPV on both the WAST (scores $\geq$5$\leq$14 points) and CAS (scores $\geq$7$\leq$74 points). This group of participants also had the highest rates of emotional abuse using the subscale of the CAS ranging from 11 to 50 points. Like participants in the distrust group, this group required multiple visits to the emergency department to develop greater comfort with the discussion of personal issues. These women did not feel able to discuss highly sensitive issues like IPV with a health care provider. Unlike women who trusted health care providers implicitly, this group

experienced numerous negative health care interactions and were rarely able to describe positive or beneficial health care experiences. Women in this group could not identify one significant person in their lives whom they trusted and instead described instances where their trust was betrayed. When asked what qualities women looked for in order to trust a health care provider, one woman stated: "[the health care provider] can't be trusted, no one can be trusted." Trust was viewed as easily established and easily betrayed resulting in vulnerability and powerlessness. Participants in this group were wary of health care providers and identified characteristics like maintaining eye contact, open and facilitative body language, and the demonstration of active listening as inspiring of their trust. Women in this group would tentatively trust a health care provider who demonstrated these characteristics but continued to "always watch [their] backs" in anticipation that their trust would be betrayed.

Unlike the other two trust groups, women who mistrusted health care providers perceived greater risks with "more to lose" in trusting health care providers. These women avoided seeking health care and did not have access to a primary care health care provider. When they did seek care, they were marginalized and judged for remaining in abusive relationships, seen to be "drug seeking" or misusing the health care system. Establishing a tentative degree of trust with a health care provider initially helped women feel greater comfort when discussing sensitive issues, but this was not enough for women in this group to feel trust and review their readiness for IPV disclosure. The consequences of an inability to build trust in a health care provider included the avoidance of health care regardless of injury severity, the inability to "open up" and share personal

information with a health care provider, and feelings of powerlessness and vulnerability in the emergency department setting.

Trust Evaluation Interrupted

Three of the six women in the mistrust group described IPV disclosure prior to their assessment of health care provider trustworthiness. Disclosure arose when a family member told the health care provider about IPV. These three participants did not expect or anticipate that the family member would disclose IPV on their behalf. This resulted in powerlessness and made it more difficult for the participant to trust the health care provider in the future:

> I was pregnant so we went to the emergency room. [My mother] goes and blurts it out to the doctor that my boyfriend beat me up...I just remember I was really nervous, you know, not knowing what's going to be asked of me or if they're going to tell me that I have to do something. I know [my mother] was just trying to help but I still can't believe she just went and did that...

Unexpected disclosure events were perceived as negative experiences with direct consequences including life disruption or the fear of retribution from the abusive partner.

Strategies to Evaluate Level of Trust

Abused women undertook different strategies to evaluate the trustworthiness of the health care provider such as (a) "watching and waiting," and (b) "testing" using a chief complaint not related to IPV.

Watching and Waiting

Upon entry into the emergency department, women began evaluation of their ability to trust health care providers when admitted by triage staff. The triage admission and assessment process influenced how comfortable and receptive a participant was to continue to evaluate and build trust with the clinician. When women were acknowledged and received into the emergency department with efficiency and respect, they felt willing to wait for care in the emergency department despite pain and discomfort. Abused women who were not admitted efficiently, or who felt ignored or judged by triage staff, had greater difficulty establishing the trustworthiness of the clinician to support IPV disclosure. During this period of "watching and waiting," participants observed both the health care interactions of other patients and the response of the health care provider. Emergency department staff who had a pleasant and professional disposition and appeared competent were more likely to be considered trustworthy. Participants were less likely to engage with a clinician who appeared to be "going through the motions," or who was overwhelmed, disinterested or disrespectful.

Testing the Health Care Provider

A second strategy used was to test the health care provider when discussing primary concerns that led the participant to the visit to the emergency department. Often the reasons like feeling ill, headaches, chronic back pain, unintentional injuries, previous mental health diagnoses, and health concerns for their children were not directly related to IPV. When women sought treatment for issues other than IPV, they did not feel concerned or worried that IPV would be detected as they suspected that the health care

provider would only consider their primary complaints as opposed to asking further questions related to IPV. As one participant explained:

> I really wanted [the doctor or nurse] in emerg to ask me more. I started by saying that I didn't feel well. A good doctor or nurse would ask more questions, you know, like "what is happening to you?" or "why don't you feel well?" When they didn't ask me more, I figured they didn't care, so I didn't try anymore.

Nurses were tested in a similar manner to physicians and were more likely to be tested prior to physicians. Testing searched for the following outcomes: empathy and support, maintenance of confidentiality, provision of privacy, and the explanation of the treatment procedure or plan for care. A nurse was deemed trustworthy if s/he explained, prior to the arrival of the physician, the procedure for the health care interaction. Participants trusted nurses who demonstrated a non-judgmental attitude, concern, and empathy. Like nurses, physicians who were deemed trustworthy by participants displayed empathy and active listening skills.

When health care providers displayed the characteristics related to trust that participants valued, participants felt respected, less vulnerable, and involved in their own health care process. This gave participants the autonomy to make decisions related to IPV disclosure and prepare for potential outcomes.

Five participants were reluctant to obtain care for their injuries and concerns related to IPV and undertook different strategies to evaluate health care provider trustworthiness including being passive and complying with requests.

Being passive

Participants passively accepted treatment and interventions provided in the emergency department as a means of coping with perceived intrusions and trauma from IPV. One participant described her inability to evaluate the clinician's trustworthiness as follows: "I just lied on the stretcher quietly and let the doctors and nurses do their jobs." Women who obtained care without resistance hoped that the treatment would be completed quickly, denied their exposure to IPV, and "tried to keep [their] story consistent with each person who asked questions to get out of there faster." Interacting with multiple providers only elevated the perception of threat, making it more challenging for these women to deem a health care provider as trustworthy.

Complying with Health Care Providers

Other strategies used by these five participants was to comply with health care providers by answering questions, permitting multiple health care providers to examine them, agreeing to evidence collection, and pressing charges against their perpetrator. Participants complied with health care providers by "obeying" their instructions so that health care providers could "do their jobs," but this did not result in an evaluation of trustworthiness.

Despite these strategies, two participants who were mistrustful of health care providers developed a small degree of trust for an emergency department clinician because s/he advocated for minimal invasion on the participant's behalf, actively listened to the participant's concerns, and/or silently remained in the room to demonstrate caring.

These actions were identified as deserving of "a little amount" of trust, yet these participants stated that they were incapable of fully trusting the health care provider.

Establishing Readiness for Disclosure

For the final phase of "managing risks," readiness was influenced by the conditions of identifying formal and informal supports, and perceived self-efficacy. A self-initiated disclosure of IPV in the emergency department was a consequence of establishing readiness.

Formal and Informal Supports

Identifying multiple supports, either through friends and family (informal) or through professional services (formal), helped participant readiness for IPV disclosure. A strong support system permitted women to develop and maintain trusting relationships with a variety of individuals. Through positive, trusting relationships, participants recognized and identified key qualities serving as pre-requisites for establishing trustworthiness. Confidence and security with decision making increased when participants had regular opportunities to discuss their concerns in a safe, supportive environment. Both self-efficacy and action-oriented behaviour developed over time with positive reinforcement from a support system. Fewer established formal or informal supports resulted in difficulty for participants in establishing and maintaining the trust needed for a self-initiated IPV disclosure.

Perceived Self-Efficacy

Women ready to disclose IPV described themselves as having an ability to create change. Before carrying out a change, like a disclosure, participants reviewed their

perceived risks and the potential outcomes. Readiness occurred when the needs for health care, support, or referrals became more prominent than the issues perceived as threatening. Participants described self-efficacy as having the power to make decisions as well as to take action supporting important life changes. As one woman explained:

> Talk brings talk. You'll know from her hesitation if she is hiding something. I'm not afraid to speak up at times, but I haven't always been that way. I'm, okay with myself now, I know myself better. I can understand how some women would be very timid and they're the ones that would probably need to be encouraged to speak a little bit more.

Self-efficacy was influenced by self-esteem, which one participant described as "deciding you are worth something" often in direct opposition to how the participants' partners made them feel about themselves (i.e. as worthless).

Participants used the following strategies to establish readiness: multiple visits to the emergency department, identifying a turning point, and "psyching themselves up." Readiness increased when participants sought health care at the emergency department over multiple occasions. Readiness was closely related to trust and increased as trust in the health care provider grew. When establishing readiness, participants reviewed potential benefits from disclosure as opposed to the potential risks. Multiple visits to the emergency department helped develop the participant's "strength over time." As one participant described:

> Talking to [the doctor or nurse] about issues other than the abuse made me stronger, a little more and more strong. Each time I went I would try and see the right people, and, yeah, it did make me progressively--slowly--but stronger.

Readiness to disclose IPV was developed when a catalyst event occurred that acted as "the last straw" or turning point. These events served as the impetus for participants to harness their perceived self-efficacy, develop confidence and self-control, and disclose IPV. One participant stated:

> When we got married things changed. I was not allowed to open mail that was addressed to me, no bank accounts, had to be home when he got home, had to have the house clean. I was responsible for the kids, and not allowed to work. When I did get a job, I got locked out of the home. That was it. I was out. I had no choice but to get help and talk about it.

Finally, the strategy of "psyching myself up" was used to prepare and practice IPV disclosure prior to meeting with the health care provider. While not every woman described practicing IPV disclosure, they did "mentally prepare" themselves in order to bolster their confidence as a motivator for action. As one participant explains:

> When you decide that you are going to tell [a doctor or nurse] about your problems, you know, like abuse and everything, you need to first think about how you are going to do it. I don't think it happens that way a lot but if you can, you need to get ready to talk. It is a sensitive issue so you need to think about what you can say and not say. If you say too much too soon it might cause more

problems for you. But the key is to try and think ahead of time of what you will say and build yourself up so that you have the guts to do it…

Intervening Conditions

For this study, intervening conditions included: the characteristics of both the health care provider and the participant, the participant's perception of care quality, and the competence of the health care provider.

Characteristics of the Health Care Providers

Of all provider qualities, participants indicated that the most important requirements were to receive genuine concern and care from a health care provider. Demonstration of concern and care included inquiries about the participant's safety, current living situation, and offering to listen to participants' stories of IPV. One participant stated: "I think a lot of doctors are not the most personable people… because that's their personality and they're more attracted to the [clients with medical problems or diseases than women dealing with abuse]."

Communication was essential for the establishment of a trusting relationship and included use of eye contact; warmth and gentleness; being present in the room; demonstrating open, non-confrontational body language; and active listening skills. If a participant's male partner was present with her in the emergency department, women requested that health care providers ask the partner to leave to enable communication. One participant stated: "The last thing you are going to do is talk about abuse with the husband standing there. That's only asking for trouble."

Health care provider competence and experience related to IPV were important qualities for participants. Having these characteristics meant that the clinician understood the challenges that abused women faced. Participants wanted health care providers to acknowledge their experience working with IPV or any extra training related to IPV. Nurses were perceived to have greater proficiency with IPV--something participants attributed to the nurses' educational background and professional responsibility to demonstrate "compassion and caring." Also, abused women preferred a female health care provider and the nurses they encountered were more likely to be female. When encountering a female physician, participants expressed concern that she might have been "hardened" by the medical profession. However, not all nurses were seen as competent. Some nurses were considered uncompassionate and non-communicative "porters" who escorted women from waiting area A to waiting area B. Despite positive interactions, emergency department physicians were seen as less caring, disinterested in communication and unable to make eye contact. Participants suggested this was due to the need for efficiency, as the physician had to be "on the ball for real medical problems."

Quality of Care

Women wanted the same level of care for IPV-related concerns as for any other acute medical situation. High quality care involved respect from triage staff, acknowledgement when waiting to meet with the physician and an estimation of wait times. Quality of care was influenced by the degree of professionalism that health care providers exuded. High quality service was provided by a health care provider who was content with their work, displayed a positive attitude, and dressed in clean and tidy

uniforms. Care quality was evaluated by participants based on the overall wait times, the reputation of the clinician and institution as well as, the degree to which perceived health care needs were met.

Characteristics of Women

Women sought health care providers who permitted autonomous decision making. This was especially important for those participants seeking referral and support to promote the safety and welfare of their children. Participants wanted health care providers to accept their choices, even if it meant not following through with the suggested options or recommendations. Participants' abilities and comfort discussing IPV differed, and some women wanted the health care provider to prompt them with questions to facilitate the discussion of IPV.

Type of Interaction

Participants either preferred to have an ongoing, long-term relationship, or a brief, short-term interaction with the health care provider depending on the participant's abilities to develop trust and readiness. Among participants in the distrust group, primary care was preferred since a long-term relationship could be established prior to IPV disclosure. Among participants in the mistrust group, the emergency department setting was preferred since brief health care interactions were seen to maintain anonymity.

Context

The emergency department either facilitated or inhibited the IPV disclosure process through wait times, the organization's reputation for care quality, the ambiguous

roles of health care providers, and access to privacy. Overall, participants stated that the emergency department environment was not an ideal place to discuss IPV:

> The ER is just terrible. It's pathetic, 'cause when I went in there, there was no bed, nothing, and I sat in a chair in a room all by myself. The ER is not a place for this type of thing--talking about abuse. Not at all. It's very personal. You're scared.

When participants disclosed IPV in the emergency department, their decision was inspired by immediate health necessity. The environment was not conducive to trust establishment and the preparation required for establishing readiness. The emergency department was seen as disruptive and disorganized. This chaotic environment, coupled with a lack of privacy, made IPV disclosure uncomfortable. While participants preferred a private space within the emergency department for disclosure of IPV, disclosure could occur if the participant both trusted the clinician and felt ready to disclose.

Participants were influenced by health care provider response to their workload. When health care providers were perceived as too busy and overwhelmed, participants refrained from discussing IPV so that time could be given to "real emergencies." IPV was not seen as an emergency and participants were desensitized due to the frequency of the physical abuse incidents or the hidden nature of emotional abuse. An overextended health care provider was perceived as disinterested and unresponsive to IPV: "They look at you like, 'You're going to bother me with this?' kind of thing... it could be a minimal thing to [the doctor or nurse] but to me it means the whole world." Four participants felt

that the health care providers were overwhelmed due to the nature of the emergency department setting and incapable of responding to an IPV disclosure.

Participants described waiting for hours but only being given a few minutes to discuss their chief complaint. Brief opportunities to discuss IPV were seen to overwhelm clinicians: "When you have a four-hour wait in emergency, there's not enough time for anything, so I think I would be better not talking.... It's too much for them to deal with. I feel bad for them."

Discussion

Results from this study indicated that the emergency department was not an ideal health care setting for IPV disclosure. "Being found out" was the basic social psychological problem. In order to resolve this problem, participants engaged in a three-phase process of "managing the risks": (a) deciding to seek care, (b) evaluating trustworthiness of the health care provider, and (c) establishing internal readiness for disclosure. A positive disclosure experience occurred when participants maintained autonomy throughout the process and interacted with clinicians who were empathetic, supportive, and non-judgmental. Maintenance of privacy and confidentiality were important conditions for a positive IPV-disclosure experience. Participants who perceived their disclosure experience as negative felt forced to disclose IPV, experienced intrusion, or felt judged by health care providers. For participants who disclosed IPV in the emergency department, consequences ranged from receiving referrals to IPV-related services, validation and support from the health care provider, and a feeling of relief after disclosure. Other consequences that were perceived as potentially harmful were

invasiveness as a result of clinician attempts to document evidence of abuse, as well as the involvement of police and child protection services.

Not all participants disclosed IPV in the emergency department. Participants who did not disclose described an inability to develop trust with the health care provider and/or a lack of internal readiness for disclosure. For these participants, the perceived risks of disclosure did not outweigh potential benefits. Consequences for these participants included multiple visits to the emergency department until they felt able to trust the health care provider and were ready to disclose. For some participants, the process of "managing the risks" was interrupted when another individual disclosed on their behalf. For these participants, future disclosure became more difficult as their trust had been violated and they felt powerless and vulnerable. These participants required more time to develop trust with a health care provider and establish the sense of readiness required for IPV disclosure.

This study adds to the limited understanding of the decision making processes related to IPV disclosure among women who seek care in emergency department settings. Despite the abundance of literature related to women's preferences for interactions with clinicians, these findings show that women encountered similar challenges across various health care settings when communicating with health care providers.

Need for Privacy and Confidentiality

Participant disclosure was inhibited due to the nature of the emergency department with long wait times, overcrowding, and a lack of space for private discussion. Providing a safe place for disclosure was important to participants for

treatment of injuries and issues related to IPV (Kearney, 2001). Many urban emergency departments provide privacy through a closed curtain (Corbally, 2001). This option is neither safe nor does it facilitate IPV disclosure. Participants in this study stated that they might have been more receptive to discuss IPV had there been a private area for discussion.

Participants were concerned that their visits to the emergency department were being tracked and they feared that other patients would hear about IPV. Consistent with Feder et al. (2006), IPV disclosure was inhibited when women feared that their privacy and confidentiality would not be honoured and maintained. The current emergency department culture manages large numbers of clients with ever increasing acuity and relies on efficient and rapid processing of clients (Ospina et al., 2006; Varcoe, 2001). However, this does not accommodate women exposed to IPV who need time to assess their surroundings and their level of trust in the health care provider before IPV disclosure. Continued advocacy for private areas in the emergency department for assessment and discussion of IPV is an important consideration for organizational decision makers.

Health Care Provider Qualities That Women Seek and Value

Participants in this study evaluated the quality of care they received. Emergency departments were chosen based on length of wait times, clinicians who appeared empathetic and non-judgmental, and organizational reputation for care quality. Participants valued health care providers who listened and showed compassion for their health concerns. These results are consistent with previous research that found that

women desired and valued open, empathic communication, verbal demonstrations of caring, and a concern for the client's comfort and safety (Battaglia, Finley, & Liebschutz, 2003; Chang et al., 2005; Dienemann, Glass, & Hyman, 2005; Liebschutz, Battaglia, Finley, & Averbuch, 2008).

Women evaluated their quality of care based on initial interactions with triage staff. Participants wanted triage clinicians to acknowledge their presence, and to be courteous and non-judgmental. If left waiting in another area, participants wanted acknowledgment from health care providers that they would still be seen and were not forgotten. Dienemann et al. (2005) also found that women wanted health care providers to treat them with respect despite the pressures of a health care system with a high client volume. Because health care providers were evaluated for their degree of trustworthiness, participants felt comfortable with those who wore a clean, crisp uniform, provided an introduction, and made eye contact. Participants wanted health care providers to greet them by name, avoid focusing on the patient chart and sit at eye level when discussing health concerns. While these appear to be basic communication skills, they continue to be a challenge for health care providers encountering women exposed to IPV as reported by Rhodes et al. (2007).

Intrusion

In this study, participants said they feared intrusion from health care providers and other providers and services. Women reported receiving care from multiple health care providers and not being able to differentiate them from the other types of hospital staff, like the cleaning staff. Feelings of intrusion increased with the "revolving door"

nature of care combined with health care providers in similar uniforms who did not introduce themselves to the client. Participants stated that they felt invaded by the processes associated with evidence collection. Following through with evidence collection procedures were seen as mandatory by women wanting to continue receiving health care and not wanting to interfere with the clinician's "job."

Women felt judged for not following the recommendations of the health care provider when they sought care over multiple occasions or chose to remain in an abusive relationship. Feder et al. (2006) also found women exposed to IPV were dissatisfied when health care providers did not understand, trivialized their situations, or expressed judgmental attitudes. When participants perceived the risks with IPV disclosure to be too high, they passively received the care offered at the emergency department and hoped that they could quickly leave the setting. This finding was consistent with Wuest, Ford-Gilboe, Merritt-Gray, and Berman (2003) who found that abused women who requested help felt obligated to follow advice from others and felt that they had given up their autonomy upon seeking health care. Further, the act of obtaining help felt intrusive to abused women who felt entrapped and unable to control their own situations any longer.

Participants feared life interruption from the involvement of police or child protective services. Intrusion from external services made some women's lives worse as they experienced retaliatory violence had children apprehended from their home. A similar finding was found by Wuest, Ford-Gilboe, Merritt-Gray, and Berman (2003) where women described incidents where they felt their situations deteriorated after they obtained help from police and other social services. These authors found that obtaining

care meant proving their eligibility and credibility to be worthy of services. An environment that facilitated women's perception of invasion caused further shame and stigmatization (Tower & McMurray, 2006). This created a perception that physical health concerns override mental and emotional health concerns and can have a profound, negative impact on women's interpretations of health care (Tower & McMurray).

Allowing Women to Guide the Disclosure Process

Women requested autonomy in making decisions related to IPV disclosure in the emergency department setting. This sentiment was echoed in other research which recommended that health care providers listen and offer options as a means of giving women control over their own decision making (Dienemann, Glass, & Hyman, 2005; Feder, Hutson, Ramsay, & Taket, 2006; Varcoe, 2001). In this study, health care providers were seen as sources of information and purveyors of referrals to community support. Health care providers can work to create an environment conducive to IPV disclosure by offering women information regarding IPV and indicating how they will maintain confidentiality (Feder et al., 2006). Further, if the woman is not ready to disclose IPV, the clinician can raise the issue of IPV which in itself can convey caring and concern for the woman (Zink, Elder, Jacobson, & Klostermann, 2004). Women in this study wanted the health care provider to be knowledgeable about IPV-related options, a finding discussed by Feder et al. After a disclosure of IPV, the clinician can support a woman's autonomy by offering support, continuing to be non-judgmental and respecting her choices even if it means not making any changes to her situation (Feder). Overall, results from this study indicated that women wanted to proceed at their own pace

when deciding whether or not to disclose IPV in the acute care setting. Women exposed to IPV did not want health care providers to pressure them to disclose IPV, leave their relationship, and/or press charges against their abusive partner.

In conclusion, health care providers can support women as they establish their readiness for IPV disclosure. This study found that women valued health care providers who introduced themselves, made eye contact with them, and listened and supported them while they expressed concerns. A key practice recommendation includes the need to initiate non-judgmental and supportive communication with the client. Because women present with issues unrelated to IPV, it is essential that health care providers convey open and empathetic communication practices regardless of the health concern. While further understanding is required relating to abused women's frequent use of the health care system, clinicians need to consider the possibility that women attend the emergency department in order to identify health care providers they can trust and to develop internal readiness for disclosure of IPV. Women seeking care for injuries related to IPV valued having a location in the emergency department where they could experience safety and privacy. Ongoing advocacy for policy change to support greater privacy and confidentiality in the acute care setting is an important step to facilitate disclosure.

References

Battaglia, T.A., Finley, E., & Liebschutz, J.M. (2003). Survivors of intimate partner violence speak out. Trust in the patient-provider relationship. *Journal of General Internal Medicine, 18*, 617–623.

Becker, P.H. (1993). Common pitfalls in published grounded theory research. *Qualitative Health Research, 3*(2), 254–260.

Brown, J.B., Lent, B., Schmidt, G., & Sas, G. (2000). Application of the woman abuse screening tool (WAST) and the WAST-short in the family practice setting. *Journal of Family Practice, 49*(10), 896–903.

Campbell, J., Snow Jones, A., Dienemann, J., Kub, J., Schollenberger, J., O'Campo, P., Carlson Gielen, A., & Wynne, C. (2002). Intimate partner violence and physical health consequences. *Archives of Internal Medicine, 162*, 1157–1163.

Chang, J.C., Decker, M.R., Moracco, K.E., Martin, S.L., Peterson, R., & Frasier, P.Y. (2003). What happens when health care providers ask about intimate partner violence? A description of the consequences from the perspectives of female survivors. *Journal of the American Medical Women's Association, 58*, 76–81.

Chang, J.C., Decker, M.R., Moracco, K.E., Martin, S.L., Peterson, R., & Frasier, P.Y. (2005). Asking about intimate partner violence: Advice from female survivors to health care providers. *Patient Education and Counseling, 59*, 141–147.

Charmaz, K. (2006). Constructing Grounded Theory. *A Practical Guide Through Qualitative Analysis*. London, UK: Sage Publication.

Corbally, M.A. (2001). Factors affecting nurses' attitudes towards the screening and care of battered women in Dublin A&E departments: A literature review. *Accident and Emergency Nursing, 9*, 27–37.

Dienemann, J., Glass, N., & Hyman, R. (2005). Survivor preferences for response to IPV disclosure. *Clinical Nursing Research, 14*(3), 215–33.

Eaves, Y. D. (2001). A synthesis technique for grounded theory data analysis. *Journal of Advanced Nursing, 35*(5), 654–663.

Feder, G.S., Hutson, M., Ramsay, J., & Taket, A.R. (2006). Women exposed to intimate partner violence. Expectations and experiences when they encounter health care professionals: A meta-analysis of qualitative studies. *Archives of Internal Medicine, 166*, 22–37.

Feder, G.S., Ramsay, J., Dunne, D., Rose, M., Arsene, Norman, R., Kuntze, S., Spencer, A., Bacchus, L., Hague, G., Warburton, A., & Taket, A. (2009). How far does screening for domestic (partner) violence in different health-care settings meet criteria for a screening program? Systematic reviews of nine UK National Screening Committee criteria. *Health Technology Assessment, 13*(16), i–136.

Glaser, B. (1998). *Doing grounded theory – Issues and discussions*. Mill Valley, CA: Sociology Press.

Glaser, B.G. (1992). *Emergence vs. forcing. Basics of grounded theory analysis*. Mill Valley, CA: Sociology Press.

Glaser, B. (1978). *Advances in the methodology of grounded theory. Theoretical sensitivity.* Mill Valley, CA: Sociology Press.

Glaser, B., & Strauss, A. (1967). *Discovery of grounded theory. Strategies for qualitative research.* Mill Valley, CA: Sociology Press.

Hegarty, K., Sheehan, M., & Schonfield, D. (1999). A multidimensional definition of partner abuse: Development and preliminary validation of the composite abuse scale. *Journal of Family Violence, 14*(4), 399–415.

Inoue, K., & Armitage, S. (2006). Nurses' understanding of domestic violence. *Contemporary Nurse, 21*(2), 311–323.

Jack, S.M., DiCenso, A., & Lofeld, L. (2005). A theory of maternal engagement with public health nurses and family home visitors. *Journal of Advanced Nursing, 49*(2), 182–190.

Kearney, M.H. (2001). Enduring love: A grounded formal theory of women's experience of domestic violence. *Research in Nursing and Health, 24*, 270–282.

Liebschutz, J., Battaglia, T., Finley, E., & Averbuch, T. (2008). Disclosing intimate partner violence to health care clinicians – What a different the setting makes: A qualitative study. *BMC Public Health, 8*, e229–e236.

Loiselle, C.G., Profetto-McGrath, J., Polit, D.F., & Tatano Beck, C. (2007). *Canadian essentials of nursing research* (2nd ed.). Philadelphia, PA: Lippincott Williams & Wilkins.

Lutz, K.F. (2005). Abused pregnant women's interactions with health care providers during the childbearing years. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 34*(2), 151–162.

Ospina, M.B., Bond, K., Schull, M., Innes, G., Blitz, S., Friesen, C., & Rowe, B.H. (2006). *Measuring overcrowding in emergency departments: a call for standardization* [Technology report no. 67.1]. Ottawa, ON: Canadian Agency for Drugs and Technologies in Health. Retrieved February 2, 2009, from www.cadth.ca

Plichta, S.B. (2004). Intimate partner violence and physical health consequences. Policy and practice implications. *Journal of Intimate Partner Violence, 19*(11), 1296–1323.

Rhodes, K.V., Frankel, R.M., Levinthal, N., Prenoveau, E., Bailey, J., & Levinson, W. (2007). "You're not a victim of domestic violence, are you?" Provider patient communication about domestic violence. *Annals of Internal Medicine, 147*(9), 620–627.

Rittmayer, J. (2000). Creating comfort: A grounded theory of intimate partner abuse survivors' perspective of primary health care visits. (Doctoral Dissertation, Texas Women's University, 2000). *Dissertation Abstracts International*. (UMI No. AAI9993960).

Schrieber, R.S. (2001). The "how to" of grounded theory: Avoiding the pitfalls. In R.S. Schreiber & P.N. Stern (Eds.). *Using grounded theory in nursing* (pp. 55–83). New York: Springer.

Schwandt, T. (2001). *Dictionary of qualitative inquiry* (2nd ed.). Thousand Oaks, CA: Sage Publications.

Teddlie, C., & Yu, F. (2007). Mixed methods sampling: A typology with examples. *Journal of Mixed Methods Research, 1*, 77–100.

Tower, M., & McMurray, A. (2006). Domestic violence, health and health care: Women's accounts of their experiences. *Contemporary Nurse, 21*(2), 186–198.

Varcoe C. (2001). Abuse obscured: an ethnographic account of emergency nursing in relation to violence against women. *Canadian Journal of Nursing Research, 32*, 95–115.

Wuest, J., Ford-Gilboe, M., Merrit-Gray, M., & Berman, H. (2003). Intrusion: The central problem among children and single mothers after leaving an abusive partner. *Qualitative Health Research, 13*(5), 597–622.

Wuest, J., & Merritt-Gray, M. (2008). A theretical understanding of abusive intimate partner violence relationships that became non-violent: Shifting the pattern of abusive control. *Journal of Family Violence, 4*, 281–294.

Zink, T., Elder, N., Jacobson, J., & Klosterman, B. (2004). Medical management of intimate partner violence considering the stages of change: Precontemplation and contemplation. *Annals of Family Medicine, 2*, 231–239.

CHAPTER 4

"I'll tell you when I am ready..."

Description of Steps Toward Intimate Partner Violence Disclosure in Emergency Department Settings: Application of the Transtheoretical Model of Change

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"I'll tell you when I am ready..."

Description of Steps Toward Intimate Partner Violence Disclosure in Emergency Department Settings: Application of the Transtheoretical Model of Change

Abstract[2]

Objective

This paper used the Transtheoretical Model of Change and examined the steps that women took to disclose intimate partner violence in urban emergency departments.

Methods

Mapping methods were used to portray the evolving nature of decision making that led to IPV. This paper is a secondary analysis using data from a mixed methods study on intimate partner violence disclosure in emergency department settings.

Results

Change maps were created for 19 women. Three participants moved sequentially through the stages of change and disclosed IPV in the emergency department. Disclosure occurred when the participant: (a) trusted the clinician, (b) was ready to disclose, and (c) experienced a "turning point" event.

Conclusions

Abused women were wary of disclosure in the emergency department due to its chaotic nature, lack of privacy, and emphasis on processing patients. Intimate partner violence

[2]Abstract will follow author guidelines for *Patient Education and Counseling* which states that abstracts should be between 150–200 words.

disclosure, was an action step that occurred over time and after multiple visits to the health care setting.

Practice Implications

Health care providers can use change maps as a communication tool during assessment. Engaging clients to discuss intimate partner violence will build trust in the clinician.

Key words: intimate partner violence against women; acute care delivery; change theory; women's health; health care provider intervention

"I'll tell you when I am ready..."

Description of Steps Toward Intimate Partner Violence Disclosure in Emergency Department Settings: Application of the Transtheoretical Model of Change

1.0 Introduction

The emergency department offers a "window of opportunity" for women to discuss intimate partner violence (IPV). Ontario one-year prevalence for IPV in emergency department settings was 13.9% (Wathen et al., 2007) and 26% (Cox, Bota, Carter, Bretzlaff-Michaud, & Sahai, 2004). In United States emergency department settings, one-year prevalence is high, with figures ranging from 14.4% (Dearwater et al., 1998) to 15% (Rhodes, Lauderdale, He, Howes, & Levinson, 2002). Women exposed to IPV obtained treatment for impairment associated with IPV at emergency departments (Dearwater et al.; Rhodes et al., 2002). Despite encountering women exposed to IPV, emergency department health care providers continue to face challenges in the detection and documentation of IPV (Kothari & Rhodes, 2006; Plichta, 2004; Zachary, Mulvihill, Burton, & Goldfrank, 2001). Common barriers to discussing IPV cited by health care providers included their own limited education, lack of time to deal with IPV, fear of offending patients, and their perception that violence is not a priority for their practice area (Cox et al., 2004; Dowd, Kennedy, Knapp, & Stallbaumer-Rouyer, 2002; Gutmanis, Beynon, Tutty, Wathen, & MacMillan, 2007; Heinzer & Krimm 2002).

Understanding how and why abused women make behaviour changes is important for health care providers. For example, a past negative communication experience with a

health care provider might prevent abused women from a future disclosure of IPV in the emergency department (Liebschutz, Battaglia, Finley, & Averbuch, 2008; Rhodes et al., 2007). According to one study, abused women regularly sought care in the emergency department and were judged as misusing the system (Corbally, 2001). Such misperceptions might be avoided if clinicians had an improved understanding of the events that led these women to seek care over multiple occasions. In studies exploring IPV disclosure, women exposed to IPV wanted health care providers who offered help and support in an empathetic manner (Battaglia, Finley, & Liebschutz, 2003; Liebschutz et al., 2008). Understanding the steps leading to IPV disclosure can improve clinician awareness and facilitate non-judgmental approaches to IPV detection and response.

Chang et al. (2006) recognized a gap in health care provider understanding of how women exposed to IPV move through the stages of change when seeking safety. Very little information exists regarding how health care providers engage in conversation with abused women and how they discussed safety issues related to IPV (Chang et al.). In order to address this gap, Chang et al. used an innovative mapping technique based on the Transtheoretical Model of Change (TTM) (Prochaska, DiClemente, & Norcross, 1992) to understand how women with a current or past history of IPV made changes that supported improved safety. Maps were created for safety-seeking behaviours and results revealed that women made changes gradually, and over long periods of time. A significant event often marked the moment when participants adopted a change that supported their increased safety. This event was identified by Chang et al. as a "turning point" serving as a catalyst for change. These authors found that abused women took

many steps towards seeking safety and these steps were often influenced by other factors that were beyond their control.

1.1 Transtheoretical Model of Change

The Transtheoretical Model of Change (TTM) (Prochaska, DiClemente, & Norcross, 1992) has been used to explore the processes that individuals undertake when making behavioural changes. Prochaska and DiClemente (1982) developed a linear scheme of change stages to compare smokers attempting to quit smoking independently with those in cessation programs. Ongoing research using this scheme led to the TTM which described an individual's progression through the following stages: precontemplation, contemplation, preparation, action, and maintenance. Behaviour change, a dynamic process, involved the potential for a person to move through the change stages numerous times before the problem was resolved (e.g. termination of addiction) (Prochaska et al., 1992). While much of the research work used the TTM for understanding smoking cessation, other research areas that have explored the use of the TTM include diet and nutrition, adolescent contraception use, and alcohol addiction (Brown, 1997).

In precontemplation individuals do not have intention for behaviour change and were unaware of their problems (Prochaska, DiClemente, & Norcross, 1992). Precontemplators experienced denial about their situations and responded defensively and with resistance to external pressure to change (Brown, 1997). When describing women exposed to IPV in this stage, Zink, Elder, Jacobson, and Klosterman (2004) found that the women did not view their partners as abusive and described their relationships as

normal. During contemplation, Prochaska et al. described a stage where participants became aware of their problem and considered how to deal with that problem. However, participants were not ready to take steps to change the problem (Prochaska et al., 1992). When considering IPV, women in the contemplation stage acknowledged IPV as a problem, but were not ready to make changes to their relationship (Zink et al., 2004). They weighed the pros and cons of their situation and the potential actions that could be taken to resolve perceived problems (Prochaska et al.). While there were no set time periods for participants to move from stage to stage, authors stated that participants could remain in the precontemplation and/or the contemplation stages for years (Prochaska et al., Zink et al.).

During the preparation stage, participants planned their action. In some cases this action may have already been undertaken sometimes unsuccessfully over the past year (Prochaska, DiClemente, & Norcross, 1992). Participants at this stage had not yet established criteria for effective action but had undertaken a series of small actions (Prochaska et al., 1992). Chang et al. (2006) stated that abused women sometimes experienced a "turning point" event at this stage that significantly altered their thinking and attitudes regarding IPV making it impossible return to the precontemplation stage. Brown (1997) argued that it remains unclear which empirical indicators to assign to women in the preparation stage. Women exposed to IPV who wished to end their relationships first disengaged from the relationship in order to prepare for its ending (Dienemann, Campbell, Landenburger, & Curry, 2002). Chang et al. found women who formulated plans to change to be in the preparation stage. The most obvious behaviour

changes occurred during the action stage where participants committed time and energy to modify their behaviours (Prochaska et al.).

According to Haggerty and Goodman (2003), women exposed to IPV defined the following turning points that served as impetus for "action": a violent encounter, financial independence or concerns about children. These events, some of which were beyond the women's control, led them to take definitive steps to resolve the problem at hand. Haggerty and Goodman stated that occasionally abused women responded with "private actions," like placating the abusive partner and being passively resistant. They also undertook "public actions" such as IPV disclosure and formal help seeking (Haggerty & Goodman). Other activities undertaken by women in the action stage included setting up their own bank account, acquiring a job, and seeking counselling to explore options for leaving the relationship (Chang et al., 2006). Women also took action by obtaining education, seeking help, attempting to empower themselves and looking for protection from their abuser.

Participants in the maintenance stage continued changing their behaviour and attempted to prevent relapse (Prochaska, DiClemente, & Norcross, 1992). When considering women exposed to IPV, Brown (1997) argued that relapse may not be as likely to occur frequently in the maintenance stage as in the action stage, since sustaining ongoing change can be challenging. Women in the maintenance stage would include those who have left their abusive partners and have attempted to rebuild their lives without returning to them.

There is a growing body of evidence regarding the use of the Transtheoretical Model of Change (TTM) (Prochaska, DiClemente, & Norcross, 1992) applied to women who have experienced IPV (Brown, 1997; Chang et al., 2006; Cluss et al., 2006; Dienemann, Campbell, Landenburger, & Curry, 2002; Haggerty & Goodman, 2003; Zink, Elder, Jacobson, & Klostermann, 2004). Early research that applied this theory with IPV focused on women leaving their partners as the ultimate outcome of change (Kearney, 2001). However, it was recognized that leaving the abuser could lead to reduced safety, diminishing resources and perpetuating ongoing harassment from the perpetrator (Cluss et al.; Ford-Gilboe, Wuest, & Merritt-Gray, 2005). Brown (1997) recommended that the clinician refrain from using the outcome of leaving the relationship as an indicator of change.

Previous research explored the process of change among women who were preparing to leave abusive relationships or who left abusive relationships (Brown, 1997; Chang et al., 2006; Cluss et al., 2006; Dienemann, Campbell, Landenburger, & Curry, 2002; Ford-Gilboe,Wuest, & Merrit-Gray, 2006; Haggerty & Goodman, 2003). However, little is known about the changes women make while they are in abusive relationships when preparing to disclose IPV in emergency department settings. Recognition of what change stage an abused woman is at in the change process can help clinicians plan appropriate support for IPV disclosure. This paper used an adapted form of the mapping methods proposed by Chang et al. to understand how women move towards IPV disclosure in emergency departments. The Transtheoretical Model of Change (TTM) (Prochaska, DiClemente, & Norcross, 1992) was used to interpret the

sequence of events leading to IPV disclosure for a series of key participants. This paper examines the decision making steps that women undertake towards change--IPV disclosure. Three examples will be presented in depth with a description of each "turning point" event that was the catalyst for change. Discussion will include how this mapping method can be used by clinicians to gather information about a women's readiness to disclose IPV so that appropriate interventions can be offered.

2.0 Methods

2.1 Study Design

A mixed methods study explored women's decision making regarding IPV disclosure in emergency departments in two phases: (a) a randomized, controlled trial with a quantitative sub-analysis, and (b) a grounded theory approach.[3] The trial sought to evaluate whether routine screening for IPV in health care settings, as compared to usual care, does more good than harm. Results from a sub-analysis of quantitative data from the trial indicated that (a) few participants with positive IPV exposures disclosed to the emergency department health care provider, and (b) large amounts of missing data regarding IPV disclosure made it necessary to incorporate a qualitative approach for further explanation. Grounded theory, using methods proposed by Glaser (1978) and Glaser and Straus (1967) was chosen to examine the problems that trial participants associated with IPV disclosure and the processes they would use to resolve these problems. Mapping analysis was a secondary analysis using the grounded theory data.

[3]Methods for the mixed methods study are reported in Chapter 1. Results of the grounded theory approach are presented in Chapter 3: *"Being Found Out--A Grounded Theory Explaining Intimate Partner Violence Disclosure Processes by Women in Urban Emergency Department Settings"*

2.2 Sampling

Participants for the grounded theory phase were recruited from the trial. They were screened for IPV over a 12-month period as part of their initial recruitment. The IPV screening instruments used were the Woman Abuse Screening Tool (WAST) (Appendix E) (Brown, Lent, Brett, Sas, & Pederson, 1996; Brown, Lent, Schmidt, & Sas, 2000) and the Composite Abuse Scale (CAS) (Appendix F) (Hegarty, Bush, & Sheehan, 2005; Hegarty, Sheehan, & Schonfield, 1999). IPV disclosure using the Clinical Actions Questionnaire (Appendix G) and demographic data was collected as part of the trial. Five participants were purposefully sampled from the randomized, controlled trial for initial coding, preliminary category development, and testing of the interview guide. Criteria for purposeful sampling are found in Appendix I. After purposeful sampling, an adapted form of theoretical sampling was used to identify participants from the randomized, controlled trial for the grounded theory phase.[4]

2.3 Data Collection

Participants completed up to four 60–90 minute interviews from July 2006 to December 2007. The interview guide (Appendix J) included questions regarding IPV disclosure, the events before and after disclosure, and the timing of events. Participants were asked about what they identified as problems related to IPV disclosure and how they acted to resolve these perceived problems. The interview guide evolved over time to

[4]Discussion of sampling methods adapted and used for the grounded theory approach can be found in Chapter 2: *"Mixing a Grounded Theory Approach With a Randomized Controlled Trial Related to Intimate Partner Violence: What Challenges Arise for Mixed Methods Research?"*

test developing relationships or hypotheses arising from the data that supported an emergent grounded theory. Interviews were audiotaped and transcribed verbatim.

2.4 Ethics

For each qualitative interview, participants completed a written consent form and received information about the study (Appendices U and V). Each participant received a resource card with local social services in the event of emotional distress. Prior to commencing the study, ethics approval was obtained from the McMaster University/Hamilton Health Sciences Research and Ethics Board, Hamilton, Ontario, Canada and the participating Ontario hospital sites where recruitment occurred (Appendices R, S, and T). Each interview transcript was removed of personal identifiers and stored in a password protected file in a password protected computer. Data collected by audiotape did not include client names and all audiotapes were destroyed upon study completion.

2.5 Data Analysis

NVIVO 7.0 was used to organize data and complete coding of transcripts. In order to assess how participants moved through the TTM stages, an adapted form of Chang et al.'s (2006) mapping methods were used. For this method, authors stated that they used a grounded theory approach to coding. meaning that a code book was not used and themes emerged from the data. Chang et al. then created a set of predetermined codes related to the TTM and applied these to transcripts. Further description of the methods used for coding by Chang et al. was not provided.

Analysis focused only on behaviours and events related to IPV disclosure in an emergency department. For this study, Chang et al.'s (2006) methods were adapted and data were coded according to each participant. Initially this involved creating a coding structure for each participant's data according to the TTM stages namely: precontemplation, contemplation, preparation, action, and maintenance. During coding, behaviours, actions, events, facilitators and barriers to disclosure were coded as one of the TTM stages. Data were reviewed for any potential factors related to the event that were beyond the participant's control (e.g. partner losing a job) and these were coded with the corresponding event. Once data were coded according to the TTM, each stage was examined closely for key behaviours and turning points that supported change towards IPV disclosure in an emergency department. When events related to the developed grounded theory--either to the basic social psychological problem or the basic social process--these were also coded as part of a phase in the TTM.[5]

After completion of the coding process, Chang et al.'s (2006) methods were followed to map the stages of change per participant. Chang et al. created a change map with an x-axis depicting time and a y-axis depicting stages of the TTM. Time was not plotted due to the fact that movement through each stage was individual and may have occurred over multiple time periods. Critical events or factors were plotted chronologically on the map. These events or factors influenced a participant's movement

[5]Results of the grounded theory phase including the basic social psychological problem (BSP) and the process to resolve this problem can be found in Chapter 3: *"Being Found Out--A Grounded Theory Explaining Intimate Partner Violence Disclosure Processes by Women in Urban Emergency Department Settings"*.

from one stage to the next. An adaptation to Chang et al.'s method was to use a large yellow arrow to identify and describe a turning point event. This event represented a significant change in a participant's movement through the TTM stages toward action. Chang et al.'s methods were adapted to include occasions when participants "weighed their options" and evaluated the perceived risk to occur before taking action. A final adaptation was to use a red arrow to indicate when an action reflected a component of the developed grounded theory. This included phases of the basic social psychological process of "minimizing risk," namely: (a) deciding to seek care, (b) evaluating level of health care provider trustworthiness, and (c) establishing readiness to disclose. These essential actions--represented by light blue boxes--served as pre-requisites for IPV disclosure. Mapping was then discussed with the master's student with content expertise in IPV who served as a second coder for transcripts. Any differences of opinion were discussed until consensus was achieved.

3.0 Results

Mapping analysis occurred with data from the 19 participants involved with the grounded theory phase of the mixed method study. Information about recruitment for the overall mixed methods study is found in Appendix W. Fifty interviews were completed for the 19 participants. Seven participants completed four interviews, two participants completed three interviews, six participants completed two interviews, and four participants completed one interview. Demographic characteristics for this sample of 19 women are provided in Table 1.

Sixteen participants scored positive for IPV on both the WAST and CAS. Two participants scored negative on the IPV screening instrument and positive on the IPV reference standard (e.g. false negative). One participant scored negative for IPV in the past 12 months using both instruments.[6]

Table 1

Demographic Results for Sample in Grounded Theory Phase

Demographic Characteristic for Sample (N=19)	Sample Mean
Age in years for total sample (N=19)	30.7
Marital status for total sample	Married
Pregnancy status for total sample	Not pregnant
Number of children at home for total	1.2
Years of education for total	12.7
Main activity for total	Work full or part-time outside of the home
Main source of income for total	Wages or salary
Household income for total	Less than $24,000

3.1 Stages of Change

Mapping analysis revealed nine participants in the precontemplation stage and seven participants in the contemplation stage. However, three of those in the

[6]Further details regarding the IPV exposure results can be found in Chapter 3: *"Being Found Out – A Grounded Theory Explaining Intimate Partner Violence Disclosure Processes by Women in Urban Emergency Department Settings"*.

contemplation stage had begun preparation for future action. Three participants had moved linearly from the precontemplation to the maintenance stage of the Transtheoretical Model of Change (TTM) and disclosed IPV in the emergency department in the past 12 months. For those nine participants in the precontemplation stage, IPV was not seen as a problem requiring immediate or short-term action, and subsequently, IPV disclosure was not seen as relevant or necessary. For this group of participants, emergency department care was sought for injuries and concerns related to IPV but these participants would leave the setting without disclosure once their perceived care needs were met. Among the seven participants in the contemplation stage, five stated that they would not disclose IPV in an emergency department because: (a) the clinicians were too busy and would not be helpful, (b) they preferred an ongoing relationship with a family physician who knows their situation, and (c) they were unable to establish a trusting relationship with a clinician in the emergency department. While these five women had taken action in the past by disclosing IPV to other health and social service providers in different types of settings, they stated that disclosing IPV in an emergency department setting required greater consideration and preparation. These participants had considered or contemplated disclosure of IPV in an emergency department, but were not ready to move beyond this stage of change.

Through the course of the study four participants in the contemplation stage moved to the preparation stage. Initially, in the contemplation stage, participants reviewed what the perceived to be the risks with the disclosure of IPV in an emergency department, including: potential retaliatory violence by the perpetrator; calling of child

protective services leading to loss of their children; police involvement and subsequent punishment of their partners; judgment by the health care provider; and facing "unknown" circumstances after IPV disclosure. Participants in the contemplation stage continually weighed their interpreted risks and benefits arising from IPV disclosure. When these participants entered the preparation stage, evaluating trust and establishing readiness for disclosure became important pre-requisites prior to IPV disclosure. Preparation actions included testing the health care provider for his/her trustworthiness and his/her ability to respond in a non-judgmental, competent manner. Other methods of preparing included "psyching self up" where participants attempted to build a sense of internal readiness and self-efficacy for disclosure. Despite a lack of readiness to disclose IPV, these participants prepared for disclosure by using multiple strategies: visiting the emergency department on multiple occasions, evaluating health care provider for trustworthiness, and working to establish internal readiness.

On some occasions, participants in the precontemplation and contemplation stages were prevented from taking action to disclose IPV when others disclosed on their behalf. The maps for these participants showed a partial, non-linear, and non-sequential movement through the stages of change. Two women reported feeling forced to disclose IPV in an emergency department when they were not planning to disclose. One woman described having no choice but to disclose IPV as she arrived at the emergency department unconscious due to strangulation by her partner. She was not aware how she had arrived at the emergency department and was told by the nurse that she come by ambulance:

> I don't know, a couple times I've had to go [to the emergency department] 'cause I was clinically dead twice, and I had a broken back so I had, I had no choice, I wasn't breathing. The nurses told me I was pretty bad and nearly was dead when I woke up. Um, so yeah, I had to talk about it, but other than that I don't go. I didn't know that was abuse, till I was, like, clinically dead or whatever, and the [health care providers in the emergency department] had to go looking out for my best interests. But I don't look at it that way. I don't want to have to talk about it [the abuse]. And when the [health care providers in the emergency department] tell me what they have to do, that's when I… I'll change the story.

For this participant, the need to protect her partner from punishment and maintain her relationship outweighed her need to protect her physical safety. She feared retaliatory violence in the event that her partner was blamed for her injuries and subsequently "changed her story" to avoid punishment of her partner. While this participant acknowledged that there were various forms of abuse in her relationships with various partners, she chose to avoid seeking care and the disclosure of IPV.

Another participant described unhappiness with her relationship which she stated was not abusive. She recalled being "forced" to disclose when her mother took action on her behalf:

> My mother came in with me and she mentioned it. Um, I was pregnant at the time, and that's how it got brought up. I didn't know she was going to tell on me…That's stupid. My mom's stupid because it's a hard situation. I didn't know

> what would happen. I didn't know if the doctors would do something about it, you know, get involved, call the cops.

This participant relayed her fears of what would happen after disclosure. Similar to the previous participant, she felt a need to maintain her relationship with her partner, despite her mother's concerns about the safety of her pregnancy. This woman feared punishment from her partner and increased violence if her partner discovered that she had disclosed IPV. She was frustrated that she was not given the opportunity to disclose IPV at a time when she felt ready. Action steps for these women occurred as a result of the influence of others, as opposed to the women's own decision making, and did not reflect sequential movement through the stages of change.

The three participants in the maintenance stage of change demonstrated a sequential process of change as seen in Figures 1–3. Figure 1 shows the progression through the stages of change for a participant where IPV disclosure and subsequent maintenance took many years. This participant sought emergency care during her first marriage over multiple occasions for severe physical injuries. For the duration of her first marriage she remained in the contemplation stage, unable to establish both trust in the clinician and an internal readiness for IPV disclosure. This participant feared losing her young children by involving child protective services, reprisal violence from her husband and judgment from health care providers in the emergency department. After her children were grown and she perceived the risks of involving child protective services to be diminished, this participant took action to leave her first husband without IPV disclosure to a health care provider. When her second marriage became physically abusive, she

sought care for her injuries but remained in the contemplation stage as she was not yet ready to disclose; she perceived the risks associated with disclosure to continue to outweigh the benefits. According to this participant, as her marriage became increasingly violent, she began to have greater fears for her physical safety. Fear for her own safety during the contemplation stage led her to build documentation to pursue future legal action against her second husband. Over the course of many visits to the same emergency department, this participant prepared for IPV disclosure by evaluating health care trustworthiness using the following strategies: (a) identifying if a health care provider judged her when responding to her injuries, (b) taking note if clinician's observed her frequent presence in the emergency department, and (c) verifying that the health care provider would maintain her confidentiality. For this client, building trust with the clinician became an essential pre-requisite for IPV disclosure which did not occur until the turning point of a severe physical assault by her husband. This event led to her decision to disclose IPV while receiving care in the emergency department:

> I mean to have it done once, but then twice and three times, and over and over.... the [health care providers in the emergency department] are going to see me in there. They're going to say, "What are you doing?" You know: "How come you're not doing anything about this?" They're going to start to be judgmental. When I don't tell them, I look at it as I'm protecting someone that doesn't deserve to be protected. I mean, I could have been dead, I could have been killed, so why would I protect someone like that.

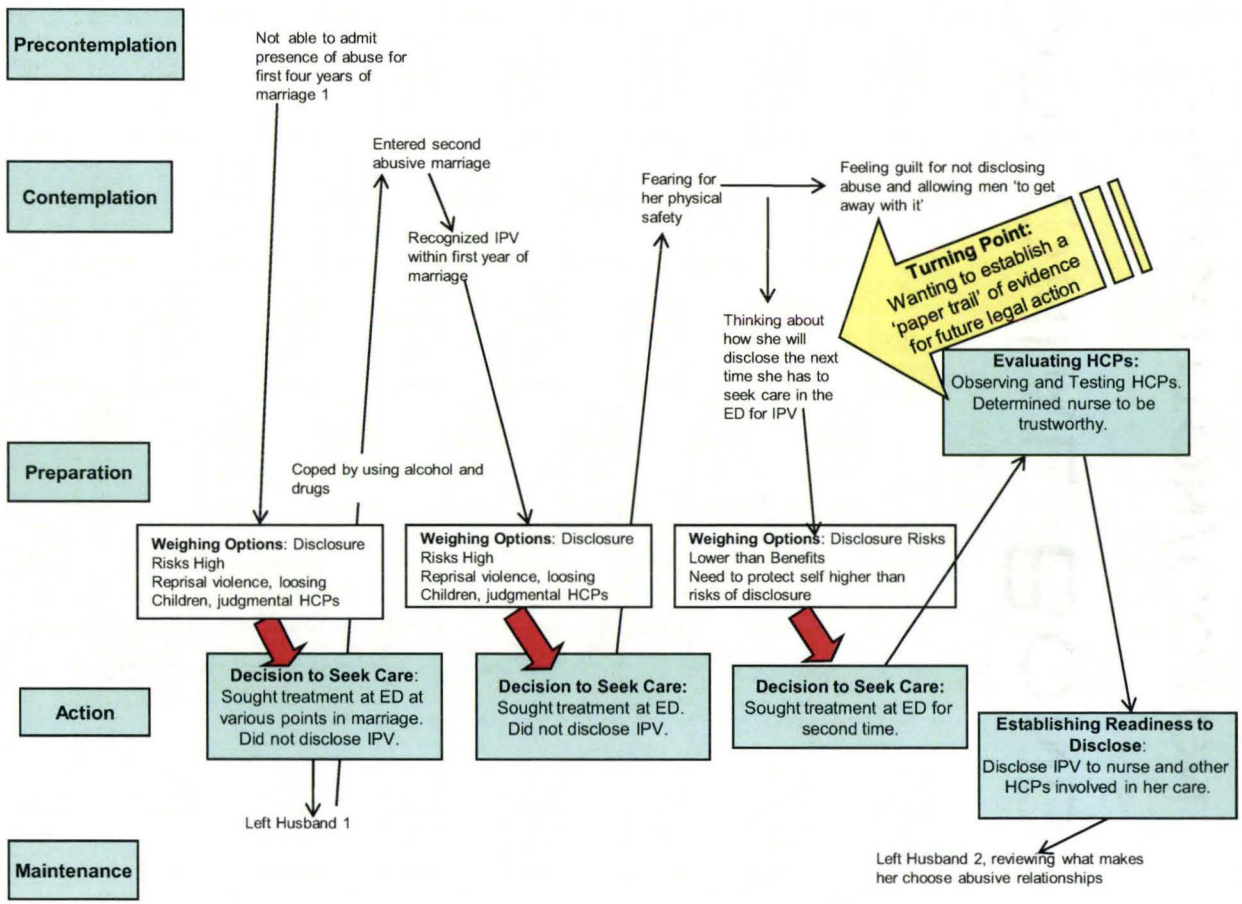

Figure 1. Example of sequential movement through the phases of disclosure.

The participant shown in Figure 2 had a similar experience. This woman remained in the precontemplation and contemplation stages of the TTM prior to IPV disclosure in an emergency department and frequently sought emergency care without disclosing IPV. The risks that she associated with disclosure included: reprisal violence leading to death from her partner; judgment from emergency care clinicians, and the unknown consequences related to police involvement. The risks associated with IPV disclosure continued to outweigh any potential benefits until one occasion when she was brought to the emergency department by ambulance with life-threatening injuries. Still preparing for action, this participant denied IPV as the cause of her injuries. The fear of death became her turning point where survival through the night became more important than the risks that she associated with disclosure. After this turning point, the participant became receptive to determining the trustworthiness of the clinician and building her internal readiness for IPV disclosure. Both trust and readiness was established in the following ways: (a) feeling safe and secure with the health care provider, (b) verifying that the health care provider was non-judgmental regarding her relationship, (c) receiving validation that IPV was not her fault, and (d) establishing physical safety with security guards present at the emergency department. This participant described the action of IPV disclosure:

> It was more the nurse. I don't really remember talking to the doctor. I was very young and my boyfriend tried to kill me, and the [emergency department health care providers] knew what happened but I wasn't talking. I wasn't going to say anything. She [the nurse] just sat with me for a long time and said, "You know, if

somebody did this to you, it's ok to talk about it. It's not your fault." I mean she made me feel comfortable so I could talk about it. It took a lot for me to even come out, I was 14 years old. I was scared he [the boyfriend] was coming to kill me. I finally told her everything, and then she phoned the police. It went from there; but she was awesome. And I mean, had she not sat with me and said, you know, "It's ok this isn't your fault," I would never have said anything. He [the boyfriend] probably would have got away with it.

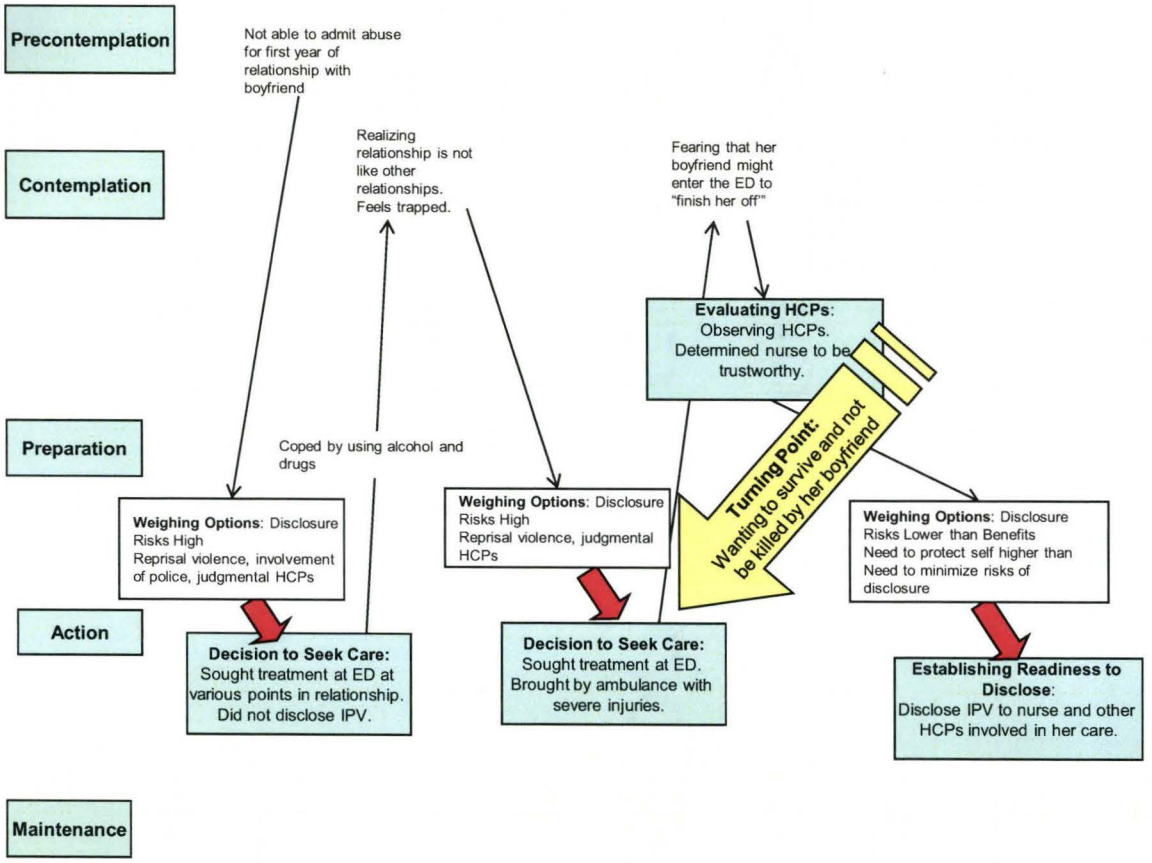

Figure 2. Example of sequential movement through phases of disclosure

Figure 3 shows a participant who initially sought care at the emergency department but did not disclose IPV. When her needs shifted from protecting her relationship to protecting her unborn child, her motivation to disclose IPV outweighed the potential risks that she identified associated with disclosure of IPV. This participant said that she had married her husband despite warnings from others that he had the potential to be verbally abusive. She sought care at the emergency department when she began to have frequent anxiety attacks, which she was able to relate to the ongoing verbal and emotional abuse from her husband. This participant did not identify her relationship as abusive and, upon realizing that it was, became embarrassed about her situation. The perceived risks associated with disclosure for this participant included experiencing judgment from health care providers, the fear of the violence "getting worse," and fear that her husband would leave the marriage. Physical abuse did not begin for this woman until after she became pregnant; she sought care at the emergency department in order to protect her unborn child. She describes her experience disclosing IPV in an emergency department:

> He threw me across the room when I was eight months pregnant, and he was very drunk, he was always drunk. He started drinking and became very abusive. With the nurse, well I told her everything that he's doing to me and she's told me that basically I've gone through every single form of abuse. I never knew that. She took the time to actually listen to what happened and didn't rush me and that's what I look for: basically people that I can trust.

This participant's turning point was the realization that IPV might cause injury to her baby. Her motivation changed and she decided that she did not want to expose a child to a father who was abusive. The need to provide a safer future for her child served as an impetus for developing trust in the clinician and a readiness to disclose IPV. This woman described her readiness for IPV disclosure when meeting an emergency department nurse who was deemed trustworthy because she: (a) was empathetic, (b) listened to the participant's story, and (c) ensured that the participant's confidentiality would be maintained.

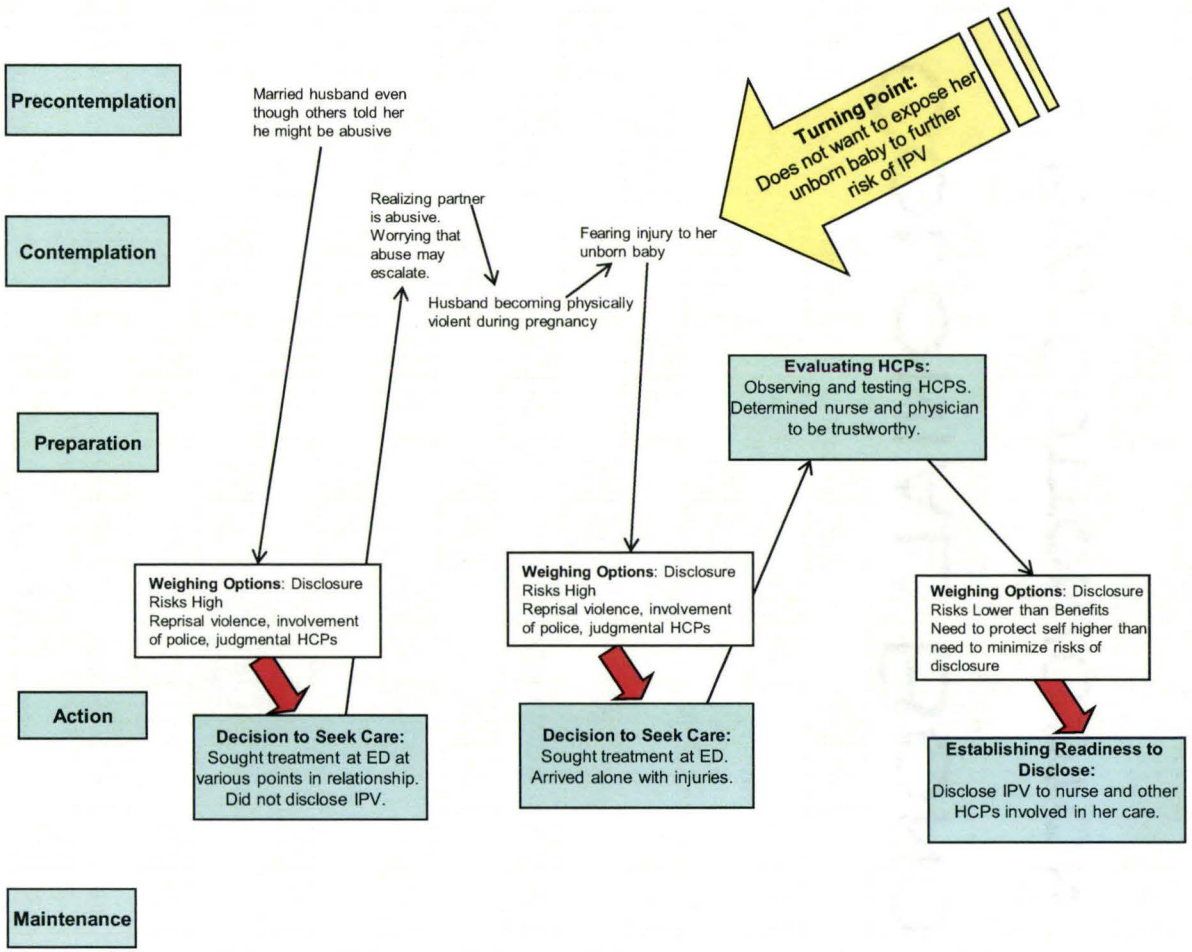

Figure 3. Example of sequential movement through phases of disclosure

4.0 Discussion and Conclusion

Chang et al.'s (2006) methods for mapping provide an innovative way to explore abused women's movements through the stages of change. This mapping exercise was useful in that it provided a visual representation of the series of steps prior to IPV disclosure in urban emergency departments. Analysis showed the progress of women's decision making towards IPV disclosure, including its lack of linearity and the multiple interruptions over time by external factors. This finding was consistent with Chang et al., who found that participants did not move through the stages of change in a linear fashion. In Chang et al.'s findings, some participants skipped stages due to factors beyond their control like pregnancy, illness, and substance use. While participants in this study did not skip stages, many participants remained in the precontemplation, contemplation, or preparation stages and were unable to move forward.

Similar to Chang et al. (2006), participants in this study identified turning point events that served as catalysts for change. However, IPV disclosure did not occur until participants were able to trust the clinician and determine their own readiness. Unlike these authors who found shortly after the turning point that women took action to protect their safety, this study found that the turning point for participants served to help improve their receptiveness to building trust and readiness prior to IPV disclosure.

This paper provides new insights including how the change maps capture time periods, called "weighing options," when women consider the risks of taking action and the potential consequences of each action. Overall, this exercise demonstrated that IPV disclosure in the emergency department is a complex process influenced by factors

beyond the participant's control. For most of the women in this study, movement through the various stages of change took years and many visits to the emergency department for treatment of injuries related to IPV. This exercise emphasized the role that clinicians can play in fostering client trust through communication and supporting a client's readiness for IPV disclosure.

All participants in this study experienced many other events that were not mapped because they did not acknowledge these events as assisting them through the phases associated with IPV disclosure. These events included developing drug and alcohol addictions; losing friends and other supports, "normalizing" IPV in their relationship(s); and life disruptions through unemployment and moving of homes. Although participants did not attribute these factors as influencers on IPV disclosure, they may nevertheless have influenced the speed at which the participant progressed through the stages of change.

For this mapping exercise, participant insight was essential in order to identify significant events, linkage of events and resultant decision making related to IPV disclosure. According to Dienemann, Campbell, Landenburger, and Curry (2002), a woman's moral development can shape how women exposed to IPV associate meaning with their experiences. Women's moral development is affected when they have to resolve conflicts between caring for themselves and other individuals that they value (Gilligan, 1982). The highest level of moral development is the recognition of need for self care and balancing this with the need to care for others (Gilligan). Many of the women in this study continued to struggle with self-care as they invested in caring for

others in their lives, such as their abusive partners and their children. For many participants not ready to take action, preservation of their intimate relationship was of greater importance than disclosing IPV in the emergency department.

Another issue worth consideration is that many factors related to IPV disclosure, including episodes of violence, perceived support from family and friends, finances and employment, and illness, are external to participants' locus of control. These factors may have affected how women viewed their situations and influenced their motivation to disclose IPV in an emergency department. Ultimately, the actions of women exposed to IPV are individual, multi-factorial and complex. Like Chang et al. (2006), this study recognized that in many cases the potential for change, in this case, the disclosure of IPV, may not be solely under the control of each woman but may also be influenced or instigated by the actions of the perpetrator. During analysis, all actions leading to disclosure of IPV were considered acceptable and no single action was considered to be a desirable indicator of change. Another similarity was that actions were limited to "steps," or behaviours that a woman undertook leading to the objective of disclosure of IPV in the emergency department. This study was different in that mapping did not occur for events that went beyond the process of disclosure, including long-term events after disclosure of IPV in the emergency department.

There are many important clinical implications that arise from this mapping exercise. Health care providers who encounter abused women can use the mapping technique to identify their location in the change process. Involving the client in this process may facilitate discussion of IPV as well as foster the development of trust

between client and health care provider. Wong et al. (2008) stated that health care providers undervalued the crucial role they can play in the response to women exposed to IPV. Among the participants of this study, IPV disclosure was found to be a positive experience when the clinician offered non-judgmental and empathetic support. Because participants must first trust health care providers before they can disclose IPV, this mapping exercise is a tool that can be used to guide conversations regarding IPV.

Mapping client behaviours and events against their stage of change could lead to the provision of appropriate interventions. Several authors recommended patterning IPV-related intervention with the client's stage of change (Brown, 1997; Haggerty & Goodman, 2003; Wong et al., 2008; Zink, Elder, Jacobson, & Klostermann, 2004). Haggerty and Goodman suggested incorporating discussion of IPV as part of a routine assessment which can be used to identify the client's stage of change. These authors stated that women's response to IPV-related questions indicated their stage within the TTM from denial of IPV (precontemplators) to describing strategies for how to deal with IPV (action). Authors recommended that health care providers conduct "consciousness-raising" whereby the clinician educates abused women on the risks associated with IPV and expresses concern about their client's safety (Haggerty & Goodman; Wong et al.; Zink et al.). For the participants of this study, consciousness-raising might have been helpful if it was provided over multiple occasions to the women who disclosed IPV. These women drew on any information or support from health care providers when they were actively preparing for disclosure.

Among the women in earlier stages such as precontemplation and contemplation, however, this intervention could have been interpreted as invasive and created further feelings of shame among women seeking treatment in the emergency department. This was especially of concern among those participants who were brought to the setting by ambulance or police services. These participants continued to be in a place of denial and perceived information provided by a clinician as further chastisement for their decision to remain in an abusive relationship. Women from this study requested a non-invasive strategy where pamphlets and written information would be made readily available in every waiting area or examining room and for health care providers to state their readiness and competence to discuss IPV when the client felt ready. Participants, regardless of their stage of change, valued a health care provider's willingness to provide support and wanted anonymous access to information.

Zink, Elder, Jacobson, and Klostermann (2004) recommended that health care providers (a) affirm IPV when women acknowledged its occurrence, (b) assess immediate safety, (c) provide education on the health impacts related to IPV, and (d) offer referral to crisis resources and/or counselling. Among women who took action to disclose IPV in the emergency department, these types of interventions were perceived as potentially helpful, especially in the maintenance of ongoing change. Women in this study viewed clinicians who offered these types of interventions as supportive and competent. The disclosure experience was perceived to be positive when the health care provider demonstrated empathy and the avoidance of judgment. Among the women in this study, evaluating the trustworthiness of a health care provider was a crucial pre-

requisite for feeling prepared to disclose IPV. Demonstrating support and competence by using the above mentioned interventions can enhance a woman's perception of health care provider trustworthiness.

This mapping technique may help explain issues that challenge health care providers such as frequent and multiple visits to the emergency department by abused women (Corbally, 2001). This author argued that clinicians frequently misunderstand client behaviours and become frustrated when women seek emergency care on multiple occasions. Women are often marginalized by health care providers for the decisions they make with regards to their relationships (Corbally). This lack of understanding of the strategies that women use to mitigate the risks that they associate with IPV disclosure could serve as a barrier to women attempting to establish the clinician's trustworthiness and ultimately, their own internal readiness for IPV disclosure. Change maps can also serve as an educational tool for health care providers, thereby addressing the lack of education- or skills-barrier related to IPV frequently cited by participants (Cox et al., 2004; Dowd, Kennedy, Knapp, & Stallbaumer-Rouyer, 2002; Gutmanis, Beynon, Tutty, Wathen, & MacMillan, 2007; Moore, Zaccaro, & Parsons, 1998). The example change maps demonstrate that taking action towards IPV disclosure is a long process involving multiple visits to the emergency department. Understanding this can help health care providers recognize the complexity of IPV disclosure, which is often a slow process towards change. Awareness of the factors that facilitate and impede IPV disclosure may help ease judgments against a client for her decision not to disclose IPV. In the absence of evidence for effective interventions related to IPV disclosure, the research provided by

authors on stage-based approaches related to IPV can help shift clinician attitudes to women exposed to IPV from one of judgment to one of neutrality.

One limitation of this study is its reliance on participants to describe events and circumstances related to IPV disclosure. It is difficult to discern whether participants shared all events related to the disclosure process or may have had difficulty recalling their experiences related to IPV disclosure. Future research could include women who had recently disclosed IPV within a specified time period, as opposed to participants who had disclosed over varied time periods.

An additional limitation is the emphasis of this analysis on IPV disclosure events specific to health care providers in emergency departments. In this study, participants disclosed to numerous other providers, including clinicians in primary care and public health, social workers, victim support volunteers, and police. These disclosure events were not included in this analysis and may have influenced the development of the change maps, especially for those participants in the precontemplation and contemplation stages. Future research might include this mapping technique for all types of disclosure actions in order to see the impact of different providers on a woman's progression through the stages of change.

In conclusion, these findings suggest that few women followed a linear pattern using the Transtheoretical Model of Change. For many participants, the chaotic physical environment of the emergency department and the unknown consequences, like the involvement of other services like police, were barriers to disclosure of IPV. Provision of interventions by health care providers that support IPV disclosure need to promote

participant trust to facilitate readiness to disclose IPV. The mapping technique can be a useful tool for health care providers working with abused women to begin and guide conversations related to IPV. Involving participants in the change-mapping process indicates clinician willingness to discuss IPV, which may further serve to promote trust and engagement.

References

Battaglia, T.A., Finley, E., & Liebschutz, J.M. (2003). Survivors of intimate partner violence speak out. Trust in the patient-provider relationship. *Journal of General Internal Medicine, 18*, 617–623.

Brown, J. (1997). Working toward freedom from violence: The process of change in battered women. *Violence Against Women, 3*, 5–26.

Brown, J.B., Lent, B., Brett, P.J., Sas, G., & Pederson, L.L. (1996). Development of the Woman Abuse Screening Tool for use in family practice. *Family Medicine, 28*(6), 422–428.

Brown, J.B., Lent, B., Schmidt, G., & Sas, G. (2000). Application of the woman abuse screening tool (WAST) and the WAST-short in the family practice setting. *Journal of Family Practice, 49*(10), 896–903.

Chang, J.C., Dado, D., Ashton, S., Hawker, L., Cluss, P.A., Buranosky, R., & Hudson Scholle, S. (2006).Understanding behaviour change for women experiencing intimate partner violence: Mapping the ups and downs using the stages of change. *Patient Education and Counseling, 62*, 330–339.

Cluss, P.A., Chang, J.C., Hawker, L., Scholle, S.H., Dado, D., Buranosky, R., & Goldstrohn, S. (2006). The process of change for victims of intimate partner violence: Support for a psychosocial readiness model. *Women's Health Issues, 16*, 262–274.

Corbally, M.A. (2001). Factors affecting nurses' attitudes towards the screening and care of battered women in Dublin A&E departments: A literature review. *Accident and Emergency Nursing, 9*, 27–37.

Cox, J., Bota, G.W., Carter, M., Bretzlaff-Michaud, J.A., Sahai, V., & Rowe, B.H. (2004). Domestic violence. Incidence and prevalence in a northern emergency department. *Canadian Family Physician, 50*, 90–97.

Dearwater, S.R., Coben, J.H., Campbell, J.C., Nah, G., Glass, N., McLoughlin, E., & Bekemeir, B. (1998). Prevalence of intimate partner abuse in women treated at community hospital emergency departments. *Journal of the American Medical Association, 280*(5), 433–438.

Dienemann, J., Campbell, J.C., Landenburger, K., Curry, M.A. (2002). The domestic violence survivor assessment: A tool for counseling women in intimate partner violence relationships. *Patient Education and Counseling, 46*, 221–228.

Dienemann, J., Glass, N., & Hyman, R. (2005). Survivor preferences for response to IPV disclosure. *Clinical Nursing Research, 14*(3), 215–33.

Dowd, M.D., Kennedy, C., Knapp, J.F., & Stallbaumer-Rouyer, J. (2002). Mothers'and health care providers' perspectives on screening for intimate partner violence in a pediatric emergency department. *Archives of Pediatric Adolescent Medicine, 156*, 792–799.

Ford-Gilboe, M., Wuest, J., & Merritt-Gray, M. (2005). Strengthening capacity to limit intrusion: Theorizing family health promotion in the aftermath of woman abuse. *Qualitative Health Research, 15*(4), 477–501.

Gilligan, C. (1982). In *a different voice: Psychological theory and women's development.* Cambridge, MA: Harvard University Press.

Glaser, B. (1978). *Advances in the methodology of grounded theory. Theoretical sensitivity.* Mill Valley, CA: Sociology Press.

Glaser, B., & Strauss, A. (1967). *Discovery of grounded theory. Strategies for qualitative research.* Mill Valley, CA: Sociology Press.

Gutmanis, I., Beynon, C., Tutty, L., Wathen, C.N., & MacMillan, H.L. (2007). Factors influencing identification and response to intimate partner violence: A survey of physicians and nurses. *BMC Public Health, 7*(12), e1–e11.

Haggerty, L.A., & Goodman, L.A. (2003). Stages of change-based nursing interventions for victims of interpersonal violence. *Journal of Obstetrics and Gynecological Nursing, 32*(1), 68–75.

Hegarty, K., Bush, R., & Sheehan, M. (2005). The composite abuse scale: Further development and assessment of reliability and validity of a multidimensional partner abuse measure in clinical settings. *Violence and Victims, 20*(5), 529–547.

Hegarty, K., Sheehan, M., & Schonfield, D. (1999). A multidimensional definition of partner abuse: Development and preliminary validation of the composite abuse scale. *Journal of Family Violence, 14*(4), 399–415.

Heinzer, M. V., & Krimm, J. (2002). Barriers to screening for domestic violence in an emergency department. *Holistic Nursing Practice, 16*(3), 24–33.

Kearney, M.H. (2001). Enduring love: A grounded formal theory of women's experience of domestic violence. *Research in Nursing and Health, 24*, 270–282.

Kothari, C.L., & Rhodes, K.V. (2006). Missed opportunities: Emergency department visits by police-identified victims of intimate partner violence. *Annals of Emergency Medicine, 47*, 190–199.

Liebschutz, J., Battaglia, T., Finley, E., & Averbuch, T. (2008). Disclosing intimate partner violence to health care clinicians – What a different the setting makes: A qualitative study. *BMC Public Health, 8*, e229–e236.

MacMillan, H.L., Wathen, C.N., Jamieson, E., Boyle, M., McNutt, L.A., Worster, A., Lent, B., & Webb, M. (2006). Approaches to screening for violence against women in health care settings: A randomized trial. *Journal of American Medical Association, 296*, 530–536.

Moore, M. L., Zaccaro, D., & Parsons, L. H. (1998). Attitudes and practices of registered nurses toward women who have experienced abuse/domestic violence. *Journal of Obstetric, Gynecologic and Neonatal Nursing, 27*, 175–182.

Plichta, S.B. (2004). Intimate partner violence and physical health consequences. Policy and practice implications. *Journal of Intimate Partner Violence, 19*(11), 1296–1323.

Prochaska, J.O., & DiClemente, C.C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research and Practice, 19*, 276–288.

Prochaska, J.O., DiClemente, C.C., & Norcross, J.C. (1992). In search of how people change: Adaptations to addictive behaviours. *American Psychologist, 47*(9), 1102–1114.

Rhodes, K.V., Frankel, R.M., Levinthal, N., Prenoveau, E., Bailey, J., & Levinson, W. (2007). "You're not a victim of domestic violence, are you?" Provider patient communication about domestic violence. *Annals of Internal Medicine, 147*(9), 620–627.

Rhodes, K.V., Lauderdale, D.S., He, T., Howes, D.S., Levinson, W. (2002). "Between me and the computer": Increased detection of intimate partner violence using a computer questionnaire. *Annals of Emergency Medicine, 40*, 476–484.

Wathen, C.N., Jamieson, E., Wilson, M., Daly, M., Worster, A., & MacMillan, H.L. (2007). Risk indicators to identify intimate partner violence in the emergency department. *Open Medicine, 1*(2), e113–22.

Wong, S.L.F., Wester, F., Mol, S., Romkens, R., Hezemans, D., & Lagro-Jansssen, T. (2008). Talking matters: Abused women's views on disclosure of intimate partner abuse to the family doctor and its role in handling the abuse situation. *Patient Education and Counseling, 70*, 386–394.

Zink, T., Elder, N., Jacobson, J., & Klosterman, B. (2004). Medical management of intimate partner violence considering the stages of change: Precontemplation and contemplation. *Annals of Family Medicine, 2*, 231–239.

CHAPTER 5

Discussion of Findings, Limitations, and Future Implications

This chapter will compare and contrast the main findings from this study against what is currently known in the literature regarding IPV disclosure. The main strengths and limitations of this study will be presented with discussion of their potential impact on the overall findings. Finally, this chapter will discuss clinical, education, and research implications arising from the results of this study.

Summary of Key Findings

Earlier chapters discussed key findings regarding the intimate partner violence (IPV) disclosure process in urban emergency departments. A quantitative sub-analysis was completed using data from three emergency departments from a randomized, controlled trial on IPV screening effectiveness. Results from this quantitative sub-analysis revealed that few participants who scored positive for IPV exposure disclosed IPV while receiving care at the emergency department. The questionnaire used to assess IPV disclosure revealed a significant amount of missing data from both participants and health care providers. As a result, more information was needed to understand participant decision making regarding IPV disclosure. A grounded theory study was conducted to

explain these results and identify the basic social psychological problem and process related to IPV disclosure. "Being found out" was the basic social psychological problem (BSP) that women stated influenced their decisions against disclosure of IPV. This led to a three-phase process where participants attempted to "minimize their risks." The basic social psychological process included: (a) deciding to seek health care, (b) evaluating trust in the clinician, and (c) establishing internal readiness for disclosure.

Participants stated that the emergency department was not an ideal place to disclose IPV because the setting was overcrowded and chaotic, involved long wait times, lacked privacy, and emphasized efficient patient processing. A positive IPV disclosure outcome occurred for those participants who could trust the health care provider and felt ready for disclosure. An innovative secondary analysis was completed on the grounded theory data using the Transtheoretical Model of Change (Prochaska, DiClemente, & Norcross, 1992). Following the methods proposed by Chang et al. (2006), participants were examined individually to create change maps that marked their progress through the change stages with an outcome of IPV disclosure in the emergency department setting.

This study revealed that severely abused women went to great lengths to avoid emergency care. This finding was confirmed when the quantitative data from the Composite Abuse Scale (CAS) (Appendix F) (Hegarty, Bush, & Sheehan, 2005; Hegarty, Sheehan, & Schonfield, 1999) was compared with the qualitative data from the grounded theory component. For severely abused women, discovery of IPV was of great concern and fear that health care provider involvement would cause disruption to their already chaotic lives. These participants responded to the perceived threat of being found out by

avoiding detection of IPV and received treatment only when they were transported by emergency services like ambulance or police. When they arrived at the emergency department, severely abused participants perceived treatment to be invasive, citing a lack of privacy; exposure to multiple, often anonymous clinicians; and been made to relive the trauma of the abusive incident. These participants responded by concealing the truth about their injuries and abusive intimate relationships. Treatment was seen to be executed by "force" and left women feeling powerless and uncertain about their futures. These findings present a number of unique areas for discussion; specifically, (a) the culture of the emergency department and its impact on IPV disclosure, (b) the nature of trust and how it impacts women in the disclosure process, and (c) how women develop internal readiness to support disclosure of IPV.

Barriers to Intimate Partner Violence Disclosure in Emergency Departments

This study found key barriers that impeded IPV disclosure specific to the context of the emergency department, namely, the categorization of complaint severity, and the "medicalization" of IPV. The Canadian Triage and Acuity Scale (CTAS) (Appendix Y) was adopted across the Canadian acute care system in order to classify clients seeking emergency care according to their level of treatment urgency, and the maximum length of time permissible to safely wait for treatment (Beverage, Clark, & Janes, 1999; Bullard, Unger, Spence, & Grafstein, 2008; Warren, Jarvis, LeBlanc, & Gravel, 2008). The CTAS was modified to include a list of chief presenting complaints and to further the organization of common issues according to acuity (Bullard et al., 2008). This classification tool provides ideal treatment response times according to illness type and

severity. It ranges from the most urgent issues (CTAS I) such as resuscitation, to the least urgent issues not likely to change in severity, like small lacerations (CTAS V) (Bullard et al.; Warren et al., 2008).

According to a study by the Canadian Institutes for Health Information (CIHI), across all types of health concerns that required treatment, 78% of emergency department clients were triaged as either urgent (CTAS III) or less urgent (CTAS IV) (CIHI, 2007). Those requiring immediate care (CTAS I) represented less than 10% of all emergency department visits (CIHI). CTAS III scores indicated care was needed for clients with urgent conditions that had the potential to progress into serious problems requiring emergency intervention, like moderate trauma (CIHI). Clients with injuries from physical or sexual violence in a 48-hour period were classified as CTAS II or III depending on the severity of physical injury (Warren, Jarvis, LeBlanc, & Gravel, 2008). IPV was also categorized as a mental health concern and labelled as a "social problem" classified according to physical or mental abuse (CTAS III), high levels of stress (CTAS III), inability to cope (CTAS IV), or lack of social support (CTAS V) (Bullard, Unger, Spence, & Grafstein, 2008). CTAS III or lower recommend a treatment response time from immediate to one hour, CTAS IV scores involve wait times of up to 2 or more hours, and CTAS V includes conditions that could be further delayed or referred to other areas of the health care system (CIHI).

Upon entering the emergency department, a client's first encounter with a clinician was for assessment of health complaints using the Canadian Triage and Acuity Scale (CTAS) (Bullard, Unger, Spence, & Grafstein, 2008). Many authors have argued

that triaging clients according to illness severity is essential to identifying and responding to urgent issues. A triage system benefits the emergency department since it helps to organize care and remedy overcrowding and patient wait times (Ospina et al., 2006; Ruger, Lewis, & Richter, 2007; Zimmerman, 2001). While a system is required to ensure that clients receive urgent and life saving treatment for the most complex and rapidly deteriorating health issues, classification imposes a "ranking and sorting" approach to clients by health care providers. Participants in this study described the effects of having their health concerns related to IPV classified according to severity and the need for urgent response. Abused women described having their health concerns discounted during triage assessment; being judged as frequently seeking medical care; fighting to have their concerns heard by the clinician; experiencing long wait times before treatment; and being ignored or forgotten while waiting for care.

These results are consistent with the findings of other authors who have suggested that ranking, processing, and medicalizing clients is part of the ingrained culture of the emergency department. Abused women sought care from an acute care setting three times more often than non-abused women (Feder et al., 2006). Health care providers are accustomed to ranking patients according to the severity of illness and injury (Corbally, 2001). Participants in this study felt drained and overwhelmed after a long wait period and did not want to bring up the issue of IPV. When health care providers ranked health needs related to IPV as non-urgent and unimportant, participants had difficulties securing the clinician's attention, let alone developing the engagement required for IPV disclosure.

In addition to classifying health concerns according to their severity and urgency, the culture of the emergency department emphasizes treating physical concerns prior to mental health or emotional concerns. Participants in this study were acutely aware when an emergency department clinician was uncomfortable discussing emotional and mental health concerns related to IPV. Other authors found that abused women frequently encountered health care providers who focused on the injury, never inquired about how it occurred, and only offered treatment for physical health concerns (Sleutal, 1998; Varcoe, 2001; Yam, 2000). These findings are consistent with results of this study where participants reported that health care providers addressed their physical concerns and did not indicate an ability to discuss and respond to an IPV disclosure. Feder et al. (2006) found that women exposed to IPV were accustomed to health care providers who medicalized their health concerns. These authors argued that abused women did not feel permitted to discuss issues of an emotional or psychological nature with a clinician (Feder et al.).

Medicalizing issues and prioritizing urgency can further victimize women exposed to IPV. As Varcoe (2001) discussed, the nature of the emergency department, with its long wait times and overcrowding, leads clinicians to make decisions that support efficient patient processing. Nurses were found to be especially driven to keep the emergency department running in a well-organized manner. This resulted in a reliance on previously held values and beliefs regarding IPV so that nurses could identify who deserved and did not deserve care (Varcoe). Participants from this study were fearful of contributing to the increasing burden of "overworked" clinicians and did not want to

cause further work overload by discussing IPV. As a strategy to resolve this concern, participants carefully observed health care providers and assessed whether or not s/he appeared overwhelmed and/or frustrated as a barometer for trustworthiness.

The Concept of Trust

Key findings from this study related to the concept of trust. Various authors have argued that the concept of trust is poorly defined, yet essential when promoting reciprocal relationships (Erikkson & Nilsson, 2008; Gilbert, 1998; Hupcey, Penrod, Morse, & Mitcham, 2001; Johns, 1996). According to Johns, trust was essential for effective health care relationships and played a role in client empowerment and adherence to treatment. Related to health care, trust was considered both an outcome and a process that involved the client and the health care provider. When considered as a process, Johns argued that trust involved the perception of risk by the "truster," or person attempting to trust another individual. In order to increase the perception of trust, the trustee offered a perceived benefit for the trusting relationship; demonstrated competence and reliability; and possessed past experience with effective trusting relationships (Johns). Elements of these findings were also discovered in this study. Participants who disclosed IPV to an emergency care clinician had preconceived expectations regarding the disclosure experience and its resulting outcomes.

An important feature of the trust process was the determination that the trustee was trustworthy (Johns, 1996). When the trustee was identified as worthy, the trusting relationship began. Developing a trusting relationship meant that the truster assumed a degree of vulnerability such as the potential loss of trust or distress from an inability to

trust (Hupcey, Penrod, Morse, & Mitcham, 2001). Trust, as a concept, was dynamic and evolutionary over time, increasing or decreasing according to how well the truster trusted the trustee (Johns). Elements from the trusting process were consistent with this study when participants described their interactions with health care providers. Participants acknowledged vulnerability if IPV became public knowledge and took risks when a clinician was evaluated as trustworthy. Establishing the trustworthiness of the health care provider took time and multiple visits to the emergency department.

Hupcey, Penrod, Morse, and Mitcham (2001) explored both the antecedents and attributes for the concept of trust. Antecedents included possessing an unmet need requiring another individual's help, having prior awareness of the trustee's reputation, and undertaking a risk assessment before engaging in the trust process. Attributes of trust included dependency on an individual to meet a need, ability to assume vulnerability, pre-determined criteria for a trusting relationship, and the testing of trustworthiness (Hupcey et al., 2001). Trust ceased to exist when the truster felt obligated to trust, and when the truster's perceived risks outweighed the perceived benefits of the relationship.

What both Hupcey, Penrod, Morse, and Mitcham (2001) and Johns (1996) did not explore were the differences among individuals who could trust with ease (trusted implicitly) and those with great difficulties bestowing trust (mistrust). In this study, internal challenges to experiencing trust affected whether or not a participant could evaluate the trustworthiness of a health care provider. Because of participants' differing abilities to trust, a clinician who presented the same qualities to both women might be deemed as trustworthy by one and not trustworthy by the other. Hupcey et al. and Johns

did not examine the mechanisms by which the trustee became trustworthy. Women exposed to IPV from this study evaluated trust through: (a) observing the emergency clinician in the waiting area, (b) testing the clinician for his/her competency related to IPV, and (c) receiving empathy and support from the clinician. When participants had difficulty developing a trusting relationship with the health care provider, they passively accepted care or complied with interventions in order to avoid engagement.

According to Gilbert (1998), in order for trust to occur, an individual must have the capacity to connect in a trusting relationship. Gilbert argued that some individuals with traumatic developmental and life experiences do not have the internal structures, like self-esteem, necessary to engage in trusting relationships. This view was consistent with participants from this study who formed the "mistrust" group. These participants had numerous life experiences where their trust had been betrayed. As a result, these women could not recall anyone from their past whom they trusted. For these participants, the process of trust was too great a risk and the perceived benefits were too few to overcome such a risk.

Gilbert (1998) also examined trust as a regulatory process whereby individuals tested for trust as a healthy means to evaluate risk. Labelled as "mistrust," this label was used to evaluate and monitor individuals for trustworthiness. While all participants in this study undertook various forms of testing the health care provider for trustworthiness, evidence of trustworthiness was especially important for participants in the "distrust" group. For these participants, it was essential that health care providers meet certain pre-established criteria in order to be deemed as trustworthy. Women who distrusted had

experienced relationships where trust had been maintained and broken and were careful to evaluate the perceived risks and benefits that they associated with trust.

While exploring the concept of trust permits greater insight into the findings related to women's evaluation of health care provider trustworthiness, there continue to be gaps in knowledge regarding unique characteristics among individuals who trust with ease and those who have extreme difficulty entering into trusting relationships with health care providers.

The Concept of Readiness

In addition to trust, women exposed to IPV required an internal sense of readiness prior to disclosure of IPV in emergency departments. Establishing internal readiness occurred after women had identified the health care provider to be trustworthy. The speed with which readiness occurred was influenced by the stage of change and the onset of a significant "turning point" incident. Results indicated that if participants contemplated IPV disclosure, the occurrence of a turning point event enabled them to prepare to disclose. Participants would not disclose IPV when they were not ready, even if the health care provider asked them about IPV. Certain situations made women exposed to IPV feel worse about their relationships, such as pressure to disclose IPV prior to being ready. This occurred when participants were transported to the emergency department by emergency services like police or ambulance or when another person disclosed IPV on their behalf.

These results are consistent with other authors who have studied readiness as a concept and as part of the overall change process. According to Dalton & Gottlieb (2003)

the term "readiness" has been examined in health care research but lacks the clear, objective criteria that identified the state of readiness. This term is also conceptualized as part of a larger process, as with this current study. Dalton and Gottlieb interviewed 28 participants and found that readiness was inductive and involved both an outcome and a process involving the balancing of competing factors. When considering the findings related to a turning point incident that led to IPV disclosure, Dalton and Gottlieb argued that context-specific trigger factors initiated the client's appraisal of readiness. These included the client's determination of the health concern, their level of energy and physical health, the number of stressors present, and their overall access to support. Dalton and Gottlieb suggested that readiness was a process which involved phases including the identification of a need for change, weighing options, and determining a course of action--features consistent with findings of this study.

Dalton and Gottlieb's (2003) found that prior to realizing that a change is required, an individual's current situation becomes intolerable and s/he becomes aware of a need to create change. Participants in this study experienced a similar phenomenon after the turning point episode. While abused women may not have known what steps to take, they realized that they could not continue in their current situation and needed to embark on a change process related to IPV disclosure. The second stage in the process of readiness was weighing the costs and benefits associated with changing and beginning to plan for action (Dalton & Gottlieb). Similarly, women exposed to IPV also weighed options when they considered seeking care for health concerns related to IPV. At this stage, participants were not ready to disclose IPV but were concerned with the outcomes

of "being found out." As a result, managing the risks they associated with violence becoming public was a concern, especially for women whose lives could become more chaotic after disclosure. Finally, Dalton and Gottlieb discussed planning for change whereby clients began to set goals, prepared to ask for help and developed the confidence to bring about change. This finding was also consistent with the theory of being found out, where women described "psyching themselves up" as a form of preparation for disclosure of IPV. Likewise, women in this study described rehearsing how they would disclose IPV and considered various consequences after disclosure, which Dalton and Gottlieb described as visualizing readiness. While participants did not describe feeling confident about a decision to disclose IPV, they did anticipate that disclosure might bring both positive and negative changes to their lives.

These findings regarding readiness were also consistent with Brown, Melchior, Panter, Slaughter, and Huba (2000), who discussed readiness for change among substance-abusing women, including those who experienced IPV. These authors found that a facilitator for readiness occurred when an immediate response to a life-threatening problem was required. Abused women responded by addressing immediate problems that posed the greatest threat (Brown et al., 2000).

Overall, readiness was a complex topic that involved a degree of subjective determination. Consistent with Cluss et al. (2006) this study found that readiness to change was influenced by a number of factors, including a woman's awareness of the problem, her sense of support, and her perceived self-efficacy. Making changes is an ongoing process where women move through various stages from precontemplation of

change, to taking action, to maintaining the new change (Brown, 1997; Prochaska & DiClemente, 1982; Prochaska, DiClemente, & Norcross, 1992). While it was not always clear to abused women how they arrived at readiness to disclose IPV, preparation and confidence were key components.

Strengths and Limitations[7]

This study had a variety of strengths and limitations. A significant strength of this study was the innovative use of methods so that a grounded theory study could be embedded within a randomized, controlled trial. Modifications were made to include a "unit of analysis" approach for theoretical sampling, maximum variation sampling, and negative case analysis. These adaptations adhered to the principles of grounded theory, yet made it possible for the same sample of participants from the trial in the grounded theory phase to be used. This decision was essential to maintaining participant context so that the grounded theory results could inform the randomized, controlled trial.

Another strength of this mixed methods study was its strategies for mixing both quantitative and qualitative data. Two mixing strategies were used, connecting and embedding quantitative data with qualitative data, which served to inform and validate the developing grounded theory. These examples of data mixing added to the overall rigour of the study and helped to confirm that the theoretical developments were derived from data and not from the researcher's intuition or past knowledge (Tobin & Begley, 2004). Additional methods to improve confirmability included having a master's student

[7] A full discussion of the strengths and limitations of this study can be found in Chapter 2: *"Mixing a Grounded Theory Approach with a Randomized Controlled Trial Related to Intimate Partner Violence: What Challenges Arise for Mixed Methods Research?"*

act as a second coder of the transcripts and verify that the developing categories and relationships were grounded in the data. In addition to confirmability, this study undertook specific actions to address credibility, dependability, and transferability when incorporating grounded theory with a randomized, controlled trial.[8]

Finally, an innovative qualitative secondary analysis was used with an adaptation of Chang et al.'s (2006) mapping techniques based on the Transtheoretical Model of Change (TTM) (Prochaska DiClemente, & Norcross, 1992). This study's substantive grounded theory was developed from participant recount of multiple IPV disclosure stories. IPV disclosure involved various types of professionals, including physicians, nurses, social workers, crisis volunteers, and police. Because these disclosure events were not exclusive to the emergency department, it was difficult to discern a specific pattern of behaviour among participants who disclosed IPV there. As a result, Chang et al.'s mapping methods permitted exploration of behaviours related to the stages of change specific to IPV disclosure within the emergency department. The selection of this method for secondary analysis of the grounded theory data was both a strength and a limitation. One of the strengths of the mapping analysis was that it gave researchers the ability to examine specific behaviour patterns leading to IPV disclosure in the emergency department. This method also placed IPV disclosure in the context of time, making it possible to see the many factors that facilitated and inhibited IPV disclosure. This visual

[8]A full discussion of methods to address rigour can be found in Chapter 2: *"Mixing a Grounded Theory Approach With a Randomized Controlled Trial Related to Intimate Partner Violence: What Challenges Arise for Mixed Methods Research?"*

representation could provide health care providers with a tangible tool for use during assessments or ongoing discussions with women exposed to IPV. Finally, the mapping analysis was innovative in its application of the findings from the grounded theory component to the overall change process. This provided a more comprehensive explanation for participant behaviour as they moved through the stages of change.

The mapping analysis used in this study also has limitations. The visual representation of the change maps may oversimplify the nature of abused women's progression through the stages of change, especially in the change maps, which suggest a linear movement through each stage. In order to avoid this misconception, analysis involving other IPV disclosure events may have helped to provide further explanation for participant decisions and behaviours. Such analysis might include a review of the disclosure stories from other health care settings to enhance the understanding of women's progression through the stages of change.

The most significant limitations of this mixed methods study relate to its planning and to the timing of phases. The study began after the trial examining IPV screening effectiveness was already underway. Because the trial about IPV screening effectiveness was a new endeavour, the need for a mixed methods study was not anticipated at the outset. Careful attention was paid to design so that the methodological integrity of both the trial and the mixed methods was maintained. However, beginning a mixed methods study after the trial posed challenges for the timing of the grounded theory phase with the trial recruitment. Starting recruitment for the grounded theory phase earlier would have provided the time needed for theoretical sampling. When new participants were sought

for the grounded theory phase, they might thus still have been involved in the trial and have had continued interest in participating in the qualitative study. However, once a participant was no longer involved in the trial, it was more difficult to re-engage their interest in participating in the grounded theory component.

A limitation of this study is the lack of consideration assessment of literature related to decision making from cognitive psychology. According to Siong-Soon, Brass, Heinze, & Haynes, (2008), many processes in the brain occur automatically and do not involve the conscious mind. Decisions are made ahead of time but could still be reversed and are based on rapid responses occurring before a conscious decision. Siong-Soon et al.'s (2008) study was unique because it explored decisions before they were made as opposed to after the decision was made. Siong-Soon et al.'s findings suggest that decisions are made by the subconscious mind before an individual can identify 'how' or 'why' such decisions were made. Decision-making related to IPV was examined long after participants had reached their decisions. This time lag may have offered opportunity for participants to have consciously created a rationale for their decisions or changed their views related to decision making. Future research might consider recent evidence in cognitive psychology and explore decision-making related to IPV using these insights.

Implications

Clinical Implications

Results from this study have important clinical implications for nurses and other health care providers working in the emergency department setting. Participants indicated specific barriers unique to the emergency department that inhibited IPV disclosure, such

as long wait periods, overcrowding, few private areas for discussion, and the hurried nature of health care providers' work. While advocacy to change these environmental barriers can occur over the long-term, there are more immediate actions that clinicians can take to facilitate discussion of IPV. Participants, for example, expressed a need to be acknowledged and respected by health care providers when they entered the emergency department while they waited for care and during interactions with the health care provider. This finding appears simplistic but suggests that health care providers continue to struggle with empathetic and supportive communication techniques. Small efforts made by health care providers towards demonstrating empathy and caring were valued by women exposed to IPV. Feasible communication strategies in the emergency department could include triage staff acknowledging clients who are waiting for their assessment and the provision of an estimated wait time. When interacting with the health care providers, participants valued those that introduced themselves as it helped to reduce role ambiguity and convey respect. Women exposed to IPV were aware of health care providers' discomfort discussing IPV and suggested that clinicians make eye contact, sit at eye level, and refrain from using the medical chart as a visual barrier between themselves and their client.

These preliminary communication activities can foster client comfort with discussing IPV. Active listening and provision of non-judgmental support are other clinical actions recommended from this study. In other studies that recommended clinician communication behaviours, listening and offering support was crucial for the validation of a client disempowered by IPV (Battaglia, Finley, & Liebschutz, 2003;

Feder, Hutson, Ramsay, & Taket, 2006; Liebschutz, Battaglia, Finley, & Averbuch, 2008; Tower and McMurray, 2006). Participants from this study wanted health care providers to demonstrate empathy, which they felt served as evidence that the health care provider was interested in the discussion. According to Neumann et al. (2009) the provision of empathy, an indicator of care quality, can have profound therapeutic potential with the possibility to enhance patient outcomes. Patient engagement can be supported through the provision of information about IPV that empowers them to take action when they are ready (Protheroe, Rogers, Kennedy, MacDonald, & Lee, 2008). This sentiment was echoed in other research that recommended that health care providers listen and offer options as a means of giving women control over their own decision making (Dienemann, Glass, & Hyman, 2005; Feder et al., 2006; Varcoe, 2001).

Participants receiving emergency care for injuries related to IPV have described the process of evidence collection to be intrusive. In addition to improving their communication skills, emergency care providers can work to minimize the intrusion created during the assessment of IPV. Photographs are increasingly used as part of the patient health record and as evidence for medico-legal proceedings (Bhangoo, Maconochie, Batrick, & Henry, 2005). However, there is great variation across emergency department policies regarding procedures to obtain permission and consent to photographs injuries. On occasion, a lack of policy within an emergency department can compromise the safety and confidentiality of the client through mismanagement and misuse of these photographs (Bhangoo et al., 2005). These authors recommend that health care providers obtain client consent prior to using photographs. Not having patient

consent to photograph injuries poses an ongoing ethical concern for clients experiencing trauma due to IPV and their ability to provide consent. Seeking consent to conduct potentially invasive investigations is one strategy that health care providers can use to reduce the perception of invasion among clients exposed to IPV.

The clinical implications arising from the change mapping exercise indicated that participants need health care providers to be aware of the impact of the stages of change on behaviour related to IPV disclosure. Health care providers should tailor their assessments and interventions on a case-by-case basis to meet the needs of the client. Discussing IPV on an individual basis as a means of developing rapport and trust among abused women can facilitate IPV disclosure. Women in this study feared consequences of IPV disclosure like disruption of their lives, potential retaliatory violence from their partners, and the involvement of other services like police and child protection. Routine, universal screening also helped create greater vigilance among participants who wanted to keep IPV secret.

Participants were receptive to the use of a "case finding" approach by health care providers during periods of assessment. Case finding involves asking women about IPV when either risk indicators for, or signs suggestive of IPV are present (Nelson, Nygren, McInerney, & Klein, 2004; Taft & Hegarty, 2002). This approach is part of what can be considered prudent clinical assessment (e.g. during an exam or history taking), where clinicians identify and respond to the signs and symptoms of IPV arising from physical injury patterns, mental health concerns, or unexplained complaints (e.g. pain and/or depression) (Tacket, Wathen, & MacMillan, 2004). Too often, clinicians mistake the case

finding approach to include only the assessment for physical indicators of IPV and fail to include mental health concerns identified as risk indicators for IPV (Wathen, Jamieson, & MacMillan, 2008). Avoidance of key IPV risk indicators or symptoms during assessment could lead to a health care provider missing key concerns, making inappropriate diagnosis(es), and/or potentially unsuitable investigations or treatments (Cole 2000; Tacket et al.; Wathen & MacMillan, 2003). A case finding approach supports asking about IPV during situations requiring comprehensive history taking, a physical examination, or when the client presents symptoms that are associated with IPV. This approach can be used during different stages of assessment in the emergency department such as triage, while a patient is waiting for care, and during assessment of chief complaints.

While "case finding" offers an option for IPV identification, it is not likely to lead to disclosure of IPV when women are not ready to discuss it. This suggests that health care providers need to use a variety of interventions to facilitate disclosure of IPV. Numerous authors have recommended that stage-based interventions be offered to women exposed to IPV (Brown, 1997; Chang et al., 2006; Cluss et al., 2006; Dienemann, Campbell, & Landenburger, Curry, 2002; Frasier, Slatt, Kowlowitz, & Glowa, 2001; Haggerty & Goodman, 2003; Wong, 2008; Zink, Elder, Jacobson, & Klostermann, 2004). Other authors recommend different interventions depending on the stage the woman is at (Brown; Chang et al.; Dienemann et al., 2002; Frasier et al., 2001; Haggerty & Goodman; Zink et al., 2004). The challenge of this approach is that these interventions have not yet been evaluated for their ability to impact important health and social outcomes. Because

the impact of stage-specific interventions on health and social outcomes has not yet been evaluated, they cannot be recommended at this point. It is preferable to identify evidence-based interventions that support women to move towards self-initiated IPV disclosure. Until this evaluation has occurred, however, health care providers can work towards becoming aware of the impact of this stage of change on women's willingness to disclose IPV. It is important for clinicians to understand the strategies that women use to manage the risks of "being found out" in order to avoid imparting blame and judgment on them for such actions as frequent visits to the emergency department, denial of abuse despite obvious physical injury, and failure to make use of referral options.

Approaches like "case finding" and other evidence-based intervention options that support disclosure of IPV require a clinical setting that facilitates privacy and confidentiality. When women decided that they were ready to disclose IPV, they wanted to be reassured that their confidentiality would be maintained and that they would not experience judgment for their decision to remain in an abusive relationship--a finding consistent with Feder et al. (2006). In addition to long wait times and overcrowding, finding space for private discussion in the emergency department environment is often a challenge. Being provided with a safe place for disclosure was important to women who attended the emergency department for treatment of injuries and issues related to IPV (Kearney, 2001). In many acute care settings, privacy is offered only by means of a closed curtain which is neither comfortable nor safe for IPV disclosure (Corbally, 2001). Greater effort--perhaps through advocacy for policy change within emergency departments--is needed to create a less chaotic, more private environment that facilitates

IPV disclosure. While the current culture of the emergency department may be capable of managing large numbers of clients with ever increasing acuity, this emphasis on efficient and rapid processing does not accommodate women who may wish to disclose IPV. Abused women need time to assess their surroundings, the degree to which they trust the health care provider, and their internal readiness for disclosure.

Implications for Education

Results from this study clearly indicated that health care providers have a need for education related to communication, client engagement, awareness, and comfort with the discussion of IPV. As previously discussed, women exposed to IPV used clinicians' communication practices as indicators for trustworthiness. They described great variation in clinician ability to convey openness, engage in active listening, and use supportive communication techniques that facilitate women's initiation of IPV disclosure. Health care providers need educational opportunities on topics like professional presentation, empathic communication techniques, and fostering a neutral, private environment for discussion of sensitive issues. Education initiatives could potentially offer activities that encourage the development of empathy as well as communication strategies specifically related to sensitive topics. In addition to education on supportive communication, the literature suggests that clinicians also require targeted education related to IPV. Across various health care settings, barriers that inhibited health care provider discussion of IPV were: limited education regarding IPV; provider perception of self-efficacy related to the issue; lack of time in a busy schedule to deal with a complex social issue; concerns about safety and confidentiality; fear of giving offense; feeling helpless when clients

disclose/experience violence; and the perception that IPV is not a priority practice issue (Catallo et al., 2006; Cox 2003; Dowd, Kennedy, Knapp & Stallbaumer-Rouyer, 2002; Gutmanis, Beynon, Tutty, Wathen, & MacMillan, 2007; Heinzer & Krimm, 2002; Sugg et al., 1999; Moore, Zaccaro, & Parsons, 1998; Thompson et al., 1998). In the emergency department, meaningful communication related to IPV was discouraged by clinician actions such as abuse inquiry with a third party present, using humour when asking about IPV, failure to assess risk or safety, and failure to offer resources (Rhodes et al., 2007). Furthermore, health care providers were found to ask about IPV in an automated, mechanical manner using strategies that may have inhibited a potential disclosure of IPV (Rhodes et al.).

These results suggest that IPV-related education should not only include content related to IPV, its assessment and response, but also health care provider attitudes toward and comfort with the issue of IPV. As previously mentioned, women who disclosed IPV regularly felt judgd by the health care provider. Education is needed that promotes awareness about common behaviours (Corbally, 2001) and women's need for trust prior to disclosure. Understanding that women seek frequent emergency care as a strategy for disclosure decision making may help dispel the negative connotations of multiple visits to the emergency department. Further, understanding the Transtheoretical Model of Change (TTM) (Prochaska, DiClemente, & Norcross, 1992) along with common behaviours women exhibit at each stage may aid in fostering a neutral view of women exposed to IPV.

A recent scan of educational curricula for health care professionals at colleges and universities in Ontario found variability regarding IPV content, education delivery, and its evaluation (Catallo et al., 2006; Wathen et al. (2009). In preparing health care professionals for future careers, educational institutions cited multiple competing priorities that forced IPV to be a less important consideration. Other barriers, like limited funding, the political climate at individual institutions, and pressure to meet provincial accreditation requirements also impeded inclusion of IPV-related content (Catallo et al.; Wathen et al.). As a result, health care providers may complete their entire education without ever having been exposed to the topic of IPV. Multifaceted educational opportunities are required to provide clinicians with the tools to appropriately assess for evidence-based physical and mental health indicators and determine appropriate interventions for the acute and chronic effects of IPV (Wathen). Finally, for emergency care clinicians, education strategies need to be readily available and easy to access. Policy changes that support the institutional uptake of evidence-based education strategies related to empathic communication and IPV assessment and response could facilitate client disclosure in emergency department settings.

Research Implications

This research study attempts to offer new information regarding IPV disclosure in emergency departments. Many new research opportunities could be considered as important follow-up steps to this work. One such study could involve the quantitative testing of the grounded theory results to identify predictors of IPV disclosure within emergency departments. Statistically significant predictors of disclosure could be used in

the development of evidence-based educational strategies and assessment tools for clinicians. This study utilized a bounded sample of participants recruited as part of a provincial randomized, controlled trial. As previously mentioned, a possible limitation to the grounded theory portion of this study was the modification of the traditional Glaserian theoretical sampling methods to facilitate the overall mixed methods design. Theoretical sampling where new participants are sought from various health care settings might potentially provide new insights related to IPV disclosure decision making.

Key gaps that require investigation include an evaluation of both the concept of trust and internal readiness among women seeking to disclose IPV in the emergency department setting. These concepts were found to be important components in the process of managing risks related to "being found out," and require further investigation for conceptual antecedents, attributes, individual processes, boundaries, outcomes, and unique consequences. Further exploration is also needed regarding the development aspect of trust development, especially among participants who have the greatest difficulties forming trusting relationships with health care providers. As Gilbert (1998) has stated, trust establishment requires key internal resources like self-esteem and confidence. Internal readiness, which involves self-efficacy, could potentially be closely related to the concept of trust. Further investigation of these concepts could provide explanations for women's IPV disclosure decision making.

This research highlights a research gap regarding access to assessment and intervention among women who avoid obtaining emergency care despite severe abuse. These participants were at the greatest risk for long-term physical and mental health

impairment and lethality. Little is known regarding how to encourage these women to access health care, or the kinds of interventions that would encourage them to initiate their own care.

Other research opportunities relate to the provision of quality of care. For participants in this study, care quality impacted decisions regarding which emergency department they attended. Negative experiences in the emergency department served to inhibit participants from seeking emergency care in the future. More research is needed regarding the perception of quality of care among abused women. This could include studying the facilitators and barriers to care quality, as well as patient satisfaction. Understanding these elements can help to improve health care delivery for women exposed to IPV.

While the focus of this study was on women's decision making related to IPV disclosure, the results highlighted gaps in skills and behaviours of health care providers. Future research on interventions to facilitate self-initiated IPV disclosure in health care settings is required. In addition, research on educational strategies and effective uptake among emergency department clinicians is important.

Conclusion

In conclusion, this sequential explanatory mixed methods study examined the decision making process among women exposed to IPV attending urban emergency department settings. Phase one involved a quantitative sub-analysis of data from three emergency departments from a randomized, controlled trial. Results indicated that despite IPV exposure, most participants chose to not disclose IPV. A grounded theory phase

sought to identify and explain the central problem that participants associated with IPV disclosure and the processes that they used to resolve this problem. "Being found out" was the basic social psychological problem that women stated influenced their decisions against disclosure of IPV in the emergency department setting. In order to resolve the problem of being found out, women undertook a three-phase process related to decision making about IPV disclosure, including: (a) deciding whether to seek care, (b) evaluating their level of trust, and (c) establishing readiness to disclose IPV. Results of this study indicated that the emergency department was not an ideal place for disclosure of violence due to a lack of privacy, sense of chaos, and an emphasis on efficient patient processing. In order for women to report a positive disclosure outcome, they needed to first establish the trustworthiness of the health care provider and determine their own internal readiness for disclosure. In the absence of evidence-based interventions to support IPV disclosure in emergency departments, clinicians should consider the role of empathy and supportive communication strategies to facilitate patient engagement. This research highlights the need for health care provider skill-building education that is accessible and multifaceted. Potential study topics could include client engagement and empathy and the provision of non-judgmental responses to clients seeking care for physical and mental health impairment related to IPV. Finally, future research is required to understand how to create an environment that supports self-initiated disclosure of IPV.

References

Battaglia, T.A., Finley, E., & Liebschutz, J.M. (2003). Survivors of intimate partner violence speak out. Trust in the patient-provider relationship. *Journal of General Internal Medicine, 18*, 617–623.

Beveridge, R., Clark, B., & Janes, L. (1999). Canadian emergency department triage and acuity scale: Implementation guidelines. *Canadian Journal of Emergency Medicine, 1*(suppl), s2–s8.

Bhangoo, P., Maconochie, I., Batrick, N., & Henry, E. (2005). Clinicians taking pictures--a survey of current practice recommendations in emergency departments and proposed best practices. *Emergency Medicine Journal, 22*, 761–765.

Brown, J. (1997). Working toward freedom from violence: The process of change in battered women. *Violence Against Women, 3*, 5–26.

Brown, V.B., Melchior, L.A., Panter, A.T., Slaughter, R., & Huba, G.J. (2000). Women's steps of change and entry into drug abuse treatment. A multidimensional stages of change model. *Journal of Substance Abuse Treatment, 18*, 231–240.

Bullard, M.J., Unger, B., Spence, J., & Grafstein, E. (2008). Revisions to the Canadian emergency triage and acuity scale (CTAS) adult guidelines. *Canadian Journal of Emergency Medicine, 10*(2), 136–142.

Canadian Institutes for Health Information (CIHI). (2007). *Understanding emergency department wait times: Who is using emergency departments and how long are they waiting?* Toronto, Ontario: Canadian Institutes for Health Information. Retrieved February 2, 2009, from www.cihi.ca

Catallo, C., Wathen, C.N., Jamieson, E., Freeman, C., MacMillan, H. and the McMaster University Domestic Violence Education Research Team. (2006). *Professional education for responding to violence against women: Review of current practices in Ontario's health sector*. Hamilton, ON: Offord Centre for Child Studies.

Chang, J.C., Dado, D., Ashton, S., Hawker, L., Cluss, P.A., Buranosky, R., Hudson Scholle, S. (2006). Understanding behaviour change for women experiencing intimate partner violence: Mapping the ups and downs using the stages of change. *Patient Education and Counseling, 62*, 330–339.

Cluss, P.A., Chang, J.C., Hawker, L., Scholle, S.H., Dado, D., Buranosky, R., & Goldstrohn, S. (2006). The process of change for victims of intimate partner violence: Support for a psychosocial readiness model. *Women's Health Issues, 16*, 262–274.

Cole, T. (2000). Is domestic violence screening helpful? *Journal of the American Medical Association, 284*(5), 551–553.

Corbally, M.A. (2001). Factors affecting nurses' attitudes towards the screening and care of battered women in Dublin A&E departments: A literature review. *Accident and Emergency Nursing, 9*, 27–37.

Cox, J., Bota, G.W., Carter, M., Bretzlaff-Michaud, J.A., Sahai, V., & Rowe, B.H. (2004). Domestic violence. Incidence and prevalence in a northern emergency department. *Canadian Family Physician, 50*, 90–97.

Dalton, C.C., & Gottlieb, L.N. (2003). The concept of readiness to change. *Journal of Advanced Nursing, 42*(2), 108–117.

Dienemann, J., Glass, N., & Hyman, R. (2005). Survivor preferences for response to IPV disclosure. *Clinical Nursing Research, 14*(3), 215–33.

Dowd, M.D., Kennedy, C., Knapp, J.F., & Stallbaumer-Rouyer, J. (2002). Mothers'and health care providers' perspectives on screening for intimate partner violence in a pediatric emergency department. *Archives of Pediatric Adolescent Medicine, 156*, 792–799.

Eriksson, I., & Nilsson, K. (2008). Preconditions needed for establishing a trusting relationship during health counselling – an interview study. *Journal of Clinical Nursing, 17*, 2352–2359.

Feder, G.S., Hutson, M., Ramsay, J., & Taket, A.R. (2006). Women exposed to intimate partner violence. Expectations and experiences when they encounter health care professionals: A meta-analysis of qualitative studies. *Archives of Internal Medicine, 166*, 22–37.

Frasier, P.Y., Slatt, L., Kowlowitz, V., & Glowa, P.T. (2001). Using the stages of change model to counsel victims of intimate partner violence. *Patient Education and Counselling, 43*, 211–217.

Gilbert, T. (1998). Towards a politics of trust. *Journal of Advanced Nursing, 27*, 1010–1016.

Gutmanis, I., Beynon, C., Tutty, L., Wathen, C.N., & MacMillan, H.L. (2007). Factors influencing identification and response to intimate partner violence: A survey of physicians and nurses. *BMC Public Health, 7*(12), e1–e11.

Haggerty, L.A., & Goodman, L.A. (2003). Stages of change-based nursing interventions for victims of interpersonal violence. *Journal of Obstetrics and Gynecological Nursing, 32*(1), 68–75.

Hegarty, K., Bush, R., & Sheehan, M. (2005). The composite abuse scale: Further development and assessment of reliability and validity of a multidimensional partner abuse measure in clinical settings. *Violence and Victims, 20*(5), 529–547.

Hegarty, K., Sheehan, M., & Schonfield, D. (1999). A multidimensional definition of partner abuse: Development and preliminary validation of the composite abuse scale. *Journal of Family Violence, 14*(4), 399–415.

Heinzer, M. V., & Krimm, J. (2002). Barriers to screening for domestic violence in an emergency department. *Holistic Nursing Practice,16*(3), 24–33.

Hupcey, J.E., Penrod, J., Morse, J.M., & Mitcham, C. (2001). An exploration and advancement of the concept of trust. *Journal of Advanced Nursing, 36*(2), 282–293.

Johns, J.L. (1996). A concept analysis of trust. *Journal of Advanced Nursing, 24*, 76-83.

Kearney, M.H. (2001). Enduring love: A grounded formal theory of women's experience of domestic violence. *Research in Nursing and Health, 24*, 270–282.

Liebschutz, J., Battaglia, T., Finley, E., & Averbuch, T. (2008). Disclosing intimate partner violence to health care clinicians – What a different the setting makes: A qualitative study. *BMC Public Health, 8*, e229–e236.

Moore, M. L., Zaccaro, D., & Parsons, L. H. (1998). Attitudes and practices of registered nurses toward women who have experienced abuse/domestic violence. *Journal of Obstetric, Gynecologic and Neonatal Nursing, 27*, 175–182.

Nelson, H.D., Nygren, P., McInerney, Y., & Klein, J. (2004). Screening women and elderly adults for family and intimate partner violence: A review of the evidence for the U.S. preventive services task force. *Annals of Internal Medicine, 140*, 387–396.

Neumann, M., Bensing, J., Mercer, S., Ernstmann, N., Ommen, O., Pfaff, H. (2009). Analyzing the "nature" and "specific effectiveness" of clinical empathy: A theoretical overview and contribution towards a theory-based research agenda. *Patient Education and Counseling, 74*, 339–346.

Ospina, M.B., Bond, K., Schull, M., Innes, G., Blitz, S., Friesen, C., & Rowe, B.H. (2006). *Measuring overcrowding in emergency departments: a call for standardization* [Technology report no. 67.1]. Ottawa, ON: Canadian Agency for Drugs and Technologies in Health. Retrieved February 2, 2009, from www.cadth.ca

Protheroe, J., Rogers, A., Kennedy, A., MacDonald, W., & Lee, V. (2008). Promoting patient engagement with self-management support information: a qualitative meta-synthesis of processes influencing uptake. *Implementation Science, 3*, 44–56.

Prochaska, J.O., & DiClemente, C.C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research and Practice, 19*, 276–288.

Prochaska, J.O., DiClemente, C.C., & Norcross, J.C. (1992). In search of how people change: Adaptations to addictive behaviours. *American Psychologist, 47*(9), 1102–1114.

Rhodes, K.V., Frankel, R.M., Levinthal, N., Prenoveau, E., Bailey, J., & Levinson, W. (2007). "You're not a victim of domestic violence, are you?" Provider patient communication about domestic violence. *Annals of Internal Medicine, 147*(9), 620–627.

Ruger, J.P., Lewis, L.M., & Richter, C.J. (2007). Identifying high-risk patients at triage and resource allocation in the ED. *American Journal of Emergency Medicine, 25*, 794–798.

Siong-Soon, C., Brass, M., Heinze, H., & Haynes, J. (2008). Unconscious determinants of free decisions in the human brain. *Nature Neuroscience, 11*, 543-545.

Sleutal, M.R. (1998). Women's experiences of abuse: A review of qualitative research. *Issues in Mental Health Nursing, 19*, 525-539.

Sugg, N.K.,Thompson, R.S., Thompson, D.C., Maiuro, R., & Rivara, F.P. (1999). Domestic violence and primary care. *Archives of Family Medicine, 8*, 301–306.

Taft, A., & Hegarty, K. (2002). Safe healthcare system needs to be in place. *British Medical Journal, 325*, 1418.

Taket, A., Wathen, C.N., & MacMillan, H.L. (2004). Should health care professionals screen all women for domestic violence? *PLoS Medicine, 1*(1), e4–e9.

Thompson, R.S., Meyer, B.A., Smith-DiJulio, K., Caplow, M.P., Maiuro, R.D., Thompson, D.C., Sugg, N.K., & Rivara, F.P. (1998). A training program to improve domestic violence identification and management in primary care: Preliminary results. *Violence and Victims 13*(4), 395–410.

Tobin, G.A., & Begley, C.M. (2004). Methodological rigour within a qualitative framework. *Journal of Advanced Nursing, 48*(4), 388–396.

Tower, M., & McMurray, A. (2006). Domestic violence, health and health care: Women's accounts of their experiences. *Contemporary Nurse, 21*(2), 186–198.

Varcoe C. (2001). Abuse obscured: an ethnographic account of emergency nursing in relation to violence against women. *Canadian Journal of Nursing Research, 32*, 95–115.

Warren, D.W., Jarvis, A., LeBlanc, L., & Gravel, J. (2008). Revisions to the Canadian triage and acuity scale paediatric guidelines (PaedCTAS). *Canadian Journal of Emergency Medicine, 10*(3), 224–232.

Wathen, C.N., Jamieson, E., & MacMillan, H.L. and the McMaster Violence Against Women Research Group (2008). Who is identified by screening for intimate partner violence? *Women's Health Issues, 18*, 423–432.

Wathen, C.N., & MacMillan, H.L. (2003). Interventions for violence against women: Scientific review. *Journal of American Medical Association, 289*, 589–600.

Wathen, C.N., Tanaka, M., Catallo, C., Lebner, A.C., Friedman, M.K., Hanson, M.D., Freeman, C., Jack, S.M., Jamieson, E., MacMillan, H.L. and the McMaster IPV Education Research Team. (2009). Are clinicians being prepared to care for abused women? A survey of health professional education in Ontario, Canada. *BMC Medical Education, 9:34.*

Wong, S.L.F., Wester, F., Mol, S., Romkens, R., Hezemans, D., Lagro-Jansssen, T. (2008). Talking matters: Abused women's views on disclosure of intimate partner abuse to the family doctor and its role in handling the abuse situation. *Patient Education and Counseling, 70*, 386–394.

Yam, M., & Oradell, N.J. (2000). Seen but not heard: Battered women's perceptions of the ED experience. *Journal of Emergency Nursing, 26*(5), 464–470.

Zimmerman, P.G. (2001). The case for a universal, valid, reliable 5-tier triage acuity scale for US emergency departments. *Journal of Emergency Nursing, 27*(3), 246–54.

Zink, T., Elder, N., Jacobson, J., & Klosterman, B. (2004). Medical management of intimate partner violence considering the stages of change: Precontemplation and contemplation. *Annals of Family Medicine, 2*, 231–239.

Appendix A:

Quality Appraisal Criteria for Systematic Reviews[9]

Appraisal Criteria
1. Source and description
2. Are the results of the study valid?
3. Were the criteria used to select the articles for inclusion appropriate?
4. Is it unlikely that important relevant studies were missed?
5. Was the validity of the included studies appraised?
6. Were assessments of studies reproducible?
7. Were the results similar from study to study?
8. What are the overall results?
9. Are these results applicable to IPV disclosure in urban emergency departments?

[9]Oxman, A.D., Cook, D.J., & Guyatt, G.H. (1994). Users' guides to the medical literature. VI. How to use an overview. *Journal of the American Medical Association, 272*(17), 1367–1371.

Appendix B:

Quality Appraisal Criteria for Primary Studies[10]

Appraisal Criteria
1. Source and description
Are the Results of the Study Valid?
2. Were the participants randomized?
3. Was randomization concealed? (e.g. blinding of participants, clinicians, outcome assessors?
4. Were participants analyzed in the groups to which they were randomized?
5. Were participants in the treatment and control groups similar with respect to known prognostic variables?
6. Was follow-up complete? Was there a report of dropouts, withdrawals and losses?
7. What are results?
8. Are the concluding results consistent with those presented in the analysis
9. Are the results applicable to this paper's question?

[10]Guyatt, G.H., Sackett, D.L., & Cook, D.J. (1993). Users' guides to the medical literature. II. How to use an article about therapy or prevention. *Journal of the American Medical Association, 270*(21), 2598–2601.

Appendix C:

Quality Appraisal for Qualitative Studies[11]

Quality Appraisal Criteria for Qualitative Studies
1. What was the worth and relevance of the study?
2. How has the study contributed to knowledge?
3. By the end of the research process, was the research question clear?
4. Was the research design appropriate for the question?
5. Was the context or setting adequately described? Could findings be transferrable to other settings?
6. Did the sample include the full range of possible causes or setting?
7. Were efforts made to obtain data that might contradict or modify the analysis extending or modifying the sample?
8. Were the data collection and analysis procedures systematic?
9. Was an "audit trail" provided?
10. How well did the analysis succeed in incorporating all of the observations?
11. Did the analysis develop concepts and categories capable of explaining key processes?
12. Was it possible to follow iteration between data and theory?
13. Did the researcher search for disconfirming cases?
14. Did the researcher assess the likely impact of the methods used on the data obtained?
15. Was sufficient data included in the reports to provide sufficient evidence to assess whether or not analytic criteria were met?

[11]Robinson, L., & Spilsbury, K. (2008). Systematic review of the perceptions and experiences of accessing health services by adult victims of domestic violence. *Health and Social Care in the Community, 16*(1), 16–30.
Mays, N., & Pope, C. (2000). Qualitative research in health care: Assessing quality in qualitative research. *British Medical Journal, 320*, 50–52.

Appendix D:

Inclusion and Exclusion Criteria for the Randomized, Controlled Trial

Inclusion Criteria	Exclusion Criteria
Women between the ages of 18 and 64 years of age.	Women accompanied by individuals from whom they will not or cannot separate (i.e. a dependent child; the abusive partner) Non-English speaking women
Women who present at one of the above specified settings for a health care visit (women who accompany another person(s) for a visit will not be asked to complete the screen) and give informed consent to participate.	Women who are unable to participate due to acute medical or psychiatric illness

Appendix E:

Woman Abuse Screening Tool[12]

These questions ask you about your experiences in intimate relationships in the last 12 months. By intimate relationship we mean a husband, partner or boyfriend/girlfriend for longer than one month. If you have had more than on partner in the last 12 months, please answer these questions about the person you were with the longest, or if it applies, the person who was abusive towards you. If you have had more than one partner who has been abusive, choose the most recent.

Please circle the answer that best describes your relationship.

In the last 12 months...	2	1	0
In general how would you describe your relationship...	A lot of tension	Some tension	No tension
Did you and your partner work out arguments with ...	A lot of difficulty	Some difficulty	No difficulty
Did arguments ever result in you feeling put down or bad about yourself?	Often	Sometimes	Never
Did arguments ever result in hitting, kicking or pushing?	Often	Sometimes	Never
Did you ever feel frightened by what your partner says or does?	Often	Sometimes	Never
Has your partner ever abused you physically?	Often	Sometimes	Never
Has your partner ever abused you emotionally?	Often	Sometimes	Never
Has your partner ever abused you sexually?	Often	Sometimes	Never

[12]Brown, J.B., Lent, B., Schmidt, G., & Sas, G. (2000). Application of the woman abuse screening tool (WAST) and the WAST-short in the family practice setting. *Journal of Family Practice, 49*(10), 896–903.

Appendix F:

The Composite Abuse Scale[13]

This section asks about your experiences in adult intimate relationships. By adult intimate relationship we mean a husband, partner or boyfriend/girlfriend for longer than one month.

If you have had more than one partner in the last 12 months, please answer these questions about the person you were with the **longest**, or if it applies, the person who was **abusive** towards you.

If you have had more than one partner who has been abusive, choose the most **recent**. We would like to know if you experienced any of the actions listed below and how often it happened in the past 12 months. Please circle the number which matches the frequency, over a 12 month period that it happened to you.

0 = Never
1 = Only once
2 = Several times
3 = Once a month
4 = Once a week
5 = Daily

		Never	Only once	Several times	Once a month	Once a week	Daily
1	Told me that I wasn't good enough.	0	1	2	3	4	5
2	Kept me from medical care.	0	1	2	3	4	5
3	Followed me.	0	1	2	3	4	5
4	Tried to turn my family, friends and children against me.	0	1	2	3	4	5
5	Locked me in the bedroom.	0	1	2	3	4	5

[13]Hegarty, K., Sheehan, M., & Schonfield, D. (1999). A multidimensional definition of partner abuse: Development and preliminary validation of the composite abuse scale. *Journal of Family Violence, 14*(4), 399–415.

Appendix F Continued:

The Composite Abuse Scale

6	Slapped me.	0	1	2	3	4	5
7	Forced me to have sex.	0	1	2	3	4	5
8	Told me that I was ugly.	0	1	2	3	4	5
9	Tried to keep me from seeing or talking to my family.	0	1	2	3	4	5
10	Threw me.	0	1	2	3	4	5
11	Hung around outside my house.	0	1	2	3	4	5
12	Blamed me for causing their violent behaviour.	0	1	2	3	4	5
13	Harassed me over the telephone.	0	1	2	3	4	5
14	Shook me.	0	1	2	3	4	5
15	Tried to force me to have sex.	0	1	2	3	4	5
16	Harassed me at work.	0	1	2	3	4	5
17	Pushed, grabbed or shoved me.	0	1	2	3	4	5
18	Used a knife or gun or other weapon.	0	1	2	3	4	5
19	Became upset if dinner/housework wasn't done when they thought it should be.	0	1	2	3	4	5
20	Told me that I was crazy.	0	1	2	3	4	5
21	Told me that no one would ever want me.	0	1	2	3	4	5
22	Took my wallet and left me stranded.	0	1	2	3	4	5
23	Hit or tried to hit me with something.	0	1	2	3	4	5
24	Did not want me to socialize with my female friends.	0	1	2	3	4	5
25	Made me perform sex acts that I did not enjoy or like.	0	1	2	3	4	5
26	Refused to let me work outside the home.	0	1	2	3	4	5
27	Kicked me, bit me or hit me with a fist.	0	1	2	3	4	5
28	Tried to convince my friends, family or children that I was crazy.	0	1	2	3	4	5

Appendix F Continued:

The Composite Abuse Scale

29	Told me that I was stupid.	0	1	2	3	4	5
30	Beat me up.	0	1	2	3	4	5

Appendix G:

Clinical Actions Questionnaire

These questions ask about the care related to intimate partner violence that you may have received during your visit:	
1. Did you discuss the issue of intimate partner violence during your visit with the health care provider (e.g. doctor, nurse) today?	
☐Yes ☐Nurse ☐Doctor ☐Other, specify	☐No
2. Please indicate which of the following things the health care provider did (if any) during your discussion about violence today:	
☐Acknowledged my disclosure of violence/abuse	
☐Supported my feelings	
☐Assured me that there are options to get help	
☐Provided some verbal information or education about woman abuse	
☐Gave me written information (different that what the researcher gave me)	
☐Discussed the situation and asked me if I wanted to get help	
☐If yes, helped me to decide what type of help to get	
☐Offered to link me directly to services	
☐Yes, I wanted to be linked to services today	☐No, I did not want to be linked to services today
☐Asked me about my immediate safety	
☐Discussed ways for me to keep safe	
3. Please indicate if the health care provider referred you to any of the following services during your discussion about violence today (check all that apply):	
☐Not applicable	
☐Services in this location (specify)	
☐Domestic violence/sexual assault care team	
☐Counselling (social work, psychology etc.)	
☐Other: services in the community (not this location)	
☐Shelter for abused women	
☐Hotline or other phone-based service	
☐Other:	
4. Did the health care provider take any other actions or discuss anything else with you today that was related to violence? Specify:	
5. Did you take any brochures or other information about partner violence from this location today (other than that given to you by the researcher or health provider)?	
☐Yes	☐No

Thank-You

Appendix H:

Hypotheses Generated After Quantitative Sub-Analysis

Phase 1 Results Requiring Explanation	Potential Hypotheses or Considerations for Qualitative Phase
Influence of the IPV screening instruments	Participation in a research study or completion of the screening instrument (e.g. WAST) may have encouraged participant's decisions for or against disclosure of IPV during the acute care visit
Knowledge that HCP may initiate discussion of IPV	For screen group participants — being informed by research assistant that health care provider may make inquiries may have encouraged participant's decisions for or against disclosure of IPV during the acute care visit
Discussion of IPV was not relevant	Participants determined that the visit to the acute care setting were for reasons other than IPV
IPV not identified by participant Unknown reasons	Participant may not have realized that she was involved in a violent relationship. IPV not viewed as a problem. Participant was uncertain about whether or not to discuss IPV with the clinician
Other reasons	Reasons women identified that encouraged or discouraged them to disclose IPV in an acute care setting

Appendix I:

Criteria for Initial Purposeful Sampling in Grounded Theory Component

Number	Inclusion Criteria for Purposeful Sample
1	Women 18 years or older enrolled in the randomized, controlled trial on a screening day with a positive score for IPV (e.g. ≥4 WAST, ≥7 CAS).
2	Women from #1 who responded "Yes" to the following question from the Clinical Interactions instrument "Did you discuss the issue of intimate partner violence with a health care provider (e.g. doctor, nurse) today?"
3	Women who were healthy enough to participate in up to four 60-90 minute interviews
4	Women who could speak, read and write in English

Appendix J:

Interview Guide[14]

Sample of Interview Questions from Interview Guide (not in order)
1. How would you describe your experience with the doctor or the nurse when you were in the emergency department? Probe: for nature of the interaction, what promotes comfort, what are barriers to comfort, how the participant defines care and quality of care.
2. Tell me about your intimate relationship? Probe: for nature of relationships, whether participant acknowledges IPV, other questions relate to how participant defines problems in their relationship and how they go about solving these problems.
3. What is your opinion about discussing intimate partner violence with a doctor or nurse? What are some of the benefits/difficulties in talking with a doctor/nurse about violence? Other questions relate to identifying: barriers and facilitators, how participant would go about talking about IPV with a doctor or nurse, what issues related to IPV would/would not be discussed with a doctor/nurse
4. Now think about any times when you have spoken at all to your doctor or nurse about abuse in your relationship. In your opinion, did talking to the doctor or nurse change the amount of problems that you had in your relationship? What would you have liked to have happened?
5. At what point did you decide that you could talk about IPV in your relationship? Who did you talk to? What was happening at that time (e.g. probing for "turning point" event). At what point were you in your relationship (e.g. during abuse, after a severe injury, left partner)? When did you decide you could talk to a doctor/nurse? What type of doctor/nurse was it? At what point were you in your relationship (e.g. during abuse, after a severe injury, left partner)?
6. You mentioned that you are open and willing to talk about violence in an emergency department (ED) any time. Can you think of any reasons why you would avoid talking about abuse in an ED? What steps do you take to avoid talking about abuse?
7. Can you think of the steps that you take before getting ready to talk to a doctor/nurse about violence in your relationship? Are there different steps you would take when talking to a nurse?
8. Tell me about the ED environment? Describe what it is like? How would the ED support/inhibit talking about violence in your intimate relationship?
9. If you had a friend or a family member, someone close to you who was experiencing abuse, who would you encourage that person to tell about the abuse?

[14]Above is a selection of interview questions used throughout the four interviews with participants. Other questions may have also been used depending on the evolving nature of the analysis and emergent theory.

Appendix K:

Example Recruitment Script for Grounded Theory Component of Mixed Methods Study

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Sample Telephone Script

One of the researchers on the Women's Health Study team is interested in speaking with women about their experiences talking with doctors and nurses about violence their relationships. This is an opportunity for women to talk in a face-to-face format and does not include filling out survey forms. [Insert researcher name] may like to contact you to describe the interview and see if you are willing to participate at a time and place convenient to you. She is providing women who complete the one-hour interview with $25 in consideration for their time.

Appendix L:

Quantitative Sub-Analysis Results: Demographic Summary Across Screen and Non-Screen Groups

	Frequency (n)	Percentage	Mean
Age in years for total sample (N=1182)			*25-34 years*
18–24 years	259	21.9	
25–34 years	366	31.0	
35–44 years	262	22.2	
45–54 years	193	16.3	
55–64 years	90	7.6	
Unknown/not reported	12	1.0	
Marital status for total sample (N=1173)			*Common-Law*
Single, never married	342	29.1	
Married	66	5.6	
Common law	496	42.2	
Separated	59	5.0	
Divorced	203	17.3	
Widowed	8	0.7	
Missing	8	0.7	
Pregnancy status for total sample (N=1182)			*No*
Yes	46	3.9	
No	1086	91.9	
Don't know	49	4.1	
Missing	1	0.1	
Number of children at home for total (N=1182)			*1.45*
No children	533	45.1	
1 or more children	649	54.9	
Years of education for total (N=1182)			*13.92*
Less than 14 years	558	47.2	
Greater than 14 years	624	52.8	

Appendix L Continued:

Quantitative Sub-Analysis Results:
Demographic Summary Across Screen and Non-Screen Groups

Main activity for total (N=1182)			*Work full or part-time outside of the home*
Work full or part-time outside of the home	778	65.8	
Homemaker, student, unemployed, disabled	404	34.2	
Main source of income for total (N=1182)			*Wages or salary*
Wages or salary	430	36.4	
Partner's income, alimony or child support, social assistance	714	60.4	
Missing	38	3.2	
Household income for total (N=1182)			*$40,000-$62,000*
Less than $24,000	279	23.6	
$24,000–$39,999	287	24.3	
$40,000–$62,999	246	20.8	
$63,000–$89,999	196	16.6	
$90,000 and over	174	14.7	

Appendix M:

Quantitative Sub-Analysis Results: Summary of Intimate Partner Violence Exposure Status Across Screen and Non-Screen Groups

Participants Number (percent) N = 1182	Woman Abuse Screening Tool (WAST) Score	Composite Abuse Scale (CAS) Score	Overall Intimate Partner Violence (IPV) Exposure Status
174 (14.7%)	Positive	Positive	True Positive Score
118 (10.0%)	Positive	Negative	False Positive Score
20 (1.7%)	Negative	Positive	False Negative Score
870 (73.6%)	Negative	Negative	True Negative Score

Appendix N:

Quantitative Sub-Analysis Results:
Summary of Intimate Partner Violence Exposure Status Across Screen Group Only

Participants Number (percent) N = 563	Woman Abuse Screening Tool (WAST) Score	Composite Abuse Scale (CAS) Score	Overall Intimate Partner Violence (IPV) Exposure Status
71 (12.6%)	Positive	Positive	True Positive Score
57 (10.1%)	Positive	Negative	False Positive Score
10 (1.8%)	Negative	Positive	False Negative Score
425 (75.5%)	Negative	Negative	True Negative Score

Appendix O:

Quantitative Sub-Analysis Results: Summary of Intimate Partner Violence Disclosure Across Screen and Non-Screen Groups

Overall IPV Exposure Status	Disclosure of IPV in the ED According to the Participant (Using the Clinical Interactions Instrument)	
	Yes (%)	No (%)
Total	N=35	N=1147
True Positive Score	22 (62.9%)	152 (12.9%)
False Positive Score	11 (31.4%)	107 (9.1%)
False Negative Score	0	20 (1.7%)
True Negative Score	2 (5.7%)	868 (73.4%)

Appendix P:

Quantitative Sub-Analysis Results: Summary of Intimate Partner Violence Disclosure Across Screen Group Participants and Health Care Providers

Overall IPV Exposure Status	Disclosure of IPV in the ED According to the Participant (Using the Clinical Interactions Instrument) (N=563)		Disclosure of IPV in the ED According to the Health Care Provider (Using the Clinical Interactions Instrument) (N=48) (Missing = 515)	
	Yes (%)	No (%)	Yes (%)	No (%)
True Positive Score	20 (3.6%)	51 (9.1%)	26 (54.2%)	22 (45.8%)
False Positive Score	11 (1.9%)	46 (8.2%)	22 (45.8%)	26 (54.2%)
False Negative Score	0	10 (1.8%)	0	0
True Negative Score	1 (0.2%)	424 (75.3%)	0	0
Total	32 (5.7%)	531 (94.3%)	48 (100%)	48 (100%)

Appendix Q:

Quantitative Sub-Analysis Results: Summary of Clinical Interactions Offered by Health Care Providers According to Screen and Non-Screen Group Participants and Health Care Providers

Type of Clinical Interaction	Women Reported as Offered (N=36) (Missing N=563)	HCP Reported Offering To Women (N=48) (HCP Types, Physician N=10, Nurse N=38) (Missing N=515)
Acknowledged disclosure of IPV	13 (36%)	18 (37.5%)
Provision of verbal information or education on IPV	13 (36%)	15 (31.3%)
Validated or supported feelings	6 (16.7%)	13 (27.1%)
Provided written information if safe to do so	6 (16.7%)	5 (10.4%)
Information regarding options to obtain help	15 (41.7%)	15 (31.3%)
Discussion of relationship situation and inquiry about need for help	8 (22.2%)	15 (31.3%)
Decision making about type of help to obtain	1 (2.8%)	2 (4.2%)
Assessment of immediate safety	13 (36.1%)	13 (27.1%)

Appendix Q Continued:

Quantitative Sub-Analysis Results: Summary of Clinical Interactions Offered by Health Care Providers According to Screen and Non-Screen Group Participants and Health Care Providers

Provision of referral to Domestic Violence Sexual Assault Care Centre	3 (8.3%)	39 (81.3%)
Counseling/social work	3 (8.3%)	1 (2.1%)
Women's shelter	3 (8.3%)	1 (2.1%)
Telephone help line	3 (8.3%)	2 (4.2%)
Other clinical actions taken	2 (5.6%)	5 (10.4%)
Discussed ways to keep safe	2 (5.6%)	5 (10.4%)

Appendix R:

Ethics Approval Notification--McMaster University

McMaster University

Hamilton Health Sciences

RESEARCH ETHICS BOARD

March 28, 2006

PROJECT NUMBER: 06-138

PROJECT TITLE: Women's Disclosure of Intimate Partner Violence to Health Care Providers in Urban Emergency Department Settings: A Grounded Theory Study

PRINCIPAL INVESTIGATOR: Cristina Catallo/Donna Ciliska

This will acknowledge receipt of your above-named study submitted to the Research Ethics Board. As requested we have provided an expedited approval for your study. This study has been reviewed and approved by members of the REB Executive and has been given an expedited *final* approval. The research protocol dated March 18, 2006 including the Participant Information Sheet and the Consent Form was found to be acceptable on both ethical and scientific grounds. This study will be presented for information to the full Research Ethics Board at their meeting to be held on April 18, 2006. ***Please note*** attached you will find the Information Sheet/Consent forms with the REB approval affixed; all consent forms and recruitment materials used in this study must be copies of the attached materials.

We are pleased to issue final approval for the above-named study for a period of 12 months from the date of this letter. Continuation beyond that date will require further review and renewal of REB approval. Any changes or amendments to the protocol or consent form must be approved by the Research Ethics Board.

We wish to advise the Research Ethics Board operates in compliance with ICH Good Clinical Practice Guidelines and the Tri-Council Policy Statement.

Investigators in the Project should be aware that they are responsible for ensuring that a complete consent form is inserted in the patient's health record. In the case of invasive or otherwise risky research, the investigator might consider the advisability of keeping personal copies.

A condition of approval is that the physician most responsible for the care of the patient is informed that the patient has agreed to enter the study. Any failure to meet this condition means that Research Ethics Board approval for the project has been withdrawn.

PLEASE QUOTE THE ABOVE-REFERENCED PROJECT NUMBER ON ALL FUTURE CORRESPONDENCE

Sincerely,

F. Jack Holland, MD, FRCP, FRCP(C)
Chair, Research Ethics Board

/dm

All correspondence should be addressed to the REB Chair and forwarded to:
REB Coordinator, Hamilton Health Sciences, REB Office
1057 Main Street West, Suite 1
Hamilton ON L8S 1B7
Telephone: 905-521-2100, Ext. 42013
Fax: 905-577-8379

Appendix S:

Ethics Approval Notification--Niagara Health System

NIAGARA HEALTH SYSTEM
SYSTÈME DE SANTÉ DE NIAGARA

Niagara Health System Research Ethics Board
65 Third Street Welland, Ontario, Canada L3B 4W8
Tel. (905) 378-4647 Ext 32202 Fax: (905) 732-2928

May 30, 2006

Ms. Cristina Catallo, RN, BScN, PhD (Student)
Faculty of Health Sciences, School of Nursing
153 Beecroft Road, Unit 615
Toronto, Ontario
M2N 7C5

Dear Ms. Catallo:

Re: Women's Disclosure of Intimate Partner Violence to Health Care Providers in Urban Emergency Department Settings: A Grounded Theory Study

On behalf of the Niagara Health System Research Ethics Board (REB) we would like to thank you for submitting the above noted new application.

This letter will confirm that the Niagara Health System Research Ethics Board (REB) at a full board meeting on Thursday, May 25, 2006 has received and reviewed the above named new application. The Board member's comments on how well this application was completed. This study has been conditionally approved in principle based on the following clarifications required:

- A Locally Responsible Investigator would need to be appointed within the Niagara Health System

The Niagara Health System Research Ethics Board is in compliance with the Tri-Council Policy Statement: Ethical Conduct for Research Involving Human (TCPS), and the International Conference on Harmonization: Good Clinical Practice guidelines for REB's, as well as the Food and Drug Administration (U.S. FDA) and the Therapeutic Products Directorate (Health Canada TPD). As the Primary Investigator you are required to notify the REB of any amendments or changes in the protocol, significant protocol deviations, or termination of this project.

Should you require anything further, please do not hesitate to contact me through the REB office at: 905-378-4647, ext 32202.

Sincerely,

Dr. K. Greenway, Chair
Research Ethics Board
Niagara Health System

/atc

Cc: Dr. Donna Ciliska (Thesis Supervisor for PhD Current Study)
Dr. Daniel MacMillan (Co-Investigator)
Professor Helen Thomas (Co-Investigator)
Dr. Susan Jack (Co-Investigator)

Appendix T:

Ethics Approval Notification--St. Joseph's Healthcare

St. Joseph's Healthcare Hamilton

McMaster University

50 CHARLTON AVENUE EAST, HAMILTON, ONTARIO, CANADA L8N 4A6

RESEARCH ETHICS BOARD

Tel. (905) 522-4941 ext. 3537 Fax: (905) 521-6092

September 22, 2006

Dr. Karen Woolfrey
Emergency Medicine
St. Joseph's Healthcare Hamilton

Dear Dr. Woolfrey:

RE: R.P. #06-2718: Women's disclosure of intimate partner violence to health care providers in urban emergency department settings: a grounded theory study - **Protocol dated Aug 25 2006 by REB, Information/consent form with REB approval stamp Sep 22 2006, Qualitative Study Eligibility Criteria, Revised Script for Recruitment, Revised Interview Procedures and Guide, Attachment 6: RCT Safety Protocol, IIHS McMaster REB approval, Niagara Health System REB approval, Thesis dated March 18, 2006**

The Research Ethics Board reviewed R.P. #06-2718 at its meeting on September 18, 2006 and approved it with some conditions. Those conditions have now been met. You have final approval to commence your research.

This approval will be for a one-year period **ending September 22, 2007.** We will request a progress report at that time.

If your project is terminated, it is your responsibility to notify the REB. Any changes or amendments to the protocol or consent form must be approved by the Research Ethics Board prior to implementation.

Please ensure that all study personnel are familiar with the REB requirements on the appended page.

Please reference R.P. #06-2718 in any future correspondence.

We wish you well in the completion of this research.

Sincerely yours,

Raelene Rathbone

Raelene Rathbone, MB, BS, MD, PhD
Chairperson, Research Ethics Board
RR:ah

cc: Marnie Fletcher - Mary Jane Sayles - Dr. Lisa Dolovich - Cristina Catallo
Appeal

Appendix U:

Participant Information Form

Attachment 1
Participant Information Form

Purpose: You are being asked to volunteer for a research study from McMaster University. This study is led by Cristina Catallo RN, BScN, PhD (student). Cristina will ask you questions about women, abuse and talking to a doctor or nurse. This study will help researchers understand what it is like for women to talk about abuse with doctors and nurses.

Procedures: If you agree to be in the study, the interview will take about 1 hour. For the whole study, you will be invited for two in-person interviews. These will be audio-taped.

Confidentiality: All information about you will be kept confidential. No one will be able to identify you. Study materials will be kept in a locked file or a computer with a secret password. Information will not be shared with anyone else outside of the research team. All study tapes will be kept in a locked drawer. Your name will not be on the tape. When the study is over, all tapes will be destroyed. If the study is published, no one will know that you participated. Your doctor or nurse will not know that you were in this study. The study will have to call Children's Aid Society if you provide information about a child that experienced harm or is at risk of harm. This law is the same for any health care professional.

Risks/Benefits: There are no known risks to you by answering these questions or being in this study. Some women who are abused may be at risk for more abuse if they choose to leave their partner. If you experience any personal discomfort it will be responded to by a member of the study staff. You will receive an information card with local services for woman abuse. You can choose to destroy this card, or any study material, if it is not safe to take home with you.

Your participation in this study is voluntary. You can refuse to participate. You can refuse to answer any questions. You can leave the study at any time. There will be no effect on you or on any services if you want to use them (now or in the future).

Compensation: You will be given a $25 honorarium for each interview that I finish. If you need it, you can receive cash assistance for transportation and child care costs.

If you have any questions, please call Cristina Catallo at 1-800 - or email her at catal.c@mcmaster.ca . You may also contact her thesis supervisor Dr. Donna Ciliska at (905) 525-9140 x22529. Thank you very much for your help.

Appendix V:

Participant Consent Form

Attachment 2
Participant Consent Form

Purpose: I am being asked to volunteer for a research study from McMaster University. This study is led by Cristina Catallo RN, BScN, PhD (student). Cristina will ask me questions about women, abuse and talking to a doctor or nurse. This study will help researchers understand what it is like for women to talk about abuse with doctors and nurses.

Procedures: If I agree to be in the study, the interview will take about 1 hour. For the whole study there will be two interviews with Cristina Catallo from McMaster University. Cristina will audio-tape the interviews.

Confidentiality: All my information will be kept confidential. No one will be able to identify me. Study materials will be kept in a locked file or a computer with a secret password. Information will not be shared with anyone else outside of the research team. All study tapes will be kept in a locked drawer. My name will not be on the tape. When the study is over, all tapes will be destroyed. If this study is published, no one will know that I was in the study. My doctor or nurse will not know. The study will have to call Children's Aid Society if I provide information about a child that experienced harm or is at risk of harm. This law is the same for any health care professional.

Risks/Benefits: There are no known risks to me by answering these questions or being in this study. Some women who are abused may be at risk for more abuse if they choose to leave their partner. I have been told that the study staff will respond to any personal discomfort I experience. I will receive an information card with local services for woman abuse. I can choose to destroy this card, or any study material, if it is not safe to take home with me.

I know that **my participation in this study is voluntary.** I can refuse to participate. I can refuse to answer any questions. I can leave the study at any time. There will be no effect on me or on any services if I want to use them (now or in the future).

Compensation: I will be given a $25 honorarium for each interview that I finish. If I need it, I can receive cash assistance for transportation and child care costs.
I will receive a signed copy of this form.

If I have any questions about my rights in a research study, I will contact the Hamilton Health Sciences Patient Relations Specialist at 905-521-2100 Ext. 75240.

I fully understand the nature of this consent as explained to me by _____ and agree to participate in this study.

_____ _____ _____
Signature of Participant Print Name Date

I, the undersigned, have fully explained the study to the above person.

Appendix W:

Women's Health Study Safety Protocol

Participant Safety--Follow-up Interviews (Baseline through 18 months):

1. All research team members will have a regional list of shelters and other services for abused and sexually assaulted women with them during all contacts with participants. Research assistants will provide referral information as needed if the woman agrees.

2. During the initial discussion with the participant, the research assistant will:
   (a) Explain that the honorarium will be paid in cash
   (b) At each face-to-face contact, assist the woman to assess her risk of participating in the study, if any, by reviewing:
   i) The degree of continuing harassment and abuse ongoing by the partner
   ii) Physical proximity to the abuser (e.g. same house/city?) and level of contact
   iii) Status of any restraining orders
   iv) Any ongoing disputes or court cases related to relationship
   v) Potential risks during phone contacts and face-to-face interviews
   vi) Potential risks of participant keeping written study materials
   (c) Help women who choose to participate to:
   i) Review participant's preferred means of contact by the research team for follow-up
   ii) Decide the best time for the first telephone interview
   iii) Develop a safety plan regarding: where she would like to keep the letter of information (i.e. take home or keep on file at research office); leaving messages for the woman; what the research assistant should do if a phone call is suddenly terminated (e.g. call back, wait for woman to call back, call a neighbour or friend to check on her, call police); the best location for face-to-face interviews (woman's home, university, or other safe location). Research assistant will encourage the woman to consider her visibility, particularly in small communities, and will have alternate locations to offer such as a shelter, or a conference room in a health care facility; care of children while participating in the study; what the woman will do if she decides on the day of the interview that the situation is unsafe (e.g. someone comes to her home at the scheduled interview time, she is followed to the interview or seen by someone whom she perceives is a threat). Women will be provided with a cell phone number for the interviewer
   (d) The research assistant will record the collected information and safety plan on a contact sheet designed for this purpose.

Appendix W Continued:

Women's Health Study Safety Protocol

3. During each subsequent contact with the woman, research assistants will:
   (a) Determine if it is safe to talk at the beginning of the conversation
   (b) Reaffirm consent to proceed
   (c) Update how to safely contact the participant and the contact information, recording it on the contact sheet
   (d) At face-to-face contacts, review the risk assessment
   (e) Confirm when the next contact will be
   (f) Avoid leaving the interview location with the participant. The research assistant may provide money for transportation or otherwise reimburse the woman for any expenses related to participating in the interview, as necessary.

Research Assistant Safety (Index through to 18 months):

1. At each site, the site coordinator will establish a protocol for researcher safety, which includes:
   (a) Equipping research assistants with cellular phones
   (b) Avoiding scheduling more than three interviews daily per research assistant
   (c) Providing the research assistant with explicit directions indicated by the participant how best to contact her
   (d) Establishing with the research assistant a plan for:
      i) Informing the clinical coordinator or alternate of the date, time, and location of the interview
      ii) Checking in with the clinical coordinator or alternate when interview is completed (establish a time by which the research assistant will call)
      iii) What to do if the research assistant does not notify the clinical coordinator or alternate within a reasonable time
      iv) Being aware of potential emotional attachment on the part of the participant
      v) Maintaining a non-judgmental, professional detachment when interviewing or contacting the participant

2. Research assistants will participate in a training session regarding the safety of participants and research assistants in this study. General guidelines for research assistant safety include:
   (a) Knowing the interview location, approaching the interview confidently, organizing necessary materials and bringing only essentials to the interview
   (b) Ensuring that study cell phone is charged and carried on person (i.e.

Appendix W Continued:

Women's Health Study Safety Protocol

not in purse or case) during interview and while travelling to and from interview
(c) Observing the neighbourhood before leaving vehicle, and being alert for signs of risk in the interview location (e.g. listening for a minute from outside the door for excessive banging, yelling, etc.)
(d) Wearing clothes and accessories that do not attract attention
(e) Limiting personal items carried to interview
(f) Ensuring that vehicle is in good state of repair (i.e. gas, tires)
(g) Avoiding conspicuous rental cars
(h) Avoiding giving out personal information or carrying items that display identifying information (car keys, for example, often have identifiable items on them)
(i) Being aware of their safety zone (three feet around them) in identifying and responding to a threat. If this space is threatened, they should follow their instincts to leave if they feel that something is unusual or they feel uncomfortable
(j) Deciding on a team safety code phrase to be used while speaking to another team member to indicate danger and to call the police (e.g., "Please tell Mr. Alphonse that I won't be able to meet with him today")
(k) Not resisting attempts to grab purse or equipment
(l) Looking for anyone following them after the interview and going to a neutral site (e.g. coffee shop) rather than directly home

SAFETY PLANNING

When doing safety planning with a woman it is important to have a clear understanding of the resources available, before they are presented as options. If there are conditions or requirements for access the research assistant must be aware of them. If there are barriers to a resource it is not an option.

Options that are presented are made in response to the reviewed risk analysis and built on a woman's safety plan. They must be explained as to how they will proceed, steps involved, the usual timetable, roles of the people involved, decisions that will be needed along the way and what influence if any the woman can have.

Safety planning may include strategies for staying and leaving. We must build on the woman's plan and avoid preconceived notions of what will make a woman or her children safer.

Appendix W Continued:

Women's Health Study Safety Protocol

SAFETY PLANNING GUIDE

If an individual decides to remain with her partner or leave the relationship, the following guide provides some information for ensuring that process includes some measures to increase an individual's safety, though by no means guarantees it.

In case of an Emergency, do you have...

- passports, birth certificates, immigration papers
- school and vaccination records
- medications, prescriptions, medical records
- social assistance identification
- work permits
- divorce papers, custody documentation, court orders, restraining orders, marriage certificate
- lease/rental agreement, house deed, mortgage payment book
- bank books
- insurance papers
- address/telephone book
- picture of spouse/partner
- health cards
- all cards you normally use (e.g. VISA, phone, social insurance. ATM)

Is it possible to store any or all of these documents outside the house (e.g. at a friend's house, in a safety deposit box)?

If not, can you keep them all in a box or bag that can be hidden near an exit?

Do you know that your community has agencies to help women who are being hurt or intimidated by their partners/husbands/boyfriends?

In Hamilton there are/is...

- a women's centre
- shelters--Interval House, Inasmuch House, Martha House
- an immigrant women's centre
- an Aboriginal women's centre
- a legal clinic

You can use services at these agencies whether or not you leave your partner.

Appendix W Continued:

Women's Health Study Safety Protocol

You can access these services immediately or you can wait until you are ready to use any of them.

Are there some Informal Supports you might be able to use to increase your safety?

- Can you tell your neighbours to call the police if they hear a fight or screaming in your house?
- Can you tell the people who take care of your children which people have permission to pick up your children?
- Can you tell people in your neighbourhood that your partner no longer lives with you, and they should call the police if they are seen near your home? You may want to give them a picture and a description of their car.
- Can you ask your neighbours to look after your children in an emergency?
- Can you hide clothing and your Emergency Escape Plan items at a neighbour's house?

In an Emergency

- Start to position yourself to get out quickly or near a phone so you can call 911, if necessary.
- If an argument seems unavoidable, try to have it in a room or area that has access to an exit. Avoid the bathroom, kitchen or anywhere near weapons.
- Do you have a code word to use with your children so they know to call for help?
- Use your judgment and intuition - if the situation is very serious, you can agree with your partner or give him/her what s/he wants to calm him/her down. You have to protect yourself until you are out of danger.
- When or after you have been assaulted, call the police at 911 if you can. Leave the phone off the hook after your call.
- Make as much noise as possible so that the neighbours may call the police for you.

Safety When Preparing to Leave

- Do you know anyone who would let you stay with them and/or lend you money?
- Always try to take your children with you or make arrangements to leave them with someone safe. If you try to get them later, the police cannot help you remove them from the other parent unless you have a valid court order.
- Can you leave money, an extra set of keys, copies of important documents and extra clothes with someone you trust?

Appendix W Continued:

Women's Health Study Safety Protocol

- Do you have a savings account in your own name? If not, can you open one at a bank where your partner does not do his/her banking? Arrange that no bank statements or other calls are made to you.
- Keep shelter numbers close at hand and keep change or a calling card with you at all times.
- Could you consider getting a safety deposit box at a bank that your partner does not go to?

A Child's Safety Plan

- Have your children pick a safe room/place in the house, preferably with a lock on the door and a phone.
- The first step of any plan is for the children to get out of the room where the abuse is occurring.
- Stress the importance of being safe, and that it is not the child's responsibility to make sure their mother is safe.
- Teach your children how to call for help. It is important that children know they should not use a phone that is in view of the abuser. This puts them at risk. Talk to your child about using a neighbour's phone or a pay phone if they can not use a phone at home. If you have a cell phone teach your child how to use it.
- Ensure children know their full name and address.
- Rehearse the telephone call with your child.
- It is important for the child to leave the phone off the hook so that the police do not call back.

Provide handouts with this information if deemed appropriate.

Appendix W Continued:

Women's Health Study Safety Protocol

SAFETY FOR RESEARCH ASSISTANTS AND PARTICIPANTS

- The research assistant and participant should always meet in a public place.
- Before entering and leaving the meeting spot, the research assistant should be aware of her surroundings. (e.g. stop and listen before leaving car etc.)
- While interviewing the participant, the research assistant should be aware of her environment.
- Caution should be exercised when discussing the participant, so that her name or her whereabouts is not unintentionally disclosed.
- Research assistants should never escort a participant from the meeting place.
- Staff phone numbers must never be given out.
- Discuss a plan with the participant in the event an abusive partner shows up at meeting place unannounced (e.g. plan ahead of time that you will leave premises and notify police).
- Avoid confronting an abusive partner.
- The name of our participants must never be released. If for any reason a call gets forwarded, disclose nothing. You can respond by saying, "Who is calling? May I have your number? That name is not familiar to me, but I can check and get back to you?" If the woman is still present you can check the name and number with her. Never say, 'I am not allowed to give out any information'. Just say 'no, I don't have anyone here by that name'.
- Avoid emotional attachments with participants and their families. Maintain a sense of professional objectivity.
- Call clinical coordinator or delegate to problem solve, debrief or for help planning for personal safety as a research assistant.

Appendix X

Recruitment Flow Diagram For Mixed Methods Study

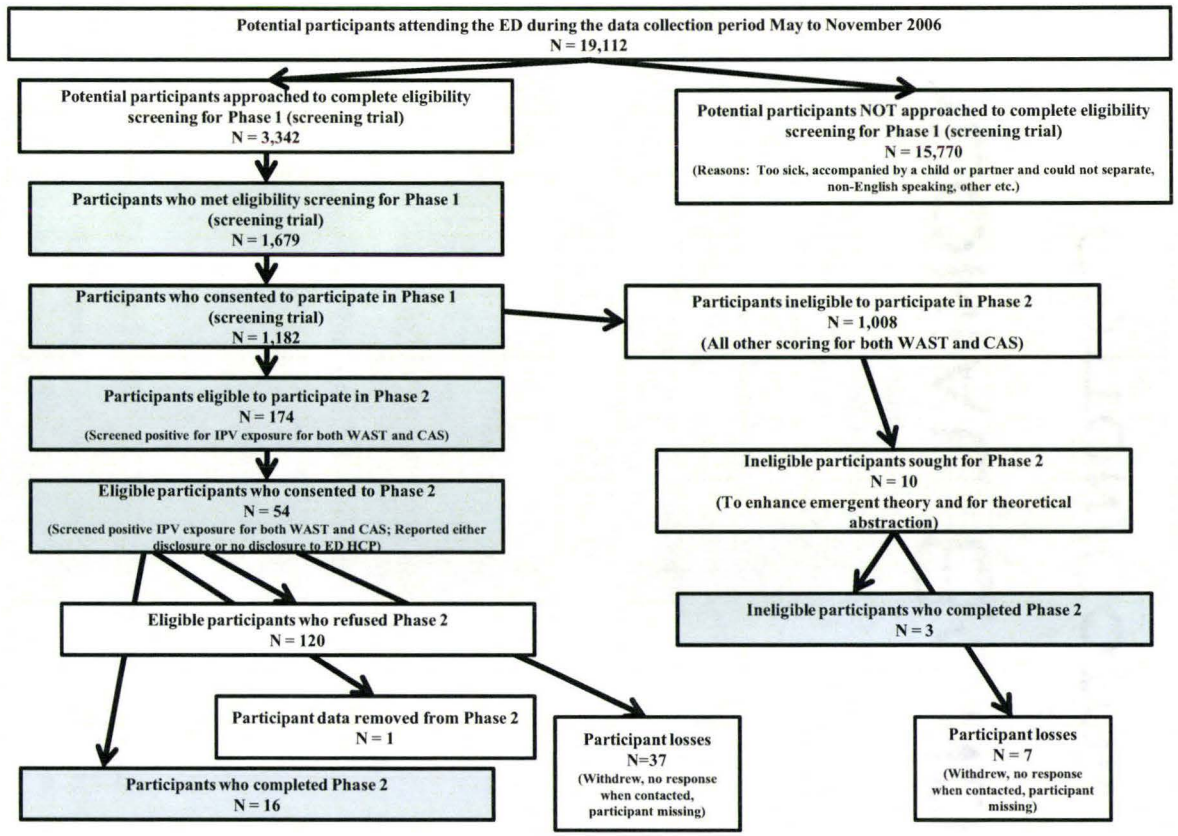

Figure 2. Participant Recruitment for Phase 1 and 2

Appendix Y

Canadian Triage and Acuity Scale[15]

Canadian Triage and Acuity Scale Level	Description of Example Cases
CTAS 1	Resuscitation--Conditions that are threats to life or limb (or imminent risk of deterioration) requiring immediate aggressive interventions. Examples: Cardiac or respiratory arrest, major trauma, shock states, unconscious patients, severe respiratory distress.
CTAS II	Emergent--Conditions that are a potential threat to life limb or function, requiring rapid medical intervention or delegated acts. Examples: altered mental states, head injury, severe trauma, neonates, myocardial infarction, overdose and cerebral vascular accident.
CTAS III	Urgent--Conditions that could potentially progress to a serious problem requiring emergency intervention. May be associated with significant discomfort or affecting ability to function at work or activities of daily living. Examples: moderate trauma, asthma, gastrointestinal bleed, vaginal bleeding and pregnancy, acute psychosis and/or suicidal thoughts and acute pain.

[15]Canadian Triage and Acuity Scale Levels I–V as adapted from the Canadian Association of Emergency Physicians. (1999). Canadian emergency department triage and acuity scale implementation guidelines. *Journal of Canadian Association of Emergency Physicians, 1*(Suppl): s1–s16.

Appendix Y Continued

Canadian Triage and Acuity Scale

CTAS IV	Less Urgent--Conditions that are related to patient age, distress, or potential for deterioration or complications would benefit from intervention or reassurance within 1–2 hours). Examples: headache, corneal foreign body and chronic back pain.
CTAS V	Non Urgent--Conditions that may be acute but non-urgent as well as conditions which may be part of a chronic problem with or without evidence of deterioration. The investigation or interventions for some of these illnesses or injuries could be delayed or even referred to other areas of the hospital or health care system. Examples: sore throat, URI, mild abdominal pain which is chronic or recurring, with normal vital signs, vomiting alone and diarrhea alone.