Author's response to reviews

Title: Preparedness to provide nursing care to women exposed to intimate partner violence: a quantitative study in primary health care in Sweden

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Author's response to reviews: see over
Thank you for your valuable comments that have helped us to improve this manuscript ‘Preparedness and intimate partner violence in Primary Health Care: A quantitative study among district nurses in Sweden’. A point-by-point description of the revisions can be found below.

Please note that our extracts from the manuscript are in italics.

Revisions

Comments on the report of reviewer dr. Angela Taft

1. Background
   Comments:
   1a. Context: Readers need to understand the IPV/nursing context. Is there legislation allowing prosecution of perpetrators, protection for victims and children and community-based IPV services to which nurses can refer? Can women who leave partners receive priority housing, welfare payments – in other words, please provide a brief outlines of the context so we understand whether these are additional barriers for health care providers (HCPs). Can nurses receive supervision or support for dealing with stressful issues such as IPV?
   Answer: Information is now added in ‘Background’ in the revised manuscript to help readers understand the IPV/nursing context.

   ’In order for health care professionals to be prepared encounter and deal with abused women good organisational and individual conditions are required [15-18], including training options, continuing support, and adequate time to meet with the women exposed to IPV [9, 19]. There have been major reforms in the Swedish legal since the 1980s, when IPV became recognised as a public offence. The law provides IPV victims with orders of protection and enhances the possibilities for police intervention. Children living in a place where IPV occurs are exposed to psychological mistreatment. In this case, all health care personnel are obligated to report to social services but not the police. The Swedish welfare system offers the women exposed to IPV shelter where they are provided a space and temporary refuge. This shelter may also break the isolation that women exposed to IPV often experience. Usually the shelter workers are volunteers with experience and a developed expertise to advise and assist the abused women... Supervision of PHC nurses and policies from national nursing associations could be helpful when encountering IPV victims. In Sweden supervision of PHC nurses is usually not offered nor does the Swedish Nursing Association have a policy for IPV. The consequences of IPV are often treated unquestioningly, without identifying the underlying cause, the IPV itself [24]’ (p 3).
2. Preparedness to provide nursing care to women exposed to IPV

Comments:
This section should include current Swedish context, eg as you refer later to nurses referring to doctors. Are they more likely to be better trained and supported? Does the Swedish Nursing Association have an IPV policy? Also explain what the ‘volunteer organisations’ are to which you later refer?

Answer: All the information about the Swedish context requested is now added in the revised manuscript. It is included in the extract above (p 3).

3. Methods

Comments:
Please tell us on what assumptions and how you powered the study. Did you use clinic as a (cluster) variable, as nurses would be clustered in clinics?

Answer: The information is now added in the revised manuscript and reads ‘The study was powered on the assumption that 125 nurses answered the question for a power of 90%. In addition, the clinic was not used as a variable in this study’ (p 6).

4. Setting and data collection

Comments:
How were the 40 clinics randomised? What happened to one as you then refer to 39.

Answer: The randomization process is now included in the revised manuscript (p. 6). ‘At the time of the study there were 174 PHCC across urban and rural areas in Stockholm County that employed nearly 1,200 active nurses. Of the 174 PHCC 40 were randomly selected. During the randomisation process, every PHCC was given a unique number that was written on a paper card and placed in a pot. Two colleagues independently drew 20 paper cards each, a total of 40. All PHCCs selected were then contacted and were invited to participate in the study. One of the 40 PHCCs declined to participate’ (p 6).

Comments: Are the clinics urban/rural? What was the average nurse employee rate and what the SD.

Answer: The clinics are both urban and rural. For details please see in the revised manuscript on page 6.

Comments: How many nurses overall were eligible to be in the study? That is, what was your original denominator?

Answer: There were 1200 nurses eligible to be in the study. Please see in the revised manuscript on page 6.

Comments: Please tell us which questions attracted the higher missing rate (eg was it income–this is common).

Answer: The two questions that attracted the highest missing rate were: ‘do you ask women if they are exposed to IPV when you suspect it?’ and ‘nurses’ assessment of the degree to which general attitudes towards IPV corresponded with their own’. For the dropout percentages please see the revised manuscript (p 8).
5. Results
Comments:
Please move the description of your response rates and demographic descriptions of nurses to this section and note the proportion that had experienced IPV themselves (12%).

Answer: The description of the response rate and demographic descriptions of nurses have been moved to ‘Results’. We have also included the figure for the proportion of nurses that had experienced IPV themselves.

'Two hundred seventy-seven questionnaires were distributed to nurses working at the 39 PHCCs. The response rate was 70% (n=193) after one reminder, see figure 1. Totally 16 (6%) of the questionnaires were returned without answers. Of the 67 (30%) nurses not responding, 48 returned their questionnaires and reported not answering due to lack of time, illness, holiday or maternity leave. The internal dropout was between 0% and 5% except for the following questions with a dropout of 9%: ‘do you ask women if they are exposed to IPV when you suspect it?’ and ‘nurses’ assessment of the degree to which general attitudes towards IPV correspond with their own’.

Demographic data, working experience and personal experience with IPV based on completed questionnaires by the respondents are shown in Table 1. All respondents (n=190), except one were women. Most of the nurses were born in Sweden (87%, n=167), the mean age was 49 and the mean number of years in the nursing profession was 21. Twenty-three respondents (12 %) stated that they had personally experienced IPV’ (pp 7-8 in the revised manuscript).

Tables 7 and 8.
Comments:
Please correct the titles of these (which have slipped) as it took me a while to understand your CIs and p values.

Answer: The table titles are now changed as shown below. Corresponding changes in the revised text were also made.

Table 7. Factors associated with identification of women exposed to IPV. Age-adjusted model.

| Identify          | Odds Ratio | Std. | Err.  | z    | P>|z| | [95% Conf. Interval] |
|-------------------|------------|------|-------|------|-----|----------------------|
| Preparedness      | 6.30       | 3.65 | 3.17  | 0.002| 2.02| 19.66                |
| Age 20-39         | 1.64       | 0.80 | 1.00  | 0.315| 0.62| 4.31                 |
| Age 40-60         | 0.89       | 0.54 | -0.18 | 0.854| 0.27| 2.93                 |

Table 8. Factors associated with identification of women exposed to IPV. Model adjusted for gaining knowledge by own initiative.

| Identify | Odds Ratio | Std. | Err.  | z    | P>|z| | [95% Conf. Interval] |
|----------|------------|------|-------|------|-----|----------------------|
| Gaining knowledge by own initiative | 9.07 | 5.39 | 3.71 | 0.001 | 2.82 | 29.12               |
| Age 20-39 | 0.38 | 0.26 | -1.37 | 0.170 | 0.09 | 1.50                |
| Age 40-60 | 0.57 | 0.46 | -0.68 | 0.493 | 0.11 | 2.84                |
6. Discussion
Comments:
Under limitations, mention your wide CIs and the sample size limits.
Answer: The wide CIs and the sample size are now stated under ‘limitations’ as requested.
'The confidence intervals were rather wide, indicating a somewhat low statistical power. However, the response rate was 70% which must be considered large in this kind of a study, and the calculated power to detect a significant difference in the study sample was 90%, which is satisfactory' (p 15 in the revised manuscript).

Minor Essential Revisions
Comments:
Please remove all references to ‘these’ women. You do not intend it, but it sounds oddly negative in English. I recommend either victimized or abused women or women experiencing IPV.
Answer: We have removed all references to ‘these’ women and replaced them with ‘women exposed to IPV’ in the revised manuscript.

Comments: I suggest ‘profound’ rather than ‘deep’ in the abstract and p3.
Answer: The word ‘deep’ is changed to ‘profound’ in the abstract and as advised (p 4 in the revised manuscript).

Comments: p.3 Health problems – ‘can present very differently’ - I think you mean in diverse ways.
Answer: ‘Differently’ has been changed to ‘diverse’.
‘To identify victims, it is important for health care professionals to know that IPV is an extensive problem that can present in diverse ways’ (p 2 in the revised manuscript).

Preparedness paragraph p.4
Comments:
Line 2: Suggest ‘such organisational conditions ‘include....
Answer: The suggested change has been made and the word ‘include’ is now used.
‘good organisational and individual conditions are required [15-18], including training options, continuing support, and adequate time to meet with the women exposed to IPV [9, 19]’ (p. 3 in the revised manuscript).

Comments: Line 4. Education is known (although not explored in PHC etc (two examples below) suggest you remove this statement)
Answer: This sentence has been removed.

Comments: Page 5. First para, last few lines> since IPV often occurs in isolation. This is ambiguous- do you mean women often live in isolation or that IPV occurs in...
isolation from other problems?

**Answer:** ‘...since IPV occurs in isolation...’, page 5, means that women exposed to IPV often live in isolation. We have written this sentence differently to avoid confusion. ‘...since IPV often occurs in isolation women exposed to violence become isolated from others as a part of the abusers’ controlling behaviour’ (p. 4 in the revised manuscript).

**Comments:** Last sentence – when children ‘are involved’, a report to social services is needed. Please clarify. In Australia, nurses are mandated to report to child protection if the child is ‘in danger’ or actually abused. If they are witnessing, the nurse can seek to help the mother keep her and children safer without reporting necessarily. Our nurses find this a clinically difficult judgment.

**Answer:** The important issue of children being ‘involved’ has now been explained further in the Swedish context. ‘Children living in a place where IPV occurs are exposed to psychological mistreatment. In this case, all health care personnel are obligated to report to social services but not the police’ (p. 3 in the revised manuscript).

**Comments:** Second para: Line 4 ‘under-explored in PHC – I suggest, only recently being better explored? It does not detract from your contribution.

**Answer:** The sentence now reads ‘This matter has only recently being better explored in the context of primary health care’ (p. 4 in the revised manuscript).

**Comments:** Bottom of page 5. ‘personal experience of IPV is repeated.

**Answer:** The sentence now reads ‘the nurses’ demographic data and IPV experience (9 questions): sex, age, birth country, profession, numbers of years as a nurse, years as a district nurse, years at the current workplace, personal experience of IPV’ (page 5 in the revised manuscript).

**Results:**

**Comments:**

Table 3 – please organise from highest% to lowest% as this would be quicker to scan.

**Answer:** Table 3 has been organized as advised.

<table>
<thead>
<tr>
<th>Attitudes</th>
<th>*Agrees to some degree %</th>
<th>Does not agree at all %</th>
<th>No opinion %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol and drugs are common reasons for IPV (n=182)</td>
<td>91</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>The perpetrator simply loses control (n=180)</td>
<td>69</td>
<td>25</td>
<td>6</td>
</tr>
<tr>
<td>IPV is most common among the lower socioeconomic groups (n=178)</td>
<td>25</td>
<td>71</td>
<td>4</td>
</tr>
<tr>
<td>Victims of IPV can always leave the perpetrator if they want to (n=181)</td>
<td>22</td>
<td>77</td>
<td>1</td>
</tr>
<tr>
<td>For the children’s sake, it is important to keep the family together even when IPV occurs (n=180)</td>
<td>12</td>
<td>86</td>
<td>2</td>
</tr>
</tbody>
</table>
It is the victim’s fault that she has been abused \(^{(n=182)}\)

*These answers include the following alternatives: agree perfectly, agree somewhat and agree to some degree.

**Comments:** P.8 Middle para. Final line: lack of cooperation. (from whom?)

**Answer:** The sentence in question now reads ‘the 26 (13 %) free comments regarding reasons for insufficient preparedness concerned: lack of experience, training and continuing education, resources, guidelines and lack of cooperation with other authorities in the community’ (p. 9 in the revised manuscript).

**Comments:** Table 7. Reduce the ORs to two decimal places and add 0 before those below 1. (eg 0.57) . Please line up around the ‘.’ so that they are easier to read.

**Answer:** We have made the changes suggested.

**Table 7. Factors associated with identification of women exposed to IPV. Age-adjusted model.**

| Identify          | Odds Ratio | Std. | Err. | z    | P>|z|  | [95% Conf. Interval] |
|-------------------|------------|------|------|------|------|---------------------|
| Preparedness      | 6.30       | 3.65 | 3.17 | 0.002| 2.02 | 19.66               |
| Age 20-39         | 1.64       | 0.80 | 1.00 | 0.315| 0.62 | 4.31                |
| Age 40-60         | 0.89       | 0.54 | -0.18| 0.854| 0.27 | 2.93                |

**Table 8. Factors associated with identification of women exposed to IPV. Model adjusted for gaining knowledge by own initiative.**

| Identify          | Odds Ratio | Std. | Err. | z    | P>|z|  | [95% Conf. Interval] |
|-------------------|------------|------|------|------|------|---------------------|
| Gaining knowledge by own initiative | 9.07       | 5.39 | 3.71 | 0.001| 2.82 | 29.12               |
| Age 20-39         | 0.38       | 0.26 | -1.37| 0.170| 0.09 | 1.50                |
| Age 40-60         | 0.57       | 0.46 | -0.68| 0.493| 0.11 | 2.84                |

**Discretionary**

**Comments:** Did you think to use this to see whether the factor of 12% nurses who had experienced IPV was a barrier or facilitator to willingness to ask? Overall this could be a significant factor.

**Answer:** We looked into this factor but were not shown to be either barrier or facilitator to willingness to ask. As stated in the revised text ‘being sufficiently prepared was found to be the only variable significant as an independent variable’ (page 11 in the revised manuscript).

**Quality of written English:**

**Comments:** Needs some language corrections before being published

**Answer:** The revised manuscript has been further copyedited and the language has been checked twice by professional translators.
Comments on the report of reviewer dr. Sylvie Lo Fo Wong

Title.
Comments:
Should be shortened.
Answer: We have shortened the title for the revised manuscript.
The Title now reads: Preparedness and intimate partner violence in Primary Health Care: A quantitative study among district nurses in Sweden

3. Introduction.
Comments:
Page 3, 4, 5: Background paragraphs are all too long and should be shortened. Focus especially on nurses preparedness which is the topic of this study. Refer to more recent studies.
Answer: The background has been shortened and more recent studies have been added.

Comments: Page 4: Effect of education in primary health care is studied and published, authors state that this is not explored, see: Lo Fo Wong ea PJGP 2006; Shefet ea Med teach 2007.
Answer: The effect of education in primary health care is studied and published. This is now changed and completed with new references. See page 4 in the revised manuscript. ‘This matter has only recently been better explored in the context of primary health care. Studies have explored the effect of education in the context of PHCC but have not included district nurses in PHCC [17, 26-30]’.

4. Methods
Comments:
Page 5: Provide more information on the process of developing the questionnaire. How many questions were formulated initially and test among the group of 45? The demographics questions should not be conducted in the questionnaire, the provide background data on the respondents which can be used in the analysis as variables. The main instrument is about nurses preparedness.
Answer: Information about the process of developing the questionnaire and that of testing it are now explored in more detail in the revised manuscript, p 5: ‘A study-specific questionnaire was developed based on the authors’ knowledge and experiences but mainly on a systematic literature review. The aim of the study was to assess the nurses’ abilities to identify women exposed to IPV[31]. The questions were based on what is known to affect the nurses’ preparedness when dealing with women exposed to IPV. The first version of the questionnaire consisted of 27 questions and was completed by six nurses working in PHCC. The questionnaire has been revised since then by us and professional survey designer at the Statistics Sweden. Revised versions have been pilot-tested and re-tested on 39 nurses from another county who did not take part in the present study. The nurses answered 20 questions on dealing with women exposed to IPV and 9 questions about demographic data and own experiences of IPV. They were also asked to provide feedback on content, intelligibility and question relevance (p 5).
Setting and data collection:
Comments:
Page 6: I assume that 40 PHCC were ‘chosen randomly’ out of the 174 and not ‘randomised’
Answer: The sentence now reads: ‘At the time of the study there were 174 PHCC across urban and rural areas in Stockholm County that employed nearly 1,200 active nurses. Of the 174 PHCC 40 were randomly selected’ (p 6 in the revised manuscript.)

Comments: Page 6: Remove all text in the section about the response rate to results section. The numbers are not presented clear: 67, 48, 22 questions had been returned with or without comments. How many were never returned? A flowchart will be clear enough.
Answer: The section ‘Setting and data collection’ has been moved to ‘Results’ (see p 7-8 in the revised manuscript) as suggested and a flowchart (Figure 1) have been included.

5. Results
Comments:
Page 7: Start result section with response rate and demographics of respondents.
Answer: The result section starts now with response rate and demographics of respondents (see p 7-8 in the revised manuscript).
‘Two hundred seventy-seven questionnaires were distributed to nurses working at the 39 PHCCs. The response rate was 70% (n=193) after one reminder. Totally 16 (6%) questionnaires were return without answers. Of the 67 (30%) nurses not responding, 48 returned their questionnaires and reported not answering due to lack of time, illness, holiday or maternity leave. See figure 1. The internal dropout was between 0% and 5% except following questions: ‘do you ask women if they are exposed to IPV when you suspect it?’ with a dropout of 9 % and ‘nurses’ assessment of the degree to which general attitudes towards IPV match their own’ with a dropout of 9 %.
Demographic data, working experience and personal experience with IPV based on completed questionnaires by the respondents are shown in Table 1. All respondents (n=190), except one, were women. Most of the nurses were born in Sweden (87%, n=167), the mean age was 49 and the mean number of years in the nursing profession was 21. Twenty three respondents (12 %) stated that they have personally experienced IPV’.

Comments: Page 8: Present numbers of respondents with percentages in brackets consistently throughout the results section, for clearness.
Answer: Numbers of respondents are now presented with percentages in brackets consistently throughout the revised manuscript.

Comments: Page 9: Rename Paragraph ‘Logistic regression analysis’: It is about nurses preparedness relation to age category and knowledge and should not refer to the statistical test. Also be more clear on the meaning of age adjusted ration in the text.
Answer: Table titles have been changed as suggested. The new titles are used in the revised text instead and reads now: ‘Factors associated with identification of women exposed to IPV.’ (p 11).
More details on age-adjustments were added in the text:
‘The age-adjusting consisted of three age-groups. The eldest were > 60 years. The age-adjusted odds ratio (OR) was 6.30 (95% CI 2.02–19.67) and referred to whether nurses identified women exposed to IPV and whether they felt sufficiently prepared’ (see p 11 in the revised manuscript).
6. Discussion

Comments:
Page 10: A lot has to be changed in this section. “...and many different attitudes” is meant: various attitudes? Distinct attitudes?
Answer: The sentence now reads ‘A majority of the nurses did not feel sufficiently prepared and many had distinct attitudes’ (see p 11 in the revised manuscript).

Comments: One can only state that not identifying abused women leads to delay in appropriate care.
Answer: The sentence has been changed to ‘Such shortcomings may lead to delay in appropriate care for women exposed to IPV’ (see page 11 in the revised manuscript).

Comments: Supporting preparation among nurses is important? Is it meant as: increasing preparedness through training etc...
Answer: Yes, that is what we meant by that. Since it is a conclusion it has been removed from the first section.

Comments: The paragraph on preparedness to provide nursing care is too much of an iteration of the results. Discuss the meaning of this finding.
Answer: The discussion section has been revised; see pp 11-15 in the revised manuscript.

Comments: Regarding the effects of guidelines. There are conflicting findings. Guidelines on their own seldom improve willingness and ability. The authors can search for these studies.
Answer: The part about guidelines has been changed.
‘Guidelines are meant to support IPV detection and interventions about findings of their effectiveness are equivocal [17, 32, 33, 35]’ (see p 12 in the revised manuscript).

Comments: Page 11: Remove Sentence: Thus the cycle of IPV... The cycle of IPV is never stopped because of identification, only awareness, readiness and action of a victim or perpetrator can do so. Identification by providers can only open the door to these mind states.
Answer: The sentence has been removed.

Comments: Different attitudes: use another term for different.
Answer: The wore different as been changed and now reads; ‘distinct attitudes towards women exposed to IPV ’ (see page 13 in the revised manuscript).

Comments: Page 12. Study limitations. The authors should name their response rate as strength. Compared to studies most other countries, this can be called a success.
Answer: We have named the response rate as strength under limitations.
‘The confidence intervals were rather wide, indicating a somewhat low statistical power. However, the response rate was 70% which must be considered large in this kind of a study, and the calculated power to detect a significant difference in the study sample was 90%, which is satisfactory’ (see page 15 in the revised manuscript).
Comments: In this section 45 nurses are mentioned, in the methods 48? If this is new information than it should be presented in the results section.
Answer: In the method sections, number 48 refers to the number of nurses not completing the questionnaire whereas in ‘limitations’ the number 45 refers to the number of incomplete questionnaires. The number 45 were summarized in a confusing way. We have now made it clear in the flowchart. See figure 1.

7. Conclusion
Comments:
Page 13: The shortcomings in the first place lead to inappropriate care for abused women and children.
Answer: The conclusion is changed.
‘These shortcomings can lead to inappropriate care for abused women and their children’ (see pp 15-16 in the revised manuscript).

8. References
Comments:
Comments: As stated before: more recent references should be added.
Answer: More recent references have been added.

9. Tables
Comments:
Rename table 7 & 8. According to text in results.
Answer: Both tables are renamed.
Table 7. Factors associated with identification of women exposed to IPV. Age-adjusted model.
Table 8. Factors associated with identification of women exposed to IPV. Model adjusted for gaining knowledge by own initiative.

Comments: Language: Needs some language corrections before being published
Answer: The revised manuscript has been further copyedited and the language has been checked twice by professional translators.