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Employee Assistance Program and Occupational Health Providers' Perceptions and Experiences with Intimate Partner Violence in the Workplace: A Grounded Theory Study

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Employee Assistance Program and Occupational Health Providers' Perceptions and Experiences with Intimate Partner Violence in the Workplace: A Grounded Theory Study

by

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Dedication

To Roy, whose love and support has made the journey possible.

To my family and friends who have lovingly waited for me to finish this work.

To my mentor Dr. Carolyn Phillips, who showed me education is not the filling of a pail, but the lighting of a fire.

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Abstract:

Title: Employee Assistance Program and Occupational Health Providers' Experiences and Perceptions of Intimate Partner Violence in the Workplace

Purpose/Significance: Employee Assistance Program/Occupational Health Providers ("providers") are often the first point of contact for employees, both victims and perpetrators, affected by intimate partner violence (IPV). This Classical Grounded Theory (CGT) study explored providers' experiences and perceptions of working with employees in IPV relationships. This study advances the mission of the Southern Nursing Research Society by communicating research findings related to a persistent social and health issue: IPV.

Methods: CGT (Glaser, 1978) guided the study. Semi-structured interviews were conducted with ten providers from across the United States. The interviews were analyzed using constant comparison and open coding to identify categories and concepts within transcripts to ultimately reveal a substantive theory grounded in the study data. The study and resulting substantive theory adhered to Glaser's (1978) criteria for trustworthiness: Fit, work, relevance and modifiability.

Findings: Providers work within organizations to promote employee safety and organizational stability. IPV poses a threat to the welfare of the organization. Providers Manage the Threat of IPV by Doing What They Can to assist both victims and perpetrators involved in IPV relationships. The provider first must Recognize which employees are involved in IPV relationships, then Respond to them. Finally, providers engage in Informal Knowing to understand what happens to the employees after treatment. Limitations: Study findings may be limited by the small n; moreover, they self-selected to participate.

Implications for Practice: Providers are concerned about the threat of IPV in the workplace and Do What They Can to Recognize and Respond to both victims and perpetrators but are constrained by organizational limitations from knowing the outcome of their interventions.

TABLE OF CONTENTS

List of Tables

List of Abbreviations

BSN	Bachelor of Science Nursing
CGT	Classical Grounded Theory
CCM	Constant Comparative Method
CEAP	Certified Employee Assistance Provider
COHN	Certified Occupational Health Nurse
EAP	Employee Assistance Program
GSBS	Graduate School of Biomedical Science
IPV	Intimate Partner Violence
IRB	Institutional Review Board
LPC	Licensed Professional Counselor
LCSW	Licensed Clinical Social Worker
MSN	Master of Science Nursing
MSW	Master of Science Social Work
NCC	National Certified Counselor
RN	Registered Nurse
SPHR	Senior Professional in Human Resources
UTMB	University of Texas Medical Branch

Chapter 1 Introduction

This dissertation presents the findings of the Classical Grounded Theory (CGT) study that explored employee assistance program and occupational health providers' experiences and perceptions of employees engaged in intimate partner violence (IPV) relationships. Chapter One presents the study background, the study problem, the research question, and the study significance. The Chapter concludes with a discussion of the study methodology and delimitations.

BACKGROUND

The 2010 National Intimate Partner and Sexual Violence Survey of 16,507 adults revealed that 35.6% of women and 28.5% of men had experienced rape, physical violence, or stalking by an intimate partner in their lifetime (Black, Basile, Breiding, Smith, Walters, Merrick, Chen, & Stevens, 2010). The Centers for Disease Control and Prevention (CDC) defines IPV as "physical violence, sexual violence, stalking and psychological aggression (including coercive acts) by a current or former intimate partner that can occur among heterosexual or same-sex couples and does not require sexual intimacy" (CDC, 2017, Intimate Partner Violence: Definitions section para.1).

Intimate partner violence (IPV) as a social concern has been well researched (Breiding, Basile, Smith, Black, & Mahendra, 2015; Black, Basile, Breiding, Smith, Walters, Merrick, Chen, & Stevens, 2010; Jewkes, 2002: Smith, Zhang, Basile, Merrick, Wang, Kresnow, & Chen, 2018) and poses serious implications for organzations and society. The estimated cost of intimate partner violence (IPV) victimization in 2012 exceeded 5.8 billion dollars with 4.1 million dollars going to medical and mental health

services and 727.8 million dollars resulting from lost productivity including 7.9 million lost workdays (Moe & Bell, 2004). Studies of IPV mostly have been conducted with IPV victims, many of whom are under-employed or unemployed, and describe victims' risk factors, protective factors, and the consequences they suffer as victims of IPV (Borchers, Lee, & Maler, 2016; Blodgett & Lanigan, 2018; Moe & Bell, 2004; Swanberg, Logan & Macke, 2005, 2006; Swanberg, 2007). Some studies also described the tactics perpetrators use to control and manipulate victims, preventing them from attaining or attending work.

The cost of IPV to organizations is substantial including lost productivity, increased medical and liability costs, absenteeism and the costs associated with job turnover (Peterson, Kearns, McIntosh, Estefan, Nicolaidis, McCollister, Florence, 2018; Reeves & O'Leary-Kelly, 2007). Studies of employed IPV victims describe the impact of negative work behaviors associated with IPV as tardiness, absenteeism, and distraction that lead to work mistakes (Paludi, 2019; Swanberg J. E., 2006; Swanberg & Macke, 2006; Swanberg, Macke, & Logan , 2006). IPV perpetration is also costly to organizations. Perpetrators often abuse company time and resources to harass their partner, are distracted while doing so, and make more mistakes than employees not engaged in IPV (Rothman & Corse, 2008; Rothman, & Perry, 2004).

STUDY PROBLEM

"Employee assistance programs are professional services designed to improve and/or maintain the productivity and healthy functioning of the workplace through the application of knowledge and expertise about human behavior and mental health"

(International Employee Assistance Professionals Association, 2020). Occupational Healthcare is employer-sponsored healthcare promoting wellness and safety for employees in the workplace with a strong focus on primary prevention of hazards (World Health Organization, 2020). Both Occupational Health and Employee Assistance Program providers are trained and experienced in assisting employees with personal and work-related problems that may affect the health and safety of the organization and offer a unique perspective of IPV in the workplace. Intimate partner violence in the workplace has not yet been explored from the perspective of employee assistance program or occupational health providers nor are there any extant theories how employee assistance program or occupational health providers manage IPV in the workplace.

RESEARCH QUESTION

The research question that guided this study was: What are the experiences and perceptions of Employee Assistance Program and Occupational Health providers working with employees engaged in intimate partner violence relationships? The design of this Classical Grounded Theory study is to understand what is going on (Glaser, 1978, 1989) and what is it like for Employee Assistance Program and Occupational Health providers working with employees in IPV relationships.

SIGNIFICANCE

Studies of IPV in the workplace have focused on victim risk factors, protective factors, and consequences (Mankowski, Galvez, Perrin, Hanson, & Glass, 2013; Swanberg, 2005, 2006, 2007, 2012; Tolentino, Raymund, Garcia, Restubog, Scott, Aquino &Tang, 2017); the effects of IPV perpetrators in the workplace (Mankowski,

Galvez, Perrin, Hanson,, & Glass, 2013; Rothman & Corso, 2008; Rothman, & Perry, 2004); and, IPV legislation (Swanberg, Ojha, & Macke, 2012). Many studies focus on women, who are more likely to be victims of IPV, (35.6%) than are men (28.5%); however, victimization negatively affects the productivity of both men and women, increasing costs for their employers (MacGregor, Wathen, Olszowy, Saxton, & MacQuarrie, 2016; Reeves & O'Leary-Kelly, 2007). No studies have been identified that explore IPV in the workplace from the perspective of Employee Assistance Program or Occupational Health providers, nor have any extant theories addressing the experiences of Employee Assistance Program and Occupational Health providers working with employees engaged in intimate partner violence in the workplace been identified in the literature.

OVERVIEW OF METHODS

Classical Grounded Theory (Glaser, 1978) is an inductive, qualitative methodology first introduced by Glaser and Strauss (1967) and further developed by Glaser, who applied the term Classical Grounded Theory (1978, 1998, 2005, 2011, 2012, 2013, & 2014). Classical Grounded Theory is "a general methodology of analysis linked with data collection that uses a systematically applied set of methods to generate an inductive theory about a substantive area" (Glaser, 1992, p. 16). Glaser and Strauss developed grounded theory as an alternative to qualitative methods that they perceived began with *a-priori* theories then forced the data to fit the theory. Theories generated using Classical Grounded Theory are "grounded" in data that has been systematically collected and analyzed (Glaser & Strauss, 1967) using a set of analytic techniques delineated by Glaser (1978, 1998, 2005, 2011, 2012, 2013, & 2014). Classical Grounded

Theory is based on three assumptions. The first is that the researcher has no preconceived ideas or theories about the findings of the study; the second is the data will determine the direction of the study; and finally, that theory is generated by systematically analyzing the data. "CGT helps us to see things as they are, not as we preconceive them to be" (Glaser, 2014, p. 6).

The University of Texas Medical Branch (UTMB) Institutional Review Board (IRB) approved all study procedures. Seven Employee Assistance Program providers and three Occupational Health providers participated in the study. Study data consisted of demographic data, the transcribed participant interviews, and this researcher's memos.

Data analysis was guided by Classical Grounded Theory (CGT) techniques as described by Glaser (1978, 1998, 2005, 2011, 2012, 2013, & 2014) including the constant comparative method (CCM), coding, theoretical sampling, memoing, sorting, theoretical coding, and writing up. The constant comparative method (CCM) is a CGT data analysis technique in which data is analyzed in an iterative process of comparing each element within the data set with every other element, ultimately resulting in generation of conceptual codes. The conceptual codes are then compared to each other, identifying boundaries among the codes as well as the relationships among emerging concepts; codes are compared with codes, codes with categories and categories with categories. Utilization of the CGT analytic techniques, including the processes of constant comparison and data coding, allows "latent social patterns and structures to emerge and be conceptualized; the developing theory guides the direction of subsequent questions and data collection" (Glaser, 1978, p. 37).

DELIMITATIONS

EAP and Occupational Health providers in this study spoke English, had worked in internally managed (employer-based programs serving a single company) programs and had encountered employees experiencing intimate partner violence.

SUMMARY OF CHAPTER ONE

Chapter One began with an introduction to the research study followed by a discussion of the study's background and the research problem. The Chapter then stated the research question followed by an overview of the study's methodology, Classical Grounded Theory (CGT). The Chapter concludes with a description of the study's delimitations.

PLAN FOR THE REMAINING CHAPTERS

Chapter Two will provide a review of literature related to the topic of intimate partner violence in the workplace. Chapter Three will discuss the application of Classical Grounded Theory methodology (Glaser, 1978, 1992, 1998, 2005, 2012, 2013, 2014) to answer the research question 'What are the experiences and perceptions of Employee Assistance Program and Occupational Health providers working with employees engaged in intimate partner violence in the workplace?' Chapter Four will present the study's findings as well as the substantive theory that emerged from the data. Chapter Five will compare the study findings to the extant literature, and include a discussion of the study's significance, implications, future research, and lastly, the conclusion.

Chapter 2 Review of Literature

In the United States 36.4% of women and 10.9% of men experienced intimate partner violence (IPV) during their lifetime (Breiding, Chen, & Black, 2014; Breiding, Basile, Smith, Black, & Mahendra, 2015). IPV is a serious public health concern resulting in chronic adverse health effects that can be both physical and psychological (Black, 2010; Berger, 2015; Smith, et al., 2015). IPV is defined as "physical violence, sexual violence, stalking, or psychological harm by a current or former partner or spouse occurring among heterosexual or same-sex couples that does not require sexual intimacy" (Breiding, Basile, Smith, Black, & Mahendra, 2015).

Studies of IPV more often focus on women as they are smaller than men and often experience greater trauma as a result of IPV (Tolentino, et al. 2017; Blodgett & Lanigan, 2018); yet, IPV is gender neutral, either sex may be the victim or the perpetrator, and both partners may exhibit violence. The violent behavior of men is often driven by a desire to restore power and regain control while violence among women is motivated by retaliation (Tolentino, et al., 2017).

Intimate partner violence research encompasses studies from the disciplines of medicine, nursing, social work and criminal justice. Studies of IPV from medicine and nursing explore IPV victim prevalence, risk factors and the impact of IPV within healthcare settings as well as qualitative studies examining the IPV from the perspectives of victims, healthcare providers and nurses (Al-Natour, Gillespie, Felblin, & Wang, 2014). Studies of IPV in the healthcare setting tend to focus on IPV victim disclosure (Catallo, Jack, Ciliska, & MacMillan; Kataoka, Yaju, Eto, & Horiuchi, 2010; Hamberger, Rhodes, & Brown, 2015), and provider recognition of IPV (Davila, 2006; Davila,

Mendias, & Juneau, 2013). Criminal Justice studies of IPV have explored the lethality of IPV, perpetrator interventions and the development of IPV laws and polices (Berger, 2015; Swanberg, Ojha, & Macke, 2012; Runge, 2010; Savarda & Kennedy, 2013).

A smaller number of studies from social sciences and social psychology have explored the relationship between IPV victims, perpetrators and employment. The victim's in these studies were mostly women recruited from domestic violence shelters, court lists of women seeking restraining orders or community assessment phone surveys. Often, the victims were not able to maintain long term employment and were often on welfare as a result of their IPV relationships (Swanberg, Logan & Macke, 2005, 2006; Swanberg, 2007 Blodgett & Lanigan, 2018; Borchers, Lee, & Maler, 2016; Moe & Bell, 2004). While IPV perpetration is gender neutral most studies addressing IPV perpetrators in the workplace have mostly been of male perpetrators. These studies have explored tactics perpetrators use to maintain control over victims while they are at work, including perpetrator stalking, which may continue even after the IPV relationship has ended (Logan, Shannon, Cole, & Swanberg, 2007). A few studies explored batterer homicide rates among perpetrators of IPV and legal interventions for perpetration (Berger, 2015; Mankowski, Galvez, Perrin, Hanson, & Glass, 2013; Savarda & Kennedy, 2013; Tiesman, Gurka, Konda, Coben, & Amandus, 2012).

IPV does not only occur in the home, the effects follow victims and perpetrators into the workplace and are costly to organizations. There have been few studies exploring how organizations address the workplace consequences of IPV and no studies from the perspective of Employee Assistance Program and Occupational Health Providers who are

often the first people in an organization to encounter employees engaged in IPV relationships.

Risk Factors, Protective Factors and Consequences

IPV occurs across all socioeconomic levels and cultures (Black et al., 2010; Borchers, Lee, & Maler, 2016). Risk factors for IPV are unemployment, financial instability, low income, lack of education, having experienced violence, previous victimization, and abuse or neglect as a child. Additional factors may include a history of skipping school and substance abuse (Blodgett & Lanigan, 2018: Cundari, Mair, & Todd, 2014). Childhood physical or sexual abuse puts victims at risk to become perpetrators themselves continuing the cycle of IPV (Blodgett & Lanigan, 2018; Borchers, Lee, & Maler, 2016). Men working low wage, blue collar jobs or men who are unemployed are at increased risk of becoming IPV perpetrators (Cunradi, Ames & Moore, 2008).

Factors that are protective or preventative against IPV include employment, school attendance with good grades, a college education, housing stability, community norms that do not support intimate partner violence and living in an area with few stores that sell alcohol (Center for Disease Control and Prevention, 2017; Borchers, Lee, & Maler, 2016). Several studies have concluded having a job, working, and disclosure of IPV to someone at work are protective factors against IPV (Rothman, 2007; Kwesiga, Bell, Marshall, & Moe, 2007; Swanberg, Macke, & Logan, 2006).

The consequences of intimate partner violence for victims may include physical, sexual, psychological and economic harm. Physical violence may include being beaten, grabbed by the hair, pushed, strangled, burned, or assaulted with some type of weapon to injure or kill the partner. Sexual violence may include rape, penetration, coercion, and

unwanted sexual contact (Breiding, et al, 2015). Sexual violence effects both genders but women are disproportionately victimized (Berger, 2015). Abusers may seek to control the vicitms' reproductive or sexual health by not engaging in safe sexual practices or birth control (Berger, 2015). IPV increases the risk of sexually transmitted diseases for both men and women and places women at risk for miscarriage, low birth weight infants and poor pregnancy outcomes from lack of prenatal care (LaPlante, Gopalan, & Glance, 2015). Psychological violence may result in anxiety, depression, post-traumatic stress disorder and substance abuse (Berger, 2015; Black et al., 2010; Cundari, Mair, & Todd, 2014). IPV victims may have difficulty sleeping, chronic headaches, activity limitations, poor mental health, depression and low self esteem which can have negative effects on job performance and productivity (Black et al., 2010). IPV victims of both genders were more likely to report being distracted at work (Lindquist, Mckay, Clinton-Sherrod, Pollack, Lasater, & Walters, 2010). Economic harm may occur when the perpetrator prevents a victim from earning money, uses the victim's credit unknowingly, forces the victim to take out a loan or sign property over to the perpetrator or prevents the victim from accessing their own funds (The National Coalition Against Domestic Violence, 2015). The adverse physical, reproductive, and mental health consequences of IPV may remain long after the initial event frequently spanning generations (Black et al., 2010).

CONSEQUENCES OF INTIMATE PARTNER VIOLENCE IN THE WORKPLACE

IPV accounts for substantial workplace interference as nearly twenty percent of all employee victims reported a work consequence associated with IPV (Blodgett & Lanigan, 2018). Victims may have trouble finding and/or maintaining employment due to absenteeism, tardiness, frequent job loss, short employment histories and poor job

references (Borchers, Lee, & Maler, 2016; Swanberg & Logan 2005). Victims of IPV may leave their jobs due to safety concerns or be forbidden from working by their abusive partners (Moe & Bell, 2004). The ability to secure work may allow IPV victims the financial resources to transition out of an abusive relationship. Victims who are employed, seeking employment or job training are often at a greater risk for violence from their partners (Swanberg & Logan, 2005). Blodgett & Lanigan (2018) explored predictive factors for IPV in the workplace finding workplace perpetration increased with the frequency of IPV incidents and perpetrator stalking behavior. Female victimization was increased in social service and health workplaces as well as organizations with a high percentage of younger, female, low income and lower educational attainment employees. Employees working in construction or lower socioeconomic occupations were more likely to be perpetrators of IPV. In a study of one hunderd construction industry workers in Northern California Cundari found an IPV perpetrator rate of 26%; reasons cited for increased prevalence involved workplace stressors, "perceived racial/ethnic discrimination, interpersonal workplace conflict, and job strain that lead directly to IPV behaviors" (Cunradi, Ames, & Moore, 2008 p. 109).

Perpetrator Job Interference Tactics

One of the most frequently cited causes of IPV victim absenteeism and tardiness is attributed to perpetrator job interference tactics. Job interference tactics are categorized as sabotage, job harassment, and stalking. Sabotage includes acts that prevent the victim from going to or looking for work. Some examples of sabotage are disabling a car, cutting hair, cutting clothing, turning off an alarm, depriving the victim of sleep, or refusing to care for children. Harassment is the interruption of the victim's work by the

perpetrator who may phone the victim, victim's supervisor or victim's co-worker repeatedly or physically appear at the job. Job-related stalking is threating or harassing behavior by the perpetrator who waits for the victim somewhere outside the victim's workplace (Swanberg & Macke, 2006; Swanberg, Macke, & Logan, 2006).

Swanberg & Macke (2006) explored perpetrator job interference tactics utilizing a municipal government phone survey that incorporated the Workplace Violence Survey tool to determine the prevalence of IPV in the workplace. Thirty-four of 868 men and women self-identified as victims of IPV. The most frequently reported interference tactics used by perpetrators were calling and harassing the victim at work followed by showing up in person, lying to co-workers, sabotaging the victim's efforts to go to work and avoiding childcare responsibilities. Victims reported job interference tactics cause an inability to concentrate resulting in poor job performance and the need to go home sick or call in sick. Swanberg, Macke, & Logan (2006) surveyed 518 women who had recently received protective orders against their abusers and had been employed for less than a year. Job interference tactics were measured using the work/school abuse scale and 85% of the women surveyed reported experiencing at least one type of job interference from their partner. The most frequent pre-work job interference tactic was trying to prevent the woman from going to work (43%) followed by interfering with transportation by stealing money or car keys (40%). The most frequent interference tactics occurring at work were phone harassment (59%) followed by the perpetrator showing up at the victim's workplace (49%) then stalking (39%). The women reported job interference tactics prevented them from concentrating on their work resulting in having to leave work early or not going to work at all. The workplace may become a target for perpetrators as the

workplace may become the only point of accessing the victim if they choose to leave an IPV relationship, creating an unsafe work environment for all employees (Logan, Shannon, Cole, & Swanberg, 2007).

Perpetrators the Workplace

A small number of studies have explored the impact of IPV perpetrators in the workplace. Rothman & Corso (2008) conducted a cross-sectional survey of 61 working males who self-reported their tendency toward aggression. Study findings indicated a correlation between IPV aggression, perpetrator absenteeism, underperformance, mistakes and poor health. Rothman & Perry's (2004) qualitative study of 29 employed men attending certified batterer intervention programs found perpetrators missed work due to having to appear in court for IPV related charges and some were absent from work for up to 6 months due to being jailed for IPV, yet were not terminated from their jobs. Participants in the study admitted to making mistakes and causing safety hazards at work, citing difficulty concentrating due to feelings of shame about their behavior and anxiety about possibly going to prison. Perpetrators used company resources including time, vehicles, computers, and phones to harass their partners.

Mankowski, Galvez, Perrin, Hanson, & Glass (2013) surveyed 198 adult men in batterer intervention programs (BIPs) who self-reported their lifetime work-related IPV. The study stratified the perpetrator's IPV work-related behaviors into five categories from low level tactics to extreme abuse. Study findings suggest perpetrators in the category of extreme abuse have the greatest probability of poor work outcomes such as absenteeism, lack of concentration, and on-the-job mistakes

ORGANIZATIONAL SUPPORTS

Organizational supports are "programs, policies, and practices used by organizations to assist employees in managing work and family responsibilities" (Swanberg, Macke, & Logan, 2007). Organizational supports may be formal as in organizational policies that are IPV informed or may be informal such as a supervisor accommodating an employee experiencing IPV with a flexible work schedule. Several studies have indicated working mitigates IPV (Borchers, Lee, & Maler, 2016; Swanberg & Macke, 2006; Swanberg & Logan, 2005; Rothman, 2007). A qualitative study of 34 men and women who self-disclosed they were victims of IPV revealed working gave them a sense of self-esteem and independence. Fifteen of the thirty-four reported they disclosed their abuse to someone at work. The reasons for disclosure were to gain support or advice, the need for safety or protection or the need to explain a situation to a supervisor to prevent job loss. The participants who stated they disclosed their IPV to someone at work gained a variety of workplace supports which included someone to listen to them, distraction from their situation, information about IPV resources, referral to counselors and more flexible work scheduling (Swanberg & Macke, 2006). A study by MacGregor, Wathen, Olszowy, Saxton & MacQuarrie (2016) of domestic violence in workplaces in Canada surveyed 2,831 men and women who self-disclosed their IPV experience; 43.2% responded that they discussed their IPV relationship with someone at work, most often to a co-worker, followed by a supervisor or manager. Victims reported co-worker listening as the most common form of support and most victims found their co-workers to be helpful. Supervisor/manager support was characterized by time off with pay and help developing a safety plan. Men are less likely to discuss their IPV than

women, as a result, men were less likely to have been offered safety planning. Tolentino et al. (2017) surveyed 214 employee/supervisor dyads in the Philippines and found that perceived organizational support moderated the long-term outcomes of IPV and job sustainability. Organizational support is the expectation that the organization values the employee's work and shows concern for their welfare. Low levels of perceived organizational support resulted in a strong negative relationship between IPV, supervisor performance review and promotability. At high levels of organizational support, the relationship was not significant.

Co-worker Support

IPV literature from the perspective of IPV victims suggests co-worker support is a form of informal workplace support that may help IPV victims. However, intimate partner violence in the workplace has an impact on an employee's co-workers who also are impacted by the behaviors of the victim's abuser. Co-workers screen or answer the perpetrator's harassing phone calls and try to manage the perpetrator's tactics. Co-workers may encounter the perpetrator in the workplace, especially if the victim is being stalked, placing them in danger. Moreover, co-workers may be distracted from their own work, fear for their own safety, and resent having to fill in for the victim (Katula, 2012; Rothman E. F., 2007; Tolentino, et al., 2017).

EMPLOYEE ASSISTANCE PROGRAMS

Employee Assistance Programs are formal organizational supports offered by employers to employees and their families without cost, providing confidential counseling and follow-up services for personal and work-related problems (U.S. Office

of Personnel Management, 2017). EAPs also provide guidance and consultation to organizations to enhance organizational performance (Lindquist, et al., 2010). There are two main EAP structure types: management-sponsored and external. In a management-sponsored EAP, the EAP staff are directly employed by the organization. Externally structured EAPs are businesses usually providing services to more than one organization. Statistics from the 2008 National Survey of Employers indicated 68% of organizations in the United States have EAP's but the rate of employee utilization is only 5%-10% (Pollack, Austin, & Grisso, 2010).

There are few studies of IPV and employee assistance programs. Lindquist, et al., (2010) surveyed 28 external EAPs that offered IPV services to determine what services they offered. The EAPs offered assistance with organizational policy development, educational training for staff and managers, critical incident response training, workplace security assistance, referrals and compliance monitoring. Each of these services was geared toward workplace violence in general and were not specific to intimate partner violence. The study also found lack of IPV documentmetaton is a problem; lacking an understanding of the number of IPV cases screened and treated leaves organizations unable to know the prevalence or magnitude of IPV within their organizations.

Pollack (2010) reported providers used telephonic intake services and only 18% of the 28 employee assistance programs universally screen for IPV. Post-assessment services entailed emergent intervention/safety planning, counseling, referral to a community IPV resource, employer awareness and facilitation of IPV workplace issues, and case management. No screening protocols or referral resources for perpetrators were offered other than standard counseling and case management services.

Walter, et al (2012), found EAP case management of IPV cases was the same for vicitms and perpetrators. Each received just one follow-up contact to ensure the employee's needs had been met and to assess satisfaction with the services. High-risk or employer-referred cases may have had more frequent follow-up. IPV perpetrators are rarely identified or followed so their progress is not reported back to the employer.

OCCUPATIONAL HEALTH

Occupational health providers include occupational and environmental health nurses, occupational medicine physicians, and occupational health psychologists (United States Department of Labor, 2019). An extensive search for studies about occupational health providers and intimate partner violence produced only one study. Felblinger (2008) conducted a survey of 1,265 occupational health nurses perceived ability to screen and treat IPV in the workplace. Findings indicated occupational health nurses consider intimate partner violence screening and treatment part of their professional nursing role but may not know how to actualize care for employees in IPV relationships. For example, when the nurses were asked if they felt confident performing an IPV assessment, 33% agreed or strongly agreed feeling confident and 67% reported feeling unsure. Only half of the nurses knew what course of action to take when employees disclosed IPV relationships or IPV stalking. Less than half of the respondents knew the warning signs for IPV, how to obtain a protective order, or other legal protections available to employee victims.

THE COST OF INTIMATE PARTNER VIOLENCE TO ORGANIZATIONS

The estimated cost of IPV victimization in 2012 exceeded 5.8 billion dollars with 4.1 million dollars going to medical and mental health services and 727.8 million dollars resulting from lost productivity including 7.9 million lost work days (Moe & Bell, 2004). The cost of IPV to organizations is also substantial including lost productivity, increased medical and liability costs, absenteeism due to victimization and court appearances, and the cost associated with job turnover. In a survey of 1550 women and 823 men employed by three midsize business organizations, Reeves & O'Leary-Kelly (2007) examined work-related organizational costs. All participants completed items from the National Violence Against Women Survey. Participants were categorized as victims or non-victims based on survey results. The organizational cost of absenteeism, tardiness and work distraction of the victim participants was compared to the non-victim participants using their reported salaries. Employees who had experienced IPV victimization had higher absentee rates and lower salaries.

The negative impact of IPV perpetration also costs employers. For example, Rothman & Corse (2008) found that perpetrator work productivity and performance are affected when the perpetrators miss work, leave early, come in late, and are distracted leading to errors due to their pursuit of abusive behaviors. Perpetrators may further cost organizations by using work resources for their abusive acts. Employers may be held liable for retaining known IPV perpetrators (Walters, et al., 2012) thereby increasing an organization's legal costs.

When employers do not respond to known threats to the safety of their organization, they may find themselves facing legal consequences and financial penalties.

For example:

> In Texas, the ex-boyfriend of an employee warned his victim's supervisor that he would come to her worksite and kill her if she was not fired. The next day, with a loaded gun, he walked past a security guard and killed his ex-girlfriend. The employer was found responsible, and the court awarded the daughter of the victim $850,000 (Katula, 2012, p. 217).

If an employer discovers an employee is threatened or endangered, the employer may have a legal responsibility to ensure the employee's safety under the Occupational Safety and Health Act of 1970 (OSHA) general duty clause. OSHA mandates that employers must provide a place of employment that is free from recognized dangers that may cause death or physical harm to employees. OSHA recommends organizations use threat management teams that "receive, evaluate and respond to threats in the workplace" (Paludi, 2019, p. 207). Thereafter teams should receive training on intimate partner violence and "must not intervene inappropriately or endanger employees by their response (Paludi, p. 207).

INTIMATE PARTNER VIOLENCE LEGISLATION

There are, to date, no federal laws addressing employment protection and accommodations for IPV victims in the workplace (Berger, 2015). Swanberg, Ojha, & Macke (2012) reviewed federal and state employment protection statutes for IPV victims and reported there are no explicit federal statutes protecting IPV victims from adverse employer actions. The Family Medical and Leave Act (FMLA), Title VII of the Civil Rights Act, and The Americans with Disabilities Act (ADA) afford some protections for some employees although they do not protect against employer adverse job actions. The

Family Medical and Leave Act allows for up to twelve weeks of unpaid leave for illness if the victim fits within the criteria for FMLA which is having worked at least 1,250 hours in the previous year and the employer employs fifty or more workers for twenty weeks in the previous year (Kwesiga, Bell, Marshall, & Moe, 2007).

There is substantial variation among state statutes for IPV protection. In an analysis of IPV statutes by state, Swanberg, Ojha, & Macke, (2012), identified 369 state statues, plans and administrative regulations aimed at protecting victims of intimate partner violence. Most of these actions could be grouped into three categories: policies supporting work leave, anti-discrimination policies, and policies promoting workplace safety. The work leave category encompassed granting leave to IPV victims to attend a legal hearing and leave for reasons resulting from IPV or sexual harassment. Policies preventing IPV victim discrimination included protections against employer retaliation, loss of unemployment insurance benefits and policies that allowed employer intersession services. Workplace awareness policies are aimed at educating the general work force and supervisors about work concerns relevant to IPV and enabling employers to obtain restraining orders to stop perpetrators from coming to or calling the workplace.

SUMMARY CHAPTER TWO

Chapter Two has explored the current body of literature addressing intimate partner violence (IPV), a serious psychosocial problem and public health concern (Black, 2010; Breiding, 2015), from the perspectives of medicine (Hamberger, Rhodes, & Brown, 2015; LaPlante, Gopalan, & Glance, 2015; Choo & Houry, 2014; Catallo, Jack, Ciliska, & MacMillan, 2012), nursing (Davila, 2006; Davila, Mendias, & Juneau, 2013; Malecha & Wachs, 2003), social work and behavioral sciences (Swanberg, Logan &

Macke, 2005, 2006; Swanberg, 2007; Blodgett & Lanigan; 2018; Borchers, Lee, & Maler, 2016; Moe & Bell, 2004), and criminal justice (Berger, 2015; Swanberg, Ojha, & Macke, 2012; Runge, 2010; Savarda & Kennedy, 2013). Most of this research has concentrated on the risk factors, protective factors, and consequences of IPV. A small number of studies (Blodgett & Lanigan, 2018; Borchers, Lee, & Maler, 2016; Cunradi, Ames, & Moore, 2008; Moe & Bell, 2004; Swanberg, Logan, & Macke, 2005, 2006) have focused on IPV victims who are employed and the workplace. Most of these studies have explored the consequences of IPV in the workplace and perpetrator tactics used to prevent victims from being successful at work. Studies of IPV in the workplace describe a range of formal and informal organizational supports of which co-workers are informal supports.

There have been a few studies exploring IPV from the perspective of IPV perpetrators (Mankowski, Galvez, Perrin, Hanson, & Glass, 2013; Rothman & Corso, 2008; Rothman & Perry, 2004). Perpetrators in these studies have most often been recruited from lists of offenders attending court-ordered batterer interventions. The findings from these studies indicate perpetrator IPV is costly to organizations resulting in lost productivity due to perpetrator absenteeism for consequences related to IPV perpetration and the unauthorized use of company resources

Other studies exploring the cost of IPV to organizations quantify lost productivity, work place distraction, and safety hazads (Moe & Bell, 2004; Peterson, Kearns, McIntosh, Estefan, Nicolaidis, McCollister, Gordon, Florence, 2018; Reeves & O'Leary-Kelly, 2007; Paludi, 2019). Studies of IPV legilation discuss the impact of

national and state legislation for IPV in the workplace (Berger, 2015; Kwesiga, Bell, Marshall, & Moe, 2007; Swanberg, Ojha, & Macke, 2012).

Employee Assistance Program and Occuapational Health providers are formal organizational supports for employees, including those engaged in IPV relationships. Only two studies have been identified that address Occupational Health providers, Occupational Health Nurses, and IPV, and each study was based on the same data set (Felblinger, 2008; Malecha & Wachs, 2003). These studies indicated that while IPV identification and intervention is an occupational health nurse role, most occupational health nurses felt unprepared to intervene in IPV in the workplace. The studies recommended formal screening intervention for workplace IPV. There were three studies, each derived from the same study data, exploring external EAP services for both perpetrators and vicitms of IPV (Lindquist, et al., 2010; Pollack, McKay, Cumminskey, Clinton-Sherrod, Lindquist, Lasater, Walters, Krotki, & Grisso, 2010; Walters, et al., 2012). These studies of external EAP programs and IPV described program services for vicitms, perpetrators and organizations.

There have been many studies exporing the risk factors, protective factors and consequences of intimate partner violence (IPV) for vicitms and perpetrators. Fewer studies have explored the consequences of IPV in the workplace and these studies have been from the perspective of employees engaged in IPV relationships. Employee Assistance Progam (EAP) and Occupational Health providers work within orgainzations to promote employee health and safety; as such, they are often the first to see the consequences of employee IPV in the workplace. At this time there are no studies of the experiences of Employee Assistance Progam (EAP) and Occupational Health providers

working with employees engaged in IPV nor are there any extant theories. Utilizing Classical Grounded Theory (Glaser, 1978, 1992, 1998, 2005, 2012, 2013, 2014) the present study explored the experiences and perceptions of Employee Assistance Progam (EAP) and Occupational Health providers resulting in a grounded theory which emerged from the data.

PLAN FOR REMAINING CHAPTERS

Chapter Three will describe the application of Classical Grounded Theory (Glaser, 1978, 1992, 1998, 2005, 2012, 2013, 2014) to answer the research question: "What are the experiences of Employee Assistance Program and Occuaptional Health providers working with employees engaged in intimate partner violence relationships?" Chapter Four will discuss the study findings including the substantive theory that emerged from the data. Chapter Five will be a discussion of the study's findings, significance, implications, recommendations for future research and conclusions of the study.

Chapter 3 Methods

Chapter Three describes the implementation of Classical Grounded Theory (Glaser, 1978) (CGT) to explore the research question, "What are the experiences of Employee Assistance Program (EAP) and Occupational Health providers who manage the effects of Intimate Partner Violence (IPV) in the workplace?" The Chapter begins with a description of Classical Grounded Theory and its appropriateness for the study, followed by a description of how CGT techniques were implemented, including study recruitment and sampling strategies, the study setting, data collection, data analysis and management. The Chapter will continue with a description of how the study and its findings met Glaser's (1978, 1998) criteria for trustworthiness, followed by a discussion of human subjects and ethical considerations.

Grounded Theory is an inductive, methodology first introduced by Glaser and Strauss (1967) and further developed by Glaser, who applied the term Classical Grounded Theory (1978, 1998, 2005, 2011, 2012, 2013, & 2014). Classical Grounded Theory is "a general methodology of analysis linked with data collection that uses a systematically applied set of methods to generate an inductive theory about a substantive area" (Glaser, 1992, p. 16). Glaser and Strauss developed grounded theory as an alternative to qualitative methods that they perceived began with *a-priori* theories then forced the data to fit the theory. Theories generated using Classical Grounded Theory are "grounded" in data that has been systematically collected and analyzed (Glaser & Strauss, 1967) using a set of analytic techniques delineated by Glaser (1978, 1998, 2005, 2011, 2012, 2013, & 2014). Classical Grounded Theory is based on three assumptions. The first is that the researcher has no preconceived ideas or theories about the findings of

the study. The second is the data will determine the direction of the study. And finally, that theory is generated by systematically analyzing the data. "CGT helps us to see things as they are, not as we preconceive them to be" (Glaser, 2014, p. 6).

There has been little research regarding the experiences of Employee Assistance Program (EAP) and Occupational Health providers working with employees involved in IPV relationships. Classical Grounded Theory can be used to explore the patterns of social behavior employed by providers working with employees involved in IPV relationships and provide a theoretical explanation of how providers manage their main concern. The following sections will describe how CGT was implemented in this study.

RECRUITMENT

The study was submitted to and approved by the University of Texas Medical Branch Institutional Review Board (UTMB IRB) (See Appendix A). Recruitment of study participants began upon approval by the UTMB IRB. The study utilized both purposive and snowball sampling strategies to recruit participants. Streubert & Carpenter (2011) define purposive sampling as "selecting individuals based in their particular knowledge of a phenomenon and for the purpose of sharing their knowledge" (p. 28). Eight participants were recruited using purposive sampling. Snowball sampling occurs when "participants assist in recruiting other people they know to participate" (Melnyk & Fineout-Overholt, 2005, p. 144); two of the participants were recruited by snowball sampling.

Recruitment was initiated through Employee Assistance and Occupational Health providers' professional associations. The following professional associations distributed the study's recruitment flier (Appendix B) and recruitment letter (Appendix C) to their

membership: The Employee Assistance Roundtable (Appendix D), the Employee Assistance Professionals Association (Appendix E), the Association of Occupational Health Professionals in Healthcare (Appendix F), the American Association of Occupational Health Nurses (Appendix G) and the Texas Association of Occupational Healthcare Providers (Appendix H). The Texas Association of Occupational Healthcare Providers then shared the study recruitment materials with the American Board for Occupational Health Nurses, Inc., who posted the recruitment materials on its website (Appendix I).

The recruitment letter described the project, stipulating participation in the study was voluntary and there would be no compensation for participation. Interested providers were asked to contact this researcher by email with their name and phone number as well as date and time preferences for a short telephone call to discuss the research project. Upon receiving contact information from interested providers, the researcher phoned each provider to discuss the project, answer any questions, ensure the provider met the inclusion criteria, and secure a date and time for data collection if the provider was interested in participating. The researcher also informed the providers that data collection should not exceed 90 minutes and would focus on the provider's experiences working with employees involved in IPV relationships. A follow-up confirmation email (Appendix J) with the agreed-upon date and time for data collection was sent after the telephone call with the provider. Each provider who contacted the researcher met the study's inclusion criteria; none were excluded, and none opted not to participate in the study.

SAMPLE

Ten providers participated in the study; seven were Employee Assistance Program providers and three were Occupational Health providers. Participants in the study included EAP and Occupational Health providers who:

1. Worked in internally- managed (employer-based programs serving a single company) programs who encountered employees experiencing intimate partner violence.
2. Spoke and understood English.
3. Willing to participate in data collection lasting up to 90 minutes and a possible follow-up interview that would not exceed 30 minutes.

SETTING

Data was collected by telephone interview. The researcher asked participants to schedule their data collection session for a time when they were not working and suggested they plan to receive the call in a quiet location where there would be privacy and minimal interruptions. The researcher conducted data collection from a home office which was a quiet, secure location allowing for a reduction in distractions and providing privacy and confidentiality for the participant.

DATA COLLECTION

Study data consisted of demographic data, interviews and the researcher's memos and field notes. The researcher telephoned the participant on the agreed-upon date and time of the interview, welcomed the participant, and engaged in general conversation to put the participant at ease. The researcher then used the informed consent script (Appendix K) to discuss the informed consent process including participant confidentiality, methods of

recording and securing data, and the possibility of contacting the provider in the future with follow-up questions, and potential risks of study participation. Discussion of study risks included potential psychological distress due to the sensitive subject of intimate partner violence. Although providers routinely care for employees engaged in intimate partner violence relationships, providers themselves may have experienced IPV which potentially may cause them distress. The researcher discussed the potential study risk of loss of confidentiality and strategies that would be used to protect each participant's confidentiality as well as the data.

The researcher gave the provider an opportunity to ask questions, then asked the provider if they were willing to participate in the study, securing their verbal consent to participate. The script ended by asking providers if they consented to participate in the study, to which all the providers agreed. The providers' agreement to participate in the study allowed the researcher to turn on the digital recorder and with the recorder running, she asked the participants to reiterate their willingness to participate in the study.

The data collection session began with collection of demographic information (Appendix G: Demographic Questions and Interview Script). Providers were asked how long they had practiced as an Occupational Health or EAP provider, their educational background, professional certifications, and asked for a general description of the nature of their current organization and the approximate number of employees eligible for their services. The participants' demographic data will be discussed in detail in Chapter Four.

The researcher began the interview after demographic data had been collected. Data collection was guided by the study's semi-structured interview guide (Appendix G: Demographic Questions and Interview Guide). The interview began with the grand tour

question, “Tell me about your experiences working with people involved in intimate partner violence.” Using open-ended questions allow the participant to elaborate, such as, “Can you tell me a little bit more …?” and “Can you tell me what that looks like?” The researcher also used encouraging words or phrases to indicate active listening, such as, “that’s very interesting . . .” and “please continue.” Glaser (1998) says the “participant knows they are being listened to; thus, the researcher becomes a ‘big ear’ to pour into incessantly” (p. 125). At the conclusion of the interview, the researcher thanked the provider and asked if there were any questions or additional comments the participant would like to add. The researcher encouraged participants to contact the researcher by email with any further comments or questions and asked participants if they were willing to be contacted again if the researcher had further questions; each participant was willing to be contacted again.

At the conclusion of each data collection session, the researcher wrote field notes recording her thoughts about the content and tone of the provider’s discourse and overall impressions of the interview. Coding of field notes allow the researcher to “stay focused on what is really happening” (Glaser, 2011, p. 172).

The initial interviews ranged in duration from 23 minutes and 7 seconds to 58 minutes and forty-three seconds with a mean duration of forty-one minutes and nineteen seconds. Follow-up interviews of five participants were conducted for the purpose of theoretical sampling. These interviews ranged in duration from 36 minutes and twenty-two seconds to six minutes and one second with a mean duration of sixteen minutes and forty-six seconds. After each interview the researcher recorded field notes and memos about each conversation

DATA MANAGEMENT

Telephone interviews with the providers were digitally recorded using two audio recorders, one for back-up purposes. The original audio recordings were stored in the researcher's home office in a locked file cabinet. The researcher transcribed each audio recording into a Microsoft Word document and assigned an alpha numeric participant code (e.g., P1, P2). The codes and associated names were recorded in a separate electronic file on the researcher's personal computer. The researcher read each transcript while listening to the recording to assure accuracy of the transcript then stored a copy of the transcript on her personal computer and a dedicated flash drive as back-up. A second copy of the transcript was de-identified, i.e. all information linking the participant to the data was masked with participants' names being replaced by an assigned alpha numeric code (e.g., P1, P2) and names of places replaced with a nonspecific generic term, such as "city," "state," or "organization." The transcripts of the second interviews were coded with the participant's alpha numeric code with the addition of a dash and the number two (e.g., P1-2, P2-2) to differentiate them from the initial interviews.

The second, de-identified copy of the transcript was stored on the researcher's personal computer in a separate electronic file and on a dedicated flash drive for back-up. The de-identified transcript was used for data analysis. The researcher's personal computer was password protected and dedicated to this study with no other users able to access the PC. The two flash drives purchased for this study were stored in a locked file in the researcher's locked home office. All study materials will be destroyed when all study reports are complete.

DATA ANALYSIS

Data analysis was guided by Classical Grounded Theory (CGT) techniques as described by Glaser (1978, 1998, 2005, 2011, 2012, 2013, & 2014). The following sections will discuss CGT data analysis techniques including, the constant comparative method (CCM), coding, theoretical sampling, memoing, sorting, theoretical coding, and writing up.

CONSTANT COMPARATIVE METHOD

The constant comparative method (CCM) is a CGT data analysis technique in which data is analyzed in an iterative process of comparing each element within the data set with every other element, ultimately resulting in generation of conceptual codes. The conceptual codes are then compared to each other, identifying boundaries among the codes as well as the relationships among emerging concepts; codes are compared with codes, codes with categories and categories with categories. The constant comparative method allows for the conceptualization of "latent social patterns and structures; the developing theory guides the direction of subsequent questions and data collection" (Glaser, 1978, p. 37).

CODING

Coding is the process of identification and conceptualizing data related to the phenomenon of interest. There are two types of coding in Classic Grounded Theory data analysis; these are substantive coding and theoretical coding (Glaser, 1998). Substantive coding is comprised of two phases: open coding and selective coding. In open coding the data is broken down, or fractured, by identifying each data element that seems to answer the question, "What is going on here?" (Glaser, 1978, p. 57) then grouping similar data

elements into categories that emerge from the data. New data is compared to the categories until a core category and related concepts emerge. The core category explains the study participants' main concern (Glaser, 1978, 1998). The core category and its subcategories explain "what's going on" (Glaser, 1978, p. 57) in the data. Once the core category has emerged, selective coding begins. Selective coding is the process of delimiting coding to data concepts related to the core category and its subcategories. The core category becomes a guide to further data collection and theoretical sampling (Glaser, 1978, p. 61).

THEORETICAL CODING

Theoretical coding is the process of integrating to each other the core category and subcategories to form a theoretical model explaining how the study participants resolve their main concern (Glaser, 2005). "Theoretical codes conceptualize how the substantive codes may relate to each other as hypothesis to be integrated into a theory" (Glaser, 1970, p. 72). Theoretical codes should not be forced, they are grounded, and should emerge from the constant comparison of field notes and memos; in this way theoretical codes "earn their way into the theory as much as substantive codes" (Glaser, 1998, p. 164). Theoretical codes "weave the fractured story back together again" (Glaser, 1978, p. 72). The pattern of social behavior that emerged from data analysis leads the researcher to the identification of a theoretical code that fits the data and explained how study participants resolve their main concern.

MEMOING

Memoing is a continuous, iterative data analysis process that carries through all phases of CGT. Memos record the researcher's thoughts and ideas about the developing theory. The researcher may stop any time during data collection and analysis to memo as thoughts and ideas may be fleeting while the data is not. The goals of memoing are to "theoretically develop ideas (codes) with complete freedom into a 'memo fund' that is highly sortable" (Glaser, 1978, p. 83). The ideas found in memos allow the researcher to think on a conceptual level while developing categories and properties, identifying interrelationships among categories, integrating the categorical relationships into an emerging theory, and lastly, relating the emerging theory to existing theories of patterns of human behavior. **"**Memos are the theorizing write-up of ideas about codes and their relationships as they strike the analyst while coding" (Glaser, 1978, p. 83).

SORTING

Sorting is the conceptual categorization of memos to show the interrelationships within the study's emerging theory. Memos are sorted into categories then the categories are conceptually related to each other using the constant comparative method. "Theoretical codes will emerge in the sorting of memos into relationships" (Glaser, 2012, p. 32). Sorting may lead to the stimulation of additional memos or further data collection. Sorting creates a theoretical outline that explains most of the behavior in the data and becomes the basis for writing-up.

THEORETICAL SAMPLING

Theoretical Sampling is the process of data collection and analysis in which the study's emerging theory guides subsequent data collection. Theoretical sampling guides

the researcher as to "what data to collect next and where to find them in order to develop his theory as it emerges" (Glaser, 1978, p. 35). Theoretical Sampling stops when each category becomes saturated and can be integrated into the emerging theory.

WRITING-UP

Writing-up the theory generated by integrated concepts and sorted memos is the culmination of the CGT process. Writing-up is the final step in data analysis and allows for communication of the theory to others. "The purpose of the write-up is to capture the . . . grounded theory into a conceptual explanation of how a core category is continually resolved" (Glaser, 2012 p. 25).

DATA ANALYSIS PROCESS

The CGT researcher begins data analysis by reading the data line by line, identifying elements of data that reflect the phenomenon of interest, and coding each data element into as many categories as possible. Open coding is the breaking down or fracturing of data to generate concepts while continually asking, "What category does this data indicate?" "What property of what category does this data indicate?" and "What is the participants' main concern?" (Glaser, 1998, p. 140). As categories are generated, CCM is utilized to compare concept to concept, concept to category, then category to category, ultimately revealing the properties of the categories (Glaser, 1998). The objective of open coding is the "identification of the core category and its properties that account for the behavior in the substantive area that continually resolves the main concern of the participants" (Glasser, 1998, p. 141). The core category, *Managing Threat,* emerged as the providers' main concern during coding of the seventh interview.

Providers *Manage the Threat* of negative work behaviors exhibited by employees in IPV relationships that can cause disruption in the work environment or endanger the workplace.

Identification of the participants' main concern is an essential tenant of CGT and is necessary for integration of categories into a theory that is grounded in the data. Once the participants' main concern emerges, it guides the selective coding process. The purpose of selective coding is to delimit coding to only the participants' main concern, the core category, and the related sub-categories. The selective coding process was continued through interviews eight, nine and ten, from which a few new concepts emerged, expanding the properties of the sub-categories and leading the researcher to determine theoretical saturation had not yet been achieved. Theoretical saturation occurs when data analysis, utilizing CGT data analysis strategies, does not generate any further properties of the category and each "category has earned its way into the theory" (Glaser, 1998, p. 141).

The researcher reviewed the data and memos from all ten interviews and identified lack of saturation of one subcategory within the emerging theory. As a result, the researcher used the CGT strategy of theoretical sampling to guide collection of additional data. Theoretical sampling guides the researcher in deciding what data to collect and where to collect it. "As the researcher memos and puts down ideas of where to take, or how to question, his [sic] growing theory this becomes a motivated occasion for theoretical sampling on a category or its properties" (Glaser, 1998, p.158). The researcher emailed all ten participants requesting the opportunity to re-interview them. Eight of the ten providers responded, three of whom were unavailable; therefore, the

researcher re-interviewed the five available providers. The researcher began the interviews by reviewing the verbal consent script with each provider and obtaining the provider's continued consent to participate. The subsequent interviews were analyzed in the same fashion as the initial interviews, utilizing the CGT techniques of substantive coding, memoing, and constant comparative method. The additional data saturated the subcategory and confirmed the core category, subcategories, the relationship among the categories, and thus, the emerging theory. As a result, the researcher was able to determine that the providers resolve their main concern, *Managing Threat,* by a process labeled, "*Doing What They Can,"* which consists of three sequential phases: *Recognizing, Responding,* and *Informally Knowing*. The theory will be further discussed in Chapter Four.

TRUSTWORTHINESS

Scientific rigor means implementing the highest standards and best practices of the scientific method throughout the entire research process. Scientific rigor, or trustworthiness, in qualitative research is valued because it is associated with greater worth of the research outcomes (Burns & Grove, 2003). Evalaution of a qualitative study's trustworiness is guided by evaluation criteria that are specific to the qualitative research methodology used in the study. Therefore, this study adhered to Glaser's (1978, 1998) four criteria for evaluating rigor of a CGT study. Glaser's criteria are Fit, Work, Relevance, and Modifiability.

1. *Fit* – Fit is the evaluation of the theory's accuracy in representing the patterns within the study data: "fit is another word for validity" (Glaser, 1998 p. 236). Concepts in Classical Grounded Theory are generated from the data. "What fits

will emerge as the pattern gets named" (Glaser, 1998 p. 236). The theory *Managing Threat* fits because it emerged from data. The theory's concepts, categories, and conceptual codes were generated from (were grounded in) the study's data and were not forced nor preconceived.

2. *Relevance* - A theory is relevant when it reflects the participants' main concerns and describes "how what is really going on is continually resolved" (Glaser, 1998 p. 236). A theory has relevance when it allows the "core problems and process in the substantive area to emerge" (Artinian, Giske, & Cone, 2009) The theory "*Managing Threat*" has relevance because it emerged from the data, reflecting the reality of the participants, and describes how the participants resolve their main concern. Providers *Manage the Threat* of intimate partner violence by *Doing What they Can.*
3. Work - In order to work, a Classical Grounded Theory must be able to explain what is going on in the data and how the participants resolve their main concern. The theory *Managing Threat* works because it explains the providers' patterns of behavior *as they Manage the Threat* of intimate partner violence. When "concepts and theoretical coding are tightly related to what's going on, they work" (Glaser 1998, p. 237).
4. *Modifiability* - A theory should be open to modification when new data emerges. It is natural that new data may emerge "generating qualification for what came before" (Glaser, 1978, p. 5) as basic social processes may change in variation and relevance over time. Classical Grounded Theory (CGT) methodology allows for

theory modification to explain new or surprising variations (Glaser, 1978). The theory *Managing Threat* is open to modification using CGT analytic techniques.

HUMAN SUBJECTS

This research study presented minimal risk to human subjects. The primary risks for study participants were the potential for emotional distress due to the sensitive nature of intimate partner violence and the possible loss of confidentiality.

Although the study participants professionally work with employees engaged in intimate partner relationships, they themselves may have experienced an IPV relationship. During the verbal consent process before each data collection session, the researcher explored the risk of potential emotional distress with each participant. The researcher ensured the providers they could ask to stop the interview at any time or decline to answer any question. During the interviews the researcher listened to each provider's response, evaluating vocal tone and verbal cues for signs of emotional distress. Had any of the providers indicated they were uncomfortable with the interview subject matter; this researcher was prepared to stop the interview and offer support and a referral to the *National Domestic Violence Hotline* 1−800−799−7233. None of the providers indicated they were uncomfortable during the interviews, nor did any decline to answer questions or request the researcher stop the interview. The researcher did not sense any changes in the providers' behavior indicating emotional discomfort while interviewing therefore the National Domestic Hotline information was not necessary.

Breach of confidentiality of data was also considered a risk of participation in the study. The processes to ensure confidentiality of data were discussed with each provider during the informed consent process. The researcher enhanced confidentiality of the data

by personally transcribing the interviews, storing interview recordings and transcripts on a personal computer that was password protected, masking all identifying information from working transcript copies, and assigning each provider a numerical code. All study data will be destroyed when all study reports are complete.

SUMMARY CHAPTER THREE

Chapter Three has presented a discussion of this study that utilized Classical Grounded Theory (CGT) methodology and its appropriateness for this study. The Chapter has described how Classical Grounded Theory techniques were implemented to guide, collect, and analyze the study data leading to the emergence of the main concern, *Managing Threat*, and the means by which the providers resolve their main concern by *Doing What They Can.*

PLAN FOR REMAINING CHAPTERS

Chapter Four will describe the study findings and substantive theory, *Managing Threat*, that emerged through analysis of the study data. Chapter Five will provide a comparison of the study findings to the extant literature as well as a discussion of the study's strengths, limitations, implications for practice, suggestions for future research, and conclusions.

Chapter 4 Findings

Chapter Four discusses the findings of this Classical Grounded Theory (CGT) study that explored the experiences of Employee Assistance Program (EAP) and Occupational Health providers working with employees in intimate partner violence relationships (IPV). The design of this study was to explore how EAP and Occupational Health providers work with employees involved IPV relationships and develop a substantive theory, grounded in the study data, that explains what is going on during these interactions.

This Chapter will begin with a description of the study sample followed by a discussion of the substantive theory that emerged from the study data, *Managing Threat*. Providers' contact with members of their organization's workforce varies according to the role designated for them by the organization; and this is reflected in their title. Occupational Health providers may see all the employees in their organization as they are responsible for annual workforce healthcare screening and employment testing as well as employees who are injured on the job or have health issues that affect their work performance. On the other hand, Employee Assistance Providers only see employees who self-refer, or employees referred to them by the organization for work performance issues. This study will use the term *provider* to refer to each of these types of providers.

SAMPLE

The sample consisted of ten providers of which one was male and nine were female (this document will use female pronouns to protect the male participant's identity). Table 4.1 summarizes the participants' demographic information. The number

of years the providers had practiced in an organization ranged from 2 – 34 years (M = 23 years) at the time of data collection. The provider's highest academic degrees were: one bachelor's degree (Nursing), eight master's degrees (Social Work, Psychology, Counseling, Education, Public Health) and one doctoral degree (Social Work). Four providers held Certified Employee Assistance Providers (CEAP) certifications, three providers held Certified Occupational Health Nurse-Specialist (COHN-S) certifications, one provider held a Senior Professional in Human Resources (SPHR) certification, and one held a National Certified Counselor (NCC) certification. Three providers were licensed Registered Nurses (RN), two providers were Licensed Professional Counselors (LPC), and two providers were Licensed Clinical Social Workers (LCSW). The providers worked within the following industries: The United States Government, Manufacturing, Healthcare, Academia, Oil and Gas, and Construction. The providers served employees working in the United States and other countries. One provider declined to describe the industry in which she practiced.

Table 4.1: Study Demographics

Provider type	EAP (7)	Occupational Health (3)			
Gender	Male (1)	Female (9)			
Certification	CEAP (4)	COHN-S (3)	SPHR (1)	NCC (1)	
License	LPC (2)	LCSW (3)	RN (3)		
Years worked as an EAP or Occupational Health Provider	1-10 years (1)	11-20 years (5)	21-30 years (1)	31-40 years (3)	
Industry type	Construction	Oil and Gas	Healthcare	Academia	Manufacturing
	U.S. Government	Marketing	Research	Declined to answer (1)	
Education	Baccalaureate	Masters	PhD		

Highest Degree Awarded	Nursing (1)	Social Work (2)	Social Work (1)		
		Education (1)			
		Public Health (1)			
		Counseling (2)			
		Psychology (2)			

The role of Employee Assistance Providers (EAP) and Occupational Health providers within organizations is to promote an environment that supports employee safety and organizational stability. Intimate partner violence (IPV) among an organization's employees poses a threat to the safety of employees and the productivity and stability of the organization. Data analysis revealed that the providers' main concern was *Managing Threat*, which they resolved through a process of *Doing What They Can. Doing What They Can* was a process that began with *Recognizing* which employees are involved in IPV relationships, either as victims or perpetrators, then *Responding* to those employees. Finally, providers engage in *Informal Knowing* to learn/discover what happened to employees in IPV relationships after the employee's sessions with the provider have been completed.

RECOGNIZING

Providers report IPV is a small subset of the employees they see each year, and most are not aware of the actual number of employees in their organization who are in IPV relationships. "I think that domestic violence is actually significantly under reported" P7, L63. Most of the study participants reported that they did not keep a record of the

numbers of IPV cases they encountered each year, but a few providers felt they could query their electronic databases for a yearly total.

> How many [IPV cases] do I see at a time? There are periods of time where I am not seeing anybody where that is identified, that may be interesting to ponder, but I would say in the course of a year I am probably conscious of 6-8 [cases of IPV]" P4, L133.

In order to *Manage the Threat* of IPV, providers *Do What They Can* to *Recognize* IPV. *Recognizing* occurs when providers identify or come to know that a case of IPV exists among the employees in their workplace practice. Providers *Do What They Can* to *Recognize* employees in IPV relationships based on their previous experiences, their knowledge, and their skills; they may *Recognize* IPV when employees disclose their IPV relationships. In addition, employees may be referred to the provider who may *Recognize* IPV as a contributing factor to the employee's negative work behaviors. Providers also may miss *Recognizing* that an employee is in an IPV relationship.

Recognizing employees impacted by IPV relationships may be challenging for providers as both IPV victims and perpetrators may be reluctant to discuss IPV, especially in the workplace. *Recognition* of an IPV relationship is difficult because of the stigma associated with IPV, causing both victims and perpetrators to have feelings of shame and embarrassment and to fear that their IPV relationship will not be kept confidential.

One of biggest barriers to getting help is stigma. "'I'll be looked upon poorly in some way, shape or form if people know that I am in this situation, so therefore I don't reveal it'" P4, L552. "I think there is a lot of stigma around it [IPV]. It's shameful, it's

shameful, nobody wants to be in that situation" P9, L509. Moreover, employees may fear that disclosing their IPV relationship will affect their job status or continued employment: "When you alert your employer that there is an [IPV] issue, I think there's additional concern and [dis]comfort for you both" P3, L224.

What the Provider Brings to the Table

The provider's observational and interviewing skills, professional training, and previous experiences help them *Manage Threat* by *Recognizing* an employee may be in an IPV relationship. Providers understand that IPV relationships do not occur in any one demographic group; it can happen to anyone, regardless of gender, culture, economic status, ethnicity, or sexual preference:

> I think that people think of domestic violence as something that occurs in ghettos and with lower class people . . . [BUT] people who are from the upper middles class or middle class have the ability to conceal [IPV]" P7, L60.

"One of the things I really started to recognize is IPV doesn't discriminate, it doesn't matter your race, your income, it's going to happen" P5, L180.

The study participants reported that they assisted either party in an IPV relationship, the victim or the perpetrator, although they tend to *Recognize* the parties based on different indicators.

Observing

Providers' interviewing skills involve assessing the employee's affect and physical appearance during the interview including any signs of physical injury. When a physical injury is detected the provider explores how the injury occurred. "We do a face

to face interview, especially the first report of injury, to find out um how that they say they were injured" P1, L122. Providers reported seeing injuries that might indicate IPV; injuries such as bruises in various stages of healing, injury patterns that suggest rope burns, bruising around the neck, or a hoarse raspy voice. Another frequent predictor of an IPV relationship is when the employee's explanation of how the injury occurred does not correspond with the injury nor seem accurate. "Physically, actually seeing suspicious bruises, trying to cover up injuries, not believable explanations on causal relationships of injuries… strangulations, you know bruising on the neck or vocal cord, where voice was off" P3, L176. Providers also may notice that employees may try to cover their injuries by wearing long sleeves or using make-up. "If I notice anything clinically suspicious then I start digging: '-is he hurting [you]?' 'is she hurting you?'" P5, L168. Providers *Recognize* the employee may be trying to hide their IPV relationship when they cannot provide a reasonable explanation for an observed injury or pattern of injuries.

> "[What prompted] coming in . . . was that he had broken her arm" P7, L72. She came in with a black eye and basically said, 'I rear-ended somebody in the car, and I hit the steering wheel,' and it became a little bit suspect, well very suspect, when she had too many kinds of accidents" P8, L239. "[Victims may say] 'Every time I get into a relationship, I end up in the emergency room, it's only because I'm a klutz' and then we dig a little deeper" P4, L321.

Providers *Do the Best They Can* to *Recognize* the emotional abuse of IPV as well as the signs of physical abuse. One provider reported she had become suspicious that the employee was a victim of IPV because of the woman's apparent fear of her husband.

> She did come back into the clinic and wanted to know if she could be released so she could go back to work because her husband was upset that she wasn't working . . . I didn't see any physical abuse at that time, but this had potential to be an abusive relationship in my mind P1, L115.

Interviewing

The providers bring a number of skills to their interactions with employees, including identifying IPV relationships. One of these skills is interviewing. Providers strive to build trusting relationships with all employees who come to them; many emphasized the importance of maintaining eye contact, conducting the interview in a safe, calm location, and giving the employee time to respond: "…looking at the person like you really do want an answer . . . not being rushed . . . give them a chance" P1, L141. Providers attempt to create an environment where employees involved in an IPV relationship, whether victims or perpetrators, will feel safe to reveal what is going on in their relationships.

The provider may ask simple interview questions such as: 'Were you ever hit by a partner or abused in any other way?' and 'Do you feel safe at home?' P1 L141. However, some providers believe that asking about abuse too quickly will deter the employee from disclosing IPV so they wait for the right time to use exploratory questions or may not use them at all. "If you hit them too soon with these questions, you're not going to get the right answers" P4, L347.

While most providers relied on their interviewing skills to identify IPV, some also used their interview to determine whether to use an IPV screening tool or screening

questionnaire. The most common single screening question they used was, "Do you feel safe?"

> I don't use one [screening tool] specifically for domestic violence . . . unless I have an inkling it might be appropriate. If I slip that one in there, I think that women would find it intimidating, so if my radar goes up, I start asking more detailed questions. P9, L282.

Only one provider reported using an IPV screening tool with all employees who came to the office.

The providers know that an employee would be reluctant to disclose an IPV relationship in the presence of a third party. Sometimes the employee may be accompanied to the interview by a manager or, occasionally, by the perpetrator, so it is important for the provider to manage the space in which interviewing takes place.

> We always try to have the injured worker in the exam room by themselves on the first interview, so they don't feel compelled to say the injury happened this way because her boss is sitting there, or the injury happened this way because her partner is sitting there. P1, L131

In the case of IPV victims, the provider's interviewing skill can help the provider *Recognize* IPV as a component of the victim's problem: "We were taught to look for the silence, the withdrawal, the gaining or losing weight, the not participating, not having the spouse over, you know the subtle, the silent signs" P10, L46. In the case of perpetrators: "[listening for] rage, frustration, lashing out instead of trying to figure out what's wrong" P1, L80. While they interview employees, they listen carefully for what is said and for what is not said. Gaps or missing pieces of the employee's story, along with information

the provider has gleaned using other skills, may lead the provider to explore the possibility of an IPV relationship. “Call it learning what you don’t hear; there are strange gaps in stories, that’s usually a red flag . . . realize a pattern of strange, inexplicable gaps” P4, L313. “[The provider doesn’t] feel they are getting the whole story. There is strange interaction… [they say], ‘yeah everything is just fine,’ but then the atmosphere in the room is very strange” P1, L34.

Providers use their skill and experience to *Recognize* the employee’s IPV relationship even when the employee is reluctant to share that they are having relationship problems that involve physical and/or emotional violence.

> They [employees] don’t walk in the office and say, ‘I’m in a violent relationship,’ it will be, ‘I’ve got a problem in my marriage’ or ‘I’ve got a problem with my kids,’ or ‘I’ve got a financial problem.’ It will be under the guise of something else and then it will unfold. I’ll Identify it . . . but they [employees] won’t come in with that [IPV] as the language that they use. There is some skill on the clinician’s part to Recognize it when it presents even if that is not exactly what they are saying. Ok so, they don’t maybe see, [or] understand that it’s [IPV] P9, 138.

Employee Self -Disclosure

The providers reported that employees who were in IPV relationships occasionally disclosed the relationship without prompting by the provider. “Clients sometimes are self-referrals, they initiate the call on their own” P2, L31. These employees usually were the victims of IPV: “Probably, you would think we would have more perps . . . but they are less likely to come forward; victims are more likely to come forward” P4, 163. One provider noticed that victims tended to self-disclose when they

were ready to get help: “Typically, they [the victim] came right in and told us …. that was overwhelming[ly] the case. That’s what was bringing them in” P7, L187.

The providers reported that the motivations for perpetrators to seek their services were different. A few providers described perpetrators who self-disclosed because they no longer wanted to be perpetrators.

> I can think of two or three occasions over time [when perpetrators self-disclosed]. I can recall two men who presented saying, you know, ‘I am hitting my wife and cannot stop. We get into a disagreement then I don’t have any idea to how to respond when I feel this way’ P9, L184.

More frequently, the perpetrator had exhibited some form of violent behavior that resulted in a legal action such as restraining order or court-mandated anger management therapy that brought them to the provider: “They self-disclosed because it was a condition of a legal ruling that they get treatment” P2, L112. The perpetrator, often at the request of an attorney, will self-disclose the IPV to a workplace provider and request anger management treatment to mitigate pending legal actions or satisfy a court order. “You’re going to see the motivation [for a perpetrator to self-disclose] being much more intensified when there is somebody going to court and they want to prove that they have had some level of intervention” P2, L61.

Providers in the study report a recent increase in victims’ willingness to disclose IPV. They attribute this change to a cultural movement toward acceptance of IPV as a social problem, encouraging victims to speak out about abuse.

> You know, I think again it has changed dramatically, the stories, the news stories, the frequency, the whole reality of the commonness of it. I think . . .that it is not

> as uncomfortable. [I'm] not saying it's comfortable but it's not as uncomfortable P10, L1.

Conversely perpetrator self-disclosure remained mostly the result of legal issues. "Perpetrators are rarely reported" P3, L27.

Organizational Referrals

The provider may *Recognize* the employee's IPV relationship when the employee has been referred to the provider by a member of the management team. Organizational referrals may be informal as when a manager or supervisor suggests the employee make an appointment with the provider to discuss what is affecting the employee's productivity. Such a referral is informational and optional for the employee.

> There is something called soft referral, or leader suggested [referral], someone goes in talking to their manager and their manager is like, 'gosh you got a lot going on. Have you heard of our EAP, why don't you go talk with them?' P 5, L52.

A mandatory referral or formal request that the employee see the provider may be based on poor job performance and is an attempt to correct negative work behavior. "The company feels that it is that important for the employee to seek some intervention so it [the provider visit] can be made into a mandatory referral" P2, L104. A mandatory referral is usually reflected in the employee's personnel file and may include stipulations that the employee complete a course of treatment with the provider or risk being terminated.

> Then there is a formal referral or the hard referral, that's the job performance-based referral so there is something significant that a leader has noticed and their

> job performance has declined so they are using this, hopefully, as part of the plan to keep this person on board P5, L56.

Mandatory organizational referrals are often generated by managers and supervisors as part of an employee remediation plan.

> I would say 15% [of perpetrators] were referred by the company in one way or another so in that 15% you had people who were coming in as a result of manager suggestion, the manager did not make a formal referral to the EAP but the manager said, 'Gee, I noticed you were upset maybe you should go to see the EAP.' A smaller percentage out of 15% were manager-suggested where the manager is making a formal referral to the employee assistance program. 'If you choose not to go that is your right, but if you go, we would like you to sign a consent form for the release of information to show you were attending.' The smallest percentage that were mandatorily referred most often [worked in] companies where the employees had regulations and were . . . in safety sensitive positions P7, L107.

The organization may refer IPV victims or perpetrators to the provider based on observed negative work behaviors such as tardiness, absences or inattention. Such behaviors frequently are exhibited by IPV victims and can impact the organization's productivity and safety. "[The referral is from] Human Resources [based on] job performance, attendance issues, that is when domestic violence gets impacted, so while investigating what was causing the tardies, the absences, [the]domestic violence comes out" P3, L17. Perpetrators may be referred to the provider by the organization for negative work behaviors usually consisting of workplace aggression and/or sexual

harassment. “A formal [perpetrator] referral to the EAP [is] expected to go to some sexual harassment prevention training, diversity training, depending on what the situation is … violence management training” P7, L388. The organization may also refer the employee to the provider based on negative behaviors that impact the organization’s security clearances or legal standards.

> The employee’s criminal status [is monitored by] the company . . . [the company] is constantly alerted about all of these [behaviors that could become security breaches and] will pay for a service that provides them an update, if there has been anything that comes up from a legal perspective. It is very important to the organization because of the potential to pose [a threat to] security clearances P2, L69.

Many of the study participants worked for organizations that have an international presence and therefore must adhere to the laws and standards of every country in which they are located. IPV behaviors may place the organization at risk. “We can’t, we can’t risk having an employee that is demonstrating that sort of behavior in a foreign country and risk the exposure to the company” P2, L351.

Failure to Recognize

Despite experience, skills and training providers may miss *Recognizing* the employee’s IPV relationship. For example, providers missed an IPV relationship by not identifying the cause of the employee’s injuries or behaviors; and then realized the employee was the victim of IPV when it was too late:

> So, I had this situation where [the employee’s explanation of the injuries] made very little sense. I mean, it was just confusing because she was just so secretive.

> Within about a year of that, about a year later, she was murdered by her spouse and that then made sense to me why she was so anxious P6, L32.

Providers also may miss IPV when they observe visible injuries during their interactions with the employees but do not follow up with the employee as to how the injuries were sustained.

> "I can only kind of guess and speculate unless they tell me. I did not directly ask her … she gave me a story and I did not pursue beyond that, I talked to my colleague, another nurse, to say, 'Have you had any encounters with her?'…. In my mind I was thinking, 'My goodness, has this person been involved …maybe they were involved with bondage or participated willingly in bondage sex?' I wondered [about the injuries]" P6, L146.

Providers in some organizations may fail to Recognize IPV because the organization uses third party vendors as the initial contact for employees with health issues. The employee enters pertinent information into an online system, leaving the provider without the opportunity for a face-to-face interaction in which *Recognition* of IPV might occur.

> Sometimes there is not resources available or so much is done by computer, so they don't ever really interview the person directly, even after they had an injury. The interview is done by phone or the interview is done by an accident report and you don't get the same amount of kind of information all the time P1, L168.

While IPV can happen regardless of gender, providers working in male-dominated organizations have additional barriers to *Recognizing* IPV cases.

> Organizations that are very male in nature like manufacturing or police, fire, [the] post office, things that are more male. . . are not as equipped to deal with it [IPV]… because the perpetrators are typically not as expensive [to the organization] as the victims. In other words, it's not as disruptive, or obvious P3, 481.

Moreover, perpetrators can be difficult to Recognize if they are skilled at manipulation and present themselves as very likeable. In addition, perpetrators most often do not see their abusive behavior as a problem, so they do not seek assistance from the workplace providers.

> I have never had a perpetrator admit they did anything wrong (laugh). Everyone thinks the perpetrator is a really good guy. Typically, this may be a little bit emotional, but no one ever thinks that the person next to them in the cube is a perpetrator of domestic violence P3, L386.

Failure to recognize may result in poor outcomes. "I did not know [she was in an IPV relationship] until she was deceased. She was murdered by her spouse" P6, L14.

SUMMARY

In order to *Manage Threat* by *Doing What They Can* providers first must *Recognize* that a given employee is involved in an IPV relationship that poses a potential threat to the workplace. Providers are aware that some employees in their workforce may be in IPV relationships, but these employees cannot be *Recognized* simply by looking at their demographic characteristics. *Recognizing* IPV is difficult because of the stigma associated with IPV. Employees may not wish to disclose their IPV relationship due to feelings of shame and humiliation. Providers understand that employees fear disclosing

their IPV relationship because of the possibility that the IPV label may place them in a bad light within the organization, resulting in barriers to job opportunities or job termination.

Providers strive to promote environments where the employee can feel safe and comfortable disclosing or discussing IPV. During any interactions with employees, providers rely on their skills of observation to assess for injuries that might be indicative of IPV then call on their interviewing skills to follow up on their observations of the employee's injuries. Occasionally, providers use IPV screening tools to *Recognize* IPV, although most do not, relying instead on their interviewing and observational skills. Providers are concerned that using a screening instrument to identify IPV could spook the employee if it is used before the employee is ready to discuss IPV.

Employees who exhibit negative work behaviors may be referred to the provider by the organization in an attempt to correct such behaviors. Negative work behaviors may consist of the employee frequently calling in absent to work, being late to work or exhibiting inattention or distraction while working. Negative work behaviors also may include exhibiting anger and aggression at work or aggressive behavior while outside the workplace that results in legal actions such as restraining orders, loss of security clearances, violations of terms of employment, or embarrassment to the organization. Organizational referrals may be in the form of an informal suggestion or they may be a mandatory, a demand by the employee's manager or supervisor to make an appointment with the provider. Employees may see the referral to the provider as a threat to their continued employment rather than an opportunity to change their IPV behaviors. Providers may also miss the opportunity to *Recognize* IPV.

RESPONDING

In order to *Manage the Threat* of IPV, providers *Do What They Can* to first *Recognize* IPV and then *Respond. Responding* occurs when the provider *Recognizes* the employee's IPV relationship and then formulates a course of action to assist the employee to begin working through their IPV issues while, at the same time, promoting employee and organizational safety. The provider *Responds* to victims and perpetrators, as well as to the organization. How the providers *Respond* is different for each party: whether it is the victim, the perpetrator, or the organization. In each case a primary goal of the provider's *Response* is the overall well-being of the organization. "We are looking for the safety for our population, not just the individual but all the employees" P3 L141. "There is a lot of time, energy and resources for addressing intimate partner violence in the workplace. It is high alert" P2 L146. The provider's primary *Response* to victims and perpetrators in IPV relationships is counseling. Some providers refer employees to therapists outside of their organizations that specialize in IPV counseling. Providers also may have a network of resources to augment both victim and perpetrator counseling that vary by organization. Resources available for IPV victims outside the organization may include women's shelters and legal assistance; additional resources available within the organization may include security and threat management teams, flexible scheduling, and in some cases financial assistance. Resources for perpetrators include referrals to anger management groups specific to IPV perpetrators and legal assistance. The provider also may *Respond* to the organization as a member of a threat management team by evaluating, monitoring, and reporting on the progress of employees who are referred for negative workplace behaviors. Providers also *Respond* to the organization as the source

for IPV education and organizational policies for all employees. Provider's *Response* to IPV in the workplace comes at some cost to the provider and involves emotional labor.

Counseling

Many of the organizations where the study participants were employed provided free counseling sessions to the employee, and occasionally to employees' family members. "All full-time employees are eligible for service including, at minimum, their benefit-covered relatives so it would be typically your spouse, sometimes domestic partner, your children; but many companies had more generous programs than that" P7 L147. Counseling sessions usually are limited by the organization to six to eight sessions.

> "We are short-term counseling, so we will see people generally anywhere from one up to roughly eight sessions; some are resolved sooner than that depending on the nature of the concern. I don't have lot of long-term cases in this area [IPV]" P4, L124.

If short term counseling is not sufficient, the employee may be referred to an outside agency for long term counseling which may or may not be covered by the employee's health plan: "We are short term counseling so if they are coming in and [IPV] is their presenting concern then we would set them up with help even if we do not do it directly" P5, L343.

Provider's Response to Victims

The provider's *Response* to employees who are victims of IPV begins with assessing their safety. If the employee is in immediate danger the provider's *Response* is to help that person be safe.

Let's go to the situation where we have to remove somebody from their home and [go to a] shelter. You would be surprised about how quickly that conversation could happen. I've seen it happen in 20 minutes [after discovery of IPV] P10, L86. Providers know that leaving the IPV relationship is when the employee is most vulnerable, and they are careful to thoroughly discuss the dangers of leaving an abusive partner; providers are careful not to give unrealistic assurances. "It's extremely difficult to leave, it can be dangerous for [victims] to leave, you have to be very careful when working with this population" P5, L197.

> Be careful not to be the knight in shining armor, if you come in too strong and say, 'You poor thing, let me rescue you, let me help you pack your bags!" . . . We know that's the most vulnerable point in the life cycle of that victim, when they try to extricate themselves. So, tread carefully that you are not increasing their risk rather than doing some wonderful magical, savior-style maneuver P4, L174.

"I can't promise that this is going to go well and nothing else you will do will ever put you in more jeopardy" P3, L385. Providers frequently send employees who are fearful their partners will be physically violent directly to domestic violence shelters and encourage employees who have been battered to file a police report. Domestic violence shelters offer short-term housing and counseling services; some also offer legal assistance and help with restraining orders.

> Often times it just requires a higher level of care, [to provide] services to them. "[Victims] need a domestic violence shelter, or the engagement of the police force, I prefer to deal specific[ly] with domestic violence units for that and legal services can come with it P3 L149.

Providers discuss emergency safety planning with victims that includes creating a plan to leave the abuser when it becomes necessary.

> [Victims] need to know when to make the phone call. To have …the emergency bag, knowing where the keys are, those kinds of things. My part is to educate [the victim] to what those resources are, why they may be beneficial. . .We start by talking about this being an assessment and then either short term treatment here in-house or referral. There [are] a number of cases where it is both... I want to make you aware of extra resources P4, L200.

In addition to counseling and referral to police and domestic violence shelters, providers assist IPV victims with accessing organizational resources, which vary by organization. For example, if the perpetrator is harassing, threatening to harm the victim, or stalking the victim in the workplace, the provider's goal is to create a safe environment within the workplace. Providers working in organizations that have security guards or security teams may provide escorts for victims moving within the workplace and to the parking area when they are ready to go home.

> "We created a safety plan actually, it included an entire chart, so the victim never walked to the car alone, never went to lunch alone. They really put a human shield up, and I can tell you it worked, I mean it stopped. It was a situation where she was dating someone at work and it had become violent P10, 169.

"We contact . . .security to come over and have them talk to you about how they can protect you while you're here because the issue is, [the perpetrator can] come up here too" P5 L247. Providers also may ask the organization's security team to actively deter the perpetrator from entering the workplace. The security team may circulate the

perpetrator's picture, ask the perpetrator to leave if the perpetrator is on the premises, and report the perpetrator to the police. "I would also be talking about 'let's get the [organization's] police aware this person should not be here on these grounds'" P4, L240. Providers also may enlist the organization's security team to monitor the victim's work phone and emails for perpetrator threats. "We don't want this person to be able to harass you over the phone. What can we do to create blocks? What can we do to create ways that will mitigate the chance that he can reach you?" P4, L513.

> A member of the core security [team] frequently would go through emails [sent from the perpetrator] on a daily basis so we could monitor what was on the perpetrator's mind and refer to the police . . . then we would at least have access to what was on the perpetrator's mind versus totally cutting of communication . . . I would tell them not to cut off the phone to the perpetrator. 'Let those calls continually come in, have someone else listen to them if you want but by cutting off communication that would often force the [perpetrator] to show up either at your doorstep or your workplace or your family member's home it would just raise the ante on what they would need to do to communicate with you' P3, L453.

Providers may be able to move the location of the employee's work or parking space to a different location. "We move their parking spot, or we will assign them to a designated workspace that is not marked" P2, L131. One provider had intruder alarms as a resource that could be loaned to IPV victims to use at home to alert victims to unannounced visitors.

> [We have] mobile security devices that we can lend out, like library books, so if the issue was they had no home security and needed to borrow, the Tattle Tale,

was the name of the brand we often purchased [we] let the employees use them P3, L61.

Providers may work with the organization's Human Resources department to arrange either paid time off, non-paid leave, or create flexible scheduling allowing the employee time to move, arrange for childcare, or go to court appointments. "Some companies will really stick behind the victim, if the victim is working for them, and transfer them to another location or put them on another shift" P8, L145. "We accommodated whatever time she needed to go for the order of protection, testify in court . . . if she wanted to leave work early or take the day off, all of those things were ok" P7, L248.

> We would [ensure] the supervisor wouldn't have to know that this is a domestic violence court appearance. We would have Human Resources communicate that periodic absences, for a limited time, were to be approved but we would work with the employee . . . we would be following the court dockets, the trials, all those types of thing so that we would know exactly when they had to appear in court as well . . . we would be the ones who would actually enter the time into the system for the leave protection for the employee P3, L346.

Some providers have access to funding to assist employees who are facing difficult circumstances; providers may facilitate the victim's access to those funds.

> One employer had employee assistance grants that covered things like natural disasters that weren't covered in insurance and we put victims of violence in that category as well. If someone would have their tires slashed by an abusive partner,

> they could apply for that grant money if it was something their insurance wouldn't cover P3, L64.

Providers in some states may facilitate the IPV victim's awareness of and access to state legal protection available to IPV victims.

> [IT] looks and acts a lot like family medical leave with respect to domestic violence; it allows the person to have protected time away from the job to address issues like needing to move, to attend court, to attend therapy, to attend to child care where there is a domestic problem P9, L41.

Many of the providers have organizational web pages that feature IPV education and provider contact information. "We have a portal for services, if somebody doesn't want to directly speak to somebody about the issue, they can go to the portal . . . then there is a Skype forum available for them" P2, L335.

Provider's Response to Perpetrators

The provider's *Response* to the perpetrator is counseling with an emphasis on anger and behavior management. "I get a lot [of perpetrators] for anger management, and inappropriate conduct in the work environment" P9, L253. Although providers may assist employee perpetrators, at the employee's request, with anger management counseling to mitigate pending legal problems that stem from their IPV behaviors, most employee perpetrators are required by the organization to see the provider as part of a behavioral, disciplinary, or corrective action plan. The provider *Responds* with counseling sessions for the perpetrator that are geared toward correcting negative workplace behaviors or mitigating legal issues. The provider also documents the perpetrator's compliance with attending sessions or may place perpetrators on a behavioral contract or monitoring plan

for negative behaviors attributed to IPV. The perpetrator must comply with the parameters of the behavioral contract or monitoring, or risk being terminated.

> Sometimes their continued employment here includes something called a last chance agreement, meaning that they agree to certain terms and those terms might include 'go see the [provider]' and then I confirm their attendance, with the person's authorization, and then what transpires is between that person and me P9, L249.

"[the provider] will put [the perpetrator] on monitoring . . . where the leader is responsible for doing an observational questionnaire to identify any concerns that might be seen in the workplace" P2, L356.

> Basically, it involved setting up a behavioral contract up to and including termination for going to the person's desk, showing up on their floor for no reason, things like that . . . in that case there wasn't any actual restraining order issued so we had to address it as co-workers who are disruptive P3, L293.

The provider may require the perpetrator to attend classes or training sessions addressing acceptable workplace behaviors. "[When] a formal referral [is made the employee is] expected to go to some sexual harassment prevention training, diversity training, depending on what the situation … violence management training" P7, L388. The provider may refer the perpetrator to someone who specializes in group interventions for perpetrators.

> I was also very fortunate that one of our EAP clinicians, a guy, actually ran a group for perpetrators" P7, L52. "I can't always be the person who goes all the

way there, but I can identify it and try and find, you know, the right person to do that [perpetrator counseling] P9, L197.

Provider's Response to the Organization

The provider role within some organizations encompasses being a member of the organization's threat management team. Threat management teams are designed to protect the organization from dangerous, threatening, or violent behaviors in the workplace. The threat management team is composed of representatives from several organizational departments such as legal, executive, human resources, security and EAP or Occupational Health.

> Any sort of threat to the environment . . . multiple disciplinary teams gather at the organizational level which consisted of a physician, a counselor, an attorney, EOC, labor, human resources, security, [and] investigations, and we convene and review the information . . . then, there is an action plan that is designed P2, L77.
>
> [we] bring in additional parties should the need arise . . . that core solid team needs to be highly functioning and know what service option tools are available to them because if you build it, they will come P3, L114.

Some threat management teams have professional training in managing and *Responding* to workplace violence, which can include IPV.

> The dedicated crisis response team [has] similar reference points for education on what tools [they use to] rate a crisis, how are they going to assess it. All [team members] have an understanding of what that means . . . the degree of threat triggers the action and degree of involvement of the crisis response team P3, L104.

Employees in IPV relationships have the potential to bring violence into the workplace and some threat management teams have specific strategies for perpetrators.

> Some organizations will talk with the perpetrator and try to de-escalate it and just kind of monitor them, there are so many different programs out there now that some of these more sophisticated groups can use to monitor the [perpetrator] to see where they are, to track them, kind of keep an eye on them, kind a draw a line in the sand and say, 'this is what's going to happen.' It keeps the company out of it for the most part, the company feels like it can be safe because somebody else has intervened P8, L133.

The providers also *Respond* to the organization by educating the workforce about IPV and the organization's IPV policies. The provider educates organizational leadership on provider resources that are available for employees in IPV relationships from a management perspective.

> [Providers facilitate] education for stakeholders and the threat management team. We are actively engaged with the resources that are available, we constantly are trying to become more educated, [and] the organization takes it very seriously, they pay consultants to proactively create strategies for us consistently on managing this issue P2, L322.

In most organizations the provider delivers IPV education to the workforce during every employee's initial orientation to the organization then periodically through educational classes and brown bag lunches. "Trainings were posted on the company intranet. . . about programs that were going to be offered" P7, L406. "New hires have to do [IPV] LMS, learning management modules at hire and [again] periodically" P9, L491.

Educational sessions are often offered with new hire training then again periodically with leadership training opportunities. “We [providers] talk about it, post a seminar session and that kind of thing. Initially in orientation it may be human resources that brings it [IPV] up in orientation and the employee handbook” P8, L331.

Failure to *Respond*

Failure to *Respond* occurs when the provider *Recognizes* that employees are in IPV relationships but does not formulate a course of action to assist the employees with their IPV issues. The provider may fail to *Respond* to the victim, the perpetrator, or the organization. How the provider fails to *Respond* is different for each party: the victim, the perpetrator, and the organization

Failure to *Respond* to an IPV victim may occur if the provider is uncomfortable working with employees who are victims in IPV relationships. Such providers are unsure of what to do with their suspicions that the employee may be involved in an IPV relationship. “I don’t feel I am very well trained in [IPV counseling] . . . I did not pursue beyond that,” P6, L143. The provider may also be uncomfortable if they themselves were in an IPV relationship. “I certainly have lived with [a perpetrator] so I learned it from that way. It’s not something I’m an expert on” P10, L118.

Failure to *Respond* to an employee perpetrator may occur when providers perceive the organization will tolerate the perpetrator’s behavior; this tolerance may happen when the perpetrator is well liked or in a position of power or authority.

> [The perpetrator] was in a higher position than [the victim] and [the victim] took quite a risk to report. The way it was handled was [the victim] was sent to a different location, so they didn’t handle it, they just moved her to a different

> organization. They actually had some other sexual harassment suits and things like that against [the perpetrator] with other employees. [The perpetrator] was a handful and nothing was done because [the organization] deemed him as being too valuable P8, L224.
>
> I would not say that the [workforce] knows that there's no tolerance [of IPV perpetrators] because there is some tolerance, sometimes. It depends specifically on what is gathered by the investigators, it depends on the longevity of an employee and whether or not there's been a demonstration of any violence in the workplace P2, L154.

Sometimes the provider cannot *Respond* to the perpetrator, who is an employee of the organization, because the victim wants to keep the IPV relationship confidential.

> [The Victim] never reported and it wasn't a situation where we could violate confidentiality. . .. one of the dynamics for [the victim] was [the victim] did not want anybody to know she was having a relationship with a subordinate. [The victim] certainly did not want anyone to know she had a relationship with a subordinate that beat her P7, L92.

Providers *Do the Best They Can* to *Respond* within the framework of the organization's guidelines. Sometimes the provider's *Response* is constrained by organizational boundaries such as union restrictions or organizational policies.

> We had a husband and a wife involved a love triangle that went south. He shot her . . . they had a horrible relationship; she was the one who was emotionally violent, and he was the one who after so many years said, 'I know how I'm going to finish this'. They were both in the same department. There was really very little

> [providers] could do about it because they tried to separate them, they didn't want to be separated, they wanted to be put back in their old positions, they were very reluctant to give up their drama. . . . Until recently in [name of State] unions were pretty powerful, and you know they had the union behind them, and they didn't want to be moved so they could continue their drama and they did, all the way to the ugly end P9, 348.
>
> [Responding] depends on the employer, the setting that [the employees] are working in, if they are working at [a fast food restaurant] there is not a lot of invested [IPV] support offered for those type of jobs. ...I don't think some employers have the means or the education" P1, 161.

PROVIDER'S EMOTIONAL LABOR

Providers also must cope with the emotional labor involved in dealing with IPV, whether it be victims or perpetrators. Hochschild (1983, p.7), describes emotional labor as:

> Labor [that] requires one to induce or suppress feeling in order to sustain the outward countenance that produces the proper state of mind in others . . . This kind of labor calls for a coordination of mind and feeling, and it sometimes draws on a source of self that we honor as deep and integral to our individuality.

Providers acknowledge there is no quick fix for IPV; they know it takes patience to work with employees in IPV relationships. Providers must regulate their own feelings while working with employees in IPV relationships and each reports frustration working with IPV victims, especially when dealing with the victim's vacillation between staying or leaving the relationship. The repetitive nature of IPV victim counseling can be

emotionally exhausting for the provider. “I certainly have encountered the difficulty of encouraging those who are victims to move forward” P4, L175. Providers find it especially difficult when they have worked hard to provide counseling and resources to the victim who then does not leave the abuser but stays in the IPV relationship.

> This woman, she was brilliant, and attractive and wealthy, and I thought ‘this is going to be a no brainer’… well after all that she just went back to him” P7, L78.
>
> “[We would] give them lists of shelters and other resources hoping the person might do one of the things we [suggested]. We [would] actually get on the phone and find a shelter that had an opening and sometimes the person said they would go, and they didn’t, sometimes they went and then they still went back [to the relationship] P7, L352.

Providers know the odds of the victim successfully leaving the IPV relationship is low and the providers’ efforts often go unrewarded. “What can we do to not have you go back? What needs to happen for you not to retract the charges?” P4, L174. “This is what I discovered over and over and over is that our successes with these types of clients were extraordinarily low. . .nine times out of ten they would go back to the abuser” P7, L80. The providers understand it may take repeated exposure to both IPV and counseling before the victim is ready to attempt a change.

> It’s not a single dip, it’s not like, ‘Let’s put you in a big classroom and have a full day of education and we are good for the next twenty years.’ It doesn’t play out that way, you have to have multiple dips that’s how we behaviorally learn and the first time…let’s just dip, daydream, maybe it’s on the second or third. it’s like, ‘Wow, yeah, guess what, this is more relevant than it used to be, now I’m

listening!' ... making sure that you appreciate the fact that it's not a once and done type of learning, it has to be a re-exposure P4, L558 another commented:

> The way we think about them [IPV victims], is really like an addiction, an addiction is characterized by relapse, and what it consists of is a process that could take doing something over and over again, making very small gains and maybe over time succeeding in getting the person to leave the relationship, that was a big reality check for us P7, L382.

> One of the most frustrating things to Recognize is that the [victim] who this is happening to is not going to change the perpetrator. It's working with the victim to remove themselves from the victim mentality because that cycle continues over and over again and both are at fault. The victim is not asking for the abuse, but they are staying in the relationship due to the intensity of the manipulation P5, L188.

Employees who are victims of IPV may want to remain in their relationship hoping they can work it out and providers must respect the employee's choice: "You have to meet the client where they are at, not necessarily where <u>we</u> are, so they might not want to leave, they might come in and say, 'How do I stay in this [relationship]?'" P5, L348.

> Instead of just working with me to decide what she wanted to do, she had in mind, 'we need marriage counselling,' and brought him in . . . she actually brought him into our encounter with the expectation that I was going to fix them, or fix him,

> and I'm like, 'No.' I didn't get anywhere with them, it was very, very, difficult P9, L380.

Providers experience conflicting feelings when working with IPV perpetrators. Some providers expressed a desire to help the perpetrator. "I mean my basic philosophy is everybody deserves help. I certainly believe that. I believe we have an obligation to get everybody help" P10, 119. Providers realize perpetrators usually do not seek help unless their behavior puts them in legal jeopardy. "There is very rarely an opportunity to get any clinical care for that person, at least unless he gets arrested, or went to jail, maybe is court ordered to some kind of perpetrator intervention" P9, L172. Some providers noted if their obligation was to the employee victim, they could not ethically also work with the IPV partner who also may be an employee of the organization.

> The person [perpetrator]sitting in front of me guilty as the day is long is also in pain. . . I don't get to go there or to address what might be going on with that person because my primary concern has to be the person [victim] who is in danger P9, L200.

Some providers had interactions with perpetrator whom they felt to be repellent:

> The only time in my career where I actually had to resign from a case because I eventually found the person to repugnant too work with. As a counselor we have to be careful about that and search our own conscience. [But] the more I learned about this human being the harder it is to look him in the eyes P4, L412.

Some providers were frustrated by societal double standards where violence is supposed to be denounced but in reality, is admired creating environments where IPV may seem normal.

> Society is going down the drain and our propensity towards validating violence as both an entertainment and a response to conflict often times is the first choice valued. We have a lot of double talk around violence. On one hand it's, 'oh no, we can't touch anybody, you can't hit anybody, you have to harness your impulses, you can't ever get into a fight!' But then, really just under the surface, that is what we promote and validate, we admire the guy who can kick some ass... Our sexual assault reporting is through the roof now that it has got the stamp of approval as a behavior that is valid, considered valid, and will be tolerated. It is in this environment that all the pretenses are gone, are down, we don't even have to pretend to be civil anymore and the translation into the sexual domain is through the roof and is now reported, documented…. numbers are up P9, L79.

SUMMARY

Providers *Manage Threat* by *Doing the Best They Can* to *Recognize,* then *Respond,* to employees involved in IPV relationships. *Responding* to employees in IPV relationships involves formulating a course of action to assist the employee to begin working through their IPV issues.

The provider's primary *Response* to both victims and perpetrators is short term counseling. Many organizations include the provider's services as an employee benefit and pay for short-term counseling sessions. Some providers may refer IPV counseling to counselors outside of their organization who are specifically trained to work with victims or perpetrators. Providers also may facilitate group counseling sessions on the subjects of anger management, sexual harassment, or organizational diversity.

Providers may have access to additional organizational resources for victims of IPV. If necessary, the provider will assist with the victim's entry into a domestic violence shelter where counseling and legal services are often offered. Providers may facilitate the use of the organization's security department to assist the victim. Security guards may escort the victim to locations within the organization or to the parking lot. Security guards may also restrict the perpetrator from entering the organization. Providers may assist the victim with obtaining a flexible work schedule or time off to relocate, care for children, or go to court. Providers may facilitate victims' access to the legal system and be knowledgeable about any state protections or funding opportunities that may be available.

Provider *Response* to perpetrators is often anger management counseling requested by the perpetrator to mitigate a pending legal action. Provider counseling may be a mandatory job requirement for the perpetrator exhibiting negative work behaviors. The provider may be required to document the perpetrators session attendance or place the perpetrator on a behavior management contract.

Providers may be part of the organization's threat management team where they offer advice and consultation to the team about employees in IPV relationships. Providers educate the work force about IPV and the organizations policies surrounding IPV at employee orientation and intermittently by way of seminars or brown bag lunches.

The Provider's *Response* to IPV comes at an emotional cost to the provider. When providers counsel employees they must project a professional demeanor, keeping their own feelings and biases to themselves, often leading to frustration or emotional turmoil. Providers may find IPV victim counseling to be frustrating and futile when, despite

counseling, allocation of resources, and the provider's diligent efforts, the victim may remain indecisive about leaving the abuser or leave temporarily and then return. Perpetrator counseling also may emotionally affect the provider. Providers are conflicted in their desire to help perpetrators who often are known to be manipulative and violent. Some providers want to help the perpetrator but feel they do not have the skill set for working with them or already are committed to counseling the victim who may work for the same organization.

Failure to *Respond* to victims may occur when providers are uncertain or conflicted about how to *Respond*. This may occur in work environments that are predominantly male where the provider may not encounter many employee IPV victims or when the provider is inexperienced. Some providers are IPV victims themselves and that experience may affect the way in which they *Respond*. The provider may not be able to *Respond* to the perpetrator if the perpetrator is in a position of authority or thought to be indispensable by the organization.

INFORMALLY KNOWING

Providers *Manage Threat* by *Doing the What They Can* to *Recognize* and *Respond* to employees in IPV relationships. Few providers track or follow-up with employees they have seen for IPV issues. Providers report the lack of a formal tracking mechanisms for IPV outcomes causes them great concern. "No, there is no formal program, plan or policy about the follow-up. There is nothing; that does not exist" P6-2, L15. Because no formal follow-up procedures are in place, most providers don't know whether the employee has resolved the IPV issues, has assimilated back into the workplace, or has been terminated.

"That's a big problem [not following employees in IPV relationships] . . .. And that is one of the most broken problems. You have kind of written it off; it is cured, and it's a problem. There are some counselors that will follow up, it does happen. But in general, the practice is we have decided, 'you are good to go, goodbye, good luck and that's it'" P10-2, L4.

"Unfortunately, the norm is inadequate. I would have to say that most employers, especially in manufacturing, don't have the means to respond to these situations on an expert level and it is all pretty much not followed or tracked adequately" P3-2, L75.

Providers acquire information about the status of employees in IPV relationships after they have concluded their work with the employee through a process labeled *Informally Knowing*. The provider does not have direct knowledge about what happens to the employee and only learns what happened to the employee through informal processes. For example, the provider knows employees in IPV relationships are still employed if they see them in the workplace, "Well, my sense is that we still see the person around" P6-2, L24. Some providers may check organizational directories to see the employee's job status in the company's data base. "I will do some of my own investigating because in my system I can tell if people were fired. So, I would follow up if I had not heard from a client lately" P5-2, L22. Providers who formed close relationships with the employee may receive updates on their progress from the employee.

". . .once [a] therapeutic relationship is formed there may be knowledge through [informal] communication channels" P3-2, L84. "[Does the provider know] it has

come to some resolution? I think it becomes whether or not the person has shared it and they let folks know if it has been resolved" P8-2, L54.

Confidentiality

Providers report the employee/provider interaction is confidential. Providers may not disclose the employee's IPV relationship to the organization or any other topics discussed during therapy. "Sometimes nobody knows except for the therapist; and the therapist they get referred to may not share anything if the person doesn't want it shared. [However,] they should because it [IPV] does have some effect on the workplace" P8-2, L21. Even providers working with employees that the organization has mandatorily referred may only report back to the organization the employee's attendance and treatment compliance, not the content of the visits. "We can disclose minimally when it's a formal referral. So, what that means is we can say, 'yes or no' [to the referring manager] they are attending their appointments,' 'yes or no' they are following their treatment plan'" P5-2, L54. Providers working with perpetrators who are under court ordered therapy also do not know what happens to the perpetrator when the intervention is complete. "That is all confidential information so what ends up happening is they are left alone [not tracked or followed up by the provider]". P10-2, L47.

Occasionally an employee may waive confidentiality by signing a confidentiality waiver, especially if they fear being terminated.

> "If the employee says, 'yes, please tell my supervisor about any and everything,' they can sign a full release of information then we can have an ongoing dialogue. . .[but] A lot of people want to keep what they are going through private. They want to come to work and not be judged. Other people feel supported by their co-

workers and absolutely want them to know what is going on. We leave it up to them if we feel their job is in jeopardy" P5-2, L59.

Victim Outcomes

Providers *Do the Best They Can* to *Informally Know* what happens to IPV victims from the employees' peers in the workplace. "Peers are able to alert somebody and say, 'we are concerned, can you just check into this'" P2, L393. Providers report co-workers are empathic toward the employees who are victims of IPV, although the co-workers do not know how to help and often encourage the victim to immediately leave the IPV relationship. Co-workers do not understand that leaving an IPV relationship is when the victim is the most vulnerable and in the most danger. "What I hear more often is that they will get advice from the coworker telling them 'Oh, just get out of there.' Well that's not so easy" P10, L457.

> "People in the workplace may be horrified but they don't know what to say or do. They might [say] something very simplistic like 'leave the guy, get an order of protection.' What we know is that an order of protection can escalate the violence. You have to be incredibly careful with when and why you go that route. The workplace in general utterly lacks sophistication when it comes to these issues" P7, L370.

Providers report co-workers may become less empathetic with victims over time; especially when the victim does not leave the abusive situation or leaves only to return to the perpetrator.

> "[Co-workers think,] 'They should know better, did [the victim] think something different was going to happen? Why did they go back? Obviously, this is not the

first time this happened so why are they still there?' I think there is some frustration. [Co-workers may conclude:] 'I'm not even going to offer to help because what's done is done'" P1, L237.

The victim's frequent tardiness and absences may even engender antipathy when co-workers have to work extra hours or work shorthanded to cover the duties of the person who is absent or tardy.

> "I've seen several reactions from teams. They are beyond frustrated and fed up with the victim because they don't really have knowledge of what is really going on. They just know that this person has inconsistent attendance at work and tardies and maybe distracted, at times emotional, not completing their work assignments and so their reaction is that [co-workers] are totally frustrated and disgusted with the person" P3, L402.

In some organizational environments, involvement with an employee who is involved in an IPV relationship can be viewed as risky, so the co-worker may actively avoid personal interactions due to fear of association or harm.

> "The boundaries are very, very clear in the workforce. Sometimes I think that we step a little bit back and try not to be involved" P2, L390. "I have had situations where the team members knew the potential harm that can come to them from being involved and so they avoid it all" P3, L418.

Perpetrator Outcomes

Providers who are part of their organization's threat management team may *Informally Know* about IPV perpetrators after they have been seen by providers. This is most often the case when the perpetrator is still under a restraining order or behavioral

contract. Nevertheless, the provider does not gain follow-up information directly, but because the provider is a part of another group that does some follow-up. "You do have a few more sophisticated companies; some companies follow people [under restraining orders] for years but there are other companies where it's out of sight out of mind. The initial problem has gone away" P8-2, L75.

Not Knowing

Unfortunately, providers may only *Informally Know* what happened to employees in IPV relationships when the IPV escalates resulting in the injury or death of the victim, perpetrator or others in the workplace. Poor outcomes often lead to organizational change. "Usually the pattern that happens is something terrible happens and the employers wake up say, 'Holy sh*'!' So, it takes that horrible thing that happens to create change" P10-2, L37.

> "Afterwards became a watershed event that changed a lot of things going forward I mean the [organization] got into hot water and the Departments of Labor and Justice got involved. it resulted in committees being formed, and a lot of what can you do and what can't you do" P9, L370.

SUMMARY

Providers *Manage Threat* by *Doing What They Can* but only learn the outcome of their interventions through a process of *Informally Knowing*. Providers in the study do not have a formal process for following up with employees they have seen because of issues related to IPV, so they do not know if the employee is still involved in the IPV relationship or whether the person is still employed by the organization. The provider

also does not know whether their intervention helped the employee. Providers themselves are concerned that they have no formal follow-up process, in part because they are unable to predict whether the employee's IPV relationship may be a continuing threat to the welfare and safety of the organization.

One of the explanations providers give for the lack of a formal follow-up process is confidentiality. The employee-provider relationship is confidential unless the employee signs a confidentiality waiver. Confidentiality may be waived by the employee and sometimes employees waive confidentiality in an attempt to save their job.

Providers may have *Informal Knowledge* of what happens to IPV victim's post-treatment by talking with the employee's peers in the workplace. Providers may have *Informal Knowledge* of perpetrators if they are a member of the organization's threat management team. Some teams engage in tracking perpetrators under a court order or behavioral contract until they believe the employee is no longer a threat. The provider is not responsible for this follow-up or tracking but may be aware of outcomes as a member of the team. Lastly, providers may gain knowledge of the employees they have seen for IPV if the IPV has escalated and resulted in injury or death of the victim, perpetrator or other employees. Poor outcomes from IPV events often result in the incentive for a change in organizational policies.

Employee Assistance Providers (EAP) and Occupational Health providers work within organizations to promote an environment that supports employee safety and organizational stability. Intimate partner violence (IPV) among an organization's employees poses a threat to that environment. EAP and Occupational Health providers *Manage the Threat* intimate partner violence poses within the organization by the process

of *Doing What They Can* to assist both victims and perpetrators involved in IPV. In order to *Do What They Can*, the provider first must *Recognize* which employees are involved in IPV relationships, then *Respond* to those employees. Finally, providers engage in *Informal Knowing* to understand what happens to employees in IPV relationships post intervention.

Chapter Four has been a review of findings from the CGT study exploring EAP and Occupational Health providers' experiences with employees in IPV relationships. The Chapter began with a discussion of the substantive theory that emerged from the data, M*anaging the Threat.* The providers *Managed Threat* through a process of *Doing What They Can*, which consisted of the phases of *Responding, Recognizing, and Informally Knowing.* Providers *Do What They Can to Manage Threat* within the organization by assisting both victims and perpetrators of IPV by *Recognizing* which employees are involved in IPV relationships and then R*esponding* to those employees. Finally, providers engage in *Informal Knowing* to understand what happened to employees in IPV relationships after the providers' interventions.

PLAN FOR CHAPTER FIVE

Chapter Five will provide a summary of the study's methodology as it was used to answer the research question: What are Employee Assistance Program and Occupational Health providers' experiences and perceptions of employees engaged in IPV relationships in the workplace? Next, there will be a discussion of the study's findings, a comparison of the study findings to the extant literature, the study's significance followed by implications, strengths and limitations, future research and conclusion.

Chapter 5

This study utilized Classical Grounded Theory (CGT) (Glaser, 1978, 1992, 1998, 2005, 2012, 2013, 2014) to explore Employee Assistance Program (EAP) and Occupational Health providers' experiences working with employees engaged in intimate partner violence (IPV) relationships. Chapter Five will begin with the statement of the research problem and a summary of how the methodology answered the research question. Next, a discussion of the study findings and substantive theory *Managing Threat*, a comparison of the study findings to the extant literature, followed by the study's significance, implications, strengths and limitations, future research, and lastly, conclusions.

STATEMENT OF PROBLEM

Intimate partner violence (IPV) as a social problem has been widely researched from the standpoint of behavioral sciences including women's studies, social work, psychology and criminal justice (Black, 2010; Breiding, Basile, Smith, Black, & Mahendra, 2015; Jewkes, 2002; Paludi, 2019). IPV also has been explored from the perspective of healthcare providers' responses to IPV vicitms, the majority of whom are female (Catallo, Jack, Ciliska, & MacMillan, 2012; Choo & Houry, 2014; Davila, 2006; LaPlante, Gopalan, & Glance, 2015). Some studies have examined the effects of IPV on the employment situations of victims living in shelters. A few studies explored IPV victims in the workplace (Blodgett & Lanigan, 2018; Moe & Bell, 2004; Paludi, 2019; Rothman, 2007; Swanberg, 2005, 2006, 2007), and an even smaller number of studies explored IPV perpetrators in the workplace (Berger, 2015; Makowski et al., 2013;

Rothman & Perry, 2004). EAP and Occupational Health providers are often the first point of contact for employees affected by IPV relationships; yet prior to the present study, no studies have been identified that have explored the experiences of Occupational Health and Employee Assistance Program providers who work with employees in IPV relationships, nor are there any extant theories describing the experience of Occupational Health and Employee Assistance Program providers working with employees engaged in intimate partner violence relationships.

REVIEW OF METHODOLOGY

The study utilized Glaser's Classical Grounded Theory (CGT) approach (1978, 1992, 1998, 2005, 2012, 2013, 2014) to explore the experiences and perceptions of Employee Assistance Program (EAP) and Occupational Health providers working with employees involved in intimate partner relationships. Glaser's (1992) CGT is a "general methodology of analysis linked with data collection that uses a systematically applied set of methods to generate an inductive theory about a substantive area" (p.16). The goal of CGT is to "understand the action by discovering the participants' main concern (Glaser, 1998, p. 115) and how the participants resolve their main concern. In the case of the present study, utilization of CGT procedures revealed that Employee Assistance Program and Occupational Health providers' main concern was *Managing Threat to* the workplace posed by the presence of IPV victims and perpetrators.

STUDY FINDINGS: THE SUBSTANTIVE THEORY

The theory, *Managing Threat,* describes how Employee Assistance Program (EAP) and Occupational Health Providers *Do What They Can* to help employees, both

victims and perpetrators, who are involved in Intimate Partner Violence relationships in order to promote a safe work environment for all employees. The process of *Doing What They Can* consists of three phases: *Recognizing, Responding and Informally Knowing*.

In order to *Manage the Threat* posed by employees who are involved in IPV relationships, Employee Assistance Program (EAP) and Occupational Health providers must first *Recognize* an employee is involved in an IPV relationship. *Recognizing* occurs when providers identify or come to know that a case of IPV exists among the employees in their workplace. Providers *Do What They Can* to *Recognize* employees in IPV relationships based on their previous experiences, their knowledge, and their skills; they may *Recognize* IPV when employees disclose their IPV relationships or when employees are referred to the provider by individuals within the organization. Providers also may not *Recognize* that an employee is in an IPV relationship. Once the provider *Recognizes* the employee is involved in an IPV relationship, the provider can *Respond.*

Responding occurs after the provider has *Recognized* the employee is in an IPV relationship then formulates a course of action to assist the employee while also promoting employee and organizational safety. The provider *Responds* to victims, perpetrators, and to the organization; how providers *Respond* is different for each party. In each case, a primary goal of the provider's *Response* is the overall safety and welfare of the organization.

Informally Knowing, the third phase of *Doing What They Can*, is the only way the providers can learn the outcome of their interactions with employees in IPV relationships. Providers have no formal process for following-up with employees in IPV relationships, so they do not know whether the employees have resolved their IPV issues, retained their

jobs and assimilated back into the workplace, or if they continue to pose a threat to the organization. A provider may informally learn of the employee's outcome by seeing the person in the workplace, checking the company directory to see if that person is still employed, hearing about the person from others, or learning about the person if their IPV results in death.

COMPARISON TO THE EXTANT LITERATURE

The following section will compare the present study's findings with the extant literature. It will be organized according to the phases of *Doing What They Can: Recognizing, Responding, and Informally Knowing*.

Recognizing

Occupational Health and Employee Assistance Program (EAP) providers are often the first to recognize an employee's negative work behaviors may be attributed to their IPV relationship (Felblinger, 2008; Lindquist, et al., 2010; Malecha & Wachs, 2003; Pollack, Austin, & Grisso, 2010; Walters, et al., 2012). Only two studies were identified that examined the experiences of occupational health providers, occupational health nurses, and IPV; each utilized the same data set and focused on the use of universal IPV screening to aid in the recognition of employees engaged in IPV relationships (Malecha & Wachs; Felblinger). Felblinger (2008) found that 63% of occupational health nurses surveyed reported they had received formal training to recognize IPV, yet only 32% of the 63% thought their training was adequate. In addition, only twelve percent of the occupational health nurses reported working with an employee involved in an IPV

relationship during the previous year, supporting their reported difficulty in recognizing employees in IPV relationships.

The Occupational Health providers in the present study consisted of two occupational health nurses, and one social worker. These providers gave mixed responses when asked how they recognize employees in IPV relationships. One provider had not recognized an IPV relationship until learning of an employee's death at the hands of their partner; the provider retrospectively put the pieces together and realized that the dead employee had been in an IPV relationship. Other Occupational Health providers in the present study spoke confidently about their ability to recognize both victims and perpetrators of IPV.

Malecha (2003) and Felblinger (2008) recommended Occupational Health providers perform universal IPV screening of all employees who were seeking assistance. However, only one provider in the present study, an Employee Assistance Program provider, engaged in universal IPV screening. The other nine providers all reported utilizing a simple screening question such as 'Does anyone hurt you at home?' or a validated IPV screening tool in circumstances where they already suspected IPV. Providers were reluctant to screen for IPV using an IPV screening tool believing it could intimidate employees who were not ready to disclose their IPV relationship and interfere with their efforts to build a trusting, therapeutic relationship with the employee.

Providers in the present study had many strategies for *Recognizing* IPV victims, including screening questions, observational and interviewing skills, professional training, and previous experiences; findings that have not been described in the extant literature. Providers in the present study reported IPV victims often self-disclosed their

IPV when they felt they could trust the provider and seek help. Several of the providers in this study reported an increase in IPV victim self-disclosure; they attributed this increase in victim self-disclosure to recent changes in societal mores regarding sexual harassment and sexual assault exemplified by the #MeToo movement which they thought helped destigmatize IPV. Providers also *Recognized* IPV victims when they saw the physical signs of IPV abuse compounded by the employee's account of how the injury happened not adding up. Providers *Recognized* IPV victimization during counselling for other issues and when the employee was referred to the provider by a manager or supervisor for negative work behaviors.

Perpetrators rarely self-disclose their role in IPV making it difficult for providers to recognize them. Walters's (2012) study of employee assistance programs revealed that EAPs usually identified IPV perpetrators when they self-disclosed for legal reasons. Two of the 28 EAP providers in the Walters study also reported identifying IPV perpetrators when they were referred to the EAP by an organization's management team for poor work performance.

Nine of the ten providers in the present study described strategies for Recognizing IPV perpetrators; the providers reported perpetrators often self-disclosed their IPV when asking for help with court-mandated counselling, anger management, sexual harassment training, or batterer support groups to mitigate legal problems incurred by their IPV behaviors. Providers in this study also *Recognized* perpetrators when they were referred for negative work behaviors that affected the organization's accreditations, security clearances or brand, or when their partner/victim worked in the same organization.

Providers in the present study reported recognizing employees impacted by IPV relationships may be challenging as both IPV victims and perpetrators experience the stigma of IPV and fear a breach of confidentiality, creating reluctance to discuss IPV, especially in the workplace. The extant literature describes what happens when IPV *is* unrecognized, the consequences of which often result in violence towards the employee and/or the organization (Berger, 2015; Tiesman, 2012; Savarda & Kennedy, 2013). All providers in the present study had experienced the impact of an unrecognized IPV employee relationship that had poor outcomes.

Responding

Responding occurs after the provider has *Recognized* the employee is in an IPV relationship then formulates a course of action to assist the employee while also promoting employee and organizational safety. The provider's response to IPV victims and perpetrators differs and is constrained by the nature of the organization: whether it is blue collar or white collar; whether it predominantly employs men or women; and, the organization's expectations and its resources. Providers are often frustrated when responding to IPV victims and perpetrators because of the cyclic nature of IPV; the result can lead to frustration and "emotional labor" (Fleischack, Macleod, & Böhm, 2019), with the potential for emotional exhaustion. Providers' responsibilities to the organization include engaging in IPV prevention education and serving on threat management teams. The provider's response to the organization often is constrained by the confidential nature of counseling and state and national laws.

Responding to Employees

Three studies were identified that addressed providers' responses to IPV victims or perpetrators; each study involved providers who were employed by external Employee Assistance Provider programs. Each of the three studies utilized the same data (Lindquist, 2010; Pollard 2010; Walters, 2012). The three studies revealed a range of providers' responses to employees engaged in IPV relationships. Walters explored external EAP services for IPV perpetrators and found the services offered were limited due to lack of specific programs for perpetrators such as batterer intervention groups or anger management programs. In contrast, all providers in the present study were employed by the organizations they worked for rather than being external to the organization. Providers in the present study were actively engaged in responding to IPV victims and perpetrators within the framework of the organization's policies and resources.

Providers in the present study responded to IPV victims who needed emergency assistance by arranging for emergent placement in a victim's shelter or with family or friends, assistance with legal aid, and safety planning. Employee victims in non-emergent IPV relationships also were offered safety planning and short-term counselling, paid for by the organization, with potential referral to an outside agency for victims should long term counseling be necessary. Occupational Health providers often did not counsel employees but rather referred employees in IPV relationships to the organization's EAP provider for counseling while facilitating access to other available resources. Providers in the present study responded to IPV victims by arranging for IPV victims to have schedule flexibility, time off for court appearances, and increased security presence if the organization had such services available. Providers in the present study also *Responded*

to IPV perpetrators by providing specialized IPV perpetrator interventions when possible. Some providers had the resources to offer these programs within their organizations; some referred perpetrators to specialized batterers' programs or anger management classes outside of the organization.

Responding: Emotional Labor

Providers in the present study were comfortable working with both male and female IPV victims although they did express frustration over working with employees who leave their abuser only to return to the abuser a short time later. A study by Fleischack (2019) of IPV counselors in South Africa described counselor frustration with IPV victims who do not leave their abusers. Fleischack calls this frustration a "bondage and deliverance narrative" (p.10) labeling the process "emotional labor." Fleischack attributes the counsellors' emotional labor to the limited effectiveness of IPV counseling based on an all or none outcome of whether IPV victims will leave their abusers. Many of the providers in the present study reported that working with employees engaged in IPV relationships could be frustrating and took an emotional toll on the providers. Providers understood the cyclical nature of IPV relationships and realized that it may take a victim many cycles of leaving and returning to successfully end the relationship. The providers who attempt to assist IPV victims can become part of the cycle, expending energy and resources in an ongoing process they hope will be therapeutic for the employee, but seeming to have no end point nor closure.

Responding to the Organization

The third study, by Lindquist (2010), inventoried the types of IPV services provided by the EAPs and found the types of workplace services fell into four categories: policy development, training, education, and consultation with the organization's security management teams. These services did not specifically address IPV; rather IPV was covered as a topic within general workplace violence. Most of the providers in the present study were actively engaged in educating their organization's workforce and management teams about IPV and organizational policies affecting employees engaged in IPV relationships. They provided IPV education at new employee orientations, brown bag lunches, and on organizational websites, and worked with management teams on policies for responding to employees whose negative work behaviors could be attributed to IPV.

Pollack, Austin, & Grisso (2010) reported organizational IPV education, training and policy development were services provided by EAP programs. No studies were identified that described organizational threat management teams' response to IPV as a distinct problem; instead the EAPs in the study responded to workplace violence in general, of which IPV is a subset. Some providers in the present study were part of their organization's threat management team. Their threat management teams might be called on to provide security for IPV victims including monitoring their email and phone calls for perpetrator threats and workplace supports. The participants' threat management teams also could monitor perpetrators working within the organization for compliance with restraining orders or place perpetrators on behavioral contracts.

Responding within the Organization

Pollard (2010) reported EAP services and resources are not standardized across organizations, a finding which is supported by the present study. Providers in the present study reported IPV resources were more available in organizations that had a higher proportion of female employees; they also described a difference in resource allocation between "white collar" and "blue collar" organizations. White collar organizations are those in which the workforce is engaged in work such as office work, usually indoors, and employ a greater percentage of women. Employees in blue collar organizations are engaged in manual work and the workforce is predominantly male. Providers in the present study reported that white collar organizations tend to have more resources allocated for IPV than blue collar organization and blue-collar organizations sometimes have no IPV resources at all. Providers in the present study also described a distinction between "public" and "private" organizations. Providers working in public organizations must practice within the framework of legal and regulatory policies unique to that organization, while private organizations may have little, if any, regulatory oversight. Providers reported privately held companies may simply terminate employees, both victims and perpetrators, who are exhibiting work behaviors that have or pose a threat to the organization's welfare and productivity. These organizational distinctions were not reflected in the extant literature.

The second study, by Pollard (2010), surveyed employee victims' satisfaction with their organizations' EAP services. IPV victims expressed concerns over confidentiality and lack of referral resources specific to IPV. Some EAP providers in the study expressed discomfort working with women in IPV relationships. Providers in the present study responded to all employees by discussing confidentiality before beginning

services, including areas of counseling that may involve mandatory reporting such as child abuse or neglect. Although the providers reported all employee counselling was short term, confidential, and paid for by the organization, some providers were required to monitor and report the perpetrator's attendance and compliance with counseling to the organization. Employees also were able to waive their confidentiality to enable the provider to share their circumstances with their employer in order to save their job.

LEGALLY RESPONDING

Providers must work within the framework of legislation and policies governing IPV. The extant literature addressing IPV legislation cites workplace antidiscrimination legislation such as the Americans with Disabilities Act of 1990, which does not offer workplace protections to victims of IPV. On the other hand, the Family and Medical Leave Act (FMLA) of 1993 offers some protections to employees who meet the FMLA eligibility requirements of one year's employment and a minimum of twenty-four work hours per week (Berger, 2015). The Occupational Safety and Health Act (1970) appears to have the greatest impact on IPV within organizations due to the Act's general duty clause which mandates a workplace must be free from hazards that may cause serious harm or death. Therefore, organizations that know of an employee's IPV relationship and do not intervene may be held accountable for any harm resulting from that relationship. Some states do have legislation providing work protections for IPV victims. State's legislation for IPV victims focuses on work leave, reduction of employment discrimination, and safety awareness. These workplace protections most often come in the form of allowing time off to attend court or other IPV-related legal issues and flexible scheduling. (Berger; Runge, 2010; Swanberg, Ojha, & Macke, 2012; Savarda &

Kennedy, 2013; Widiss, 2008). Providers in the present study provided mixed responses when asked about laws and workplace protections for IPV. Most reported they knew there were no federal laws for victim workplace protections, and most were very knowledgeable about their state's laws that afford workplace protection for IPV victims.

Informally Knowing

Informally Knowing appears to be the only way the providers can learn the outcome of their interactions with employees in IPV relationships. Lindquist (2010) reported the EAPs did not document the number of IPV cases nor the disposition of the cases, making it difficult to determine the prevalence of IPV within organizations or employee outcomes such as job retention, resolution of IPV behaviors, or increased threat of violence. Consistent with the extant literature, EAP and Occupational Health providers in the present study did not document nor report the number of IPV cases they handled. When asked how many cases of IPV they see in a year, none of the providers reported that they kept track, nor did their organizations require them to do so. One provider postulated the number of IPV cases could be retrieved from an electronic data base should they choose to do so, yet none of the providers documented the number of IPV cases as part of a reporting process, prevalence count, or cost analysis. Providers did not document nor record post-intervention outcomes for employees in IPV relationships citing the short-term nature of EAP counseling, referrals to long-term or specialized victim or perpetrator counseling groups outside the organization, and employee confidentiality. Providers did see employee job retention as a motivating factor for employees to comply with provider intervention sometimes resulting in employees waving confidentiality to save their jobs. Nevertheless, the providers did not receive

information from the organization regarding whether the employees remained in their job.

Providers reported that while the effects of increased social awareness of IPV has helped to destigmatized IPV resulting in greater rates of IPV disclosure, they did not see a corresponding increase in the organizational response to IPV perpetration. Providers in the present study reported being unable to respond to perpetrators if the organization has a tolerance for negative IPV behaviors, especially if the perpetrating employee is generally well-liked within the organization, is considered irreplaceable, or has a high-ranking position within the organization.

Providers saw employees in IPV relationships who had been referred for tardiness, absenteeism, inattentiveness, court-ordered counseling, aggression, and IPV perpetration, yet the providers did not know if there was a resolution to the problems for which the employee had been referred. Therefore, it was not possible to determine whether the provider's interventions were successful, promoted safety, or were cost effective. Providers in this study reported the confidential relationship between providers and employees precluded the provider from following up with the employee so providers did not know how, or whether, the employee assimilated back into the work environment. The extant literature suggests these outcomes should be important to organizations since intimate partner workplace violence costs U.S. employers 8 million workdays and 1.8 billion dollars in lost productivity annually (Lassiter, Bostain, & Lentz, 2018 as cited in Giga, Hoel, & Lewis, 2008) and statistically homicide due to IPV accounts for the majority of female workplace homicides (Tiesman, 2012; Swanberg & Logan, 2005).

Occasionally, providers in the present study learned about the status of employee victims through informal conversations with the employee's peers. The extant literature suggests IPV victims may be able to find informal supports by disclosing their IPV relationship to their peers. Workplace peers may be able to provide emotional support by listening, spending time with the victim, assisting with work and non-work responsibilities, and suggesting resources of referrals to counseling (Rothman, Hathaway, Stidsen, & Devries, 2007; Swanberg, 2006; Swanberg & Logan , 2005; Swanberg & Macke, 2006). Providers in the present study reported that while peers may be supportive, over time the relationship between IPV victims and peers can become more complicated. Peers initially may be supportive of the victim, offering comfort and advice, but the advice peers give most often is for the victim to leave the abuser. Peers may not understand that when a victim decides to leave the abuser is when the victim is the most vulnerable and in the most danger; leaving the abuser should involve a well-thought-out safety plan. Peers may not understand the cyclical nature of IPV, so when the employee in an IPV relationship begins to struggle with job attendance or productivity, their peers may be required to perform the employee's work or take their shifts, creating what one provider called a begrudging environment in which the victim comes to be resented or seen as someone receiving special treatment; other workplace peers do not wish to involve themselves with employees in IPV relationships fearing the employee's abuser may harm them as well.

STUDY SIGNIFICANCE

The findings of this Classical Grounded Theory study emerged from data reflecting Employee Assistance Program and Occupational Health providers' experiences

with employees engaged in intimate partner violence and therefore reflect their practice. The substantive theory, *Managing Threat,* is significant in it describes the main concern and the basic social process by which providers *Do What They Can* to *Manage the Threat* of IPV within the constraints of their organizations' expectations. An understanding of the process described by this substantive theory will give providers working with people experiencing IPV or other social problems a framework from which they can develop and evaluate their interventions. This study is the first to explore the experience of EAP and Occupational Health providers' experiences with employees engaged in IPV relationships and the findings from this study may inform the practice of other providers and organizations who work with IPV victims and perpetrators.

IMPLICATIONS

This study has important implications for Employee Assistance Program and Occupational Health providers and others who work with employees engaged in IPV relationships. As reflected in the substantive theory, *Managing Threat,* providers *Do What They Can* to manage the threat of IPV within their organizations. *Doing What They Can* consists of three phases, *Recognizing*, *Responding*, and *Informally Knowing,* and each phase has implications for those working with IPV in the workplace. Providers must first *Recognize* the employee is engaged in an IPV relationship before they can *Respond.* The implication of failing to *Recognize* the employee's IPV relationship results in the provider missing the opportunity to *Manage the Threat* IPV poses to the employee and the organization. The provider may discover they missed *Recognizing* an employee in an IPV relationship by learning about an employee's involvement in a violent event after the fact. Once the provider *Recognizes* the employee's IPV they can *Respond*. Provider's

Response is constrained by the resources, policies, regulations, and culture of each individual organization. Failure to respond also may result in the provider missing the opportunity to *Manage the Threat* IPV poses to the employee and the organization. The result can be that the provider only learns of through *Informally Knowing*. Because providers can only informally observe some IPV outcomes, most never know whether they have successfully managed the threat of IPV.

Intimate partner violence is not a problem that employees can keep at home; the consequences of IPV often spill over into the workplace impacting the productivity and safety of IPV victims, perpetrators, and the organization. Since IPV victimization overwhelmingly effects women and because a greater number of women work in white collar organizations, there is a societal and organizational bias that IPV victims are female. IPV victims have high rates of absenteeism and tardiness and are often passed over for promotion. Victims are often distracted from their work and may get harassing calls or visits from their abusive partner while at work also impacting their productivity and posing an organizational safety risk. IPV victims who sustain injuries incur higher medical costs and increased sick leave (Reeves & O'Leary-Kelly, 2007; Peterson, et al., 2018) which are passed on to the organization in the form of higher health insurance premiums and lost workdays. Interventions for IPV victims such as flexible scheduling, security monitoring and counselling also are costly to an organization. Nevertheless, going to work may increase an IPV victim's self-esteem and financial independence (Swanberg & Macke, 2006; Swanberg, 2006), enabling the victim to leave the abuser. While the financial cost of IPV victims to organizations has been explored (Reeves & O'Leary-Kelly, 2007; Peterson, et al., 2018), the financial impact of IPV perpetrators has

not. IPV perpetrators can be costly to organizations as they are often engaged in harassing their partner instead of working creating workplace distraction and error. There are the additional costs of court-ordered counseling and monitoring; moreover, their behavior may become a liability, potentially leaving an organization open to costly legal and regulatory violations as well as damage to the organization's public image.

All providers in the present study reported that promoting organizational safety was an important part of their professional role. Providers engage in IPV prevention strategies by educating the work force about the signs of IPV, how to respond to employees engaged in IPV behaviors, and the organization's policies addressing IPV. Providers work within the constraints of their professional role, which mandates provider/employee confidentiality. Providers are unable to disclose the nature of an employee's visits and therefore cannot impact any decisions concerning the employee's job retention or dismissal. In fact, providers are not informed of an employee's disposition and have no idea if the employee has been dismissed or assimilated back into the work environment resulting in a future risk of IPV behaviors. The present study begs the question: What should be the responsibility of organizations related to IPV? On one hand, organizations have included IPV among the workplace concerns to be managed by Occupational Health and EAP providers. although organizations pay for short term employee counseling and various other resources, they do not seem concerned about keeping any records of IPV prevalence or the outcomes of IPV interventions, making it difficult to assess the efficacy and cost-effectiveness of organizational IPV risk management. Moreover, across the United States there is wide variation in legislation and policies addressing IPV. A few states have legislation directed at IPV workplace

protections and the general duty clause of the Occupational Safety and Health Administration Act may place some responsibility on organizations related to IPV.

Providers understand the psychosocial implications of working with both victims and perpetrators of IPV. Victims may leave the abuser only to return repeatedly; perpetrators rarely cease their aggression; and providers know employees engaged in IPV often need long term counselling with varying success. While intervention may be considered successful when the partners in an IPV relationship terminate the relationship, this outcome also presents dangers, and it may take years and years of intervention. The long-term, cyclic nature of IPV puts Occupational Health and EAP providers in a difficult position: their ability to intervene often is short term, limited to 6-8 sessions, which is a very temporary fix for a long-term problem which, if not addressed, may fester into an organizational threat. The short term or acute care model for this chronic problem does not fit and is frustrating for providers who usually are empathetic and caring individuals. The emotional labor of regulating their own emotions in order to create a therapeutic environment is taxing for providers and may result in emotional dissonance and provider burn-out.

STRENGTHS AND LIMITATIONS

This Classical Grounded Theory (CGT) study has several strengths and limitations. Study strengths include using CGT to explore Employee Assistance Program and Occupational Health providers' experiences with employees engaged in IPV relationships. This CGT study is grounded in the data from Employee Assistance Program and Occupational Health providers and reflects the concerns the providers have about working with employees in IPV relationships and how they

attempted to resolve that concern. Previous studies have been conducted from the perspective of IPV victims or perpetrators. The present study is the first study to explore the problem of IPV in organizations from the perspective of Employee Assistance Program and Occupational Health providers who are the central to *Recognizing* and *Responding* to IPV in the workplace. An additional strength is that the study sample included providers who had worked in organizations across the United States representing a wide cross section of organizational types and cultures. The choice to sample providers from internally based Occupational Health and Employee Assistance Programs was a strength as these providers worked with employees in IPV relationships face-to-face, at the workplace, as opposed to external providers who contract EAP or Occupational Health services with many organizations and function primarily as case managers. Providers who worked internally within organizations gave insights into the effects of IPV in the workplace**;** and the processes, resources, and constraints that govern providers' interactions with employees in IPV relationships. An unanticipated study strength was that providers who participated in the study had many years' experience and were able to reflect on their practice within a wide variety of organizations.

An additional, although temporary, limitation of the study was this researcher's inherent bias resulting from being trained within the discipline of nursing. Glaser (2012) says, "Preconceived concepts do not have to be forgotten. They are just to be suspended for the CGT research, so the researcher is open to the emergent" (p.5). The researcher's nursing mindset created an expectation that there would be some measurable outcome of the providers' efforts when dealing with employees in IPV relationships.

Nevertheless, it was a strength of the CGT process that this researcher's bias was revealed when she focused on the dictum of CGT requiring no preconceptions (Glaser, 2012), which ultimately revealed both the researcher's bias and what was truly "going on" (Glaser, 1978, 1998) in the data. The providers were *Doing What They Could* within the organization's expectations of their positions; and while their position did not require that they record (and thereby have access to) data evaluating their efforts with IPV victims and providers, they did retain interest in and curiosity about the IPV victims and perpetrators with whom they have worked.

A potential study limitation is that the participants in the study self-selected when responding to the recruitment materials. It is not known whether providers who did not respond to the recruitment materials would have different opinions and experiences. Another potential limitation is the small sample size, although participant recruitment continued until data analysis revealed theoretical saturation; the participants in the study represented a wide geographic area and had worked for many years in a variety of organizations as providers.

FUTURE RESEARCH

This study explored IPV in the workplace from the perspective of Occupational Health and Employee Assistance Program providers who are one part of the workplace IPV triad that includes the provider, the employee and the organization. Future research into IPV in the workplace could focus on the organization's perspectives including organizational leaders to answer research questions such as, "What is the organization's role in IPV in the workplace?" "Does organizational involvement in IPV come from a place of societal concern for employees, organizational risk management, cost

effectiveness, legislative mandates, or perhaps a combination of all these influences?" Future research also could quantify the prevalence of IPV, efficacy of IPV interventions, and investment on return for efforts to deal with employees involved in IPV relationships from the standpoint of the workplace.

Many studies of IPV victims have revealed that having a job aids in developing victims' self-esteem and financial stability, providing pathways toward independence from their abusers (Swanberg, 2006, 2007). Future research could explore the impact job retention has on both employee vicitms and perpetrators engaged in IPV relationships and whether retaining employee vicitms affects the organization's ability to manage the threat of IPV as well as the effects on the organization of retaining IPV perpetrators.

Providers in the present study cited employee/provider confidentiality and short term counseling as factors that further inhibited their ability to follow-up with employees engaged in IPV and potentially limiting their ability to collect and record outcome data. Future research could be informed by other intervention models that take the barriers of confidentiality and length of treatment into account while still encompassing treatment and providing measurable outcomes. One example is the Texas Peer Assistance Program for Nurses (TPAPN), a program that helps employeees who have had problems with substance abuse retain their jobs by providing workplace oversight and monitoring.

Another area for future research is the provider's emotional labor, a topic which may apply to all practioners working in professions where listening, empathy and being present are part of professional role requirements. Practioners in positions that require emotional labor are at risk for worker isolation, job dissatisfaction, emotional exhaustion, and burnout (Wortmann & Jie , 2011; Fleischack, Macleod, & Böhm, 2019); this problem

is further compounded by the emotional effort of working with social problems that are not easily resolved.

CONCLUSIONS

The effects of IPV do not remain in the home but follow employees into the workplace, potentially impacting their safety, the workforce, and the organization. Employee Assistance Program and Occupational Health providers are in the best position to assist employees in IPV relationships in organizations. This Classical Grounded Theory study explored the experiences of Employee Assistance Program and Occupational Health providers working with employees in intimate partner violence relationships. Data analysis utilizing Classical Grounded Theory techniques revealed that the substantive theory, *Managing Threat*, which was enacted through a process of providers *Doing What They Can*. This substantive theory has implications for employees in IPV relationships, Employee Assistance Program and Occupational Health providers, as well as organizations, legislation, and society.

Appendix A: Institutional Review Board Approval

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Institutional Review Board
301 University Blvd.
Galveston, TX 77555-0158
Submission Page

01-Jun-2018

MEMORANDUM

TO: Carin Adams
Grad School Biomedical Science GSBS9999

FROM: Michael Loeffelholz, PhD
Vice-Chairman, IRB #1

RE: Initial Study Approval

IRB #: IRB # 18-0092

TITLE: Employee Assistance Program and Occupational Health Provider Experiences with Intimate Partner Violence in the Workplace: A Grounded Theory Study

DOCUMENTS: Interview Guide C Adams
Protocol
Recruitment Materials
Verbal Consent Script

The UTMB Institutional Review Board (IRB) reviewed the above-referenced research protocol via an expedited review procedure on **31-May-2018**. Having met all applicable requirements, the research protocol is approved for a period of 12 months. The approval period for this research protocol begins on **31-May-2018** and lasts until **31-May-2019**.

The research protocol cannot continue beyond the approval period without continuing review and approval by the IRB. In order to avoid a lapse in IRB approval, the Principal Investigator must apply for continuing review of the protocol and related documents before the expiration date. A reminder will be sent to you approximately 90 days prior to the expiration date.

The approved number of subjects to be enrolled is **25.00**. The IRB considers a subject to be enrolled once s/he signs a Consent Form. If, additional subjects are needed, you first must obtain permission from the IRB to increase the approved sample size.

Appendix B: Recruitment Flyer

Intimate Partner Violence in the Workplace
Share Your Voice

You are invited to participate in a research study exploring provider's experiences with survivors and perpetrators of intimate partner violence in the workplace.
Study Participants should be:

- Providers working within internally managed (employer-based programs serving a single company) Employee Assistance Programs or Occupational Health Clinics
- Willing to participate in at least one ninety-minute telephone/Skype interview during non-working hours.
- Able to speak and understand English
- Over 18 years of age

For more information or if you would like to participate in this study, please contact:

Carin Adams
cadadams@utmb.edu

Please include the following in the body of the email.
Your name, contact telephone number and best two dates and times to call

This study is approved by the
The University of Texas Medical Branch Institutional Review Board #18-0092

Appendix C: Interested Participant Letter

Dear Colleague:

Thank you for your interest in my research project, "Employee Assistance Program and Occupational Health Provider Experiences of Intimate Partner Violence in the Workplace: A Grounded Theory Study." One in three women and one in four men experience intimate partner violence in their lifetime. The consequences of intimate partner violence affect both the victim and perpetrator and impact the work environment. Study participants are needed to explore provider's experiences of intimate partner violence in the workplace. Please share you voice.

Study Participants should be:

- Providers working in Employee Assistance Programs or Occupational Health Clinics that are internally managed (employer-based programs serving a single company)
- Willing to participate in at least one ninety-minute telephone or Skype interview during non-working hours with the potential for a follow up call.
- Able to speak and understand English

If you are interested in sharing your viewpoints and experiences of the consequences of intimate partner violence in the workplace, I would like to schedule a time for a brief telephone call or Skype to discuss the study with you.

Please send the following in an email reply:

- A telephone number that I may use to contact you.
- Two options for dates and times when it would be convenient for me to contact you, please include the time zone you will be in at the time of the call.

Thank you for your interest in this important study. I look forward to speaking with you.
Sincerely,

Carin Adams RN, MSN, CPN
Principle Investigator
Cadadams@utmb.edu
Cell 817-917-8390

Appendix D: Employee Assistance Roundtable Recruitment Letter

Dear Employee Assistance Roundtable Manager,
Thank you for your assistance in identifying providers who may be potential study participants for my research project Employee Assistance Program and Occupational Health Provider Experiences of Intimate Partner Violence in the Workplace: A Grounded Theory Study.
Study Participants should be:

- Providers working within internally managed (employer-based programs serving a single company) Employee Assistance Programs or Occupational Health Clinics
- Willing to participate in at least one ninety-minute telephone or Skype interview during non-working hours.
- Able to speak and understand English
- Over 18 years of age

Please help me by sharing this invitation in the following ways:

- Email the attached participant letter and flyer directly to your Employee Assistance Program providers.
- Post the participant letter and flyer on bulletin boards (real or virtual).
- Tell your colleagues about this opportunity

Participation is voluntary. There will be no monetary compensation for participation in this study. Thank you for your assistance with my recruiting efforts. EAP providers will add a valued voice to the intimate partner violence conversation. Please contact me anytime with any questions or concerns.

Thank You,

Carin Adams RN, MSN, CPN
Principal Investigator
Cadadams@utmb.edu
817-917-8390

Appendix E: EAPA Recruitment Letter

Dear Employee Assistance Professional Association,

Thank you for your assistance in identifying providers who may be potential study participants for my research project Employee Assistance Program and Occupational Health Provider Experiences of Intimate Partner Violence in the Workplace: A Grounded Theory Study.

Study Participants should be:

- Providers working within internally managed (employer-based programs serving a single company) Employee Assistance Programs or Occupational Health Clinics
- Willing to participate in at least one ninety-minute telephone interview during non-working hours.
- Able to speak and understand English
- Over 18 years of age

Please help me by sharing this invitation in the following ways:

- Email the attached participant letter and flyer directly to your Employee Assistance Program providers.
- Post the participant letter and flyer on bulletin boards (real or virtual).
- Tell your colleagues about this opportunity

Participation is voluntary. There will be no monetary compensation for participation in this study. Thank you for your assistance with my recruiting efforts. Employee Assistance Program providers will add a valued voice to the intimate partner violence conversation. Please contact me anytime with any questions or concerns.

Thank You,

Carin Adams RN, MSN, CPN

Principal Investigator

Cadadams@utmb.edu

817-917-8390

Appendix F: OHPH recruitment letter

Dear Association of Occupational Health Professionals in Healthcare,

Thank you for your assistance in identifying providers who may be potential study participants for my research project Employee Assistance Program and Occupational Health Provider Experiences of Intimate Partner Violence in the Workplace: A Grounded Theory Study.

Study Participants should be:

- Providers working within internally managed (employer-based programs serving a single company) Employee Assistance Programs or Occupational Health Clinics
- Willing to participate in at least one ninety-minute telephone interview during non-working hours.
- Able to speak and understand English
- Over 18 years of age

Please help me by sharing this invitation in the following ways:

- Email the attached participant letter and flyer directly to your Occupational Health providers.
- Post the participant letter and flyer on bulletin boards (real or virtual).
- Tell your colleagues about this opportunity

Participation is voluntary. There will be no monetary compensation for participation in this study. Thank you for your assistance with my recruiting efforts. Occupational Health providers will add a valued voice to the intimate partner violence conversation. Please contact me anytime with any questions or concerns.

Thank You,

Carin Adams RN, MSN, CPN

Principal Investigator

Cadadams@utmb.edu

817-917-8390

Appendix G: AAOHN Recruitment Letter

Dear American Association of Occupational Health Nurses,

Thank you for your assistance in identifying providers who may be potential study participants for my research project: "Employee Assistance Program and Occupational Health Provider Experiences of Intimate Partner Violence in the Workplace: A Grounded Theory Study."
Study participants should be:

- Providers working within internally managed (employer-based programs serving a single company) Employee Assistance Programs or Occupational Health Clinics
- Willing to participate in at least one ninety-minute telephone or Skype interview during non-working hours.
- Able to speak and understand English
- Over 18 years of age

Please help me by sharing this invitation in the following ways:

- Email the attached participant letter and flyer directly to your Occupational Health providers.
- Post the participant letter and flyer on bulletin boards (real or virtual).
- Tell your colleagues about this opportunity.

Participation is voluntary. There will be no monetary compensation for participation in this study. Thank you for your assistance with my recruiting efforts. Occupational Health providers will add a valued voice to the intimate partner violence conversation. Please contact me anytime with any questions or concerns.

Thank You,

Carin Adams RN, MSN, CPN
Principal Investigator
Cadadams@utmb.edu
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Appendix H: TAOHP Recruitment Letter

Dear American Association of Occupational Health Providers,

Thank you for your assistance in identifying providers who may be potential study participants for my research project: "Employee Assistance Program and Occupational Health Provider Experiences of Intimate Partner Violence in the Workplace: A Grounded Theory Study."
Study participants should be:

- Providers working within internally managed (employer-based programs serving a single company) Employee Assistance Programs or Occupational Health Clinics
- Willing to participate in at least one ninety-minute telephone or Skype interview during non-working hours.
- Able to speak and understand English
- Over 18 years of age

Please help me by sharing this invitation in the following ways:

- Email the attached participant letter and flyer directly to your Occupational Health providers.
- Post the participant letter and flyer on bulletin boards (real or virtual).
- Tell your colleagues about this opportunity.

Participation is voluntary. There will be no monetary compensation for participation in this study. Thank you for your assistance with my recruiting efforts. Occupational Health providers will add a valued voice to the intimate partner violence conversation. Please contact me anytime with any questions or concerns.

Thank You,

Carin Adams RN, MSN, CPN
Principal Investigator
Cadadams@utmb.edu
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Appendix I: Snowball OHN Website

Industry Information

Intimate Partner Violence in the Workplace Share Your Voice

You are invited to participate in a research study exploring provider's experiences with survivors and perpetrators of intimate partner violence in the workplace.

Study Participants should be:

- Providers working within internally managed (employer-based programs serving a single company) Employee Assistance Programs or Occupational Health Clinics
- Willing to participate in at least one ninety minute telephone/Skype interview preferably during non-working hours.
- Able to speak and understand English
- Over 18 years of age

For more information or if you would like to participate in this study, please contact
Carin Adams at cadadams@utmb.edu or cell: 817-917-8390
Please include the following in the body of the email.
Your name, contact telephone number and best two dates and times to call
This study is approved by
The University of Texas Medical Branch Institutional Review Board (UTMB IRB # 18-0092)

Appendix J: Confirmation Email for Telephone Appointment

Dear Colleague:

Thank you for your interest in becoming a study participant in my research study, "Employee Assistance Program and Occupational Health Provider Experiences of Intimate Partner Violence in the Workplace: A Grounded Theory Study." This email is a confirmation of the date, time and phone number I will use to call you to discuss the project.

Please choose a quiet, secure location to accept the call during non-working hours in order to reduce distraction and to provide yourself with privacy and confidentiality. If for any reason the date, time or phone number has changed please contact me by email at cadadams@utmb.edu and we can reschedule.

Date: _____
Time: _____
Phone Number: _____

Thank you for your help with this important study.

Carin Adams RN, MSN, CPN
Principal Investigator
cadadams@utmb.edu

Appendix K: Verbal Informed Consent Script

Hello, my name is Carin Adams. I am a graduate student at the University of Texas Medical Branch undertaking research that will be used in my dissertation. I am researching Employee Assistance Program providers' and Occupational Health professionals' experiences with intimate partner violence in the workplace. The information you share with me will be used to explore the process of working with the victims and perpetrators of intimate partner violence in the workplace.

This interview will take about ninety minutes of your time. I also will ask your permission to contact you with any follow up questions. Participation in this study is voluntary. There will be no monetary compensation for participation in this study.

Participation in the study poses minimal risks. Intimate partner violence is a sensitive topic and there is a risk that hearing these questions or discussing this topic will make you feel uncomfortable. You can decline to discuss any issue or answer any question, as well as to stop participating at any time, without any penalty. Another risk would be the loss of confidentiality which I will protect against by using the following data management strategies:

1. I will record our interview on two recorders so that I can have an accurate record of the information that you provide to me.
2. The interview will be transcribed by myself into a word document.
3. I will not link your name or your company's name to anything you say, either in the transcript of this interview or in the text of my dissertation or any other publications.
4. Your personal data will be protected in the following manner:

a. One copy of the original, unedited transcript will be stored on my personal computer and a dedicated flash drive as back-up.
b. A second copy of the transcript will be de-identified so that any information linking you to the data will be masked by assigning your interview a numerical code. The de-identified transcript will then be used for data analysis.
c. My computer is password protected and I will store both flash drives and the digital voice recorders in separate, locked file cabinets in my locked office.
d. I have a personal computer that is designated solely for this research project with no other users having access to the data stored on the computer.
e. All study data will be destroyed when all study reports are complete.

Do you have any questions about this research? Do you agree to participate in this study? When I turn on the recorder, I will ask for your verbal consent to participate in the study and we will begin the interview. Are you ready for me to start the tape recorders?

Appendix L: Demographic Questions and Interview guide

1. How long have you been working in this field?
2. What is your educational background?
3. What type of product does your company produce or service do they provide?
4. How many employees are eligible for your services? Family members?
5. How many employees experiencing IPV do you see a month?

Grand Tour Interview Question:

Tell me about your experiences working with people involved in intimate partner violence.

Follow up questions:

1. How are clients referred to you?
2. Tell me about how you recognize IPV.
3. What is your experience with IPV perpetrators?
4. Have you ever experienced an IPV victim and perpetrator both working for the same company?
5. What type of support is offered to people experiencing IPV?
6. What strategies do you think are effective in working with IPV?
7. In your experience, what happens to employees who have disclosed IPV?

Appendix M: Theoretical Sampling Guide

Thank you for taking the time to speak with me again about your experiences with intimate partner violence. I have a few more questions to ask and our conversation should not take more than 20-30 minutes. The consent that you gave earlier still applies to this conversation. Do you have any questions about the informed consent?

1. What happens to employees who are victims in IPV relationships after the provider has seen them?
2. What happens to employees who are perpetrators in IPV relationships after the provider has seen them?
3. It appears that a lot of organizations do not track what happens to employees in IPV relationships, has that been you experience?
4. Do you follow the employee's progress after you have seen them?
5. Do you know if the employee has been fired?

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Poster Presentations

Employee Assistance Program and Occupational Health Provider Perceptions and Experiences of Intimate Partner Violence in the Workplace: A Grounded Theory Study, Southern Nurses Research Society, 2020

Analysis of a Multidisciplinary Communication Tool in a Pediatric Setting. University of Texas at Arlington, Sigma Theta Tau, Delta Theta chapter, 2009

Analysis of a Multidisciplinary Communication Tool in a Pediatric Setting. Children's Hospital Association of Texas (CHAT), San Antonio, Texas, 2008

An Evidenced Based Protocol for Hypertensive Pediatric Patients with Renal Disease. Children's Hospital Association of Texas (CHAT), Dallas, Texas, 2006

Podium Presentations

The Bucket List: Making the Most of Clinical Learning Opportunities
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This dissertation was typed by Carin D. Adams