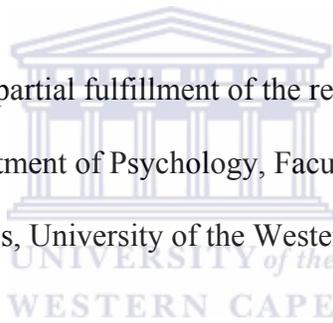


Nursing students' beliefs and perceptions toward routine universal screening for intimate partner violence

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DECLARATION

The author hereby declares that this entire thesis, unless specifically indicated to the contrary in the text, is her own work.

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Elzette Rousseau



ABSTRACT

Intimate partner violence (IPV) has reached epidemic proportions in South Africa, prompting the government to pass the Domestic Violence Act 116 (1998). However, numerous scholars still believe that legislation is lacking due to inadequate implementation of protocol in the healthcare sector. In the healthcare setting, nurses are usually the first people that abused women make contact with and so they are in an excellent position to identify IPV victims and prevent further abuse. Routine universal screening in the healthcare setting is recommended as a means to identify women who suffer in abusive relationships. However, several problems have been encountered with the attempts to implement screening practices. In this study the various perceived barriers to IPV screening among nursing students were examined by use of a descriptive survey approach. The research participants were 103 nursing students from the University of the Western Cape. Data were collected by means of a self-administered questionnaire and analysed using descriptive as a means to uncover the relationship between perceived barriers and the screening practices of the participants. The aim of this study was to identify the barriers that will discourage a nurse from routinely screening for intimate partner violence in a healthcare practice. The present study's results indicated that the majority of variance in routinely screening for IPV can be explained by barriers related to HCP knowledge of managing IPV disclosure; the perceived responses of patients to screening; the privatisation of abuse; and whether HCP regard IPV as a healthcare issue. Information, regarding the beliefs of healthcare providers (HCP) with regard to IPV as well as the barriers they perceive toward screening, will be helpful in designing curricula that will successfully teach HCP how to screen for IPV and it will also be useful in making positive changes to the screening conditions in healthcare settings.

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CHAPTER 1: INTRODUCTION

Intimate partner violence is a significant social problem, existing in epidemic proportions throughout the demographics of South Africans. Although, South Africans have celebrated thirteen years of democracy, intimate partner violence is still violating the safety, wellbeing, health, economy and productivity of women. The phenomena of intimate partner violence (IPV) are difficult to define since it involves a wide range of actions and subjective components. According to the 1998 Domestic Violence Act 116, intimate partner violence is:

Physical abuse; sexual abuse; emotional, verbal and psychological abuse; economic abuse; intimidation; harassment; stalking; damage to property; entry into complainant's residence without consent, where the parties do not share the same residence; or any other controlling or abusive behaviour towards a complainant, where such conduct harms, or may cause imminent harm to, the safety, health or well-being of the complainant (section 1(viii)).

This paper will focus on abuse of men toward women in intimate relationships, where a relationship is defined according to the Domestic Violence Act (116 of 1998) as:

The complainant and respondent are or were married to each other, including marriage according to any law, custom or religion; they live or lived together in a relationship in the nature of marriage, although they are not, or were not, married to each other, or are not able to be married to each other; or they are or were in an engagement, dating or customary relationship, including as an actual or perceived romantic, intimate or sexual relationship of any duration (section 1(vii)).

The population of South Africa is multi-cultural and multi-racial but they all cultivate attitudes, norms and traditions permitting domestic violence (Van der Hoven, 2001). Victims of intimate partner violence (IPV) affirm that abuse takes place in people from every community, class, race, culture and religion (Bennett, 2005). The Beijing

Conference on Women document (1995) state that IPV is derived from cultural traditions that draws on historically unequal power relations, and it is exacerbated by society's practices that bestow women with lower status (socially and economically) than men. Other factors predictive of IPV in South Africa include the excessive use of alcohol; the extent of poverty and unemployment; beliefs that masculinity is associated with dominance and aggression; and the acceptance of interpersonal violence (Jewkes, Levin, & Penn-Kekana, 2002). All these aspects make South Africa one of the countries with the highest statistics of domestic violence in the world (Van der Hoven, 2001).

By definition IPV is concealed within the restrictions of an individual's milieu and relationships (Doolan, 2005). This 'private' nature of intimate partner violence makes it difficult to accurately consider the entire scope of the problem. Although IPV is considered to be extremely underreported, available statistics already indicate the severity of the problem in South Africa:

- In Cape Town, 72 % of pregnant teenagers and 60 % of teenagers who have never been pregnant had had coerced sex in dating relationships (Jewkes, Vundule, Jordaan, & Maforah, 2001).
- An estimated one in four women is abused regularly by her intimate partner (National Department of Health, 2005).
- In South Africa a woman is killed by her intimate partner every six hours (MRC, 1999).

As an approach to address the high intensity of IPV the Domestic Violence Act (DVA) was passed in 1998. The DVA represents significant progress in the fight for women's rights on paper, but efforts to effectively put the DVA into practice has been challenging.

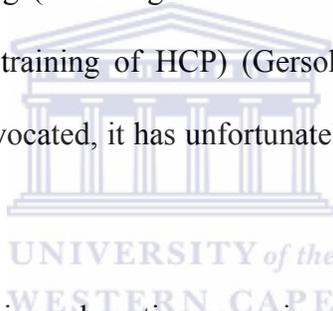
Numerous scholars believe that the effect of the DVA is deficient because of improper or even lack of implementation of adequate protocol in the healthcare sector (Doolan, 2005; Martin & Artz, 2006). The health sector can play an important role on several levels in IPV prevention as health care providers (HCP) are often the first people that will be approached by victims of IPV for assistance (Mick, 2006). For instance, HCP can ensure early identification of IPV which will reduce further victimisation (Garcia-Moreno, 2002); they can reduce the stigma associated with domestic violence by addressing it in a public domain; they can supply victims with sufficient resources and referrals (Doolan, 2005); and they can provide detailed medical notes as a supplement for positive judicial outcomes (Martin, *et al.*, 2006). However, the ‘private’ nature of IPV and the uniqueness of each case make it difficult for HCP to identify victims and many women will not easily volunteer their disclosure (Martin, *et al.*, 2006). To address the low frequency of disclosure and identification of IPV, universal screening at healthcare practices is recommended (Martin, *et al.*, 2006; McFarlane, Groff, O’Brien, & Watson, 2006; Doolan, 2005; Garcia-Moreno, 2002).

Universal screening means that all women presenting at a health care practice will be asked the same questions regarding IPV regardless of their demographics or reason for visit (Davis & Harsh, 2001). Doolan (2005) suggests that as soon as screening becomes part of general health practice women will start to view the health sector as a refuge. In a study conducted at an emergency department in America, the introduction of a universal screening protocol lead to the increase in IPV identification and referral from 1% to 18% (Larkin, Hyman, Mathias, D’Amico, MacLeod, 1999). Screening may also lead to an increase in disclosure and documentation of incidences of violence that will assist the

victim in judicial dealings and hereby the abuser might be positively identified and apprehended (Doolan, 2005). In addition, by creating a standard screening questionnaire and protocol, also the responsibility load will be lighter for the already over-worked HCP (Garcia-Moreno, 2002). Furthermore, health care costs can be reduced through early detection of IPV. Given that, Doolan (2005) found that victims of IPV are a serious health burden as they visit practices with chronic conditions (such as sleeplessness, anxiety, stress, depression, gastrointestinal problems and substance dependency) resulting from the abuse and victims are also greatly exposed to the health risks of HIV/AIDS and STDs (Department of Health, 2005).

In South Africa IPV has already been identified in the Department of Health's Strategic Plan of 2000 - 2004 as a high priority area and strategies were outlined to address the issue (Doolan, 2005). However, currently there are still no policy guidelines for universal screening in the healthcare sector, even though it is essential when the high incidence of IPV is considered along with victims' difficulty to volunteer information (Martin, *et al.*, 2006). The health sector can assist in the implementation of the DVA through standardising screening protocol and by ensuring adequate medico-legal examinations (Artz, *et al.*, 2005). Standardising the detection, assessment and referral of victims of IPV in the healthcare sector is an important step towards eliminating revictimisation; to serve as an intervention and primary, secondary, or tertiary prevention strategy; and to ultimately reduce domestic violence in South Africa. The South African Government has adopted the primary health care approach which place new demands on specifically nurses to meet the health needs of all South African citizens (Health Systems Trust and Department of Health, 2004).

Literature shows that routine universal screening is already in use in America, Australia, Israel and England (Gersohn, 2004). Studies from America confirm that the majority (80% - 89%) of both abused and non-abused women support routine IPV screening (Glass, Dearwater & Campbell, 2001). Gersohn (2004) conducted a qualitative study, in South Africa, exploring women's attitudes towards screening and found that it is seen as acceptable and even favourable under certain conditions. These conditions are related to the approach of the HCP conducting the screening (including validation, empathy, sensitivity, respect, caring, and being non-judgmental) and with regard to structural factors in the healthcare setting (including confidentiality, privacy, safety, appropriate referrals, and knowledge and training of HCP) (Gersohn, 2004). However, although screening for IPV is widely advocated, it has unfortunately proven difficult to implement in medical practice.



Successful implementing of universal routine screening depends on attributions of both the health professionals and the public. The effectiveness of the screening device depends on the consensus reached between the expectations and optimum disclosure conditions for female patients and the perceptions and barriers of health professionals towards domestic violence and screening. Studies internationally indicate that the deterrence from screening can be largely explained by HCP beliefs, perceptions and incomprehension of IPV. These studies indicate that HCP negative feelings toward assisting victims of abuse is due to the personal (affective), informational, and institutional barriers that they hold of IPV. A quantitative study is needed to sample the opinions of HCP in relation to routine universal IPV screening, in the South African

medical context. In the current study this objective was investigated through the research question: How do nursing students perceive barriers towards routine universal screening for IPV?

In this study, the research problem was investigated by means of a descriptive survey method. Data was collected by use of a structured, self-administered questionnaire, focusing on nursing students at the University of the Western Cape, who will be the future health care providers in South Africa. This paper doesn't explore the existence and roots of IPV but rather assumes that it exists at epidemic proportions and therefore focuses on the prevention and barriers to intervention of it, from the health provider and patient. Therefore, this paper commence with Chapter 2 giving a review of the relevant literature with regard to intimate partner violence (IPV), how IPV can be addressed through the use of routine universal screening in the health sector, and the barriers that health care providers hold against screening for abuse. This chapter is concluded with a review of the theoretical framework wherein this study establishes itself. Chapter 3 describes the research methodology used in this study by outlining the hypotheses, procedures, participants, data collection instruments used and the data analysis applied. Chapter 4 reveals the results of the study through a description of the most significant personal, informational and institutional barriers that will withhold a HCP from routinely screening for IPV. Chapter 5 discusses the results of the study and concludes with the limitations and recommendations for future research in this area.

CHAPTER 2: LITERATURE REVIEW

South Africans are experiencing violence at an extraordinary rate, with mostly women on the receiving end of this crime in the form of IPV (Govender, 2003). According to Kruger (2004) previous alleviation to the victims of IPV has proved to be ineffective. However, the health sector can play an important role in IPV prevention (primarily, secondary and tertiary) through routine universal screening. But effective interventions are unlikely without accurate assessment of IPV (McCloskey & Grigsby, 2005) due to dynamics in the patient-professional relationship.

2.1 INTIMATE PARTNER VIOLENCE

Intimate Partner Violence (IPV) is globally viewed as a public, social and medical health crisis, which is often also referred to as “domestic violence”, “battering”, or “spouse abuse”. Explanations of domestic violence mainly perceives the abusive behaviour as a symptom of a predominantly patriarchal social structure that is rooted in stereotypical male and female gender roles and values male supremacy (Slabbert, 2003). Accordingly, the majority of studies position the perpetrators of these abusive behaviours as men and the victims as women (WHO, 2002). IPV can be defined as the regular occurrence, over a period of time, of abusive behaviour (physical, sexual, and/or psychological) for the purpose of coercion, control, and/or domination of a current or former intimate partner (Schornstein, 1997). This intentional violence against women is a severe violation of human rights that fosters overwhelming personal, social, and health implications for all affected entities (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006).

2.1.1 Prevalence and Demographics of IPV

Intimate partner violence is the most widespread violation of human rights in the world and common in all types of communities, ages, social classes, religions, races and ethnic groups (Jewkes, Jacobs, Penn-Kenkana, & Webster, 2001). IPV can affect any woman, there is no profile of a 'typical' abused woman, however the stereotypical view of a poor, helpless, ethnic minority, abused woman is very established (Davis & Harsh, 2001).

The *World Report on Violence and Health* (WHO, 2002) features numerous studies that challenge the common risk factors of IPV. Some studies have established a relationship between socioeconomic status and educational level and physical violence, but the data have shown to not be entirely consistent. Further, childhood experience of violence are frequently found with partners that are in an abusive relationship, however studies show that not all children who witness abuse grow up to themselves be involved in abusive behavior. Another risk factor of IPV that appears across different settings is the use of alcohol. Most studies which investigate the use of alcohol as a risk factor find significant associations between alcohol and IPV, however, a debate exists about the causality of this relationship. Many studies indicate that women are more likely to be assaulted when alcohol is involved, but that alcohol plays a more facilitative role in that it reduce inhibitions, obscure judgment, feed arguments and serve as an excuse for violent behaviour. Research across cultures indicates a variety of social conditions that present as markers that increase the risk for IPV, but suggests that the response of society towards violence affect the overall levels of abuse. The conclusion from the report (in agreement with Jewkes, *et al.*, 2002) suggests that IPV cannot be attributed to a person's

demographics or history, but is rather most strongly associated with the status of women and the normative use of violence in a society to implement power.

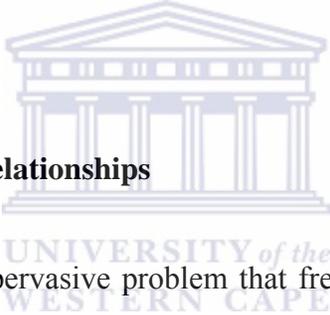
According to Jewkes *et al.* (2001), the origins of the high frequency of IPV in South Africa is particularly complex. The creation of this particular extent of IPV is situated in the society's patriarchal beliefs wherein a woman, her needs, her decision making, and her possessions are seen as inferior to that of a man. The patriarchal ideologies that prevail in South Africa can be identified with the broader historical context wherein for decades apartheid created the opinion of acceptable forms of violence as a way to resolve conflict (Jewkes, *et al.*, 2001). In accordance, violence in relationships is generally also perceived as largely acceptable to both the partners within the relationship as well as outsiders. According to the World Health Organisation (2002), even in societies where the culture is substantially tolerant of abusive behavior, men nevertheless generally exceed the violence norm.

In South Africa the normative use of violence is prominent in intimate relationships from the commencing of dating during adolescence (Jewkes, Vundule, Maforah, & Jordaan, 2001). This violence amongst the youth is often related to the girl's attempts to end the relationship, her suspected infidelity, her rejection of a boy's suggestion to start a relationship, and her opposition of a boyfriend's involvement with other women. The violence varies between threats to beat her, coerced sex, striking her or hitting with sticks and other objects, shoving, physical and violent sexual assault, stabbing with sharp objects or shooting at her (Wood & Jewkes, 2001). In addition these violent acts are

often accompanied by emotional abuse through attempts to control the woman's interaction with society, intentional belittling, bringing other girlfriends to the home, and withholding money for essential items (Jewkes, Penn-Kekana, Levin, Ratsaka, & Schrieber, 2001).

A crucial challenge in exploring IPV is in understanding the prevalence rates which are normally underestimated. Still, in the South African society the control of women is very prominent - in all racial and cultural groups there are perceptions, norms and traditions that enable IPV. The most significant feature of IPV in South Africa is that the society is exceptionally tolerant of it.

2.1.2 Features of Abusive Relationships



Intimate partner violence is a pervasive problem that frequently challenges a woman at every level of her being. As a result of the dismal and threatening effects of abuse, women want to escape the abusive situation, but they often face numerous barriers that prevent them from seeking help. A woman's reaction to violence is time and again restricted by the opportunities available to her. Wilson (1997; in Makofane, 2002) identified four categories of barriers, namely: (1) personal barriers including fear, shame and lack of emotional support and personal resources; (2) relationship barriers in the form of physical abuse or restricted access to money or transport; (3) institutional barriers concerning lack of services, cultural inconsiderateness, immigration policy, discrimination and sexism; and (4) cultural barriers through differences in beliefs regarding marriage, family, gender roles and religion, as well as language differences. In

addition, intimate partner violence is disguised in the public because of many misconceptions, resulting in victim blaming.

A significant correlation exists between victim blaming and justification of violence, which indirectly supports and encourages abuse (Van der Hoven, 2001). The societal myths and misconceptions facilitating lack of intervention include the beliefs that the victim provoked the violence or deserves it; the victim enjoys the abuse; domestic violence is a private issue; domestic violence is only a result of substance abuse; domestic violence only occurs in poor communities; the assault is an isolated incident; the perpetrator is mentally ill or have poor impulse control; the abuser grew up in a violent home so it is not his fault; and stress or unemployment causes abusive behaviour (Schornstein, 1997). These myths and barriers make it difficult for victims to disclose IPV and therefore it concerns Government and other organisations to urgently and effectively address the problem of domestic violence.

2.1.3 Implications of Intimate Partner Violence

It is clear that IPV has a negative impact on a woman's physical and psychological wellbeing, trapping the victim in a situation of isolation, fear and confusion (Arendse, 1998). The consequences of intimate partner violence can be severe, extending beyond the wellbeing of individuals to influence the interests of families, communities and entire countries (WHO, 2002).

2.1.3.1 Personal Implications

Violence against women is associated with acute and chronic physical and psychological trauma. The most apparent physical injuries include cuts, temporary bruises, organ damage, cigarette burns, premature labour, miscarriage, abortions, STI's, HIV/AIDS, physical disability and death (Martin & Artz, 2006; Govender, 2003; Jewkes, Jacobs, Penn-Kekana, & Webster, 2001). During health care visits patients may also complain of vague or chronic conditions such as diarrhea, constipation, frequent indigestion, irritable bowel syndrome, neck or back pain, headaches, poor nutrition, gynecological problems, reduced physical functioning, sexual dysfunction, and infertility (Mick, 2006; Martin & Artz, 2006; Coker, Smith, Bethea, King, & McKeown, 2000).

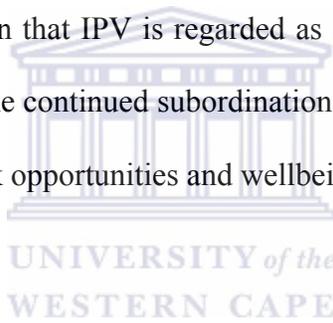
In addition to the physical health outcomes, the harm in being a victim of abuse jeopardise the psychological health of women through depression, anxiety, panic disorder, low self-esteem, post-traumatic stress disorder (PTSD), substance abuse, flat affect, insomnia, eating disorders, chronic fatigue, psychosomatic disorders, unsafe sexual practice, and suicidal ideation (Martin & Artz, 2006; Campbell, 2002; 2001). Also, IPV victims are more likely to be restricted from accessing needed social support from their friends and family (Jaffee, Epling, Grant, Ghandour, & Callendar, 2005).

In South Africa, another dimension is added to the social outcomes of IPV by the high incidence of HIV infection. Women often have insufficient influence in their sexual relations which expose them to elevated vulnerability of HIV infection (Jewkes, et al., 2001). The stigma associated with HIV/AIDS leads to added fear; secrecy; isolation; and eventually actual avoidance and termination of relationships essential for social support

(Duffy, 2005). All these negative health consequences lead to lower quality of life, lower health status and higher health service utilisation of victims of abuse (Campbell, 2001).

2.1.3.2 Social Implications

An overview of the prevalence of IPV in South Africa estimate that one in every four women is abused regularly by her partner and one in three women will in her lifetime be a victim of rape (National Department of Health, 2005). Given that in South Africa more than half of the population is women, IPV have a considerable impact on society as an ever-present fear exist among women, those close to them, and the communities they live in. Furthermore, the perception that IPV is regarded as a normal and acceptable part of life in South Africa assists in the continued subordination of women that uphold their low levels of education, skills, work opportunities and wellbeing (Govender, 2003).



2.1.3.3 Economic Implications

Although, IPV is traditionally viewed as a private family matter, it also influences our country as a whole in the form of lost productivity and extreme medical expenses due to misdiagnosis, over-prescribing of drugs and needless medical tests (Doolan, 2005). The multiple physical and psychological consequence of IPV rests an overwhelming health burden on individuals, families and the healthcare sector. Abused women access healthcare services more frequently than non-abused women and also complain of more symptoms (Mick, 2006). The annual IPV related health costs for South Africa hasn't been estimated, but in England and Wales expenditure was estimated in 2004 at £ 22.9 billion, in Canada the annual cost is estimated at \$ 1 500 million, and in the USA it is

estimated at \$ 4.1 billion yearly (Martin & Artz, 2006; Jewkes, *et al.*, 2001; Department of Health and Human Services, 2003).

In addition, the World Health Organisation (2002) report that the ramifications of IPV also contribute to indirect costs in the high poverty and unemployment levels of the country through absenteeism, decreased work functionality, lack of motivation, morale, creativity and competitiveness, and other conditions discouraging productivity. The poor organisational commitment and inferior quality of service by IPV victims often results in unemployment, which in turn leads to the re-victimisation of women as they are unable to leave abusive relationships due to financial dependence on the abuser (Govender, 2003).

2.1.3.4 Human Rights Implications

According to the Constitution (South Africa, 1996), IPV violates the following fundamental human rights of the victim: the right to life; the right to have their dignity protected and respected; the right to be free from all forms of violence; the right to freedom; the right not to be subjected to cruelty or inhumane and degrading treatment or punishment; and the right to psychological and bodily integrity which include security and control over their bodies and decisions concerning reproduction.

In conclusion, the literature suggest that IPV is widely viewed as a serious burden on personal, economic, social, and human rights, with substantial consequences for women's physical, sexual, reproductive and mental health. However, the variation of the prevalence of IPV within and between different situations and settings draw attention to the fact that violence is not inevitable, and therefore steps need to be taken to address this

condition.

2.2 ADDRESSING INTIMATE PARTNER VIOLENCE

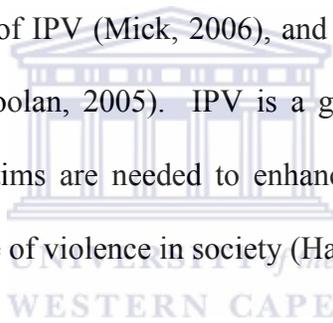
International human rights principles require the state to protect the rights of the nation, also counting the rights of victims of IPV (Kruger, 2004). Since the 1994 democratic elections, South Africa has been paying special attention to women's issues with Government introducing legislation that eliminates discriminatory practices through the Bill of Rights, the Choice in Termination of Pregnancy Act of 1996, and the Domestic Violence Act of 1998 (Jewkes, *et al.*, 2002). The Domestic Violence Act (DVA), specifically, was passed with the aims to reduce the high prevalence of domestic violence in the country; to provide maximum protection to domestic violence victims; to promote the human rights of all citizens; and to ensure that the South African government and all relevant state role-players strive to achieve the provisions of the Act (Smith & Nel, 2002).

Often, the stereotyped view is that IPV takes place within the private domain and therefore the state cannot really be accountable for the prevention of such treatment between partners, but the Constitution declares that a person has the right to be free from all forms of violence perpetuated in private as well as by the state (Section 12, South Africa, 1996). Hereby, the state is liable to "act with due diligence to prevent violations of rights or to investigate and punish acts of violence" (para.9, CEDAW, 1999). Roth (1994) affirms this by calling attention to the state's "duty to protect those within its territory from private acts of violence and illicit force. When the state makes little or no

effort to stop a certain form of private violence, it tacitly condones that violence” (p.326). As a result, the DVA obliged both the Heads of Public Prosecutions and the South African Police Services (SAPS) to issue national instructions to their members with mandatory tasks that should be performed in the face of a domestic violence case (Artz & Smyth, 2005). Training in domestic violence of SAPS members started in 1999 and addressed issues such as behavior which represent domestic violence; procedures to follow upon receiving a complaint; securing a domestic violence scene; keeping records; assisting the complainant; and applying for a protection order. In essence the members were sensitised to the experiences of domestic violence victims and given guidelines on how to perform their duties in accordance with the DVA (Smith & Nel, 2002). However, South Africa is currently experiencing violent crime at an extraordinary rate, and the possibility exists that endeavors, of the police, to address IPV will be suppressed by the more apparent threat of violence in society (Govender, 2003). In addition, most victims of IPV feel that the state is responsible for the prevention of abuse in South Africa, yet, they feel that it is specifically hospitals that can play a significant role in assisting women and inform them of their rights and options (Gersohn, 2004). Furthermore, Schornstein (1997) proposed, on the basis of numerous interviews, that victims of IPV turn to the healthcare community rather than the police after a violent incident and they seek medical help earlier in the abusive cycle than they seek police assistance.

South African literature increasingly confirms that IPV is the foremost cause for women seeking medical attention. According to a national study, more than half of victims of physical abuse seek medical help after an incident (Rasool, Vermaak, Pharoah, Louw & Stavrou, 2002). In recognition of the public health consequences of IPV, healthcare

providers need to develop and implement screening protocol and interventions. In addition, Doolan (2005) maintain that abuse management protocol and standardised domestic violence screening guidelines in the health sector is essential for the successful implementation of the DVA. Currently, disclosure of IPV requires the HCP to complete a J88 document that is essential, in addition to a criminal charge, to give the patient access to prosecution and justice. The J88 is the official document from the Department of Justice that has to be completed by the HCP and hopefully contribute to positive judicial outcomes for the patient (Martin & Artz, 2006). The regular assessment of abuse, in the form of routine universal screening, can increase the identification and assistance of victims and at risk patients of IPV (Mick, 2006), and thorough reports from the HCP can assist in legal matters (Doolan, 2005). IPV is a growing public health issue and effective interventions for victims are needed to enhance the healthy outcomes of the public and reduce the incidence of violence in society (Hayward & Weber, 2003).



Screening for IPV in the healthcare setting is widely advocated internationally (Martin, *et al.*, 2006), since women that are victims of IPV are more likely than non-abused women to use health services (Jaffee, Epling, Grant, Ghandour, & Callendar, 2005). Davis & Harsh (2001) stated that the most important thing that HCP can do is to ask about IPV. As a result, there is an increasing recognition that health services can play an important role in addressing intimate partner violence, by adopting a more holistic approach to healthcare instead of focusing only on a patient's symptoms. HCP must be competent in the accurate assessment of IPV victims, so that opportunities can be identified to provide prevention education, safety planning and lethality assessment, options for leaving the relationship, and referrals to community resources (Glass *et al.*, 2001). Screening in a

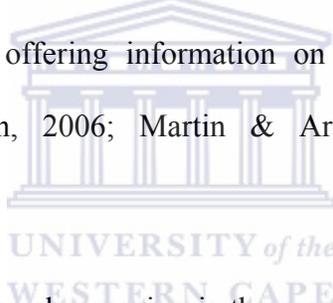
healthcare setting incorporate the capacity of HCP to accurately and sensitively identify indicators of IPV and provide an appropriate response to the situation (Garcia-Moreno, 2002). However, most victims of abuse will not voluntarily disclose this information, but will confirm and discuss abuse when asked directly. Therefore, inquiries about IPV should be a standard component of a patient's assessment in order to avoid missed opportunities to provide support and intervention to patients experiencing abuse (Mick, 2006). Active routine universal screening for abuse serve as an intervention and prevention of violence by intimate partners and can possibly improve the safety of women and facilitate their health-seeking behaviour.

2.3 ROUTINE UNIVERSAL SCREENING

Acknowledgement of IPV as a public health problem, have led medical organisations to recognise the important role that health care providers (HCP) and facilities can play in identifying and preventing this under-recognised epidemic. There is a call for the health sector and HCP to supplement women's physical health needs through the development and implementation of routine universal screening protocols for IPV and interventions that encourage an attitude of caring, respect and assistance (Chang, Cluss, Ranieri, Hawker, Buranosky, Dado, McNeil, & Scholle, 2005). These basic changes in healthcare service provision can facilitate the uncovering and healing of more women disempowered by IPV. An opportunity for a woman to discuss her situation with a supportive professional can be initiated by a HCP routinely asking about abuse during a health care visit (Mick, 2006).

2.3.1 Defining Routine Universal Screening

Routine universal screening means that every woman is asked about her experience of IPV, regardless of her culture, age, ethnicity, socio-economic status, or level of education (Hindin, 2006; National Guideline Clearinghouse, 2005; Davis & Harsh, 2001). Universal screening practice incorporate 1) using the same direct questions in any case, whether abuse is suspected or symptoms are present; 2) asking the patient in complete privacy to ensure security, with no attendance of children over 2 years of age; 3) asking standardised questions; 4) asking the questions in person with sensitivity, supportiveness, and being non-judgmental; 5) providing appropriate medical care and documenting the details of the abuse; and 6) offering information on safety planning and available community resources (Hindin, 2006; Martin & Artz, 2006; National Guideline Clearinghouse, 2005).



Literature emphasise that universal screening is the most effective means of identifying abused women, as direct questions offer opportunities for disclosure that may not have occurred otherwise. Given the high morbidity and mortality coupled with IPV it is suggested that universal screening should be implemented in the medical setting, such that all women would be asked about violence in their lives. Besides, research by Saunders, Hamberger, and Hovey (1993) implies that the profile of an IPV victim cannot be accurately predicted by health or demographic factors alone. It is argued that routine universal screening will increase the awareness of IPV and its social and health consequences, while also giving abused women the opportunity to come to terms with the violence in their own lives (Taket, Wathen & MacMillan, 2004). Numerous reasons exist

for patients not disclosing the violence they experience to HCP, yet in seeking out health care they are inviting help and actually relieved when asked about IPV (Krassnoff & Moscatti, 2002). A HCP's concern and response to IPV is therefore important to their patients' present and future wellbeing, and can be facilitated through the implementation of routine universal screening practice.

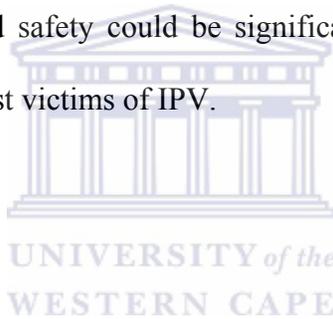
2.3.2 The Need for Routine Universal Screening

In the early stages of a violent relationship a woman may not fully comprehend that her physical and mental symptoms are a consequence of the abuse in her life. A HCP who has formed a trusting and confidential relationship with the woman is in an ideal position to do a thorough history taking and assessment of psychological and physical symptoms, and link these with the underlying abuse that is threatening the woman's wellbeing (Nauman, Langford, Torres, Campbell, & Glass, 1999). When HCP screen routinely for IPV they can start uncovering a woman's hidden agony and start reframing the woman's situation as she is validated and her self-worth recovered. With the disclosure of abuse HCP can assist women in drawing up safety plans or refer her to services (social and legal) that can support her in the crisis (Gersohn, 2004).

Fruend, Bak and Blackhall (1996) found that with the inclusion of only one IPV question in a history taking questionnaire, a primary care clinic increased their identification of abused women from 0 to 12 %. However, according to McFarlane, Christoffel, Bateman, Miller, and Bullock (1991) victims of IPV respond even more positively (four times more

disclosure) when nurses asked questions about abuse than when they replied to question on a history or intake form. In a study on the factors associated with the disclosure of IPV in a healthcare setting, directly asking about abuse was the strongest predictor of disclosure (Rodriguez, Sheldon, Bauer, & Perez-Stable, 2001).

Dubowitz, Prescott, Feigelman, Lane, and Kim (2008) found that just by asking screening questions, women recognise HCP as a resource and might turn to them in the future. Raising the issue of IPV conveyed to the women the message that they are important, that IPV is a crisis, and that their HCP care and want to help (Dubowitz, *et al.*, 2008). In summary, women's health and safety could be significantly improved through a HCP preparedness to assess and assist victims of IPV.



2.3.3 What Women Want

Several studies of abused women in health care settings reveal that they want to be asked routinely about abuse by their health care providers. Even though many women state that they find it difficult to begin discussions with their HCP, they are willing to disclose and explore IPV when asked (Nauman, *et al.*, 1999). Talking about the abuse in their lives may yield a great deal of anxiety, but women indicate that they are not overwhelmed if it happens in a supportive, respectful and caring manner (Samuelson & Campbell, 2005). If the women feel that they are listened to, understood, and acknowledged for the abuse, they are more inclined to discuss their abuse and attempt to leave the unsafe situation (Gerbert, Abercrombie, Caspers, Love & Bronstone, 1999).

2.4 HEALTH CARE PROFESSIONAL'S BARRIERS TOWARDS ROUTINE UNIVERSAL SCREENING FOR INTIMATE PARTNER VIOLENCE

Intimate partner violence is a common problem in medical practice that healthcare providers often disregard as a significant health issue (Davis & Harsh, 2001). Although the medical community can play a vital role in the identification, intervention and prevention of IPV, HCP face numerous barriers in screening for abuse just as women face barriers in reporting abuse (Jaffee, *et al.*, 2005). Numerous studies from the United States of America have found that the gap between recommendations for IPV screening and the actual implementation of it still exists and is due to personal (affective), informational and institutional barriers perceived by the HCP.

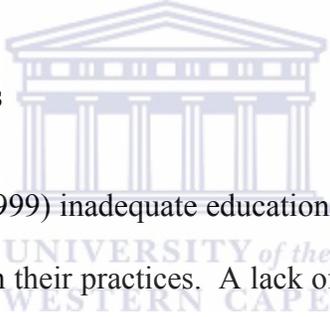
2.4.1 Personal (affective) Barriers

Perceptions, values and prejudices strongly influence the perception of IPV's position within the medical environment. Personal barriers to screening may include HCP past personal experience of abuse that might lead to questions being asked in a way that discourages disclosure (Jewkes, *et al.*, 2002). Some HCP experience frustration when identified victims refuse referrals and this might lead to decreased screening rates in the future (Davis & Harsh, 2001). In interviews with 38 HCP Sugg and Inui (1992) found that the feelings preventing them from engaging in IPV encounters are "close identification with their clients", "frustration and feelings of inadequacy when discussing interventions", and "fear of offending patients". These personal barriers can severely compromise HCP confidence in assisting victims of IPV. Gerber, Leiter, Hermann, and

Bor (2005) found that only 63% of HCP feel confident in their ability to manage patients who have experienced IPV, compared to 93% of the sample feeling at ease with depression and 83% with substance abuse (conditions which have in the past also been considered as sensitive and private).

Waalén, Goodwin, Spitz, Petersen, and Saltzman (2000) also found the following barriers for HCP: the belief that the victim played a role in eliciting the abuse; the belief that it is inappropriate to intervene; the fear for their safety; and the view that IPV is not a medical issue.

2.4.2 Informational Barriers



According to Nauman, *et al.* (1999) inadequate education leaves a lot of HCP unprepared or unsure how to address IPV in their practices. A lack of understanding of the dynamics and sequelae of IPV can decrease HCP level of comfort in dealing with victims (Samuelson & Campbell, 2005). HCP most often declare informational barriers in the form of inadequate education about IPV and the lack of knowledge of community intervention organisations. Several studies suggest that both victims of abuse and their HCP often fail to link indicating medical conditions to the abuse from which it could have originated (in Nauman, *et al.*, 1999). Davis & Harsh (2001) found that a feeling of inadequacy in giving effective referrals to patients is a challenging barrier for HCP. HCP's preconceptions about the demographics of IPV victims are another informational barrier that can increase the likelihood that a vulnerable patient will not be screened (Jonassen, *et al.*, 2003). Also, when HCP think that women will volunteer information

regarding IPV without being asked or if they think that screening will offend patients, they would be less likely to screen for IPV (Jaffee, *et al.*, 2005). Jonassen *et al.* (2003) found that high self-assessed competence in medical students to identify IPV is a strong positive predictor of IPV screening.

2.4.3 Institutional Barriers

In order for HCP to effectively address IPV the medical community needs to create an accommodating milieu wherein the demanding circumstances of medical institutions can coexist with the supportive and compassionate requirements for dealing with IPV victims.

The main institutional barrier experienced by HCP is the limited time they have with each patient (Davis & Harsh, 2001). Another is connected to privacy and confidentiality, especially in poorly resourced setting where patients are only separated by curtains or thin walls (Garcia-Moreno, 2002). Also, family members often accompany patients into the treatment quarters (Davis & Harsh, 2001), which along with the lack of general privacy at the health care settings can put victims of IPV at further risk (Cole, 1999 in Gersohn, 2004). A further barrier is the lack of effectively implemented protocols due to staffing and funding shortages, and the lack of education on the topic (Runy, 2001 in Gersohn, 2004).

In informal discussions, with medical students at the University of Cape Town, Doolan (2005) also identified barriers in the form of age differences making it awkward; cultural differences making communication difficult; the inability to change the victims'

situation; and the fear or unpreparedness to assist emotionally upset victims.

2.5 THEORETICAL FRAMEWORK: THE HEALTH BELIEF MODEL

HCP are in a unique position to identify and assist victims of IPV, but they rarely screen their patients for abuse. The health belief model (Appendix A) provides an exploration of the likelihood that a HCP will take action and screen for IPV by reviewing two personal assessments that a person make. The one is a person's assessment of the perceived threat of the health problem and the other consist of the weighing of the *costs (barriers)* and *benefits* involved in taking action to estimate whether the health behaviour will be effective in reducing the threat (Forshaw, 2003). A person's assessment of the perceived threat of the health problem are influenced by the belief of the *perceived seriousness* of the problem (for example the severity of a patients injuries); the HCP's belief of the *susceptibility* of a patient for IPV (possibly influenced by patient's demographics); and *cues to action* (whether internal or external in the form of protocol or health education) necessary to elicit suitable health behaviour (Sarafino, 2002). According to Ogden (1996) the health belief model have been revised to also include the constructs of *health motivation* to reflect an individual's readiness to be concerned with IPV (influenced by his/her beliefs concerning IPV) and *perceived control* (an individual's confidence in being able to make a difference). Behaviour will then be the product of the beliefs that certain actions will benefit an individual in a manner that will outweigh any barriers.

Several studies, concerning a broad array of health screening programmes (Janz &

Becker, 1984; Ronis, 1992; Holm, Frank, & Curtin, 1999; Roden, 2004; Martin, 2006; Gillibrand & Stevenson, 2006), indicate that health beliefs are a qualified determinant of the intention to perform a health action. Janz and Becker (1984) found that the most powerful belief, that influences whether a person will actually practice healthy behaviour, is the perceived barriers. These barriers are mainly defined as an individual's personal evaluation of the possible obstacles to adopting a new health behaviour. In the current study, a particular focus was on the influence of nursing students' perceived personal, informational and institutional barriers on their intentions to screen patients for intimate partner violence.

2.6 HYPOTHESIS

The main research question of the study is to determine nursing students' perception of barriers towards routine screening for abuse. The research question is investigated through three key hypotheses:

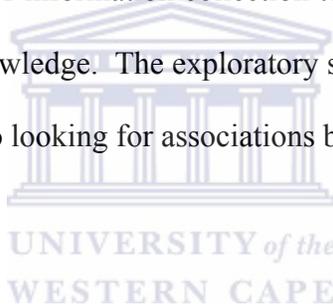
Hypothesis 1: Nursing students perceive personal barriers to routine screening for IPV

Hypothesis 2: Nursing students perceive informational barriers to routine screening for IPV

Hypothesis 3: Nursing students perceive institutional barriers to routine screening for IPV

CHAPTER 3: RESEARCH DESIGN AND METHODOLOGY

A quantitative study was conducted in the Western Cape through an exploratory research design. The quantitative methodological framework emphasises the quantification of constructs through the use of variables that describes and analyse human behaviour (Babbie & Mouton, 2001). This study more specifically employed a cross-sectional survey design to give an overview, of the perceptions of nursing students about routine universal screening for IPV, at a specific point in time (Durrheim, 1999). Survey methodology allows for the representation of the complex systems that makes up reality (Byrne, 2002). It is a means for information collection to describe, compare and explain behaviour, perceptions and knowledge. The exploratory survey makes the data go further than just describing variables to looking for associations between them (Gray, 2004).



3.1 PARTICIPANTS

Nurses were identified as the general population for the investigation into the beliefs and perceptions of health-care practitioners towards routine universal screening in South-Africa. The rationale behind the choice of respondents is directly related to the National Health Departments' majority focus on primary healthcare services that is mainly facilitated by nursing staff. Nursing students were chosen in this study since they are currently trained as the future HCP and are likely to encounter IPV in their work. Participants in this study consisted of a purposive sample of 103 final year nursing students from the University of the Western Cape. For the current study relevant modifying factors in the participants perceived barriers to screening for IPV were

identified as gender, age and exposure to violence of the sample. The gender distribution of the sample is indicated in Figure 1.

Figure 1: Gender Distribution of participants

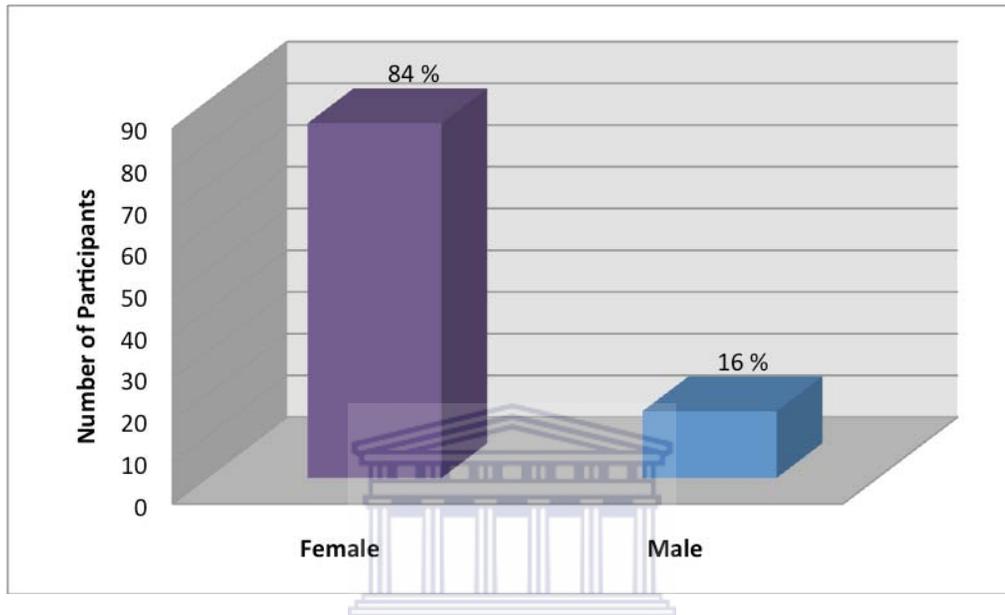


Figure 1 represents the distribution of the gender of the sample participants. The majority of the sample consisted of females (84.16 % of the sample) in comparison with the male participants making up only 15.84% (n = 16) of the research sample. This difference in the representation of gender may possibly be explained by the fact that the majority of individuals in the occupation of nursing are female.

The age of the research sample is illustrated (in Figure 2) in line with a subjective age category that they fall into. The age of the sample ranges from 21 to 46 years, with the majority of participants (n = 51 or 52.58 %) falling within the 21-25 years category, followed by 30.93 % (n = 30) of the sample who represent the 26 – 30 years category.

Figure 2: Age distribution of participants

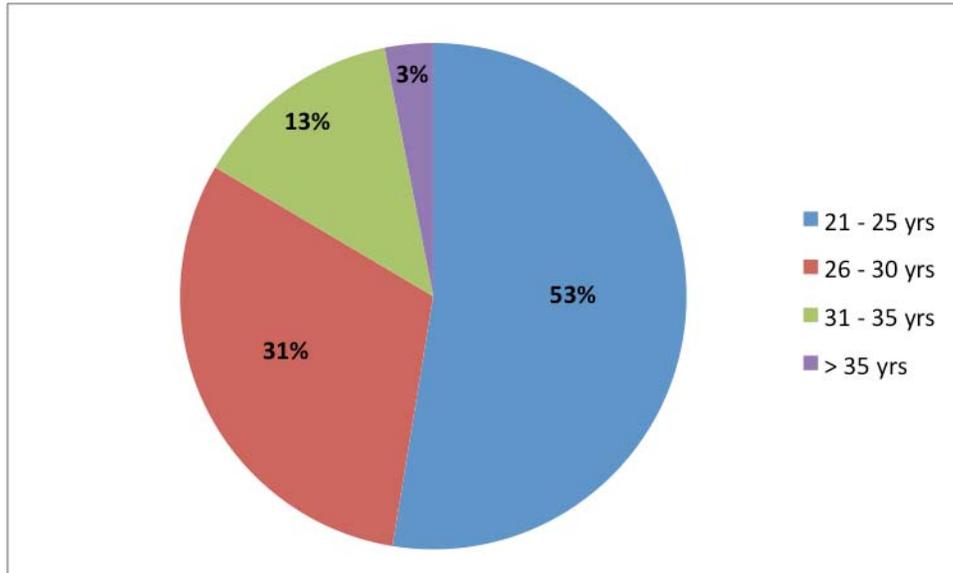


Figure 3: Exposure to Intimate Partner Violence

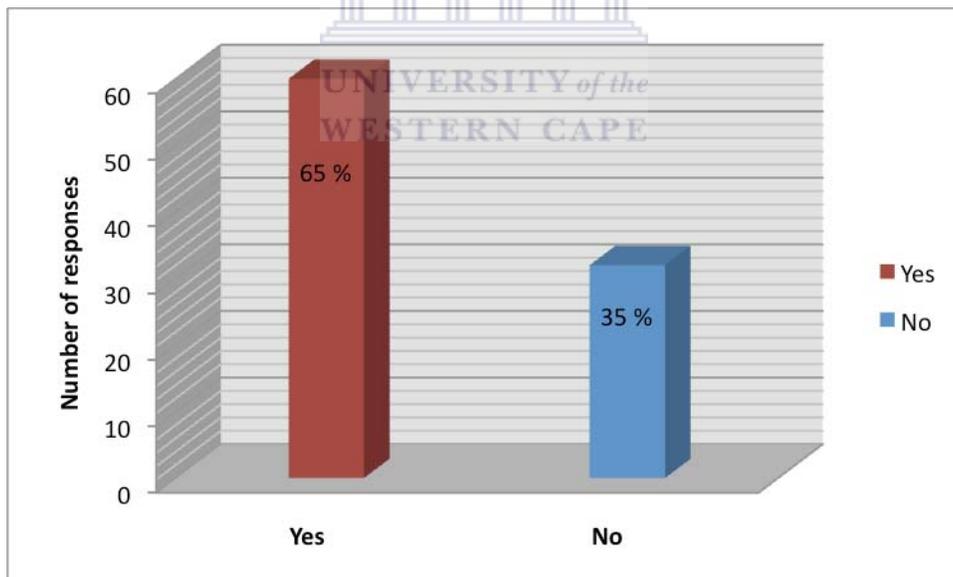


Figure 3 illustrates the research sample's life-time exposure to IPV, either by being a victim themselves or having someone close to them being a victim of IPV. The majority of participants (n = 60 or 65.22 %) have been exposed to IPV, whilst the remaining

34.78% haven't been exposed, neither personally nor through someone close to them.

3.2 PROCEDURES

After a draft questionnaire was prepared, which the researcher believed covered all the questions necessary to obtain the information needed to achieve the aims of the study, it was pre-tested under survey conditions and followed the guidelines presented in Iarossi (2006). The pilot study used 25 junior nursing students to test the appropriateness of the survey questionnaire. The questions were pre-tested to reduce possible misinterpretation of questions and to increase response rate. The pilot study respondents were requested to evaluate the questionnaire from their point of view by sharing their experiences and problems throughout the process. The pilot study attempted to address questionnaire concerns such as (1) Are the questionnaire instructions clear? (2) Do the participants understand the purpose of the survey? (3) Is the wording of the questions understandable? (4) Are there questions which the participants are likely not to know the answers to? (5) Does the style of certain questions generate bias? (6) Are there questions that need to be rewritten to prevent ambiguity? At the conclusion of the pilot study, the comments and recommendations of the participants were considered in the adjustment of the questionnaire, where after the amended questionnaire were administered to the selected research sample.

The sample design used was decided on by weighing what is theoretically sought and practically possible for the current study. The sampling procedure that was used is that of purposive (non-probability) sampling. That is, the sample was not selected according to

the principles of statistical randomness, but rather a sample was chosen that fit particular criteria (Babbie & Mouton, 2001). Knowledge of the Health Department's focus on primary healthcare, lead to the selection of the purposive sample of nursing students in this study as they will serve possible IPV victims in the future. This sampling method has the disadvantage that statistical theories of probability do not apply to it and the properties of the sample cannot be used to describe the population's properties. This method has the advantage of being less expensive, and it is adequate for use in descriptive and exploratory surveys (Babbie & Mouton, 2001).

3.3 DATA COLLECTION TOOLS

Data was collected by use of a self-administered questionnaire (Appendix B) that is appropriate for the sample as they were all adequately literate (Babbie & Mouton, 2001). The sample is not widely distributed geographically and therefore the researcher was able to administer and collect the questionnaire on one occasion. The contact made with the respondents during administering of the questionnaire possibly assisted the study by leading to a higher response rate, even though, it still maintained the confidentiality necessary to complete personal and delicate questions with minimal social desirability (Gray, 2004). The presence of the researcher also contributed to the integrity of the questionnaire in that assurance could be made that the respondents followed the questionnaire instructions accurately (Rea & Parker, 1992). A disadvantage of this method of data collection is the severe reduction of anonymity.

A literature search failed to reveal an existing instrument that can be used to measure the

research topic or its sub-problems. Therefore it was necessary to compile a devoted questionnaire with the choice of items for inclusion informed by various sources (Jaffee *et al.*, 2005; Garimella, Plichta, Housman & Garzan, 2000; Peltzer, Mashego, & Mabeba, 2003; Zeitler, Pain, Breitbart, Rickert, Olsen, Stevens, Rottenberg & Davidson, 2006; Ellis, 1999; Shearer, Forte, Dosanjh, Mathews & Bhandani, 2006; Short, Alpert, Harris, & Suprenant, 2006). The questionnaire consisted of 83 items covering the following themes:

1. Beliefs / myths about intimate partner violence.
2. Perceptions towards routine universal screening for IPV.
3. Readiness/preparedness to manage IPV in a healthcare setting

The Likert rating scale was used for this questionnaire as it have unambiguous response categories, are typically very reliable, is a summative scale, and can measure the relative intensity of different questionnaire items (Babbie & Mouton, 2001). For the key analysis of the current research hypotheses on nursing student's perceived barriers to routine screening for IPV, the participants' responses were grouped into three sections with items devoted to perceived personal barriers, informational barriers and institutional barriers.

3.4 DATA ANALYSIS

The use of a descriptive study permits the describing and quantification of the extent of the barriers that respondents hold with regard to the research topic. After the questionnaires were returned to the researcher, the process of "cleaning up" was performed to validate the questionnaires. This process entailed the process of making certain that all the questions were answered in a questionnaire and that the appropriate

amount of responses were marked for each question. Data from complete questionnaires were recorded on a computer and analysed by use of Microsoft Excel and the Statistical Package for the Social Sciences (SPSS) with α set at 0.05.

Analysis of the data commenced with a calculation of the frequencies (f), percentages (%), and standard deviations (SD) of the research items. Because this was a descriptive, exploratory survey, the findings are primarily reported statistically through percentages.

3.5 ETHICS

Approval and permission to conduct the study was obtained from the Head of Department of Nursing and the ethics committee from the University of the Western Cape. Informed consent was obtained from the respondents and any participation in the study was voluntary and confidential. All participants were fully informed about the purpose of the study through a description on the first page of the survey that they could detach and keep (Appendix B). All participants had the option to refuse participation, but if a questionnaire was completed and returned it was considered as consent to participate in the survey. The recipients were assured that non-response will not negatively impact on their personal career as a student. Completed surveys contained no names or contact details that might link a response to a specific individual.

3.6 SIGNIFICANCE OF STUDY

This study can significantly contribute to the uncovering of how health providers' perceived beliefs and barriers influence their IPV screening behaviour; in order to help

them address their feelings about assisting IPV victims; to develop more accurate training modules for healthcare students; and to initiate positive changes in healthcare settings to increase the rate of IPV screening and disclosure. When IPV is acknowledged and addressed in the health sector, it may begin to emerge from the privacy of a home into a public issue that demands attention.



CHAPTER 4: RESULTS

4.1 Internal Consistency Reliability of constructed measures

The questionnaire administered to the research sample was constructed by combining relevant items from different existing questionnaires. The final measuring instrument consisted of 3 main section: (1) the measurement of how often the participants will screen for IPV according to the patients' presenting symptoms; (2) a measure of how much the participants feel they know about IPV; and then (3) numerous devoted items that measures the barriers that participants perceive towards screening for abuse. A Cronbach alpha reliability coefficient revealed that the measurement of the section 1 rating scale had a high internal consistency ($\alpha = 0.898$); that of section 2 also had a high internal consistency ($\alpha = 0.951$); and that of section 3 had a moderate internal consistency ($\alpha = 0.736$).

4.2 Perceived Severity as indicator for how often participants will screen for IPV

The research samples perceived susceptibility and severity of patients' exposure to IPV were assessed as cues to action to assist victims of abuse. The nursing students indicated how often they will screen a patient for IPV when that patient is presenting with the symptoms listed in Table 1.

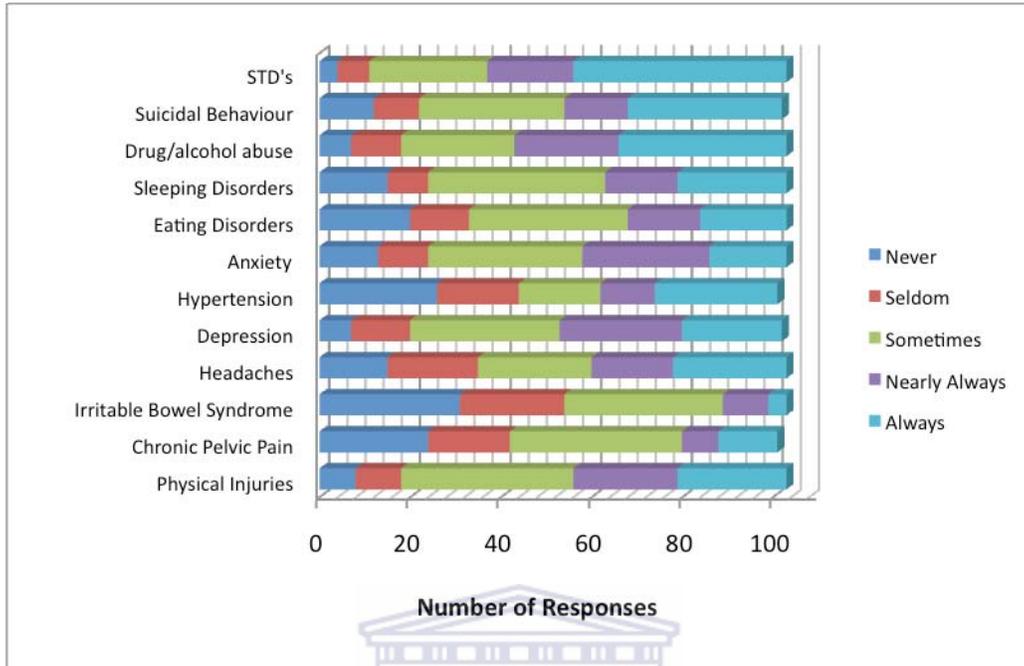
Table 1: Frequency of IPV screening for presenting symptoms

Presenting Symptoms	Mean	Median	Std. Dev
Physical injuries	3.44	3	1.177
Chronic pelvic pain	2.68	3	1.28
Irritable bowel syndrome	2.35	2	1.126
Headaches	3.17	3	1.382
Depression	3.43	3	1.165
Hypertension	2.96	3	1.555
Anxiety	3.24	3	1.224
Eating disorders	3.01	3	1.347
Sleeping disorders	3.24	3	1.31
Substance abuse problem	3.7	4	1.251
Suicidal behaviour	3.47	3	1.355
STD's	3.95	4	1.158

Table 1 illustrates that the sample were most likely to *nearly always* screen patients for IPV if they present with a Sexually Transmitted Disease ($x = 3.95$), followed by substance abuse problems ($x = 3.7$), suicidal behaviour ($x = 3.47$), and physical injuries ($x = 3.44$). The sample were least likely to screen patients who come to the clinic with irritable bowel syndrome ($x = 2.35$), followed by chronic pelvic pain ($x = 2.68$), hypertension ($x = 2.96$), and eating disorders ($x = 3.01$).

According to Figure 4, patients presenting at the health care practice with an STD will *always* be screened for IPV by 46 % of the sample, followed by drug/alcohol abuse that constitute 36 % of the sample that will *always* screen and 22 % that will *nearly always* screen.

Figure 4: Distribution of samples prevalence of screening



An investigation into the distribution of intended screening practice according to gender (Table 2) revealed that there exist minimal differences in the intentions of male and female nursing students. The only indicated differences is in the case of Chronic pelvic pain where female participants indicated that they will screen *sometimes* and male participants will *seldom* screen; and female participants will *sometimes* screen when a patient presents with depression whereas male participants will *nearly always* screen in these circumstances.

Table 2: Gender distribution of screening intention

	Female (x _f)	Male (x _m)
Physical injuries	3	3
Chronic pelvic pain	3	2
Irritable bowel syndrome	2	2

Headaches	3	3
Depression	3	4
Hypertension	3	3
Anxiety	3	3
Eating disorders	3	3
Sleeping disorders	3	3
Substance abuse problem	4	4
Suicidal behaviour	3	3
STD's	4	4

4.3 Perceived Informational Barriers for routine universal screening of IPV

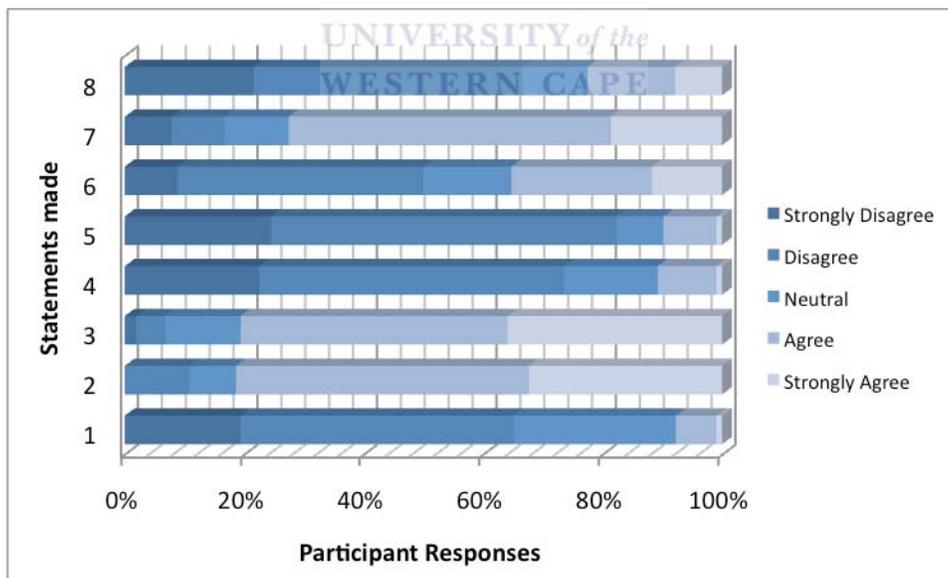
The measure in Table 3 appraised the sample's believe about how much they know about the different aspects of IPV.

Table 3: Self-stated knowledge of IPV as cues to action

KNOW ABOUT:	Mean	Mode	Median	Std. Dev.	Min	Max
Your legal reporting requirements for IPV	4.20	4	4	1.60	1	7
Signs or symptoms of IPV	5.27	6	5	1.33	2	7
How to document IPV in a patient's chart	4.15	4	4	1.72	1	7
Making appropriate referrals for IPV victims	4.57	5	5	1.57	1	7
Perpetrators of IPV	3.94	4	4	1.61	1	7
What questions to ask to identify IPV	4.69	5	5	1.45	1	7
Why a victim might not disclose IPV	4.63	5	5	1.49	1	7
Your role in detecting IPV	4.66	5	5	1.30	1	7
What to say and not say in IPV situations	4.72	4	5	1.36	1	7
Determine danger for a patient experiencing IPV	4.66	5	5	1.42	1	7
Developing a safety plan with an IPV victim	4.39	3	4	1.63	1	7
Appropriately responding to disclosures of IPV	4.76	5	5	1.51	1	7
Total	4.55	5	5	1.50	1	7

The sample's responses had a range from 1 (*know nothing*) to 7 (*know very much*) on all the statements except for knowledge about the signs and symptoms of IPV which had an overall minimum score of 2 (*know very little*). The sample also indicated that they believe they know most about the *signs and symptoms of IPV* ($x = 5.27$; mode=6), followed by knowledge of *appropriately responding to disclosures of IPV* ($x = 4.76$), *what to say and not say in IPV situations* ($x = 4.72$), and *what questions to ask to identify IPV* ($x = 4.69$). The nursing students believed that they had the least knowledge of *perpetrators of abuse* ($x = 3.94$), *how to document IPV in a patient's chart* ($x = 4.15$), and their *legal reporting requirements for IPV* ($x = 4.20$).

Figure 5: Prevalence of perceived Informational Barriers to IPV Screening



1. Patients are generally willing to discuss issues of IPV
2. I feel confident that I can make appropriate referrals for abused patients
3. I feel confident that I can identify warning signs of abuse
4. I don't know how to ask about IPV
5. I don't know what to do if a patient discloses IPV
6. I do not have sufficient training to assist individuals in addressing

situations of IPV

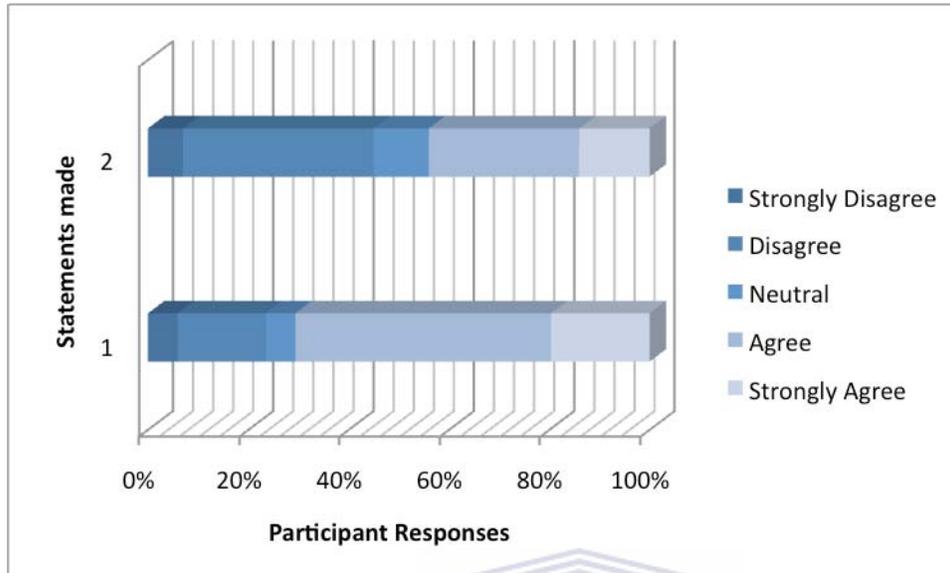
- 7. I am aware of the legal requirements in this country regarding reporting of suspected cases of IPV**
- 8. Nurses do not have the knowledge to assist patients in addressing IPV**

Factors affecting the perceived informational barriers that nursing students hold towards routine universal screening for IPV are depicted in Figure 5. Most nursing students tended to (strongly) disagree that they *don't know what to do if a patient discloses IPV* (82%), *don't know how to ask about IPV* (74%), and *do not have the knowledge to assist patients in addressing IPV* (67%). The majority of nursing student also (strongly) agreed that they *feel confident that they can make appropriate referrals for abused patients* (81%), *can identify warning signs of abuse* (81%), and are *aware of the legal requirements in the country regarding reporting of suspected cases of IPV* (73%). From the sample only 50% disagreed that they *do not have sufficient training to assist individuals in addressing situations of IPV* (35% agreed and 15% were neutral). In addition a big informational barrier for the nursing students were the belief that *patients are not generally willing to discuss issues of IPV* (65% disagreed with statement 1).

4.4 Perceived Institutional Barriers to routine universal screening for IPV

A few institutional factors were identified (Figure 6) to refrain a nurse from screening for intimate partner violence in a clinic setting.

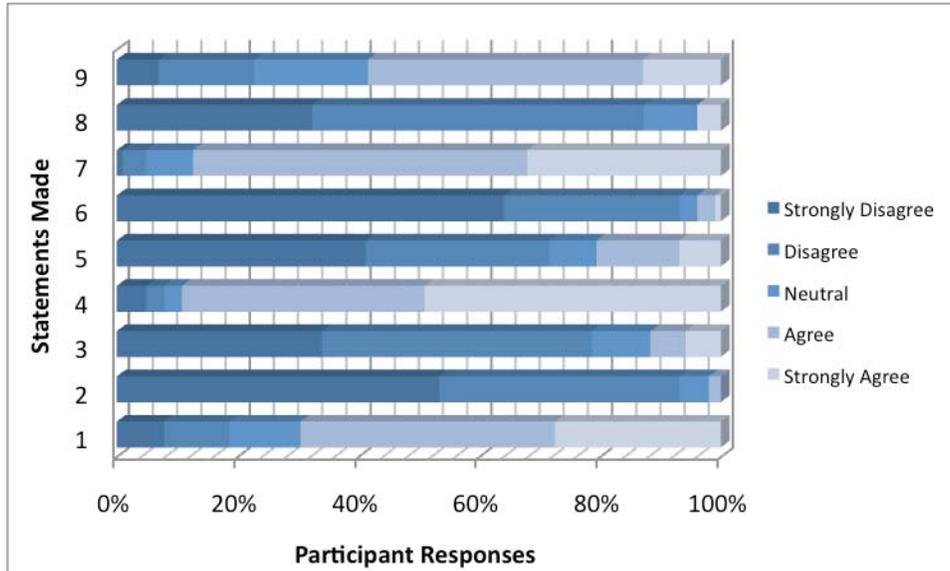
Figure 6: Prevalence of perceived Institutional Barriers to IPV Screening



- 1. A lack of privacy in the clinic will withhold me from screening for IPV**
- 2. I feel that I don't have enough time to ask about IPV**

The majority of the sample agreed (51%) or strongly agreed (20%) that the lack of privacy in the clinic is a major institutional barrier that withholds them from screening for IPV (Statement 1). Whereas the sample was torn on the prevalence of the perceived barrier that there is not enough time to ask about IPV, as 45% disagreed and 44% agreed with the statement. The individual's readiness to be concerned with IPV can further be affected by external cues to action in the form of protocol or health education in the clinic or the individual's belief regarding his/her role in IPV situations that can serve as a health motivation (Figure 7).

Figure 7: Prevalence of Health Motivation



1. Domestic violence should be treated and regarded as a medical syndrome or problem
2. It is not a nurse's responsibility to initiate discussions concerning IPV
3. I am hesitant to screen for IPV because I do not want to get stuck in the middle of a complicated family or legal battle
4. I believe screening and treatment of IPV should be a priority in the health-care sector
5. I consider IPV screening to be of relatively minor importance in a healthcare setting
6. Nurses should only treat the injuries and not query or give advice to abused women
7. Nurses should be on the look out in diagnosing abuse
8. I don't feel it is really my job to screen for IPV
9. My workplace encourages me to respond to IPV

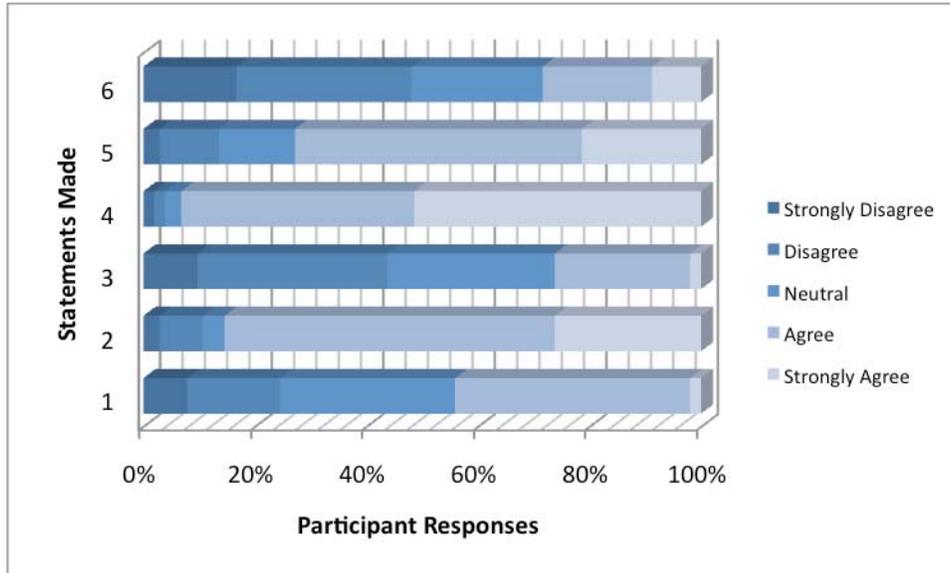
It seems as if the vast majority of nursing students held a strong health motivation towards screening and addressing IPV in a health setting. For the most part nursing students (strongly) agreed that *screening and treatment of IPV should be a priority in the health-care sector* (89%), that *nurses should be on the look out in diagnosing abuse* (87%), that *domestic violence should be treated and regarded as a medical syndrome or problem* (70%), and that therefore *their workplace encourages them to respond to IPV*

(58%). Moreover the sample majority (strongly) disagreed that *it is not a nurse's responsibility to initiate discussions concerning IPV* (93%), that *nurses should only treat the injuries and not query or give advice to abused women* (93%), that *they don't feel that it is really their job to screen for IPV* (87%), that *they are hesitant to screen for IPV because they do not want to get stuck in the middle of a complicated family or legal battle* (77%), and that *they consider IPV screening to be of relatively minor importance in a healthcare setting* (72%).

4.5 Perceived Personal Barriers to routine universal screening for IPV

The nursing students affective personal barriers towards routinely screening for IPV are shown in Figure 8. The sample majority portrayed comfort in addressing IPV by (strongly) agreeing that they are *prepared to support women who discloses IPV* (93%), they *will be comfortable to discuss issues of IPV with these patients* (85%), and that they *will feel comfortable to ask these routine questions about IPV to all their patients* (73%). In addition, most of the research participants (strongly) disagreed that they *do not have the necessary skills to discuss abuse with an IPV victim who is from a different cultural or ethnic background* (48%). However, the sample did perceive some difficulty with regard to *thinking that a patient might find IPV screening offensive* (44% agreed; 31% neutral; 25% disagreed) and feeling that *if they ask non-abused patients about IPV, they will get very angry* (44% disagreed; 30% neutral; 26% agreed).

Figure 8: Prevalence of perceived Personal Barriers to IPV Screening

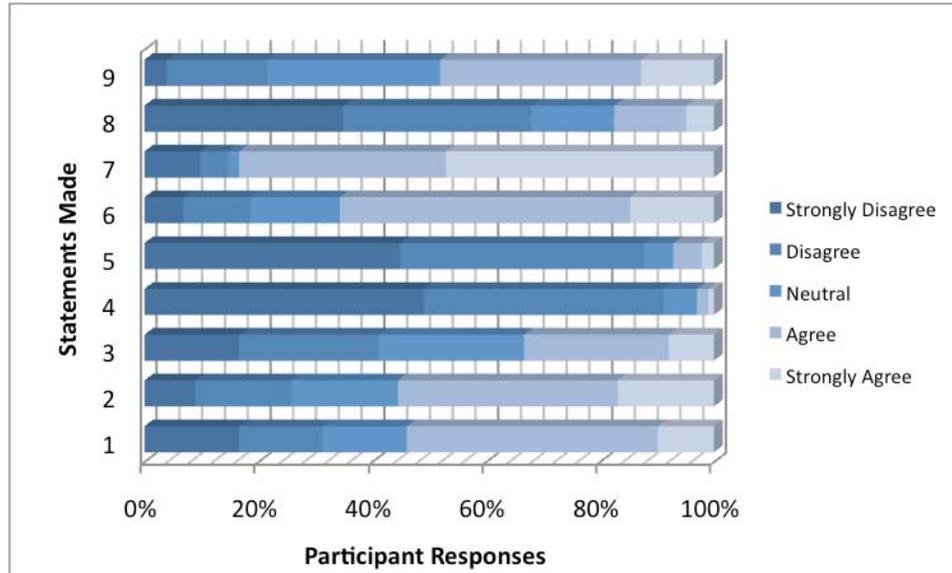


1. **I think that a patient might find IPV screening offensive**
2. **I will be comfortable to discuss issues of IPV with my patients**
3. **If I ask non-abused patients about IPV, they will get very angry**
4. **I am prepared to support women who discloses IPV**
5. **I feel comfortable to ask routine questions about IPV to all my patients**
6. **I don't have the necessary skills to discuss abuse with an IPV victim who is from a different cultural or ethnic background**

The intent of the participants to recognise victims of abuse can further be indicated by their perceptions of the demographics and risk factors of women who are exposed to IPV.

The research sample's beliefs regarding the susceptibility of women to IPV are indicated in Figure 9.

Figure 9: Perceived susceptibility of women to IPV

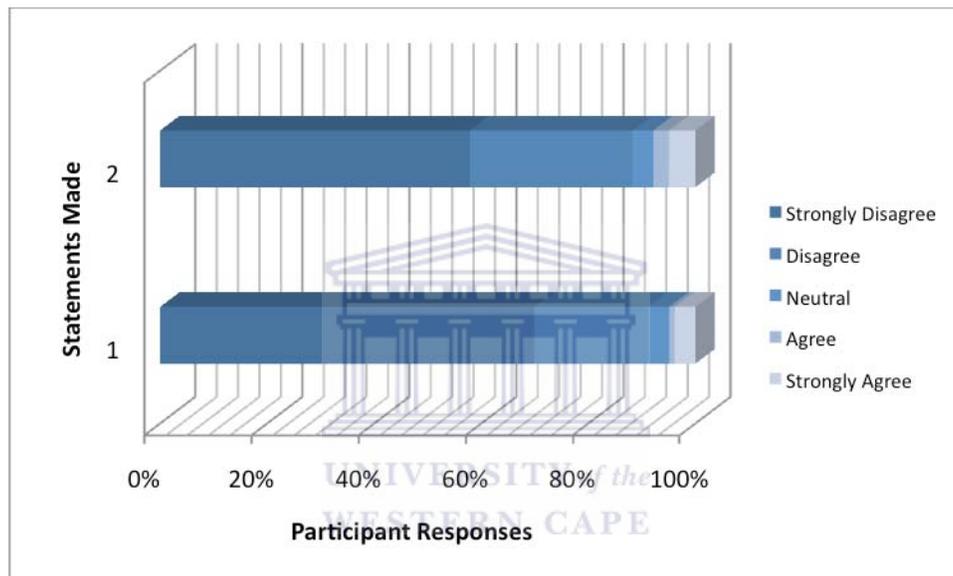


1. **IPV is caused by sociological (societal) factors like unemployment**
2. **IPV is caused by alcohol or drug abuse**
3. **IPV is caused by the partner/husband's psychological problems**
4. **IPV only affects a small amount of people**
5. **IPV occurs mainly in poor areas**
6. **There are common, non-visible presentations of abused patients**
7. **Any woman can be a victim of IPV**
8. **Allowing partners or friends to be present during a patient's physical exam ensures safety for an IPV victim**
9. **Nurses should ask every woman if she has experienced abuse**

The factors that are indicators of IPV as perceived by the nursing student's influence their screening practices of women presenting at the clinic (Figure 9). The majority of the sample tended to ascribe to the view that abuse is a universal phenomena, by agreeing that *any women can be a victim of IPV* (83.3%) and that *there are common, non-visible presentations of abused patients* (65.7%); while disagreeing that *IPV only affects a small amount of people* (91.2%); that *IPV occurs mainly in poor areas* (87.8%); and that *partners are allowed to be present during a patient's physical exam* (68%). However, the majority of the participants still agreed that IPV susceptibility can be caused by

sociological (societal) factors like unemployment (53.9%) and alcohol or drug abuse (55.4%). Packaging the nursing students perception of victims perceived susceptibility was signified by 48% of the students agreeing and 30.4% being neutral with regard to the statement that *nurses should ask every woman if she has experienced abuse*.

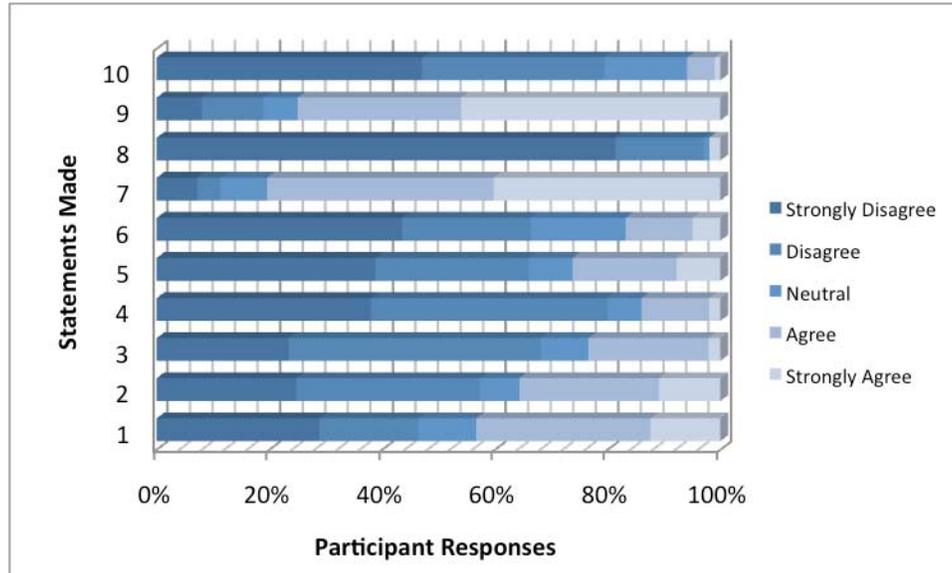
Figure 10: Privatisation of Abuse



- 1. Domestic violence is a private matter between the man and the woman**
- 2. IPV is a private matter that should be addressed only within the family**

Figure 10 indicate a reflection on whether the research participant belief towards the spheres wherein IPV operate and should be addressed. The majority of participants discarded the notion of privatisation of abuse and indicated their belief that IPV should be addressed by disagreeing with the statements that *domestic violence is a private matter between the man and woman* (91.3%) and that *IPV is a private matter that should be addressed only within the family* (88.2%). The privatization of abuse is often also associated with the belief that the victim had a role to play in the abuse (Figure 11).

Figure 11: Prevalence of beliefs that encourage Victim Blaming



1. **Victim must be getting something out of the abusive relationship, or else she would leave**
2. **People are victims only if they choose to be**
3. **When it comes to IPV, it usually "takes two to tango"**
4. **Victims' personalities cause them to be abused**
5. **If victims of abuse remain in the relationship after repeated episodes of violence, they must accept responsibility for that violence**
6. **Wife bashers should receive sympathy since they are emotionally disturbed**
7. **Wife bashers should go to prison for assault**
8. **It's OK for a man to hit his female partner if he has really been provoked**
9. **Victims of abuse could leave the relationship if they wanted to**
10. **Victims of IPV provoke their abusers and know what buttons to push**

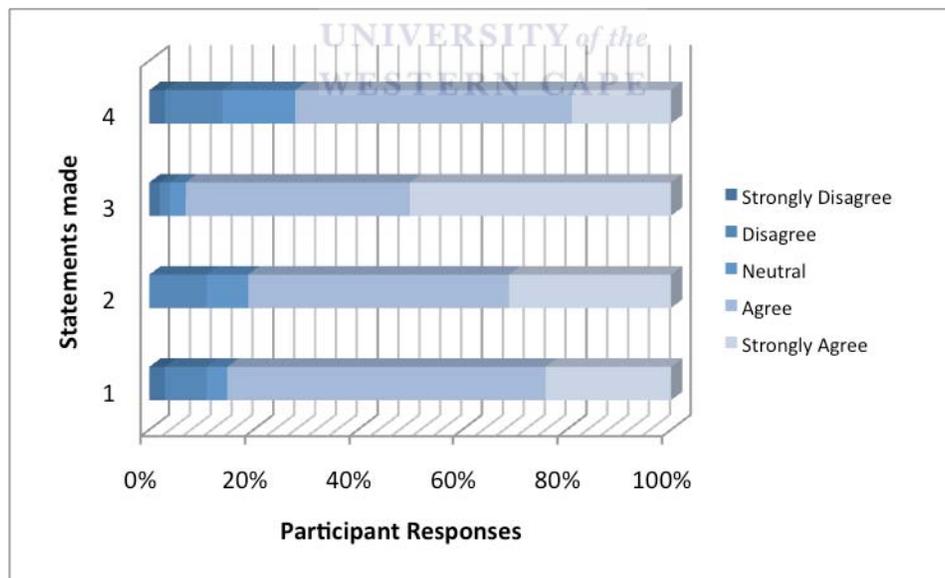
The majority of participants (Figure 11) largely did not blame the victims for the IPV in their lives by disagreeing that *it is OK for a man to hit his female partner if he has really been provoked* (97%), that *victims of IPV provoke their abusers and know what buttons to push* (79%), that *victims' personality cause them to be abused* (80%), that *when it comes to IPV it usually "takes two to tango"* (68%), and that *wife bashers should receive sympathy since they are emotionally disturbed* (66%). However, the research sample were inclined to believe that the victim had an option in the abuse, indicated by 75% of

the sample agreeing that *victims of abuse could leave the relationship if they wanted to*. Also the sample were divided on the notion that *the victim must be getting something out of the abusive relationship or otherwise she would leave* (43% agree; 46% disagree) and that *people are victims only if they choose to be* (43% agree or neutral; 57% disagree).

4.6 Summary

It seems as if overall nursing students are prepared to manage IPV (Figure 12). The majority indicated that they are *prepared to support women who disclose IPV* (93%), they *will be comfortable to discuss issues of IPV with their patients* (85%), and they *feel confident that they can make appropriate referrals for abused patients* (81%).

Figure 12: Preparedness to manage IPV



1. I will be comfortable to discuss issues of IPV with my patients
2. I feel confident that I can make appropriate referrals for abused patients
3. I am prepared to support women who discloses IPV
4. I feel comfortable to ask routine questions about IPV to all my patients

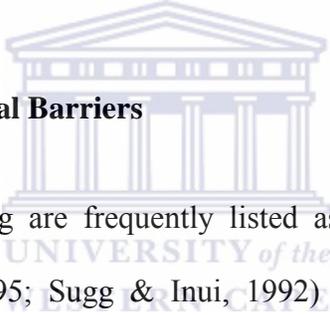
It was hypothesised that the respondents' perceptions will show that they perceive barriers to routine screening which will make them reluctant to screen for IPV. The research findings (Figure 14) indicated that 72.82 % of the research sample *felt comfortable to ask routine questions about IPV to all their patients*, and as a result the main study hypotheses could be rejected.



CHAPTER 5: DISCUSSION AND CONCLUSION

The aim of this study was to identify the barriers that will discourage a nurse from routinely screening for intimate partner violence in a healthcare practice. The present study's results specifically highlighted the three broad factors of informational, institutional and personal barriers. These screening barriers in the present study will be discussed as indicated and the implications of the study's findings will be suggested. Thereafter, the limitations of the study will be highlighted and recommendations made for future research.

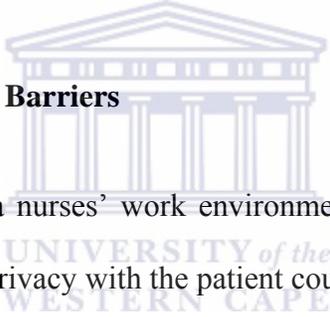
5.1 Perceived Informational Barriers



Lack of education and training are frequently listed as the most common barrier to screening (Parsons, *et al.*, 1995; Sugg & Inui, 1992) and therefore improvement in education often report increased routine universal screening. In the current study the nursing students reported minimal informational barriers as the majority felt comfortable in identifying the signs and symptoms of abuse, asking about IPV, assisting IPV victims, making appropriate referrals and subscribing to the legal requirements surrounding the reporting of suspected cases (Figure 5). Research participants in the current study were divided on whether they had received sufficient training to assist individuals with regard to issues of IPV (Figure 5). Goff, Byrd, Shelton & Parcel (2001) also found a significant association between preparedness to screen and the amount and extent of education received, which also then led to increased readiness to detecting and treating IPV. Therefore the results can possible explained through acknowledging that the situation is

not one of adequate training, but rather that the not enough time have been spent on training and experience in the field. The lack of sufficient training in the field can possibly also explain the nursing students belief that patients will generally not be willing to discuss issues of IPV (Figure 5). A study by Jewkes *et al.* (2001) found that women who are victims of abuse see the health sector as a refuge and often HCP are the first contact of these women. Studies have also found that when a comprehensive IPV management programme is implemented in a health setting nurses can start to experience the good responses victims of abuse reflect to it (Gadomski, Wolff, Tripp, Lewis & Short, 2001).

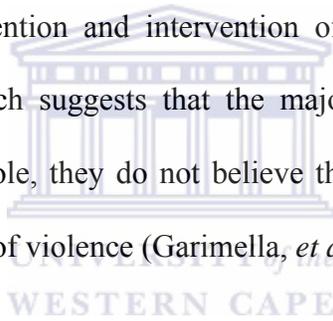
5.2 Perceived Institutional Barriers



The physical surroundings of a nurses' work environment, such as a lack of sufficient time or not being able to have privacy with the patient could greatly compromise a HCP's intent of screening for IPV. A lack of privacy (71%) and time constraints (44% agreed; 45% disagreed) also featured as significant barriers for the participants in the current study. These barriers should not be compromised on and health settings should have private areas conducive of confidential screening for IPV and ample time should be available on the initial visit of patients as to prevent repeated visits and as a result increased workload for nurses (Ellis, 1999; Sugg & Inui, 1992).

The attitudes and beliefs of HCP often strongly affect their perception of IPV and their view that it is a non-medical concern (Garcia-Moreno, 2002). However, participants in the current study (Figure 7), in contrast with previous studies (Reid & Glasser, 1997;

Cullinane, Alpert & Freund, 1997; Sugg & Inui, 1992), did not consider IPV as a private family matter for which the partners should take responsibility and blame. The current study is in agreement with the South African study by Peltzer, et al. (2003), where 96.8 % of the research sample disagreed with IPV being a private matter between a man and a woman. The present research participants further supported the need to address IPV by disagreeing with the statement of IPV screening being of minor importance in a healthcare setting. These findings is in harmony with another study, conducted in South Africa with medical doctors, where 91.2 % of the sample agreed that IPV should be treated as a medical issue and 83.4 % of participants could see the important role that doctors can play in the prevention and intervention of abuse (Peltzer, *et al.*, 2003). However, even though research suggests that the majority of HCP do perceive IPV management as part of their role, they do not believe that they have sufficient training and resources to assist victims of violence (Garimella, *et al.*, 2000).



5.3 Perceived Personal Barriers

It is not uncommon that IPV issues elicit discomfort in individuals as it often brings forward a lot of emotion and personal conflicts. In the current study results of the analysis pertaining to the respondents comfort with routinely screening for IPV indicated *If I ask non-abused patients about IPV, they will get very angry*, and the respondents perception of patients' reactions during IPV screening was supported by *I think that a patient might find IPV screening offensive*, arose as the main personal barriers towards screening. These findings are in accordance with numerous studies concluding that the most frequent barriers towards implementation of IPV screening is the fear of offending,

insulting or aggravating patients (Roelens, Verstraelen, Van Egmond, Temmerman, 2006; Moore, Zaccaro & Parsons, 1999; Limandri & Tilden, 1996; Sugg & Inui, 1992). These barriers may be a result of an outdated misconception about patients' beliefs, perceptions and expectations, as numerous studies show that patients welcome direct questioning about IPV (Rodriguez, Quiroga & Bauer, 1996; Caralis & Musialowski, 1997; McNutt, Carlson, Gagen & Winterbauer, 1999; Chang, Decker, Moracco, Martin, Petersen & Frasier, 2005). Yonaka, Yoder, Darrow and Sherck (2007) suggest that these barriers occur due to a lack of guidance on how to ask about abuse and possible language and cultural barriers between nurses and patients.

5.4 Conclusion and Implications of Study

The aim of the present study was to assess a range of barriers towards routine screening for intimate partner violence in a healthcare practice. It was hypothesised that the respondents' perceptions will show that they believe the costs (barriers) associated with screening outweigh the benefits of screening. The findings indicated that 72.82 % of the research sample *felt comfortable to ask routine questions about IPV to all their patients*, while the majority of the sample disagreed with the informational, institutional and personal barriers and as a result the study hypotheses could be rejected. This indicated that the research sample as a group of HCP are increasingly realising the importance of recognising the role they can play in dealing with violence against women. However, a more specific investigation of the barriers that might deter a HCP from screening for abuse, have identified some barriers which with more focused training commitment might result in a more effective response to IPV in a health care setting.

The findings suggest that both training (knowledge of IPV) and professional experience are necessary to increase the preparedness and confidence of the participants. Although some efforts are made by nursing departments to integrate IPV into curricula, most graduate without paying attention to this issue. It is also argued that undergraduate training is so valuable as it provides the foundations for professional in-practice training (Garcia-Moreno, 2002). Training and the in-service experience of IPV issues should also allow for the dealing with perceptions, values and prejudices that might influence nurses screening practices if they believe that “patients are not generally willing to discuss issues of IPV”; “that victims of abuse could leave the relationship if they wanted to”; “that a patient might find IPV screening offensive” or “that if they ask non-abused patients about IPV, they will get very angry”. Goff, *et al.* (2001) found that more comprehensive education of IPV made HCP more inclined to have a positive and realistic expectation of the outcome of screening, including the response of patients.

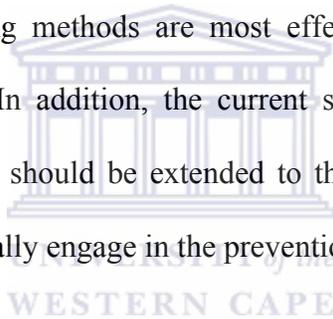
The current study adds to our understanding of the potential barriers HCP face when engaging with IPV situations in the healthcare practice. These potential barriers convincingly emphasise the importance of comprehensive education, with particular focus on skills-based training, to increase HCP preparedness and comfort in screening for IPV in a health care setting.

5.5 Limitations and Recommendations for Future Research

The research participants’ commitment to prevention and intervention of IPV in a

healthcare setting are respectable, however the respondents are currently students and therefore are not yet faced with the challenges of IPV in a 'real' context. Therefore, to truly measure the perceived barriers of HCP in South Africa it is recommended that participants should be professionals in practice. In addition, a limitation of this study, as with any self-administered questionnaire, is that the survey does not assess actual behaviours.

There are still much to be discovered in this area of IPV and the health sector's response. Future research needs to examine how HCP perceptions and behaviour can be changed, and also what specific training methods are most effective in the encouragement of routine universal screening. In addition, the current study only investigated barriers towards screening women and should be extended to the screening of adolescents and men in order for HCP to optimally engage in the prevention and intervention of abuse.



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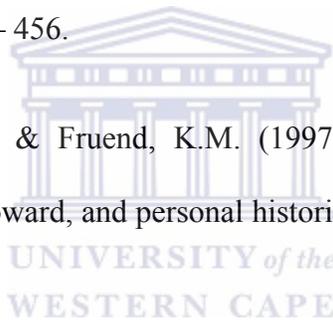
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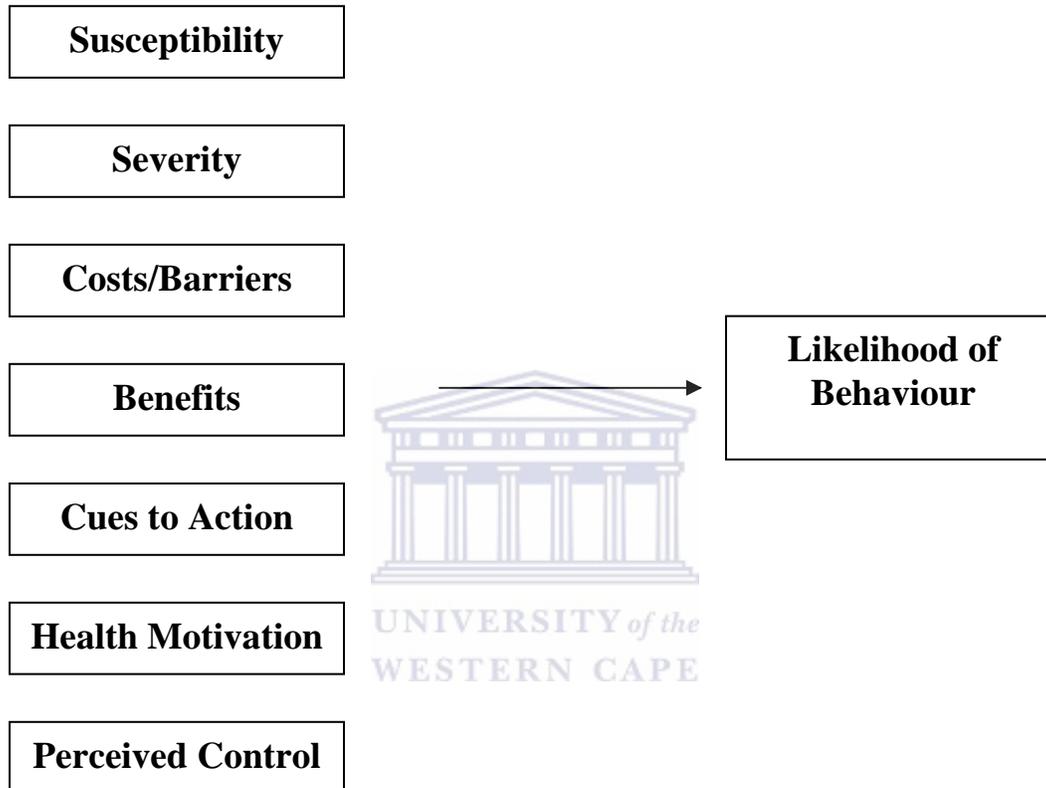
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APPENDIX A: The Health Belief Model



APPENDIX B: Research Questionnaire

INFORMED CONSENT FORM

Dear Participant

Herewith we request your participation in a research study examining the attitudes of nursing students towards routine universal screening¹ for intimate partner violence². I hope that this research will contribute to the understanding of the barriers that might exist towards universal screening for abuse.

If you are willing to participate in this study, I would like you to complete this survey. In the survey questions will be asked about your concept of intimate partner violence and your thoughts on the routine universal screening for intimate partner violence in a healthcare setting. Some of the questions in the survey may bring back some difficult memories. However, please be assured that you may end the survey at any time or that you may refuse to answer specific questions during it. Should you choose to discontinue participation, you can request that all data collected from you be destroyed and they will be.

To ensure anonymity of the research material, no names will be placed on the questionnaires. Only I, Elzette Rousseau, and my supervisor will have access to any of the data collected. Thus all information will be kept confidential. If you have any inquiry after the survey completion, please feel free to contact me at elzette.rousseau@gmail.com.

Thank you for your time and participation.

Elzette Rousseau

¹ Routine Universal Screening means that all women presenting at a health care practice will be asked the same questions regarding Intimate Partner Violence.

² Intimate Partner Violence (also referred to as Domestic Violence) is typically violence between intimate partners including spouses or boy/girlfriends.

INSTRUCTIONS

Please record your first, instinctive answer, even if you think that it might not be “politically correct”. Don’t try to think about what the answer “should” be.

Please answer all the question’s to help ensure the reliability and validity of the assessment. Thank you for taking the time to complete this survey.

YOUR BACKGROUND INFORMATION:

Age:

Sex: Male [] Female []

1. How often will you ask about the possibility of IPV when seeing a patient with the following:

	Never	Seldom	Sometimes	Nearly always	Always
Physical injuries					
Chronic pelvic pain					
Irritable bowel syndrome					
Headaches					
Depression					
Hypertension					
Anxiety					
Eating disorders					
Sleeping disorders					
Drug or alcohol abuse					
Suicidal behaviour					
STD’s (sexually transmitted disease)					

2. Please check the block that best describes your belief about intimate partner violence:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
A victim must be getting something out of the abusive relationship, or else she would leave					
People are victims only if they choose to be					
When it comes to IPV, it usually “takes two to tango”					
Victims’ personalities cause them to be abused					
Domestic violence should be treated and regarded as a medical syndrome or problem					
IPV is caused by sociological (societal) factors like unemployment					
IPV is caused by alcohol or drug abuse					
If victims of abuse remain in the relationship after repeated episodes of violence, they must accept responsibility for that violence					
IPV is caused by the partner/husband’s psychological problems					
Wife bashers should receive sympathy since they are emotionally disturbed					
Wife bashers should go to prison for assault					
It’s OK for a man to hit his female partner if he has really been provoked					
Domestic violence is a private matter between the man and the woman					
Victims of abuse could leave the relationship if they wanted to					
IPV only affects a small amount of people					
IPV occurs mainly in poor areas					
Victims of IPV provoke their abusers and know what buttons to push					
There are common, non-visible indicators of abused patients					
Any woman can be a victim of IPV					
Allowing partners or friends to be present during a patient’s physical exam ensures safety for an IPV victim					

3. Please check the block that best indicates your response on the scale from “Strongly Disagree” to “Strongly Agree”:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
It is not a nurse’s responsibility to initiate discussions concerning IPV					
I do not believe that nurses can offer much in cases of IPV					
IPV is a private matter that should be addressed only within the family					
I do not believe that I can make a difference in cases of IPV					
I am hesitant to screen for IPV because I do not want to get stuck in the middle of a complicated family or legal battle					
I believe screening and treatment of IPV should be a priority in the health-care sector					
I consider IPV screening to be of relatively minor importance in a healthcare setting					
I think that a patient might find IPV screening offensive					
I will be comfortable to discuss issues of IPV with my patients					
Patients are generally willing to discuss issues of IPV					
The role of a nurse is limited in being able to help victims of IPV					
If I ask non-abused patients about IPV, they will get very angry					
I feel confident that I can make appropriate referrals for abused patients					
Nurses should only treat the injuries and not query or give advice to abused women					
Nurses should encourage the victim to leave the abusive relationship					
Nurses should rather provide victims with referral to other agencies					
Nurses should be on the look out in diagnosing abuse					
Nurses should confront a patient if abuse is suspected but she doesn’t admit to it					
I am prepared to support women who discloses IPV					
I feel confident that I can identify warning signs of abuse					

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I feel comfortable to ask routine questions about IPV to all my patients					
A lack of privacy in the clinic will withhold me from screening for IPV					
I feel that I don't have enough time to ask about IPV					
I don't know how to ask about IPV					
I feel that I can't fix the problem anyway					
I don't know what to do if a patient discloses IPV					
I feel the women will end up staying with the abuser anyway					
I don't feel it is really my job to screen for IPV					
Nurses should ask every woman if she has experienced abuse					
If an IPV victim does not acknowledge the abuse, there is very little that I can do to help.					
My workplace encourages me to respond to IPV					
I do not have sufficient training to assist individuals in addressing situations of IPV					
I don't have the necessary skills to discuss abuse with an IPV victim who is from a different cultural or ethnic background					
I will not screen a patient if I believe she is the victim of an isolated (once-off) assault incident					
I am aware of the legal requirements in this country regarding reporting of suspected cases of IPV					
Nurses do not have the knowledge to assist patients in addressing IPV					

THANK YOU FOR YOUR PARTICIPATION

4. How much do you feel you know about:

(1 = Nothing; 2 = Very Little; 3 = A little; 4 = A moderate amount; 5 = A fair amount; 6 = Quite a bit; 7 = Very Much) (*Please circle your response*)

	<i>Nothing</i>				<i>Very Much</i>		
a. Your legal reporting requirements for IPV	1	2	3	4	5	6	7
b. Signs or symptoms of IPV	1	2	3	4	5	6	7
c. How to document IPV in a patient's chart	1	2	3	4	5	6	7
d. Making appropriate referrals for IPV victims	1	2	3	4	5	6	7
e. Perpetrators (person responsible for) of IPV	1	2	3	4	5	6	7
f. What questions to ask to identify IPV	1	2	3	4	5	6	7
g. Why a victim might not disclose IPV	1	2	3	4	5	6	7
h. Your role in detecting IPV	1	2	3	4	5	6	7
i. What to say and not say in IPV situations	1	2	3	4	5	6	7
j. Determine danger for a patient experiencing IPV	1	2	3	4	5	6	7
k. Developing a safety plan with an IPV victim	1	2	3	4	5	6	7
l. Appropriately responding to disclosures of IPV	1	2	3	4	5	6	7

Have you or anyone close to you ever been a victim of abuse?

Yes	No
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THANK YOU FOR YOUR PARTICIPATION



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