

UNDERGRADUATE NURSING STUDENTS' PERCEPTION AND UNDERSTANDING OF INTIMATE PARTNER VIOLENCE

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This Project was funded by the Centre for Rural & Remote Area Health

Acknowledgement:

The researchers would like to acknowledge the students who participated in this project.

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National Library of Australia Cataloguing-in-Publication entry

Title: Undergraduate nursing students' perception and understanding of intimate partner violence / Gavin Beccaria [et al.]

ISBN: 9781921420108 (pbk.)

Includes bibliographical references.

Family violence. Nursing--Psychological aspects. Nursing--Study and teaching

Other Authors/Contributors: Beccaria, Gavin; Beccaria Lisa, Dawson, Rhonda, Gorman, Don, Harris, Julie., Hossain Delwar.

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610.73

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ABSTRACT

This report describes a study that researched the perception and understanding of undergraduate nursing students toward intimate partner violence (IPV). The causes of abuse, victims and perpetrators, educational preparation and preparedness in identifying and treating IPV were explored to identify the level of perceptions and understanding of the students.

Keywords: Intimate Partner Violence, Nursing Students, Educational Preparation

INTRODUCTION

Intimate partner violence (IPV) is a key determinant of health and wellbeing for women affecting those from across the lifespan and from various social, cultural and economic backgrounds. The physical and emotional effects of violence often mean that women present to ‘first line’ health professionals such as nurses, for support and intervention (Resienhofer & Seibold 2007; World Health Organization 2005). Previous studies have indicated that health professionals, including nurses, often fail to recognise abuse, sometimes hold negative attitudes, and use inconsistent screening procedures, negatively impacting on the victim, by leaving them vulnerable to further abuse (Resienhofer & Seibold 2007; Roberts, G. et al. 1997; Sleutel 1998). In addition, nurses may not receive adequate education at an undergraduate level about intimate partner violence, thus ill preparing them in terms of identifying IPV and being able to provide effective strategies. It is acknowledged that undergraduate nursing education is a critical time to mould positive attitudes and to develop skills necessary to be able to effectively prevent and intervene with intimate partner violence issues (Davila 2005; Freedberg 2008; Ross 2002). To this end, the study reported here explored the perceptions and understanding of undergraduate nursing students toward intimate partner violence to determine what if anything needs to be changed to prepare them for their role as registered nurses.

Background

Intimate Partner Violence can be described as relationship violence occurring between people who are, or were formerly, in an intimate relationship. Intimate partner violence can occur on a continuum of economic, psychological and emotional abuse, through to physical and sexual violence (Victorian Health Promotion Foundation 2004). Much of the literature around IPV, also commonly referred to as domestic violence, relates to violence between heterosexual partners with women more likely to be the victims (Power et al. 2006; Resienhofer & Seibold 2007; World Health Organization 2005).

The prevalence statistics of intimate partner violence from the World Health Organisation revealed that as many as 61% of women have been physically abused by their partner up to the age of 49 (World Health Organisation 2010, p. 13). This study was conducted across 10 different countries and included 24, 000 women from low and middle income settings (World Health Organisation 2010). The World Health Organisation also estimated that 10-69% of women worldwide have been physically assaulted by an intimate male partner (World Health Organization 2002). In Australia prevalence statistics are inconsistent. The Australian Bureau of Statistics Personal Safety Survey (2006), indicated that 5.8% (443, 800) women had experienced violence in the previous 12 months, and 31% (73,800) had been physically assaulted by a previous or current partner in the previous 12 months. However, domestic violence statistics in South Australia, indicated that approximately 22.9% of women have experienced domestic violence (Grande, Hickling & Taylor 2003) whereas 15.4% of 13,978 middle aged women (45-50years) surveyed were victims of violence (Loxton, Schofield & Hussain 2004).

It is well recognised that IPV can result in effects throughout a victim's lifetime (Victorian Health Promotion Foundation 2008; World Health Organization 2002). Physical consequences of abuse may include bruising, lacerations, tears, genital injuries, head injuries, dislocations, and burns (Baker & Sommers 2008). Short term injuries often included bruising, lacerations, bites, punctures, fractures and abdominal injuries; but more serious injuries were also relatively common.

In terms of mental health, women who are victims of IPV have higher rates of depression, anxiety, eating disorders and self-harming behaviour. Reproductive health is also of major concern with many women contracting Sexually Transmitted Infections and having an increase in pregnancy complications (Janssen et al. 2003). In terms of health behaviours, victims of IPV often resort to tobacco and alcohol use, and illicit drug use as a coping mechanism. In many instances of IPV, children are also a witness to the violence and as a consequence may suffer from mood disturbances, problems with peer relationships and physical indicators of stress (Bedi & Goddard 2007).

The causes of IPV are complex, with underlying cultural, social and economic factors. The unequal distribution of power between men and women in many countries is a significant variable, influenced by socially constructed gender roles and norms (Victorian Health Promotion Foundation 2009). In some countries for example, women commonly justify abuse when they had not completed housework, refused having sex, disobeyed their husband, or were unfaithful (World Health Organization 2005).

Individually and collectively women can suffer negative effects on finances, employment stability and opportunities, and community participation. In terms of the economic impact of intimate partner violence on the Australian economy, in 2002/2003 it was estimated to be \$8.1 billion dollars. Costs can be attributable to private and public health care costs, loss of production costs, absenteeism, sick leave, staff turnover, and also second generation costs such as counselling, changing schools and adult crime (Access Economics 2004).

Health care providers are in a unique position to identify, assist and support victims of intimate partner violence. As often the first point of contact for women in the health care system (particularly in emergency departments), nurses play an important role in being able to provide assistance and support in an attempt to intervene in the violence cycle by empowering victims, linking with other support services, providing options, and advocating for victims (Barber 2008; Du Plat-Jones 2006; Roberts, G. et al. 1997).

A nurse's readiness to manage intimate partner violence may be influenced by their knowledge, attitudes, beliefs and self-reported behaviours, largely related to their self-efficacy in identifying victims (i.e. via screening procedures) and providing effective

interventions (Haggblom, Hallberg & Moller 2005; Johnson et al. 2009; Short et al. 2006; Tufts, Clements & Karolowicz 2009). Attitudinal factors i.e. negative attitudes about the seriousness of IPV and towards victims, a reluctance to get involved, lack of knowledge and educational preparation about IPV i.e. causes, symptoms and signs and screening procedures, and nursing roles, and a lack of self-efficacy or confidence to be able to screen for IPV and communicate effectively with victims (Bournnell & Prosser 2010; Ellis 1999; Haggblom, Hallberg & Moller 2005; Hinderliter et al. 2003; Johnson et al. 2009; Morgan, J. 2003; Nelms 1999; Resienhofer & Seibold 2007) may also be significant factors. Moreover, barriers such as organizational factors, e.g. lack of time, privacy, institutional policy, support service follow up, and referral processes (Bournnell & Prosser 2010), and emotional factors e.g. feeling frustrated, disillusioned (Nelms 1999; Robinson 2009), angry (Nelms 1999) and fearful (Haggblom, Hallberg & Moller 2005). These need to be considered, particularly when victims present to acute services, refuse help or admit abuse, or feelings associated with their own personal experiences with violence (Gerber & Tan 2009; Morgan, J. 2003).

In terms of attitudinal factors, patients experiences of health professionals in acute services have found that health professionals often have a matter of fact attitude towards victims; not considering their abuse situation as serious, and pitying and blaming the victim for the abuse (Sleutel 1998; Yam 2000). These negative attitudes can greatly influence whether a patient will be encouraged or discouraged towards disclosing abuse. What support they receive (Resienhofer & Seibold 2007; Shearer et al. 2006), whether they are appropriately referred to other support services (Robinson 2009) and the avoidance or reluctance of nurses to identify and intervene with victims (Bournnell & Prosser 2010; Haggblom, Hallberg & Moller 2005) can impact on the decision to disclose. A nurse's decision to question a woman about abuse can also be dependent upon their perception of the seriousness of their physical injuries (Haggblom, Hallberg & Moller 2005).

Robinson's (2009) study of (n=13) emergency nurses demonstrated that nurses did not routinely screen patients for IPV, and relied on signs e.g. the patients demeanour indicating they may be a victim, basing their decision to screen on stereotypical ideas. The nurses in the study often held negative attitudes towards victims i.e. they didn't believe that women were likely to follow advice, perceived them as untruthful, and that they would get offended if

directly questioned about the abuse. Justifying, excusing, trivializing, denying or minimizing, blaming the victim or hiding or obscuring the violence, can all be considered attitudes which may support violence (Victorian Health Promotion Foundation 2009).

Whilst these attitudinal factors may in fact be shaped the nurse's clinical experience and background, they may also be influenced by a nurse's own personal attitudes, beliefs and values. From an sociological perspective, these attitudes may most likely been formed by a variety of influences including individual (perceptions and support for traditional gender roles and relationships, personal experiences of violence), organisational (workplace cultures, screening practices), community (peer male cultures), and societal (media representations of women, violence and gender relations) factors (Victorian Health Promotion Foundation 2009).

In essence, community attitudes are often related to people's perceptions of seriousness and prevalence, who perpetrates violence and who are victims, men's responsibility for violence, whether violence against women is viewed as excusable and justifiable, individuals preparedness to intervene, and beliefs about appropriate community responses to violence (Victorian Health Promotion Foundation 2009). Common myths about domestic violence include; viewing violence as uncommon, a private not public issue, being only in lower socioeconomic groups, men and women being equally victims of violence, perpetrators always being violent, and that woman could easily leave a violent relationship (Nelms 1999; Roberts, G. et al. 1997; Robinson 2009; Victorian Health Promotion Foundation 2009). A recent National Survey on Community Attitudes to Violence Against Women involving approximately 13, 000 people across Australia, found that although positive shifts had occurred in attitudes towards violence against women, non-physical behaviours i.e. yelling abuse or controlling a partner by denying money were less likely to be considered part of domestic violence nor were they perceived as serious. In addition, approximately 22% of people considered violence being equally perpetrated by both men and women, and that violence against women could be excused if the perpetrator truly regretted what they had done. Furthermore, 49% of respondents thought that women tended to over exaggerate claims of domestic violence, specifically if involved in a court custody case and that eight in ten

people believed that a woman could leave a violent relationship if she really wanted to (Victorian Health Promotion Foundation 2009).

It is argued that these community attitudes may in fact influence nurses' stereotypes, beliefs and preconceptions of victims and dynamics of violent relationships. If nurses held these beliefs, and as a consequence integrated them within their practice (even subconsciously), then this could result in, for example, women from middle to upper income brackets not being screened for IPV if it was only considered women from poorer backgrounds likely to be victims (Roberts, G. et al. 1997).

Registered nurses in a number of studies have stated that a lack of education on IPV during their undergraduate education has greatly affected their confidence / self-efficacy in addressing it (Davila 2006; Haggblom, Hallberg & Moller 2005; Hinderliter et al. 2003; Morgan, J. 2003). Whilst a number of education programs have been successful in improving knowledge (Roberts, G. et al. 1997), skills (Davila 2006) and self-efficacy / confidence in addressing IPV (Hinderliter et al. 2003; Johnson et al. 2009) these programs have been conducted with practicing nurses often working in a narrow area of practice i.e. emergency, paediatrics, and maternity departments.

Given that these constructs are amenable to change and that often registered nurses report having had little educational preparation in addressing IPV, it is therefore important to consider the development of knowledge, skills and positive attitudes within nursing's undergraduate curricula (Davila 2005; Freedberg 2008; Ross 2002). Ross (2002) states that the curricula should be grounded in theoretical underpinnings from social sciences, victimology, ethics, feminist and critical theory and that when educators are preparing nurses to learn about violence issues they should begin at the 'feeling' level, by exploring their attitudes and values and understanding how they may be influenced and may influence their work with women and violence issues.

Very few studies however have explored undergraduate nursing students' attitudes, knowledge and skills related to IPV (Coleman & Stith 1997; Gerber & Tan 2009; Majumdar 2004). Majumbar explored the knowledge and attitudes toward violence against women of 4th year baccalaureate nursing students and 5th year medical students from two educational

institutions in India. Data were collected using two questionnaires: the Student Exposure to Women Abuse Questionnaire (SEWAQ), and Inventory of Beliefs about Wife Beating (IBWB). Although all students were sympathetic towards abuse victims, they demonstrated varying attitudes about the justification for abuse against women, help given to victims, punishment of the offender and the effect of the abuse itself. Female medical students believed more strongly than males and nursing students that wives do not personally gain from being beaten (Majumdar 2004).

Coleman & Stith's (1997) study involved (n=155) nursing students (aged 19-55years) by investigating sex-role egalitarianism, level of perceived control over one's own life events, family history of violence and current involvement in a violent relationship. The study found that control over one's own life events significantly influenced sympathy towards battered wives and as the level of nursing students' egalitarian sex-role attitudes increased, their sympathy toward victims of domestic violence also increased. This may have implications for nursing education, where educators can assist students to explore gender biases and the impact on patients and practice and on themselves, from a societal and practice level, by a variety of learning strategies (Coleman & Stith 1997; Davila 2005).

The study reported here looked at undergraduate nursing students' attitudes towards IPV. Moreover, it explored their perceptions of the causes of abuse, characteristics of victims and perpetrators, perceptions of their own educational preparation, confidence in supporting victims / perpetrators and what they perceived a nurses role to be in relation to IPV.

METHODS

Aim

This study aimed to gain an understanding of student learning needs to further inform the development of the undergraduate bachelor of nursing curriculum and in return better healthcare outcomes for the clients graduates encounter.

Intimate partner violence is a sensitive area that requires the researcher to be mindful of the impact that investigation into such topics might raise for the participants. Logan, T. K., Walker & Cole (2003) recommend that ethical principles of beneficence, respect and justice, when adhered to and used effectively, can enhance the recruitment of research participants (Logan, T. et al. 2008, p.1231). During the process of investigating the attitudes and perspectives of nursing students there is a need to consider the vulnerabilities of the student in relation to the subject matter and the context of the research. Respect for the persons involved underpinned the research activities (Logan, T. et al. 2008) and the non-dominant relationship that researchers fostered with the student participants. In this case the researchers were the teaching academics of the institution where the students were enrolled. They were cognisant of a perceived power imbalance and all participant involvement in the research was clearly explained in the plain language statement as voluntary in nature and in no way connected to the student's studies or grades.

Given the prevalence statistics of intimate partner violence it is feasible that there may have been a student participant in the research with personal experiences of intimate partner violence and through the discussion of the topic may have experienced personal distress as a result of their involvement.

The protection of participants in sensitive research is reliant upon and expected as ethical behaviour of the researcher. The ethical delivery of this research required the team to consider the effects on the participants. The team provided contact details of community based support services, such as the women's health centre and community mental health service, and as well as of the research team members. This gave the students a number of resources to access for debriefing and counselling after their involvement in the initial focus

group activity. Community specific referral played a key role in the study protocol as a means of supporting the participants through a sensitive issue and thus, is in line with the principle of beneficence (Logan, T. et al. 2008) and helped to develop a sense of trust in the researchers and credibility in the research process.

Design

A literature review was carried out using articles sourced from nursing and education databases including the topic areas of IPV, domestic violence, nursing student, perspective, attitudes, clinical nursing and nursing education. From the 38 sources used in the literature review the following themes were identified as worthy of further investigation through this current study;

- Nurses sometimes feel unprepared to deal with IPV
- Victims are often inadequately screened
- Poor attitudes of nursing staff towards victims
- Reported lack of knowledge by health professionals of support services
- Victims feeling stigmatized and are being blamed for the violence
- Disillusionment of health professionals

(Hegarty, Hindmarsh & Gilles 2000; Morgan, J. E. 2003; Natan & Rais 2010; Roberts, G. L. et al. 1997; Roberts et al. 1996).

A mixed method, utilizing a qualitative perspective through oral narrative data from focus groups and a descriptive quantitative perspective using nominal data from a subsequent survey was employed. The focus group questions were designed to draw out the nursing students' perspectives, including attitudes and knowledge. The questions were limited to 5 in total so as to engage the students and not overwhelm them.

The questions discussed were;

1. How do you define Intimate Partner Violence?
2. What are your attitudes towards – victims and perpetrators?
3. What do you see as the nurse's role with Intimate Partner Violence?
4. What do you think nurses need to know about Intimate Partner Violence?
5. What skills do you think nurses need to deal with Intimate Partner Violence?

The focus group data, once analysed, provided a number of core themes that were further investigated through the implementation of the on-line survey using Survey Monkey.

The study was conducted with students enrolled in an undergraduate nursing programme in a regional university during 2008. The total population of nursing students across all year levels and 2 campuses was 871. The demographics of this study sample can be extrapolated to show the various year levels and further analysis of the data can reveal more specific details about each group.

The two stage approach was intended to ensure that the data, as closely as possible, reflected the nursing student's perspectives and attitudes towards IPV. The research team allowed the emerging data to steer the perspective of the research through directly engaging the student participants in the focus groups and then the subsequent survey. The focus groups were used to gather the general themes and the descriptive research survey was used to collect more specific data on each of the themes including the perceptions of nursing students towards IPV and their educational preparation.

Participants

Students were recruited from all year levels of the three year bachelor of nursing program via an invitation poster and messages placed on confidential university based web forums. The initial forum messages were in regards to participation in the focus groups. They included the information about the research project and the consent form. Students were invited to return

the consent form to the academic researchers as an application to participate. At the completion of the focus group activities a survey was constructed. Students were invited to voluntarily participate in the online survey, created in Survey Monkey, through a message containing the link and password posted to the general nursing communication website. This site was available to the whole nursing student population of the bachelor of nursing at this regional university. After the initial invitation to complete the survey, two subsequent reminders were posted onto the web forum at monthly intervals to encourage further participation in the survey. A final return rate of 7% (62) was achieved using this method.

Students involve in the focus groups identified that one of the motivating factors for them to participate was the knowledge that their feedback may have a positive impact on the education of future students. This altruistic motivation is mentioned by Logan, Walker et al (2008) in their article which investigates the role of ethics in recruitment and retention of women victims of IPV in research activities.

Data Collection

Focus Groups

The focus group questions were designed to gain greater insight into the areas identified as core themes. Focus groups were held with all the different year levels of undergraduate nursing students separately to enable the analysis of the results separately and collectively. This decision was based on the assumption that, a student ready to complete their degree may have a measurably different perspective of IPV than a student who has just recently commenced their nursing studies. In scheduling the focus groups the timetable of each cohort of students was considered and the focus group sessions held on a day that the students would usually be on campus and at a time that they would not usually be in class.

The regional university chosen for this study consisted of three campuses, two of which teach the Bachelor of Nursing. It was decided therefore to host the focus groups across both campuses where nursing students were enrolled. This resulted in a total of 27 students participating in the focus groups with a breakdown of 11 students in their first year of study,

nine in their second year and seven in their third year. This can further be extrapolated to show the number of students from each campus. See table 1

Table 1 Students by year and campus

Toowoomba	Fraser Coast	Focus group (n)
year 1 (n = 3)	year 1 (n = 8)	11
year 2 (n = 2)	year 2 (n = 7)	9
year 3(n =2)	year 3 (n = 5)	7

The focus group discussions were held over a 1 hour session and were digitally recorded and subsequently, transcribed verbatim for analysis. The researcher chaired the session with the notion of ensuring that each student had a voice within the session. This time was not utilised to provide information to the participants about IPV as other researchers have done because the intent was focussed on gathering the knowledge, perspective and attitude of the students without contamination from the researcher. Henning, Ryan et al (2007) utilised time in the focus group that they held to explore the knowledge and attitudes of homeless people to chlamydia as an opportunity to impart knowledge to the participants about the sexually transmitted disease.

Lunch of pizza and drinks was provided as an incentive for students to attend during the lunch time period. This incentive, as evidenced by the small number of participants, did not seem to attract any more students than may have attended with the absence of the free lunch.

Survey

Based on the findings of the focus groups, and the literature review, an online survey instrument was developed. The instrument contained information on the demographic profile (sex, age, and year of study) of the students and the statements concerning their perceptions and understanding on six aspects of IVP. The review of the literature provided the theoretical basis for developing the statements on causes of abuse, identifying the victim and their perpetrator, nurses' beliefs, perceived roles and educational preparation.

The respondents indicated their perception and understanding on a five point Likert-type scale, ranging from 1 (strongly disagree) to 5 (strongly agree). Borg and Gall (1979) stated

that Likert scales are probably the most common type of scale used to measure perception, opinion and attitudes of the people. Edward's (1957) informal criteria for constructing the statements were used as the basis for developing the items relating to each aspect concerning the perceptions and understating of the students of IVP.

The project team spent a considerable amount of time reviewing and establishing the content validity of the survey instrument. A pilot test was conducted with 10 students similar to the respondents during January, 2010 and was used for reliability and item analysis. The reliability of the instrument was calculated on the basis of the items addressing i) the causes of abuse, ii) identifying the victim, iii) identifying the perpetrator, iv) nurses' beliefs, v) perceived roles and vi) educational preparation. The reliability coefficients for the six aspects were .691, .732, .663, .365, .821, and .907 respectively.

To determine the merit of the items to be included in the scale, an item discrimination index analysis was calculated by correlating with total scale score; this procedure was done by using PASW program. Ary, Jacobs, & Razarieh (1985) indicated that 'each item should correlate at least .25 with the total score. Items that have a very low or negative correlation with the total score should be eliminated because they are not measuring the same things in the total scale and hence are not contributing to the measurement of attitudes' (p. 197). The reliability coefficient of nurses' belief was too low (.365) and thus deleted. Another nine items (three from the causes of abuse, two items from identifying victims, two from identifying perpetrator, and two from nurses roles) were deleted because they had negative and low level of associations (<.20) with the total scores. The final version of the online survey instrument was revised on the basis of reliability, item analysis results and the suggestions and comments of the project teams and used to collect data from the students.

A posting was made available to students on 15/1/10 on the Bachelor of Nursing Forum and reminder on the 12/2/10, and the 12/3/10. On 22nd March, 2010, a cover letter was sent explaining the purpose of the study and the survey link. The students were assured that their replies would be kept confidential; they were encouraged to complete and return their responses by 3rd of April, 2010. The response rate from the first mailing was 5.5% (48). After

first and second reminders the response rate increased to 7% (62). These 62 cases were used for analysis. The exploratory data analysis method was used to summarise the data.

Data Analysis

Focus Groups

Transcripts of the focus groups were analysed thematically resulting in 6 cores themes.

Survey

Quantitative data were analysed using SPSS 18.0 for Windows. Frequency counts and percentages, as well as means and standard deviations, were calculated for the descriptive data. The correlation coefficients between perceptions of nursing educational preparedness, self-efficacy, and perceptions about nursing roles to manage IPV clinically were calculated. F-tests were used to determine whether there were significant differences in perceptions of respondents towards IPV and their educational preparation. The resulting differences were tested for significance at $p < .05$.

Ethics

Ethical approval was granted by the university's ethics committee. Information about the focus group and online survey was provided to students in the web based forums messages. Their completion of the focus group consent form and voluntary participation in the online survey was considered as having gained consent.

FINDINGS

Focus Groups

From the focus group transcripts, thematic analysis resulted in six core themes.

The themes that emerged were;

1. Most students responded that Intimate partner violence includes physical, emotional and sexual assault. Other types of abuse were not generally discussed.
2. The position of the perpetrator or abuser was invariably initially attributed to a domineering male with low self esteem, a drug or alcohol dependency and from a minority ethnic group. It was only after some discussion that other role models were considered. Students also felt that the abuser was probably once abused and would perpetrate repeatedly.
3. Students felt helpless, sad, confused and frustrated when asked what their attitude to IPV was. They expressed a sense that there was a lack of time to be able to assess and manage IPV and they were worried that any intervention may make the patient's situation worse.
4. The students were not sure of the nurse's role but felt that it included building trust, acting as an advocate and referring to support services.
5. Students were emphatic in their response that they needed more information and education about intimate partner violence and said they felt ill-prepared to manage it in the healthcare environment.
6. The response to what skills are required was varied and included but was not limited to empathy, compassion, communication and non-judgmentalism. The skill they mentioned most was communication.

Survey

In total, 62 students responded to the online survey. Between the commencement date of the online survey and the first reminder 22 students had responded. Between the first and second reminder 10 more students had responded and between the second reminder and the close of the survey 30 more students had responded.

Of the respondents, 4 had only completed the demographic information within the online survey and as such were subsequently deleted from the original 62 who had responded to the survey. In addition, two respondents had completed the demographic information and the scale items related to causes of abuse and identifying the victim (completing therefore less than 50% of the survey) and as a result were also deleted from the study. In total 58 surveys were considered usable for data analysis.

Demographic information

Of the 58 that commenced the survey, 92% were female; 42% were above 35 years of age 36% were 18-25 and 22% were 26-35. Less than one-third (30%) of the respondents were second year students whereas 28% were first year, 23% third years and 19% identified themselves as from the accelerated student group. This group of students complete their undergraduate degree program utilising the third semester break to study further courses and therefore complete the program in 24 months as compared to the traditional enrolment pattern of 36 months.

Of the 58 participants who completed the questionnaire, one was deleted because they were an outlier on the *Perceptions of Nursing Roles and Values Scale* to the extent that they changed both the reliability of the scale and the overall correlation of this scale with the other scales. In these circumstances it is recommended that these cases are deleted (Tabachnick & Fidell 2006). There were 7 items which had missing data, in each of these cases the case subscale mean was substituted for the missing item as recommended by (Tabachnick & Fidell 2006).

This study was largely exploratory; consequently no formal hypotheses were formulated. Nevertheless, there were several research questions formulated:

1. What is the relationship between educational preparedness, self efficacy to deal with IPV and attitudes to deal with IPV? While it was envisaged that there would be a link between perceptions of educational preparedness and self efficacy to clinically manage IPV, their relationship with nursing roles and values was less clear. Haggblom, et al. (2005) and Hinderliter, et al.(2003) found that one of the best ways to instil positive attitudes in controversial issues such as IPV has been to educate students.
2. What are nurses' efficacy and educational preparedness to clinically manage IPV? Are there differences between first, second, and third year level nurses? Also do accelerated program students differ from other groups? One would expect that third year students and accelerated program students, who are often the higher achieving students would indicate higher levels of efficacy, preparedness, and more positive attitudes towards the nurses role in dealing with IPV.
3. Given that life experience may contribute individuals' comfort and attitudes when encountering IPV (Goldblatt 2009), the third research question was "do older students have high levels of self efficacy, more positive attitudes about roles and higher perceptions of educational preparedness when clinically managing IPV?".

Causes of abuse

The majority of the respondents indicated that they agreed with the causes of abuse – such as control over the victims, how to manipulate the victims, alcohol, personality type, don't like women having more independence, dependent partner, not respecting women and strongly disagreed with the statement that the victim does something wrong to cause the abuse (See Table 2).

Table 2 Percentage distribution of respondents on the causes of abuse of the victims (n=58)

CAUSES OF ABUSE	SA	A	N	D	SD
The perpetrator has control over the victim	70	15	5	5	5
The perpetrator knows how to manipulate the victims response to be most in control and get what they want	80	16	2	2	0
Perpetrators are often affected by alcohol and drugs	17	39	24	18	2
The victim's personality type makes them vulnerable to being abused	18	30	16	18	18
Women are more likely to be abused by men who don't like women having more control or being more independent	30	40	12	13	5
Women who are dependent on their partner are more likely to become abused	15	25	25	18	17
The victim usually does something wrong to cause the abuse	3	0	3	22	72
Not respecting or valuing women causes the abuse	38	37	10	12	3

Identify Victim

While the majority of participants believed that victims were usually women they also acknowledged that men can be victims. Victims were seen as potentially reluctant to seek help because they had accepted the situation, they felt shame, and may want to keep their situation a secret. Victims were seen as having learned to be helpless over time, and to have poor self esteem (See Table 3).

Table 3 Percentage distribution of respondents on identifying the victims (n=58)

IDENTIFY VICTIM	SA	A	N	D	SD
Usually victims are women	38	37	15	8	2
Men can also be victims of abuse	75	23	2	0	0
Victims usually have a weak personality	8	25	17	33	17
Victims are usually not assertive people	12	25	23	30	10
Victims are socially isolated	28	37	17	13	5
Sometimes victims don't seek help because they have accepted the situation	46	40	5	6	3
Victims might feel shame about their problem	68	30	2	0	0
Victims may want to keep their problem secret	72	25	3	0	0
Victims have learnt to be helpless over time	38	36	13	13	0
Victims usually have poor self esteem	58	30	3	9	0
Victims are reluctant to ask for help	54	38	8	0	0
Victims have lots of options available to them to leave	15	28	18	29	10
If victims really wanted to leave they could	12	15	26	25	22
Abuse within homosexual relationships is common	12	13	67	3	5

Identify perpetrator

The common views about perpetrators where that they were usually male, lacked self esteem, had learned their behaviour from their family and lacked insight into their problem. They were also seen as often affected by drugs/alcohol, usually physically strong, and didn't want to seek help. The idea that they were likely to have a tattoo or come from an Indigenous background was rejected by the majority of participants.

Table 4 Percentage distribution of respondents on identifying the perpetrator (n=58)

IDENTIFY PERPETRATOR	SA	A	N	D	SD
A perpetrator is usually male	34	42	14	7	3
Perpetrators lack self esteem	30	30	17	21	2
Perpetrators have probably learnt their behaviour from their family	29	49	17	5	2
Perpetrators lack insight into their problem	46	38	8	4	4
Perpetrators are most likely affected by drug and alcohol use	17	32	24	16	11
Perpetrators often are physically strong	22	32	19	22	5
Perpetrators often don't want to seek help	45	37	8	8	2
Perpetrators are more likely to have a tattoo	0	4	15	24	57
Perpetrators are more likely to come from an Indigenous background	0	7	21	22	50

Roles of nurses

The majority indicated that nurses should provide education to the victim and that they should try to convince the victim that they could have a better life. The nurse should spend time listening to the victim, should provide good physical and emotional care to them and link them with other support services. They also indicated that the nurse should link the perpetrator with other support services but were less in agreement about the nurse providing counselling to the victim and generally against doing so for the perpetrator. There was some agreement for nurses providing screening programs and more strongly, for them identifying the victim in their assessment. There was strong agreement for the nurse working with others in the healthcare team to support victims and slightly less but still a majority support for referring onto other health professionals and not getting involved. It was agreed that the nurse should inform the victim of their legal rights and very strongly agreed that nurses need to be non-judgmental. There was a rejection of the idea that asking people about a history of abuse was an invasion of privacy (See Table 5).

Table 5 Percentage distribution of respondents on the role of nurses (n=57)

ROLES OF NURSES	SA	A	N	D	SD
Nurses should provide education to the victim	79	13	2	3	3
Nurses should try and convince the victim that they could have a better life	38	29	21	7	5
The nurse should spend time listening to the victim	90	8	0	0	2
The nurse should provide good physical care to the victim	89	5	2	2	2
The nurse should provide good emotional care to the victim	81	12	3	0	4
The nurse should link the victim with other support services	93	5	0	0	2
The nurse should link the perpetrator with other support services	85	10	2	0	3
The nurses role is to provide counselling to the victim	27	19	19	12	23
The nurses role is to provide counselling to the perpetrator	12	22	22	15	29
The nurse should identify victims via screening programs	19	36	32	10	3
The nurse should identify the victim in their assessment	37	31	22	7	3
The nurse should work with others in the health care team to support the victim	81	15	2	0	2
The nurse should refer onto other health professionals such as social workers and psychologists and not get involved	25	40	8	19	8
The nurse should inform the victim of their legal rights	48	21	13	10	8
Nurses need to be non-judgemental	93	3	0	2	2
I think asking people about a history of abuse is an invasion of their privacy	5	27	15	23	30

Educational preparation

There was some agreement that the participants considered they had a good knowledge of the causes of IPV, and greater agreement that they were aware of community/societal attitudes towards it. There was also some agreement that they had a good knowledge about the nurse's legal responsibilities and of local support services. There was stronger agreement that they had good knowledge of the other health professionals' roles in supporting victims and perpetrators and of the effects of partner abuse. Agreement was not as strong about their having a good beginning knowledge of how to effectively respond to victims and perpetrators. Agreement was even weaker about their confidence from their nursing education in addressing IPV but they agreed fairly strongly that they had a beginning understanding of the nurse's role in community interventions and had a good theoretical knowledge of abuse cycles (See Table 6).

Table 6 Percentage distribution of respondents on their educational preparation (n=58)

EDUCATIONAL PREPARATION	SA	A	N	D	DA
I have good knowledge about the causes of partner abuse	14	34	19	28	5
I am aware of community / societal attitudes towards partner abuse	22	49	24	5	0
I have good knowledge about the nurses legal responsibilities	16	29	27	19	9
I have good knowledge of local support services which may assist a victim or perpetrator	23	29	19	24	5
I am aware of other health professionals' roles in supporting victims and perpetrators	26	44	17	12	1
I have good knowledge of the effects of partner abuse	39	38	9	11	3
I have a good beginning knowledge of how to effectively respond to victims and perpetrators	17	37	15	26	5
I feel confident from my nursing education in addressing partner abuse	21	16	28	26	9
I have a beginning understanding of the nurses role in community interventions to prevent abuse	26	33	19	17	5
I have a good theoretical knowledge of abuse cycles	23	35	14	21	7
I think that we need to cover more about how to identify and address partner abuse within the nursing curriculum	67	24	5	2	2

Use of scales for analysis

Given the poor internal consistencies for some of the scales, only three of the six scales were used. These three scales were further refined to improve their psychometric properties. These were: (1) Self Efficacy in dealing with IPV; (2) perceptions of nurses role values; and (6) Educational preparedness to clinically manage IPV. The questions used appear in Appendix A.

The *Self Efficacy Scale* comprised of 6 items which assessed participants' level of confidence in dealing with IPV in the clinical setting. Participants were asked to rate their agreement

with each statement on a 5 point Likert scale ranging from (*1 = strongly disagree to 5 = strongly agree*). Two items were positively worded. An example of a positively worded statement was *I feel confident in being able to support victims in my future nursing practice*. An example of a negatively worded item was *I am worried about what I might say to the victim*. Negatively worded items were reverse scored. All scores were then summed. Scores ranged from 5 – 30, with a higher score indicating lower self efficacy. In order to make the self efficacy score more intuitive i.e., higher scores equating to higher self efficacy, the participants obtained score was subtracted from 31 giving a final self efficacy score that ranged from 1 – 25. A higher score indicated a higher level of self efficacy. Internal consistency was adequate ($\alpha = .76$).

The *Perceptions of Nursing Roles and Values Scale* comprised of 14 items regarding perceptions of the nurses role when identifying and managing IPV. Participants were asked to rate their agreement with each statement on a 5 point Likert scale ranging from (*1 = strongly disagree to 5 = strongly agree*). An example a roles statement was *The nurse should spend time listening to the victim*. An example of a values statement was *The nurse should link the perpetrator with other support services*. All scores were then summed. Scores ranged from 5 – 70 with a higher score indicating a more negative attitude about nurses' roles when dealing with IPV. In order to make the scale score more intuitive i.e., higher scores equating to a more positive attitude, the participants obtained score was subtracted from 71 giving a roles and values score that ranged from 1 – 57. A higher score indicated a more positive attitude to managing IPV. Internal consistency was fair ($\alpha = .68$), slightly below the acceptable limit of $\alpha = .70$ as recommended by Anastasi & Urbina (1997). Internal consistency would have been improved by removing item 7 *The nurse should link the perpetrator with other support services*. Nevertheless, this question would be congruent with holistic and inclusive nursing practice, and was retained.

The *Educational Preparedness Scale* comprised of 10 items regarding perceptions of students' educational preparedness to identify and manage IPV. Participants were asked to rate their agreement with each statement on a 5 point Likert scale ranging from (*1 = strongly disagree to 5 = strongly agree*). An example statement was *I have a good knowledge about the causes of partner abuse*. All scores were then summed. Scores ranged from 5 – 50, with

a higher score indicating a lower level of preparedness to clinically manage IPV. In order to make the scale score more intuitive i.e., higher scores equating to a higher level of preparedness, the participants obtained score was subtracted from 51 giving a final roles and values score that ranged from 1 – 37. A higher score indicated a perception of greater educational preparation to clinically manage IPV. Internal consistency was excellent ($\alpha = .91$)

Correlations

The correlations between perceptions of nursing educational preparedness, self efficacy, and perceptions about nursing roles to manage IPV clinically appear in Table 7. It can be seen that self efficacy and educational preparedness were significantly correlated, but roles and values was insignificantly correlated with self efficacy and educational preparedness.

Table 7 Correlations between self-efficacy, roles and values, and educational preparedness (N = 57)

MEASURE	1	2	3
1. Self -efficacy	-		
2. Perceptions of nursing roles and values	.11	-	
3. Educational preparedness	.36**	.14	-

Note. ** $p < .01$

Self-efficacy, roles and values and educational preparedness in relation to the clinical management of IPV was compared between student year groups. Their means and standard deviations and the subscales for each year group appear in Table 8. While it was expected that the third year students and accelerated program students would have higher scores on each of these scales a one way ANOVA found no difference between the four groups for self efficacy $F(3, 52) = 1.26, p = .30$. There were also no differences between the four groups for roles and values $F(3, 52) = .85, p = .47$, and educational preparedness $F(3, 52) = 2.15, p = .11$. It was also noted that the roles and values towards managing IPV was particularly low, where in general, participants did not agree that nursing had a role in clinically managing IPV.

Table 8 Means and Standard Deviations for each of the Subscales between year levels (N = 56)

SCALE	n	M	SD	Range
Self Efficacy Scale – Total	56	10.13	5.01	1 – 25
First year	16	8.51	5.26	1 – 25
Second year	16	11.89	5.49	1 – 25
Third year	13	9.77	5.23	1 – 25
Accelerated program	11	10.36	3.07	1 – 25
Perceptions of Nursing Roles and Values Scale – Total	56	11.14	5.74	1 – 57
First year	16	12.59	6.00	1 – 57
Second year	16	9.52	6.78	1 – 57
Third year	13	10.69	4.94	1 – 57
Accelerated program	11	11.92	4.50	1 – 57
Educational Preparedness Scale – Total	56	15.41	8.19	1 – 37
First year	16	13.56	8.43	1 – 37
Second year	16	12.88	7.04	1 – 37
Third year	13	17.08	8.85	1 – 37
Accelerated program	11	19.82	7.33	1 – 37

Finally the self efficacy, roles and values and educational preparedness were compared across age groups (18-25 years, 26-35 years and over 35 years). The means and standard deviations for each age group across the three subscales appear in Table 9. It can be seen that there were no differences between the three age groups on each of the scales; self efficacy $F(2, 54) = .63, p = .54$; roles and values $F(2, 54) = .46, p = .63$, and educational preparedness $F(2, 54) = 1.10, p = .34$.

Table 9 Means and Standard Deviations for each of the Subscales between age groups (N = 57)

SCALE	n	M	SD	Range
Self Efficacy Scale – Total	57	10.20	4.99	1 – 25
18 – 25 years	20	10.35	4.99	1 – 25
26 – 35 years	13	8.88	4.89	1 – 25
Over 35 years	24	10.79	5.13	1 – 25
Perceptions of Nursing Roles and Values Scale – Total	57	11.10	5.69	1 – 57
18 – 25 years	20	10.53	5.38	1 – 57
26 – 35 years	13	10.41	4.53	1 – 57
Over 35 years	24	11.96	6.55	1 – 57
Educational Preparedness Scale – Total	57	15.67	8.35	1 – 37
18 – 25 years	20	16.85	7.49	1 – 37
26 – 35 years	13	12.69	6.59	1 – 37
Over 35 years	24	16.29	9.70	1 – 37

DISCUSSION

The results of this study indicate a number of important implications for undergraduate nursing education. Overall scores on all scales were low. This means that nursing students may not have an awareness of the significance of the issues of IPV and women. They may not fully understand the social, health and economic impacts at an individual and societal level. The nurses in the study had preconceived ideas of what a victim or perpetrator may be like and as a result may miss opportunities to screen patients adequately. This may result in further under detection of the problem. Furthermore, a greater emphasis needs to be placed on nursing interventions which not only address the patient's physical needs but emotional needs as well. For nursing to play a significant role in this issue at a broader level, students also need to have an understanding of many different approaches to the issue (such as preventative strategies) beyond what they perceive to be their main clinical role supporting the individual patient. Students in this study had not perceived their role as being involved in preventive strategies. The World Health Organisation for example recommends using an ecological model which addresses the issue from a public health position, focusing also on the health professionals' role in prevention, and public change through legislation, and advocacy. As an example of this while students saw their role as convincing victims that there could be a better life, a more comprehensive approach would be for them to facilitate the empowerment of their victims e.g. by increasing their self esteem and self efficacy, ensuring routine screening, and supporting and contributing to social discourse (Australian Nursing Federation 2010). The issue of IPV needs to be integrated into the curriculum from a number of perspectives, between theory and practice. Canadian studies have found that IPV issues tend to be delivered as either brief lectures (or via readings) in very ad hoc ways with often IPV being addressed within psychiatric disorders.

Whilst potentially nursing students may, during the course of any of their clinical placements, have contact with victims of IPV, placements such as women's shelters would provide another perspective outside of a more medically focused environment. Nurses could also be placed with other community organisations working to prevent IPV to emphasise the role that others in the community play in addressing the issue and consider ways in which nurses can

foster closer relationships. Nursing students need to develop an awareness and ability to work with others in a multidisciplinary environment.

In terms of current service delivery, if student nursing attitudes towards IPV is not addressed during their professional education, then this raises major concerns about their ability to acquire the necessary knowledge and skills to deal adequately and appropriately around IPV issues. This is a major workforce issue and a women's health issue. The future nursing workforce does need to have an awareness of the social and health issues in the population and have an understanding of ways to approach it. Furthermore, in terms of rural and remote area nursing practice, if students perceive that there is easy access to other health professionals such as social workers and psychologists, then they may be ill prepared in dealing with victims when access may not be available. In addition, students need to develop the skills in networking and working collaboratively with others in the community who may also be able to support victims and perpetrators.

In summary, being aware of and addressing student nursing attitudes towards IPV is fundamental in improving the health and wellbeing of women and their families. Not feeling like you have the skills, knowledge and confidence to deal with problems can result in avoiding or providing the best quality of care. A proactive and holistic approach needs to be considered in designing undergraduate nurse education to create a responsive future nursing workforce.

CONCLUSION

This study researched the perception and understanding of undergraduate nursing students toward intimate partner violence (IPV). Focus groups were undertaken that when thematically analysed produced six core themes. These themes were built upon along with data from the literature to develop a survey tool that was subsequently validated and used to survey students online.

The causes of abuse, victims and perpetrators, educational preparation and preparedness in identifying and treating IPV were explored to identify the level of perceptions and understanding of the students.

The findings indicate that nursing students may not understand the significance of IPV. For them to be better prepared to fulfil their role as nurses there needs to be greater emphasis on meeting emotional needs and on understanding different approaches, especially preventative.

One useful educational strategy could be for students to be placed with other community organisations working to prevent IPV, to develop a preventative culture and an awareness and ability to work with others in a multidisciplinary environment.

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APPENDIX A

IPV Self-Efficacy Scale

Please indicate your response below how much you agree or disagree with the following statements

- 1. I feel confident in being able to support victims in my future nursing practice.**
- 2. I feel confident in being able to support perpetrators in my future nursing practice.**
- 3. I am worried about what I might say to the victim. ®**
- 4. I am worried about what I might say to a perpetrator which could make the situation worse. ®**
- 5. I am reluctant to get involved in abuse situations. ®**
- 6. I think that I might avoid these abuse situations. ®**

® denotes reverse scored

Nursing Roles and Values Scale

Please indicate your response below how much you agree or disagree with the following statements

- 1. Nurses should provide education to the victim.**
- 2. Nurses should try and convince the victim that they could have a better life.**
- 3. The nurse should spend time listening to the victim.**
- 4. The nurse should provide good physical care to the victim.**
- 5. The nurse should provide good emotional care to the victim.**
- 6. The nurse should link the victim with other support services.**
- 7. The nurse should link the perpetrator with other support services.**
- 8. The nurses' role is to provide counselling to the victim.**

9. The nurses' role is to provide counselling to the perpetrator.
10. The nurse should identify victims via screening programs.
11. The nurse should identify the victim in their assessment.
12. The nurse should work with others in the health care team to support the victim.
13. The nurse should inform the victim of their legal rights.
14. Nurses need to be non-judgemental.

IPV Educational Preparedness

Please indicate your response below how much you agree or disagree with the following statements

1. I have good knowledge about the causes of partner abuse.
2. I am aware of community / societal attitudes towards partner abuse.
3. I have good knowledge about the nurses' legal responsibilities.
4. I have good knowledge of local support services which may assist a victim or perpetrator.
5. I am aware of other health professionals' roles in supporting victims and perpetrators.
6. I have good knowledge of the effects of partner abuse.
7. I have a good beginning knowledge of how to effectively respond to victims and perpetrators.
8. I feel confident from my nursing education in addressing partner abuse.
9. I have a beginning understanding of the nurses' role in community interventions to prevent abuse.
10. I have a good theoretical knowledge of abuse cycles.