Knowledge, Attitudes, and Practice of Nurses toward Intimate Partner Violence: A meta-synthesis

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Learning Objectives

By the end of this presentation, the audience will be able to:
• Understand the concept of IPV and its impact
• Know nurses’ role in IPV prevention & intervention
• Consider KAP of nurses toward IPV
• Intimate partner violence (IPV) against women is a significant global health issue, and fundamental violation of women’s human rights (Garcia-Moreno & Watts, 2011; World Health Organization, 2017)
  - WHO: Behavior by an intimate partner (current and former spouses and other intimate partners) that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviors (2012)
  - US CDC: Physical, sexual, or psychological harm by a current or former partner or spouse; can occur among heterosexual or same-sex couples and does not require sexual intimacy (2018)
Background

Impact

- Globally, 1 in 3 women who have been in an intimate relationship are affected by IPV (World Health Organization, 2013)

https://www.who.int/gho/women_and_health/violence/intimate_partner_text/en/
Short- & long-term adverse effects of IPV on

- **Women** (Campbell et al., 2002; Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008; Chen et al., 2017)
  - Physical injuries, chronic pain
  - Depression, post-traumatic stress disorder
  - Alcohol use disorders/drug misuse
  - Sexually transmitted infections, HIV/AIDS
  - Unintended pregnancy-abortion, low birth weight infant
  - Homicide/suicide

- **Children** (Chen, Jacobs, & Rovi, 2013; Wood & Sommers, 2011; Jaffe, Campbell, Hamilton, & Juodis, 2012)
  - Anxiety, depression, aggression, psychological trauma
  - Physical injuries or death
  - Poor educational outcomes
  - Intergenerational continuity of IPV at adulthood

- **Financial costs** (Hoeffler, 2017)
  - Annual cost estimated at $4.4 trillion, corresponding to 5.2% of global GDP
Nurses’ role in combating IPV

• Nurses play a crucial role in IPV prevention & intervention given the access, duration, and extent of contact with patients
  ➢ Hospital, especially emergency department, is the first or even only contact that IPV victims have with healthcare professionals (Glass, Dearwater, & Campbell, 2001)

• Nurses are strongly encouraged to screen and intervene in IPV victims (American Nurses Association, 2000; American College of Nurse-Midwives, 2013; Emergency Nurses Association, 2006; Association of Women’s Health, Obstetric and Neonatal Nurses, 2015; Moyer & U.S. Preventive Services Task Force, 2013)

• “LIVES” first-line support recommended by WHO (2014)

• Healthcare professionals, including nurses, should be knowledgeable and prepared on how to respond to IPV (Alvarez, Fedock, Grace, & Campbell, 2017)
The purpose of this study was to systematically search, interpret, and synthesize the literature on knowledge, attitudes, and practice of nurses toward IPV. Adopting the meta-synthesis approach for integrating qualitative evidence.

A better understanding of nurses’ perceptions and current practice toward IPV can be useful for future IPV intervention & prevention.

- Clinical practice guidelines development
- Nursing school curriculum design
- Policy making
- etc.
Methods

Search method

• PubMed, Embase, CINAHL, PsycINFO were searched from inception to October, 2018
  ➢ MeSH terms (e.g., “perception”, “knowledge”, “attitude”, “behavior”, “intimate partner violence”, “domestic violence”, “nurses”, “midwifery”, “health personnel”)
  ➢ Keywords (e.g., “knowledge, attitudes and practice”, “dating violence”, “health care provider”)

• Other sources
  ➢ Reference lists of qualitative review articles
  ➢ Search engines (Google, Baidu)
Methods

Study selection

• Inclusion criteria
  ➢ Published in English
  ➢ Primary research report, in full-text, on peer-reviewed journals
  ➢ Focused on knowledge, attitudes, and practice of nurses toward IPV
  ➢ Used appropriate qualitative research methods or mixed methods design
  ➢ Reported qualitative data

• Exclusion criteria
  ➢ Published as secondary data analysis paper, review, commentary
  ➢ Targeted health care providers but did not provide separated data relevant to nurses
  ➢ Explored experiences regarding intervention program or evaluated the effectiveness of intervention program
  ➢ Published as dissertation, thesis, conference abstract
Methods

Quality appraisal & data extraction

- Two researchers independently retrieved, appraised, and extracted data
  - Discrepancy was solved by discussion
- Joanna Briggs Institute (JBI) critical appraisal tool
  - Checklist for Qualitative Research (JBI, 2017)
- A data extraction form was used to extract
  - Author & year, study aim (s), country, design & methods, participants & setting, results
Methods

Data analysis & synthesis

• All three researchers were involved
• Thematic synthesis method introduced by Thomas and Harden (2008)
  ➢ To identify themes in an inductive approach
• Similarities and differences across the studies were compared
• The study followed PRISMA guidelines (2009)
Results

PRISMA flowchart

Identification
Records identified through database searching (n = 732)
Additional records identified through other sources (n = 7)
Records after duplicates removed (n = 312)

Screening
Records screened (n = 427)
Records excluded (n = 380)

Eligibility
Full-text articles assessed for eligibility (n = 47)
Full-text articles excluded, with reasons (n = 23)

Included
Studies included in qualitative synthesis (n = 24)
Results

Characteristics of included studies

• Totally 24 articles were included, published from 2001 to 2017
  ➢ 22 qualitative studies
  ➢ 2 questionnaire survey studies (with open-ended questions)
• Australia (n=3), Brazil (n=1), Canada (n=2), Finland (n=1), Israel (n=1), Italy (n=1), Jamaica (n=1), Japan (n=2), Jordan (n=1), Norway (n=1), Sri Lanka (n=1), South Africa (n=2), Sweden (n=3), and United States (n=5)
• Midwives were recruited (n=7), both female and male nurses (n=10), only female nurses (n=7)
• Purposive sampling (n=13), convenience sampling (n=4)
• Phenomenology (n=5), qualitative descriptive design (n=4), grounded theory approach (n=4), Denzin’s interpretive interactionism (n=1), ethnography (n=1)
Results

Meta-synthesis of study findings

(1) Struggling to intervene with IPV victims
   a) Boundaries between professional role and personal experience
   b) Lack of preparedness

(2) Influencing factors for screening and caring IPV victims
   a) Barriers
   b) Facilitators
Results

Meta-synthesis of study findings (cont’d)

(1) Struggling to intervene with IPV victims
   a) Boundaries between professional role and personal experience
   b) Lack of preparedness
      • Nurses generally felt it was a challenge to fully implement screening during practice and provide appropriate care for IPV victims
      • For the majority of nurses, the professional role of nursing in IPV was recognized though it was challenging
      • Anger, frustration, confusion, and shame were mentioned by nurses as their personal experiences when facing IPV victims
Results

Meta-synthesis of study findings (cont’d)

(1) Struggling to intervene with IPV victims
   a) Boundaries between professional role and personal experience
   b) Lack of preparedness
      • On one hand, nurses realized their professional role in identifying and helping IPV victims (especially for nurses who were victims of IPV themselves)
      • On the other hand, nurses attempted to block the overwhelming emotions from influencing their professional practice as well as invading their individual life

“...I’ll do my nursing – administer medication, dress wounds, and do my best not to be influenced or to take the (IPV) experiences home.” (Goldblatt, 2009, Israel)
Results

Meta-synthesis of study findings (cont’d)

(1) Struggling to intervene with IPV victims
   a) Boundaries between professional role and personal experience
   b) Lack of preparedness
      • There was a prevalent expression for lack of preparedness among nurses, regardless of experience in screening and training

“If I met a woman who suffered any kind of abuse, I would seek for help from my colleagues, from senior midwives or from a consultant to figure out what to do… because by myself, I really wouldn't know what to do!” (Mauri et al., 2015, Italy)
Results

Meta-synthesis of study findings (cont’d)

• (2) Influencing factors for screening and caring IPV victims
  a) Barriers
  b) Facilitators

Lack of knowledge: “We don’t have any special lectures or in-service education on IPV, so we gain knowledge through experience. So junior nurses without much experience might not be able to successfully handle these cases and might just focus on the physical aspect. If we are given training we could intervene successfully instead of just making referrals.” (Beynon et al., 2012, Canada)

Lack of training: “I think that our education about domestic violence is somehow... lacking. For example, I finished my academic studies as a midwife more than ten years ago and we never talked about this [...] I don’t know if things have changed now but I can say that continuing education is lacking too!” (Mauri et al., 2015, Italy)

Lack of time: “The topic is big and difficult. It is big and difficult and takes time, right? And you know, if somebody discloses things you need to make time to address it.” (Henriksen et al., 2017, Norway)

Lack of resources: “In the North there are no resources or ways out for these women and I spent a lot of time listening to them. That was all we could provide and it was quite sad.” (Beynon et al., 2012, Canada)

Presence of partner: “(Difficulty) getting rid of significant others or family members to ask the question.” (Furniss et al., 2007, USA)

Inadequate institutional/societal support: “I feel very comfortable screening and do screen in my scope of practice, however this is not supported by my manager in the agency I am employed by. Therefore, we do not have a consistent tool and do not receive training.” (Beynon et al., 2012, Canada)

Legal issues: “I need to know the legal aspects of reporting to authorities.” (Furniss et al., 2007, USA)
Results

Meta-synthesis of study findings (cont’d)

• (2) Influencing factors for screening and caring IPV victims
  ➢ a) Barriers
  ➢ b) Facilitators

Training: “It would be useful, now that I’ve graduated, to participate in congresses and courses about this, to improve my knowledge and skills in detecting and dealing with domestic violence…anyway, I think it would be better to improve first-level academic education on the subject so that all midwives can be equally trained in it.” (Mauri et al., 2015, Italy)

IPV experience: “The fact that I have been a victim of domestic violence and abuse makes it easier for me to identify women who are experiencing a similar situation.” (Beynon et al., 2012, Canada)

Supports from community/intuition/policy: “It is an unrealistic expectation to be screening every woman/female over the age of 12 for abuse on each encounter with health care personnel as the guidelines have suggested. This expectation turned many emergency room nurses against screening when it was first introduced and compliance remains very low.” (Beynon et al., 2012, Canada)

Multidisciplinary collaboration: “I mean, not just by the midwife or gynaecologist…the woman must be looked after by a team of professionals.” (Mauri et al., 2015, Italy)
Conclusion & Implication

• The first of its kind that provides insight into KAP of nurses toward IPV in global settings
• The challenging and complex nature of intervening IPV victims for nurses was confirmed
• Both barriers and facilitators to screening and caring for victims of IPV were identified

• Current evidence highlights the need to improve knowledge, enhance preparedness, and implement practice for screening and caring for IPV victims
• Special attention should be paid to awareness raising, in-service training, and multidisciplinary collaboration for nurses, especially in low and middle income countries
References


References


Thank you!