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I, Ahlam Sh Al-Natour , hereby submit this original work as part of the requirements for the degree of Doctor of Philosophy in Nursing - Doctoral Program.

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Jordanian Nurses' Barriers to Screening for Intimate Partner Violence

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Abstract

Intimate partner violence (IPV) continues to be a problem worldwide. Intimate partner violence in its forms (physical, psychological, and sexual) can result in a negative impact on women's health. Despite the crucial role nurses play in screening and providing the needed support and help for IPV victims, nurse screening rates are very low. Nurses may encounter several barriers that hinder their IPV screening practice. Currently, there are no studies estimating nurses IPV screening rates and the barriers to IPV screening among Jordanian nurses. The purpose of this study was to estimate the rate of IPV screening and determine the barriers to IPV screening among Jordanian nurses. This study used a cross sectional design with a stratified random sample of 125 Jordanian nurses working at 10 health centers and three hospitals in a northern city of Jordan. The study instrument included the Domestic Violence Health Care Provider Survey (DVHCPS), Women Abuse Screening Tool (WAST), and demographic survey. Data analysis included descriptive statistics, Chi-square Goodness-of-Fit tests, and one and two tail proportion z- tests. Study results showed that Jordanian nurses screened for IPV most often when women sought care for physical injuries (25%) and lowest for Irritable Bowel Syndrome (3.3%). The one proportion z-tests revealed that the Jordanian nurse screening rates were significantly lower than the rate reported with U.S. nurses. The two-tailed two proportion z- tests revealed no significant differences between the proportions of nurses that screened for IPV based on personal IPV experiences. Jordanian nurses defined barriers to screening were contributed to several sources including their beliefs about screening practice, victims' role for being abused, the adequacy and ability of social and mental services to provide help and other important barriers presented in this study. Barriers for IPV screening should be eliminated

through education on IPV screening, therapeutic communication, and referral of victims to community services. Moreover, policies should be activated for assuring IPV screening protocols. Further research is needed to find appropriate strategies that increase nurses screening compliance and the effect of IPV screening on the quality of nursing care.

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CHAPTER I

United Nation Children Fund (UNICEF, 2000) showed that intimate partner violence (IPV) is a worldwide phenomenon cutting across the boundaries of religion, nation, culture, education, race, and gender. Intimate partner violence is also a health and social problem (Spangaro, Zwi, & Poulos, 2009). Intimate partner violence is defined as any violent act occurring between spouses, ex-spouses, separated spouses, boyfriends, ex-boyfriends, girlfriends, or ex-girlfriends. It includes sexual, physical, emotional, and threats of physical violence (Saltzman, Fanslow, McMahon, & Shelley, 1999; UNICEF, 2000).

Introduction

This chapter presents the phenomenon of IPV including its definition, types, and consequences on victims' health, children's health, and community health. Screening is described as one of the nurses' crucial roles toward their patients in health care settings. The significance of screening is seen through the estimation and identification of victims of IPV. However nurses' screening for the prevalence of IPV is still very low worldwide. Barriers to screening continue to exist. This study's significance was to promote women's health and safety by potentially increasing screening rates and improving nursing practice.

Terminology

The literature identified several terms to describe IPV. Terms included marital violence, spousal violence, domestic violence, domestic abuse, family violence, partner violence, partner abuse, couple violence, abusive relationship, intimate violence, intimate partner violence, women abuse, conjugal violence, violence against women, women battering, wife-beating, women assault, and physical violence. These terms are used interchangeably in the literature.

In this study, “intimate partner violence” was used to describe the pattern of physically, psychologically, and sexually violent acts against women by their partners.

The literature reported several terms to identify women experiencing violence against them by their partners. Terms included abused women, victims, battered women, assaulted women, and survivors. These terms are also used interchangeably in the literature. In this study, victims of IPV was used to identify women who are experiencing or have experienced IPV by their partners.

The Rate of Intimate Partner Violence

Garcia-Moreno, Jansen, Ellsberg, Heise, and Watts, (2006) conducted a multi-country study with 24,000 women living in 10 countries from Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia and Montenegro, Thailand, and the United Republic of Tanzania to investigate the rate of physical and sexual violence against women. Study findings showed that the rate of physical or sexual partner violence, or both, varied from 15% to 71%. Also, the study showed that about 50% of pregnant women were physically abused during pregnancy. The rate of IPV in Jordan was very similar to other countries ranging from 15% Clark, Hill, Jabbar, & Silverman, 2009) to 47.5% (Al-Nsour, Khawaja, & Al- Kayyali, 2009)

Consequences of Intimate Partner Violence

Intimate partner violence is a global problem warranting the attention of women’s health advocates. Intimate partner violence has a deleterious impact on women’s physical and mental health (Campbell et al., 2002; UNICEF, 2000; Garcia-Moreno et al., 2006). It is associated with several health problems including headaches, disabilities, sexual transmitted infections, unwanted pregnancies, abortions, vaginal bleeding, and irritable bowel syndrome (Campbell et

al., 2002, Garcia-Moreno et al., 2006). Intimate partner violence resulted in different injuries ranging from bruises to chronic disabilities and death (UNICEF, 2000). It also included fractures, hemorrhage, and head trauma (Centers for Disease Control and Prevention, 2009). Researchers showed that victimized women exhibited poor health behaviors such as smoking, alcohol abuse, and risky sexual activities (CDC, 2009; Savarsdottir & Orlygsdottir, 2009a).

Intimate partner violence is associated with a variety of mental health diseases and disorders including post-traumatic stress disorder (PTSD), anxiety, and obsessive-compulsive disorder (Follingstad, 2009; UNICEF, 2000). Stress and anger resulting from the experience of violence could result in eating disorders and depression (CDC, 2009). Also, IPV could result in fatal consequences such as suicide, homicide, and maternal mortality (CDC, 2009; UNICEF, 2000; Garcia-Moreno et al., 2006).

During pregnancy, the frequency and the severity of IPV were twice as high compared to non-pregnancy status (Bruch, & Gallup, 2004). Intimate partner violence against pregnant women was associated with decreased newborn Apgar scores, poor nutrition, hypertension, substance abuse, and vaginal bleeding during pregnancy (Kearney, Haggerty, Munro, & Hawkins, 2003). Also, the rate of still birth and abortions among pregnant women was significantly increased (Garcia-Moreno et al., 2006).

Intimate Partner Violence Screening and Barriers

Screening for IPV is performed by health care providers asking questions focused on identifying IPV and documenting the screening findings in the patient medical record (Trautman, McCarthy, Miller, Campbell, & Kelen, 2007). Universal IPV screening was defined as a way of asking every person over the age of 14 years about their experience with IPV,

regardless of education, ethnicity, race, religion, maternal status, and socioeconomic status (Hindin, 2006).

Spangaro et al. (2009) showed that screening was a complex intervention more than asking specific questions about IPV. They described factors that increase client engagement and disclosure of violence against them including the level of engagement among victims and screeners, suitable environment, skillful screeners, and victims' interest for disclosing their situation and experience of violence against them.

MacMillan et al. (2009) showed that screening was associated with improving IPV victims' quality of life and decreasing depression. Houry et al. (2008) found that there was no adverse effect related to screening. Spangaro, Zwi, Poulos, and Man (2010) found that screening especially at health care settings with established protocols for asking patients and referring them to the needed resources could provide opportunities for victims of IPV to disclose violence against them and receive further intervention. Houry et al. (2008) showed that about 25.7% of persons screened were identified as victims of IPV. But there were no safety interventions done with victims of IPV in the emergency department.

Health care providers play a crucial role in preventing IPV, identifying victims of abuse early in the course of the relationship, providing victims with the necessary treatment, and referring victims to the appropriate resources (Garcia-Moreno et al., 2006). Researchers showed that the rate of nurses and physicians screening for IPV was very low. Elliot, Nerney, Jones, and Friedmann (2002) found that less than 10% of physicians did screen. Tower (2006) found that about 20.8% of physicians were screening for IPV. Malecha (2003) found that 10% of nurses screened for IPV. Smith, Rainey, Smith, Alamares, and Grogg (2008) found that about

27% of nurses suspected the existence of abuse but they did not document any screening results for IPV victims. Thurston et al. (2007) found that approximately 39% of nurses were screening. Felblinger and Gates (2008) showed that approximately 16.2% of occupational health nurses were screening for workplace IPV.

There are several barriers preventing nurses from screening for IPV. Nurses' attitudes are an important barrier. Haggblom, Hallberg, and Moller (2005) descriptive study revealed that nurses were angry and frustrated at IPV victims, because victims were returning and staying in an abusive relationship. Furniss, McCaffrey, Parnell, and Rovi (2007) and Smith et al.(2008) showed that nurses feared abusers' reactions and retaliation, denied the IPV situation, and were uncomfortable being legally involved. Similarly, Heinzer and Krimm (2002) and Svavarsdottir and Oligysdottir (2009b) revealed that nurses experienced discomfort when asking women about such a sensitive subject.

Nurses' beliefs are another important barrier. Haggblom's et al. (2005) and Smith et al. (2008) found that nurses had different beliefs toward the causes of IPV including alcohol and drug abuse. Smith et al. (2008) showed that 32.1% of nurses believed there was not enough evidence of IPV and that 4.58% of the nurses were unprepared to deal with IPV cases. Felblinger and Gates (2008) findings supported the findings of Smith et al. (2008) discovering that 13.2% of nurses thought IPV screening was not considered part of a nurse's role and 10.9% of nurses believed screening was not work related. About 67% of nurses did not feel competent to screen, 32% felt their training for IPV was inadequate, and 71.1% of nurses were unsure of the existence of institutional policies related to IPV. In addition, nurses' beliefs about victims of abuse are a barrier. Haggblom et al. (2005) found that 25% of nurses thought IPV resulted from

a victim's helpless personality. In addition, the study revealed that nurses thought victims would return to their abusers. Furniss et al. (2007) reported that nurses believed that IPV is a sensitive subject and victims will lie and not disclose their IPV.

Gutmanis, Beynon, Tutty, Wathen, and MacMillan (2007) found that about 60% of Canadian physicians and nurses did not receive specific IPV training. Furniss et al. (2007) found that nurses did not screen because of lack of time (55.1%), lack of privacy (91.7%), and absence of formal training (56.4% not sure what to do, 31.7% lacked knowledge). Furthermore, Felblinger and Gates (2008) found that only about 32% of U.S. occupational health nurses perceived they had adequate training and 70% did not know the right questions to ask. In addition, 55.8% were unsure about IPV interventions and 62.7% did not know the warning signs of IPV.

Studies showed different percentages toward the existence of IPV protocols and policies within health organizations. Crandall, Schwab, Sheehan, and Esposito's (2009) mixed method study showed that 90% of health trauma centers located in Illinois were found to have a screening protocol. Hazen et al. (2007) found that about 52.8% of child welfare agencies in the U.S. had a written policy for IPV screening. Despite these findings, researchers revealed that about 34% of nurses in those settings were unaware of organizational protocols (Furniss et al., 2007; McGrath et al., 1997).

Although some victims were screened for IPV, the victims' disclosure rate was still very low at 15%. Victims' disclosure resulting from screening did not measure the accurate prevalence of IPV (Thurston et al., 2007). Also, victims stayed and did not leave their abusers due to a variety of reasons. These reasons include fear of losing the custody of their children,

fear of partner retaliation, for family sake, absence of family support, absence of community services, poor legal intervention, and financial dependence on partners (Oweis, Gharaibeh, Al-Natour, & Froelicher, 2009; Garcia-Moreno et al., 2006). In addition, women rationalized violent behavior against them. The rationalization included that perpetrators were unable to control themselves and victims' themselves played an important role in causing violence against themselves (Kearney, 2001; Oweis et al., 2009). Moreover, about 15% of women who experienced IPV did not perceive the IPV as a problem for them (Coker et al., 2007).

Nurses were also victims of IPV. Bracken, Messing, Campbell, La Flair, and Kub (2010) showed that about 25% of nurses experienced physical or sexual violence and 22.8% of them reported experiencing emotional abuse by their intimate partner. Díaz-Olavarrieta, Paz, Cadena, and Campbell (2001) found that about 40% of nurses' aides and nurses reported emotional abuse during adulthood by their partners. Also, about 13% of nurses' aides and 18% of nurses reported physical and/or sexual partner abuse by their partners.

Several factors can increase IPV screening and the success of interventions. Factors included educational programs, screening protocols implementation, and providing a suitable environment for IPV disclosure. Roark (2010) showed that a nursing educational IPV program for screeners could increase nurses' confidence and competency in screening for IPV (Hamberger & Phelan, 2006).

Thackeray, Stelzner, Downs, and Miller (2007) found that female victims showed more comfort to disclose if they were screened by same race health care providers, females, those aged 30-50 years, and with the absence of family members or friends. This study showed that screening was more than asking questions. Screening included an interaction among victims

and screeners. Screeners should pay attention to signs of victims' guilt and shame when disclosing IPV acts against them. This study indicated the importance of providing several opportunities for victims to disclose IPV such as several methods of screening, offering easy written material, and safety plans, and access to supportive community resources.

Hindin (2006) stated that nurses should establish trust and rapport with victims of IPV to promote disclosure. Also, health care providers should give patients enough time to disclose. Svavarsdottir (2010) found that establishing a trusting relationship between the health care professional and victims of IPV can promote a safe environment where women are more willing to disclose violence against them. Trautman et al. (2007) showed that using computer screening for IPV could significantly increase detection rate, referral, and providing services to victims.

Problem Statement and Study Purpose

Despite the high incidence of IPV and the devastating effect on victims of IPV, nurses' screening rate of IPV is still very low. Intimate partner violence is thought to be underreported due to the reluctance of victims and nurses to openly discuss this issue. Given this reluctance, IPV barriers to screening need further study (McFarlane, Groff, O'Brien, & Watson, 2006).

Nurses are in the prime position to detect IPV, yet the rate of nurses' screening for IPV in North American countries ranges from as little as 10% to 39% (Felblinger & Gates, 2008; Malecha, 2003; Thurston et al., 2007). Trautman et al. (2007) found that nearly all (99%) of identified victims were screened by nurses. Perciaccante, Carey, Susarla, and Dodson (2010) stated that finding cases of IPV at an early stage of the IPV could provide an opportunity for early intervention and could help in preventing future episodes of violence and injury.

Furniss et al. (2007) found that decreasing the barriers encountered by nurses toward screening for IPV might help promote women's safety and significantly could decrease the deleterious impact of IPV. Also, Bacchus, Mezey, and Bewley (2002) showed the beneficial role screening could play in the lives of victims of IPV if screening was performed in the right way. But if screening was not done in the right way, screening could result in harm.

The rate of IPV in Jordan is known to be high (Al-Nsour et al., 2009; Clark et al., 2009; Nasser, Belbeisi, & Atiyat, 2000). No studies were found that describe the barriers inhibiting nurses from screening for IPV. Further research is needed to identify Jordanian nurses' screening barriers associated with the rate of IPV screening in this Middle Eastern country. Therefore, this study's purpose was to investigate the IPV screening practices of Jordanian nurses. Specifically, this study examined the IPV screening rate and the IPV screening barriers encountered by nurses in Jordanian healthcare settings. In addition, data were collected on nurses as victims of IPV and comparisons made between victims and non-victims related to screening. This comparison is important to determine if IPV screening is affected by nurses' victimization. Beck et al. (2011) found that women experiencing IPV had PTSD and exhibited shame and guilt. Sippel and Marshall (2011) wrote that shame resulting from PTSD was associated with IPV experience and resulted in maladaptive avoidance and social isolation. These behaviors were used by victims to decrease discomfort and promote self-image. Victimized nurses could develop this same shame and guilt resulting in their avoidance of victimized patients in an effort to prevent discomfort associated with self-reflection of their own victimization.

Study Significance

Intimate partner violence still occurs in high percentages all over the world and results in a negative impact on victims and communities as a whole (Garcia-Moreno et al., 2006; UNICEF, 2000). The cost of IPV against women was estimated at \$5.8 billion in 1995. Costs included nearly \$4.1 billion in the direct costs of medical and mental health care and about \$1.8 billion in the indirect costs of lost productivity because of victims' loss of 8 million paid work days (CDC, 2003).

Despite nurses being in a critical position to screen, report, and refer victims of IPV to the appropriate services and the effectiveness of screening to victims, nurses are still screening at a low rate (10%-39%). Nurses encounter a variety of barriers that prevent them from screening including work overload, lack of knowledge and training for IPV screening and interventions, lack of private places for screening, inactive IPV screening protocols, and absence of administrative support. In addition, nurses are women and undergo IPV at rate of 30% and with a lot of them not screened, supported, or referred to the needed services.

Jordanian studies lacked information about screening rates of IPV among nurses, the presence of special training for screening for IPV, and the existence of institutional protocol for screening for IPV by nurses or other health care providers concerned and at first contact with victims of IPV victims at the health care settings.

In my perspective, it was very significant to know the frequency of IPV among nurses. This study adds new insight to the perceived barriers that prevent Jordanian nurses from screening for IPV. Determining the barriers for Jordanian nurses to screen for IPV can help health planners and researchers reduce those barriers. Reducing barriers could increase

screening rates for and detection of cases of IPV. Earlier detection can then lead to earlier referral for IPV victims. In addition it was critical to determine the rate of IPV among Jordanian nurses as women who are surrounded by cultural beliefs about male dominance and women's tendency to accept violence in their lives. Based on these facts, there was a need to compare nurses screening practice among nurses undergoing IPV and those who were not. The findings of this study may help nurses and policy makers realize the magnitude of this problem and the need to develop effective and specific programs to increase nurses' competencies and preparedness toward screening and interventions for women as victims' of IPV.

Research Questions

There were two overall questions for this study:

1. What are the barriers for Jordanian nurses to screen for IPV?
2. What proportion of Jordanian nurses are victims of IPV?

Specific Aims

The specific aims for this study were to:

1. Determine the rate of screening for IPV by Jordanian nurses compared to the U.S. nurses rates screening rate of 39%.
2. Investigate the barriers to IPV screening by Jordanian nurses.
3. Estimate the rate of IPV against female Jordanian nurses and compare it with U.S. nursing victimization rates.
4. Compare the IPV screening rate for Jordanian nurses that are victims of IPV to those that are not victims.

Summary

This chapter presented the problem of IPV in Jordan and other countries. Intimate partner violence has a deleterious impact on victims' physical and mental health. In addition, IPV can negatively affect victims' children physically and mentally as well as the community as a whole.

Screening for IPV in this chapter was described in terms of its significance in estimating and identifying victims of IPV. While nurses play a critical role in IPV screening, nurses' screening for IPV is still very low worldwide related to barriers encountered by nurses. According to the reviewed studies, nurses encountered a variety of factors and barriers for non-screening. Nurses' barriers included their belief and attitudes toward IPV. Organizational and victim barriers of IPV were significant and could play an important role for nurses' non-screening of IPV.

Lack of Jordanian studies that investigated IPV screening by Jordanian nurses reflected the need for the current study. This chapter presented the significance for this study to Jordanian nurses and policy makers. Specific aims of this study were directed to determining the rate of IPV among Jordanian nurses as victims of an IPV relationship, the rate of IPV screening, barriers for IPV screening among Jordanian nurses, and the difference between victimized and non-victimized nurses for IPV screening.

CHAPTER II: REVIEW OF THE LITERATURE

Definition of IPV

Violence is defined as aggressive acts against a person. Violence was defined as the intentional use of physical force or power that also includes threats or actual assaults against oneself, another person, or group, or community which could result in injury, death, psychological hazard, or development problems (WHO, 2012).

Intimate partner violence is defined as any violent act occurring between spouses, ex-spouses, or separated spouses, between boyfriends or ex-boyfriends and girlfriends or ex-girlfriends. It includes sexual, physical, emotional, economical, and threats of physical violence (Saltzman et al., 1999; United Nation Population Fund, 2003; UNICEF, 2000). Also, IPV is defined as behaviors within an intimate relationship that can result in physical, sexual, and psychological harm. It includes acts of physical aggression, sexual assault, mental/psychological violence and controlling partner behaviors (WHO, 2010).

The Centers for Disease Control and Prevention (CDC, 2011) indicated that IPV is a serious, preventable public health problem. Intimate partner violence includes forms of physical, sexual, or psychological harm by a partner or spouse, and can occur within heterosexual or homosexual couples. Intimate partner violence relationships can vary in frequency and severity. Intimate partner violence occurs on a continuum, ranging from one hit to a serious assault and battering.

Intimate partner violence includes acts of physical violence and aggression, psychological abuse, forced sexual practice and other forms of sexual violence. Also, IPV includes different behaviors of social isolation from supportive groups and relatives and

restricting information exchange (WHO, 2002). Intimate partner violence is considered a health and social problem (Spangaro et al., 2009). Intimate partner violence is a worldwide phenomenon cutting across boundaries of religion, nation, culture, education, race, and gender (UNICEF, 2000).

Physical violence is defined as any intentional use of physical force resulting in disability, injury, harm, and death (CDC, 2011). Physical violence occurs when a partner hurts or attempts to hurt the other partner by hitting, kicking, scratching, pushing, shoving, throwing, grabbing, biting, choking, shaking, slapping, punching, burning, using a weapon, or using any other type of physical force or power (CDC, 2009; CDC, 2011). Also, physical violence includes threats of using a gun, knife, or any type of weapon against IPV victims (Garcia-Moreno et al., 2006).

Sexual violence is defined as using physical force by perpetrators' for sexual intercourse. Sexual violence includes using force for sexual practice, abusive sexual acts, and forced humiliating sexual acts with a partner (CDC, 2011; Garcia-Moreno et al., 2006). Threats of physical or sexual violence include perpetrators' use of words, gestures, or guns when interacting with the other partner in order to harm or cause injury (CDC, 2011).

Psychological violence is defined as any intentional acts of humiliation, intimidation, threatening, and isolating victims of IPV. Psychological violence includes threatening the other partner or harming a partner's sense of self-worth. It involves stalking, name-calling, intimidation, humiliation in the presence of others, making victims feel diminished or embarrassed, denying victims' access to money and other basic resources, control over victims, isolating victims from friends and social networks, and causing emotional torture and living under terror (CDC, 2009; CDC, 2011; UNICEF, 2000; Garcia-Moreno et al., 2006).

The Rate of IPV

The WHO (1996) report on violence against women showed the prevalence rate of physical violence ranging from 20%-50%. Physical violence against women varied by country with Canada at 29%, New Zealand and Switzerland at 20%, United Kingdom at 25%, U.S. at 28%, Egypt at 35%, Kenya at 42%, Uganda at 40%, Nicaragua at 52%, Korea at 38%, India at 45%, Mexico at 30%, Poland at 60%, and Russia at 25%.

Garcia-Moreno et al. (2006) conducted a multi-country study among 24,000 women living in Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia, Montenegro, Thailand, and the United Republic of Tanzania to investigate the prevalence of physical and intimate partner violence against women. The prevalence of physical or sexual partner violence, or both, varied from 15% to 71%. Only two countries reported IPV less than 25%. Seven countries reported prevalence between 25% and 50% and six of these countries more than 50%. The prevalence of physical violence ranged from 13% to 61%. Also, the prevalence of sexual violence ranged from 10% to 50% in most of the countries. Japan showed the lowest prevalence of sexual violence (6%) and Ethiopia showed the highest prevalence (59%). Pregnant women showed 24% prevalence of physical violence.

The United Nation Fund Population (UNFPA)(2010) study among Vietnamese women revealed that about 34% reported physical or sexual violence by their husbands. The study findings revealed that Vietnamese women were three times more likely to be abused by a husband than by any other person. The researchers also found that victims of IPV were almost twice as likely to report physical health problems. In addition, Vietnamese women were three times more likely to have suicidal thoughts.

The Rate of IPV in Jordan

IPV is a problem for women in Jordan. Al-Nsour et al.(2009) found that about 47.5% of Jordanian women have been emotionally abused and about 19.6% have been physically abused by their husbands. Nasser et al. (2000) found that about 25% of Jordanian women have been physically abused by their husbands or other family members such as brothers and fathers. Clark et al. (2009) found that about 15% of pregnant women have been physically abused by their husbands. Oweis, Muntaha, and Alhourani (2010) reported that about 10.4% of pregnant women have been physically abused, 23.4% emotionally abused, 23% verbally abused, and 5.7% have been sexually abused by their husbands.

Impact of IPV

Intimate partner violence has a hazardous impact on victims' physical and mental health. Also, Intimate partner violence has a harmful effect on children's emotions, behaviors, and education. Moreover, Intimate partner violence can result in a deleterious impact on the community as a whole. The following paragraphs present studies showing the relationship between IPV and its consequences on victims, their children, and the community.

Impact of IPV on Victims' Physical Health

A variety of research studies presented the deleterious impact of IPV on women's physical and mental health (Campbell et al., 2002; UNICEF, 2000; Garcia-Moreno et al., 2006). Intimate partner violence is associated with several health problems including headaches, backache, disabilities, sexual transmitted infections, unwanted pregnancies, abortion, irritable bowel syndrome, abdominal pain, fibromyalgia, gastrointestinal disorders, limited mobility, and poor overall health (UNFPA, 2003; UNICEF, 2000; Garcia-Moreno et al., 2006; WHO, 2009).

Intimate partner violence can lead to a variety of injuries ranging from mild to severe (UNICEF, 2000; WHO, 2009). The CDC (2009) stated that victims of IPV suffer minor and serious physical injuries. Minor physical injuries include lacerations, contusions, and abrasions. Serious physical injuries include fractures, hemorrhage, and head trauma. Moreover, IPV can lead to permanent disabilities and death.

Intimate partner violence against women can result in sexually transmitted infections such as HIV/AIDS, unplanned pregnancies, abortions, and gynecological problems (Campbell et al., 2002; WHO, 2009). Victims of IPV who experienced physical and mental health problems were at risk for adopting risky behaviors such as smoking, misusing alcohol, and engaging in risky sexual activity (CDC, 2009; Savarsdottir & Orlygsdottir, 2009a; WHO, 2010).

Btoush, Campbell, and Gebbie (2009) and Fletcher (2010) presented the physical impact of IPV on victims in terms of the type of violence, severity of injury or harm, and emergency department (ED) utilization. Btoush et al. (2009) found that about 86% of IPV victims' visits to the ED were related to mild or moderate pain. About 50% of the victims presented as cases of physical or sexual violence and about 38% of victims reported injuries. About 49% of IPV victims who visited the ED were diagnosed with injuries to the upper or lower extremities. About 31% of injuries occurred to the head, neck, and trunk. This study showed that about 42% of victims were referred to other physicians or clinics, 20% were asked to return to the ED, and 14% were referred to social and supportive services.

Fletcher (2010) conducted a longitudinal study of a school-based nationally representative sample of adolescents living in the U.S. to investigate the effect of IPV on adolescent health. Study findings revealed that 29% of adolescents experienced at least one

episode of IPV. About 60% of study participants reported hospitalizations within the past five years. Also, about 30% of study participants reported at least one incident of IPV. In addition, IPV was associated with poor physical health and more utilization of health care.

Scott-Storey, Wuest, and Ford-Gilboe(2009) described the relationship between IPV and exhibiting risky behaviors and developing cardiovascular diseases. This correlational descriptive study aimed to investigate the effect of stress resulting from IPV on smoking behavior and susceptibility to cardiovascular disorders. Leaving the IPV relationship was associated with an increased risk for cardiovascular disorders. Participants smoked three times more than other Canadian women (44% vs. 15.5%). About 54.7% of survivors had high blood pressure. Also, 53.2% of them were overweight or obese. About 50.8% of study participants reported cardiovascular symptoms including shortness of breath, palpitations, chest pain, and hypertension. Only 17% of them were diagnosed with cardiovascular problems by professional health care providers.

Impact of IPV on Victims' Mental Health

Intimate partner violence can result in a negative impact on women's mental health (CDC, 2009). Victims of IPV relationships often have low self-esteem. They exhibit anger and emotional distress which can result in eating disorders, depression, and suicidal attempts. Victims also experienced post-traumatic stress disorder (PTSD), anxiety, obsessive-compulsive disorder, sleep difficulties, chronic stress, and emotional distress (Campbellet al., 2002; Follingstad, 2009; UNICEF, 2000; WHO, 2009). Stress and anger resulting from the experience of violence could lead to eating disorders and depression (CDC, 2009). Also, it could result in fatal

consequences which include suicide, homicide, and maternal mortality (CDC, 2009; UNICEF, 2000).

Svavarsdottir and Orlygsdottir (2009a) and Mburia-Mwalili, Clements-Nolle, Lee, Shadley, and Yang (2010) reported the impact of IPV in increasing the susceptibility for mental health problems such as depression. Svavarsdottir and Orlygsdottir (2009a) conducted a cross-sectional study to determine the relationship between physical and psychological health and the experience of IPV among Icelandic women. Findings revealed that some women exhibited risk behaviors' such as alcohol abuse and smoking.

Mburia-Mwalili et al. (2010) showed that 48% of study participants experienced physical abuse, 12% sexual abuse, and 40% experienced both physical and sexual abuse by their partners. About 24% of women who experienced IPV were identified to have depression based on the Patient Health Questionnaire-8 (PHQ-8). Also, women who received low to moderate social support were more susceptible to depression than women with high social support (confidence interval [CI]: 1.69-14.49).

Impact of IPV on Victims during Pregnancy and Postpartum Period

Intimate partner violence can result in a hazardous impact on pregnant women and birth outcomes. During pregnancy, both the frequency and severity of IPV were twice as high during pregnancy than before pregnancy (Burch, & Gallup, 2004). Intimate partner violence was associated with decreased infant Apgar scores, poor nutrition, hypertension, substance abuse, and bleeding during pregnancy (Kearney et al., 2003). Also, Intimate partner violence can significantly increase the rate of still births (16%) and abortions (15%) among pregnant women (Garcia-Moreno et al., 2006). Intimate partner violence can negatively affect birth outcomes

including low birth weight, fetal death, stillbirth, premature labor, and complications (Garcia-Moreno et al., 2006; UNFPA, 2003; WHO, 2009).

Tiwari et al. (2008), Beydoun Al-Sahab, Beydoun, and Tamim (2010), and Rodríguez et al. (2010) found positive relationships between IPV and mental health problems such as depression among victims of IPV during pregnancy and the postpartum period. Tiwari et al. (2008) surveyed pregnant women in Hong Kong to investigate the impact of psychological abuse by the intimate partners on pregnant women's mental health. Study findings revealed that about 9.1% of pregnant women experienced IPV. Of participants who reported IPV, 73% of them experienced psychological abuse and 27% of them experienced physical abuse by their partners. Participants who experienced psychological abuse were at more risk to develop postpartum depression (adjusted odds ratio [OR]: 1.84, 95% CI: 1.12–3.02), at more risk for harming themselves (adjusted OR: 3.50, 95% CI: 1.49–8.20), and had significantly poorer mental health ($p < 0.001$) than other women who were not experiencing psychological abuse by their partners.

Rodríguez et al. (2010) conducted a longitudinal study among American women living in the Los Angeles metropolitan area to investigate the effect of IPV on maternal depression during the perinatal period. Depression in this study was measured by the Beck Depression Inventory Fast Screen (BDI-FS). Depression was at the highest range during the prenatal period among victims of IPV and non-victims (45.7% vs. 24.6%), lowest three months after birth (28.0% vs. 7.3%), elevated again at 7 months post-delivery (42.7% vs. 12.4%), and remained elevated at the 13-month post-delivery time point (39.8% vs. 17.5%). Study findings revealed that persistent depression was five times higher in victims of IPV than non-victims (27.3% vs. 5.2%, p

< .0001). Victims of IPV showed higher ineffective and avoidant coping strategies and lower social support at three time points of the study. Moreover, social support was negatively associated with perinatal depression.

Beydoun et al. (2010) conducted a cross-sectional study to determine the effect of IPV on postpartum depression among Canadian women. About 18% of IPV victims experienced postpartum depression compared with 7% of women who did not experience IPV (OR 3.00; 95% CI: 2.22-4.05).

Impact of IPV on Victims' Children

Intimate partner violence can negatively affect children who are raised in a violent family. A hazardous impact of IPV on children includes behavioral problems, emotional problems, educational problems, and using violence against the partner and own children.

United Nations Population Fund(2010) found that IPV has an adverse impact on children's well-being and children were more likely to have behavioral problems compared to other children who were not witnessing violence in their household. World Health Organization (2010) indicated that children who were raised in IPV families exhibited behavioral and emotional problems that could lead to low educational outcomes. United Nations Population Fund (2003) reported that children who grew up in such violent environments were likely to exhibit violent behavior during adulthood. Also, Kerley, Xu, Sirisunyaluck, and Alley (2010) found a significant relationship between exposure to family violence during childhood and physical intimate partner perpetration and victimization during adulthood.

Murrell, Christoff, and Henning (2007) conducted a correlational descriptive study to investigate the difference between generality, frequency, and severity of violence and non-

violence among adults who experienced family violence during childhood. Study findings revealed that witnessing violence during childhood increased the individual likelihood of committing violence against others. Perpetrators or batterers who experienced family violence during childhood were more likely to abuse their own children. Moreover, those men who experienced family violence during childhood reported more frequent violence against others.

Cost of IPV

The cost of IPV against women is very high with an estimated cost in 1995 at \$5.8 billion. These costs included nearly \$4.1 billion in the direct costs of medical and mental health care and about \$1.8 billion in the indirect costs of lost productivity, because of victims' loss of 8 million days of paid work (CDC, 2003). Intimate partner violence can negatively affect women's earnings, job performance, and ability to keep a job (WHO, 2002). It can negatively affect the economy through workforce reductions, decreased productivity, and diminished investments. More funds are needed for victims of IPV for medical treatment, counseling services, and the justice system (UNFPA, 2003).

Qualitative Perspective on IPV Consequences

Qualitative studies present additional insight to the consequences of IPV which compliment findings in quantitative studies. Krantz, Phuong, Larsson, Thuan, and Ringsberg's (2005) phenomenological study showed that Vietnamese women perceived the consequences of violence as divorce, depression, inability to work, and negative effect to family finances. Two more important findings were parents' fears of losing control over their children and their children using violence in adulthood. Vietnamese victims also started to normalize IPV in their lives.

Oweis et al. (2009) phenomenological qualitative study revealed that participants reported their experience of IPV in terms of violence forms, frequency, severity, and impact. Participants were exposed to verbal, physical, and psychological IPV. Participants reported that the frequency and severity of IPV increased with time. Victims tolerated IPV, normalized violence against them, and justified their husband's violence. Victims rationalized the IPV in terms of financial problems, unemployment, and witnessing family violence. With time, victims of IPV blamed themselves for their husband's violent behavior against them. Moreover, victims of IPV became passive and controlled by their husbands.

Definition of IPV Screening

Operationally, IPV screening is defined as a type of practice performed by health care providers where providers ask questions about IPV and report the results of screening in the patient's medical record (Trautman et al., 2007).

The purpose and outcome of IPV screening is finding, identifying, reporting, and referring cases of IPV (Tower, 2006). Universal screening is defined as a way of asking every woman over the age of 14 years about their experience with IPV, regardless of their education, ethnicity, race, or socioeconomic status (Hindin, 2006). Spangaro et al. (2010) indicated that victims' disclosure of IPV is a very important and critical issue to break the cycle of violence. Disclosure can end victims' social isolation, validate IPV information, and increase access to community supportive services.

Spangaro et al. (2009) found that IPV screening is a complex intervention and more than asking specific questions about IPV. Intimate partner violence screening increases client engagement and help them to disclose violence against them. Intimate partner violence

screening requires an engagement among victims and screeners, a suitable environment, skillful screeners, and a victims' interest for disclosing the IPV.

Screening for IPV by health care providers can promote victims' benefits and prevent harm resulting from IPV. MacMillan et al. (2009) stated that screening is associated with improving quality of life and decreasing depression for IPV victims. Houry et al. (2008) indicated that there was no adverse effect related to IPV screening and community resources were used more by patients who screened positive for IPV.

Spangaro et al. (2010) indicated that screening, especially at health care settings with established protocols for asking patients and referring them to the needed resources, can provide opportunities for victims of IPV to disclose violence against them and receive further intervention. Bacchus et al. (2002) identified the significance and beneficial role IPV screening can play in the lives of IPV victims. But if IPV screening is not done in the right way, it could result in harm.

The Rate of IPV Screening among Nurses

Intimate partner violence screening by nurses is very low even though nurses' are more likely to screen for IPV, because they have the first contact with patients in most health care settings. Trautman et al. (2007) stated that about 99% of victims were screened by nurses while only 1% by other health care providers. Malecha (2003) found that 10% of nurses screen for IPV. Smith et al. (2008) found that about 27% of nurses suspected the existence of abuse, but did not screen or report cases of IPV. Thurston et al. (2007) found that approximately 39% of nurses were screening. Felblinger and Gates (2008) reported that approximately 16.2% of occupational health nurses were screening for workplace IPV.

Klap, Tang, Wells, Starks, and Rodriguez (2007) indicated that about 7% of women were screened for IPV by their health care providers. This study found that 46% were screened in a primary health care setting, 24% in mental health settings, 11% in EDs, 3% in gynecologic clinics, and 16% in other settings. Also, this study reported that women who showed risk factors for IPV relationships were screened in low percentage. Only 23% of women with drug abuse problems, 18% of women with mental health problems, 21% of women who recently ended their intimate relationship, and 10% of women with alcohol use disorders were screened for IPV.

Spangaro et al. (2010) conducted a cross-sectional study among women seeking care at Australian health care settings. Fifty-six percent of women that screened positive for IPV reported that this was the first time that they had been screened. About 43% of positive IPV screened women were referred to supportive community services. About 35% of them actually contacted supportive services. Also, about 14% of women who screened negative reported that they experienced both physical and mental abuse by their partners but they refused to disclose the IPV. Half of both groups still received information about IPV.

The screening of IPV in Jordan is also variable. This phenomenon is underestimated and underreported related to different barriers encountered by nurses, the victims, and the health care system. Jordanian women tend to not disclose, because they are not supported by their families and are unable to leave abusers for the sake of their children (Oweis et al., 2009). No studies were found that reported the barriers to screening for IPV by Jordanian nurses.

Variation between the percentages of prevalence of IPV screening among nurses and other care providers may be due to different instruments. MacMillan et al. (2006) reported

different percentages regarding using two screening tools for IPV in Ontario, Canada. The Partner Violence Tool (PVT) showed higher prevalence during screening (17.7% at EDs, 8.4% at family clinics, 7.6% at women health clinics) and the Women Abuse Screening Tool (WAST) showed lower prevalence (16.9%, 7.8 %, 5.9%) for the same settings. Wathen, Jamieson, and Macmillan (2008) compared two instruments for IPV screening in Ontario-Canada. Study findings showed that the WAST identified 22% of women undergoing IPV, while the Composite Abuse Scale (CAS) identified 14.4% of IPV cases.

Nurses Role in Screening for IPV

Health care providers play a crucial role in preventing IPV, identifying victims of abuse early, providing victims with the necessary treatment, and referring them to the appropriate resources. Interventions should be provided using a comprehensive approach (Garcia-Moreno et al., 2006).

Nurses are in a unique position, because they have the first contact with patients. Also, nurses promote an environment of patient disclosure and can implement appropriate interventions. Studies introduced a variety of nurses' roles toward IPV issues. Also, studies indicated victims' needs when seeking care at community health settings.

A variety of statistics revealed screening prevalence among nurses ranging from 16% to 39% (Klap et al., 2007; Thurston et al., 2007). Houry's et al. (2008) study showed that about 25.7% were identified as cases of IPV. But there were no safety interventions that were done to victims of IPV in the ED.

Olive (2007) found that nurses interacting with victims of IPV at community health settings should provide physical and psychological support, provide safety measures for victims,

refer them to other professionals such as social workers, maintain victims' forensic records, provide education about IPV and community resources, prepare needs assessments for them and their children, and promote their self-efficacy. Cann, Withnell, Shakespeare, Doll, and Thomas (2001) focused on the importance of sufficient knowledge of IPV within nursing practice including providing education, support, and proper documentation. Djikanovic, Celik, Simic, Matejic, and Cucic (2010) found that health care providers should provide empathy and understanding for victims' sensitive situation. Furthermore, they should provide support, collaborate with other community supportive networks, and encourage victims to disclose the violence against them.

Sugg (2006) reported the significance of establishing appropriate interventions for victims of IPV through appropriate education about IPV, competency in using screening tools, and institutional support. It is important to provide culturally appropriate interventions for non-English speaking women. Also, there is a critical need for a short, valid, and reliable screening tool for use in health care settings. Moreover, education about the prevalence, consequences, best practices, and interventions toward victims of IPV are very important. Administrative, institutional, and professional organizational support are also very important.

Johnston (2006) found that a nursing care approach for victims of IPV includes providing care and comfort by showing competence in responding to client needs, protecting victims from harm, promoting their dignity, developing safety plan with victims, and promoting victims' resilience. Haggblom and Moller (2006) indicated that nurses perceived the importance of therapeutic dialogue with victims of IPV. Therapeutic dialogue included understanding victims' process of a leaving violent relationship, increasing victims' awareness for consequences of IPV,

promoting victims' self-confidence, and helping them in deciding whether to stay or leave the violent relationship.

Chang et al. (2005) reported that victims of IPV reported several needs from health care providers at community settings. Victims of IPV needed an environment and rationale for asking victims, insuring support and safety measurements, and providing counseling and information for community supportive services.

Services Provided to Victims of IPV

Studies showed the existence of a variety of services for victims of IPV who seek care at health care settings. Studies presented findings in terms of types of services, effectiveness of services, location of services in urban and rural areas, and health care providers' responses and perceptions when education and training for IPV was provided to them. Studies reported the difference between services and the interventions provided for victims among health care settings.

Parker, McFarlane, Soeken, Silva, and Reel (1999) investigated the effectiveness of intervention programs for victims of IPV. The intervention group showed less violence than the comparison group at 6 and 12 months post-delivery. Spangaro et al. (2010), Trautman et al. (2007), and Crandall et al. (2009) reported services provided to victims of IPV. Spangaro et al. (2010) cross-sectional study revealed that about 56% of positively screened victims were referred to community supportive services. These services included hospital social workers (23%), police (14%), IPV advocacy services (13%), and the 24-hour IPV emergency hotline (7%). Trautman et al. (2007) reported that about 53% of IPV victims were referred to social workers. Social workers did not provide supportive services for about 77% of victims' of IPV. Crandall, et

al. (2009) conducted a mixed-method study and reported that 90% of Illinois trauma centers were found to have a screening protocol. About 51% of health care providers working at urban centers were screening all patients and about 75% of rural providers were screening. About 93% of services provided are social consulting. Other services involved outside referral (19%), sexual assault violence examiners (6%), psychiatric consultant (11%), pastoral care (6%), drug and alcohol counseling(2%), and IPV brochures (2%).

Yun, Swindell, and Kercher (2009) presented an insight for the services provided to victims of IPV. This mixed method study aimed to differentiate between the services of IPV victims that are provided to IPV in Texas rural and urban settings. Less services in the rural area were provided when compared to urban areas ($t=-6.27$, $p<.001$). Also, this study indicated lower state and federal funding for these services, 25% in the rural areas and 48% in the urban areas. Also, health care providers at rural areas received less training hours than urban providers (30 versus 50.5 hours). Furthermore, 22% of participants thought that both the information and training provided to them for IPV were inadequate. Study respondents qualitatively perceived the need for external financial support for IPV services. They also indicated the importance of educational programs to address IPV and the importance of continuing education for IPV prevention.

Nurses as Victims of IPV

Nurses as women also experience IPV. Studies showed a variety of percentages toward the rate of IPV among nurses who were providing services for victims of IPV in health care settings. Bracken et al. (2010) found that about 25% of nurses had experienced physical or

sexual violence and about 22.8% of them reported experiencing lifetime emotional abuse by their intimate partner.

Diaz-Olavarrieta, Paz, Cadena, and Campbell (2001) found that about 42% of Mexican nurses reported emotional abuse during adulthood by their partners. Also, 18% of nurses reported lifetime physical and/or sexual abuse by their partners. Early and Williams (2002) conducted a cross-sectional study among registered nurses from seven urban and suburban hospital EDs in a Midwest metropolitan area. Their findings confirmed Diaz-Olavarrieta's et al. (2001) findings with a 40% rate of IPV among registered nurses.

Christofides and Silo (2005) reported the rate of IPV among nurses who personally experienced a relative or friend undergoing IPV, and the quality of nursing care toward victims of IPV by the context of personal experience of IPV. This descriptive quantitative study among South African nurses reported the rate of IPV and nurses interventions toward victims of IPV. Study findings showed that 14.6% of nurses reported physical abuse and 37.7% reported emotional abuse. In addition, 40% of nurses reported IPV incidence among friends and relatives. About 81.6% of nurses reported that they saw victims who experienced IPV. Also, nurses with a relative or friend that was a victim of IPV exhibited better quality of care toward victims of IPV than nurses who did not report personal experience of IPV.

Haggbloom and Moller's (2006) grounded theory qualitative study revealed that 3 of the 10 nurse participants had experienced IPV. Nurses reported that they witnessed family violence during childhood. Also, nurses in this study experienced being left without help and left with feelings of frustration and anger.

Education Needed For Nurses toward IPV

Nurses' screening of IPV role dictates several roles and attitudes to promote the environment for disclosing. The roles demand certain knowledge and training toward IPV issues. Intimate partner violence knowledge can be gained through formal education introduced through a nursing curriculum. Continuing education is another area where nurses seek knowledge and insure updating for evidence based practice. Also, studies indicated that it is significant to insure appropriate and sufficient training toward IPV including skills in asking questions, competency in using screening tools, proper reporting and documenting the findings of screening, establishing rapport relationship, and establishing effective communication.

Nurses should become knowledgeable about IPV through educational programs. They should understand their victims properly and understand the cycle of violence and victims' level of dependency. Also, nurses should be knowledgeable about victims' cultural, physical, and spiritual context. Furthermore, nurses should know the appropriate referral resources, proper counseling, and legal community support services (Johnston, 2006).

Lutz (2005) supported the findings of Johnston (2006) about the importance of knowledge of community resources. In addition, according to Lutz (2005), nurses should show competence in screening, have a plan for the care of detected cases, provide health education for patients about resources and supportive assistance, and a proper approach when dealing with victims of IPV including respecting, trusting, being non-judgmental, and empathic. Also, nurses should recognize the dynamic nature of IPV.

Bacchus et al. (2002) emphasized the critical role that health care professionals play in determining victims' perceptions of the services they receive. Also, the study findings

emphasized the importance of specialized skills in communicating with victims of IPV, the need for ongoing training and education to appropriately deal with IPV situations, the presence of an IPV protocol, and community resources to support victims of IPV.

Stinson and Robinson (2006) indicated that continuing education is significant for nursing staff at health care settings. Curricula should include the definition, screening tools and interventions, recording and reporting, interventions, and the caring of victims for IPV. Also, Tufts, Clements, and Karlowicz (2009) presented the importance of integrating IPV content and formal education into the nursing curriculum to enhance their knowledge and skills.

Studies revealed the positive impact of education and training for nurses toward IPV screening. Johnson et al. (2009) and Schoening, Greenwood, McNichols, Heermann, and Agrawal (2004) reported positive changes in nursing attitudes and competency when dealing with victims of IPV after IPV training. Johnson et al. (2009) conducted a longitudinal study among pediatric nurses to find the impact of participation of IPV screening curriculum. The study showed that a 30-minute curriculum on IPV screening was accompanied by a significant improvement among nurses for IPV screening ($p = 0.012$), improvement in the nurses' perceived self-efficacy ($p < 0.001$), and decreased fears toward interacting with victims ($p = 0.0176$).

Schoening et al. (2004) conducted a quasi- experimental study to investigate the impact of educational programs on nurses' knowledge and attitudes toward IPV. Educational programs led to an improvement in nurses' attitudes. The post-test scores were significantly higher in groups who had previous training than nurses who had no previous IPV training ($t(50) = 2.08, p < 0.05$).

Davila's (2006) mixed method study supported the findings of Johnson et al. (2009) and Schoening et al. (2004) about the effectiveness of IPV educational programs in improving nursing attitudes of and interventions for IPV. Davila (2006) investigated nurses' needs about IPV and implemented an educational program to enhance their practice. Phase I of the study revealed the nurses lack of knowledge regarding community resources for IPV and their incompetence related to the skills of IPV intervention. Phase II of their quasi-experimental study showed that training programs resulted in a significant improvement in nurses' skills (pretest mean 3.6, posttest mean 4.8, $p < 0.003$).

Hagblom and Moller (2006) indicated that training and supervision for nurses was important to promote nursing competence, enhance confidence, and increase awareness when dealing with victims of IPV. Training programs should direct nurses to identify victims of IPV, how to approach and ask questions, how to intervene and provide help, and how to deal with such a sensitive subject. Stenson, Saarin, Heimer, and Sidenvall's (2001) exploratory qualitative study showed that teaching providers about referral and appropriate interventions can significantly increase confidence in dealing with IPV.

Factors that Increase IPV Screening by Nurses

Several factors can increase IPV screening. These factors were discussed in terms of the existence of educational and training programs for health care providers, competency in skills in dealing with victims of IPV, victims-care provider trust relationship, and others.

Hamberger and Phelan (2006) showed factors that could increase the likelihood of screening and success of interventions at health care settings. The factors include educational programs, screening protocol implementation, and providing a suitable environment for

disclosing sensitive information. Roark (2010) and Olive (2007) reported similar findings emphasizing that a nursing educational program on IPV can increase nurses' confidence and competency in screening for IPV. Olive (2007) emphasized the significance of ongoing professional nursing education and training toward IPV. Spangaro et al. (2010) found that screening programs with well-established protocols and policies at community settings can encourage IPV victims to disclose and assure appropriate interventions.

Thackeray et al. (2007) presented new insight into factors that promote victims of IPV disclosure. This study found that victims showed more comfort to disclose if they were screened by same race health care providers, females, persons between 30-50 years old, and without the presence of family members or friends. This study stated that screening is more than asking questions. Screening included an interaction among screeners and victims. Screeners should be attentive to victims' guilt and shame when disclosing the IPV acts against them. This study indicated the importance of providing several opportunities for victims to disclose IPV, methods of screening, offering easy written material, safety care plans, and access to supportive community resources.

Nurses should establish a trusting relationship with victims and spend enough time to promote safe environment for disclosure (Hindin, 2006; Svavarsdottir, 2010). Trautman et al. (2007) showed that computer screening for IPV could significantly increase detection rates, referrals, identifying cases, and providing services.

Liebschutz, Battaglia, Finley, and Averbuch (2008) conducted a qualitative study to describe the benefits and problems associated with IPV victims disclosing the violence to their clinicians. Victims' disclosure was not associated with harm. Disclosing IPV was associated with

benefits as perceived by victims including ending violent relationships, reporting violence against them, improving self-esteem, being aware of alternatives, and feeling empowered. Also, participants perceived positive attitudes toward their care givers. Some problems associated with victims disclosing included fears about personal safety. On the other hand, participants showed frustration and disappointment toward clinicians' avoidance and poor communication toward safety measures and referral to community resources. A clinician's negative approach resulted in victims' increased emotional distress and disappointment.

Koziol-McLain, Giddings, Rameka, and Fyfe (2008) supported the findings of the previous qualitative study. This qualitative study stated that 97% of study participants encouraged IPV screening and interventions. Study participants perceived no harm was associated with IPV screening. Benefits for disclosing and providing interventions included gaining information about IPV, increasing their awareness, being supported and cared for, and being assured by health care providers.

Colarossi, Breitbart, and Betancourt (2010) supported the findings of the previous quantitative and qualitative studies. This study showed that nurses perceived some aspects that can promote and enhance their practices toward IPV issues. Nursing practices included providing knowledge and training about IPV, providing written material about supportive community resources, activating health institution protocols for IPV, and conducting both written and verbal screening for all clients which can help in developing intervention for IPV.

Barriers to Screening for IPV

Screening barriers are operationally defined as those factors that encounter nurses and prevent them from screening victims of IPV (Furniss et al., 2007; Haggblom et al., 2005;

McGrath et al., 1997). Several barriers exist and prevent nurses from screening. These barriers are nurses' attitudes, nurses' beliefs, victims' barriers, and system barriers (Furniss et al., 2007; Goldblatt, 2009; Haggblom et al., 2005; Heinzer & Krimm, 2002; McGrath et al., 1997; Smith et al., 2008; Woodtli, 2001). In addition to these factors, Johnson et al. (2009) found that poor self-efficacy can prevent nurses from screening for IPV. These findings will be discussed in the following sections.

Nurses' Attitudes as a Barrier

Attitudes are operationally defined as different feelings that affect nurses' behavior and prevent them from screening. Attitudes include anger, frustration, empathy, discomfort, and fear (Furniss et al., 2007; Goldblatt, 2009; Haggblom et al., 2005; McGrath et al., 1997; Smith et al., 2008; Woodtli, 2001). Nurses' attitude toward screening is considered an important factor that prevents nurses from screening. Haggblom et al. (2005) conducted a descriptive study to investigate nurses' knowledge, training, and practices toward caring for victims of abuse. Nurses' attitudes toward victims of IPV included anger and frustration, because victims were returning to and staying in abusive relationships. Furniss et al. (2007) and Smith et al. (2008) descriptive studies revealed nurses' fear of abusers' reaction and retaliation, denial of the IPV situation, and being uncomfortable for being legally involved. Furthermore, Savarsdottir and Oligysdottir (2009b) supported the findings of Furniss et al. (2007) and Smith et al. (2008) toward nurses' concerns for dealing with such a sensitive subject. McGrath et al. (1997) showed the same findings toward nurses' feelings of discomfort and not wanting to be legally involved. Similarly, Heinzer and Krimm (2002) showed that nurses were uncomfortable when asking women about IPV.

John, Lawoko, Svanstrom, and Mohammed (2010) conducted a cross-sectional study among professional health care providers in Kano and Nigeria aiming to investigate factors related to IPV screening. This study revealed that Yoruba care providers who were female and younger were less likely to perceive the existence of professional role conflict for IPV screening in comparison to other health care providers. Female physicians were less likely to blame victims of IPV. Physicians and nurses showed more empathy towards victims of IPV. Muslim and Protestant health care providers were more likely to perceive the role and the importance for referral to social and religious networks.

Henderson's (2001) qualitative study revealed similar findings to other quantitative studies. Nurses experienced frustration, disbelief, rage, and fear. Nurses also experienced verbal threats and physical intimidation from victims, relatives, and visitors. Hindin's (2006) qualitative study supported the findings of Henderson (2001) in that nurses experienced fear toward dealing with women from other cultural groups. In addition, nurses' were frustrated with the outcomes of IPV. D'Avolio (2011) reported nurses' fears about leaving victims of IPV without appropriate intervention and lack of institutional resources to meet victims' needs.

Stenson, Sidenvall, and Heimer's (2005) descriptive qualitative study revealed several themes toward nurses' attitudes. The first theme described midwives' feelings of failure and frustration, because they were not screening all the clients, distressed and angry when victims shared their stories, and worried about the victims' future. The second theme revealed the presence of the partner and its influence on their practice. Midwives perceived their roles for IPV were caring, supporting, and educating for victims of IPV.

Nurses experienced different complex attitudes toward IPV victims including feelings of responsibility, care, anger, and being overwhelmed (Goldblatt, 2009). Woodtli (2001) described nurses' attitudes toward survivors and perpetrators of IPV relationships. Nurses' attitudes toward perpetrators revealed compassion, fear, and feeling sorry. Nurses' attitudes toward survivors revealed care, respect, and empathy.

Haggbloom and Moller's (2006) qualitative grounded theory study indicated that nurses were frustrated, overwhelmed, fearful, anxious, stressed, angry, and powerless related to IPV. Nurses had fear and anger when victims' were physically injured by their partners. Frustration resulted from other nurses who failed to identify victims, physician reluctance to properly intervene, offensive attitudes of the legal system, social workers lack of knowledge, and an absence of support from administration and the health institutions. In addition, nurses had respect, empathy, and understanding for IPV victims. On the other side nurses showed that they had self-blame and guilt similar to the victims of IPV.

Minsky-Kelly, Hamberger, Pape, and Wolff (2005) revealed that nurses and mental health care providers encountered several barriers. They included heavy work load, no time to establish trusting relationships with patients, concerns about privacy, and lack of appropriate community resources. Participants experienced discomfort, anxiety, ongoing fear, and avoidance of IPV screening. Participants expressed their frustration toward the issue of IPV. Frustration was defined in terms of clients' refusal for help, no time to establish trusting relationships with victims, and an absence of privacy. Participants showed their skepticism toward the effectiveness of screening interventions and identifying victims. The researcher stated that nurses and other health care providers could be victims of IPV, which made it

difficult for them to properly intervene or address IPV. Colarossi et al. (2010) indicated that nurses were frustrated, because of their inability to refer victims to needed community resources and an inability to provide an adequate intervention after victims disclosed violence against them.

Nurses' Beliefs as a Barrier

A review of the literature identified nurses' beliefs as a barrier to screening for IPV. Barriers included nurses personal beliefs' and nurses' beliefs about victims of IPV relationships. Beliefs as a barrier was operationally defined as nurses' personal opinions or facts toward victims and situations of IPV that prevented them from screening including the absence of sufficient evidence, non-nursing issue, and improper preparedness (Felblinger & Gates, 2008; Furniss et al., 2007; Smith et al., 2008). Nurses' beliefs about victims included privacy and sensitivity of IPV, victims will not disclose, victims will return and stay in the IPV relationship, and victims will be embarrassed and ashamed (Goldblatt, 2009; Haggblom et al., 2005; Smith et al., 2008).

Nurses' beliefs at most are considered myths encountering nurses toward IPV interventions. Nurses' personal beliefs included absence of evidence of IPV, nurses were not well-educated and trained to intervene for IPV, IPV was not a nursing role, and nurses were unsure and unaware of institutional policy for IPV screening (Felblinger & Gates, 2008; Haggblom et al., 2005; Smith et al., 2008).

Haggblom et al. (2005) and Smith et al. (2008) found that nurses believed a major cause of IPV was related to alcohol and drug abuse. Smith et al. (2008) indicated that about 32.1% of nurses believed there was not enough evidence to support the existence of IPV and 4.58% of

nurses were unprepared to deal with IPV cases. Findings by Felblinger and Gates' (2008) supported the findings of Smith et al. (2008) in that about 10.9% of nurses believed IPV screening was not a work-related activity to be done. In addition, 13.2% of nurses thought that IPV screening was not a nurses' role. Moreover, about 67% of nurses felt incompetent, 32% felt that their training was inadequate, and 71.1% of nurses were unsure of the existence of institutional policy for screening and intervening for IPV (Felblinger & Gates, 2008).

Tower (2006) reported that 24% of study physicians felt that screening was not relevant to their role. Furniss et al. (2007) study findings supported the findings of Felblinger and Gates (2008) and Smith et al. (2008) that indicated that 56.4% of nurses were not sure of their action toward victims of IPV, 24.4% believed it was not a nursing issue, and 31.7% were not competent in asking victims about IPV. In addition, this study found that 59.5% of nurses believed that language was an important barrier to communicate with victims. Rates varied between studies due to different instrumentation for nursing beliefs and attitudes toward screening.

Nurses' beliefs toward victims of IPV.

Nurses' beliefs about women as victims in IPV relationships are a barrier to screening. These beliefs include IPV being a private and sensitive issue, victims not willing to disclose, and victims would return to and stay with abusers. Haggbloom et al. (2005) found that about 25% of nurses thought that IPV resulted from victims' helpless personalities. In addition, nurses thought that victims would return to their abusers. Furniss et al. (2007) reported that nurses believed that IPV is a sensitive subject and victims would lie and not disclose. Smith et al. (2008) supported the findings of the two previous studies. Smith et al. (2008) showed that nurses

believed that IPV is a private issue, victims will not disclose or report the incidence of abuse, and discussing IPV will disrupt the family relationship.

Quantitative study findings are supported by Hindin (2006) and Goldblatt (2009) qualitative studies' findings. Goldblatt's (2009) phenomenological study revealed nurses' beliefs about why victims' stay in IPV relationships including victims' denial of the IPV situation, embarrassment, and being afraid to live or raise children alone. Hindin's (2006) study stated that nurses reported that victims denied the incidence of IPV and that victims' cultural backgrounds play a very important indicator for abuse. It described the male dominant role and its abusive effect on victims of IPV.

Robinson (2010) described nurses' perceptions and barriers to IPV screening. Study findings revealed that nurses held a variety of myths and stereotypical personal beliefs. These myths are described in terms of their beliefs about IPV including IPV is a social not a health problem, victims will not seek care and referral, victims will not disclose and interact with health care providers, and most women perceived IPV screening as offensive and unacceptable. Nurses were frustrated, because victims stayed in abusive relationships and nurses were unable to resolve and provide help for the victims. Nurses reported that screening for IPV could have benefits in the future. In addition, nurses were unaware of health institutional protocols and policies toward mandatory screening for all clients seeking care in community health settings.

Health Institution Barriers

Institutional barriers are operationally defined as factors present in the working environment (institution, organization) that prevent or impedes nurses from screening for IPV. Identified barriers included lack of time, lack of privacy, inactive policy, absence of formal

training, and education for health professionals including nurses. Nurses' lack of knowledge is described in terms of lack of formal education and training, and lack of knowledge of institutional protocols and policies of IPV.

Gutmanis et al. (2007) found that about 60% of physicians and nurses did not receive specific training for IPV. Furniss et al. (2007) found that 55.1% of nurses did not screen, because of lack of time, 91.7% due to a lack of privacy, and an absence of formal training (56.4% not sure what to do, 31.7% lack of knowledge). Smith et al. (2008) supported the findings of Furniss et al. (2007) showing that nurses' lack of time (2.75%) and a lack of privacy(3.66%) were problematic. Furthermore, Felblinger and Gates (2008) found that only 32% of nurses had adequate training and 70% did not know the right questions to ask. In addition, 55.8% did not know the right intervention and 62.7% did not know the manifestations of IPV.

Similarly, Haggblom et al. (2005) found a low percentage (22%)of nurses had received formal IPV education in their basic training. Approximately 91% of nurses did not know about the existence of guidelines to manage cases of IPV. This study also indicated a significant relationship between nurses' formal education, attitudes, and practices. Tufts et al. (2009) and Colarossi et al.(2010) supported the findings of the previous studies about nurses' lack of IPV knowledge. Tufts et al. (2009) found that nurses lack knowledge including experience and awareness of IPV as a social health problem. Colarossi et al. (2010) showed that nurses were unaware about knowledge for the long term effect of IPV and interventions, lack of time, absence of written material for community resources, inadequate training and preparedness for IPV issues, and an unawareness of proper documentation of IPV cases.

Nurses' lack of knowledge is described in terms of unawareness of institutional protocols and policies for screening and intervening for IPV (Furniss et al., 2007; McGrath et al., 1997). However, Crandall et al. (2009) confirmed the existence of institutional protocols. They revealed that 90% of Illinois trauma centers had a screening protocol. Hazen et al. (2007) found that about 52.8% of child welfare agencies in the U.S. had a written policy for IPV screening.

Ortiz and Ford(2005) conducted a descriptive quantitative study among 74 physicians and nurses in a military health care setting. They found that about 70% of study participants were screened for IPV. Barriers to screening included lack of time (80%), lack of education and training (72%), not being aware of institutional IPV protocols (61%), and lack and shortage of staff support (57%). This study reported that about 38% of study participants perceived discomfort when screening or educating victims and an inadequacy of referral to appropriate community resources.

Owen-smith et al. (2008) stated that only 12% of patient records indicated health care providers documented IPV screening for patients in gynecological clinics. Barriers to screening for IPV were identified and included forgetting to screen or document screening, discomfort with screening, lack of training, shortage of time, and lack of privacy and confidentiality within the institutions.

Stenson et al. (2005) described midwives experience toward institutional barriers revealing nurses' lack of time and knowledge for counseling for IPV. In addition, this study highlighted the importance of support and the assistance that should be provided by their organization. Nurses in Henderson's (2001) qualitative study experienced a lack of knowledge and formal educational content, lack of privacy, failure to care for IPV victims, and improper

emotional preparedness. Barriers in Krantz et al.'s (2005) phenomenological study to screening for IPV were health care providers' lack of knowledge of IPV, unawareness of interventions toward victims, and unawareness of IPV as a serious public health problem. Djikanovic et al. (2010) qualitative study reported a lack and weakness of social and community networks, lack of education and training on IPV issues, and feelings of insecurity and concerns toward screeners' safety.

D'Avolio (2011) indicated that study participants (18 nurses, 2 physicians) perceived time constraint as a barrier to provide screening. They described barriers in terms of the institution's expectations about health care providers' productivity which meant to provide more care, to more patients, in less time. So, time limitations prevent them from establishing therapeutic relationships to initiate and promote client disclosure. Also, participants showed that long waiting by victims of abuse at health care institutions increased their fears and anxiety for disclosing IPV. In addition, study participants reported other institutional barriers including gaps in the services provided to IPV victims, an inadequacy of supportive resources, and a lack of health institution support to health care providers.

Barriers for Victims of IPV to Disclose

Barriers exist that prevent IPV victims from disclosing their IPV. Victims of IPV come from a variety of social and cultural backgrounds. Victims hold different norms and perceptions toward their role as women and mothers in their respective cultures. Victims have fears of perpetrator revenge, losing custody of their children, and being left alone after divorce. In addition to these concerns, victims of IPV were not screened in an appropriate manner by health care providers to make them willing to disclose.

Victims disclosure rate is still very low (15%). Victims' disclosure resulting from screening does not measure the accurate prevalence of IPV (Thurston et al., 2007). Also, victims did not leave their abusers, because they feared losing the custody of their children, feared partner retaliation, absence of family support, absence of community services, poor legal intervention, and were financially dependence on their partners (Oweis et al., 2009; Garcia-Moreno et al., 2006). In addition, women rationalized the violent behavior against them. Women justified perpetrators violent acts against them as partners were unable to control their violence and the women themselves played an important role in making their husbands violent (Kearney, 2001; Oweis et al., 2009). Moreover, about 15% of women who underwent IPV did not perceive it as a personal problem (Coker et al., 2007).

In addition to these factors, Djikanovic et al. (2010) showed that victims' economic dependency and lack of trust toward community services are important reasons keeping women subjected to violence. Stenson et al. (2001) found that about 80% of pregnant women found that questions about IPV asked by midwives were acceptable and only 20% perceived them as unacceptable.

Spangaro et al. (2010) reported that about 14% of women who reported being abused intentionally refused to disclose, because they did not think it is was a serious problem, had discomfort in interacting with health care providers, worries and fears, and embarrassment or shame. In addition to these findings, IPV is an infrequent manageable problem and victims of IPV have other concerns to disclose and report that take priority.

Other important barriers were presented by Johnston (2006) and Yonaka, Yoder, Darrow, and Sherck (2007). Johnston (2006) found that victims of IPV are accompanied by self-

blame, low self-esteem, and fear. Yonaka et al. (2007) showed that victims of IPV speaking a foreign language were less able to disclose the IPV experience. Moreover, a personal history of violence within the family can also prevent the nurses from screening for IPV.

Lutz (2005) study provided a rich description for barriers to disclosure by victims of IPV, perception about factors promoting disclosure, and victims needs from healthcare providers. Lutz (2005) investigated IPV among pregnant women, their decisions to seek care and disclose violence, and their perception to preferable health care providers' response. Victims did not disclose because of a feeling of embarrassment and shame about IPV, fear from judgmental approach of health care providers, and feeling guilty of partner response to disclosing. Study participants stated their preference to be screened by female health care providers and someone of their own cultural and religious background.

According to Lutz (2005), study participants presented their frustration when they were not screened, if health care providers did not provide adequate information, or if their concerns were ignored or minimized. Also, participants felt that a supportive health care provider can provide feasible and appropriate information about IPV, if they were treated with respect, and if the care provider is concerned about their safety, happiness, and well-being. Participants' mentioned factors that increased the likelihood of disclosing abuse which included provider manner, content and timing of screening, and motivation of health care providers to screen, being treated with concern, respect and connection, understanding women's cultural background, and the occurrence of a convenient time ending IPV relationship. In addition, participants stated factors that prevented them from disclosing which included if the care provider is not interested, not believing the occurrence of IPV, lack of concern toward IPV,

being embarrassed, being judged negatively, stigma of being a victim of IPV, or being pregnant. Study participants perceived their needs from health care providers as sharing information about IPV relationship and educating pregnant women about IPV while pregnant and not pregnant.

Bacchus et al. (2002) described women's perceptions about caring for IPV cases in maternity units. This study showed that women perceived midwives approach as not caring and not responding to victims disclosing. Participants mentioned some factors that can promote disclosure which included nurses being comfortable and confident in dealing with IPV cases, being non-judgmental, showing interest, having interpersonal skills to communicate with victims of IPV, having enough time, and creating a safe and confidential environment. Participants identified some needs of victims of IPV such as support, encouragement, and reassurance. Study participants believed that health care providers most capable to deal with IPV should be female, a midwife, and capable and competent in dealing with IPV issues. Study participants presented factors preventing them from disclosing abuse against them such as being judged, feeling embarrassment and shame, not knowing how to start disclosing, uncertain if health care providers were interested or qualified to deal with IPV, confidentiality concerns, and fear about losing their children.

Jordanian Arab Muslim Culture and IPV

Middle East countries or Arabic Muslim countries are characterized by moral and ethical values that are transmitted through generations and reflected in social norms, traditions, religion, and legal practices. Cultural norms prioritize honor and shame over other moral values. Women living within a patrilineal kinship leads to protection for women by their fathers and

brothers and women are welcomed by their family during times of marital conflict or divorce (Kulwicki, Aswad, Carmona, & Ballout, 2010).

Middle East countries reflect a conservative Arab Muslim culture. Islam is the main social and cultural framework for most of the Arab Middle East countries. Islam respects and affords women's rights in all life matters. Islam gives women the right for education, occupation, choosing a husband, and divorce (Ayyub, 2000). Islam dictates male and female roles particularly in marital relationships. Islam insures that women have respectful attitudes toward their husband as written in the Qur'an (Haj-Yahia, 2002).

Muslim women should fit the roles of wife, mother, and daughter within the context of their culture, religion, and family of origin. Muslim women experiencing IPV are referred to their religion and culture for marital conflict resolution and support. Muslim women are faced by cultural resistance when leaving martial relationships, because Arab Muslim countries have implemented traditional norms beyond Islamic rules (Ayyub, 2000). So, women in Arab Muslim countries are not granted the rights awarded to them by God for protection against IPV (Douki, Nacef, Belhadj, Bouasker, & Ghachem, 2003).

Intimate partner violence is justified in the Arabic cultural context when a wife is perceived as misbehaving. A wife beating is justified by misinterpretation of Qur'an commandment about wife beating. This wrong perception leads to victim silence preventing the family, legal system, and victims of IPV to take appropriate actions against IPV perpetrators. So, for many Arab Muslim countries IPV is not considered a serious or major priority. Moreover, many Arabic countries refuse legal interventions that would treat IPV as a crime; IPV is

considered a private matter. So, the problem of IPV remains hidden in Arab Muslim countries (Douki et al., 2003).

The cultural norm of Arab countries mandates that victims accept violence in their lives for the sake of family honor and prevent the shame resulting from divorce. The family role in IPV is to provide support for women. Victims of IPV are faced with economic dependence, lack of education, lack of family support, and an unawareness of community services. Moreover, Arabic women are conservative when discussing sensitive and confidential family matters such as IPV with health care providers (Kulwicki et al., 2010). Moreover, Arabic Muslim women do not report IPV for the sake of family reputation, because reporting could lead to family harm when the women become divorced (Douki et al., 2003).

Islam introduced divorce for unresolved marital conflict and impossible continuation of marriage (Douki et al., 2003). The perception of Islam toward divorced women includes insuring mobility, respect, and the right to get married again. In contrary to Islam, the perception for divorced women in the Arab culture is biased against divorced women. Divorce is seen as the woman's fault. In many cases, divorced women are not culturally accepted and find it difficult to remarry (Ayyub, 2000).

Jordanian women live within Jordan's cultural and religious rules. Jordanian culture is conservative and believes in the dominant role of the male over the female throughout the lifespan. Women tend to stay in an IPV relationship for the sake of their children, stigma of divorce, and economical dependence on their husbands. Also, Jordanian women will not be supported by their family and culture and will experience resistance if they divorce (Oweis et al., 2009). In addition, Jordanian women experiencing IPV start to rationalize and blame

themselves for the IPV (Oweis et al., 2009). Haj-Yahia (2002) showed that 33.4%-68.5% of Jordanian women agree or strongly agree that wife beating is acceptable if their husband's manhood was threatened or he was challenged by his wife.

Overview of Jordan

Jordan is an Asian country located in the Middle East. It is one of 22 Arab Muslim countries located in Asia and Africa. Jordan is a poor country with very limited resources including limited industry and absence of petrol. About 6.11 million citizens are living in Jordan (Department of Statistics, 2010). There are about 2.69 million women and 3.15 million men. About 91%-95% of Jordanian citizens are Sunni Muslims with the remaining being Christians. Islam has a strong impact in all aspects of Jordanian life (Department of Statistics, 2010).

The Jordanian health system includes services from the government, private health providers, royal military, and United Nations for Relieving and Working Palestinian Refugees (UNRWA). The first three services provide comprehensive health care for about 65% of Jordanian citizens. UNRWA primarily provides primary health care services for Palestinian refugees. UNRWA can provide referral to other governmental health sectors for diagnostic tests and specialist care. Jordan provides one of the best advanced and scientific health care in the Middle East (Jordanian Ministry of Health, 2011).

In summary, Jordan reflects the greater Middle East Arab Muslim culture which believes in a male dominance over women including financial control, mobility, responsibility, decision making, and elderly role in determining family issues and dividing roles within family systems. The male dominant role gives the man the authority to control women. In addition, the culture

gives men the authority for unlimited control over all matters including finance, education, and socialism.

Islam attempts to uncover the devastating myths and attitudes toward women within the context of culture and some of the blind traditions. Islam attempts to liberate women from traditions that imprison and inhibit their mobility and freedom. Islam gives women the freedom of education, occupation, choosing their spouse, and sharing in the marital roles and responsibilities. Islam asks men to treat women with mercy, love, respect, and empathy. Islam introduced divorce as a way of managing unresolved marital conflict. Islam prohibits wife-beating regardless of the reason. A punishment for women who disobey God in marital issues (Nashes in Islam) is mentioned in the Holy Qur'an. These steps do not include harming, beating, or humiliating women.

Conceptual Framework

The study's conceptual framework is based on the ecological model of health promotion by McLeroy, Bibeau, Steckler, and Glanz (1988). The model describes the environmental influences on behavior that place individuals at risk for adopting and assuming a health promoting behavior. The model includes five subsystems: intrapersonal, interpersonal, institutional, community, and public policy (Figure 1). This model assumes that when implementing any intervention, healthcare providers should take into consideration the inter-influence of the five subsystems. This study will address the intrapersonal, interpersonal, and institutional subsystems.

Figure 1. *The Ecological Model.*

As applied to the context of IPV, the intrapersonal subsystem is nurses' personal beliefs and attitudes toward screening for IPV. Nurses at the intrapersonal level encounter a variety of barriers such as attitudes and beliefs. Nurses have myths and stereotypes toward victims of leaving them frustrated and angry, because they are not screening.

The interpersonal subsystem is related to nurses' interactions with other healthcare providers such as physicians, administrators, and coworkers. At the interpersonal level, nurses are confronted by victims who refuse to disclose or report violence, perpetrators who come with victims prohibiting victim's disclosure, friends and family members who come with the victims, and the absence of administrative support for screening practices.

The institutional subsystem is related to a health system's policies and procedures related to IPV. At the institutional level, nurses' lack of time to establish a trusting relationship with victims in order to do screening, lack of privacy at the health setting, and the inactivation or absence of screening protocol. In addition, nurses lack of training and education toward prevention and management of IPV.

The community subsystem is related to the culture and traditions of a population for IPV. At the community level, nurses are faced by the cultural beliefs about the definition of IPV and interventions toward victims. Nurses as a part of their community have cultural norms, religion, and traditions that reflect on their attitudes and practices toward their patients. For example, the dominant role within Arabic Muslim culture and the sensitivity of familial issues could prevent them from screening and reporting IPV.

The public policy subsystem is related to the legislation and governmental protocols identified by key health stakeholders for IPV screening. At the public policy level, nurses are confronted by the absence of legislation and laws for screening for IPV, improper legal system interventions toward victims of IPV, and an absence of community supportive resources.

Nurses as victims of IPV are faced by several barriers to disclose their personal IPV. At the intrapersonal level, nurses as victims of violence refuse to disclose IPV, because they fear losing custody of their children, fear the stigma of divorce, fear of perpetrators' revenge, and absence of family support. At the interpersonal level, nurse victims' lack trust in others for IPV disclosure. Perpetrators leave them socially isolated and control their mobility and communication. At the institutional level, nurse victims are not screened for IPV, not supported by managers and administrators, and not given time for counseling and establishment of work-

based safety plans. At the community level, victimized nurses reflect their cultural norm and rules. Female nurses accept men as superior to them, avoid disclosing family sensitive issues, and avoid seeking help from other than family members for the sake of their children, family reputation, and the prevention of the stigma of divorce. At the public policy level, nurses as victims of abuse do not seek out supportive community services or legal intervention.

Summary

This chapter presented the relevant literature about nurses' barriers to screening for IPV. Despite the high rate of IPV against women and the far consequences on victims' health, IPV screening by nurses remains very low. A variety of factors prevented nurses from screening for IPV including nurses' attitudes, nurses' beliefs, health institution barriers, and barriers of the IPV victims.

Concepts were used interchangeably in the description of IPV including domestic violence, marital violence, women abuse, partner violence, and physical violence. Another important issue was victims' reluctance to disclose which was related to the victims' personal fears and cultural background. Nurses' and victims cultural background was rarely covered in the literature although it may have significantly affected the rate of IPV screening. In addition, not all victims' disclose their IPV which continues to leave IPV as a hidden problem.

Nurses' attitudes toward IPV screening were contradictory. Most researchers reported negative nursing attitudes including frustration, anger, fear, and worry. Positive nursing attitudes included respect, empathy, and caring.

Limited studies were conducted with Jordanian women to report the prevalence of IPV and the barriers to IPV screening. Of particular note was the absence of a single study detailing the prevalence of IPV in a sample of Jordanian women.

CHAPTER III: RESEARCH DESIGN AND METHOD

This chapter presents the study methodology including design, settings, sample, instrumentation, study procedure, data analysis, and data management. This chapter also introduces the human subjects' protection.

Design

This study used a descriptive cross-sectional design. This design is applied when little is known about a phenomenon. Also, the cross-sectional design is used to study a group of people at one particular point in time. A cross-sectional design has several advantages including identifying the rate and the frequency of study phenomena and minimizes participant effort and risks (Houser, 2008). Cross sectional design can describe the relationship between independent variables (nurses attitudes' and beliefs barriers, institutional barriers, IPV victimization) and dependent variable (nurses' IPV screening).

Settings

The study settings included ten health centers and three governmental hospitals in a northern city of Jordan. The first hospital has 220 beds and provides treatment for acute and emergency cases, follow up care for chronic conditions in the outpatient clinic, dental care and follow up, diagnostic and laboratory tests, and surgical operations and procedures. The second hospital has 78 beds and provides a variety of gynecological and obstetrical health services including admission and care for high risk pregnancy, normal and cesarean deliveries, and a variety of gynecological and obstetrical operations and procedures.

The third governmental hospital is a 683 bed regional hospital with over 95,583 m² space. This hospital provides primary, secondary, and tertiary health care services to more than 1 million Jordanian inhabitants. It provides well-advanced technology by a well-prepared health

team. Also, it provides a variety of surgical and diagnostic procedures that are not provided by other governmental health hospitals.

The ten health centers include family planning clinics, primary health care centers, and maternal and child health care centers. The health care centers provide preventive, supportive, and referral services. Health centers provide family planning for female patients, medical treatment, vaccination and growth follow up for infants and toddlers, and referral to other specialty clinics.

The health centers and two smaller governmental hospitals provide services to the Jordanian citizens that have governmental health insurance. Governmental employees working at educational, health, infrastructure institutions, and community services are medically insured by governmental health insurance. Governmental health insurance applies a monthly premium payment for health services. About 65% of Jordanian citizens are medically insured by governmental, military, private, and UNRWA. The remaining 35% of Jordanian citizens' and non-Jordanian citizens have to pay out of pocket for the health services provided to them.

University employees in the study city are eligible to be treated at the larger, regional hospital and other private and governmental hospitals in Irbid city. University employees pay a monthly premium for their health insurance as well as a 10%-20% co-pay for all hospital bills and treatment costs.

Unlike hospitals in the U.S., male and female patients are separated into separate units at the Jordanian hospitals, with the exception of the emergency departments. Study settings will only include female units and the emergency departments.

Sample

A proportional stratified random sample was used to promote population representativeness. The strata sample was based on Jordanian health settings because it was the only variable with available data. The exact number of nurses, qualification, years of nursing experience, and other specific data were not given by Jordanian hospitals and authorities. A list of female hospital units at the study settings was identified and a roster of nurses from these units obtained. A simple random sample of nurses working from the eligible health settings was recruited. Nurses included registered nurses (RN), diploma nurses (DN), and midwives (MW).

Nurses were eligible to participate if they were (1) Jordanian, (2) a registered nurse, diploma nurse, or midwife, (3) live in the study city, (4) spoke and understood Arabic, and (5) work in emergency departments , antenatal clinics, or female hospital wards.

According to the Jordan Ministry of Health (2008), there are about 2,893 nurses working at the governmental health settings in the study and 1,359 nurses working in the study sites. The eligible number of nurses by job classification and health setting are presented in Table 1.

Table 1.

Number and classification of nurses eligible for study participation.

Health setting	Registered nurses	Midwives	Diploma nurses	Total
Hospital 1	188	1	205	394
Hospital2	22	60	65	147
Hospital 3	447	14	102	563
Health centers	13	71	171	255
Total	670	146	543	1,359

Power calculations were determined using DSS Research's power calculator (2010). The study would yield 95% power ($\beta = 0.05$) if 117 nurses participated assuming a test value of 39% (the reported IPV screening rate in the U.S.), Jordanian nurse screening at 25% (hypothesized value), and $\alpha = .05$. If 94 nurses participated, 90% power ($\beta = 0.10$) would be achieved, and if 69 nurses participate, 80% power ($\beta = 0.20$) would be achieved assuming the same α , test value, and hypothesized value. Based on achieving 95% power and assuming that 15% of cases would need to be deleted due to incomplete data points, it would be necessary to recruit participation from 138 Jordanian nurses.

Based on population numbers from Table 1, a strata sampling from the health settings was used. Table 2 presents the minimum desired sample size from each health setting not accounting for attrition.

Table 2.

Stratified sampling recruitment chart.

Health setting	Sample proportion	Recruitment number
Hospital 1	20%	25
Hospital 2	20%	25
Hospital 3	40%	50
Health centers	20%	25
Total	100%	125

Study Instrument

There were three parts to the study survey (see Appendix A). Part I was the Domestic Violence Health Care Provider Survey (DVHCPS). Part II was the Women Abuse Screening Tool (WAST). Part III was a demographic survey.

DVHCPS Instrument

The DVHCPS (Part I of the survey) was developed to measure healthcare providers' IPV knowledge, attitudes, beliefs, and the ability to apply this knowledge in daily practice and IPV screening. The Domestic Violence Health Care Provider Survey was developed by the Group Health Cooperative and Harborview Injury Prevention and Research Center (1997). This instrument was previously validated and indicated a comprehensive scale to study health care providers' readiness to screen for IPV (Maiuro et al., 2000). The instrument is psychometrically sound with an overall scale Cronbach alpha found to be acceptable ranging from 0.73 to 0.91 (Maiuro et al., 2000). This instrument was developed and validated to be used in the U.S. This

instrument was not validated in the Jordanian culture and was used for the first time in Jordan to investigate nurses IPV screening rates and barriers.

The DVHCPS includes 42 items with a 5-point Likert-scale ranging from *Strongly Disagree* to *Strongly Agree*. Survey items are categorized under six domains. These domains include self-efficacy (7 items), system and institutional barriers (4 items), victim blaming (7 items), professional role resistance (7 items), victims' providers' safety (10 items), and frequency of IPV screening (7 items). This instrument was used to measure the study's first and second aims related to the rate of IPV screening and barriers of IPV screening among Jordanian nurses.

Nurses' barriers to screening were operationally defined by the DVHCPS dimensions. The self-efficacy subscale includes questions about the participants' ability to intervene properly for victims of IPV. The victim blaming subscale includes participants' perceptions and beliefs toward victims of IPV such as cultural factors and barriers. The providers' safety subscale includes questions about participants concerns and interest in personal safety and victims' safety after disclosing. Professional barriers include questions about participants' perceptions and beliefs about the screening for IPV as a professional role. Institutional barriers include questions about the availability of community supportive services for victims of IPV.

WAST Instrument

The WAST (Part II of the survey) was developed by Brown, Lent, Brett, Sas, Pederson (1996). This instrument measures the frequency of physical, sexual, and psychological violence. The reliability and validity of the WAST is acceptable. The WAST was validated as a measure of violence with women in a family practice setting. Also, this instrument was used with clients

and family physicians who indicated comfort with using this instrument. Reliability was tested by Cronbach's alpha (0.95) that indicated good internal consistency.

Eight items from the WAST were measured with a 3-point Likert-scale (often, sometimes, never). The first two items reveal the experience of IPV. The other six items investigated the form of violence (physical, sexual, and psychological violence). This instrument was used to measure the third study aim for the rate of IPV among nurses as victims of IPV. Also, it was used to identify nurse victims for comparing IPV screening based on personal victimization.

Demographic Survey

The demographic survey (Part III of the survey) obtained information on study participants' age, sex, marital status, educational level, years of experience, and health setting/units where they work. Demographic information provided a description for study participants. With the exception of age and years of experience, questions used forced-choice responses.

Procedures

Instrument Content Validity

The instruments were developed for a Western culture. As a result, the validity and reliability of the instruments were assessed for this study. A group of 10 Jordanian nurses working in administration, the emergency department, the obstetrical/gynecology unit, and medical/surgical units were asked to evaluate the content validity of the DVHCPS and WAST. Each nurse determine whether the study instrument and individual items are relevant, clear, simple, and unambiguous for measuring nurses' barriers for IPV screening within the cultural

context of Jordanian nursing practice. Each survey item was ranked on a four-point Likert-scale (e.g., 1=not relevant, clear, simple, or culturally appropriate and is ambiguous; 4=very relevant, clear, simple, culturally appropriate as well as the meaning being very clear). The number of experts that indicated a score of 3 or 4 (meaning that the item was generally relevant, clear, simple, and unambiguous) was divided by the total number of experts to yield a Content Validity Index (CVI; Polit & Beck, 2006). Any survey item with minimum CVI of 0.78 were deemed valid and used without change for the study. Any item with a CVI less than 0.78 was reviewed by the principal investigator and dissertation chair. Two of the items yielded CVI of 0.7. Both items were retained due their study relevance for IPV screening. Remaining items yielded a CVI of 0.9 to 1.0 reflecting adequate instrument validity. Internal consistency reliability of the DVHCPS reflected sound reliability for the data in the current study; the overall Cronbach's alpha was 0.736. The Cronbach's alphas for the instrument domains ranged from 0.504 to 0.714.

Instrument Translation

The study instrument translation process for an Arabic version of the instrument was performed by two English professional translators holding a PhD degree in English studies residing in Jordan (see Appendix B). A reverse translation was done to ensure that there were no differences during the translation process. The first translator translated the instrument from English to Arabic and the second translator reverse translated the Arabic version of the instrument into English. The new translated English version was compared to the original instrument and submitted to the University of Cincinnati IRB for approval.

Preparation

The University of Cincinnati IRB approved this study, study instrument (see Appendices A and B), and letter of information for research (see Appendices C and D). Approval of the hospital IRB and local health official were also obtained. Next the Local Department of Health official directing the governmental hospitals and health clinics and nursing head director were approached in order to obtain the list of health centers names, locations, types, current nursing census at each health setting, and nurses education.

Data Collection

The primary investigator met with the hospital physician and nurse executives to explain the study purpose and Jordanian subjects' rights (Figure 2). Upon their approval, a random sample of hospital units and a random sample of health clinics were selected for study recruitment. Nursing managers were approached to obtain a list of nurses working in their departments. Each roster had 10-20 nurses (1,359 total nurses were eligible based on the department rosters). Two to three nurses were randomly selected from each hospital unit and health clinic roster to yield a sample of 125 nurses. After agreeing to hear about the study, potential participants were read the information sheet that detailed the study purpose, risks, benefits, voluntariness of participation, and right to withdraw or refuse to participate (see Appendices C and D). Nurses pronounced verbal consent and were given anonymous paper copy of the study survey and filled it in a private room to assure their confidentiality. Participants completed the Arabic version of the study survey over a 15 minute period while alone in a private room. Upon completion, participants put the survey in a locked box held by the researcher and were given a gift with a \$5 value as compensation for their participation.

Figure 2. *Diagram of the study data collection process.*

Data Management

Data were collected by the principal investigator during summer 2011. At the end of each day, the anonymous surveys were removed from the locked box and a code number applied. Surveys were stored in a locked file cabinet. Surveys were securely transported back to the U.S. by the principal investigator. The survey data were coded and double entered into an SPSS 19 (Chicago, IL) data base by the principal investigator and a research assistant. The double entered data were cross checked to ensure accurate data entry prior to data analysis. The original surveys were reviewed for mismatched pairs and the database was corrected.

Data Analysis

Data were analyzed using SPSS 19 (Chicago, IL) software. Descriptive statistics were computed for demographic and survey data. This analysis was conducted for the first and second study aims in order to determine the rate of IPV screening by Jordanian nurses as well as it reported nurses' barriers to screening for IPV. A one proportion z-test was computed to determine if the IPV screening rate by Jordanian nurses was significantly less than the IPV screening rate of 39% by U.S. This percentage was selected, because this statistic was the only percentage reporting IPV screening in a general setting by the general practicing nurse (albeit Canadian nurses). Other studies reported screening frequencies by physicians or specialty nurses (i.e., occupational health nurses). Frequencies and percentages were calculated to determine the agreement of the presence of IPV barriers. Chi-square Goodness-of-Fit tests were computed to compare the frequency of violence against participants in this study to statistics reported by Bracken et al. (2010) for physical (25%), psychological (22.8%), and sexual (25%) violence against nurses in the United States. A two-tailed two proportion z-test was then computed to determine if the IPV screening rate by Jordanian victimized nurses was significantly different than the IPV screening rate of non-victimized Jordanian nurses. All statistical analyses were based on alpha 0.05.

Human Subjects' Protections

The study protocol was approved by the Institutional Review Board from the University of Cincinnati Social and Behavioral Sciences prior to the study start. In addition, the Jordanian hospitals IRB approved the study. Official permission to conduct and recruit for this study had

been already granted by the Head Officer at the Department of Health in the northern city in Jordan where data were collected.

Participants completed the study survey in a private room. No names or other identifiers were requested or placed on the survey. No code key or roster was generated to match individual data to a particular participant. Only aggregate data were reported.

Study surveys were maintained in a locked box carried by the principal investigator during study visits and data collection. At the end of each day, the surveys were securely locked in a file cabinet. Nurses were informed that their study participation was voluntary and not a requirement of their employment. In addition, no data were individually reported to managers at the health settings. Nurses were given the right to withdraw from the study at any time before the survey packet was dropped into the locked box, however, no nurses withdrew their participation.

All nurses' information was treated with privacy. Data were double entered and stored in a secure research drive that is HIPAA compliant at the University of Cincinnati. Surveys were stored in U.S. file cabinets after data entry. Until confirmation of data entry reliability, surveys were then scanned, stored on the research server, and shredded. Electronically scanned surveys will be erased within seven years of study completion. Anonymous electronic data will be stored indefinitely for future use.

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Summary

This chapter presented the study method including cross-sectional design, settings, sample, procedures, and data analysis. This study was conducted with randomly selected Jordanian nurses from ten health centers and three hospitals in a northern city of Jordan. Study participants were assured voluntary participation and privacy of their data. Study instrumentation included the DVHCPS as a measure of IPV screening and barriers, the WAST as measure IPV among Jordanian nurses, and a demographic survey. Data were analyzed using descriptive statistics, Chi-square Goodness-of-Fit tests, and one/two proportion z-tests.

CHAPTER IV: STUDY RESULTS

This chapter presents the study findings. This chapter provides demographic characteristics of study participants, findings of the four research specific aims including: the rate of IPV screening, barriers to screening for IPV, the rate of IPV victimization among Jordanian nurses, and a comparison of IPV screening rate for Jordanian nurses who are victims of IPV to those that are not.

Sample Description

A total of 125 Jordanian nurses, primarily female (n=103, 82.4%) sample participated in this study. The mean age of participants was 31.9 years (SD=6.2). The mean years of nursing experience was 10 years (SD=6). Most nurses were married (76.8%, n= 96) with the remaining nurses being single (20%, n=25) or divorced (2.4%, n=3). Additional demographic data are presented in Table 3.

Table 3

Percentage and frequency of Jordanian nurses biographical data.

	Percentage	Frequency
Sex		
Female	82.4%	103
Male	17.6%	22
Marital status		
Married	76.8%	96
Single	20%	25
Divorced	2.4%	3
Religion		
Islamic	99.2%	124
Christian	0.8%	1
Education level		
Diploma in nursing	40%	50
Bachelor in nursing	51.2%	64
Master in nursing	8.8%	11

Occupation		
Midwife	31.2%	39
Diploma nurse	13.6%	17
Staff nurse	55.2%	69

The Rate of IPV Screening among Nurses

Jordanian nurses screened for IPV most often when women sought care for physical injuries (25%). Of lesser frequency was IPV screening for patients complaining of depression and anxiety (20%), chronic pelvic pain (17.8%), hypertension and coronary artery disease (14.9%), headaches (11.5%), and Irritable Bowel Syndrome (3.3%). Nurses screened 10.8% of patients receiving pregnancy and gynecologist obstetric care. The one proportion z-tests revealed that the Jordanian nurse screening rates for injuries, chronic pelvic pain, Irritable Bowel Syndrome, headache, depression and anxiety, hypertension and coronary artery disease, and pregnancy and gynecologist obstetric care were significantly lower than the 39% rate reported with U.S. nurses (see Table 4).

Table 4.

*The frequency and percentage of IPV screening among nurses.**

Criteria	Screening	z	p-value	Effect Size
Injuries (n=60)	15 (25%)	-2.223	.0131	.02
Chronic pelvic pain (n=45)	8 (17.8%)	-2.919	.0018	.045
Irritable bowel syndrome (n=59)	2 (3.3%)	-5.664	< .0001	.127
Headache (n=103)	12 (11.5%)	-5.742	< .0001	.076
Depression/anxiety (n=73)	15 (20%)	-3.374	< .0001	.036
Hypertension/coronary artery disease (n=100)	15 (14.9%)	-4.976	< .0001	.058
Patient is pregnant/seek OBS/GYN care (n=73)	8 (10.8%)	-4.972	< .0001	.08

* Rows will not add to n=125, because not all nurses provided care to each type of patient.

†The comparison value for the z-proportion test was based on the Canadian nurse screening rate of 39%.

Nurses Barriers to Screening for IPV

Jordanian nurses in this study reported several sources of barriers based on the DVHCPS items including: self-efficacy, system support, victim blaming, professional role resistance, victim provider safety (see Table 5). Related to self-efficacy and nurses capability for screening, about 72% of nurses disagreed that they have access to IPV information and 61.6% disagreed that they were confident in referring victims of IPV. For the system support domain, most (78.4%) disagreed with having access to social workers and only 50.4% agreed that social

workers can provide help to IPV victims. Moreover, most (72.6%) believe that IPV victims do not have access to mental services and most (79.8%) disagreed with the capability of mental health services to provide help for IPV victims. Related to self-blame domain, a vast majority (72%) agreed that victims' personalities contributed to the IPV against them. In addition, 52.4% agreed that people choose to be IPV victims. According to professional role domain, over half (59.2%) agreed they were afraid of offending patients when asking about IPV. Additionally, nearly half (49.6%) agreed that it was not their role to ask about IPV when victims choose not to disclose their victimization. Related to victim/provider safety domain, Jordanian nurses were concerned about their own safety and victims' safety. However, 75.2% agreed it was possible to ask about IPV without endangering themselves. Despite this, most nurses (73.6%) agreed that they were still afraid of a batterer's anger when being challenged and 62.4% were afraid that asking about IPV could increase victims' risk.

Table 5.

Barriers for IPV screening identified by Jordanian nurses.

Barrier	Disagree	Agree
Self-efficacy		
Have no time to screen	75 (61%)	48 (39%)
There are strategies to help batterers	61 (49.2%)	63 (50.8%)
Strategies to help victims change IPV situation	59 (47.2%)	66 (52.8%)
Feel confident for referring batterers	66 (52.8%)	59 (47.2%)
Feel confident to refer victims	77 (61.6%)	48 (38.4%)
Have access to IPV information	90 (72%)	35 (28%)
Know ways to ask victims to decrease IPV victims risk	68 (54.4%)	57 (45.6%)
System Support		
Access to social workers to assist IPV victims	98 (78.4%)	27 (21.6%)
Social workers can help victims	62 (49.6%)	63 (50.4%)
Access to mental health referral	90 (72.6%)	34 (27.4%)
Mental health services can help victims	99 (79.8%)	25 (20.1%)
Blame Victims		
Victims get something from IPV relationship	63 (50.8%)	61 (49.2%)
People choose to be IPV victims	59 (47.6%)	65 (52.4%)
Victims and batterers are responsible for IPV	59 (47.6%)	65 (52.5%)

Patient personalities makes them IPV victims	35 (28%)	90 (72%)
Women go against traditional roles lead to IPV	75 (60%)	50 (40%)
Victim passive personality lead to IPV	63 (50.6%)	62 (49.4%)
Victims' action leads to IPV	72 (57.6%)	53 (42.4%)
Professional Role		
Afraid of offending patient when asking about IPV	51 (40.8%)	74 (59.2%)
Asking about IPV is invasion to patient privacy	67 (53.6%)	58 (46.4%)
It is demeaning to ask about IPV	107 (85.6%)	18 (14.4%)
Asking non-abused patients makes them angry	93 (74.4%)	32 (25.6%)
It is non- nursing role to resolve couple conflict	67 (53.6%)	58 (46.4%)
Investigation causes of IPV is non-medical role	104 (83.2%)	21 (16.8%)
If patient not disclose, they feel it is not my business	63 (50.4%)	62 (49.6%)
Victim/Provider Safety		
Reluctant to ask batterers for my personal safety	64 (51.6%)	60 (48.3%)
Workplace security is not enough to deal with IPV	42 (33.6%)	83 (66.4%)
Afraid of offending patient when asking about abusive behavior	49 (39.2%)	76 (60.8%)
Challenging batterers direct their anger to care providers	33 (26.4%)	92 (73.6%)
There are ways to ask about IPV without endanger	31 (24.8%)	94 (75.2%)

nurse		
Nurses can effectively discuss IPV with batterers	73 (58.9%)	51 (41.1%)
Can discuss IPV with batterers without endanger	62 (49.6%)	63 (50.4%)
victims		
Avoid dealing with batterers for victims safety	77 (61.6%)	48 (38.4%)
No ways to ask batterers without endanger victims	81 (64.8%)	44 (35.2%)
Afraid when dealing with batterers increase victims	47 (37.6%)	78 (62.4%)
risk		

The Rate of IPV among Jordanian Nurses

Eighty female, Islamic, married, Jordanian nurses were included in this in this aim of the study. Single women do not have intimate partners in Jordanian society. Although single nurses participated in the larger study on IPV screening, questions on personal victimization by intimate partners were left blank by all single nurses. As a result, only data from the 80 married female nurses were included.

The married female Jordanian nurses experienced psychological violence most often ($n=46$, 57.5%) followed by physical ($n=10$, 12.5%) and sexual violence ($n=4$, 5%). See Table 6 for further details. Compared to rates of IPV against United States' nurses, psychological violence experienced by Jordanian nurses occurred significantly more often (22.8% vs. 59%, $\chi^2[1] = 54.726$, $p < .0001$); whereas, physical and sexual violence occurred significantly less often (25% vs. 12.5%, $\chi^2[1] = 6.667$, $p = .0098$ and 25% vs. 5.1%, $\chi^2[1] = 17.067$, $p < .0001$ respectively).

Table 6.

Types and frequencies of intimate partner violence (n=80)

Criteria	Percentage	Frequency
Physical violence	12.5%	10
Psychological violence	57.5%	46
Sexual violence	6.25%	5
Tension	69.6%	55
Argument/difficulty	65%	52
Argument/feeling Bad or Low	66.3%	53
Argument result in Kicking	17.5%	14
Have Fears of what partner say/do	32.5%	26

Fifty-five (69.6%) of the Jordanian nurses indicated the existence of tension in their marital relationships. In association with marital arguments, 52 (65%) of the nurses experienced difficulty during the argument, 53 (66.3%) felt down or bad about self, 14 (17.5%) reported hitting and kicking or pushing during an argument, and 26 (32.5%) felt frightened of what their partner might say or do.

Screening for IPV among Victimized and non-Victimized Nurses

Of the study sample, 92 (74%) nurses experienced some type of intimate partner or domestic violence (i.e., emotional, sexual, physical). The remaining 33 nurses (26%) reported no personal violence. The screening rate by Jordanian victimized nurses, while not significant, was more than non-victimized nurses for women with chronic pelvic pain (23.5% vs. 14.3%) and

patients seeking obstetric gynecologist care (12.5% vs. 9.5%). The two-tailed two proportion z-tests revealed there was no significant difference between the proportions of nurses that screened for IPV based on personal violence experiences. Conversely, non-victimized nurses screened patients more often than victimized nurses when patients presented with injuries (27.8% vs. 20.8%) or were anxious or depressed (22.4% vs. 15.4%). Again, the z-proportion tests revealed no statistical difference between screening prevalence for the two groups of nurses (see Table 7).

Table 7.

*A comparison of IPV screening based on nurses' personal history of intimate partner or domestic violence victimization. **

Criteria (client seeking care for)	Non victimized nurses (n=33)	Nurse as a victim (n=92)	z	p-value
Patient has injuries (n=60)	27.8%	20.8%	.609	.543
Patient has chronic pelvic pain (n=45)	14.3%	23.5%	-.786	.432
Patient has irritable bowel syndrome (n=60)	2.9%	3.8%	-.194	.847
Patient has headache (n=105)	10.3%	13.5%	-.495	.620
Patient has depression/anxiety (n=75)	22.4%	15.4%	.728	.467
Patient has hypertension/coronary artery disease (n=102)	14.3%	15.8%	-.206	.837
Patient is pregnant/seek OBS/GYN care (n=74)	9.5%	12.5%	-.408	.683

* Rows will not add to n=125, because not all nurses provided care to each type of patient.

Summary

This chapter presented the study findings. Key findings indicated that the Jordanian nurses IPV screening rate was significantly lower than the screening rate of U.S. nurses. Jordanian nurses presented different barriers to screening for IPV including their personal beliefs about IPV screening practice, beliefs about IPV victims, accessibility and ability of

community services to provide the needed help for victims and other barriers were discussed in this chapter. Jordanian nurses reported being the victim of IPV. This study showed that nurses underwent more psychological violence and less physical and sexual violence than nurses in the U.S. In addition, there were no significant differences in screening rates between victimized and non-victimized Jordanian nurses.

Manuscript Option Dissertation

This dissertation was completed as a manuscript option dissertation while being reported as a traditional five chapter dissertation. Three scholarly manuscripts were written. Paper one titled “The Impact, Barriers, and Implications of Intimate Partner Violence Screening” is a review of the literature for IPV screening and barriers (see Appendix E). Paper 2 titled “Intimate Partner Violence against Jordanian Nurses” is a report of the IPV victimization experience by the female married Jordanian nurses in this study (see Appendix F). Paper three titled “Jordanian Nurses Barriers to Screening for Intimate Partner Violence” is a report of the IPV barriers to screening and comparison of screening based on nurses’ personal victimization (see Appendix G).

CHAPTER V: DISCUSSION

This chapter discusses study findings based on the study four specific aims including: the rate of IPV screening, nurses' barriers to screening for IPV, the rate of victimization among Jordanian nurses, and the rate of IPV screening for victimized and non-victimized Jordanian nurses. Study limitations, implications for practice, and future research are also discussed.

The Rate of IPV Screening

Jordanian nurses screening for IPV was low. The highest screening rate was done for women seen for injuries (25%). Btoush et al. (2009) indicated that the most common diagnosis for IPV victims seeking care in the emergency department in Columbia was related to upper and lower extremity injuries (49%). Othman and Mat Adenan (2008) found that injuries resulting from violence might be one of the most common complaints seen at three primary health care clinics in Malaysia. However, only half of the clinicians screened and asked the patients about the underlying causes of their injuries. A consistent lack of screening even for females with injuries was occurring.

IPV Screening by Jordanian and US Nurses

Thureston et al. (2007) indicated that the IPV screening rate for U.S. nurses was 39%. The rate of Jordanian nurses screening for IPV was significantly lower than screening by U.S. nurses. Lower screening rates by Jordanian nurses could be related to the barriers encountered by nurses which hindered their screening of patients seeking care in Jordanian health settings.

IPV Screening Barriers

A multitude of barriers were identified that likely hindered IPV screening by Jordanian nurses. The DVHCPS categorized these barriers in five domains. The domains include self-efficacy, system support, blaming the victims, professional role, and victim/provider safety.

Self-efficacy barrier.

Only about half of the nurses reported using strategies to help victims and batterers. This low percentage might have resulted from the lack of IPV knowledge provided to nurses for IPV screening and intervention (Colarossi et al., 2010; Felblinger & Gates, 2008; Othman & Mat Adenan, 2008). In addition, 40% of the sample, a finding similarly found in other studies, reported that they did not have enough time in their daily practice for IPV screening (Furniss et al., 2007; Ortiz & Ford, 2005).

System support barrier.

System support domain was identified as the greatest cluster of barriers among study participants. System support such as social and mental health services are important so that victims can be referred to entities that will provide help and support while promoting victims safety. Nearly half of nurses disagreed with the importance of social workers providing this much needed help and support, and 78.4% disagreed with having access to social workers. Othman and Mat Adenan (2008) indicated that less than 75% of nurses and physicians had access to social services, and only 10% reported that social workers were capable of providing the needed help for IPV victims. Even when nurses were able to refer victims of IPV to social workers, Thurston et al. (2007) wrote that only 53% of victims were ultimately referred. Equally troubling is that when nurses have access to social services, there may still be gaps and an

inadequacy in the services that are provided to IPV victims (D'Avolio, 2011; Thurston et al., 2007).

Nurses overwhelmingly disagreed that mental health services were important or capable to help IPV victims. This might be a reflection that the nurses did not have access to mental health services for their patients. However, seeking mental health care is vital for IPV victims. Al-Modallal, Abuidhail, Sowan, and Al-Rawashdeh (2010) stated that Jordanian women who experienced IPV and depression symptoms did not seek mental health services because they were unaware of the serious impact that mental illness can cause or the value of mental health care. In addition, IPV victims might have fears of being stigmatized by their communities and families. Jordanian nurses undervalued the importance of mental health services and inaccurately held a perception of people seeking mental health care which could be used to justify their beliefs about the ineffectiveness of mental health care to address the psychosocial needs of victims. Additionally, few Jordanian health settings provide social or mental health services. So, even if Jordanian nurses are educated about community services available, nurses will likely be unable to access them. More importantly, Jordanian IPV victims' refused to disclose IPV or to be referred to legal, social, or mental services to avoid being culturally stigmatized and for preserving the reputations of themselves and their family (Al-Modallal et al., 2010; Douki et al., 2003; Haj-Yahia, 2000).

Blaming the victim barrier.

Jordanian nurses held beliefs and attitudes about IPV victims that likely hindered their screening and providing appropriate care. Nurses' preconceptions and beliefs included that victims had passive personalities that resulted in the IPV situation. These findings are supported

by Djikanovic et al. (2010) and Johnston (2006) who indicated that victims of IPV are sometimes perceived as having personalities that account for their victimization: low self-esteem, self-blame, and dependent personalities. Regardless a woman's personality, women should never be blamed for the violence they experience.

Jordanian nurses also believed that victims' actions such as going against traditional and cultural marital norms could result in IPV against them. Oweis et al. (2009) found that Jordanian women rationalized violence against them and reported that their actions led to violence by husbands. Living within a Jordanian culture dictates following traditional male dominant roles for marriage and going against these rules means going against familial rules and norms which is not accepted and could result in an IPV relationship (Gharaibeh & Oweis, 2009; Haj-Yahia, 2000; Ibrahim & Howe, 2011). As a result, living within this thought schema could justify why more than 60% of Jordanian men and women justify wife beating as a way for men to establish their right to control and abuse women (Khawaja, Linos, & El-Roueiheb, 2008).

Shockingly, some Jordanian nurses believed that victims could get some benefits from staying in a violent relationship. Oweis et al. (2009) explained that Jordanian women may stay with batterers due to their financial dependence on batterers, lack of family support, and fear of losing their children. Nurses are expected to provide appropriate care and assure the safety of victims despite their personal and cultural beliefs about marital relationships. As Jordanians, the nurses in this study had beliefs which were reflective of their Jordanian cultural beliefs and these views may have contributed to any negative opinions of IPV screening.

Professional role barrier.

Nurses have a professional responsibility to appropriately screen all patients seeking health care. Nurses held preconceptions about IPV screening such as their inability to ask about IPV because it is a sensitive familial issue and they fear offending patients or making them angry. Felblinger and Gates (2008) found that 70% of nurses did not know what question to ask IPV victims. Smith et al. (2008) found that nurses were reluctant to ask about IPV, because they feared disrupting their patients' privacy. More importantly, Jordanian culture is conservative and women do not report sexual violence (Oweis et al., 2009). Therefore, Jordanian nurses might be reluctant to ask about sexual violence to prevent offending patients or not feel competent to screen.

In this study, more than half of the nurses were afraid of offending their patients when asking about IPV and believed that victims would refuse to disclose IPV. This likely led to the belief that IPV screening and resolving marital conflict was not an attainable nursing function. These findings are supported by Felblinger and Gates (2008), Furniss et al. (2007), and Smith et al. (2008) whose participants indicated that IPV screening was not a nursing role. Nurses should be educated to screen and ask patients in an appropriate way about IPV. Placing value on IPV screening is a necessary first step towards the universal screening of all patients.

Victim/provider safety barrier.

Nurses' concerns about safety are an important factor hindering screening for IPV. Djikanovic et al. (2010) revealed nurses concerns and fears about their own and victims safety when screening for IPV. Nurses' safety concerns could be related to the inadequacy of security services at the Jordanian health settings to protect them when interacting with batterers and

screening victims for IPV. These findings were similar to the findings of Oweis et al. (2009) who indicated that Jordanian victims underwent batterers' retaliation and revenge and increased violence severity and intensity after their IPV disclosure. A focus on nurse and victim safety should be considered when attempting to collaborate with Jordanian nurses to increase their rate of IPV screening.

The Rate of IPV among Jordanian Nurses

Oweis et al. (2009) indicated that physical, psychological, and sexual violence by husbands was a significant problem for Jordanian women. Jordanian nurses as Jordanian women experienced the same forms of IPV by their marital partners. Jordanian female married nurses in the current study reported psychological violence (59%), physical violence (12.5%), and sexual violence (5.1%). These results while significantly different from those reported by Bracken et al. (2010) are comparable to Al-Nsour et al.'s (2009) findings of 19.6% for physical violence and 47.5% for psychological violence. Both studies with Jordanian female samples reflected the occurrence of physical violence less than that of United States' nurses and psychological violence more than that of United States' nurses.

Jordanian married nurses just as women in other countries experienced a variety of IPV by their marital partners. This lack of immunity against violence may be due to the Jordanian female nurses living within an Arab, Muslim, and Jordanian cultural context. Jordan is an Arabic and Islamic nation located in the Middle East with about 6 million residents, 95% being sunny Muslims (Department of Statistics, 2010). Within the Arabic Muslim culture, women are expected to exhibit and follow the rules of the Islam and Jordanian culture toward marital relationships such as not leaving the abusive husband and not disclosing the IPV to others

including other healthcare providers. Gharaibeh and Oweis (2009) emphasized that Jordanian married women must follow their husbands' orders, needs, and demands as part of their cultural beliefs even if they are financially independent. This cultural norm dictates that Jordanian women accept the roles and expectations of their native culture.

In Jordanian culture, the family of origin is the source of support and protection for women. The absence of family support makes women vulnerable to financial, sexual, and occupational threats, feeling different, and being stigmatized by other members of their culture (Ibrahim & Howe, 2011). This family based culture assures the role of the family for making decisions for Jordanian women related to marriage, staying with abusive partners, and getting divorced. In most cases, Jordanian women do not make the final decision for staying or leaving a marriage (Oweis et al. 2009).

Ultimately, the cultural norms and traditions of Arab countries dictate that women as victims of IPV accept marital violence for the sake of family honor, to prevent the shame resulting from a divorce, and for the sake of their personal and family reputation (Douki et al., 2003; Haj-Yahia, 2000; Kulwicki et al., 2010). In addition, Arabic women leaving their husbands home go against family beliefs and norms (Haj-Yahia, 2000). Further reasons Jordanian women are expected to stay in and not leave their marital relationships are because the women will not be supported by their family, are afraid to lose child custody, and want to prevent the stigma associated with divorce (Al-Modallal et al., 2010; Oweis et al., 2009).

Again, Jordanian culture indicates conservative rules toward male dominance and authority in controlling marital issues (Ibrahim & Howe, 2011; Khawaja et al., 2008; Oweis et al., 2009). This dominant role gives men the right to control marital issues and decisions for the

wives and unmarried daughters and sons. And in many cases, Jordanian culture justifies using violence against the wife and children as a way to control and discipline family members to resolve marital conflict. Khawaja et al., (2008) found that 61.8% of Jordanian women who experienced IPV and 60.1% of Jordanian men justified wife beating based on the Jordanian cultural male dominancy and authority role over their wives. Haj-Yahia (2000) indicated that Arabic men use violence against their wives to control them especially if their authority and power is perceived to be threatened by their wives.

The limited occurrence of physical violence documented in the current study could be a result of nurses being more accommodative to the needs of other (i.e., patients). This accommodation could have transcended to the marital relationship. As nurses become better negotiators or learn to de-escalate aggressive persons, the rate of physical violence would legitimately decrease.

Jordanian girls and women are not taught about the dynamics for breaking the cycle of violence. As a result, both Jordanian men and women may rationalize the acceptance of IPV against women. Oweis et al. (2009) showed that Jordanian women rationalized husbands' violence and blamed themselves for violent events. Khawaja et al. (2008) found that Jordanian men rationalized IPV due to their unemployment, being married at a young age (under the age of 29), and their cultural authority to control their wives. It is possible that these reasons may have also led to the violence in our study; however, the causes of the violence were not assessed.

Moreover, Jordanian women are faced by limited supportive services in the Jordanian community. Oweis et al. (2009) indicated Jordanian women reported husbands seeking revenge

when women reported IPV to the police. Without a perceived sense of community support, even Jordanian nurses may continue to live in silence following the wake of IPV.

A misinterpretation of Qur'an verse (4:30) that addresses wife beating may allow some Muslims to abuse or have the perceived right to use violence against their wives as a way to control the perceived disobedience and misbehavior of wives. On the contrary, Ibrahim and Abdalla (2010) mentioned that Islam asks husbands to treat their wives with respect and mercy. Islam seeks to combat all forms of violence against women as dictated by Qur'an verses and the Prophet Muhammad.

Another reason for the low rate of physical violence could be that the husbands of the nurses in the current study do realize that physical violence is not permitted by the Qur'an. However, the husbands may not perceive psychological violence exhibited by yelling and threatening behaviors as violence. This lack of acceptance of verbal aggression and intimidation as violence would then condone and lead to the high rate of psychological violence identified in our study.

Many married Jordanian nurses may have witnessed their mothers, aunts, neighbors, sisters, and other female relatives undergo IPV as well as see these women accept the IPV as a part of their daily lives and faith. Jordanian men may also become accustomed to using violence after witnessing violence within their family of origin. Oweis et al. (2009) indicated that Jordanian married male perpetrators typically witnessed violence during their formative years. Bandura (1977) emphasized that violence can be transmitted through generations. So, when children observe violent role models in the family or social life, they too will use violence against others. Jordanian women witnessing IPV against their mothers and female relatives may

lend them to imitating their female role models and being more accepting of violence. This transmission of violence could continue to ensuing generations if not halted.

Jordanian female nurses are highly educated, financially independent, and employed in one of the most important professions in Jordan. Jordanian female nurses may be reluctant to disclose IPV by their husbands, because they too feel shame and embarrassment. Reporting their IPV may affect their professional prestige, personal dignity and reputation among their colleagues, and the reputation of their family of origin. These desires for prestige, dignity, and reputation could justify the relatively lower percentage of physical and sexual violence reported among Jordanian female nurses in comparison to other women in the Jordanian community. If the frequency of IPV truly is higher than reported, Jordanian nurses may be even more vulnerable to the negative effects of IPV and remain excluded from the potential, albeit limited, social services afforded to victims of IPV.

Jordanian nurses reported lower sexual abuse than United States' nurses. This finding may be the result of Jordanian women being reluctant to report or discuss their sexual life. Oweis et al. (2009) emphasized sexuality being a sensitive topic in the Arab Muslim and Jordanian conservative culture. Ibrahim and Howe (2011) showed that Jordanian Bedouin beliefs indicated the controlling role of family in female sexual life until the woman is married. In addition, Islam prohibits married couples from openly discussing their intimate relationship. Furthermore, female Jordanian nurses may feel shame and embarrassment when discussing their sexual life with a family member or sexual consultant. As a result, Oweis et al. (2009) indicated that sexual violence will rarely be discussed and rarely reported to the legal authorities or health specialists. In addition, Jordanian women cannot report sexual violence by

non-marital partners to their family for fear of the family committing an honor killing (Ibrahim & Howe, 2011). Assuming that IPV would occur against an unmarried nurse, the fear of an honor killing would prevent single nurses from answering the questions for IPV. Because the single nurses in this study left the items blank for IPV victimization, it may be more likely that the nurses do not have intimate partners and any violence they experience would derive from their male family members (domestic violence) with whom they will live until marriage.

In summary, Jordanian women live within an Arab, Muslim, Jordanian culture. Jordanian culture is a family based, male dominant, and conservative culture that considers women's life events tied to family honor. This relationship to family honor can give Jordanian men a perceived justification for wife beating. Additionally, a misinterpretation of the Qur'an may further justify violence against women. The same misinterpretation by women may partially explain why female nurses felt bad about arguing with the men in their lives and continue to be victimized. Living within Jordanian cultural beliefs dictates women staying in abusive relationships, accepting their abusive relationships, and avoiding disclosure of IPV to family, nurses, and social workers. The reluctance of Jordanian nurses to report or discuss their personal IPV will keep IPV hidden and underestimated among Jordanian women and nurses.

Screening for IPV among Victimized and Non Victim Nurses

Jordanian nurses experienced some type of intimate partner or domestic violence (i.e., emotional, sexual, physical). This study showed that there is no significant difference for IPV screening between victimized and non-victimized nurses. On the contrary to that, Minsky-Kelly et al. (2005) stated that being a victim of IPV could hinder nurses in IPV screening making it difficult for the nurses to intervene on behalf of their patients that are also victims of IPV.

Additionally, this study revealed that only 45% of nurses were knowledgeable of the ways and strategies to decrease IPV. Being a nurse undergoing IPV could result in an interpersonal conflict with these strategies because victimized nurses could not help themselves or break the cycle of violence which could accordingly prohibit their IPV screening.

Fit of the Ecological Model for the Study

The CDC (2012) used the Ecological Model to better understand the causative factors and comprehensive prevention strategies of IPV at the 5-levels of the model. Woodtli (2001) also used the Ecological Model for the study questions about survivors' and perpetrators' attitudes toward domestic violence. Additionally, authors of the study mentioned that the Ecological model can provide a holistic approach for research of violence against women.

This study used three levels/subsystems of Ecological model to conceptually define study variables: the intrapersonal, interpersonal, and institutional subsystems. The three subsystems were described by study instruments and gave a description for nurses IPV screening barriers. The intrapersonal subsystem was used by the WAST to describe the existence of IPV among Jordanian nurses. Being a victim of IPV could hinder nurses IPV screening practices, because they might use avoidance in similar situations to protect their image. Sippel and Marshall (2011) showed that victims of IPV with PTSD symptoms exhibited shame and used avoidance to prevent uncomfortable feelings and promote their self-image. Additionally, nurses in this study reported their beliefs about IPV relationship and victims' role that led to violent events. Oweis et al (2009) found that victims reported their responsibilities for IPV against them. Nurses also believed that IPV was a private familial issue and was

demeaning to ask about IPV. Smith et al. (2008) indicated that nurses were reluctant to ask about IPV, because they feared disrupting their patients' privacy.

The DVHCPS presented several IPV screening barriers at the interpersonal and institutional levels. The interpersonal subsystem barriers related to nurse-victims relationship and communication during daily practice. Through that communication nurses in this study blamed victims for undergoing IPV and believed victims had passive personalities. Djikanovic et al. (2010) and Johnston (2006) indicated that victims of IPV were characterized by low self-esteem, self-blame, and dependent personalities.

The institutional subsystem barriers in this study included the inadequacy of time for screening, a finding supported by Furniss et al.(2007) and Smith et al. (2008). Inadequacy of needed IPV education occurred in this study similar to Felblinger and Gates (2008) and Robinson (2010).However DVHCPS presented several IPV screening barriers, but it did not present other important barriers such as the lack of institutional protocols for IPV screening. In conclusion, the Ecological Model provided a comprehensive framework that described different factors and barriers that prohibited and hindered Jordanian nurses IPV screening practice.

Limitations of the Study

Several limitations occurred in this study. Data were collected from Jordanian nurses in one city and the study results may not be generalizable to all Jordanian nurses. However, this study provided the unprecedented opportunity to gather not previously reported data about IPV screening from a sample of nurses who reside in this Middle Eastern country of Jordan. This study was potentially limited by selection and measurement bias. Data for participants may be different from non-participants leading to selection bias. This limitation was minimized by using

a stratified random sample recruitment strategy. Data were self-reported and recall bias may have limited the study findings. This study used a Western culture instrument which could affect its cultural congruence when used for the first time in an Eastern culture. This limitation was reduced by the high CVI scores by the Jordanian nationals serving as content experts and the study instrument delivered in Arabic.

Implications for Practice

Increasing screening frequency among nurses requires the elimination of barriers encountering nurses. Overcoming and eliminating nurses' barriers also requires a multi-sectorial partnership and effective strategies and approaches such as IPV education, health institutional support and initiatives to increase IPV screening, and access to community-based social and mental health services.

As a caring profession, all nurses should be educated on the need for IPV assessment and screening, proper documentation and reporting, proper referral to supportive community services, and dynamics to break the cycle of violence. Btoush et al. (2009) emphasized the significance for improving screening, detecting, and accurate documenting and reporting IPV. This education should start during adolescence and continue into professional education.

Adequate education and training should be provided to nurses and other health care providers about the causes and consequences of IPV (Othman& Mat Adenan, 2008). Nurses should be educated about therapeutic communication skills and wording to use that encourages victim disclosure. Nurses need to support victims even if victims choose to not seek help or report IPV.

Specific education for IPV screening should be provided to all nurses. This education should concentrate on the frequency rate of IPV screening among nurses, the critical role of nurses in IPV screening, the definition of screening, importance of detecting victims and saving victims' lives, barriers to IPV screening, strategies to improve screening practice, and types of IPV screening tools. Additionally, nurses should be taught the proper way to screen, how to create appropriate and safe environments for client disclosing, and the policies and protocols at their health institution for IPV screening. Nurses also should be aware of victims' cultural, religious background and be sensitive to these variations when screening victims.

Nurses should be knowledgeable about the accessibility, functions and types of services, and strategies for helping IPV victims offered by community-based social and mental health workers. In addition, continuing education sessions in all health institutions should be held that reveal new policies, protocols, practices, and evidence based findings to effective IPV screening practices for all health care providers.

Health institutions should decrease the patient-nurse staffing ratio to a level allowing sufficient time for the implementation of a mandatory IPV screening program of all patients. Organizations should design or redesign the patient care environment to provide private areas where screening can take place. Administrative support should be provided to screeners. The physical safety of nurses as screeners needs to be assured through adequate security measures.

Community health services such as safe shelters and social and mental health services need to be readily accessible to IPV victims without a referral. Social and mental health workers should be educated about the magnitude of IPV, proper communications, crisis intervention approaches, and proper intervention strategies to help IPV victims when receiving referrals

from nurse screeners. Social workers must also provide counseling to victimized nurses and other victims, report known violent events, provide support, and refer victims to appropriate community services.

Current resources in Jordan such as the Family Protection Unit need to take a more proactive role in addressing IPV and work in partnership with Jordanian health settings to facilitate the process of referral and care, assurance of safety after IPV disclosure, and follow-up for IPV victims in their communities. In addition, health policy makers need to enforce a mandatory IPV screening practice at all health settings and community services, provide financial and technical support for screening units, provide a national surveillance and a national database, and monitor educational screening programs at all family based services.

Jordanian community awareness needs to be directed toward combating traditional and cultural rules that trap Jordanian women in IPV marital relationships, combating the illegal actions of honor killings, and assuring women rights and decisions in marriage and staying/leaving abusive relationships. These community changes can be assured through the effective role of religious leaders in interpreting Quran verses and prophet Mohammad commands for women rights and roles in marital relationships.

Jordanian nurses are not immune to IPV. Nurses as victims of IPV need to be screened, supported, and helped by their fellow healthcare administrators, colleagues, and other healthcare providers. Nurses should help and support their professional colleagues when IPV is suspected or occurs. Nurses should talk openly about IPV, encourage victimized nurses to report IPV to legal entities, create a safe work environment that allows for disclosure of IPV

without the risk of ostracism, and use a therapeutic approach when communicating with nursing peers undergoing IPV.

Healthcare administrators and managers should support and assist nurses undergoing IPV, provide education about IPV issues and proper intervention to help victims, and enforce screening protocols at all health settings. Furthermore, religious leaders can work actively within their mosque communities to correctly interpret the Qur'an in an effort to prevent and halt IPV.

Future Research

Nurses screening for IPV is a new area for research in Jordan and Middle Eastern countries. The rate of nurses IPV screening should be compared in all Jordanian cities and other Middle Eastern countries, it is possible that barriers may vary geographically. Screening barriers should be studied by the context of culture, religion, and health care profession. There is a need for research that seeks to define strategies that increase health care providers IPV screening compliance. In addition, there is a need for research that evaluates screening intervention programs and its effect on screening rates, quality of nursing practice and care, patient satisfaction, and victims' health outcomes. There is also a critical need for qualitative research. First, the lived experience of Jordanian nurses undergoing IPV, the meaning of this IPV experience, and the effect of IPV experience on nurses' personal and professional life can be studied. Second, nurses' barriers to screening for IPV should be studied among nurses as a subculture taking in consideration different cultural, traditional, and religious variables. Finally, there is a significant need to modify Western instruments for use in Eastern cultures or the development of new Jordanian designed psychometrically sound instruments.

Conclusion

The screening rate of IPV by Jordanian nurses is low which could result in victims' continuous physical and mental suffering, more utilization of health care services, and a lack of appropriate care that can help to assure their survival. Nurses working in partnership with other health care providers and managers may start to realize increased screening rates and overcome IPV screening barriers. Jordanian nurses are not immune against IPV. Intimate partner violence is still underestimated and underreported among Jordanian nurses related to cultural and personal beliefs that dictate keeping familial issues as high sensitive subjects and avoiding disclosing IPV. It is critical that all patients and nurses be screened and interventions be applied to support the health, wellness, and safety of the Jordanian nursing and general population.

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Appendix A

English Version of Study Instrument

Part I

INTIMATE PARTNER VIOLENCE HEALTH CARE PROVIDER SURVEY

In answering the following questions, circle the appropriate number:

1 = strongly disagree, 2 = disagree, 3 = not sure, 4 = agree, 5 = strongly agree

1.	I don't have the time to ask about IPV in my practice.
1	strongly disagree
2	disagree
3	not sure
4	agree
5	strongly agree
2.	There are strategies I can use to encourage batterers to seek help.
1	strongly disagree
2	disagree
3	not sure
4	agree
5	strongly agree

3.	There are strategies I can use to help victims of IPV change their situation.
1	strongly disagree
2	disagree
3	not sure
4	agree
5	strongly agree
4.	I feel confident that I can make appropriate referrals for batterers.
1	strongly disagree
2	disagree
3	not sure
4	agree
5	strongly agree
5.	I feel confident that I can make the appropriate referrals for victims of IPV.
1	strongly disagree
2	disagree
3	not sure
4	agree
5	strongly agree

6.	I have ready access to information detailing management of IPV.
1	strongly disagree
2	disagree
3	not sure
4	agree
5	strongly agree
7.	There are ways I can ask batterers about their behavior that will minimize risk to the potential victim OF IPV.
1	strongly disagree
2	disagree
3	not sure
4	agree
5	strongly agree
8.	I have ready access to medical social workers or community advocates to assist in the management of IPV.
1	strongly disagree
2	disagree
3	not sure
4	agree
5	strongly agree

9.	I feel that medical social work personnel can help manage IPV victims.
1	strongly disagree
2	disagree
3	not sure
4	agree
5	strongly agree
10.	I have ready access to mental health services should our patients need referrals.
1	strongly disagree
2	disagree
3	not sure
4	agree
5	strongly agree
11.	I feel that the mental health services at my clinic or agency can meet the needs of IPV victims in cases where they are needed.
1	strongly disagree
2	disagree
3	not sure
4	agree
5	strongly agree

12. A victim of IPV must be getting something out of the abusive relationship, or else he/she would leave.

- 1 strongly disagree
- 2 disagree
- 3 not sure
- 4 agree
- 5 strongly agree

13. People are only victims of IPV if they choose to be.

- 1 strongly disagree
- 2 disagree
- 3 not sure
- 4 agree
- 5 strongly agree

14. When it comes to IPV victimization, it usually “takes two to tango.”

- 1 strongly disagree
- 2 disagree
- 3 not sure
- 4 agree
- 5 strongly agree

15.	I have patients whose personalities cause them to be victims of IPV.
1	strongly disagree
2	disagree
3	not sure
4	agree
5	strongly agree
16.	Women who choose to step out of traditional roles are a major cause of IPV.
1	strongly disagree
2	disagree
3	not sure
4	agree
5	strongly agree
17.	The victim's passive-dependent personality often leads to abuse.
1	strongly disagree
2	disagree
3	not sure
4	agree
5	strongly agree

18.	The victim has often done something to bring about violence in the relationship.
1	strongly disagree
2	disagree
3	not sure
4	agree
5	strongly agree
19.	I am afraid of offending the patient if I ask about IPV.
1	strongly disagree
2	disagree
3	not sure
4	agree
5	strongly agree
20.	Asking patients about IPV is an invasion of their privacy.
1	strongly disagree
2	disagree
3	not sure
4	agree
5	strongly agree

21. It is demeaning to patients to question them about IPV.

- 1 strongly disagree
- 2 disagree
- 3 not sure
- 4 agree
- 5 strongly agree

22. If I ask non-abused patients about IPV, they will get very angry.

- 1 strongly disagree
- 2 disagree
- 3 not sure
- 4 agree
- 5 strongly agree

23. It is not my place to interfere with how a couple chooses to resolve conflicts.

- 1 strongly disagree
- 2 disagree
- 3 not sure
- 4 agree
- 5 strongly agree

24. I think that investigating the underlying cause of a patient's injury is not part of medical care.

1 strongly disagree

2 disagree

3 not sure

4 agree

5 strongly agree

25. If patients do not reveal IPV to me, then they feel it is none of my business.

1 strongly disagree

2 disagree

3 not sure

4 agree

5 strongly agree

26. I am reluctant to ask batterers about their abusive behavior out of concern for my personal safety.

1 strongly disagree

2 disagree

3 not sure

4 agree

5 strongly agree

27.	There is not enough security at my work place to safely permit discussion of IPV with batterers.
1	strongly disagree
2	disagree
3	not sure
4	agree
5	strongly agree
28.	I am afraid of offending patients if I ask about their abusive behavior.
1	strongly disagree
2	disagree
3	not sure
4	agree
5	strongly agree
29.	When challenged, batterers frequently direct their anger toward health care providers.
1	strongly disagree
2	disagree
3	not sure
4	agree
5	strongly agree

30.	I feel there are ways of asking about battering behavior without placing myself at risk.
1	strongly disagree
2	disagree
3	not sure
4	agree
5	strongly agree
31.	I feel I can effectively discuss issues of battering and abuse with a battered patient.
1	strongly disagree
2	disagree
3	not sure
4	agree
5	strongly agree
32.	I feel I can discuss issues of battering and abuse with a battered patient without further endangering the victim.
1	strongly disagree
2	disagree
3	not sure
4	agree
5	strongly agree

33.	I feel it is best to avoid dealing with the batterer out of fear and concern for the victim's safety.
1	strongly disagree
2	disagree
3	not sure
4	agree
5	strongly agree
34.	There is no way to ask batterers about their behaviors without putting the victims in more danger.
1	strongly disagree
2	disagree
3	not sure
4	agree
5	strongly agree
35.	I am afraid if I talk to the batterer, I will increase risk for the victim.
1	strongly disagree
2	disagree
3	not sure
4	agree
5	strongly agree

Directions: In answering the following questions, circle the appropriate number that describes the percent of time you have asked about the possibility of intimate partner violence when caring for patients:

1 = 0% - do not screen

2 = 1-20%

3= 21-40%

4= 41-60%

5= 61% or more

36. In the past three months have you seen patients with injuries? ____YES

____NO.

If you answered YES, go to question 37.

If you answered NO, go to question 38.

37. In the past three months, when seeing patients with injuries, what percent of the time have you asked about the possibility of intimate partner violence?

1 = 0% - do not screen

2 = 1-20%

3= 21-40%

4= 41-60%

5= 61% or more

38. In the past three months have you seen patients with chronic pelvic pain?

____ YES ____ NO.

If you answered YES, go to question 39.

If you answered NO, go to question 40.

39. In the past three months, when seeing patients with chronic pelvic pain, what percent of the time have you asked about the possibility of intimate partner violence?

1 = 0% - do not screen

2 = 1-20%

3= 21-40%

4= 41-60%

5= 61% or more

40. In the past three months have you seen patients with irritable bowel syndrome?

____ YES ____ NO.

If you answered YES, go to question 41.

If you answered NO, go to question 42.

41. In the past three months, when seeing patients with irritable bowel syndrome, what percent of the time have you asked about the possibility of intimate partner violence?

1 = 0% - do not screen

2 = 1-20%

3= 21-40%

4= 41-60%

5= 61% or more

42. In the past three months have you seen patients with headaches? ____YES
____NO.

If you answered YES, go to question 43.

If you answered NO, go to question 44.

43. In the past three months, when seeing patients with headaches, what percent of the time have you asked about the possibility of intimate partner violence?

1 = 0% - do not screen

2 = 1-20%

3= 21-40%

4= 41-60%

5= 61% or more

44. In the past three months have you seen patients with depression and/or anxiety?

____YES ____NO.

If you answered YES, go to question 45.

If you answered NO, go to question 46.

45. In the past three months, when seeing patients with depression and/or anxiety, what percent of the time have you asked about the possibility of intimate partner violence?

1 = 0% - do not screen

2 = 1-20%

3= 21-40%

4= 41-60%

5= 61% or more

46. In the past three months have you seen patients with hypertension and/or coronary artery disease?

____YES ____NO.

If you answered YES, go to question 47.

If you answered NO, go to question 48.

47. In the past three months, when seeing patients with hypertension and/or coronary artery disease, what percent of the time have you asked about the possibility of intimate partner violence?

1 = 0% - do not screen

2 = 1-20%

3= 21-40%

4= 41-60%

5= 61% or more

48. In the past three months have you seen patients who require pregnancy or OB/GYN care? ____YES ____NO.

If you answered YES, go to question 49.

If you answered NO, this is your last question. Please mark your answer to this question (48) then stop.

49. In the past three months, when seeing patients requiring pregnancy or OB/GYN care, what percent of the time have you asked about the possibility of intimate partner violence?

1 = 0% - do not screen

2 = 1-20%

3= 21-40%

4= 41-60%

5= 61% or more

Part II

Woman Abuse Screening Tool (WAST)

50. What is your marital status?

- a) Single (skip to question 59)
- b) Married (go to question 51)
- c) Divorced (skip to question 59)
- d) Widower (skip to question 59)

51. In general, how would you describe your marital relationship?

- a) A lot of tension
- b) Some tension
- c) No tension

52. Do you and your husband/wife work out arguments with:

- a) Great difficulty
- b) Some difficulty
- c) No difficulty

53. Do arguments ever result in you feeling down or bad about yourself?

- a) Often
- b) Sometimes
- c) Never

54. Do arguments ever result in hitting, kicking, or pushing?

- a) Often
- b) Sometimes
- c) Never

55. Do you ever feel frightened by what your husband/wife says or does?

- a) Often
- b) Sometimes
- c) Never

56. Has your husband/wife ever abused you physically?

- a) Often
- b) Sometimes
- c) Never

57. Has your husband/wife ever abused you emotionally?

- a) Often
- b) Sometimes
- c) Never

58. Has your husband/wife ever abused you sexually?

- a) Often
- b) Sometimes
- c) Never

59. In general, how would you describe your relationship with your male family members?

- a. A lot of tension
- b. Some tension
- c. No tension

60. Do you and your male family members work out arguments with:

- a. Great difficulty
- b. Some difficulty
- c. No difficulty

61. Do arguments ever result in you feeling down or bad about yourself?

- a. Often
- b. Sometimes
- c. Never

62. Do arguments with family members ever result in hitting, kicking or pushing?

- a. Often
- b. Sometimes
- c. Never

63. Do you ever feel frightened by what your male family members say or do?

- a. Often
- b. Sometimes
- c. Never

64. Has your male family members ever abused you physically?

- a. Often
- b. Sometimes
- c. Never

65. Has your male family members ever abused you emotionally?

- a. Often
- b. Sometimes
- c. Never

66. Have male family members ever abused you sexually?

- a. Often
- b. Sometimes
- c. Never

Part III

Demographic Survey

67. How old are you?.....

68. You are

- a. midwife
- b. diploma nurse
- c. staff nurse

69. What is your level of education?

- a. Diploma in nursing
- b. Bachelor degree in nursing
- c. Master degree in nursing
- d. Doctorate degree in nursing

70. How many years of nursing experience do you have?.....

71. What is your sex?

- a. Female
- b. Male

72. What is your religion?

- a. Islam
- b. Christian
- c. Other.....

73. What is your health setting/unit?

- a. Maternal child health center
- b. Family planning clinic
- c. Antenatal clinic
- d. Hospital name.....
Hospital unit.....

Appendix B

Arabic version of Study Instrument

العوائق التي تمنع فريق التمريض في الأردن من التحري عن العنف من قبل الشريك الحميم
الباحث الرئيسي / أحلام الناطور ' 2011

استمارة مقدمي الرعاية الصحية لحالات العنف من قبل الشريك

خلال الاجابة على الأسئلة التالي ، يرجى وضع دائرة حول الرقم المناسب، حيث يعنى بالأرقام ما يلي:

1 = لا أوافق بشدة ، 2 = لا أوافق ، 3 = غير متأكد ، 4 = أوافق ، 5 = أوافق بشدة

رقم الفقرة	الفقرة
1.	ليس لدي الوقت للسؤال عن العنف من قبل الشريك الحميم أو الزوج أثناء ممارسة المهنة 1 = لا أوافق بشدة 2 = لا أوافق 3 = غير متأكد، 4 = أوافق 5 = أوافق بشدة
2.	هناك استراتيجيات يمكنني استخدامها لتشجيع المعتدين لطلب المساعدة 1 = لا أوافق بشدة 2 = لا أوافق 3 = غير متأكد، 4 = أوافق 5 = أوافق بشدة
3.	هناك استراتيجيات يمكنني استخدامها لمساعدة ضحايا العنف من قبل الشريك الحميم أو الزوج من تغيير موقفهم 1 = لا أوافق بشدة 2 = لا أوافق 3 = غير متأكد، 4 = أوافق 5 = أوافق بشدة
4.	لدي شعور بالثقة فيما يخص قدرتي على اجراء التحويل المناسب للمعتدين 1 = لا أوافق بشدة 2 = لا أوافق 3 = غير متأكد، 4 = أوافق 5 = أوافق بشدة
5.	لدي شعور بالثقة فيما يخص قدرتي على اجراء التحويل المناسب لضحايا العنف من قبل الشريك الحميم أو الزوج 1 = لا أوافق بشدة

	<p>2 = لا أوافق</p> <p>3 = غير متأكد،</p> <p>4 = أوافق</p> <p>5 = أوافق بشدة</p>
6.	<p>لدي معلومات جاهزة و مفصلة فيما يخص مساعدة حالات العنف من قبل الشريك الحميم أو الزوج</p> <p>1 = لا أوافق بشدة</p> <p>2 = لا أوافق</p> <p>3 = غير متأكد،</p> <p>4 = أوافق</p> <p>5 = أوافق بشدة</p>
7.	<p>هناك طرق تستطيع ان اطلبها من المعتدين فيما يخص سلوكياتهم لتقليل المخاطر المحتملة بالنسبة لصحية حالات العنف من قبل الزوج</p> <p>1 = لا أوافق بشدة</p> <p>2 = لا أوافق</p> <p>3 = غير متأكد،</p> <p>4 = أوافق</p> <p>5 = أوافق بشدة</p>
8.	<p>لدي نظام جاهز لطلب المساعدة من الباحثين الاجتماعيين في المجال الطبي، و من المؤسسات المجتمعية لإدارة حالات العنف من قبل الشريك الحميم أو الزوج</p> <p>1 = لا أوافق بشدة</p> <p>2 = لا أوافق</p> <p>3 = غير متأكد،</p> <p>4 = أوافق</p> <p>5 = أوافق بشدة</p>
9.	<p>أشعر بأن الباحثين الاجتماعيين في المجال الطبي قادرين على المساعدة فيما يخص ادارة حالات العنف من قبل الشريك الحميم أو الزوج</p> <p>1 = لا أوافق بشدة</p> <p>2 = لا أوافق</p> <p>3 = غير متأكد،</p> <p>4 = أوافق</p> <p>5 = أوافق بشدة</p>
10.	<p>لدي نظام جاهز للتحويل الى الخدمات النفسية، في حال برزت الحاجة لذلك عند اي من حالات العنف من قبل الشريك الحميم أو الزوج</p>

	<p>1 = لا أوافق بشدة</p> <p>2 = لا أوافق</p> <p>3 = غير متأكد،</p> <p>4 = أوافق</p> <p>5 = أوافق بشدة.</p>	
11.	<p>أشعر بأن خدمات الصحة النفسية في عيادتي أو مكان عملي، قادرة على تلبية الجوانب العديدة من احتياجات ضحايا العنف من قبل الشريك الحميم أو الزوج</p> <p>1 = لا أوافق بشدة</p> <p>2 = لا أوافق</p> <p>3 = غير متأكد،</p> <p>4 = أوافق</p> <p>5 = أوافق بشدة</p>	
12.	<p>أعتقد بأن الضحية تحصل على شيء ما خلال العلاقة الاضطهادية، والا لما استمرت فيها، و لعملت على رفع تلك الاساءة</p> <p>1 = لا أوافق بشدة</p> <p>2 = لا أوافق</p> <p>3 = غير متأكد،</p> <p>4 = أوافق</p> <p>5 = أوافق بشدة</p>	
13.	<p>الناس هم ضحايا، فقط اذا ما اختاروا أن يكونوا كذلك</p> <p>1 = لا أوافق بشدة</p> <p>2 = لا أوافق</p> <p>3 = غير متأكد،</p> <p>4 = أوافق</p> <p>5 = أوافق بشدة</p>	
14.	<p>عندما يتعلق الأمر بضحايا العنف من قبل الشريك الحميم أو الزوج ، فإنه عادة ما يمكن القول بأنه : ”كلاهما مسؤول عن الاساءة“</p> <p>1 = لا أوافق بشدة</p> <p>2 = لا أوافق</p> <p>3 = غير متأكد،</p> <p>4 = أوافق</p> <p>5 = أوافق بشدة</p>	

15.	<p>لدي بعض المرضى ممن تعد شخصياتهم سبباً لتعرضهم للاساءة 1 = لا أوافق بشدة</p> <p>2 = لا أوافق</p> <p>3 = غير متأكد،</p> <p>4 = أوافق</p> <p>5 = أوافق بشدة</p>
16.	<p>النساء اللواتي يخترن الخروج عن الادوار التقليدية، هن السبب في العنف من قبل الشريك الحميم أو الزوج</p> <p>1 = لا أوافق بشدة</p> <p>2 = لا أوافق</p> <p>3 = غير متأكد،</p> <p>4 = أوافق</p> <p>5 = أوافق بشدة</p>
17.	<p>شخصية الضحية المتمسكة بالسلبية – الاعتمادية، هي غالباً السبب في حدوث الاساءة</p> <p>1 = أوافق بشدة</p> <p>2 = لا أوافق بشدة</p> <p>3 = لا أوافق</p> <p>4 = غير متأكد،</p> <p>5 = أوافق</p>
18.	<p>غالباً ما تقوم الضحية بعمل ما يتسبب في احداث العنف في العلاقة مع الشريك</p> <p>1 = لا أوافق بشدة</p> <p>2 = لا أوافق</p> <p>3 = غير متأكد،</p> <p>4 = أوافق</p> <p>5 = أوافق بشدة</p>
19.	<p>أخشى من اشعار المريض بالمهاجمة، اذا ما قمت بسؤاله عن العنف من قبل الشريك الحميم أو الزوج</p> <p>1 = لا أوافق بشدة</p> <p>2 = لا أوافق</p> <p>3 = غير متأكد،</p> <p>4 = أوافق</p> <p>5 = أوافق بشدة</p>

20.	سؤال المرضى عن العنف من قبل الشريك الحميم أو الزوج، هو خرق لخصوصيتهم 1 = لا أوافق بشدة 2 = لا أوافق 3 = غير متأكد، 4 = أوافق 5 = أوافق بشدة
21.	سؤال المرضى عن العنف من قبل الشريك الحميم أو الزوج هو بلا معنى بالنسبة لهم 1 = لا أوافق بشدة 2 = لا أوافق 3 = غير متأكد، 4 = أوافق 5 = أوافق بشدة
22.	سؤال المرضى غير المعنفين عن العنف من قبل الشريك الحميم أو الزوج، سيغضبهم بشدة 1 = لا أوافق بشدة 2 = لا أوافق 3 = غير متأكد، 4 = أوافق 5 = أوافق بشدة
23.	ليس لي التدخل في الكيفية التي يختار الزوجان بها حل نزاعاتهم 1 = لا أوافق بشدة 2 = لا أوافق 3 = غير متأكد، 4 = أوافق 5 = أوافق بشدة
24.	أعتقد بأن التحقيق في الأسباب الكامنة وراء إصابة وجروح المريض ليست جزءاً من الرعاية الطبية 1 = لا أوافق بشدة 2 = لا أوافق 3 = غير متأكد، 4 = أوافق 5 = أوافق بشدة

25.	<p>إذا لم يكشف المرضى عن تعرضهم للاساءة، فذلك يعني بأنهم يشعرون بأن ذلك ليس من شأني</p> <p>1 = لا أوافق بشدة</p> <p>2 = لا أوافق</p> <p>3 = غير متأكد،</p> <p>4 = أوافق</p> <p>5 = أوافق بشدة</p>
26.	<p>أتردد في سؤال المعتدين عن سلوكهم المسيء حرصاً على سلامتي الشخصية</p> <p>1 = لا أوافق بشدة</p> <p>2 = لا أوافق</p> <p>3 = غير متأكد،</p> <p>4 = أوافق</p> <p>5 = أوافق بشدة</p>
27.	<p>ليس هناك ما يكفي من الأمن في مكان عملي بما يسمح بمناقشة المعتدين عن العنف من قبل الشريك الحميم أو الزوج</p> <p>1 = لا أوافق بشدة</p> <p>2 = لا أوافق</p> <p>3 = غير متأكد،</p> <p>4 = أوافق</p> <p>5 = أوافق بشدة</p>
28.	<p>أخشى من مهاجمة المرضى إذا ما قمت بسؤالهم عن سلوكهم المسيء</p> <p>1 = لا أوافق بشدة</p> <p>2 = لا أوافق</p> <p>3 = غير متأكد،</p> <p>4 = أوافق</p> <p>5 = أوافق بشدة</p>
29.	<p>إذا ما تم تحدي المعتدين، فإنهم في كثير من الأحيان يحولون غضبهم مباشرة الى مقدمي الرعاية الصحية</p> <p>1 = لا أوافق بشدة</p> <p>2 = لا أوافق</p> <p>3 = غير متأكد،</p> <p>4 = أوافق</p> <p>5 = أوافق بشدة</p>
30.	<p>أشعر بأن هناك طرقاتاً ما للسؤال عن السلوك المسيء دون تعريض نفسي للخطر</p>

	<p>1 = لا أوافق بشدة</p> <p>2 = لا أوافق</p> <p>3 = غير متأكد،</p> <p>4 = أوافق</p> <p>5 = أوافق بشدة</p>
31.	<p>أشعر بأنني قادر على مناقشة المعتفين بما يتعلق بالضرب و الاساءة على نحو فعال</p> <p>1 = لا أوافق بشدة</p> <p>2 = لا أوافق</p> <p>3 = غير متأكد،</p> <p>4 = أوافق</p> <p>5 = أوافق بشدة</p>
32.	<p>أشعر بأنني قادر على مناقشة قضايا الضرب وسوء المعاملة مع المعتفين دون تعريض الضحية الى المزيد من الخطر</p> <p>1 = لا أوافق بشدة</p> <p>2 = لا أوافق</p> <p>3 = غير متأكد،</p> <p>4 = أوافق</p> <p>5 = أوافق بشدة</p>
33.	<p>أشعر أنه من الأفضل تجنب التعامل مع المعتدين خوفاً على سلامة الضحية</p> <p>1 = لا أوافق بشدة</p> <p>2 = لا أوافق</p> <p>3 = غير متأكد،</p> <p>4 = أوافق</p> <p>5 = أوافق بشدة</p>
34.	<p>لا يمكن مناقشة المعتدي في قضايا الضرب و الاساءة دون تعريض الضحية الى مزيد من الخطر</p> <p>1 = لا أوافق بشدة</p> <p>2 = لا أوافق</p> <p>3 = غير متأكد،</p> <p>4 = أوافق</p> <p>5 = أوافق بشدة</p>
35.	<p>أخشى بأن تتسبب مناقشة المعتدي في قضايا الضرب و الاساءة الى تعريض الضحية مزيد من الخطر</p> <p>1 = لا أوافق بشدة</p>

2 = لا أو افق	
3 = غير متأكد،	
4 = وافق	
5 = وافق بشدة	

الارشادات: في الاجابة عن الأسئلة التالية ضع دائرة حول الرقم الذي يعبر عن النسبة المناسبة عن عدد المرات التي قمت بالسؤال عن العنف ضد الشريك الحميم عند قيامك بتقديم الرعاية التمريضية للمرضى

- 1 = 0 % لم اقم بالفحص أو السؤال
 2 = 1 % - 30 %
 3 = 31 % - 50 %
 4 = 51 % - 70 %
 5 = 71 % او اكثر

36	في الأشهر الثلاثة الماضية هل قمت برؤية مرضى يعانون من الاصابات أو الجروح ؟ نعم لا إذا كانت الاجابة نعم اجب على السؤال 37 إذا كانت الاجابة لا اجب على السؤال 38
37	في الأشهر الثلاثة الماضية ، عندما كنت ترى المرضى الذين يعانون من الاصابات أو الجروح ، كم كانت عدد أو نسبة المرات التي قمت فيها بالسؤال عن احتمالية حدوث العنف من قبل الشريك الحميم أو الزوج؟ 1 = 0 % لم اقم بالفحص أو السؤال 2 = 1 % - 30 % 3 = 31 % - 50 % 4 = 51 % - 70 % 5 = 71 % او اكثر
38	في الأشهر الثلاثة الماضية هل قمت برؤية مرضى يعانون من ألم مزمن في الحوض؟ إذا كانت الاجابة نعم اجب على السؤال 39 إذا كانت الاجابة لا اجب على السؤال 40
39	في الأشهر الثلاثة الماضية ، عندما كنت ترى المرضى الذين يعانون من ألم مزمن في الحوض كم كانت عدد أو نسبة المرات التي قمت فيها بالسؤال عن احتمالية حدوث العنف من قبل الشريك الحميم أو الزوج؟ 1 = 0 % لم اقم بالفحص أو السؤال 2 = 1 % - 30 % 3 = 31 % - 50 % 4 = 51 % - 70 % 5 = 71 % او اكثر
40	في الأشهر الثلاثة الماضية هل قمت برؤية مرضى يعانون من متلازمة القولون العصبي ؟ إذا كانت الاجابة نعم اجب على السؤال 41 إذا كانت الاجابة لا اجب على السؤال 42
41	في الأشهر الثلاثة الماضية ، عندما نرى المرضى الذين يعانون من متلازمة القولون العصبي ، كم كانت عدد أو نسبة المرات التي قمت فيها بالسؤال عن احتمالية حدوث العنف من قبل الشريك الحميم أو الزوج؟ 1 = 0 % لم اقم بالفحص أو السؤال 2 = 1 % - 30 % 3 = 31 % - 50 %

	<p>4 = 1% - 70% 5 = 61% أو أكثر</p>	
42	<p>في الأشهر الثلاثة الماضية هل قمت برؤية مريض يعانون من الصداع إذا الإجابة نعم اجب على السؤال كانت 3 إذا كانت الإجابة لا اجب على السؤال 44</p>	
43	<p>في الأشهر الثلاثة الماضية ، عندما نرى المرضى الذين يعانون من الصداع كم كانت عدد او نسبة المرات التي قمت فيها بالسؤال عن احتمالية حدوث العنف من قبل الشريك الحميم أو الزوج؟ 1 = 0% لم اقم بالفحص أو السؤال 2 = 1% - 30% 3 = 31% - 50% 4 = 51% - 70% 5 = 61% أو أكثر</p>	
44	<p>في الأشهر الثلاثة الماضية هل قمت برؤية مريض يعانون من الاكتئاب / أو القلق إذا كانت الإجابة نعم اجب على السؤال 45 إذا كانت الإجابة لا اجب على السؤال كانت 7</p>	
45	<p>في الأشهر الثلاثة الماضية ، عندما نرى المرضى الذين يعانون من الاكتئاب / أو القلق كم كانت عدد او نسبة المرات التي قمت فيها بالسؤال عن احتمالية حدوث العنف من قبل الشريك الحميم أو الزوج؟ 1 = 0% لم اقم بالفحص أو السؤال 2 = 1% - 30% 3 = 31% - 50% 4 = 51% - 70% 5 = 61% أو أكثر</p>	
46	<p>في الأشهر الثلاثة الماضية هل قمت برؤية مريض يعانون من ارتفاع ضغط الدم و أو مرض الشريان التاجي إذا كانت الإجابة نعم اجب على السؤال 17 إذا كانت لا اجب على السؤال الإجابة 48</p>	
47	<p>في الأشهر الثلاثة الماضية ، عندما نرى المرضى الذين يعانون من ارتفاع ضغط الدم و أو مرض الشريان التاجي ، كم كانت عدد او نسبة المرات التي قمت فيها بالسؤال عن احتمالية حدوث العنف من قبل الشريك الحميم أو الزوج؟ 1 = 0% لم اقم بالفحص أو السؤال 2 = 1% - 30% 3 = 31% - 50% 4 = 51% - 70% 5 = 61% أو أكثر</p>	
48	<p>في الأشهر الثلاثة الماضية هل قمت برؤية مريض يحتاجون إلى رعاية الحمل أو التوليد و النسائية إذا الإجابة نعم اجب على السؤال كانت 49 إذا كانت الإجابة لا هذا هو سؤالك الاخير توقف عند سؤال 48</p>	
49.	<p>في الأشهر الثلاثة الماضية ، عندما نرى المرضى الذين يحتاجون إلى رعاية الحمل أو التوليد و النسائية ، كم كانت عدد التي أو نسبة المرات قمت فيها بالسؤال عن احتمالية حدوث العنف من قبل الشريك الحميم أو الزوج؟ 1 = 0% لم اقم بالفحص أو السؤال 2 = 1% - 30% 3 = 31% - 50% 4 = 51% - 70% 5 = 61% أو أكثر</p>	

الجزء الثاني

أداة التحري عن الإساءة للمرأة

50. ما هو وضعك العائلي؟

1. أعزب (انتقل إلى السؤال 59)
2. متزوج (اذهب إلى السؤال 51)
3. المطلق (انتقل إلى السؤال 59)
4. أرمل (انتقل إلى السؤال 59)

51. بشكل عام ، كيف تصف علاقتك الزوجية؟

1. هناك الكثير من التوتر
2. بعض التوتر
3. لا توتر

52. تتم المجادلة بينك وبين زوجك / زوجتك

1. صعوبة كبيرة
2. بعض الصعوبات
3. لا صعوبة

53. هل ادت المجادلة مع الشريك أو الزوج الى شعورك بالسوء اتجاه نفسك؟

1. غالبا
2. أحيانا
3. أبدا

54. هل ادت المجادلة مع الشريك أو الزوج الى الضرب أو الركل؟

1. غالبا
2. أحيانا
3. أبدا

55. هل تشعر بالخوف بسبب ما يقوله أو يفعله زوجك / زوجتك ؟

1. غالبا
2. أحيانا
3. أبدا

56. هل سبق أن قام الزوج/الزوجة بالإساءة اليك جسديا ؟

1. غالبا
2. أحيانا
3. أبدا

57. هل سبق أن قام الزوج/الزوجة بالاساءة اليك عاطفيا؟

1. غالبا
2. أحيانا
3. أبدا

58. هل سبق أن قام الزوج/الزوجة بالاساءة اليك جنسيا؟

1. غالبا
2. أحيانا
3. أبدا

59. بشكل عام ، كيف تصف علاقتك مع أفراد عائلتك من الذكور ؟

1. هناك الكثير من التوتر
2. بعض التوتر
3. لا توتر

60. كيف تتم المجادلة بينك و بين أفراد عائلتك من الذكور؟

1. صعوبة كبيرة
2. بعض الصعوبات
3. لا صعوبة

61. هل ادت المجادلة بينك و بين أفراد عائلتك من الذكور الى شعورك بالسوء اتجاه نفسك ؟

1. غالبا
2. أحيانا
3. أبدا

62. هل ادت المجادلة بينك و بين أفراد عائلتك من الذكور الى الضرب أو الركل ؟

1. غالبا
2. أحيانا
3. أبدا

63. هل تشعر بالخوف بسبب ما يقوله أو يفعله أحد أفراد عائلتك من الذكور ؟

1. غالبا
2. أحيانا
3. أبدا

64. هل سبق أن قام أحد أفراد عائلتك من الذكور بالاساءة اليك جسديا؟

1. غالبا
2. أحيانا
3. أبدا

65. هل سبق أن قام أحد أفراد عائلتك من الذكور بالاساءة اليك عاطفيا؟

1. غالبا
2. أحيانا
3. أبدا

66. هل سبق أن قام أحد أفراد عائلتك من الذكور بالاساءة اليك جنسيا؟

1. غالبا
2. أحيانا
3. أبدا

الجزء الثالث

المسح الديموغرافي

67. كم عمرك.....

68. الوظيفة

1. قابلة قانونية.
2. ممرض/ ممرضة مساعدة / دبلوم تمريض. /
3. ممرض/ ممرضة قانونية

69. ما هو مستوى التعليم؟

1. دبلوم في التمريض
2. درجة البكالوريوس في التمريض
3. درجة الماجستير في التمريض
4. درجة الدكتوراه في التمريض

70. عدد سنوات العمل في التمريض.....

71 . الجنس

1. أنثى
2. ذكر

72 . الديانة

1. الإسلام
2. المسيحية
3. غير ذلك.....

73 . مكان عملك ؟

1. مركز رعاية الأمومة و الطفولة
2. عيادة تنظيم الأسرة
3. عيادة رعاية الحوامل
4. اسم المستشفى.....
5. اسم وحدة المستشفى.....

Appendix C

English Version of Information Sheet for Research

**Information Sheet for Research
University of Cincinnati
Department: College of Nursing
Principal Investigator: Ahlam Al-Natour
Faculty Advisor: Gordon Gillespie, PhD, RN**

Title of Study: Jordanian Nurses Barriers to Screening for Intimate Partner Violence

Introduction:

You are being asked to take part in a research study. Please read this paper carefully and ask questions about anything that you do not understand.

This research is sponsored by Sigma Theta Tau International.

Who is doing this research study?

The person in charge of this research study is Ahlam Al – Natour is a student at the University of Cincinnati (UC) Department of College of Nursing. She is being guided by Gordon Gillespie, PhD, RN.

What is the purpose of this research study?

The purpose of this research study is to investigate the intimate partner violence (IPV) screening practices of Jordanian nurses. Specifically, this study will examine the IPV screening rate and the IPV screening barriers encountered by nurses in Jordanian health care settings in Irbid, City. In addition, data will be collected on nurses as victims of IPV and comparisons will be made between victim and non victim groups related to screening willingness.

Who will be in this research study?

About 138 nurses will take part in this study. You may be in this study if you are (1) Jordanian, (2) a registered nurse, diploma nurse, or midwife, (3) live in the city of Irbid, (4) speak and understand Arabic, and (5) work in emergency, antenatal clinics, or female hospital wards. Nurses working on male hospital wards will be excluded from this study.

What if you are an employee where the research study is done?

Taking part in this research study is not part of your job. Refusing to be in the study will not affect your job. You will not be offered any special work-related benefits if you take part in this study.

What will you be asked to do in this research study, and how long will it take?

1. Complete a study questionnaire that takes 10-15 minutes during one time.
2. Only one visit is needed for completing study questionnaire.
3. You will complete the study questionnaire in a private room where you work.
4. All finished and completed questionnaires will be inserted in a locked box to keep your information private.

Are there any risks to being in this research study?

There is no risk for study participation.

Are there any benefits from being in this research study?

There is no direct benefit from participation in this study. But participation in this study could increase nurses understanding for the importance of screening for intimate partner violence.

What will you get because of being in this research study?

You will be given a pen/pad as a compensation for participation in the study regardless whether or not you complete the study.

Do you have choices about taking part in this research study?

If you do not want to take part in this research study, you can choose to not participate or leave the survey blank.

How will your research information be kept confidential?

Official permission to conduct and recruit for this study has been already granted by the Head Officer at the Department of Health in Irbid city.

No names or other identifiers will be requested or placed on the survey. No code key or roster will be generated to match individual data to a particular participant. Only aggregate data will be reported. In addition, no data will be individually reported to managers at the health settings.

Study documentation will be maintained in a locked box carried by the principal investigator during study visits and data collection. At the end of each day, the documents will be securely locked in a file cabinet with surveys separately stored from the consent documentation. Surveys will be stored separately from the consent documents in a locked file.

All nurses' information will be treated with privacy. Data will be entered and stored in a secure research drive. Surveys and consent forms will be stored in U.S. file cabinets after data entry. Consent documentation and completed survey forms will be destroyed by shredding within seven years of study completion. Electronic data will be stored indefinitely for future use.

What are your legal rights in this research study?

Nothing in this consent form waives any legal rights you may have. This consent form also does not release the investigator, the sponsor Sigma Theta Tau International the institution, or its agents from liability for negligence.

What if you have questions about this research study?

If you have any questions or concerns about this research study, you should contact Ahlam Al-Natour at 027259370 in Irbid, Jordan. You may also contact Dr. Gordon Gillespie at +1 (513) 558-5236 in the United States.

The UC Institutional Review Board reviews all research projects that involve human participants to be sure the rights and welfare of participants are protected.

If you have questions about your rights as a participant or complaints about the study, you may contact the UC IRB at (513) 558-5259. Or, you may call the UC Research Compliance Hotline at (800) 889-1547, or write to the IRB, 300 University Hall, ML 0567, 51 Goodman Drive, Cincinnati, OH 45221-0567, or email the IRB office at irb@ucmail.uc.edu.

Do you HAVE to take part in this research study?

Refusing to take part will NOT cause any penalty or loss of benefits that you would otherwise have.

You may start and then change your mind and stop at any time. To stop being in the study, you should tell the primary investigator Ahlam al- Natour at 027259370 in Irbid, Jordan.

BY TURNING IN YOUR COMPLETED SURVEY YOU INDICATE YOUR CONSENT FOR YOUR ANSWERS TO BE USED IN THIS RESEARCH STUDY.

PLEASE KEEP THIS INFORMATION SHEET FOR YOUR REFERENCE.

Appendix D

Arabic Version of Information Sheet for Research

جامعة سينسيناتي
القسم : كلية التمريض
الباحث الرئيسي : أحلام الناطور
مستشار هيئة التدريس : د. غوردون غيليسي

عنوان الدراسة : العوائق التي تمنع فريق التمريض من التحري عن العنف من قبل الشريك الحميم

مقدمة :

سيطلب منك المشاركة في دراسة بحثية. الرجاء قراءة هذه الورقة بعناية وطرح أسئلة حول أي شيء أنت لم تفهمه. يقوم بدعم هذا البحث من قبل سيغما ثيتا تاو الدولية.

من هو الشخص المسؤول عن هذه الدراسة البحثية؟

الشخص المسؤول عن هذه الدراسة البحثية هي أحلام الناطور وهي طالبة في جامعة سينسيناتي - كلية التمريض. بإشراف د. غوردون غيليسي

ما هو الهدف من هذه الدراسة البحثية؟

الهدف من هذا البحث هو التحقيق في ممارسات التحري عن العنف من قبل الشريك الحميم من قبل الممرضين الأردنيين. على وجه التحديد ، ستقوم هذه الدراسة بتحديد معدل التحري عن العنف من قبل الشريك الحميم والموانع التي تواجه الممرضات عند التحري عن العنف من قبل الشريك الحميم في أماكن الرعاية الصحية الأردنية في مدينة اربد ، وبالإضافة إلى ذلك ، يتم جمع بيانات من الممرضات المعنفات من قبل الشريك الحميم. وسيتم مقارنة ممارسة التحري عن العنف من قبل الشريك الحميم بين الممرضات المعنفات وغير المعنفات.

من هم المشاركون في هذه الدراسة البحثية؟

ستشارك في هذه الدراسة البحثية حوالي 138 ممرض وممرضة. يشترط في المشاركين أن يكون (1) أردني (2) ممرض قانوني، دبلوم تمريض ، أو قابلة قانونية ، (3) يسكن في مدينة اربد ، (4) فهم و يتحدث باللغة العربية ، (5) والعمل في الوحدات النسائية في المستشفيات وقسم الطوارئ والعيادات النسائية والتوليد و المراكز الصحية ،. وسيتم استبعاد الممرضين الذين يعملون في اقسام الذكور في المستشفيات من هذه الدراسة.

ماذا لو كنت موظفا حيث تتم هذه الدراسة ؟

المشاركة في هذه الدراسة البحثية ليست جزءا من وظيفتك. ورفض المشاركة في هذه الدراسة لن تؤثر على عملك. فلن تكون هناك منافع مرتبطة بالعمل اذا قمت بالمشاركة في هذه الدراسة.

ما سوف يطلب منك أن تفعل للمشاركة في هذه الدراسة البحثية ، وإلى متى سوف يستغرق ذلك؟

1. ملء استبيان الدراسة . و يحتاج إكمال استبيان الدراسة 10-15 دقيقة خلال جلسة واحدة.
2. و تحتاج هذه الدراسة زيارة واحدة فقط لاستكمال الاستبيان.
3. سوف يتم إكمال استبيان الدراسة في غرفة خاصة حيث يكون مكان عملك.
4. سيتم وضع جميع الاستبيانات التي استكملت في صندوق مغلق للحفاظ على خصوصية معلوماتك.

هل هناك أي مخاطر للمشاركة في هذه الدراسة البحثية؟

لا يوجد أي مخاطر ناتجة عن المشاركة في الدراسة.

هل هناك أي فوائد ناتجة عن المشاركة في هذه الدراسة البحثية؟

ليس هناك فائدة مباشرة من المشاركة في هذه الدراسة. ولكن المشاركة في هذه الدراسة يمكن لها زيادة فهم الممرضات لأهمية الكشف عن العنف من قبل الشريك الحميم.

ما سيتم الحصول بسبب المشاركة في هذه الدراسة البحثية؟
وسوف تحصل على هدية قيمتها 5 دولار وهي عبارة عن (قلم، ميدالية، ودفتر) عند المشاركة في هذه الدراسة بغض النظر ما إذا تم إكمال الدراسة أو لم يتم إكمال الدراسة.

هل لديك الخيار حول المشاركة في هذه الدراسة البحثية؟
إذا كنت لا ترغب في المشاركة في هذه الدراسة البحثية ، يمكنك أن تختار عدم المشاركة أو ترك الاستبيان فارغا .

كيف سيتم الاحتفاظ بسرية معلومات البحث ؟
تم الحصول على إذن رسمي لإجراء هذه الدراسة من قبل مديرية صحة اربد - وزارة الصحة.
لن يتم وضع الاسماء او معلومات معرفة على استبيان البحث . لن يتم وضع أي مفتاح رمز أو قائمة لمطابقة المعلومات الفردية الخاصة لأحد المشاركين. وسيتم إبلاغ بيانات جماعية. وبالإضافة إلى ذلك ، لن يتم تبليغ أية بيانات فردية للمديرين في أماكن الرعاية الصحية.

سيتم وضع جميع الاستبيانات التي استكملت في صندوق مغلق محمول بواسطة باحث الدراسة الرئيسي اثناء الزيارات وجمع البيانات. في نهاية كل يوم ، سيتم حفظ الوثائق مع استبيانات الدراسة ونماذج موافقة المشاركين في خزانة مغلقة .

سيتم التعامل مع جميع معلومات الممرضات بخصوصية. وسيتم إدخال البيانات وتخزينها في محرك بحث آمن. وسيتم تخزين استبيانات الدراسة ونماذج موافقة المشاركين في خزائن الملفات الموجودة في الولايات المتحدة بعد إدخال البيانات. وسيتم أتلاف استبيانات الدراسة ونماذج موافقة المشاركين بعد سبع سنوات من انتهاء الدراسة. وسيتم تخزين البيانات الإلكترونية لاستخدامها في المستقبل لأجل غير مسمى.

ما هي حقوقك القانونية في هذه الدراسة البحثية؟
لا شيء في نموذج الموافقة هذا يلغي أية حقوق قانونية قد تكون لديكم. كما أن نموذج الموافقة هذا لا يعفي باحث الدراسة ، أو الراعي مؤسسة سيغما ثيتا تاو الدولية ، أو وكلائها من المسؤولية عند التقصير.

ماذا لو كان لديك أسئلة حول هذه الدراسة البحثية؟
إذا كان لديك أي أسئلة أو استفسارات حول هذه الدراسة البحثية ، يجب عليك الاتصال: أحلام الناطور في 027259370 في مدينة اربد ، الأردن. يمكنك أيضا الاتصال: د. غوردون غيليسبي 1(315)855-6325+ في الولايات المتحدة.

سيتم مراجعة جميع مشاريع البحث و التي تتضمن على مجموعة البشر المشاركين للتأكد من حماية حقوق وعدالة المشاركين بواسطة مجلس مراجعة البحوث .

إذا كان لديك أسئلة عن حقوقك كمشارك أو شكاوى حول هذه الدراسة ، اتصل بمجلس مراجعة البحوث في جامعة سينسيناتي 5259-558 (513). أو ، يمكن الاتصال على الخط الساخن (800) 1547-889 ، أو الكتابة إلى

IRB,
300 University Hall, ML, 0567,
51 Goodman Drive,
Cincinnati, OH 45221-0567,
or email the IRB office at
irb@ucmail.uc.edu

هل ستقوم بالمشاركة في هذه الدراسة البحثية ؟

رفض المشاركة لن يتسبب بأي عقوبة أو خسارة الفوائد التي قد تحصل عليها .

يمكنك البدء ثم تغيير رأيك والتوقف في أي وقت. للتوقف عن المشاركة في هذه الدراسة البحثية ، يجب ابلاغ الباحث الأساسي أحلام الناطور في 027259370 في مدينة اربد ، الأردن.

تحويل و اكمال استبيان الدراسة تشير إلى موافقتكم على استخدام إجاباتك في هذه الدراسة البحثية.

الرجاء الاحتفاظ بورقة المعلومات هذه للرجوع اليها

Appendix E

Manuscript 1

The Impact, Barriers, and Implications of Intimate Partner Violence Screening

Ahlam Al- Natour PhD(C), MSN, RN

University of Cincinnati

College of Nursing

The Impact, Barriers, and Implications of Universal Intimate Partner Violence Screening

Abstract

Intimate partner violence is an international public health phenomenon with a negative impact on victims' health. Nurses are among the first health care providers with whom patients interact in health settings and can play a crucial role in preventing, screening, and managing cases of intimate partner violence. Unfortunately, nurse screening rates remain low. Barriers to screening relate to nurses' personal beliefs and attitudes, health institutions, and victims. This review has implications for reducing screening barriers including educating health care providers for proper screening approaches. Health institutions should activate and enforce policies and protocols for universal screening. Health care administrators should provide support to health workers who screen. Further research should be conducted to investigate the effectiveness of reducing screening barriers.

Keywords: Intimate partner violence, screening, barriers, beliefs, victims

Introduction

Intimate partner violence (IPV) is an international public health problem taking the form of physical, sexual, and psychological violence. Physical and sexual violence against women ranges from as low as 15% to as high as 71% for women living in Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia and Montenegro, Thailand, and the United Republic of Tanzania. In addition, about 50% of these women were physically abused during pregnancy (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006). The IPV is also a problem for women in Islamic countries such as Jordan, where 15% of pregnant women underwent physical violence, 5.7% sexual violence, and 23.4% psychological violence by their husbands (Clark, Hill, Jabbar, & Silverman, 2009; Oweis, Gharaibeh, & Alhourani, 2010). The purpose of this manuscript is to provide an overview of the impact of IPV, the prevalence of IPV screening, the provision of services to victims of IPV, the existing IPV screening barriers, and implications for practice.

Physical and Mental Impact of IPV

Intimate partner violence has far-reaching consequences on the health of victims, specifically on women's physical and mental health. The physical health problems that IPV has been associated with includes headaches, disabilities, sexual transmitted infections, unwanted pregnancies, abortion, irritable bowel syndrome, gastrointestinal disorders, and poor overall health (Campbell et al., 2002; Garcia-Moreno et al., 2006). These physical health problems have a direct impact on emergency department (ED) utilization (Btoush, Campbell, & Gebbie, 2009; Fletcher, 2010). Btoush et al. (2009) found that about 86% of IPV victims' visits to the ED were related to mild or moderate pain, most commonly for injuries to the upper and lower extremities. This study showed that about 42% of victims were referred to other physicians or

clinics, 20% were asked to return to the ED, and 14% were referred to social and supportive services. In addition, Fletcher (2010) found IPV to be associated with poor physical health and more utilization of health care in a school-based nationally representative sample of adolescents living in the U.S.

Several researchers reported the impact of IPV for increasing the susceptibility to mental health problems such as depression (Mburia-Mwalili et al., 2010; Svavarsdottir & Orlygsdottir, 2009). Mburia-Mwalili et al.'s (2010) reported that 24% of women who experienced IPV were identified to have depression. Svavarsdottir and Orlygsdottir (2009) conducted a cross-sectional study to determine the relationship between physical and psychological health and the experience of IPV among Icelandic women. Findings revealed that researchers could predict physical and mental health problems when women were victims of IPV concomitant with risk behaviors such as alcohol abuse and smoking.

These findings reflect the extent of the problems IPV presents for victims. Screening for IPV is imperative as a first line effort to identify IPV earlier and decrease the deleterious effects of IPV.

The Prevalence of IPV Screening among Nurses

Nurses may be more likely to screen for IPV, because they have the first contact and prolonged contact with patients in most health care settings. Trautman et al. (2007), for example, found that of victims screened for IPV, 99% of screening was performed by nurses and the remaining 1% by other health care providers. However, researchers have shown that IPV screening by nurses is variable (Felblinger & Gates, 2008; Malecha, 2003; Smith, Rainey, Smith, Alamares, & Grogg, 2008; Spangaro, Zwi, Poulos, & Man, 2010; Thurston et al., 2007; Trautman,

McCarthy, Miller, Campbell, & Kelen, 2007). Malecha (2003) found that only 10% of nurses were actually screening for IPV. Felblinger and Gates (2008) reported that approximately 16.2% of occupational health nurses were screening for workplace IPV. Further, Thurston et al. (2007) found that approximately 39% of nurses were screening for IPV. More disturbing was the finding by Smith et al. (2008) that even though 27% of nurses suspected the existence of abuse, they did not screen or report the cases. Spangaro et al. (2010) found that of Australian women seeking care at Australian health care settings who screened positive for IPV, 56% (n=67) reported that this was the first time that they had been screened.

Intimate partner violence screening rates are variable and done infrequently. Even with 100% IPV screening, screening alone is not enough for the proper prevention and management of IPV. Services need to be provided to assure the safety and health of women victimized by IPV.

Services Provided to Victims of IPV

There are numerous services for victims of IPV. About 93% of services provided are social consulting (Crandall, Schwab, Sheehan, & Esposito, 2009). Other services involve referrals, sexual violence examinations, psychiatric consultations, pastoral care consultations, drug and alcohol counseling, and distributing IPV brochures. Spangaro et al.'s (2010) cross-sectional study showed that 56% of positively screened victims were referred to community services. These services included hospital social workers, police, IPV advocacy services, and a 24-hour IPV emergency hotline. Trautman et al. (2007) reported that while 53% of IPV victims were referred to social workers, 77% of the cases did not receive supportive services. Yun, Swindell, and Kercher (2009) gave potential insight to why the referral rate and services

provided to IPV victims were low. There were half the federal funding dollars given to IPV service providers in rural areas compared to urban area. In addition, there were significantly fewer services provided to victims in rural settings as compared to urban areas ($t = -6.27$, $p < .001$).

Many victims of IPV are referred to supportive resources and services. Despite the variety of services that may be available, many existent barriers may still prevent IPV screening by nurses.

Barriers for IPV Screening

Screening barriers are defined as those factors that prevent nurses from screening women for potential IPV (Furniss, McCaffrey, Parnell, & Rovi, 2007; Häggblom, Hallberg, & Möller, 2005; McGrath et al., 1997). Barriers contributing to the low rate of IPV screening by nurses can be clustered as nurse attitudes, nurse beliefs, victim barriers, and health institution barriers (Furniss et al., 2007; Goldblatt, 2009; Heinzer & Krimm, 2002; Häggblom et al., 2005; McGrath et al., 1997; Smith et al., 2008; Woodtli, 2001).

Nurses' Attitudes as Barriers

Attitudes are defined as the feelings that affect nurses' rate of IPV screening and will inhibit nurses from screening. Attitudes include anger, frustration, discomfort, and fear (Furniss et al., 2007; Goldblatt, 2009; Häggblom et al., 2005; McGrath et al., 1997; Smith et al., 2008; Woodtli, 2001).

Häggblom et al.'s (2005) descriptive study indicated nurses' attitudes toward victims of IPV were anger and frustration, because victims were returning to and staying in abusive relationships. Furniss et al.'s (2007) and Smith et al.'s (2008) descriptive studies identified

nurses' fear of abusers' reaction and retaliation, denial of the IPV situation, and being uncomfortable when legally involved. McGrath et al. (1997) showed the same findings toward nurses' feelings of discomfort and not wanting to be legally involved. Similarly, Heinzer and Krimm (2002) revealed nurses being uncomfortable when asking women about IPV. Nurses' feelings of discomfort, anxiety, and ongoing fear contributed to avoidance of IPV screening (Haggbloom & Moller, 2006; Minsky-Kelly, Hamberger, Pape, & Wolff, 2005; Woodtli, 2001). Nurses reported qualitatively that they experienced frustration, disbelief, rage, and fear (Henderson, 2001) when they were verbally threatened and physically intimidated by victims, relatives, and visitors. Hindin's (2006) findings supported those of Henderson (2001) in that nurses experienced fear when caring for women from other cultural groups. Also, nurses reported their fears about leaving victims of IPV without appropriate interventions and resources to meet victims' needs (D'Avolio, 2011). Nurses experienced conflicting attitudes toward IPV victims, including feelings of responsibility, care, anger, and being overwhelmed (Goldblatt, 2009; Haggbloom & Moller, 2006; Woodtli, 2001). Midwives in a qualitative study by Stenson, Sidenvall, & Heimer (2005) perceived their roles as caring for, supporting, and educating victims of IPV. Then the midwives experienced distress and anger when listening to victims' share their stories and worried about the victims' future. Finally, the midwives reported that when the partner was present, it influenced their practice. Feelings of failure, frustration, and guilt resulted when nurses or midwives were not screening all clients (Haggbloom & Moller, 2006; Stenson et al., 2005).

Frustration was commonly expressed by nurses (Hindin, 2006). Sources of frustration were other nurses' failure to identify victims, physicians' reluctance to properly intervene,

social workers' lack of knowledge, and an absence of administrative support. Furthermore, nurses were frustrated because of their inability to screen all clients, lack of privacy, heavy work load, no time to establish a trusting relationship, lack of community resources, and inability to provide help for IPV victims (Colarossi, Breibart, & Betancourt, 2010; D'Avolio, 2011; Djikanovic, Celik, Simic, Matejic, & Cucic, 2010; Haggblom & Moller, 2006; Minsky-Kelly et al., 2005; Ortiz & Ford, 2005; Stenson et al., 2005; Yun, Swindell, & Kercher, 2009). When clients refused help and stayed in abusive relationship, nurses' frustration was accentuated (Haggblom & Moller, 2006; Minsky-Kelly et al., 2005). Lack of screening was not always a conscious decision. Some providers simply forgot to screen or forgot to document the screening findings when they did screen (Owen-Smith et al., 2008). Moreover, Henderson (2001) reported nurses' improper emotional preparedness as an important barrier that may have led to a subconscious avoidance for IPV screening.

Nurses' attitudes toward screening are but one group of barriers affecting nurses' compliance for IPV screening. Even with a positive attitude towards screening, there remains the beliefs of nurses that may impact whether the nurses conduct IPV screening.

Nurses' beliefs as a barrier.

Nurses' personal beliefs are a second group of barriers to screening for IPV. Beliefs as a barrier are operationally defined as nurses' personal opinions or knowledge about victims and situations of IPV that explain why nurses do not screen for IPV. Some nurses believe there is not sufficient evidence for IPV being a problem, IPV is not a nursing issue, they are not properly prepared to address the problem of IPV, and thus are unsure and unaware of institutional policies for IPV screening (Felblinger & Gates, 2008; Furniss et al., 2007; Smith et al., 2008).

Also, nurses believed that victims require privacy and sensitivity when discussing IPV, victims will not disclose, victims will return to the abusive relationship, and victims will be embarrassed and ashamed (Goldblatt, 2009; Haggblom et al., 2005; Smith et al., 2008). In addition, Furniss et al. (2007) found that 59.5% of nurses believed language an important barrier to communicate with victims because of victims' cultural background.

Nurses' beliefs about IPV issues and practices were described as barriers that prevent nurses from screening for IPV. Nurses' beliefs about victims of IPV are a third group of barriers for IPV screening.

Nurse beliefs about victims of IPV.

Nurses held a variety of stereotypical myths about IPV. Myths were that IPV is a social problem not a health problem, victims will stay in abusive relationships, victims will not seek care and referral, victims have helpless personalities, IPV is a private and sensitive issue that should not be discussed with health care providers, victims will not disclose and interact with health care providers if IPV is discussed, and most women perceived being screened for IPV as offensive and unacceptable (Furniss et al., 2007; Haggblom et al., 2005; Robinson, 2010; Smith et al., 2008). The myth that victims would not disclose was qualitatively explored by Goldblatt (2009). Nurses in Goldblatt's (2009) phenomenological study reported that victims were embarrassed, and victims were afraid to live or raise children alone. Nurses in Hindin's (2006) and Goldblatt's (2009) studies stated that victims denied IPV. No evidence was found to support the other myths.

Nurses' personal attitudes, beliefs about IPV, and beliefs about victims of IPV are important barriers to IPV screening. In addition to these barriers, there are barriers deriving from the victims themselves that may negate the value of IPV screening.

Barriers for Victims to Disclose IPV

Victims of IPV refusal to disclose violence against them is a profound barrier to IPV screening. Victims' disclosure rate is very low at only 15% which discounts the ability of IPV screening to accurately identify the prevalence of IPV (Thurston et al., 2007). The lack of IPV confession may be due to women rationalizing the violent behavior against them. Women justified perpetrators violent acts by believing that the partners were unable to control their violence, the women themselves were the reason that their husbands became violent, or they did not think the violence was a serious problem (Johnston, 2006; Kearney, 2001; Lutz, 2005; Oweis et al., 2009; Spangaro, Zwi, Poulos, & Man, 2010).

Spangaro et al. (2010) reported that about 14% of women who reported being abused intentionally refused to disclose, because they did not think it was a serious problem, had discomfort in interacting with health care providers, and were worried and afraid of abusers. Lutz (2005) and Spangaro et al. (2010) found that women were also embarrassed or ashamed of being abused. Even though IPV is a manageable problem, victims of IPV have other priority concerns to disclose and report that these take priority during a health care visit.

Whether victims reported the IPV, victims did not routinely leave their abusers because they feared losing the custody of their children, feared partner retaliation, had no family support, lacked community services, had poor legal intervention, and were financially dependent on their partners (Garcia-Moreno et al., 2006; Oweis, Gharaibeh, Natour, &

Froelicher, 2009). In addition, Djikanovic et al. (2010) indicated that victims' economic dependency was not the only barrier keeping women in violent relationships; a lack of trust toward community services was also present as well as a lack of self-esteem or poor language skills native to the country where they were now living (Johnston, 2006; Yonaka, Yoder, Darrow, & Sherck, 2007).

Most importantly, women reported their frustration when they were not screened, if health care providers did not provide adequate information, or if their concerns were ignored or minimized (Lutz, 2005). Participants stated that their lack of reporting was sometimes due to the actions of the nurses conducting the screening: the care provider exhibited disinterest, did not believe them, didn't show concern towards them, judged them negatively, or stigmatized them. Women truly wanted health care providers to share information with them about IPV relationships (Lutz, 2005).

Health Institution Barriers

Institutional barriers are those factors present in the working environment (e.g., institution, organization) that prevent or impede nurses from IPV screening. Identified barriers were a lack of formal employee education, formal policy, administrative support, time to screen, and privacy.

It is the responsibility of health institutions to provide adequate education and training to nursing staff on IPV and screening procedures. Haggblom et al. (2005) found that only 22% of nurses received formal IPV education in their basic nursing education and 91% did not know the guidelines to manage IPV cases. A lack of preparation for IPV management was a common report (Furniss et al., 2007; Gutmanis et al., 2007; Yun et al., 2009). These findings reflect the

need for health care institutions to fill this educational gap so that patients may receive optimal care. As a result, nurses did not have adequate knowledge for IPV as a problem or how to conduct screening. Further, nurses didn't know the interventions available for victims, written materials documenting community resources, and the proper documentation practices after identifying cases of IPV (Colarossi et al., 2010; Djikanovic, Celik, Simic, Matejic, & Cucic, 2010; Ortiz & Ford, 2005; Owen-Smith et al., 2008). Additional gaps in knowledge that burden health care institutions are not knowing the right questions to ask, and the interventions for IPV victims, the institutional protocols and policies for IPV screening (Felblinger & Gates, 2008; Furniss et al., 2007; McGrath et al., 1997; Ortiz & Ford, 2005; Robinson, 2010).

Insufficient time was reported as a barrier for IPV screening (Furniss et al., 2007; Owen-Smith et al., 2008; Smith et al., 2008; Stenson et al., 2005). Ortiz and Ford (2005) indicated that (80%) of nurses and physicians reported the lack of time as a barrier for not screening for IPV while D'Avolio (2011) indicated that a heavy work load left no time for IPV screening. The expectation by institutions to provide more nursing care to more patients prevented them from establishing therapeutic relationships to initiate and promote client disclosure of IPV.

A lack of privacy and confidentiality within the institution served as yet another barrier to IPV screening (Henderson, 2001; Owen-Smith et al., 2008). Furniss et al. (2007) found that 91.7% of nurses did not screen due to a lack of privacy. Henderson (2001) found that nurses qualitatively indicated that they could not provide privacy which led women to feel uncomfortable and distressed, a situation certainly not conducive to IPV screening.

Summary and Implications for Practice

Victims of IPV suffer physically and psychologically due to IPV (Campbell et al., 2002). Intimate partner violence remains a hidden phenomenon preventing health care providers from providing a proper screening and proper referral to the needed services. Intimate partner violence screening among nurses is still very low (Malecha, 2003; Thurston et al., 2007); likely a result of the barriers present.

Nurses reported their fears of abusers revenge, anger from abusers and discomfort for being legally involved. Also, they reported their frustration when they found no administrative support, victims' refusal to leave abusers, and not being adequately prepared or educated to intervene for IPV (Colarossi et al., 2010; Furniss et al., 2007; Goldblatt, 2009; McGrath et al., 1997; Woodtli, 2001). Moreover, nurses believed that IPV screening was not a job-related task, IPV was a family sensitive matter, and victims would not disclose IPV opting to stay with their abusers (Smith et al., 2008). These attitudes and beliefs allowed nurses to justify their lack of IPV screening, not providing appropriate care, and not properly referring as expected for a health care provider. For some, this lack of screening and referral resulted in nurses blaming themselves and feeling guilty (Hägglom & Möller, 2006).

Nurses did not receive formal preparatory IPV screening education or training in either academia or employer-based institutional settings. Even with proper education, IPV screening may have been limited due to heavy workloads and a lack of time and patient privacy. A lesser emphasis may have been placed on IPV screening by health care institutions, because of a need to treat patients' primary complaints rather than screening for potential problems such as IPV.

It's important that health care leaders identify the IPV screening rate at their institutions and determine why screening rates may be lower than desired. It's possible that nurses' have a skepticism toward the effectiveness of screening and interventions for victims. It's equally possible that nurses themselves are victims of IPV, making it difficult for them to properly intervene or address IPV (Colarossi et al., 2010). By avoiding patient IPV screening, victimized nurses can avoid addressing their personal experience of IPV. Providing compassionate care to nurse victims is a critical step to addressing the problem of limited or ineffective IPV screening by nurses at large.

Ultimately, it is essential that the real and perceived barriers to IPV screening be eliminated. Appropriate screening and intervention of IPV dictates a multidisciplinary approach and partnership. A education of curriculum for prevention and IPV intervention needs to be adopted to detect cases of IPV early. The curriculum should address how to screen in a safe, caring, and compassionate manner. Ongoing periodic education is recommended to update and translate new research findings into practice and to assure continuity of updated interventions to overcome barriers to IPV prevention.

Finally, policies and procedures should be in place and operationalized that require the universal screening of all patients presenting to health care institutions. Screening should not be limited to young and middle aged adult women. All patients of all ages and both genders require IPV screening.

Conclusion

Intimate partner violence is not a problem likely to disappear. Unless IPV screening becomes a priority focus of nursing practice, the incidence of IPV will persist and potentially

escalate. Early case identification may allow early intervention through referrals of victims to community resources. Screening and intervention has the potential to preserve millions of lives around the world, promote the health of women and families, and decrease the deleterious effects of IPV. Future research should be conducted to examine effective measures that increase screening rates among health care providers and reduce perceived barriers. Additionally, further research is needed to investigate the effectiveness of community resources to assist in the reduction of continued victimization upon referral of IPV victims.

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Appendix F

Manuscript 2

Intimate Partner Violence against Jordanian Nurses

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ABSTRACT

Intimate Partner Violence against Jordanian Nurses

Purpose of the Article: The purpose of this cross sectional study was to estimate the rate of IPV against a stratified random sample of Jordanian nurses using the Woman Abuse Screening Tool.

Design: A cross sectional design was used with a sample of Jordanian nurses from public hospitals and clinics. Data were collected during summer 2011.

Methods: Participants were selected using stratified random sampling. Participants completed the Women Abuse Screening Tool and a demographic questionnaire. Chi-squared Goodness-of-Fit tests were computed to compare the rate of IPV against Jordanian nurses to U.S. prevalence rates.

Findings: The rate of IPV was significantly higher for Jordanian nurses experiencing psychological violence ($p < .0001$), lower for physical violence ($p < .0001$), and lower for sexual violence ($p < .0001$).

Conclusion: Violence against nurses is a problem in Jordan. Interventions should be adopted to protect the psychological health of Jordanian nurses.

Clinical relevance: IPV screening should target nurses the same as would be done for patients.

Key words: intimate partner violence, physical, psychological, sexual

Intimate Partner Violence against Jordanian Nurses

Physical, sexual, and psychological violence against intimate partners continues to be a global phenomenon with a detrimental impact on community health. Intimate partner violence (IPV) has been reported among ten countries as high as 71%, with physical violence during pregnancy at 50% (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006). The frequency rate of IPV against women in Jordan is comparable at up to 47.5% for psychological violence and 19.6% for physical violence by their husbands (Al-Nsour, Khawaja, & Al-Kayyali, 2009). During pregnancy, 10.4%-15% of Jordanian pregnant women reported physical violence, 23.4% psychological violence, and 5.7% sexual violence by their husbands (Clark, Hill, Jabbar, & Silverman, 2009; Oweis, Gharaibeh, & Alhourani, 2010).

Intimate partner violence results in poor physical and mental health. Intimate partner violence sequelae include headaches, unwanted pregnancies, spontaneous abortions, gastrointestinal disorders, depression, and poor overall health (Campbell et al., 2002; Garcia-Moreno et al., 2006; Mburia-Mwalili, Clements-Nolle, Lee, Shadley, & Yang, 2010; Svavarsdottir & Orlygsdottir, 2009). Furthermore, about 38% of IPV victims incur physical injuries (Btoush, Campbell, & Gebbie, 2009; Fletcher, 2010). Not surprisingly, IPV is associated with a greater utilization of health care services (Fletcher, 2010).

Nurses just like women in the general population are victims of IPV and experience IPV by their partners. Bracken, Messing, Campbell, La Flair, and Kub (2010) found that about 25% of American nurses reported physical or sexual violence and about 22.8% of them reported psychological violence by their intimate partners. A study conducted among registered nurses from seven urban and suburban hospital emergency departments in a Midwest metropolitan

area revealed that about 40% of registered male and female nurses reported experiencing IPV (Early & Williams, 2002). In another study conducted among female Mexican nurses, 42% reported psychological abuse and 18% reported physical and/or sexual abuse by their partners (Diaz-Olavarrieta, Paz, De la Cadena, & Campbell, 2001). In South Africa, Christofides and Silo (2005) reported the prevalence of IPV among nurses for physical abuse at 14.6% and psychological abuse at 37.7%. In addition, 40% of nurses reported intimate violence from friends and relatives.

Nurses are the primary caregivers in any health system. They play a significant and critical role in detecting, intervening, and providing referrals for victims of IPV. Although nurses are not frequently studied, nurses too are victims and should be screened for IPV. In Jordan, it is essential to determine the magnitude of IPV against Jordanian nurses. The purpose of this cross-sectional study was to investigate the rate of violence by intimate partners among Jordanian nurses working in governmental health settings in a northern city of Jordan.

This study is significant, because IPV against women has been linked to anger, frustration, distraction at work, and the loss of eight million days of paid work and 5.6 million days of household productivity each year (CDC, 2003; Häggblom & Moller, 2006; Reeves & O'Leary-Kelly, 2007). As the nursing shortage worsens, the impact of nurses missing work or being distracted while at work can be detrimental to patients and the health care system.

Method

This study used a descriptive cross-sectional design with nurses from ten health centers (maternal child health, primary health care, and family planning) and three public governmental hospitals in a city in northern city, Jordan. The study protocol was approved by the University of

Cincinnati Institutional Review Board (IRB) before and the study sites prior to the study initiation. The data reported in their study were part of a larger study addressing IPV screening in Jordan.

Sample

An *a priori* power analysis determined the need for a sample size of 103 nurses to achieve 80% power ($\beta = 0.20$). To account for attrition and missing data, 125 participants were approached for study participation. All participants approached agreed to participate and completed the study procedures. For each study site, a simple random sample of eligible nurses was recruited. Nurses were eligible to participate if they were (1) Jordanian, (2) female, (4) worked as a registered nurse, diploma nurse, or midwife at one of the study sites, (5) spoke and understood Arabic, and (6) worked in the emergency department, antenatal clinic, or female hospital ward. The final sample size meeting study inclusion criteria was 80. A post hoc power analysis based on sample size 80 and alpha .05 yielded 100% power for the psychological and sexual violence data and 79.2% power for the physical violence data.

Study Instrument

The study survey included the Woman Abuse Screening Tool (WAST) and a biographical questionnaire. The WAST was developed by Brown, Lent, Brett, Sas, Pederson (1996) to measure the frequency of physical, sexual, and psychological violence. The reliability of the WAST instrument is acceptable with a Cronbach's alpha indicating good internal consistency (0.95). The WAST items were measured using a 3-point Likert scale (often, sometimes, never). The demographic questions surveyed participants' personal information related to age, sex,

marital status, educational level, occupation, years of experience, religion, and health setting where they work.

Procedures

To assess the WAST's content validity, 10 bilingual Jordanian nurses working in administration, the emergency department, obstetrical/gynecology unit, and medical/surgical units were selected to evaluate the English version of the WAST. Each nurse was asked to determine whether the study instrument and individual items were valid to measure nurses IPV in the cultural context of Jordanian nursing. The 10 experts rated each item based on relevance, clarity, simplicity, and ambiguity on a four-point scale to yield an index of content validity (CVI) (Beck & Gable, 2001). All items were deemed as sufficiently relevant, clear, simple and unambiguous with a CVI ranging from 0.9 to 1.0.

The study instrument and informed consent document were translated to Arabic and reverse translated by two English professional translators holding a PhD degree in English studies and teaching in Jordan. The reverse translation for the study instrument and informed consent documents were reviewed to ensure that there were no differences between the original English versions and the back-translated English versions. No changes were warranted.

Participants were recruited during summer 2011. A list of nurses working in each unit was obtained from each nurse manager. Nurses were then randomly selected to achieve the quota for that study site. Study surveys were given a unique identifier. Potential participants were approached privately and explained the study purpose, benefits, and risks of participation. Participants provided verbal consent for study participation and received an information sheet, then completed the study survey in a private room. After finishing the

survey, participants put the survey in a locked box held by the investigator and received a small notepad and ink pen (\$5 value) as gratuity and compensation for participation.

Data Analysis

Data were analyzed using SPSS 19 (Chicago, IL) software. Descriptive statistics were computed for the WAST and demographic data. Chi-square Goodness-of-Fit tests were computed to compare the frequency of violence against participants in this study to statistics reported by Bracken et al. (2010) for physical (25%), psychological (22.8%), and sexual (25%) violence against nurses in the United States.

Study Results

Eighty female, Islamic, married, Jordanian nurses participated in this study. Single women do not have intimate partners in Jordanian society. Although single nurses participated in the larger study on IPV screening, questions on personal victimization by intimate partners were left blank by all single nurses. As a result, only data from the 80 married nurses were included. The mean age of nurses was 31.9 years (SD=6.2) and the mean for experience in nursing was 10 years (SD=6). Additional demographic data are presented in Table 1.

This study investigated the rate of IPV among Jordanian nurses (Table 2). Jordanian nurses experienced psychological violence most often ($n=46, 57.5\%$) followed by physical ($n=10, 12.5\%$) and sexual violence ($n=4, 5\%$). Compared to rates of IPV against United States' nurses, psychological violence experienced by Jordanian nurses occurred significantly more often (22.8% vs. 59%, $\chi^2[1] = 54.726, p < .0001$); whereas, physical and sexual violence occurred significantly less often (25% vs. 12.5%, $\chi^2[1] = 6.667, p = .0098$ and 25% vs. 5.1%, $\chi^2[1] = 17.067, p < .0001$ respectively).

Fifty-five (69.6%) of the Jordanian nurses indicated the existence of tension in their marital relationships. In association with marital arguments, 52 (65%) of the nurses experienced difficulty during the argument, 53 (66.3%) felt down or bad about self, 14 (17.5%) reported hitting and kicking or pushing during an argument, and 26 (32.5%) felt frightened of what their partner might say or do.

Discussion

Oweis, Gharaibeh, Al-Natour, and Froeliche (2009) indicated that physical, psychological, and sexual violence by husbands was a significant problem for Jordanian women. Jordanian nurses as Jordanian women experienced the same forms of IPV by their marital partners. Jordanian female married nurses in the current study reported psychological violence (59%), physical violence (12.5%), and sexual violence (5.1%). These results while significantly different from those reported by Bracken et al. (2010) are comparable to Al-Nsour et al.'s (2009) findings of 19.6% for physical violence and 47.5 for psychological violence. Both studies with Jordanian female samples reflected the occurrence of physical violence less than that of United States' nurses and psychological violence more than that of United States' nurses.

Jordanian married nurses just as women in other countries experienced a variety of intimate partner violence by their marital partners. This lack of immunity against violence may be due to the Jordanian female nurses living within an Arab, Muslim, and Jordanian cultural context. Jordan is an Arabic and Islamic nation located in the Middle East with about 6 million residents, 95% being sunny Muslims (Department of Statistics, 2010). Within the Arabic Muslim culture, women are expected to exhibit and follow the rules of the Islam and Jordanian culture toward marital relationships such as not leaving the abusive husband and not disclosing the IPV

to others including other healthcare providers. Gharaibeh and Oweis (2009) emphasized that Jordanian married women must follow their husbands' orders, needs, and demands as part of their cultural beliefs even if they are financially independent. This cultural norm dictates that Jordanian women accept the roles and expectations of their native culture.

In Jordanian culture, the family of origin is the source of support and protection for women. The absence of family support makes women vulnerable to financial, sexual, and occupational threats, feeling different, and being stigmatized by other members of their culture (Ibrahim & Howe, 2011). This family based culture assures the role of the family for making decisions for Jordanian women related to marriage, staying with abusive partners, and getting divorced. In most cases, Jordanian women do not make the final decision for staying or leaving a marriage (Oweis et al. 2009).

Ultimately, the cultural norms and traditions of Arab countries dictate that women as victims of IPV accept marital violence for the sake of family honor, to prevent the shame resulting from a divorce, and for the sake of their personal and family reputation (Douki et al., 2003; Haj-Yahia, 2000; Kulwicki et al., 2010). In addition, Arabic women leaving their husbands home go against family beliefs and norms (Haj-Yahia, 2000). Further reasons Jordanian women are expected to stay in and not leave their marital relationships are because the women will not be supported by their family, are afraid to lose child custody, and want to prevent the stigma associated with divorce (Al-Modallal, Abuihail, Sowan, & Al-Rawashdeh, 2010; Oweis et al., 2009).

Again, Jordanian culture indicates conservative rules toward male dominance and authority in controlling marital issues (Ibrahim & Howe, 2011; Khawaja et al., 2008; Oweis et al.,

2009). This dominant role gives men the right to control marital issues and decisions for the wives and unmarried daughters and sons. And in many cases, Jordanian culture justifies using violence against the wife and children as a way to control and discipline family members to resolve marital conflict. Khawaja, Linosand El-Roueiheb (2008) found that 61.8% of Jordanian women who experienced IPV and 60.1% of Jordanian men justified wife beating based on the Jordanian cultural male dominancy and authority role over their wives. Haj-Yahia (2000) indicated that Arabic men use violence against their wives to control them especially if their authority and power is perceived to be threatened by their wives. The limited occurrence of physical violence documented in the current study could be a result of nurses being more accommodative to the needs of other (i.e., patients). This accommodation could have transcended to the marital relationship. As nurses become better negotiators or learn to de-escalate aggressive persons, the rate of physical violence would legitimately decrease.

Jordanian girls and women are not taught about the dynamics for breaking the cycle of violence. As a result, both Jordanian men and women may rationalize the acceptance of IPV against women. Oweis et al. (2009) showed that Jordanian women rationalized husbands' violence and blamed themselves for violent events. Khawaja et al. (2008) found that Jordanian men rationalized IPV due to their unemployment, being married at a young age (under the age of 29), and their cultural authority to control their wives. It is possible that these reasons may have also led to the violence in our study; however, the causes of the violence were not assessed.

Moreover, Jordanian women are faced by limited supportive services in the Jordanian community. Oweis et al. (2009) indicated Jordanian women reported husbands seeking revenge

when women reported IPV to the police. Without a perceived sense of community support, even Jordanian nurses may continue to live in silence following the wake of IPV.

A misinterpretation of Qur'an verse (4:30) that addresses wife beating may allow some Muslims to abuse or have the perceived right to use violence against their wives as a way to control the perceived disobedience and misbehavior of wives. On the contrary, Ibrahim and Abdalla (2010) mentioned that Islam asks husbands to treat their wives with respect and mercy. Islam seeks to combat all forms of violence against women as dictated by Qur'an verses and the Prophet Muhammad. Another reason for the low rate of physical violence could be that the husbands of the nurses in the current study do realize that physical violence is not permitted by the Qur'an. However, the husbands may not perceive psychological violence exhibited by yelling and threatening behaviors as violence. This lack of acceptance of verbal aggression and intimidation as violence would then condone and lead to the high rate of psychological violence identified in our study.

Many married Jordanian nurses may have witnessed their mothers, aunts, neighbors, sisters, and other female relatives undergo IPV as well as see these women accept the IPV as a part of their daily lives and faith. Jordanian men may also become accustomed to using violence after witnessing violence within their family of origin. Oweis et al. (2009) indicated that Jordanian married male perpetrators typically witnessed violence during their formative years. Bandura (1977) emphasized that violence can be transmitted through generations. So, when children observe violent role models in the family or social life they too will use violence against others. Jordanian women witnessing IPV against their mothers and female relatives may lend

them to imitating their female role models and being more accepting of violence. This transmission of violence could continue to ensuing generations if not halted.

Jordanian female nurses are highly educated, financially independent, and employed in one of the most important professions in Jordan. Jordanian female nurses may be reluctant to disclose IPV by their husbands, because they too feel shame and embarrassment. Reporting their IPV may affect their professional prestige, personal dignity and reputation among their colleagues, and the reputation of their family of origin. These desires for prestige, dignity, and reputation could justify the relatively lower percentage of physical and sexual violence reported among Jordanian female nurses in comparison to other women in the Jordanian community. If the frequency of IPV truly is higher than reported, Jordanian nurses may be even more vulnerable to the negative effects of IPV and remain excluded from the potential, albeit limited, social services afforded to victims of IPV.

Jordanian nurses reported lower sexual abuse than United States' nurses. This finding may be the result of Jordanian women being reluctant to report or discuss their sexual life. Oweis et al. (2009) emphasized sexuality being a sensitive topic in the Arab Muslim and Jordanian conservative culture. Ibrahim and Howe (2011) showed that Jordanian Bedouin beliefs indicated the controlling role of family in female sexual life until the woman is married. In addition, Islam prohibits married couples from openly discussing their intimate relationship. Furthermore, female Jordanian nurses may feel shame and embarrassment when discussing their sexual life with a family member or sexual consultant. As a result, Oweis et al. (2009) indicated that sexual violence will rarely be discussed and rarely reported to the legal authorities or health specialists. In addition, Jordanian women cannot report sexual violence by

non-marital partners to their family for fear of the family committing an honor killing (Ibrahim & Howe, 2011). Assuming that intimate partner violence would occur against an unmarried nurse, the fear of an honor killing would prevent single nurses from answering the questions for IPV. Because all the single nurses in this study left the items blank, it may be more likely that the nurses do not have intimate partners and any violence they experience would derive from their male family members with whom they will live until marriage.

In summary, Jordanian women live within an Arab, Muslim, Jordanian culture is a family based, male dominant, and conservative culture that considers women's life events tied to family honor. This relationship to family honor can give Jordanian men a perceived justification for wife beating. Additionally, a misinterpretation of the Qur'an may further justify violence against women. The same misinterpretation by women may partially explain why female nurses felt bad about arguing with the men in their lives and continue to be victimized. Living within Jordanian cultural beliefs dictates women staying in abusive relationships, accepting their abusive relationships, and avoiding disclosure of IPV to family, nurses, and social workers. The reluctance of Jordanian nurses to report or discuss their personal IPV will keep IPV hidden and underestimated among Jordanian women and nurses.

Study Limitations

This study was limited by its cross-sectional design and use of self-report data. Participants that were victims of IPV may not have honestly reported their violence. This limitation was minimized by private data collection, anonymous surveys, and the ability of participants to place their completed surveys in a locked box. Additionally, this study was

conducted in a single city of northern Jordan which limits the generalizability of the study findings.

Implications

Jordanian nurses are not immune to IPV. Nurses as victims of IPV need to be screened, supported, and helped by their fellow healthcare administrators, colleagues, and other healthcare providers.

As a caring profession, all nurses should be educated on the need for IPV assessment and screening, proper documentation and reporting, personal safety plans, proper referral to supportive community services, and dynamics to break the cycle of violence. This education should start during adolescence and continue into professional education. Nurses should help and support their professional colleagues when IPV is suspected or occurs. Nurses should talk openly about IPV, encourage victimized nurses to report IPV to legal entities, create a safe work environment that allows for disclosure of IPV without the risk of ostracism, and use a therapeutic approach when communicating with nursing peers undergoing IPV.

Healthcare administrators and managers should support and assist nurses undergoing IPV, provide education about IPV issues and proper intervention to help victims, and enforce screening protocols at all health settings. Social workers at the health institutions must provide counseling to victimized nurses, report known violent events, provide support, and refer victims to appropriate community services. Furthermore, religious leaders can work actively within their mosque communities to correctly interpret the Qur'an in an effort to prevent and halt IPV.

Conclusion

Jordanian nurses experienced IPV, especially psychological violence, by marital partners. It is critical that all nurses be screened and interventions be applied to support the health, wellness, and safety of the Jordanian nursing population. Further studies are needed to investigate the severity and negative impact of IPV on the health and work productivity of Jordanian nurses. Phenomenological studies can explore the meaning of the lived experience of nurses undergoing IPV within their cultural context and contrast their experiences to those of United States' nurses.

Clinical Resources

- Centers for Disease Control and Prevention:
<http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/index.html>
- National Center for PTSD: <http://www.ptsd.va.gov/public/pages/domestic-violence.asp>
- National Institute of Justice: <http://www.nij.gov/topics/crime/intimate-partner-violence/welcome.htm>
- United Nations Population Fund: <http://www.unfpa.org/swp/2005/english/ch7/>
- World Health Organization:
http://www.who.int/violence_injury_prevention/violence/sexual/en/index.html

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Table 1

Sample demographics (n=80).

	Percentage	Number
Education level		
Diploma in nursing	52.5%	42
Bachelor in nursing	42.5%	34
Master in Nursing	5%	4
Occupation		
Midwife	41.3%	33
Diploma nurse	13.8%	11
Staff nurse	45 %	36

Table 2

Types and consequences of intimate partner violence (n=80).

Criteria	Percentage	Frequency
Physical violence	12.5%	10
Psychological violence	57.5%	46
Sexual violence	6.25%	5
Tension	69.6%	55
Argument/difficulty	65%	52
Argument/feeling Bad or Law	66.3%	53
Argument result in Kicking	17.5%	14
Have Fears of what partner say/do	32.5%	26

Appendix G

Manuscript 3

Jordanian Nurses Barriers to Screening for Intimate Partner Violence

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ABSTRACT

Screening rates for intimate partner violence (IPV) among nurses are still very low. The study purpose is to evaluate IPV screening and barriers by Jordanian nurses. A cross-sectional design was used with a stratified random sample (n=125) of Jordanian nurses. Findings included a significantly lower IPV screening rate among Jordanian nurses compared to U.S., no difference in screening between IPV victims compared to non-victimized nurses, and the IPV screening barriers related to a lack of system support were the most clinically important barriers. Nurses can work in partnership with healthcare providers and managers to increase screening and overcome barriers.

Key words: intimate partner violence screening, attitudes, barriers,

Jordanian Nurses Barriers to Screening for Intimate Partner Violence

Study Background and Significance

Combating intimate partner violence (IPV) needs to be a priority for healthcare organizations worldwide because of the serious impact on patients and the community. IPV is a global phenomenon linked to physical and psychological harm as well as increased healthcare utilization (Btoush, Campbell, & Gebbie, 2009; Fletcher, 2010; Campbell et al., 2002; Garcia-Moreno et al., 2006; Mburia-Mwalili, Clements-Nolle, Lee, Shadley, & Yang, 2010; Svavarsdottir & Orlygsdottir, 2009). This increased healthcare utilization provides ample opportunity to screen patients for IPV victimization. The purpose of this study is to estimate the rate of IPV screening and to investigate IPV screening barriers among Jordanian nurses. The specific aims of this study are to (1) investigate the frequency rate of IPV screening, (2) identify barriers to IPV screening, (3) compare screening rates between U.S. American nurses and Jordanian nurses, and (4) differentiate IPV screening rates between victimized and non-victimized Jordanian nurses.

Screening for IPV by nurses is necessary and important because screening can increase early detection of IPV victims. Upon identification, victims can then be provided psychosocial support and community service referrals (Tower, 2006; Trautman, McCarthy, Miller, Campbell, & Kelen, 2007). Screening for IPV may also improve victims' quality of life (MacMillan et al., 2009). Despite the importance of IPV screening, nurse screening rates remain abysmally low ranging from 10% to 39% (Malecha, 2003; Thurston et al., 2007).

The low rate of IPV screening may be attributed to barriers encountered by nurses. Previously identified barriers include nurses' beliefs and attitudes about IPV victims, health

institutions, and the IPV victims themselves (Furniss, McCaffrey, Parnell, & Rovi, 2007; Goldblatt, 2009; Häggbloom, Hallberg, & Möller, 2005; Heinzer & Krimm, 2002; McGrath et al., 1997; Smith, Rainey, Smith, Alamares, & Grogg, 2008; Woodtli, 2001). Nurses' attitudes as barriers were perceived in terms of frustration with the inability to provide help, anger from perpetrators, and fear of becoming legally involved (Furniss et al., 2007; Goldblatt, 2009; Häggbloom et al., 2005; McGrath et al., 1997; Smith et al., 2008; Woodtli, 2001). Nurses held some beliefs that limited IPV screening: IPV screening is not a nursing role, IPV is a sensitive familial topic, and victims will not disclose IPV events or leave their abusers due to low self-esteem and helplessness (Felblinger & Gates, 2008; Furniss et al., 2007; Goldblatt, 2009; Häggbloom et al., 2005; Johnston, 2006; Robinson, 2010; Smith et al., 2008). Barriers for IPV screening were the lack of nursing education and training on IPV, the inadequacy of time and privacy to conduct IPV screening, and the lack of administrative support for IPV screening and screeners (D'Avoilio, 2011; Felblinger & Gates, 2008; Furniss et al., 2007; Ortiz & Ford, 2005; Thurston et al., 2007). Additionally, nurses held several perceptions about why IPV victims would not disclose their violence: victims feared losing child custody, victims felt ashamed or embarrassed, and victims believed nurses had an inappropriate approach to screening (Garcia-Moreno et al., 2006; Lutz, 2005; Oweis, Gharaibeh, Natour, & Froelicher, 2009; Spangaro, Zwi, Poulos, & Man, 2010).

Research reporting nurses' barriers to IPV screening was mostly conducted in Western countries, which have a different cultural context than the Middle Eastern, conservative culture of Jordan. While the prevalence of IPV in Jordan is high and thus warrants the need for IPV screening (Al-Natour, Gillespie, Wang, & Felblinger, 2012), there were no studies found

estimating the rate of IPV screening by Jordanian nurses nor barriers to IPV screening. Also, there were no Jordanian studies comparing the screening rates of nurses based on their personal IPV experience (victimized vs. non-victimized). Minsky-Kelly, Hamberger, Pape, and Wolff (2005) found that experiencing IPV could hinder nurses IPV screening or providing the help for victims of IPV relating the importance of comparing these two groups.

So, determining the barriers for Jordanian nurses to screen for IPV can help health planners and researchers reduce those barriers. Reducing barriers could increase screening rates for, and detection of cases of IPV. Earlier detection can lead to earlier referral for IPV victims. Based on available information, it was hypothesized that the frequency of IPV screening would be significantly lower in Jordan than Western countries and the IPV screening rate would differ between Jordanian nurses victimized by IPV and non-victimized Jordanian nurses.

Study Method

A descriptive cross-sectional design was used to estimate the rate of IPV screening by Jordanian nurses and barriers impacting their ability to screen for IPV. This study was approved by the University of Cincinnati Institutional Review Board (IRB), and received official permission by government officials and health care leaders in the Jordanian city where the study was conducted.

Settings and Sample

A stratified random sample was employed to recruit 125 nurses from Jordanian hospitals and public health clinics; specifically, three adult hospitals and ten public health clinics. To participate, the nurses had to be a Jordanian nurse (registered nurse, midwife, or diploma

nurse), live in the Jordanian city where the data were collected, and work in an area that provided nursing care to female patients (female hospital units, health clinics, or emergency department).

Study Instrument

Instrumentation included the Domestic Violence Health Care Provider Survey (DVHCPS), Women Abuse Screening Tool (WAST), and a demographic survey. The DVHCPS measures healthcare providers' IPV knowledge, attitudes, beliefs, and the ability to apply this knowledge in daily practice and IPV screening (Maiuro et al., 2000). This 42-item instrument was previously validated and deemed a comprehensive scale to study health care providers' readiness to screen for IPV as well as the frequency and barriers of IPV screening (Maiuro et al., 2000). The instrument is psychometrically sound with Cronbach alphas found to be acceptable ranging from 0.73 to 0.91 (Maiuro et al., 2000).

The DVHCPS items are categorized under six domains using a 5-point Likert-type scale ranging from *Strongly Disagree* to *Strongly Agree*. The domains are self-efficacy, system support, victim blaming, professional role resistance, victim provider safety, and frequency of IPV screening. The self-efficacy subscale includes questions about nurses' ability to intervene properly for victims of IPV. The system support subscale includes questions about the availability of community supportive services for victims of IPV. The victim blaming subscale addresses perceptions and beliefs toward victims of IPV. The professional role resistance subscale includes questions about perceptions and beliefs of the professional role of IPV screening. The victim providers' safety subscale includes questions about concerns and interest in personal safety and victims' safety after IPV disclosure. The frequency of IPV screening

questions relate to the frequency of IPV screening when providing care for patients seeking care for injuries, irritable bowel syndrome, chronic pelvic pain, hypertension, headaches, and signs and symptoms of anxiety and depression.

The WAST developed by Brown, Lent, Brett, Sas, and Pederson (1996) was used in this study to categorize the Jordanian nurses as having been a victim of physical, sexual, and psychological violence. The reliability of the WAST instrument is acceptable with a Cronbach's alpha indicating good internal consistency (0.75). No validity information was found. The 16-item tool measures the presence of intimate partner and domestic violence.

The demographic questionnaire asked for participants' age, sex, marital status, religion, educational level, occupation, years of experience, and health settings/units where they work. With the exception of age and years of experience, questions used forced-choice responses.

The instruments were developed for a Western culture. As a result, the validity and reliability of the instruments were assessed for this study. A group of 10 nursing professionals served as content experts to evaluate the content validity of the instrumentation for the Jordanian cultural context using a four-point content validity index (CVI; Polit & Beck, 2006). Two of the items yielded CVI of 0.7. Both items were retained due to their clinical significance for IPV screening. Remaining items yielded a CVI of 0.9 to 1.0 reflecting adequate instrument validity. Internal consistency reliability of the DVHCPS reflected sound reliability for the data in the current study; the Cronbach alpha was 0.736. The Cronbach's alphas for the instrument domains ranged from 0.504 to 0.714.

Procedures

An Arabic version of the study instruments was provided to participants. The process of translation/reverse translation is reported with details in another study (Al-Natour et al., 2012).

A random sample of hospital units and a random sample of health clinics were selected for study recruitment. Nursing managers were approached to obtain a list of nurses working in their departments. Each roster had 10-20 nurses (1,359 total nurses were eligible based on the department rosters). Two to three nurses were randomly selected from each hospital unit and health clinic roster to yield a sample of 125 nurses. After agreeing to hear about the study, potential participants were read the information sheet that detailed the study purpose, risks, benefits, voluntariness of participation, and right to withdraw or refuse to participate. Nurses pronounced verbal consent and were given anonymous paper copy of the study survey and filled it in a private room to assure their confidentiality. Participants completed the survey over a 15 minute period while alone in a private room. Upon completion, participants put the survey in a locked box held by the researcher and were given a gift with a \$5 value as compensation for their participation.

Data Analysis

Data were analyzed using SPSS 19 (Chicago, IL) software. Descriptive statistics were computed to determine the frequency rate of IPV screening, barriers to IPV screening, and nurses as victims of IPV. A one proportion z-test was computed to determine if the IPV screening rate by Jordanian nurses was significantly less than the IPV screening rate of 39% by U.S. This percentage was selected, because this statistic was the only percentage reporting screening by a representative sample of U.S. nurses vs. physicians or occupational health

nurses. Frequencies and percentages were calculated to determine the agreement of the presence of IPV barriers. Also, a two-tailed two proportion z-test was computed to determine if the IPV screening rate by Jordanian victimized nurses was significantly different than the IPV screening rate of non-victimized Jordanian nurses. All statistical analyses were based on alpha 0.05.

Study Results

A total of 125 Jordanian nurses, primarily female (n=103, 82.4%) sample participated in this study. The mean age of participants was 31.9 years (SD=6.2). The mean years of nursing experience was 10 years (SD=6). Most nurses were married (76.8%, n= 96) with the remaining nurses being single (20%, n=25) or divorced (2.4%, n=3). All but one of participant was Muslim. Additional demographic data are presented in Table 1.

Jordanian nurses screened for IPV most often when women sought care for physical injuries (25%). Of lesser frequency was IPV screening for patients complaining of depression and anxiety (20%), chronic pelvic pain (17.8%), hypertension and coronary artery disease (14.9%), headaches (11.5%), and Irritable Bowel Syndrome (3.3%). Nurses screened 10.8% of patients receiving pregnancy and gynecologist obstetric care. The z-tests revealed that the Jordanian nurse screening rates for injuries, chronic pelvic pain, Irritable Bowel Syndrome, headache, depression and anxiety, hypertension and coronary artery disease, and pregnancy and gynecologist obstetric care were significantly lower than the rate reported with U.S. nurses (see Table 2).

Jordanian nurses in this study reported several sources of barriers based on the DVHCPS items including: self-efficacy, system support, victim blaming, professional role resistance,

victim provider safety (see Table 3). Related to self-efficacy and nurses capability for screening, about 72% of nurses disagreed that they have access to IPV information and 61.6% disagreed that they were confident in referring victims of IPV. For the system support domain, most (78.4%) disagreed with having access to social workers and only 50.4% agreed that social workers can provide help to IPV victims. Moreover, most (72.6%) believe that IPV victims do not have access to mental services and most (79.8%) disagreed with the capability of mental health services to provide help for IPV victims. Related to self-blame domain, a vast majority (72%) agreed that victims' personalities contributed to the IPV against them. In addition, 52.4% agreed that people choose to be IPV victims. According to professional role domain, over half (59.2%) agreed they were afraid of offending patients when asking about IPV. Additionally, nearly half (49.6%) agreed that it was not their role to ask about IPV when victims choose not to disclose their victimization. Related to victim/provider safety domain, Jordanian nurses were concerned about their own safety and victims' safety. However, 75.2% agreed it was possible to ask about IPV without endangering themselves. Despite this, most nurses (73.6%) agreed that they were still afraid of a batterer's anger when being challenged and 62.4% were afraid that asking about IPV could increase victims' risk (see Table 3).

Of the study sample, 92 (74%) nurses experienced some type of intimate partner or domestic violence (i.e., emotional, sexual, physical). The remaining 33 nurses (26%) reported no personal violence. The screening rate by Jordanian victimized nurses, while not significant, was more than non-victimized nurses for women with chronic pelvic pain (23.5% vs. 14.3%) and patients seeking obstetric gynecologist care (12.5% vs. 9.5%). The two-tailed two proportion z-tests revealed there was no significant difference between the proportions of nurses that

screened for IPV based on personal violence experiences. Conversely, non-victimized nurses screened patients more often than victimized nurses when patients presented with injuries (27.8% vs. 20.8%) or were anxious or depressed (22.4% vs. 15.4%). Again, the z-proportion tests revealed no statistical difference between screening prevalence for the two groups of nurses (see Table 4).

Discussion

IPV Screening By Jordanian Nurses

Intimate partner screening rates by Jordanian nurses was low. The highest screening rate was done for women seen for injuries (25%). Btoush et al. (2009) indicated that the most common diagnosis for IPV victims seeking care in the emergency department in Columbia was related to upper and lower extremity injuries (49%). Othman and Mat Adenan (2008) found that injuries resulting from violence might be one of the most common complaints seen at three primary health care clinics in Malaysia. However only half of the Malaysian clinicians screened and asked the patients about the underlying causes of their injuries. A consistent lack of screening even for females with injuries is occurring.

IPV Screening by Jordanian and U.S. Nurses

Thureston et al. (2007) indicated that the IPV screening rate for U.S. nurses was 39%. The rate of Jordanian nurses screening for IPV was significantly lower than screening by U.S. nurses. Lower screening rates by Jordanian nurses could be related to the barriers encountered by nurses which hindered their screening of patients seeking care in Jordanian health settings.

IPV Screening Barriers

A multitude of barriers were identified that likely hindered IPV screening by Jordanian nurses. The DVHCPS categorized these barriers in five domains. The domains include self-efficacy, system support, blaming the victims, professional role, and victim/provider safety.

Self-efficacy barrier.

Only about half of the nurses reported using strategies to help victims and batterers. This low percentage may have resulted from the lack of IPV knowledge provided to nurses for IPV screening and intervention (Colarossi, Breitbart, & Betancourt, 2010; Felblinger & Gates, 2008; Othman & Mat Adenan, 2008). In addition, 40% of the sample, a finding similarly found in other studies, reported that they did not have enough time in their daily practice for IPV screening (Furniss et al., 2007; Ortiz & Ford, 2005).

System support barrier.

System support domain was identified as the greatest cluster of barriers among study participants. System support such as social and mental health services is important so that victims can be referred to entities that will provide help and support while promoting victims safety. Nearly half of nurses disagreed with the importance of social workers providing this much needed help and support, and 78.4% disagreed with having access to social workers. Othman and Mat Adenan (2008) indicated that less than 75% of nurses and physicians had access to social services, and only 10% reported that social workers were capable of providing the needed help for IPV victims. Even when nurses were able to refer victims of IPV to social workers, Thurston et al. (2007) wrote that only 53% of victims were ultimately referred. Equally troubling is that when nurses have access to social services, there may still be gaps and an

inadequacy in the services that are provided to IPV victims (D'Avolio, 2011; Thurston et al., 2007).

Nurses overwhelmingly disagreed that mental health services were important or capable to help IPV victims. This might be a reflection that the nurses did not have access to mental health services for their patients. However, seeking mental healthcare is vital for IPV victims. Al-Modallal, Abuidhail, Sowan, and Al-Rawashdeh (2010) stated that Jordanian women who experienced IPV and depression symptoms did not seek mental health services because they were unaware of the serious effects of mental illness or the value of mental health care. In addition, IPV victims might have fears of being stigmatized by their communities and families. Jordanian nurses undervalued the importance of mental health services and inaccurately held a perception of people seeking mental healthcare which could be used to justify their beliefs about the ineffectiveness of mental healthcare to address the psychosocial needs of victims. Additionally, few Jordanian health settings provide social or mental health services. So, even if Jordanian nurses are educated about community services available, nurses will likely be unable to access them. More important, Jordanian IPV victims refused to disclose IPV or to be referred to legal, social, or mental services to avoid being culturally stigmatized and for preserving the reputations of themselves and their family (Al-Modallal et al., 2010; Douki et al., 2003; Haj-Yahia, 2000).

Blaming the victim barrier.

Jordanian nurses held beliefs and attitudes about IPV victims that likely hindered their screening and providing appropriate care. Nurses' preconceptions and beliefs included that victims had passive personalities that resulted in the IPV situation. These findings are supported

by Djikanovic, Celik, Simic, Matejic, and Cucic, (2010) and Johnston (2006) who indicated that victims of IPV are sometimes perceived as having personalities that account for their victimization: low self-esteem, self-blame, and dependent personalities. Regardless of a woman's personality, women should never be blamed for the violence they experience.

Jordanian nurses also believed that victims' actions such as going against traditional and cultural marital mores could result in IPV against them. Oweis et al. (2009) found that Jordanian women rationalized violence against them and reported that their actions led to violence by husbands. Living within a Jordanian culture dictates following traditional male dominant roles for marriage and going against these rules means going against familial rules and norms which is not accepted and could result in an IPV relationship (Gharaibeh & Oweis, 2009; Haj-Yahia, 2000; Ibrahim & Howe, 2011). As a result, living within this thought schema could justify why more than 60% of Jordanian men and women justify wife beating as a way for men to establish their right to control and abuse women (Khawaja, Linos, & El-Roueiheb, 2008).

Shockingly, some Jordanian nurses believed that victims could get some benefits from staying in a violent relationship. Oweis et al. (2009) explained that Jordanian women may stay with batterers due to their financial dependence on batterers, lack of family support, and fear of losing their children. Nurses are expected to provide appropriate care and assure the safety of victims despite their personal and cultural beliefs about marital relationships. As Jordanians, the nurses in this study had beliefs which were reflective of their Jordanian cultural beliefs and these views may have contributed to any negative opinions of IPV screening.

Professional role barrier.

Nurses have a professional responsibility to appropriately screen all patients seeking health care. Nurses held preconceptions about IPV screening such as their inability to ask about IPV because it is a sensitive familial issue and they fear offending patients or making them angry. Felblinger and Gates (2008) found that 70% of nurses did not know what question to ask IPV victims. Smith et al. (2008) found that nurses were reluctant to ask about IPV, because they feared disrupting their patients' privacy. More importantly, Jordanian culture is conservative and women do not report sexual violence (Oweis et al., 2009). Therefore, Jordanian nurses might be reluctant to ask about sexual violence to prevent offending patients or not feel competent to screen.

In this study, more than half of the nurses were afraid of offending their patients when asking about IPV and believed that victims would refuse to disclose IPV. This likely led to the belief that IPV screening and resolving marital conflict was not an attainable nursing function. These findings are supported by Felblinger and Gates (2008), Furniss et al. (2007), and Smith et al. (2008) whose participants indicated that IPV screening was not a nursing role. Nurses should be educated to screen and ask patients in an appropriate way about IPV. Placing value on IPV screening is a necessary first step towards the universal screening of all patients.

Victim/provider safety barrier.

Nurses' concerns about safety are an important factor hindering screening for IPV. Djikanovic et al. (2010) revealed nurses concerns and fears about their own and victims safety when screening for IPV. Nurses' safety concerns could be related to the inadequacy of security services at the Jordanian health settings to protect them when interacting with batterers and

screening victims for IPV. These findings were similar to the findings of Oweis et al. (2009) who indicated that Jordanian victims underwent batterers' retaliation and revenge and increased violence severity and intensity after their IPV disclosure. A focus on nurse and victim safety should be considered when attempting to collaborate with Jordanian nurses to increase their rate of IPV screening.

IPV Screening by Victimized and Non-victimized Jordanian Nurses

Jordanian nurses experienced some type of intimate partner or domestic violence (i.e., emotional, sexual, physical). This study found no significant difference between victimized and non-victims nurses in screening practice. Contrary to that, Minsky-Kelly et al. (2005) stated that being a victim of IPV could hinder nurses' IPV screening making it difficult for the nurses to intervene on behalf of their patients that are also victims of IPV. Additionally, this study revealed that only 45% of U.S. nurses were knowledgeable of the ways and strategies to decrease IPV. Being a nurse undergoing IPV could result in an interpersonal conflict with these strategies because victimized nurses could not help themselves or break the cycle of violence which could accordingly prohibit their IPV screening.

Limitations

This study was potentially limited by selection and measurement bias. Data for participants may be different from non-participants leading to selection bias. This limitation was minimized by using a random sample recruitment strategy. Data were self-reported and may have limited the study findings. Data were collected from Jordanian nurses in one city and results may not be generalizable to all Jordanian nurses. This study used a Western culture instrument which could affect its cultural congruence when used for the first time with a

Middle Eastern culture. This limitation was curtailed based on the high CVI scores provided by the Jordanian nationals serving as content experts.

Study Implications

Increasing screening frequency by Jordanian nurses requires the elimination of barriers. Overcoming and eliminating nurses' barriers to screening requires a multi-sectoral partnership and effective strategies and approaches including IPV education, health institutional support and initiatives to increase IPV screening, and access to community-based social and mental health services.

Adequate education and training needs to be provided to nurses and other health care providers about the causes and consequences of IPV, safety plans (Othman & Mat Adenan, 2008), and strategies to stop the cycle of violence. Jordanian nurses can be educated about therapeutic communication skills and wording to use that encourages victim disclosure. Nurses need to support victims even if victims choose to not seek help or report IPV. Btoush et al. (2009) emphasized the significance for improving screening, detecting, and accurate documenting and reporting IPV. Nurses can be knowledgeable about the accessibility, functions and types of services, and strategies for helping IPV victims offered by community-based social and mental health workers.

System support is perceived as the most significant barrier to IPV screening by Jordanian nurses. Health institutions can decrease the patient-nurse staffing ratio to a level allowing sufficient time for the implementation of a mandatory IPV screening program of all patients. Organizations should design or redesign the patient care environment to provide private areas

where screening can take place. Administrative support can be provided to screeners. The physical safety of nurses as screeners needs to be assured through adequate security measures.

Community health services such as safe shelters and social and mental health services need to be readily accessible to IPV victims without a referral. Social and mental health workers can be educated about the magnitude of IPV, proper communications, crisis intervention approaches, and intervention strategies to help IPV victims when receiving referrals from nurse screeners. Current resources in Jordan such as the Family Protection Unit need to take a more proactive role in addressing IPV and work in partnership with Jordanian health settings to facilitate the process of referral and care, assurance of safety after IPV disclosure, and follow-up for IPV victims in their communities. In addition, health policy makers need to enforce a mandatory IPV screening practice at all health settings and community services, provide financial and technical support for screening units, provide a national surveillance and a national database, and monitor educational screening programs at all family based services.

Jordanian community awareness needs to be directed toward combating traditional and cultural rules that trap Jordanian women in IPV marital relationships, combating the illegal actions of honor killings, and assuring women rights and decisions in marriage and staying/leaving abusive relationships. These community changes can be assured through the effective role of religious leaders in interpreting Quran verses and prophet Mohammad commands for women rights and roles in marital relationships.

Conclusion

The screening rate for IPV by Jordanian nurses is low. Until the screening rate is 100%, victims of IPV will continue suffering physical and mental problems, more utilization of health

care services, and a lack of appropriate care that can help to assure their survival. Nurses working in partnership with other health care providers and managers may start to realize increased screening rates and overcome IPV screening barriers. Further research is needed to develop and study the effectiveness of IPV screening programs on Jordanian nurses screening practices, screening rates, and quality of patient care. In addition, research is needed to determine the proper strategies that increase nurses' awareness and participation in IPV screening.

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Table 1.

Demographic characteristics (N=125).

Demographic variable	%	N
Gender	82.4%	103
Female	17.6%	22
Male		
Marital Status	76.8%	96
Married	20%	25
Single	2.4%	3
Divorced		
Education level	40%	50
Diploma in nursing	51.2%	64
Bachelor in nursing	8.8%	11
Master in nursing		
Occupation	31.2%	39
Midwife	13.6%	17
Diploma nurse	55.2%	69
Staff nurse		

Table 2.

*The frequency and percentage of IPV screening among nurses. *†*

Criteria	Screening	z	p-value	Effect Size
Injuries (n=60)	15 (25%)	-2.223	.0131	.02
Chronic pelvic pain (n=45)	8 (17.8%)	-2.919	.0018	.045
Irritable bowel syndrome (n=59)	2 (3.3%)	-5.664	< .0001	.127
Headache (n=103)	12 (11.5%)	-5.742	< .0001	.076
Depression/anxiety (n=73)	15 (20%)	-3.374	< .0001	.036
Hypertension/coronary artery disease (n=100)	15 (14.9%)	-4.976	< .0001	.058
Patient is pregnant/seek OBS/GYN care (n=73)	8 (10.8%)	-4.972	< .0001	.08

* Rows will not add to n=125, because not all nurses provided care to each type of patient.

† The comparison value for the z-proportion test was based on the U.S. nurse screening rates of 39%.

Table 3.

Barriers for IPV screening identified by Jordanian nurses.

Barrier	Disagree	Agree
Self-efficacy		
Have no time to screen	75 (61%)	48 (39%)
There are strategies to help batterers	61 (49.2%)	63 (50.8%)
Strategies to help victims change IPV situation	59 (47.2%)	66 (52.8%)
Feel confident for referring batterers	66 (52.8%)	59 (47.2%)
Feel confident to refer victims	77 (61.6%)	48 (38.4%)
Have access to IPV information	90 (72%)	35 (28%)
Know ways to ask victims to decrease IPV victims risk	68 (54.4%)	57 (45.6%)
System Support		
Access to social workers to assist IPV victims	98 (78.4%)	27 (21.6%)
Social workers can help victims	62 (49.6%)	63 (50.4%)
Access to mental health referral	90 (72.6%)	34 (27.4%)
Mental health services can help victims	99 (79.8%)	25 (20.1%)
Blame Victims		
Victims get something from IPV relationship	63 (50.8%)	61 (49.2%)
People choose to be IPV victims	59 (47.6%)	65 (52.4%)
Victims and batterers are responsible for IPV	59 (47.6%)	65 (52.5%)

Patient personalities makes them IPV victims	35 (28%)	90 (72%)
Women go against traditional roles lead to IPV	75 (60%)	50 (40%)
Victim passive personality lead to IPV	63 (50.6%)	62 (49.4%)
Victims' action leads to IPV	72 (57.6%)	53 (42.4%)
Professional Role		
Afraid of offending patient when asking about IPV	51 (40.8%)	74 (59.2%)
Asking about IPV is invasion to patient privacy	67 (53.6%)	58 (46.4%)
It is demeaning to ask about IPV	107 (85.6%)	18 (14.4%)
Asking non-abused patients makes them angry	93 (74.4%)	32 (25.6%)
It is non- nursing role to resolve couple conflict	67 (53.6%)	58 (46.4%)
Investigation causes of IPV is non-medical role	104 (83.2%)	21 (16.8%)
If patient not disclose, they feel it is not my business	63 (50.4%)	62 (49.6%)
Victim/Provider Safety		
Reluctant to ask batterers for my personal safety	64 (51.6%)	60 (48.3%)
Workplace security is not enough to deal with IPV	42 (33.6%)	83 (66.4%)
Afraid of offending patient when asking about abusive behavior	49 (39.2%)	76 (60.8%)
Challenging batterers direct their anger to care providers	33 (26.4%)	92 (73.6%)
There are ways to ask about IPV without endanger	31 (24.8%)	94 (75.2%)

nurse		
Nurses can effectively discuss IPV with batterers	73 (58.9%)	51 (41.1%)
Can discuss IPV with batterers without endanger	62 (49.6%)	63 (50.4%)
victims		
Avoid dealing with batterers for victims safety	77 (61.6%)	48 (38.4%)
No ways to ask batterers without endanger victims	81 (64.8%)	44 (35.2%)
Afraid when dealing with batterers increase victims	47 (37.6%)	78 (62.4%)
risk		

Table 4.

*A comparison of IPV screening based on nurses' personal history of intimate partner or domestic victimization.**

Criteria (client seeking care for)	Non victimized nurses (n=33)	Nurse as a victim (n=92)	z	p-value
Patient has injuries (n=60)	27.8%	20.8%	.609	.543
Patient has chronic pelvic pain (n=45)	14.3%	23.5%	-.786	.432
Patient has irritable bowel syndrome (n=60)	2.9%	3.8%	-.194	.847
Patient has headache (n=105)	10.3%	13.5%	-.495	.620
Patient has depression/anxiety (n=75)	22.4%	15.4%	.728	.467
Patient has hypertension/coronary artery disease (n=102)	14.3%	15.8%	-.206	.837
Patient is pregnant/seek OBS/GYN care (n=74)	9.5%	12.5%	-.408	.683

* Rows will not add to n=125, because not all nurses provided care to each type of patient.