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Are Australian universities adhering to national and international guidelines? Intimate partner violence related content within nursing, midwifery and paramedicine undergraduate curricula

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Are Australian universities adhering to national and international guidelines? Intimate partner violence related content within nursing, midwifery and paramedicine undergraduate curricula

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Spelling: English (Australian)
Abstract

Intimate partner violence (IPV) is a worldwide public-health issue that affects millions of women, men and children each year and can be defined as behaviour within an intimate relationship that can cause physical, sexual or psychological harm (World Health Organisation [WHO], 2016). This doctoral thesis focuses on the education of nurses, midwives and paramedics because they are frequently the first point of contact in episodes of IPV. The primary aim of this thesis is to influence a drive for change in the Australian nursing, midwifery and paramedicine curricula so that undergraduate (UG) nursing, midwifery and paramedicine students are effectively taught about the multiple components of screening, identifying and caring for IPV survivors and their children.

To achieve this aim, a multiple-phase mixed-methods case study was conducted adopting the principles of Yin (2014) within a realist paradigm. Yin’s (2014) case-study approach was adopted because it advocates multiple methods of data collection and examines the phenomenon under research within its natural context, which is essential for the current study. The current study was a three-phase case study with phase one incorporating documentary content analysis, phase two an on-line survey and phase three qualitative telephone interviews.

Evidence found that there was minimal inclusion of IPV-related content within Australian UG nursing, midwifery and paramedicine degrees. Numerous personal and professional barriers were noted to impede the inclusion of such content, however, there were personal enablers, which contributed to its inclusion. Planned clinical placements with survivors of IPV were not advocated by the academics within this case study. In regards to the adoption of national and international organisations and committees guidelines and recommendations advocating for the inclusion of IPV-related content within UG health care professional (HCP) degrees, there was a large percentage of academics who were unaware of
such guidelines and recommendations. In response to these findings a framework for the integration of IPV-related content focusing on three components was developed. Those being the elimination of barriers, the promotion of enablers and the acceptance of evidence-based practice (EBP).

This study has implications for theory as it has laid the theoretical foundation for the examination of IPV-related content within UG HCP degrees and also has numerous implications for policy and practice, including those associated with professional role identity. Lastly, implications for future research were discussed including the need for replication in other western countries and with other UG HCP degrees within Australia and the further in-depth examination of the barriers and enablers for the inclusion of IPV-related content within Australian UG HCP degrees.
Declaration of Originality

I certify that the work presented in this thesis is, to the best of my knowledge and belief, original, except as acknowledged in the text, and that the material has not been submitted, either in whole or in part, for a degree at this or any other university.

I acknowledge that I have read and understood the University's rules, requirements, procedures and policy relating to my higher degree research award and to my thesis. I certify that I have complied with the rules, requirements, procedures and policy of the University (as they may be from time to time).

Name: Renee Lovi

Signature:  Date:  13\textsuperscript{th} April 2017
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blessing. Even though you are too young to understand what has been happening over the last seven months, I want to thank you for motivating me to become the best person possible.

I dedicate this thesis to my children….I want you to know that no matter what you go through in life, you keep pushing, you keep going and eventually you will succeed. You never stop until you achieve what you want to achieve.
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List of Abbreviations

AACN  America Association of Colleges of Nursing
ABS  Australian Bureau of Statistics
ACT  Australian Capital Territory
AHPRA  Australian Health Practitioner Regulation Agency
AIC  Australian Institute of Criminology
AIFS  Australian Institute of Family Studies
AIHW  Australian Institute of Health and Welfare
AMA  Australian Medical Association
ANMAC  Australian Nursing and Midwifery Accreditation Council
ANMC  Australian Nursing and Midwifery Council
ANMF  Australian Nursing and Midwifery Federation
BM  Bachelor of Midwifery
BN  Bachelor of Nursing
BP  Bachelor of Paramedicine
CAA  Council of Ambulance Authorities
DV  Domestic violence
EBP  Evidence-based practice
EMT  Emergency medical technician
FA  Factor analysis
GLBTI  Gay, lesbian, bisexual, transgender and intersex
HCCW  Healthcare Can Change from Within
HCP  Health-care professionals
HEI  Higher Education Industry
HIV  Human immunodeficiency virus
HREC  Human Research Ethics Committee
Chapter 1: Introduction

The thought of someone you love and who is supposed to love you back continuously
inflicting physical and emotional pain towards you is unthinkable—yet it happens all too
often throughout the world we live in.

1.1 Chapter Preamble

Intimate-partner violence (IPV) is a public-health issue that has and continues to
destroy the lives of women, men and families worldwide (Peterson, 2013; Tutty, Ogden,
Giurgiu & Weaver-Dunlop, 2014; World Health Organisation [WHO], 2010). At the time of
writing, this is the first national Australian study to examine the tertiary undergraduate (UG)
education of registered nurses (RNs), registered midwives (RMs) and paramedics in IPV.
Additionally, it is one of the first national or international studies to examine whether
academics are utilising the guidelines and recommendations of national and international
organisations and committees in teaching IPV-related content. The rationales related to the
adherence or non-adherence to these guidelines and recommendations will be examined,
which is another reason for the significance of this study.

The primary objective of Chapter 1 is to provide a detailed background of the issues
that led to undertaking this study. The justifications for the research will be presented along
with the research issues, questions and propositions. Research methodology, including data-
collection and data-analysis procedures will be discussed, accompanied by the delimitations
of the research. Figure 1.1 outlines the structure of Chapter 1. Section 1.2 presents the
background to the research, including a brief introduction to IPV and the context of the
research. Section 1.3 provides the statement of the research problem, and Section 1.4
discusses the objectives of the research. Section 1.5 lists the six research questions that will
answer the research problem, and Section 1.6 outlines the six propositions that were
developed in accordance with case-study methodology. The numerous justifications for this
research will be presented in Section 1.7, and the research methodology, encompassing the research paradigm, the justification for the research design, data-collection procedures, research quality and case-study specific data-analysis procedures will be outlined in Section 1.8. The outline of the thesis is presented in Section 1.9, and the key term ‘IPV’ is defined in Section 1.10. The three delimitations of this research are reported in Section 1.11 and Section 1.12 concludes the chapter.
1.1 Chapter preamble

1.2 Background to the research

1.3 Statement of the research problem

1.4 Objectives of the research

1.5 Research questions

1.6 Research propositions

1.7 Justification for the research

1.8 Research methodology

1.9 Outline of this thesis

1.10 Definition of key terms

1.11 Delimitations of the research

1.12 Conclusion

1.2.1 Brief background of IPV

1.2.2 Context of the research

1.7.1 Gaps in the literature

1.7.2 The important role of HCPs

1.7.3 Inadequate case-study research

1.7.4 IPV as a public-health priority

1.7.5 Personal experience of IPV

1.8.1 Research paradigm

1.8.2 Justification for the research design

1.8.3 Data-collection procedures

1.8.4 Research quality

1.8.5 Case-study specific data-analysis procedures

Source. Developed for this research.

Figure 1.1. Map of Chapter 1.
1.2 Background to Research

1.2.1 Brief background of IPV

Having introduced the research in Section 1.1, this section lays the foundation for this study. The WHO (2016) defines IPV as ‘behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours’ (para 3). Latest statistics indicate that 17% of Australian women (1,479,900 women) and 5% of Australian men (448,000 men) experience some form of IPV from 15 years of age (Australian Bureau of Statistics [ABS], 2013). Within the 12 months prior to the conduction of the Personal Safety Survey by the ABS (2013), 51,800 (0.6%) men in Australia had experienced IPV, while 132,500 (1.5%) women in Australia had experienced this type of violence. These statistics highlight the highly prevalent nature of this public-health issue. The high prevalence of IPV is not confined to Australia. IPV occurs in all countries in differing intensity. Further information on the prevalence of IPV within Australian and overseas is reported in Section 2.5.

The acts of physical aggression, sexual assault, psychological and emotional abuse and controlling behaviours that constitute IPV have negative effects on the physical, emotional and psychological health of survivors (Garcia-Moreno & Watts, 2011; Peterson, 2013; Rees et al., 2011; WHO/London School of Hygiene & Tropical Medicine, 2010). In addition, the social and economic outcomes for these survivors and their dependents are affected negatively, resulting in situations of homelessness and poverty (Australian Institute of Health and Welfare [AIHW], 2016; Tuttty et al., 2014). It must also be acknowledged that the silent and secondary victims of IPV are the children of the abused or the perpetrator.

Health complaints such as headaches, stomach aches, and difficulty eating and sleeping have been found among this population of victims (Edleson, 1999; Kovacs & Tomison, 2003). Additionally, this violence has been shown to have intergenerational transmission. Thus, IPV behaviours are sustained from childhood into adulthood unless this
cycle is broken. Interrupting this cycle of violence is paramount in the social and health-care needs of women, men and children, an imperative that has been acknowledged for more than 30 years (Walker, 1979). The consequences of IPV are further elaborated in Section 2.6.

1.2.2 Context of the research

Given that the overarching purpose of this study is to gain a better understanding of the current education health-care professionals (HCPs) receive in IPV-related content, it is first necessary to provide a brief background on the past research that has been conducted in this area. As a result of the consequences of IPV briefly outlined in Section 1.2.1, IPV survivors and their dependents frequently present to health-care facilities (Black, 2011). Therefore, it is the responsibility of HCPs to be knowledgeable in the specific health-related practices and skills related to IPV, including screening methods, treatment modalities, support services and referral agencies (Black et al., 2011; Clements, Holt, Hassan & Fay-Hillier, 2011; WHO, 2013b). However, research to date indicates that HCPs are not knowledgeable in IPV-related content because of a lack of this content being taught in their UG degree. Australian and international research reveals the lack of IPV-related content within the Bachelor of Nursing (BN) degree, and unanimously supports the integration of IPV-related content into this degree (Beccaria et al., 2013; Bradbury-Jones & Broadhurst, 2015). The Bachelor of Midwifery (BM) degree is still in its infancy as a university degree, thus there is a scarcity of research conducted into the amount of IPV-related content covered in this degree. The minimal research that has been conducted illustrates that IPV-related content is not presented in the BM, and thus it is necessary for this content to be added to the curriculum (Bohn, Paluzzi & Vivio, 2002; Mezey, Bacchus, Haworth & Bewley, 2003). The research on the IPV-related content in the Bachelor of Paramedicine (BP) or an equivalent degree is even more limited. This is also a result of the recent move of this education into the university system.
However, what has been discovered is that Australian paramedics are not equipped to
deal with IPV survivors or perpetrators, and therefore, need IPV-related content to be taught
in their UG degree (Dousek, Parekh, Williams & Williams, 2012; Sawyer, Parekh, Williams
& Williams, 2014). These three UG degrees and their association with IPV-related content
will be further elaborated on in Section 3.6.

The inclusion of IPV-related content in the UG degrees of HCPs has not only been
recognised by researchers, but it has also been acknowledged by national and international
organisations and committees such as the Australian Nursing and Midwifery Federation
(ANMF), the Australasian College of Emergency Medicine, the Joint Commission on
Accreditation of Healthcare Organisations and the WHO. Therefore, the background to this
research illustrates the widely recognised significance and necessity of the current study. This
study is the first Australian study to examine the BN, BM and BP (or equivalent) degrees
Australia-wide in relation to the inclusion of IPV-related content, and it is the first national or
international study to examine adherence to the recommendations and guidelines of national
and international organisations and committees in relation to the inclusion and teaching of
IPV-related content.

1.3 Statement of Research Problem

The review of the literature revealed the problem of the paucity of IPV-related content
in the UG nursing, midwifery and paramedicine curricula. However, there remains a lack of
research in this area, thus the current Australian situation in relation to teaching IPV-related
content in these UG degrees is unknown. Therefore, the research problem for this study is
stated as follows:

How effective are Australian universities that offer UG nursing, midwifery and
paramedicine degrees at incorporating IPV-related content into these degrees, and how
can this content be more consistently integrated to bring about a more responsive
workforce in health care? Further, are Australian universities utilising national and
international organisations and committees’ guidelines and recommendations on the inclusion of IPV-related content in UG HCP degrees?

1.4 Objectives of Research

The ultimate objective of this study is to influence a drive for change in the Australian UG nursing, midwifery and paramedicine curricula so that the students of these degrees are effectively taught about the multiple components of screening, identifying and caring for IPV survivors and their children. A further six research objectives were developed for this current study and they are:

- To establish whether IPV-related content is included in Australian BN, BM and BP (or equivalent) degrees;
- To examine the amount of IPV-related content included in Australian UG nursing, midwifery and paramedicine degrees and if there are any barriers to such inclusion;
- To examine the type of IPV-related content included in Australian UG nursing, midwifery and paramedicine degrees and the type of units this content is included in;
- To investigate if IPV-related content is being integrated throughout the BN, BM and BP (or equivalent) degrees;
- To investigate frontline academics’ attitudes and thoughts in relation to the inclusion of IPV-related content in these degrees; and
- To discover whether Australian universities are adopting national and international organisations and committees’ guidelines and recommendations on the inclusion of IPV-related content in UG HCP degrees.

1.5 Research Questions

This research aims to draw attention to the issue of IPV and tertiary education by asking research questions that directly reflect the stated objectives for the study. The following six research questions were developed from the literature review presented in
Chapter 3 and stated in Section 3.8.4:

Research question 1: How prominently has IPV-related content appeared in the curricula being offered in the currently available Australian UG nursing, midwifery and paramedicine degrees?

Research question 2: How is this IPV-related content being integrated into the curricula of nursing, midwifery and paramedicine?

Research question 3: How are the units that contain IPV-related content chosen by academics and why are they the units chosen to include this content?

Research question 4: How is this IPV-related content being taught and what is being taught in relation to this content in the disciplines of nursing, midwifery and paramedicine?

Research question 5: How do academics explain their inclusion or non-inclusion of IPV-related content in their unit/s?

Research question 6: How are academics utilising national and international organisations and committees’ guidelines and recommendations in their teaching of IPV-related content?

1.6 Research Propositions

According to Yin (2014), propositions are statements that direct the researcher and provide direction for the study. In accordance with the case-study methodology adopted for this study, the following six propositions were created:

Proposition 1: It is the proposition after an extensive literature review that the amount of time spent on IPV-related content in the above curricula will be minimal because of the barriers of a lack of awareness, an overcrowded curricula and a lack of support for
Proposition 2: The proposition for this research question is that there exists a lack of integration of IPV-related content into the UG curricula of nursing, midwifery and paramedicine and IPV-related content is only included in units when the unit coordinator (or equivalent) feels competent and passionate about this content.

Proposition 3: Units containing IPV-related content in the examined curricula will be those associated with mental health units and child and family units as this topic has been traditionally seen as a mental health issue and a family issue that occurs behind closed doors.

Proposition 4: IPV-related content is usually only delivered via didactic lectures and readings only, with minimal interactive class time and clinical experience. In terms of what is being taught, types, prevalence and effects is assumed to be taught more often that the appropriate screening, detection and care principles for survivors of IPV.

Proposition 5: It is the proposition that non-inclusion of IPV-related content into these UG curricula is because of a lack of expertise in this topic, the lack of understanding of its importance to be included in the UG curricula and negative attitudes/beliefs towards survivors of IPV.

Proposition 6: It is the proposition of the researcher that academics have little awareness of national and international organisations and committees’ guidelines and recommendations on IPV-related content and are thus not implementing any of these guidelines/recommendations into their teaching.
1.7 Justification for Research

This research on the inclusion of IPV-related content in the UG nursing, midwifery and paramedicine degrees, and the adoption of national and international organisations and committees’ guidelines and recommendations on this inclusion can be justified because of the lack of national and international research on this topic. However, other justifications for this study include the important role HCPs play within the area of IPV, inadequate case-study research within this research field, the status of IPV as a public-health priority, and the personal experiences of IPV. These justifications will now be discussed.

1.7.1 Gaps in the literature

The first justification for this research is that it addresses gaps in the literature concerning IPV-related content and HCP UG education. This was briefly highlighted in Section 1.2.2, and will be discussed further in Chapter 3. A great deal of research conducted to date on IPV-related content within the BN is becoming outdated, and therefore cannot be classified as current evidence-based practice (EBP) (Titler, 2008). This study attempts to rectify this problem by providing current evidence for the inclusion of IPV-related content in HCP UG education. Additionally, a great proportion of the available research was conducted overseas, thus the current situation in Australian universities in relation to the inclusion of this content is largely unknown. Once again, this study is an Australia-wide study, and will therefore provide evidence for the Australian situation. An additional advantage of this study is that it will survey and interview academics that teach the students, rather than deans, programme managers, coordinators, curriculum chairpersons, HCPs or students which have previously been involved in research studies (Glaister & Kesling, 2002; Haggblom, Hallberg & Moller, 2005; Ross, Hoff & Coutu-Wakulczyk, 1998). This is an advantage as these academics are at the forefront of this teaching and are thus the first point of call for students.

The following points highlight the significance of this study and how it will address the gaps in the literature:
• It is the first Australia-wide study to examine the inclusion of IPV-related content in the UG degrees of nursing, midwifery and paramedicine.

• It is the first Australia-wide study to investigate the teaching methods used to provide IPV-related content to UG nursing, midwifery and paramedicine students collectively.

• It is the first known study to examine frontline academics’ attitudes and beliefs about the inclusion of IPV-related content in the UG curricula of nursing, midwifery and paramedicine.

• It is the first national or international study to examine academics’ adoption of national and international organisations and committees’ guidelines and recommendations on the inclusion of IPV-related content in HCP UG degrees.

• It is the first national or international study to research the rationales related to the adherence or non-adherence to these guidelines and recommendations.

1.7.2 Important role of HCPs

The second justification for this research is the important role HCPs play in IPV. HCPs are in a crucial position to screen, identify, treat and initiate referral pathways for survivors of IPV, along with aiding the prevention and elimination of such violence (WHO, 2010). As of June 2016, there were 272,733 RNs in Australia, 4,050 RM s and 28,889 dual RNs and RM s (Nursing and Midwifery Board of Australia, 2016), and the total number of paramedics in Australia in 2011 was 12,800 (Paramedics Australasia [PA], 2012). Therefore, it is highly likely that these HCPs will have contact with survivors and perpetrators of IPV (WHO, 2010).

1.7.3 Inadequate case-study research

The third justification for this research is the adoption of the case-study approach utilising the principles of Yin (2014). Researchers in the field of IPV and HCP education have failed to use this methodology in their studies, and therefore, this study seeks to highlight the
value of case-study research in IPV and HCP education. The justification for the adoption of the case-study approach is presented in Section 1.8.2, and further elaborated in Chapter 4.

1.7.4 IPV as a public-health priority.

The fourth justification for this research is that IPV is now recognised as a serious human-rights and public-health problem and therefore, this study is conducive to current health, social and political priorities (Public Health Association of Australia, 2010; WHO, 2010). In 2016, two of the nine National Health Priority Areas were relevant to IPV (AIHW, 2017). As outlined briefly in Section 1.2.1, and further discussed in Sections 2.4 and 2.6, IPV can occur via a variety of behaviours and can affect the survivor and their dependents physically, emotionally, psychologically, socially and economically (Peterson, 2013; Tutty et al., 2014). Therefore, the physical consequences of IPV can be categorised under the priority area of injury prevention and control, and the emotional and psychological consequences can be categorised under the priority area of mental health. As has been demonstrated, IPV is a current public-health issue that needs to be furthered researched to obtain current information on how best to approach this complex and difficult topic.

1.7.5 Personal experience of IPV

It is essential for the researcher to be aware of choices one is making and their consequences (Reason & Bradbury, 2001; Tsing, 2005; Neuman, 2011). When using and measuring interventions, the researcher must recognise themselves as an agent of change and a key instrument of the study, their role being to design a process that can produce the relevant information that can lead to action and subsequently improvement (Martin, 2001). Hence this section on the personal experience of IPV.

I am a survivor of IPV. For numerous years, I spent every moment scared, worried, and/or in pain and being controlled in who I spoke to and where I went. I experienced all forms of IPV, that is, physical and sexual violence, emotional and psychological abuse, and societal and financial restraints. The details of my abuse are too horrific to detail here;
however, I often say to people that the only things I never experienced were a stabbing or a
gunshot wound. As can be imagined, I ended up in the emergency department of hospitals
on numerous occasions, and was seen by a variety of doctors, RNs and RMs. To my horror,
there was a lack of screening, treatment or even discussion on IPV during these many visits
to health-care facilities. Never did one HCP attempt to ask me about IPV, nor did they
attempt to provide assistance with my situation in any other way. This violence (and the
associated bruises, cuts, black eyes, burst operation sites etc.) were never addressed. All I
wanted was someone to ask the question. I was too ashamed to bring it up myself. I wanted
my then partner to be asked to leave the room. I wanted to be by myself, away from his
watchful eyes. I wondered, were they not interested or were they not educated about this
severe public-health issue?

At the time, I took it personally, believing that they were not interested in my situation
and thought of me as useless and pathetic. After escaping this abusive relationship and
looking back on my experience, I began to wonder how many other survivors of IPV had also
been treated this way by HCPs. I believed that this treatment needed to change for IPV
survivors to feel comfortable disclosing and receiving help from HCPs. This led me to the
question: Is tertiary UG education addressing the topic of IPV in HCP degrees to ensure that
HCPs know how to enquire about IPV, know how to treat the many forms of this abuse, and
know how to and when to refer them to further services? This question led to this study.

My professional life has also influenced the development of this study. As an
academic, I recognised the need to analyse the amount of IPV-related content in the nursing,
midwifery and paramedicine disciplines after teaching across the three years of the BN degree
in three different universities, and being involved in curriculum development as a national
lecturer-in-charge for a national university. It became obvious to me that there was a lack of
IPV-related content integrated into HCP degrees. At the time of commencing this study, I was
a lecturer-in-charge of units that incorporated nursing, midwifery and paramedicine students
collectively, which provides part of the rationale for these three disciplines being examined in this study. Additionally, these HCP disciplines are frequently the first point of contact in episodes of IPV.

Further, the only time I have come across IPV-related content in an HCP UG degree was when I was in a position to include it as part of the content and assessment as the lecturer-and unit-coordinator-in-charge. As an academic, I have often heard from other academics that it is too difficult to include such content in UG nursing, midwifery and paramedicine degrees, but despite such protestations, I have managed to include this content in a variety of UG units. For example, I have included IPV-related content in first-year units of beginning professional practice, second-year units for contexts of nursing and acute-care nursing, as well as third-year units for the preparation for graduate practice. These successes led me to the following reflective question: If I can include IPV-related content in these units, what is stopping other academics from doing the same thing? This is one of the questions that this study will address.

1.8 Research Methodology

The previous sections have provided a background to the research, and presented the research problem, research objectives, research questions and research propositions, as well as five justifications for the research. This section will now present the research methodology adopted for this study. Given that the research methodology is justified and described in Chapter 4, this section will merely introduce the methodology through discussing the issues of research paradigms, the justification for the research design, data-collection procedures, the research quality, and the data-analysis techniques.

1.8.1 Research paradigm

A paradigm is a ‘set of interrelated assumptions about the social world which provides a philosophical and conceptual framework for the organised study of that world’ (Filstead, 1979, p. 34). Paradigms aid in creating avenues of enquiry, formulating questions, selecting
methods to examine questions, defining areas of relevance and establishing and creating meaning (Kuhn, 1996, p. 15). They are comprised of three elements (Guba & Lincoln, 1994, p. 108):

1. ontology—the form and nature of reality
2. epistemology—the nature of the relationship between the researcher and reality
3. methodology—the process of the research (e.g., the techniques used to collect data).

This study uses Guba and Lincoln’s (1994) categorisation of research paradigms as the basis for this discussion. According to Guba and Lincoln (1994), there are four paradigms: positivism, postpositivism/realism, critical theory and constructivism. A full description of each paradigm can be found in Section 4.2. The paradigm utilised in this study is realism because it is the preferred paradigm for case-study research (Perry, 1998). This is because this research is contemporary and pre-paradigmatic, which means it requires inductive theory building rather than theory testing and verification. Additionally, the research topic of this study has only limited existing understanding, and hence requires a thorough building of the understanding of the phenomenon under study (Christie, Rowe, Perry & Chamard, 2000; Perry, 1998; Perry, Riege & Brown, 1999). Further justification for the adoption of the realism paradigm is presented in Section 4.2.4. Justification for the case-study approach will now be provided.

1.8.2 Justification for research design

In addressing the research questions presented in Section 1.5, it rapidly becomes evident that the IPV-related content included in a degree cannot be readily distinguishable from the university at which the degree is delivered. Consequently, the research examined exemplars rather than replicates as each degree had a different curriculum at each university, thus resulting in the phenomenon under investigation not being able to be separated from its context. The inability to separate the phenomenon from its context means that a case-study research approach (as described in Chapter 4) was adopted, rather than an experimental
research design, which purposely separates the phenomenon from its context to manipulate the variables under study (Yin, 2014).

Case-study design has the ability to be both descriptive and exploratory, and is conducive to this study because exploration is needed to establish the extent of IPV-related content coverage, to identify the units in which this content is covered, to discover why or why not this topic is covered, as well as how it is taught, and whether there is adherence to national and international organisations and committees’ guidelines and recommendations. Further, according to Yin (2014), the case-study approach should be utilised only if the study meets three conditions. The first is the use of ‘how’ and ‘why’ questions. This was achieved in this study as demonstrated by the research questions presented in Section 1.5. The second condition is that there is no control exerted over the behavioural events. The third condition is that the focus is on contemporary events (Yin, 2014). This study has no control over the inclusion of IPV-related content in the UG nursing, midwifery and paramedicine degrees, thus meeting Yin’s (2014) second condition. IPV is a current public-health issue and priority and is increasingly receiving greater focus and attention by both the public and politicians.

Therefore, the study meets the third condition of the study investigating a contemporary event. In conclusion, this study meets Yin’s (2014) three conditions for adopting a case-study research design, and thus, the adoption of this research approach is justified in this study.

An additional characteristic of case-study research that highlights its utility in this study is that it is a research approach that is not limited to only one case (Yin, 2014). Rather, multiple case studies can be researched in depth within a single study, as has occurred in this research. Examining the multiple cases represented by the HCP degrees in multiple universities throughout Australia is required to strengthen the representativeness of the findings (Stake, 1995).
1.8.3 Data-collection procedures

Case-study research is not confined to either qualitative or quantitative research. A mixture of qualitative and quantitative evidence can be collected in case studies, and these multiple sources of evidence converge in a triangulating process that subsequently forms a chain of evidence without losing the contextualised natural setting (Burns, 2000; Yin, 2014).

Phase one of this case study, the content analysis of documentation (publicly available unit outlines/descriptions for the units taught in Australian UG nursing, midwifery and paramedicine degrees) was undertaken to explore the principal terminology used to denote IPV, and to identify patterns of included or excluded IPV-related content. The findings of this phase subsequently informed the development of a quantitative online-survey tool, which constitutes phase two of this study.

Phase two, the quantitative online survey that was analysed via the Statistical Package for the Social Sciences (SPSS) version 22, widely established the perceptions and rationales of academics in relation to the inclusion of IPV-related content in the UG curricula. Additionally, the survey findings informed the researcher’s emerging propositions, and the subsequent qualitative interview phase that was undertaken as phase three of the case study. Phase three involved developing and conducting semi-structured telephone interviews with individual academics with subsequent thematic analysis.

1.8.4 Research quality

To ensure high-quality case-study research, the following four tests that are commonly used to assess the quality of empirical social research were employed: construct validity, internal validity, external validity, and reliability (Yin, 2014). A description of each of these tests and the tactics used for these quality factors, along with an explanation of the phase of research to which each one of these tests relates is presented in Section 4.7.
1.8.5 Case-study specific data-analysis procedures

Data analysis in case-study research involves the examination, categorisation, tabulation, testing and combining of evidence to produce empirically based findings (Yin, 2014). According to Yin (2014), data analysis can occur via two different approaches: general data-analysis strategies and specific data-analysis techniques. There are four general data-analysis strategies: relying on theoretical propositions; working the data from the ground up; developing a case description; and examining plausible rival explanations (Yin, 2014).

Two of these strategies were employed in this study: relying on theoretical propositions and examining rival explanations. Pattern matching, explanation building, time-series analysis, logic models and cross-case synthesis are the five specific analytic techniques (Yin, 2014). Of these five techniques, three were used in this study: pattern matching, explanation building, and cross-case synthesis. Further information on these data-analysis strategies and techniques can be found in Section 4.10.

1.9 Outline of Thesis

This thesis is organised into seven chapters, and is supported by a glossary and a list of abbreviations. Figure 1.2 presents the structure of this thesis.
Chapter 1 introduces the case-study research presented in this thesis. A background to the research, including a brief introduction to IPV and the current situation of UG HCP education nationally and internationally is provided, and the research problem and objectives of the study are presented. Chapter 1 also presents the six research questions and the six research propositions that will be examined in this study, and provides a justification of this research. Finally, this chapter presents the research methodology, including the research paradigm, research design, data-collection procedures, factors to establish the quality of the research and the data-analysis procedures employed.

Chapter 2 lays the foundation for this study. It provides the contextual foundation and general knowledge about IPV. The terminology and definition of IPV used for this study are

**Figure 1.2.** Map of thesis.
provided, along with a historical overview of IPV. There are generally five types of IPV: physical violence; sexual violence; emotional, verbal and psychological abuse; economic violence; and controlling behaviours. Each one of these is discussed with an explanation of the behaviours displayed for each type of IPV. IPV is a highly prevalent public-health issue in Australia and internationally, and statistics are provided in this chapter to highlight this. As there are many forms of IPV, there are also many types of consequences that can occur as a result of this violence, and these consequences will be reviewed. Finally, the characteristics that increase a person’s risk of experiencing IPV (e.g. age, education, socioeconomic status) are explained and the chapter concludes with a chapter summary.

Chapter 3 presents the literature review. The chapter sets the scene for the current study by providing EBP on IPV and HCPs nationally and internationally. This chapter demonstrates that HCPs will inevitably have contact with survivors of IPV and should therefore be educated on the multicomponent aspects of IPV. Included in this education should be how to screen adequately for and identify survivors of IPV. Screening rates, recommendations, barriers to and enablers of screening, consequences of screening and required changes are examined in this chapter, as is the need for HCPs to be educated about their response and attitude to the disclosure of IPV. However, the principal literature review examines the present situation of HCP education in IPV. National and international research on the inclusion of IPV-related content in UG nursing, midwifery and paramedicine curricula are presented, along with the average number of hours in which this content is taught, the usual content covered, and the teaching methods used. Finally, national and international organisations and committees’ guidelines and recommendations on the inclusion of IPV-related content in HCP UG degrees are presented.

Chapter 4 reports the research methodology of the current study. First, justifications are provided for the use of the realism paradigm, the mixed-methods research design and the
The case-study research approach. The five components of a case-study research design as articulated by Yin (2014) are introduced and applied to the current study, and the type of case-study design employed in this research is discussed. The criteria used to report on the quality of case-study research designs are presented, and the principles of data collection are introduced. The data-collection techniques utilised in this multiple-phase mixed-methods case study are reported, including their design, sample, instruments used, and data-analysis techniques employed. In addition, the case-study specific data-analysis techniques used are stated, and the limitations of case-study research are discussed. Finally, the process of gaining ethics approval, and a consideration of the ethical principles related to this study are outlined.

Chapter 5 provides a description of the three discipline cases under examination along with the evidence obtained via the three phases of this case study. The evidence pertaining to each research proposition will be presented via with-in case analysis, the examination of rival explanations, cross-case analysis and the testing of the research proposition. Lastly, unplanned findings, findings which were not anticipated by the researcher and thus do not fit within the research propositions, will be presented.

Chapter 6 presents a critical discussion of the findings of this study along with the conclusions drawn and response to the research problem. The conclusion drawn in relation to the amount and depth of IPV-related content inclusion and integration, content location and teaching strategies for IPV and drivers influencing content inclusion and delivery will be discussed followed by the conclusion on the research problem. Within this conclusion, the framework for the integration of IPV-related content into UG HCP degrees developed by the researcher will be presented and outlined. This framework comprises three components of integration, these being the elimination of barriers, the promotion of enablers and the acceptance of EBP.

Chapter 7 concludes this thesis by providing four recommendations arising from the evidence obtained from this multiple-phase mixed methods case study. The implications for
this research, including the implications for theory, policy, practice, methodology and future research will be outlined along with the strengths and limitations of the research. Lastly, this chapter concludes with a summary of this research project.

1.10 Definitions of Key Terms

Academics, researchers and practitioners often have different views on the correct definitions of key terms. Therefore, it is essential that all key and controversial terms are clearly defined in a research project (Perry, 2012). The principal key term used in this study is ‘IPV’. As stated in Section 2.2, there are many definitions and terms used for IPV in the literature but the following definition is used in this study: IPV is a ‘behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours’ (WHO, 2016, para 3). This definition was used as it is derived from the leading world organisation on health.

1.11 Delimitations of Research

Although this study provides strong evidence relating to IPV-related content being taught in UG nursing, midwifery and paramedicine degrees within Australia, it must be acknowledged that there are delimitations of the study. Delimitations refer to the ‘planned, justified scope of the study beyond which generalisation of the results was not intended’ (Perry, 2013, p. 32). Delimitations are different to limitations because delimitations are within the control of the researcher, and limitations are not (Perry, 2013). There are three delimitations of this study.

First, this study focuses on Australian universities and their inclusion of IPV-related content in their UG nursing, midwifery and paramedicine degrees. Australia may have differing curriculum requirements and standards to other countries, and therefore, the findings of this research are delimited to Australia and may not apply to other countries. Second, this study focuses on the health-care disciplines of nursing, midwifery and paramedicine. This is
because the researcher was teaching these disciplines at an Australian university at the commencement of this study. Therefore, the results of this study are delimited to these disciplines, and may not apply to other HCPs such as doctors and psychologists. Third, this study includes only academics who teach UG nursing, midwifery and paramedicine students. This restriction was implemented intentionally as previous research has focused on HCPs already in the workforce, students, heads of school, curriculum chairpersons, while often neglecting the academics at the forefront of the teaching.

1.12 Conclusion

This chapter has laid the foundation for this study. The chapter provided the background and rationale for the commencement of this study, and presented the research problem, research objectives, research questions and research propositions. Numerous justifications for this research were provided and the research methodology was explained. The chapter also presented an outline of the thesis and the definition of the key term, ‘IPV’. Finally, the chapter explained the three delimitations of this study. From this foundation, a detailed description of the research can commence. Chapter 2 presents the initial background to this study by critically exploring the historical context of the study, and variety of dimensions in relation to IPV.
Chapter 2: Context—IPV

The thought of someone you love and who is supposed to love you back continuously inflicting physical and emotional pain towards you is unthinkable—yet it happens all too often throughout the world we live in.

2.1 Chapter Preamble

The intention of this chapter is to provide a contextual foundation and a general understanding of the issue of IPV. To achieve these intentions, first the terminology used to refer to this type of violence is discussed, and a conclusion is drawn about the definition of IPV that will be utilised throughout this study. Second, to understand what IPV encompasses in today’s society, it is important to explore the historical context in which it developed to highlight its longevity and contemporary characteristics. Third, the five types of IPV are highlighted, and their prevalence in Australia and internationally is discussed. Fourth, the burden of IPV, and the physical, psychological, social and economic consequences of IPV, as well the consequences it creates for dependents are outlined. Finally, the characteristics that increase the risk of experiencing IPV, such as age, education and socioeconomic status, are presented. The structure of this chapter is presented in Figure 2.1.

This chapter is divided into eight main sections. Following the chapter preamble (Section 2.1) and pictorial outline of Chapter 2 (Figure 2.1), the terminology and definitions for IPV are presented (Section 2.2), along with IPV’s historical context (Section 2.3). Section 2.4 discusses the types of IPV, including physical violence, sexual violence, emotional, verbal and psychological abuse, economic violence and controlling behaviours. Section 2.5 discusses the prevalence of IPV in Australia and internationally. Section 2.6 examines the many consequences of this form of violence. The characteristics that increase the likelihood of experiencing IPV will be outlined in Section 2.7. The chapter concludes with a chapter summary (Section 2.8).
2.1 Chapter preamble

2.2 Terminology and definition

2.3 Historical view

2.4 Types of IPV

2.4.1 Physical violence
2.4.2 Sexual violence
2.4.3 Emotional, verbal and psychological abuse
2.4.4 Economic violence
2.4.5 Controlling behaviours

2.5 Prevalence rates

2.5.1 Australia
2.5.2 Worldwide

2.6 Consequences of IPV

2.6.1 Burden of disease
2.6.2 Physical consequences
2.6.3 Psychological consequences
2.6.4 Social consequences
2.6.5 Consequences for dependents
2.6.6 Economic consequences

2.7 Characteristics increasing risk of IPV

2.8 Chapter summary

Figure 2.1. Map of Chapter 2.
2.2 Terminology and Definition

Many competing definitions of IPV exist, with some of these varying according to the stakeholder’s focus and interests. Health-care organisations’ definitions usually focus on a holistic approach to the planning and delivery of support services to survivors of IPV; in contrast, the criminal justice systems’ definitions are more specific, and vary according to the state or territory of jurisdiction within Australia, and its legislation (ABS, 2009). There are many terms used to refer to acts of IPV (Duncan & Weston, 2011), including:

- wife battering
- indecent assault
- rape
- gender-based violence
- family violence
- relationship violence
- sexual abuse
- sexual assault
- rape in marriage
- partner rape
- marital rape.

However, the most well-known term used to refer to IPV is ‘domestic violence’ (‘DV’). These two terms are used interchangeably in some documents, but the term ‘DV’ has now been replaced by the term ‘IPV’ when specifically referring to the violence between intimate partners. The rationale behind this terminology change is that DV is not specific to intimate partners and may refer to child abuse, IPV or violence against the elderly (Garcia-Moreno, Jansen, Ellsberg, Heise & Watts, 2005).
This study adopts the WHO (2016) definition of IPV as ‘behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours’ (para 3). This definition relates to current or past violence perpetrated by a spouse or partner. Additionally, the relationship can be heterosexual or a homosexual (WHO, 2016). This definition was adopted as it is the definition adopting by the leading health organisation in the world. Now that the terminology and definition of IPV has been clarified, a historical examination of IPV for both female and male survivors is provided.

2.3 An Historical View

The history of IPV is more than just a chronological list of dates and acts. Understanding the historical origins of IPV helps provide an understanding of how acts of IPV have developed, and how treatment options and resources have increased and improved throughout the years. A thorough examination of this history also allows an understanding of the patriarchal structure of many societies, the laws sanctioning the use of violence by husbands, and the violence resulting from the shift in power between men and women, and the changes in feelings about marriage and romance. This investigation also allows a thorough examination of treatment options and resources by outlining the women’s shelter movement, women’s refuges and associated living quarters, as well as the lobbying for changes in policies and practices, and the development of key organisations.

IPV and violence against women in general are rooted in the historical context of the patriarchal structure of many societies throughout the world (Kelly, 2011, p. E30). The power of patriarchy can be seen in the historical precedents of suttee, witch-burning and foot binding, as well as in mutilating surgery, female infanticide, and in today’s acts of IPV, rape, homicide of women and genital mutilation (Kelly, 2011, p. E31). The earliest written evidence of the physical form of IPV dates back to the Bible. Deuteronomy 22:3–21 (The New King James Version) names a law sentencing brides to death by stoning if they were
unable to prove their virginity (Davidson, 1978). In medieval times, physical forms of IPV were documented in a variety of ways. For example, Spanish law stated a woman who committed adultery could be killed with impunity, while in France, female sexual infidelity and disobedience was punishable by beating. In Italy, unfaithful women received severe beatings and exile for three years (Dobash & Dobash, 1978).

In the medieval and early-modern periods, nonlethal IPV was probably more common than it is today; however, lethal IPV was rare (Roth, 2014, p. 176). This is because of the laws sanctioning the use of violence by husbands. Husbands were given the power to correct their wives’ behaviours. Strangers in the medieval and early-modern periods were more likely to intervene in IPV situations than people today, even if it meant putting their own lives in danger (Hurl-Eamon, 2005, p. 49–61; Pleck, 1987, p. 17–33). Further, chronic perpetrators of IPV during the medieval and early-modern periods received sanctions from the courts, ranging from peace bonds and fines to jail terms and legal separations (Roth, 2014, p. 181). Although civil and ecclesiastical law did not recognise divorce before the late eighteenth century, formal separation was possible (Roth, 2014).

From the 1500s to the 1700s, the witch-hunts executed in Western Europe are a very well-documented form of IPV. Although exact statistics are not available, it is estimated that 200,000 to nine million women were punished for their perceived healing abilities, usually via hanging or burning. These perceived healing abilities were said to be acquired through consorting with Satan (Achterberg, 1991). During the same period in India, suttee was being performed as a result of cultural beliefs that the man’s death was caused by the widow. A common saying in India during this time was ‘women, like walnut trees, should be beaten every day’ (Davidson, 1978, p. 14).

The occurrence of nonlethal IPV decreased in the nineteenth century, but the rates of lethal IPV increased (Roth, 2014, p. 177). This increase in lethal IPV was a result of a shift in the balance of power between men and women, and changes in feelings about marriage and
romance. This shift in the balance of power between the genders resulted in women becoming more economically independent, which then resulted in delayed marriage. Women could be more selective in the men they chose to marry, and had the opportunity to leave unhappy marriages (Roth, 2014, p. 183). At the same time, men became more economically dependent as a result of higher land prices and the increase in large firms (Roth, 2014, p. 183). The changes in the feelings and beliefs associated with marriage and romance included ideals of sobriety, companionate marriage, respectability and domesticity, which raised expectations emotionally and materially (Bushman, 1992; Larkin, 1988; Ryan, 1981). These feelings could destabilise marriages, particularly if wives embraced them but their husbands did not (Roth, 2014, p. 183). Interestingly, not only did the rates of intimate-partner homicide increase, but rates of murder of people trying to defend the wives also increased (Roth, 2014, p. 184).

Stealth murders of unwanted spouses also increased during this period. It is impossible to know the exact statistics because these murders were committed via the use of poison or other acts that were intended to appear to be an accident or suicide, but historians believe the number of these types of murders increased during the nineteenth century (Roth, 2014, p. 185). Interestingly, one-third of these murders were committed by women. These perpetrators killed their spouses because they wanted better lives, more money, another chance of love or escape from a spouse who was a burden (Roth, 2014, p. 185).

In the latter half of the nineteenth century into the mid-twentieth century, the women’s shelter movement advocated for victims of IPV (Dunphy, 2001; Schechter, 1998). Women had louder voices about domestic relations because of their right to vote, the emergence of feminism, and the role they played in both world wars (Barner & Carney, 2011). This point in the history of IPV marks significant change.

Leaders of the movement against what was then referred to as ‘DV’ shared an egalitarian approach in the 1970s (Murray, 2014, para 1). Well-known women leaders of the early decades of the twentieth century who paved the way to eradicate violence against
women and their children included Rose Scott, Louisa Lawson, Vida Goldstein, Bessie Rischbieth, Ada Bromham and Jessie Street (Murray, 2014, para 2). These advocates differed from the leaders of the women’s movement of the later decades of the twentieth century because of the development of the DV protest movement in the 1970s. This movement advocated the prevention of DV through working with women affected by DV, and by lobbying for changes to the policies and practices of police, courts and welfare agencies (Murray, 2014, para 3).

The feminist women’s refuge movement emerged in the mid-1970s in Australia and initiated state-based women’s refuges. These refuges were quite different from the refuges offered by the Salvation Army or other church-based organisations because they were initiated by a small group of women coming together in response to the needs of abused women in their local area (Murray, 2014, para 4), and offered crisis support to these women and their children, along with ways of leaving the abusive relationship. By the 1980s, all Australian governments undertook taskforces or commenced major enquiries into DV. Representatives of the feminist women’s refuge movement partook in these taskforces, and paved the way for changes to occur over the following two decades (Murray, 2014, para 10). At that time, IPV became part of the political and social landscape, arguably for the first time.

The 1990s were known for the shift from refuges to separate living units. The refuge movement of the 1990s was known for women living together in a large suburban house. Here, women supported each other and workers from the refuge guided and assisted them (Murray, 2014, para 11). However, living with fellow victims of DV was not easy, therefore, some services developed alternative models that consisted of separate living units (Murray, 2014, para 11).

The years towards the end of the twentieth century saw the development of the Domestic Violence and Incest Resource Centre (now the Domestic Violence Resource Centre Victoria) in 1986, and the Education Centre Against Violence in New South Wales (Murray,
In the twenty-first century, the movement against DV has continued its ongoing evolution and now includes refuge workers, policy makers, police and legal officers, as well as health practitioners, community educators and academics. There remains a commitment by those in the DV field to the feminist understandings of DV with its purpose of challenging violence and empowering women affected by this violence (Murray, 2014, para 19).

The fact that males can experience IPV perpetrated by their female partners has only begun to gain recognition in recent years; however, it has been known for centuries that males can experience this form of violence at the hands of their female partner (Dempsey, 2013). ‘Battered husbands’, as they were known, were ridiculed in the past rather than provided with sympathy and support (Dempsey, 2013). An example of this social ridicule and humiliation can be seen in post-Renaissance France and England (George, 1994). In France, a ‘battered husband was trotted around town riding a donkey backwards while holding its tail’ (George, 1994, p. 137). In England, ‘battered husbands were strapped to a cart and paraded around town, all the while subjected to the people’s derision and contempt’ (George, 1994, p. 137). This treatment resulted from patriarchal beliefs that a husband should be the dominant partner and the wife should be the victim of marital chastisement if needed, not the other way around, despite that this was indeed occurring (George, 1994).

The feminist movement brought with it issues about male survivors of IPV (Dempsey, 2013). In the feminist model, men were considered violent and women the victims of abuse. This only reinforced gender stereotypes, minimised the seriousness of female-perpetrated IPV, and increased the invisibility of male survivors of IPV (Dempsey, 2013). Not only did this disadvantage male survivors, it also created disadvantages for same-sex relationships because it failed to acknowledge females as perpetrators of IPV (Richards, Noret & Rivers, 2003).
Many societies have traditionally held a patriarchal belief system that valued masculinity, and encompassed hierarchy, aggression and heterosexuality (Dutton, 2006; Hatty, 2000). In many modernised industrial nations, men continue to be seen as being able to cause more harm to others than women are (Hatty, 2000). This belief may lead to female-perpetrated violence not being recognised or acknowledged in today’s society (DeFrancisco & Palczewski, 2014).

Now that the significant historical events associated with IPV have been discussed, the focus changes to the types of IPV that can occur. In the following section, the many types of IPV will be discussed and the behaviours that constitute each type will be presented. The types of IPV that will be discussed are physical violence, sexual violence, emotional, verbal and psychological abuse, economic abuse and controlling behaviours.

2.4 Types of IPV

Physical violence is the most publicised and noticeable form of violence, yet it is only one component of IPV. There are many forms of IPV, including physical violence, sexual violence, emotional, verbal and psychological abuse, as well as economic abuse and controlling behaviours (Garcia-Moreno et al., 2005). There are many actions that constitute each form of this IPV, and the number of these actions varies between relationships. Frequently, more than one form of violence occurs in the same relationship (ABS, 2007).

2.4.1 Physical violence

There are many types of physical violence that can occur between intimate partners. The commonly seen or reported acts of physical violence are listed below (ABS, 2007; Garcia-Moreno et al., 2005; Mouzos & Makkai, 2004; Morgan & Chadwick, 2009):

- throwing objects at the person
- pushing/shoving/dragging
- slapping
- kicking
• denying basic needs
• biting
• hitting with fist or another object
• threatening or hurting with a weapon
• injuring pets
• choking
• burning
• causing death.

2.4.2 Sexual violence

Survivors of IPV perceive this form of IPV as the ultimate insult (Duncan & Western, 2011, p. 1), stating that forced sexual intercourse is more of a betrayal by their partner than the physical or emotional abuse because of the social standards of intimacy, and intimacy partnering. This intimacy partnering involves trust, reciprocity and respect, and an environment that is safe and secure in which healthy negotiation can occur (Cowan, 2008). Duncan and Western (2011) highlight that ‘signing up for marriage or participating in any form of intimate relationship is not synonymous with perceptual consent to sexual activity’ (p. 3). For the survivor of IPV, this type of sexual violence includes, but is not restricted to, the following: being forced to take their clothes off; being forced to remain naked; being psychologically forced into having sexual intercourse because of fear of the repercussions from the perpetrator if they do not; being physically forced into having sexual intercourse against their will; being forced to do something sexual that they find degrading or humiliating; being forced to pose for pornography or watch pornography; being forced to have sexual intercourse with a person or people other than their partner (ABS, 2007; Garcia-Moreno et al., 2005; Mouzos & Makkai, 2004).
2.4.3 Emotional, verbal and psychological abuse

Although the physical effects of IPV are the most noticeable to the outside world, survivors who have experienced IPV state that the emotional and verbal abuse is more devastating than the physical abuse (Garcia-Moreno et al., 2005). They state that ‘long after the bruises have healed, words continue to cause damage to one’s self-esteem and self-worth’ (Mouzos & Makkai, 2004, p. 41). Examples of emotional, verbal and psychological abuse inflicted by the perpetrator include making threats of abandonment; isolating the partner from friends; spreading negative rumours; targeting insults and making the partner feel bad; having outbursts of anger; inducing humiliation; blaming or belittling in front of others; making threats to the partner, children or pets; and inducing terror by forcing the partner to watch violence towards a person or animal (ABS, 2007; Loring & Bolden-Hines, 2004; McKinnon, 2008).

2.4.4 Economic violence

There are three main types of economic violence. The first is deprivation of basic necessities, for example, sleep, nutrition or medication. The second is confiscation of income or assets, and the third is the unreasonable denial of the means necessary for participation in social life (ABS, 2007).

2.4.5 Controlling behaviours

The last major form of IPV is that of controlling behaviours (ABS, 2009). Again, there are multiple acts committed by the perpetrator encompassed by this broad category, some of which are listed below (ABS, 2009; D’Ovidio & Doyle, 2003; Hand, Chung & Peters, 2009):

- preventing the partner from seeing friends
- restricting contact with family
- insisting on knowing whereabouts at all times
- getting angry if partner speaks to members of the opposite sex / same sex
- making accusations of unfaithfulness
controlling access to health care

- cyberstalking and cyber surveillance via the use of information and communication technologies.

IPV encompasses many forms of abuse, including physical violence, sexual violence, emotional, verbal and psychological abuse, economic abuse and controlling behaviours. Within these different types of IPV, many behaviours can be executed by perpetrators. In the following section, the prevalence for IPV within Australia and worldwide will be discussed in relation to female and male survivors.

2.5 Prevalence Rates

2.5.1 Australia

It is important not only to understand the differing forms of IPV, but also to acknowledge its prevalence. Caution must be taken when critically analysing the statistics provided because it is considered that IPV is under-reported by both female and male survivors (Marcus & Braaf, 2007). Survivor denial is one key reason for this, as are the survivor experiencing feelings of shame and responsibility for the violent act (Corbally, 2001). The survivor fearing retribution from the partner, social isolation, financial constraints and child-rearing difficulties are other reasons cited for this reporting bias (Corbally, 2001). Societal beliefs and stereotypes also influence reporting behaviours because IPV continues to be considered a private family matter, and thus a non-serious form of violence (Cardarelli, 1997).

The Personal Safety Survey, conducted in 2012 by the ABS is the largest and most recent survey of violence in Australia (ABS, 2013). Approximately 1.5 million women in 2012 reported experiencing IPV since the age of 15 years, which constituted 17% of the Australian female population (ABS, 2013). Within the 12 months prior to conducting the Personal Safety Survey, 132,500 women or 1.5% of women in Australia had experienced IPV (ABS, 2013). There was no statistically significant change between the 2005 survey and the
2012 survey in relation to the proportion of women experiencing IPV during the 12 months prior to the survey, with 1.5% of women experiencing IPV in the 12 months prior to conducting both surveys (ABS, 2013). These statistics equate to one in four women having experienced IPV and one in six women having experienced IPV by a partner with whom they were living (Cox, 2016).

In the male population, approximately 448,000 men, which constituted 5.3% of all men aged 18 years and over, had experienced violence by a partner since the age of 15 years (ABS, 2013). In the 12 months prior to conducting the survey, 51,800 men or 0.6% of the male population aged 18 years and older had experienced IPV. As with the female population, there were no statistically significant changes in the proportion of men who had experienced IPV within the 12 months prior to the survey from the 2005 survey to the 2012 survey. In 2005, 0.4% of men had experienced IPV in the 12 preceding months compared to 0.6% in 2012 (ABS, 2013).

The Personal Safety Survey divided IPV into three main categories: physical violence, sexual violence and emotional abuse (ABS, 2013). More women reported experiencing emotional abuse than experiencing physical violence by a partner since the age of 15 years, with 25% of women experiencing this form of abuse (ABS, 2013). Physical violence was the second most frequent form of IPV reported, with 15.6% of women experiencing this form of IPV, and 4.9% of women experiencing sexual violence (ABS, 2013). The same pattern was found for the male population, with 14% experiencing emotional abuse, 5% experiencing physical violence, and 0.4% sexual violence since the age of 15 years (ABS, 2013).

These statistics demonstrate that more than 1.8 million Australian women have experienced physical IPV by a male partner, and more than 1.7 million Australian women have been physically assaulted by a male intimate partner. This equates to one in five women in Australia (Cox, 2016, p. 79). In addition, one in ten Australian women have experienced sexual violence by a male intimate partner, and more than 800,000 Australian women have
experienced sexual assault by a male intimate partner, equating to one in eleven women (Cox, 2016, p. 80).

Examining statistics from sources other than the ABS illustrates an even higher prevalence of IPV for women in Australia. The International Violence against Women Survey (IVAWS) Australian component, conducted by the Australian Institute of Criminology (AIC) found that 34% of women who had been in an intimate relationship had experienced IPV during their lifetime, with 31% experiencing physical violence and 12% experiencing sexual violence (Mouzos & Makkai, 2004, p. 44). When examining the five years prior to the survey, 13% of women stated they had experienced IPV within this period, and 4% had experienced it within the 12 months prior to the survey (Mouzos & Makkai, 2004).

The Australian Institute of Family Studies (AIFS) in their Experiences of Separated Parents Study (2015) found that men accounted for 41.3% of the parents who reported physical violence before and/or during separation, and 51.8% of the parents who had experienced emotional abuse during separation (Kaspiew et al., 2015). The highest level of fear associated with their ex-partner was felt by the male parents, with male parents accounting for 42.6% of the parents experiencing this fear. Of the parents who experienced severe coercion, 44.6% were male (Kaspiew et al., 2015).

Intimate-partner homicide is slowly decreasing in Australia. The rate decreased from 1.8 per 100,000 population per year in the period 2001–2002 to 1.1 per 100,000 population in the 2010–2011 and 2011–2012 financial years (Bryant & Cussen, 2015, p. 3). Referring to data from the National Homicide Monitoring Programme (NHMP), Bryant and Cussen (2015) examined homicide rates and types of homicides throughout the 2010–2011 and 2011–2012 financial years. Of the 479 homicides that occurred during these periods, 39% (n=187) were classified as domestic homicides. Of these 187 domestic homicides, 109 (58%) were categorised as intimate-partner homicides. In relation to gender, females represent the
majority of victims of intimate-partner homicide and are typically murdered in the context of a relationship that has a history of IPV (Bryant & Cussen, 2015).

2.5.2 Worldwide

IPV occurs in all countries around the world with differing rates of prevalence. Care should be taken when analysing prevalence rates between different countries for several reasons (Krug, Dahlberg, Mercy, Zwi & Lozano, 2002). First, as stated, there are numerous definitions of IPV and this inconsistency renders direct comparison nearly impossible. Second, inclusion criteria used for research studies differ, which also hinders direct comparison. For example, certain age groups, types of relationships, and cultures are examined more often than others in different contexts (Krug et al., 2002). Third, triggers for IPV, for example socioeconomic status and levels of education, also influence the rate of occurrence of IPV and the rate of disclosure of IPV (Krug et al., 2002).

International prevalence rates of IPV range from 10 to 69% of women aged 15 to 49 years who have experienced physical violence by a partner at least once during their lifetime, and 6 to 47% of women who have experienced actual or attempted sexual violence by their partner during their lifetime (Heise, Ellsberg & Gottemoeller, 1999; Krug et al., 2002). The WHO’s Multi-Country Study on Women’s Health and Domestic Violence against Women included 24,000 women from 10 countries to obtain a multicultural perspective. Results clearly demonstrated that IPV is prevalent in all countries surveyed, with the rate of physical or sexual violence or both by an intimate partner ranging from 15 to 71% with the average ranging from 29 to 62% (Garcia-Moreno et al., 2005). The country with the lowest rate of reported IPV was Japan, while provincial settings in Bangladesh, Ethiopia, Peru and the United Republic of Tanzania reported the highest rates (Garcia-Moreno et al., 2005). When categorising IPV into its different forms of abuse, physical violence was most prevalent in provincial Peru (61%) and least prevalent in Japan (13%). Likewise, Japan had the lowest rate of sexual violence (6%), while Ethiopia had the highest rate (59%). Finally, for controlling
behaviours, Japan was once again the country with the lowest prevalence (21%), while 90% of women in urban United Republic of Tanzania experienced this form of abuse (Garcia-Moreno et al., 2005).

More recent statistics were obtained via the first global systematic review and synthesis of scientific data on the prevalence of violence against women, which was conducted by WHO, the London School of Hygiene and Tropical Medicine, and the South African Medical Research Council (WHO, 2013a). Worldwide, 30% of all women who had been in an intimate relationship had experienced physical and/or sexual violence by an intimate partner (WHO, 2013a, p. 2). Prevalence was highest in the WHO’s African, Eastern Mediterranean and South East Asia Regions, where 37% of ever-partnered women had experienced IPV (WHO, 2013a, p. 16). The next highest prevalence was in the Region of the Americas in which 30% of ever-partnered women had experienced IPV. The prevalence was lowest in what the authors defined as high-income regions (23%) and in Europe and the West Pacific Regions (25%) (WHO, 2013a, p. 16). Interestingly, this report did not include IPV against male survivors, thus no statistics were provided for the prevalence of IPV against male survivors worldwide.

As indicated by the National Intimate Partner and Sexual Violence Survey, in the United States (US), 22.3% of women had experienced severe physical violence by an intimate partner during their lifetime, while 14% of males had experienced this form of violence. Additionally, in the 12 months preceding the survey, 2.3% of women had experienced severe physical violence by their partner, while 2.1% of males had experienced this (Breiding et al., 2014). Rape by an intimate partner was less prevalent than physical violence. The lifetime prevalence rate of rape by an intimate partner for women and males was 8.8% and 0.5% respectively. In the 12 months preceding the survey, 0.8% of women had experienced rape by their intimate partner, whereas, for the males, the percentage was too small to produce a statistically reliable prevalence rate (Breiding et al., 2014). Other forms of sexual violence
were more prevalent. For women, 15.8% (during their lifetime) and 2.1% (in the 12 months preceding the survey) had experienced other forms of sexual violence. For males, 9.5% (during their lifetime) and 2.1% (in the 12 months preceding the survey) had experienced other forms of sexual violence (Breiding et al., 2014). Finally, the lifetime prevalence rate for stalking by an intimate partner was 9.2% for women and 2.5% for men. This decreased to 2.4% for women and 0.8% for males in the 12 months prior to the survey (Breiding et al., 2014).

This section has highlighted the prevalence of IPV, both within Australia and internationally. It further illustrated that IPV victimisation is not gender specific and can occur to both women and men. Irrespective of gender, experiencing IPV can lead to many consequences, which will be discussed in the following section.

2.6 Consequences of IPV

As stated in Section 2.4, there are numerous types of abuse that constitute IPV, and Section 2.5 illustrated the highly prevalent nature of some of these forms of abuse. Similarly, there are numerous types of consequences that can result from IPV. The consequences of IPV are profound, and result in negative physical, emotional and psychological effects, and have negative effects on social and economic outcomes for the survivor and their dependents (Ellsberg & Heise, 2005; Perryman & Appleton, 2016; WHO, 2013a). The following sections present some of the consequences of IPV.

2.6.1 Burden of disease

Information on the effects of IPV on burden of disease was readily available for women survivors; however, very little information from reputable sources was available for male survivors. Therefore, most of the information in this section refers to women survivors of IPV. According to Webster (2016), an estimated 5.1% of the burden of disease for women aged 18 to 44 years is a result of IPV. This includes the physical and sexual forms of IPV in both cohabiting and non-cohabiting relationships, and the emotional form of IPV in
cohabiting relationships. When considering all women, 2.2% of the total burden of disease is a result of IPV, and for women over the age of 18 years, IPV ranked as the seventh largest risk factor contributing to the burden of disease (Webster, 2016). Unfortunately, there has been no change in the effects physical and sexual forms of IPV had on the estimated burden of disease from 2003 to 2011 (Webster, 2016).

Mental-health conditions such as depression and anxiety accounted for the largest proportion of burden of disease attributable to IPV in women. These mental-health conditions accounted for 70% of the total burden of disease (Webster, 2016). Homicide and violence related to IPV accounted for 40% of the total burden of disease for women, while suicide and self-inflicted injuries and early pregnancy loss attributable to IPV accounted for 25% of the total burden of disease for women (Webster, 2016).

The Young Australians: Their Health and Wellbeing 2007 statistical report conducted by the AIHW (2007) examined key national indicators of health, development and wellbeing of Australians between 12 and 24 years of age. Of the 14 risk factors examined, IPV was one of the five identified as contributing the most to the burden of disease and injury among this group of Australians. The other four risk factors were illicit drugs, alcohol, child sexual abuse and occupational exposures (AIHW, 2007, p. 22).

An earlier study, conducted in 2003 (Begg et al., 2007), identified IPV as accounting for 1.1% of the total burden of disease and injury in Australia. Of the 14 risk factors examined in the Burden of Disease and Injury in Australia 2003 study, IPV accounted for the most burden for females under the age of 45 years (Begg et al., 2007). This burden peaked at approximately 30 years of age for females and then declined thereafter. Anxiety, depression and conditions associated with the harmful use of alcohol, tobacco and illicit drugs accounted for most of the burden of disease caused by IPV (Begg et al., 2007). Once again, this information was provided only for female survivors of IPV because there was insufficient
evidence on the prevalence and risk among the male population according to the researchers (Begg et al., 2007).

2.6.2 Physical consequences

The physical injuries a person can sustain from IPV range from bruises, cuts, scratches, fractures, broken teeth to life-threatening penetrative wounds and gunshot wounds. Of the women who reported experiencing physical violence by an intimate partner in the Personal Safety Survey in 2005, 66% had sustained an injury from this violence. Bruises (59%) represented the most common form of injury, followed by cuts (19%) and fractured bones (9%). However, 2.3% of the women had sustained a penetrative wound, gunshot wound or stab injury, and 2.1% had sustained broken teeth (ABS, 2007). The WHO’s Multi-Country Study on Women’s Health and Domestic Violence against Women report concurs with these findings (Garcia-Moreno et al., 2005).

The reproductive health of the woman survivor also deteriorates as IPV continues. Unwanted pregnancies, vaginal and cervical infections, miscarriages and abortions are common consequences of this form of violence (Garcia-Moreno et al., 2005; Garcia-Moreno & Watts, 2011; Webster, 2016; WHO/London School of Hygiene and Tropical Medicine, 2010). IPV during pregnancy is also common, causing effects of delayed prenatal care, inadequate weight gain and premature labour, as well as foetal distress, stillbirths and bleeding during pregnancy (Garcia-Moreno et al., 2005; Garcia-Moreno & Watts, 2011; Webster, 2016; WHO, 2013a; WHO/London School of Hygiene and Tropical Medicine, 2010). In addition, women who experience IPV are 1.5 times more likely to contract human immunodeficiency virus (HIV), syphilis infections, chlamydia and gonorrhoea (WHO, 2013a). Further physical consequences of IPV for women are presented in Table 2.1.
Table 2.1

**Physical Consequences of IPV for Women**

<table>
<thead>
<tr>
<th>Dysmenorrhea</th>
<th>Dyspareunia</th>
<th>Sexually transmitted infections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Migraines/headaches</td>
<td>Urinary-tract infections</td>
<td>Gastrointestinal disorders</td>
</tr>
<tr>
<td>Chronic pain</td>
<td>Hypertension</td>
<td>Musculoskeletal problems</td>
</tr>
<tr>
<td>Constant fatigue</td>
<td>Sleep problems</td>
<td>Weight changes/poor appetite</td>
</tr>
<tr>
<td>Nightmares</td>
<td>Dizziness</td>
<td>Ocular damage</td>
</tr>
</tbody>
</table>

*Sources.* Eby, Campbell, Koss, Sullivan and Davidson (1995); Mouton, Rovi, Furness and Lasser (1999); Pigeon, Cerulli, Richards, Perlis and Caine (2011); Sillito (2012)

The physical consequences of IPV for male survivors are different. Male survivors usually experience quite superficial physical injuries such as scratches and bruises (Hines & Douglas, 2010a, 2010b; Tilbrook, Allan & Dear, 2010), and do not usually experience the compromised physical health that women survivors experience (Coker et al., 2002; Reid et al., 2008). The physical consequences of IPV for males have been reported as high blood pressure, asthma and sexually transmitted diseases (Singh, 2016).

### 2.6.3 Psychological consequences

The devastating effects on psychological health among women survivors of IPV are well documented. The WHO’s (2005) Multi-Country Study on Women’s Health and Domestic Violence against Women reports that the psychological effects are prevalent throughout all countries and across all cultural variances (Garcia-Moreno et al., 2005). In a study of 1,218 Australian women who had experienced IPV, Rees et al. (2011, p. 518) concluded that women who experience this form of violence are at an increased risk of developing mental illness over the course of their life, with increased exposure resulting in an increased risk of mental illness.

Women survivors of IPV are more likely to develop depression (Mechanic, Weaver & Resick, 2008; Romito & Grassi, 2007; Webster, 2016); post-traumatic stress disorder (PTSD)
and anxiety disorders (Bennice, Resick, Mechanic & Astin, 2003; Dutton et al., 2006; Robertiello, 2006; Temple, Weston, Rodriguez & Marshall, 2007; Webster 2016) and other stress-related syndromes (Almeida, Cunha, Pires & Sa, 2013; Cole, Logan & Shannon, 2005; Ferrari et al., 2014). Prevalence rates in Rees et al.’s (2011, p. 513) Australian study were 77% for anxiety disorders, 52% for mood disorders, 47% for substance-use disorders, 56% for PTSD and 35% for suicide attempts. Results from Peterson’s (2013) cross-sectional descriptive research study conducted in Virginia, US, highlighted higher prevalence rates of mental illness among women survivors. Significant levels of depressive symptoms were experienced by 74% (n=31) of the participants, PTSD criteria were met by 67% (n=28) of the participants, and 62% (n=26) of participants had a comorbidity of depression with positive PTSD symptomology (Peterson, 2013, p. 391).

Personality disorder is another significant mental-health condition that may be experienced by women survivors of IPV. Torres et al. (2013) examined the association between IPV and personality-disorder symptoms. Using the Dimensional Assessment of Personality Pathology-Basic Questionnaire, Index of Spouse Abuse and Beck Depression Inventory II instruments, these authors discovered that IPV survivors scored higher than non-abused women on intimacy problems and lower on rejection traits (Torres et al., 2013, p. 369). The length of IPV was negatively associated with this rejection. The severity of IPV was related to cognitive distortions, suspiciousness, restricted expression and intimacy problems (Torres et al., 2013, p. 369).

Women who have experienced IPV are also known to experience problems with smoking, and the use of alcohol and non-prescription drugs (Loxton, Schofield, Hussain & Mishra, 2006; Okuda et al., 2011; Reingle, Staras, Jennings, Branchini & Maldonado- Molina, 2012; Webster, 2016). The co-occurrence of problems with substance use and IPV is identified in 25–50% of women survivors (Bennett & Bland, 2008). However, Capaldi, Knobbe, Shortt and Kim (2012) stated that the association between substance use and IPV was
not as strong as believed. Therefore, Langenderfer (2013) conducted a review of eight studies and found an association between alcohol consumption and IPV, with problematic alcohol consumption more highly correlated with psychological abuse than with physical abuse. Additional research also suggests women survivors are twice as likely to have alcohol-use disorders than women who have not experienced IPV (WHO, 2013a), while Scott-Storey (2013) found that women who are abused turn to behaviours that are not good for them, such as smoking tobacco, drinking alcohol and using illicit drugs. Other common psychological consequences of IPV for women are listed in Table 2.2.

Table 2.2

<table>
<thead>
<tr>
<th>Psychological Consequences of IPV for Women</th>
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<tbody>
<tr>
<td>Loss of self-esteem</td>
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<tr>
<td>Dissociative disorders</td>
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<tr>
<td>Suicidal thoughts</td>
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Sources. ABS (2007); Begg et al. (2007); Black et al. (2011); D’Amico and Nelson (2008); Matheson et al. (2015); Parkinson (2008); VicHealth (2004); Webster, 2016; WHO (2013a)

The psychological consequences for male survivors of IPV are also highly prevalent. Tilbrook et al.’s (2010) two-stage grounded-theory study into men’s experiences of IPV found that men were often left feeling mentally crushed, lonely, and with no dignity following IPV. They reported often experiencing strong feelings of helplessness and withdrawing from people to live a solitary lifestyle (Tilbrook et al., 2010). Psychological disorders such as anxiety, depression, PTSD and suicidal ideation were also experienced (Tilbrook et al., 2010; Singh, 2016), and it has been found that men are also more likely to report heavy alcohol use and therapeutic and recreational drug use as a means to deal with the emotional of IPV (Perryman & Appleton, 2016; Tilbrook et al., 2010; Drijber, Reijnders & Ceelen, 2013). Storey and Strand (2012) also found that 54% of male survivors in their study had personal problems such as substance misuse, mental-health issues and feelings of fearfulness.
2.6.4 Social consequences

For some women survivors of IPV, leaving their abusive partner can lead to homelessness (AIHW, 2016; Morgan & Chadwick, 2009; Tutty et al., 2014; Webster, 2016). According to the Urban Research Centre and New South Wales Women’s Refuge Movement Resource Centre (2009), availability in accommodation for women survivors of IPV and their children is deteriorating in quality because of a lack of affordability, decreased length of stay, conditions of accommodation, safety concerns, and availability of maintenance. Often, once survivors leave an emergency shelter, they are faced with the decision to either become homeless or return to their abusive partner. They often begin to live a life of poverty, in which they live in unsafe housing or are homeless (Tutty et al., 2014, p. 1,499). This is of great concern considering that access to accommodation is one factor women survivors of IPV think about before leaving their abusive partners (Franzway et al., 2015; Macdonald, 2007; Tutty et al., 2014; Webster, 2016). Loss of employment and housing is also problematic for male survivors of IPV (Tilbrook et al., 2010).

The connection between IPV and homelessness has been confirmed by numerous studies (AIHW, 2016; Bopp et al., 2007; Canada Mortgage and Housing, 2006; Franzway et al., 2015; Novac, 2006; Tutty, Ogden & Weaver-Dunlop, 2007). According to the 2015–2016 annual report of the Specialist Homelessness Services (SHS) Collection, domestic and family violence is the main reason women and children in Australia leave their homes, and is the most common reason for seeking assistance from SHS collection (AIHW, 2016). In the period 2015–2016, 106,000 people experiencing domestic and family violence sought assistance from homelessness agencies throughout Australia, constituting 38% of all people requesting assistance. This represents an increase of 14% from 2014 to 2015. Since the period 2011–2012, there has been a significant average increase of 7% each year of clients seeking assistance as a result of domestic and family violence (AIHW, 2016). Single parents with a child or children represented 47% of the domestic- and family-violence clients, and 77% of
these clients were female, which means that 23% were male (AIHW, 2016). Finally, short-
term or emergency accommodation was needed by 44,500 of the domestic- and family-
violece clients because they had left their permanent home to escape the abuse (AIHW, 
2016).

2.6.5 Consequences for dependents.

Children witnessing IPV are the forgotten, unintended, invisible and secondary 
victims of IPV (Edleson, 1999; Kovacs & Tomison, 2003; Tomison, 2000). It has been 
demonstrated that women with children are three times more likely to experience IPV than 
women without children (Humphreys, 2007). According to the Personal Safety Survey 2012, 
an estimated 53,100 men who had experienced IPV with their current partner had children in 
their care, while 143,900 men who had experienced IPV with a previous partner had children 
in their care. Of these men, 99,400 (34%) stated their children had seen or heard this violence 
(ABS, 2013). In contrast, an estimated 128,500 women who had experienced IPV by a current 
partner had children in their care and of these women, 74,300 (31%) stated their children had 
witnessed this violence. An estimated 733,900 of women experiencing IPV by a previous 
partner had children in their care, of which 568,000 (48%) stated their children had witnessed 
this IPV (ABS, 2013).

Grip, Almqvist, Axberg and Broberg (2014, p. 686) conducted a study of 35 girls and 
30 boys nine to 13 years of age in Sweden. They found that a quarter of these children stated 
that the perpetrator had sometimes or often prevented their mother from sleeping or eating.

Additionally, one-fifth of the children stated that the perpetrator had sometimes or often hurt a household pet, and 67% reported that they had sometimes or often seen the 
perpetrator hurt their mother physically (Grip et al., 2014). Finally, one-quarter of the children 
stated they had sometimes or often seen the perpetrator threaten their mother with a weapon 
(Grip et al., 2014). Grip et al. (2014) also questioned the mothers of these children on the
frequency with which their child/children had witnessed different types of violence, reporting the following results:

- 44% had sometimes witnessed their mother being hit
- 46% had seen their mother thrown against a wall
- 37% had seen their mother kicked
- 25% had seen their mother choked
- 40% had seen their mother beaten up or hit with an object
- 88% had heard their mother being cursed at or humiliated.

Health complaints are common in dependents of IPV survivors (Angus, 2015; Morgan & Chadwick, 2009; Webster, 2016; Zerk, Mertin & Proeve, 2009). However, as with any condition, the degree to which it affects a child is individualised. Factors said to influence the degree to which IPV influences a child’s development include whether physical abuse is also experienced by the child, the child’s gender and age, the timeframe of exposure to the violence and the child’s relationship with each parent (WHO/London School of Hygiene and Tropical Medicine, 2010). The children in Grip et al.’s (2014) study reported a greater number of recurrent health complaints than the comparison sample of Swedish children of the same age group who had ordinary dental care for their yearly check-up. Frequent complaints included conditions such as headaches, stomach aches and difficulty sleeping (Grip et al., 2014). These findings are consistent with Lamers-Winkelman, Clasien De Shipper and Oosterman (2012), whose study involved 275 children who had witnessed IPV. IPV-exposed children compared to the general-population sample in Lamers-Winkelman et al. (2012) more often had complaints relating to eating, sleeping, and aches and pains. In addition, it has been found that these health complaints occur more with girls than with boys (Kuhlman, Howell & Bermann, 2012).

The health complaints experienced by children witnessing IPV are not only physical. The mental health of such children is also affected. Children who witness IPV are at an
increased risk of developing or experiencing psychological, social, emotional and behavioural problems (Campo, Kaspiew, Moore & Tayton, 2014). They are more at risk of developing and experiencing mood and anxiety disorders, PTSD, substance abuse and social-related problems (Angus, 2015; Dehon & Weems, 2010; Kennedy, Bybee, Sullivan & Greeson, 2010; Levendosky, Bogat & Martinez-Torteya, 2013; Luthra et al., 2009), and having other problems such as low self-esteem, impaired cognitive functioning, peer conflict, loneliness, presence of pervasive fear, school difficulties, increased aggression and temperament problems (Angus, 2015). These physical and mental-health complaints are very rarely short term. The increased health risks in adulthood for these children include severe obesity, sleep disturbance, somatic problems and risk-taking behaviour (Anda et al., 2006; Greenfield & Marks, 2009; Holmes, 2013).

### 2.6.6 Economic consequences

Not only does IPV affect the women, men, children and families directly involved in the violence, but it also has an economic cost to society. Domestic and family violence costs the Australian economy $13.6 billion each year, with the cost projected to increase to $15.6 billion by 2021 (AIHW, 2015). According to Pricewaterhouse Coopers Australia (2015), this figure increases if combining health, administration and social-welfare costs of violence against women. By this estimation, violence against women costs $21.7 billion per year, and if no further action is taken to prevent this violence, the cost will increase to $323.40 billion over a 30-year period from 2014 to 2044 (Pricewaterhouse Coopers Australia, 2015).

IPV affects a woman survivor’s ability to work and seek employment (Franzway et al., 2015). This is because of trauma, fear of their safety at work and instances of stalking and violence at the workplace by the perpetrator (Braaf & Barrett-Meyering, 2011). Women experiencing repeated or prolonged IPV also have more difficulty paying their bills and often go without food (Braaf & Barrett-Meyering, 2011). They also place a higher demand on welfare agencies for material assistance (Cortis & Bullen, 2016).
This section has demonstrated that IPV has devastating consequences on its survivors and their dependents. Physical, psychological, social and economic consequences are profound for both women and male survivors of IPV, and the dependents of these survivors. They suffer physical, psychological, social and developmental consequences from witnessing this violence towards one of their parents. To prevent IPV and these devastating consequences, it is important to discover whether there is a connection between a survivor’s personal characteristics and their risk of experiencing IPV.

### 2.7 Characteristics Increasing Risk of IPV

This section examines the connection between a survivor’s personal characteristics and the chance of experiencing IPV. Research demonstrates a correlation between certain characteristics of women and the chance of experiencing IPV. However, there is very little evidence for the characteristics that increase a male’s chance of experiencing IPV.

Although risk markers can be used to understand who are more at risk of experiencing IPV, it is important to realise that this type of violence is more closely related to the characteristics of the perpetrator not the survivor (Piispa, 2000). Further, a survivor may experience IPV and not have any or have only one of these associated risk factors. Therefore, any person is at risk of IPV, irrespective of their race, ethnicity, age, socioeconomic status, employment status, educational attainment or sexual orientation (Fishwick, 1998). This is important for all HCPs to note. The well-known characteristics associated with female victimisation of IPV, derived from both national and international studies, are presented in the following sections.

#### 2.7.1 Female characteristics

##### 2.7.1.1 Age

Younger women of 25–34 years of age experience higher levels of IPV (ABS, 2007; Garcia-Moreno et al., 2005; WHO, 2012).
2.7.1.2 Education

Women who have attained a lower level of education are more at risk of experiencing IPV than women who have attained a high level of education (ABS, 2007; Ackerson, Kawachi, Barbeau & Subramanian, 2008; Boy & Kulczyck, 2008; Boyle, Georgiades, Cullen & Racine, 2009; Chan, 2009; Dalal, Rahman & Jansson, 2009; Johnson & Das, 2009; Tang & Lai, 2008; WHO, 2012). However, having a higher level of education than the intimate partner can also be a risk factor for IPV (Ackerson et al., 2008; Chan, 2009).

2.7.1.3 Socioeconomic status

Women with higher socioeconomic status experience a lower rate of IPV than women with a lower socioeconomic-status (ABS, 2007).

2.7.1.4 Previous abuse

There is a connection between experiencing IPV and experiencing child abuse (ABS, 2007; Martin, Taft & Resick, 2007; Vung & Krantz, 2009), as well as between previous exposure to IPV and an increased risk of experiencing IPV again (Boyle et al., 2009; Sochting, Fairbrother & Koch, 2004; Uthman, Lawoko & Moradi, 2009).

2.7.1.5 Relationship problems

Relationship disharmony has been associated with an increased risk of experiencing IPV (WHO/London School of Hygiene and Tropical Medicine, 2010). In particular, dissatisfaction in the relationship felt by one or both partners, male dominance in the family, economic stress, male partner having multiple partners, and disparity in educational attainment, particularly if the woman has a higher education level than the male partner (WHO, 2012);

2.7.1.6 Marital status

Women living in a de facto relationship are at a higher risk of experiencing IPV than women who are married or have a boyfriend (Mouzos & Makkai, 2004).
2.7.1.7 Gender orientation.

IPV occurs in heterosexual relationships as well as gay, lesbian, bisexual, transgender and intersex (GLBTI) relationships (Leonard, Mitchell, Patel & Fox, 2008; Pitts, Smith, Mitchell & Patel, 2006).

2.7.1.8 Dependency on alcohol and other drugs

Male partners who consume excessive amounts of alcohol are more frequently the perpetrators of IPV and inflict more serious injuries on their partner, including femicide (Browne, 1997; Dearden & Payne, 2009; Foran & O’Leary, 2008; Gil-Gonzalez, Vives-Cases, Alvarez-Dardet & Latour-Perez, 2006; Mouzos & Makkai, 2004; Roberts, 2009). Additionally, cannabis consumption by a male partner at least twice per month is correlated with increased physical and non-physical forms of IPV (Nancarrow, Lockie & Sharma, 2009).

2.7.1.9 Pregnancy

Pregnancy is a significant life event associated with an increased risk and frequency of IPV (ABS, 2006; Burch & Gallup, 2004; Martin, Harris-Britt, Moracco, Kupper & Campbell, 2004; Pereira Silva, Valongueiro, Barreto de Araujo & Ludermir, 2015; Taft, 2002).

2.7.1.10 Disability

IPV against women with disabilities is believed to be widespread, yet statistics are limited on this occurrence (Barranti & Yuen, 2008; Brownridge, 2006; Coker, Smith & Fadden, 2005; Frohmader, 2011; Slayter, 2009; Smith, 2008).

2.7.1.11 Rural and remote living

Conflicting evidence exists about whether living in rural and remote areas increases a woman’s risk of experiencing IPV (Nancarrow et al., 2009; Renner, Habib, Stromqvist & Peek-Asa, 2014; Women’s Services Network, 2000). However, it is known that rural and remote hospitals have fewer resources to address IPV (Choo, Newgard, Lowe, Hall & McConnell, 2011), geographic and economic barriers exist to seeking assistance with IPV in these areas (Choo et al., 2011; Cook-Graig, Lane & Seibold, 2010), and there are limited
alternatives for following up with survivors and limited referral pathways (Iyenger & Sabik, 2009).

2.7.1.12 Indigenous Australians

Consistent with other health conditions and violence-related injuries, the rate of IPV is higher in the Indigenous population in Australia compared to the non-Indigenous population (Al-Yaman, Van Doeland & Wallis, 2006; Bryant & Willis, 2008; Cripps, Bennett, Gurrin & Studdert, 2009; Lumby & Farrelly, 2009; Mouzos & Makkai, 2004; National Council to Reduce Violence against Women and their Children, 2009; Steering Committee for the Review of Government Service Provision, 2016).

2.7.1.13 Culture/religion

IPV occurs in all settings and among all cultural and religious groups (WHO, 2012; Phillips & Vandenbroek, 2014; Taylor & Putt, 2007). For example, a man has the right to correct or discipline female behaviour in India, Nigeria and China, while physical violence is considered an acceptable way to resolve marital conflict in South Africa (WHO, 2009, p. 5).

2.7.2 Male characteristics

Information on the risk factors for male victimisation of IPV is very limited. However, some risk factors have been noted by researchers. First, age has been found to be a significant risk factor; however, in contrast to women survivors, the physical and psychological forms of IPV increases with age (Pournaghash-Tehrani & Feizabadi, 2007). Additionally, childhood experiences have been connected to male victimisation of IPV in that males exposed to physical and sexual abuse in childhood are more likely to experience IPV (Afifi et al., 2009; Gass, Stein, Willliams & Seedat, 2011). Witnessing parental violence and a lack of a close relationship with the primary female caregiver in childhood are also connected to male IPV victimisation (Gass et al., 2011). Finally, Gass et al. (2011) found that males with a low income are more likely to experience IPV.
2.8 Chapter Summary

This chapter has provided a comprehensive overview of the critical factors influencing IPV, as well as the consequences of those behaviours. There are many conflicting definitions and a variety of terms used to refer to this violent act, but the term IPV has been chosen for this study, along with WHO’s definition of IPV. The chapter also described the evolution of IPV, with a particular focus on the effects of patriarchal societies, the power shift between genders and the changing feelings about marriage and romance. Understanding what constitutes IPV allows the reader to appreciate the various forms it takes, including physical violence, sexual violence, emotional, verbal and psychological abuse, economic violence and controlling behaviours. In addition, the chapter highlighted that IPV is highly prevalent in Australia and worldwide, and results in profoundly negative physical, emotional, psychological, social and economic effects for the survivor and their dependents. Finally, although the chapter explains that there are certain characteristics associated with IPV, it is important to acknowledge that any person is at risk of IPV, irrespective of their age, race, ethnicity, socioeconomic status, employment status, educational attainment and sexual orientation.

This chapter has provided the rationale for IPV being a significant and prevalent public-health issue about which all citizens should be informed, and has demonstrated why HCPs, as a subset of the population, need to be fully informed of IPV and its consequences. The following chapter explores the literature as it applies to HCPs and IPV, and in particular, the inclusion or exclusion of IPV-related content and national and international guidelines and recommendations of IPV-related organisations and committees in the UG curricula of nursing, midwifery and paramedicine degrees.
Chapter 3: Literature Review/Research Issues

The thought of someone you love and who is supposed to love you back continuously inflicting physical and emotional pain towards you is unthinkable—yet it happens all too often throughout the world we live in.

3.1 Chapter Preamble

This chapter presents the current evidence-based literature on IPV nationally and internationally. The overarching purpose of this study is to better understand the current preparation of HCPs in relation to managing IPV. This chapter continues to build this understanding by providing a literature review focusing on the care and treatment of IPV survivors by HCPs, and the UG education of nurses, midwives and paramedics. First, the parameters upon which this literature review is based will be outlined. The significant relationship between HCPs and IPV will then be discussed. Part of this significant relationship is the need to screen patients for IPV effectively and efficiently, and to have non-judgemental attitudes about IPV and its survivors, as well as to treat survivors with respect and dignity. Recommendations for this screening process and HCPs’ responses and attitudes to IPV will also be discussed. Literature on the UG nursing and midwifery curricula will also be discussed in relation to these degrees including IPV-related content. The relationship between the care and treatment provided for IPV survivors and the National Competency Standards, Code of Ethics, and Code of Professional Conduct will also be discussed. The paramedicine curriculum will then be examined in relation to its inclusion of IPV-related content in the UG BP or equivalent degree. The Professional Competency Standards, Australasian Competency Standards for Paramedics, and the Code of Conduct for Paramedics will also be discussed in relation to the appropriate care and treatment of IPV survivors. A discussion on why continuing education/in-services are a better reinforcement method for IPV-related education than an initiation method will also be presented. To provide an
universal perspective of the education of HCPs in IPV-related content, international organisations and committees’ recommendations will also be highlighted, followed by the research issues, including the gaps in the literature, and the research problem, objectives, questions and propositions.

This chapter is presented in nine sections. Section 3.1 provides a chapter preamble and a conceptual map of the literature review (Figure 3.1). Section 3.2 explains the parameters of the literature review. The parent discipline of HCPs and their unique position in IPV is presented in Section 3.3, and the parent discipline of screening for IPV is discussed in Section 3.4. The final parent discipline, HCPs’ responses and attitudes, is explored in Section 3.5. Section 3.6 presents the immediate discipline of HCP education in IPV in the following subsections: nursing curriculum (Section 3.6.1), midwifery curriculum (Section 3.6.2), additional national standards for the RN and the RM (Section 3.6.3), paramedicine curriculum (Section 3.6.4), and continuing education/in-services (Section 3.6.5). Key international organisations and committees’ guidelines and recommendations for the inclusion of IPV-related content in UG HCP curricula and the appropriate screening and treatment of IPV survivors is reported in Section 3.7, and the research issues are presented in Section 3.8. Finally, a chapter conclusion is presented in Section 3.9.
3.1 Chapter preamble

3.2 Literature-review parameters

3.3 Parent discipline: HCPs and IPV

3.4 Parent discipline: Screening for IPV
   3.4.1 Screening rates
   3.4.2 Screening recommendations
   3.4.3 Barriers to screening
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3.5 Parent discipline: HCPs’ responses and attitudes
   3.5.1 Survivors’ experiences of disclosing abuse
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3.6 Immediate discipline: HCP education in IPV

3.6.1 Nursing curriculum
   ➢ 3.6.1.1 Number of hours
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   ➢ 3.6.1.5 National Competency Standards for the Registered Nurse
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3.6.2 Midwifery curriculum
   ➢ 3.6.2.1 Contemporary issues in midwifery undergraduate education
   ➢ 3.6.2.2 National Competency Standards for the Midwife
   ➢ 3.6.2.3 Code of ethics for midwives
   ➢ 3.6.2.4 Code of professional conduct for midwives

3.6.3 Additional national standards for the RN and RM
### 3.2 Parameters of Literature Review

A valid and effective literature review is essential for obtaining all pertinent information on any selected research topic (Havard, 2007). According to Havard (2007), there are four steps involved in an effective literature search: 1) create a well-focused research question; 2) identify sources of information; 3) create a search strategy; 4) critically appraise the information. First, a well-focused research question needs to be developed to determine keywords and limitations for the literature search (Havard, 2007). From personal experience with the research topic and through preliminary research for the research proposal, the following broad research question was developed: Is tertiary UG education addressing the
topic of IPV in HCP degrees, so that HCPs know how to enquire about IPV, know how to treat the many forms of this abuse and know how and when to refer survivors onto further services?

Second, sources of information must be identified. Given that the literature review was seeking current literature, journals articles and the Internet were utilised. Journal articles are the best source of information for current EBP, particularly if they appear in peer-reviewed journals (Havard, 2007). Additionally, grey literature, including government, academic and non-profit agency websites are reputable and can provide statistics and other relevant information on this topic (Havard, 2007).

Third, a well-conceived search strategy must be established (Havard, 2007). A scoping exercise was conducted to determine the search terms that would be relevant for the current study. The first keywords used were ‘IPV’, ‘DV’, ‘partner violence’ and ‘family violence’. Literature for this review was identified via several health-science databases, including CINAHL, Medline, PsycINFO, Academic Search Premier, and PsycARTICLES, and published theses related to the topic were also identified via the Open Access Theses and Dissertations database. Examples of the grey literature utilised include the ABS, AIHW, Australian Domestic and Family Violence Clearinghouse and AIC. To make the search more systematic, the following limitations were implemented: articles and documents needed to be published from 2000 to 2013 and written in English, and the source type was restricted to academic journals. With these limiters in place, 36,421 articles were found.

As the number of articles was very large, the following additional keywords were identified to focus the search: ‘advocacy’, ‘assessment’, ‘screening’, ‘safety’, ‘students’, ‘nursing’, ‘midwifery’, ‘paramedicine’, ‘curriculum’, ‘education’, ‘RNs’, ‘RMs’, ‘paramedics’, ‘university’, ‘BN’, ‘BM’ and ‘BP’. Duplicates were removed, resulting in 316 research articles. Hand searches were also performed in a manner referred to as ‘backward
chaining’, which involves hand searching the reference list of existing journal articles and
documents to find other references relevant to the topic (Booth, 2008).

The 316 research articles included quantitative studies, qualitative studies, literature
reviews and systematic reviews. Additionally, research was obtained from developed and
developing countries to gain national and international perspectives of IPV and its related
education. Later in the search process, the search date was extended to 2016 to ensure all
current EBP was included in the current study. An additional 13 articles were included
following this extension of publication date.

Fourth, it is essential to critically appraise the research articles obtained for reliability,
validity and relevance (Bialocerkowski, Klupp & Bragge, 2010). The appropriateness of the
study design for the research question and the key methodological features should be
assessed, along with other strengths and weaknesses of the research method (Young &
Solomon, 2009). This was implemented for all research articles obtained, and the limitations
of the research are noted through the literature review. The principal points that emerged from
the literature in relation to IPV-related content in the UG degrees of nursing, midwifery and
paramedicine will now be discussed, along with the literature’s relevance to the research aims,
objectives and research questions.

3.3 Parent Discipline: HCPs and IPV

As outlined in Chapter 2, IPV is a prevalent worldwide public-health issue that has
devastating consequences for the survivor and their dependents. As a result of these
consequences, IPV survivors access more health-care resources than non-abused people
(Ansara & Hindin, 2010; Black, 2011). HCPs will inevitably have contact with these
survivors and their dependents and therefore, should have knowledge about the specific
aspects of IPV, as well as on screening methods, treatment modalities, sources of support and
referral pathways for IPV (Black et al., 2011; Clements et al., 2011; Johnson et al., 2009;
Mason, Schwartz, Burgess & Irwin, 2010; Public Health Association of Australia, 2010;
WHO, 2010, 2013b). HCPs are often classified as the initial surveillance mechanism for the
detection and identification of IPV survivors, and apart from doctors (the study of whom was
beyond the scope of this thesis), all first responders (paramedics, nurses and midwives) were
included in this study (Mouton, as cited in Ismailji, Callahan & Mettner, 2010; WHO, 2013b).

According to the Australian Health Practitioner Regulation Agency (AHPRA)
statistics, in June 2016, there were 272,733 RNs in Australia, 28,889 dual RN/RMs and 4,050
RMs (Nursing and Midwifery Board of Australia, 2016). As Australian paramedics are not
registered under AHPRA, current statistics on the number of paramedics in Australia is
difficult to obtain. However, according to PA (2012), there were 11,642 paramedics working
in Australia in 2011. With this large number of nurses, midwives and paramedics working in
Australia, it is clear these HCPs are in a unique position to respond to IPV survivors and their
dependents (Beccaria et al., 2013; Fiolet, Sands & Nagle, 2013; Frederick-Amar, 2008;
International Council of Nurses [ICN], 2009). The unique positioning of HCPs reinforces the
importance of this study in examining the curricula of Australian universities that offer UG
degrees in nursing, midwifery and paramedicine to determine the amount and type of IPV-
related content these degrees teach student HCPs.

3.4 Parent Discipline: Screening for IPV

3.4.1 Screening rates

The first and most essential task these HCPs must undertake to treat IPV is screening
and detecting survivors. Without screening and detection, no further treatment can be offered
(Gerlock, Grimesey, Pisciotta & Harel, 2011), which is why screening and identification of
survivors is the first step in the education of HCPs, and the first type of literature to be
reviewed. Moreover, the current study aims to examine whether screening procedures and
policies are incorporated in the curricula of nursing, midwifery and paramedicine by
answering research question 4, which examines what IPV-related content is currently being
taught within these disciplines.
Irrespective of the setting in which HCPs work (e.g., hospital, clinic, community), it is essential that screening is performed (Gerlock et al., 2011). However, rates for screening remain low, despite ongoing recommendations for better screening (WHO, 2013b). Stayton and Duncan (2005) conducted an international review of 44 studies, examining IPV screening and found a median screening rate of only 23%. According to other research, rates for IPV screening vary from 5 to 47% across a variety of settings in numerous countries (Bacchus et al., 2010; Gutmanis, Beynon, Tutty, Wathen & MacMillan, 2007; Renker & Tonkin, 2006; Trautman, McCarthy, Miller, Campbell & Kelen, 2007).

More recently, via a cross-sectional study of psychiatrists and psychiatric nurses in South London, Nyame, Howard, Feder and Trevillion (2013) examined the rate of IPV knowledge, attitudes and preparedness to respond to IPV. Of the 131 participants included in Nyame et al. (2013), only 20 participants (15%) routinely screened all patients for IPV, and less than 10% screened for IPV periodically. Despite such inadequacies, in the six months prior to the study, 54 participants (41%) had identified at least one case of IPV (Nyame et al., 2013). In another study, Al-Natour, Gillespie, Felblinger and Wang (2014) examined screening rates in relation to the presenting issue of the patients. In this descriptive, cross-sectional design study, a stratified random sample of 125 nurses from three Jordanian public hospitals and 10 public-health clinics was examined using the DV Health Care Provider Survey and the Woman Abuse Screening Tool. Results demonstrated that IPV screening occurred more when the woman presented with physical injuries (25%) than when reporting 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%). Only 10.8% of women receiving gynaecological or obstetric care were screened for IPV (Al-Natour et al., 2014). However, his study failed to incorporate the screening rates for male survivors of IPV. Important to these studies and to the recommendations presented in the following section, in a nurse-based randomised controlled trial (RCT), Hooker, Small and Taft (2016) demonstrated
that when given screening tools and support, over time, nurses will integrate IPV screening into their normal practice.

3.4.2 Screening recommendations

As illustrated above, screening rates of IPV remain low, irrespective of the numerous recommendations from significant organisations advocating this screening. These recommendations can be divided into those endorsing case-based screening and those advocating universal screening. The leading global health organisation, the WHO (2013b), advocates for case-based screening, stating that ‘HCPs should ask about exposure to IPV when assessing conditions that may be caused or complicated by IPV, to improve diagnosis, identification and subsequent care’ (p. 19). Australian organisations such as the Australian Nursing and Midwifery Federation (ANMF) (2016) also advocate for this type of screening, acknowledging that nurses and midwives play a significant role in the identification of survivors of IPV and can facilitate access to assistance and support. IPV screening is also recommended in the Clinical Practice Guidelines: Antenatal Care developed by the Department of Health and Ageing (2012). These guidelines recommend that midwives explain to all women at their first antenatal visit that screening for IPV is a routine part of antenatal care and that is the reason they are enquiring about this form of violence (Department of Health and Ageing, 2012, p. 83).

Case-based screening is also supported by international organisations. For example, The American College of Obstetricians and Gynecologists (2012) recommends screening at the first antenatal visit, once during each trimester, and at the postpartum visit, and that there be provision of continual support and appropriate referrals to pregnant and postpartum women. Additionally, the United States Preventive Services Task Force (2012) endorses HCPs screening women of childbearing age for past or present IPV, and providing referral to appropriate services upon a positive screening.
Universal screening refers to the screening of all women irrespective of their age, reasons for seeking health care, health status or history of IPV (Association of Women’s Health, Obstetrics and Neonatal Nurses, 2015). The Association of Women’s Health, Obstetrics and Neonatal Nurses (2015) proposes universal screening for all women in a private, safe setting by all health-care facilities (p. 405). The Institute of Medicine (IOM) also recommends universal IPV screening in their Clinical Preventive Services for Women Report (2011). However, dissimilarity exists in relation to male patients. Many health-care organisations fail to universally screen men for IPV, and are less likely to believe them when they disclose such violence (One in Three Campaign, 2015).

There are proponents for and against universal screening for IPV. The arguments for universal screening include the high prevalence of IPV in today’s society, IPV being negatively associated with poor health outcomes, IPV needing to be uncovered to provide safe and useful services, and the fact that spontaneous disclosure is very unlikely (Phelan, 2007; Stith, Rosen & McCollum, 2003; Todahl, 2003). Arguments against universal screening are that it is intrusive, can alienate patients, can cross over into forensic investigation, and can lead to an increase in IPV (Hamberger & Phelan, 2004; Minsky-Kelly, Hamberger, Pape & Wolff, 2005; Tower, 2006).

Irrespective of the type of screening that is being proposed, it is evident that national and international health-care organisations certify the need to screen patients for IPV. As a result of this certification, it is essential to discover whether Australian universities are educating student HCPs on the importance of this screening and how to screen appropriately and adequately for IPV. It is also important to determine whether Australian universities and their academics are aware of the guidelines and recommendations, and incorporate them into their teaching. One of the aims of the current study is to determine whether Australian universities are adopting national and international health organisations and committees’ guidelines and recommendations on the inclusion of IPV-related content. As stated, this is the
first national or international study examining the adoption of these guidelines and recommendations in university curricula, and thus plays an important role in closing the gap in research.

### 3.4.3 Barriers to screening

Although there are numerous guidelines and recommendations supporting the screening of patients for IPV, failure to screen for such violence by HCPs can be attributed to numerous barriers. In addition to determining the rate of screening among Jordanian nurses, Al-Natour et al. (2014) also aimed to determine the barriers to such screening. In their descriptive cross-sectional study, Al-Natour et al. (2014, p. 1,478) revealed five main barriers to screening: self-efficacy, system support, victim blaming, professional role resistance, and victim and provider safety.

For self-efficacy, 39% of nurses (n=48) stated there was a lack of time to screen for IPV, and 72% (n=90) stated they had no access to IPV information. These nurses also lacked the confidence to refer patients to services, with 52.8% (n=66) acknowledging this (Al-Natour et al., 2014).

System-support barriers referred to access to other services such as social workers and mental-health services. A lack of access to social workers was acknowledged by 78.4% (n=98) of participants, and a lack of access to mental-health services was acknowledged by 72.6% (n=90). Additionally, 79.8% of participants (n=99) disagreed that mental-health services are capable of providing help to IPV survivors (Al-Natour et al., 2014).

Victim blaming appeared to be a major barrier to screening. The results demonstrated that 72% of the nurses (n=90) believed that the woman’s personality contributed to the IPV, and 42.4% (n=53) believed the survivor’s actions led to the IPV (Al-Natour et al., 2014). Further, 52.4% of participants (n=65) agreed that people choose to become IPV survivors.

Another barrier to screening found in the study, was that of professional role resistance. Screening for IPV is not part of a nurse’s role, and screening for IPV was viewed
as an invasion of privacy by 49.6% (n=62) and 46.4% (n=58) of participants, respectively (Al-Natour et al., 2014). Agreement with the statement ‘it is a non-nursing role to resolve couple conflict’ was reported by 46.4% of the participants (n=58) (Al-Natour et al., 2014).

The final barrier found in Al-Natour et al.’s (2014) study was victim and provider safety. A concern for their own safety and for their patient’s safety was reported by many of the nurses, with 66% (n=83) believing that workplace security is insufficient to deal with IPV (Al-Natour et al., 2014).

DeBoer, Kothari, Kothari, Koestner and Rohs (2013) found contradictory findings to the aforementioned studies about barriers to screening. In DeBoer et al.’s (2013) cross-sectional survey of 156 hospital-based trauma nurses in the US, 45.8% stated they had identified no IPV survivors in the past year, 82.6% stated they had looked after two or fewer survivors, 7.7% stated they had looked after three to five survivors, and 9.7% stated they had looked after more than five survivors. This study did not find support for the barriers of self-efficacy, victim blaming and professional role resistance that were found by Al-Natour et al. (2014). DeBoer et al. (2013) found that 81% of participants felt they had sufficient time to screen patients for IPV, and therefore did not consider this a barrier to screening. Neither did the participants in DeBoer et al. (2013) blame the victim for the violence, with 98% ‘highly disagreeing’ or ‘disagreeing’ with the statement ‘women often bring the violence on themselves’, and 89% ‘highly disagreeing’ or ‘disagreeing’ that a small amount of IPV occurs in all families (DeBoer et al., 2013, p. 157). Finally, no professional role resistance was found in this study, with 95% of the nurses surveyed stating it is the nurse’s business if their patient is a survivor of IPV, and 90% agreeing that screening for IPV is part of a nurse’s responsibility. They even believed this responsibility was more theirs than it was the physician’s, with only 5% delegating this screening responsibility to the physician (DeBoer et al., 2013, p. 157).
Another factor the literature demonstrates affecting HCP willingness to initiate IPV screening is the physical environment in which care is provided, and the lack of privacy that exists. A lack of privacy is an enormous issue for screening and disclosure of IPV (Beynon, Gutmanis, Tutty, Wathen & McMillan, 2012; Cronin & O’Connor, 1993; Spangaro, Poulos & Zwi, 2011). Usually in the emergency department, there is only a curtain or a wall dividing the emergency bays from each other, and it is common to be able to hear what is being said in the next bay. An HCP cannot ask the partner to wait just outside the room because the partner can hear the conversation. Usually, a survivor will not respond positively to any screening questions if they believe their partner can hear because they fear retaliation (Beynon et al., 2012; Spangaro et al., 2011).

However, the most significant barrier to screening appears to be HCPs’ lack of knowledge. In a cross-sectional survey of 96 nurses in a Canadian urban hospital, Guillery, Benzies, Mannion and Evans (2012) found that a lack of knowledge was the most significant barrier to screening. In DeBoer et al. (2013, p. 156), only 56% of the nurses surveyed believed they were adequately trained to recognise the signs and symptoms of IPV. Beynon et al. (2012) found further quantitative evidence supporting HCPs’ lack of knowledge as a significant barrier to screening in their study surveying 931 HCPs in Ontario, Canada, as did Nyame et al. (2013) in their cross-sectional study of 131 psychiatrists and psychiatric nurses in South London.

Quantitative research is not the only form of research highlighting a lack of knowledge as a significant barrier to screening. Shamu, Abrahams, Temmerman and Zarowsky (2013) conducted in-depth interviews and observed six midwives in six antenatal clinics in Harare, Zimbabwe. They also conducted focus groups with 64 pregnant and postpartum women. Thematic content analysis found that none of the midwives had received training or skills in the screening and identification of IPV, and thus were able to recognise only the most obvious cases of IPV (Shamu et al., 2013). Likewise, Tower, Rowe and Wallis (2012) discovered a
lack of training via in-depth qualitative interviews with nurses in Brisbane, Australia. LoGuidice (2015) conducted a literature review of articles from 2000 to 2013, which included seven qualitative studies and one mixed-methods study. It was discovered that midwives were inadequately prepared and ill-equipped to deal with disclosure of IPV because they lack education in this area and lack awareness of resources and agencies.

All the barriers listed above can arguably be overcome with the inclusion of IPV-related content in the UG curricula of nursing, midwifery and paramedicine. If HCPs receive adequate education on IPV screening, a lack of time and lack of information will no longer be barriers because HCPs would be competent in effectively and efficiently screening and identifying IPV survivors, and would understand the best means of treatment and referral. Additionally, enhanced self-efficacy would potentially replace the current lack of confidence because HCPs would be prepared and practised in how to screen and identify survivors through their UG degree. Further, HCPs would understand that screening and identification is part of their scope of practice, rather than believing it to be an invasion of privacy; they would understand that if such screening is completed correctly, it does not jeopardise their own safety or that of their patients. Victim blaming would also potentially be minimised because beliefs and attitudes towards IPV would have been challenged in their degree, and an accurate depiction of IPV survivors would have been presented. Finally, the most significant barrier, a lack of knowledge and training, would certainly no longer exist if IPV-related content were effectively and comprehensively incorporated into the UG degrees of these HCPs.

3.4.4 Enablers of screening

Irrespective of the barriers to screening, it has been found that survivors of IPV want to be screened and would discuss the violence if asked (Burge, Schneider, Ivy & Catala, 2005; Duncan & Weston, 2011; Feder et al., 2009; Sethi, Watts, Zwi, Watson & McCarthy, 2004). A spontaneous declaration of violence is rare because of the shame survivors feel or because of their belief that HCPs will not believe them (Ellsberg, 2006). Survivors are often relieved
when asked by HCPs about IPV because they benefit greatly from telling their story to someone who wants to listen (Campbell, Pliska, Taylor & Sheridan, 1994; Radomsky, 1995). It is extremely important for HCPs to respond to the hints survivors provide about experiencing IPV (Duncan & Weston, 2011). Survivors often do not use the words ‘IPV’, ‘sexual assault’, ‘rape’, or similar words. They may use less severe terminology such as ‘letting them have their way’, ‘keeping the peace’, ‘giving in’ or for Indigenous Australians something such as ‘blackfella’s love’ (Parkinson, 2008, p. 76).

Iverson et al. (2014) conducted five focus groups with 24 female Veteran’s Health Administration patients who had and had not experienced IPV in Boston, Massachusetts. Via content analysis, it was revealed that the women supported routine screening for IPV across different settings because it has implications for women’s health, but that women should be given the option about whether they answer the question (Iverson et al., 2014). The participants of this study reported believing that women should be given power by giving them the choice on how to disclose this violence and to whom they disclose it. Additional recommendations were made by the participants of these focus groups, including having a female HCP perform the screening questions for a female patient, that screening should be conducted through a sensitive and respectful approach that screening should be asked in less clinical terminology, conveying human qualities and sensitivity, and that follow-up support must be provided because failure to follow up could be detrimental to the survivor (Iverson et al., 2014).

Screening enablers were also explored by Sprague et al. (2013) in their quantitative cross-sectional study examining the perceptions and opinions of patients on screening for IPV in fracture clinics in Canada and the Netherlands. A questionnaire was administered to 750 patients, with 554 participants (74%) supporting screening for IPV in a fracture clinic. In relation to gender, 196 participants (26%) supported screening of all women for IPV, and 176
(24%) supported screening of all men for IPV (Sprague et al., 2013). Face-to-face screening was preferred by 671 participants (90%), followed by written questionnaires (n=168; 22%).

Further, 685 participants (91%) believed it should be conducted privately while 536 participants (72%) endorsed using screening questions written by experts (Sprague et al., 2013). Participants appeared to be comfortable with the idea of being screened for IPV. Screening by a social worker was preferred by 547 participants (73%); 429 participants (57%) preferred screening with an orthopaedic surgeon, and 381 participants (51%) preferred screening with an orthopaedic nurse. Only 58 participants (8%) stated they would feel uncomfortable with this screening (Sprague et al., 2013).

A mixed-methods approach was adopted by Stockl et al. (2013) in their survey on IPV screening conducted with 401 women from a hospital’s maternity ward in Munich, and interviews were performed with seven women who experienced IPV during pregnancy. Routine or cased-based enquiry for IPV in general care was supported by 85% (n=338) of the surveyed participants, while screening within antenatal care was supported by 92% (n=362) (Stockl et al., 2013). This favourability was associated with a woman’s experience of child sexual abuse, being aged 22 to 31 years, less educated, being single or divorced and smoking during pregnancy (Stockl et al., 2013).

One of the most significant enablers to screening is the training of HCPs (Beynon et al., 2012; Jayatilleke et al., 2015; Spangaro et al., 2011; Stockl et al., 2013). In Beynon et al. (2012), 296 participants (38.5%) rated training as the most significant facilitator to screening for IPV (2012). Likewise, via focus groups conducted with 59 HCPs in New South Wales (NSW), Australia, training of HCPs was identified as one of the top three enablers to IPV screening (Spangaro et al., 2011), and Stockl et al.’s (2013) mixed-methods approach also found the need for training HCPs in IPV screening. An example of the effect training can have on screening rates is seen in Jayatilleke et al. (2015). From 2009 to 2010, the Sri Lankan Ministry of Health conducted training on IPV for public-health midwives. Completed
questionnaires were received from 408 midwives, and demonstrated that training improved IPV practices significantly. Before the IPV training, 73.3% of participants (n=299) identified at least one IPV survivor in the preceding three months, but after the IPV training, 98.5% (n=402) identified an IPV survivor in the preceding three months. Further, post-intervention, 96.5% of participants (n=387) discussed IPV with survivors and suggested solutions compared to 67.3% (n=201) pre-intervention (Jayatilleke et al., 2015).

Another enabler of screening includes having a personal history of IPV. Nurses with a personal history of IPV screened for this violence more often than nurses with no history of IPV (Al-Natour et al., 2014). However, this difference was not statistically significant, thus further research needs to be conducted on this issue. Other enablers include having scripted questions, access to referral services and, professional protocols and policies in place (Beynon et al., 2012; Spangaro et al., 2011).

This literature has demonstrated that the most significant facilitator for screening is the education and training of HCPs. Thus, it is important to ensure this content is covered in UG HCP degrees, and the current study will be the first national or international study to examine the quantity and type of IPV-related content in the UG degrees of nursing, midwifery and paramedicine collectively. Research question 1 of this study examines the prominence of IPV-related content in these three UG degrees, while research question 4 examines what type of content is being taught if IPV is addressed within a degree.

### 3.4.5 Consequences of screening

To promote the enablers of IPV screening and to eliminate the barriers to IPV screening, the benefits and risks of such screening must be understood. According to Taft et al.’s (2013) systematic review of the effectiveness of screening for IPV, screening increases identification of survivors of IPV, particularly in antenatal settings, but fails to result in an increase of referrals to support services. Screening was also found to fail to reduce the amount of abuse experienced by survivors (Taft et al., 2013). According to Devine, Spencer, Eldridge,
Norman and Feder’s (2012) clinical RCT, identification of and support for survivors of IPV resulted in improved health status and was cost-effective. Thus, failure to screen is a lost opportunity, resulting in survivors remaining vulnerable to poor health outcomes and further injury (Houry et al., 2008).

It has been found that routine IPV screening poses no risk to survivors if conducted appropriately (Houry et al., 2008). This finding is further supported by Taft et al.’s (2013) systematic review; however, only a limited number of studies examine this outcome. Further research must be conducted to examine this outcome of screening (Taft et al., 2013).

Additionally, little is known about false measurements (positives or negatives) of IPV, and therefore, further research needs to be conducted in this area also (Taft et al., 2013). This literature illustrates that there are beneficial consequences of IPV screening, and a lack of negative consequences of this practice, supporting the argument that IPV screening along with other IPV-related content should be incorporated into the curricula of UG HCP degrees.

### 3.4.6 Required change

According to the literature, screening patients for IPV will not be successful unless there are changes made at the individual HCP level, as well as the system level (D’Avolio, 2011; Hooker & Taft, 2013). However, changes must occur at the system level before HCPs can implement their knowledge and skills related to IPV, as system changes will enable and promote the screening of IPV (Ambuel et al., 2013). Examples of system-level changes include re-writing existing policies and procedures, implementing screening tools or reminders to screen for IPV in medical notes, creating multi-sectoral partnerships, and redesigning patient-care environments (Ambuel et al., 2013; Al-Natour et al., 2014).

These changes are supported by Ambuel et al.’s (2013) three elements of change.

According to Ambuel et al. (2013, p. 835), the following three elements are needed to implement IPV prevention successfully into health-care services:

1. **provider level**—training for all HCPs so that they have the knowledge, attitudes
and behavioural skills to identify, treat and prevent IPV

2. health-care-system level—changes such as administrative buy-in, ongoing
   quality-improvement strategies and patient education that enhances IPV
   identification, treatment and prevention

3. cultural level—important changes that enable identification, treatment and
   prevention of IPV to be supported by prevailing values and norms, which will be
   integrated into the roles of clinical and administrative staff.

An example of these three elements of change is the Healthcare Can Change from
Within (HCCW) intervention for IPV. This intervention was implemented in the Midwest of
the US in an emergency department, paediatric clinic and two family-medicine clinics. The
participants were physicians, nurses, physician assistants and administrative staff (Ambuel et
al., 2013). Two training programmes and a clinical toolkit were implemented in this
intervention. The first training programme was an in-depth 20-hour training session for all
HCPs, while the second training programme was designed for saturation training of all
clinical and administrative staff that had contact with patients. The training programme was
three hours in length. Physicians, nurses, physician assistants and other clinical staff
underwent an additional one-hour module (Ambuel et al., 2013). The clinical toolkit
encompassed model policies and procedures, templates for paper and computer medical
records, questionnaires, safety-planning guides and patient-education handouts, posters, and
articles (Ambuel et al., 2013).

The HCCW intervention was found to be was effective at the provider level and the
health-care-system level. At the individual-provider level, there was an increase in self-
efficacy in helping patients experiencing IPV, an increase in knowledge of referral resources,
and an increase in knowledge of legal and regulatory requirements related to IPV (Ambuel et
al., 2013). However, there was no change in knowledge of IPV dynamics and its effect on
health. This could be because the HCPs already had sufficient knowledge of this topic or
because of an invalid test (Ambuel et al., 2013). At the health-care-system level, the intervention was found to lead to more patient-education material, availability of bilingual patient-education material, the development of collaborative relationships with local non-profit organisations, and three of the four sites adopted written IPV policies and procedures and implemented routine enquiry. However, the paediatric clinic developed a draft of new policies and procedures that included routine IPV enquiry, but this was not implemented because of a lack of consensus about IPV inquiry and intervention in the paediatric setting among physicians (Ambuel et al., 2013). The intervention also found some improvement at the cultural level, with more support by staff for IPV interventions, and better preparation of HCPs to assist patients suffering IPV. However, the most significant finding was that a continued increased rate of IPV screening was discovered at the two-year follow up (Ambuel et al., 2013).

Investigating change at the health-care-system level and the cultural level is beyond the scope of the current study. However, change at the provider level is exactly what this study aims to examine. The ultimate aim of this study is to change the nursing, midwifery and paramedicine curricula so that UG nursing, midwifery and paramedicine students are effectively taught about the multiple components of IPV screening, and identifying and caring for IPV survivors and their children.

3.5 HCPs’ Responses and Attitudes

3.5.1 Survivors’ experiences of disclosing abuse

Screening and detecting survivors of IPV is only the beginning of managing IPV. Enhancing HCPs’ responses and actions concerning IPV detection is also necessary (Signorelli, Taft & Pereira, 2012). Unfortunately, according to the literature, HCPs’ responses and attitudes to a positive screen for IPV are often negative and traumatising (Liebschutz, Battaglia, Finley & Averbuch, 2008; Tower, McMurray, Rowe & Wallis, 2006). Rather than being provided a caring response, it has been found that IPV survivors are often neglected,
betrayed and made invisible by the HCPs who are supposed to be looking after them (Edin, Dahlgren, Lalos & Hogberg, 2010; Liebschutz et al., 2008).

Pratt-Eriksson, Bergbom and Lyckhage (2014) conducted a phenomenological hermeneutic study of 12 women living in a women’s shelter in Stockholm, Sweden. The interviews demonstrated that these women experienced re-traumatisation and uncaring behaviours at the hands of HCPs (Pratt-Eriksson et al., 2014, p. 1). The participants reported feeling disappointed, dismayed and saddened by the lack of support, care and empathy provided (Pratt-Eriksson et al., 2014, p. 1). Other feelings experienced by these 12 women included (Pratt-Eriksson et al., 2014, p. 3-5):

- being betrayed by the system
- not being taken seriously
- fearing losing autonomy
- being degraded to nothing
- losing hope
- feeling neglected and invisible
- not being treated with dignity and respect
- experiencing feelings of existential loneliness.

Reisenhofer and Seibold (2013) reported similar findings in their grounded-theory study that used semi-structured interviews with seven women survivors of IPV in Victoria (Vic), Australia. These survivors of IPV sought empathy, respect and safety. What they reported receiving was pity and blame, which resulted in them experiencing negative feelings of self and self-worth (Reisenhofer & Seibold, 2013, p. 2,257). These women wanted a physically safe environment and an open, informed and supportive emotional environment. All the women reported feeling disappointed with the emotional care they received (Reisenhofer & Seibold, 2013, p. 2,257). They reported that the physical care they received was offered devoid of any emotion or therapeutic relationship, leaving them with
feelings of violation, shame and vulnerability. These women also felt that HCPs blamed them for the abuse they were suffering or blamed them if they chose to stay in their abusive relationship (Reisenhofer & Seibold, 2013, p. 2,258).

Likewise, Trevillion et al. (2012) conducted in-depth interviews with 24 users of community mental-health services in South London. Of the 24 participants, 18 had experienced IPV and provided information about their experiences with HCPs. Most of these participants stated that HCPs did not acknowledge their abuse, and some participants identified that HCPs were not receptive to their disclosure (Trevillion et al., 2012). Additionally, several participants believed their mental-health problems were stigmatised, and that HCPs failed to deliver on the support that was offered (Trevillion et al., 2012).

Other researchers have found there is inadequate assessment of IPV by HCPs, and a quick labelling of a survivor’s condition results in the survivor feeling stigmatised, punished and undeserving of care (Tower et al., 2006). This result has been reported as perpetuating the situation through doubting the survivor’s experience (Bacchus, Mezey & Bewley, 2003; Chang et al., 2005; Yoshihama, 2002). Further, women have reported experiencing anger, embarrassment and frustration, believing they were blamed, pitied and misunderstood in relation to their experience of IPV (Anderson & Aviles, 2006; Yam, 2000).

However, Morse, Lafleur, Fogarty, Mittal and Cerulli (2012) reported contradictory findings. They conducted structured interviews with women about IPV discussions experienced with an HCP. The participants were recruited from a family court, a community-based inner-city primary-care practice, and a tertiary-care-based outpatient psychiatric practice. Of the women who participated (n=142), 51% (n=72) had reported IPV to an HCP (Morse et al., 2012, p. 337). The HCP was open (85%, n=61) and knowledgeable (74%, n=53) according to participants who disclosed their abuse. Additionally, 71% of the participants (n=51) stated that the HCP advocated them leaving the abusive relationship (Morse et al., 2012, p. 337).
When examining male survivors and screening experiences, it is clear that a lack of public recognition of male survivors of IPV makes disclosure of this violence very difficult for male survivors, particularly when accessing health care. If IPV is considered by an HCP, it is usually for female survivors, not male survivors (Department of Health, 2009, 2013) because of the gendered notions of male and female roles (Arndt, 1982; Lye & Biblarz, 1993; Sweeney, 2007; Walker & Browne, 1985). Therefore, males must overcome numerous and significant internal and external obstacles to seek help (Galdas, Cheater & Marshall, 2005).

In a survey of 302 men seeking help for IPV victimisation, 84.9% sought help from friends, neighbours, relatives or parents, while 53.8% sought help from a website that provided information and support, and 23.8% from an online support group (Douglas & Hines, 2011). The men in the study also accessed formal professional resources. 66.2% received help from a mental-health professional, and 43.7% sought help from a DV agency. Only 18.1% pursued help from an HCP (Douglas & Hines, 2011). The following percentages of men found these resources to be helpful (Douglas & Hines, 2011):

- DV agency—44.8%
- DV hotline—31.4%
- family/friends—90%
- HCPs—78.4%
- mental-health professional—70.6%
- online support—69.1%.

Responses by these formal resources were reported as different from the responses received by female survivors. A common response by these agencies were ‘we only help women’. This response was received by 49.9% of men who accessed DV agencies, 63.9% who accessed DV hotlines, and 42.9% who accessed online resources (Douglas & Hines, 2011). Of the 132 men who accessed a DV agency, 44.1% (n=86) said they were not helpful. Additionally, some of the men reported being accused of being the perpetrator: 40.2% of men
accessing DV agencies were accused, 32.2% accessing DV hotlines were accused, and 18.9%
accessing online resources were accused. Being made fun of occurred for 16.4% of the men
accessing a DV hotline, and for 15.2% accessing a DV agency (Douglas & Hines, 2011).
Only 54% of these men sought help from a medical practitioner, with only 14% receiving
information about getting help for this IPV. 198 men accessed a mental-health professional,
and of these, 68% stated they were taken seriously; however, only 30.1% were provided with
information about where to receive help (Douglas & Hines, 2011).

There exists uncertainty among IPV professionals and HCPs about how to respond to
male survivors of IPV. Some HCPs respond by not understanding how that can possibly be
happening to a man, while others state they cannot believe the amount of violence perpetrated
by a female (Hogan, Hegarty, Ward & Dodd, 2012, 47–49). Male IPV survivors also report
being told they did something to provoke the violence, and experiencing feelings of shame,
embarrassment and social stigma because they were unable to protect themselves (One in
Three Campaign, 2015). Minimalising the violence they have experienced and self-blame
were also reported by male survivors of IPV (Hogan et al., 2012; Storey & Strand, 2012).

The literature demonstrates that irrespective of whether positive or negative responses
are provided by HCPs, safety-planning actions are very limited. In Morse et al. (2012, p. 337),
only 22 of the 72 participants (31%) who disclosed IPV received safety information, while six
participants (8%) received safety information, but perceived that the HCP was not advocating
that they leave the abusive relationship. Leppakoski and Paavilainen’s (2013) descriptive,
cross-sectional multi-centre study reported similar findings. Their study was conducted to
examine the effects of intervening in IPV situations in 28 emergency departments in Finland.
457 nurses, practical nurses and emergency medical technicians (EMTs) completed the
questionnaires. Only 115 of these participants (25%) always or often made a safety plan with
women survivors of IPV, with 32% of participants never making a safety plan (Leppakoski &
Paavilainen, 2013).
3.5.2 Recommendations for HCPs’ responses and attitudes

The above findings for HCPs’ responses and attitudes to the disclosure of IPV and their inaction in safety planning contradict the recommendations made by the WHO (2013b). According to WHO (2013b), HCPs should provide a non-judgemental and supportive attitude to survivors of IPV (and survivors of other forms of abuse), as well as validation of what the survivors are reporting. They should be non-intrusive and non-pressuring but provide practical care and support according to the survivor’s needs.

Assistance in increasing safety by developing a safety plan and mobilising social support is a necessity, as is ensuring privacy and confidentiality (WHO, 2013b, p. 16).

The current study will investigate whether stereotypical attitudes and beliefs are being challenged and corrected by true representations of who IPV survivors and perpetrators are. To achieve this, the study adopts Yin’s (2014) case-study principles to examine the curricula of HCP UG degrees in Australia to establish whether challenging beliefs and attitudes is occurring. The answers to this question will be provided through an examination of research question 4.

3.5.3 LIVES mnemonic

To adhere to the WHO’s (2013b) recommendations, certain procedures must be changed or introduced into practice. Once disclosure of IPV occurs, a statement of belief and validation that no one should be hurt should be provided by the HCP, followed by an assessment of the IPV survivor’s immediate safety (Cronholm, Fogarty, Ambuel & Harrison, 2011). Safety planning should occur, including providing referral to support services and performing documentation of relevant history, physical examination, assessments, diagnostics and a treatment plan (Alpert, 2015; WHO, 2014). The mnemonic LIVES has been developed by WHO (2014, p. 14) to assist HCPs to respond to IPV disclosure appropriately and respectfully; LIVES stands for:

- L—Listen closely with empathy and without judgement
I—Inquire about needs and concerns (e.g., emotional, physical, social, practical)

V—Validate by showing the survivor you understand and believe them

E—Enhance safety by developing a safety plan

S—Support the survivor by connecting them to information services and social support.

However, for HCPs to adequately respond to IPV disclosure and to intervene appropriately and respectively, they first must be educated on this topic adequately. The question remains whether HCPs (i.e., nurses, midwives and paramedics in this research) are being adequately educated on IPV. Research conducted on each speciality area in relation to the inclusion of IPV-related content in their UG education will now be explored.

3.6 Immediate Discipline: HCP Education in IPV

The literature reviewed so far in this chapter has provided evidence on why HCPs need education in IPV-related content. For example, they are in a unique position to interact with IPV survivors, and will inevitably have contact with survivors, irrespective of where they work. HCPs need to screen and detect survivors of IPV much more effectively than they are currently doing, and their responses and attitudes must be challenged. One way to ensure HCPs are knowledgeable in the screening and detection of IPV survivors, and are able to provide treatment and referral, as well as caring and respectful responses is to provide HCPs with necessary information about IPV in their UG degree. The current study will answer whether this is occurring in Australia. Current literature on the inclusion of IPV-related content in the nursing, midwifery and paramedicine curricula will now be discussed, beginning with the nursing curriculum.

3.6.1 Nursing curriculum

Researchers examining the amount of violence-related content in the BN curriculum unanimously support the integration of this public-health content into all BN degrees using a variety of teaching methods, including lectures, role plays and clinical placements (Belknap,
2003; Davila, 2005, 2006; Gerber & Tan, 2009; Gibson-Howell, Gladwin, Hicks, Tudor & Rashid, 2008; Glaister & Kesling, 2002; Helton & Evans, 2001; Hinderliter, Doughty, Delaney, Pitula & Campbell, 2003; McCann, Moxham, Usher, Crookes & Farrell, 2009; Tufts, Clements & Karlowicz, 2009; Woodtli, 2000). The idea of incorporating IPV-related content and skills into the BN curriculum is not new. Research has been conducted in this area for many years with IPV-related content identified as a relatively invisible curriculum topic that needed to be included as early as 1992 (McBride, 1992; Campbell, 1992). In their scoping review of nursing and midwifery, Crombie, Hooker and Reisenhofer (2016) highlight that despite this longitudinal acknowledgement, IPV content in BN degrees remains minimal. Research conducted in Australia as well as international research will now be presented.

Australian research conducted on the inclusion of IPV-related content in the BN curriculum is scarce. In a mixed-methods study using qualitative focus groups and a quantitative survey, Beccaria et al. (2013) aimed to explore nursing students’ perceptions, attitudes and knowledge of IPV. Students enrolled in the BN programme at a Queensland (Qld) university were approached, with 27 students participating in the focus groups and 58 students completing the quantitative survey. The focus groups provided the most significant results. Students stated that IPV consisted of physical, emotional and sexual assault, thus failing to identify the other types of IPV, and they identified a perpetrator of IPV as a dominant male with low self-esteem, having an alcohol or drug dependency, and being from a minority ethnic group, thus adhering to the typical stereotypes of perpetrators (Beccaria et al., 2013). Students also stated they believed there was a lack of time to adequately assess and intervene in IPV situations, and worried they would make the situation worse for the woman. Finally, the students reported being unsure of the role of the nurse in IPV situations, and stated they need more information and education on IPV because they felt ill prepared to deal with this situation (Beccaria et al., 2013). Overall, the researchers concluded that the BN students were unaware of the significance of this issue, did not fully understand the social,
health, and economic consequences of this violence, need placements in areas such as women’s shelters and community organisations, and also concluded that there is a need to create a responsive future nursing workforce (Beccaria et al., 2013, p. 910).

Adopting a different approach, McCann, Lu and Berryman (2009) aimed to examine the mental-health content of BN degrees via a survey sent out to all schools of nursing in Australia. A total of 27 universities participated. Only four of these universities (15%) included Indigenous mental health and DV in their mental-health units. In their elective theory units, the areas of Indigenous mental health and DV were typically not included (McCann et al., 2009). Although McCann et al.’s (2009) research illustrates the lack of IPV-related content in the BN degree; the question arises of why DV/IPV would be included in a mental-health unit? IPV has many consequences, with mental-health disorders being only one, thus IPV should be included in a variety of units throughout the BN degree.

The literature also reveals a lack of IPV-related content within the BN curriculum internationally. Via a descriptive-survey design, Woodtli and Breslin (2002) aimed to examine all baccalaureate nursing programmes listed in the American Association of Colleges of Nursing (AACN) mailing list in 1998. Their aim was threefold: to determine the amount of violence-related content in the nursing curriculum, to evaluate faculty development activities directed at violence-related content, and to identify changes in content and development that had occurred since their 1995 survey (Woodtli & Breslin, 2002). Of the 369 responses received, 63% participants (n=231) reported that there had been no faculty development activities surrounding the introduction and extension of violence-related content into the BN curriculum, and 67% (n=260) stated that no evaluation of the violence-related content had been conducted in the past four years. Additionally, 74% (n=289) of the surveys reported no student competencies related to the assessment and nursing care of a woman experiencing IPV (Woodtli & Breslin, 2002).
Other researchers took a different approach to evaluating the extent of IPV-related content within the BN curriculum. Instead of questioning academics or evaluating the curriculum, they decided to ask practising nurses if they had received this education in their UG degree. Examining the East Texas Health Education Centre geographical area, Glaister and Kesling (2002, p. 138) surveyed nurses about screening for IPV, knowledge of legal requirements for reporting, identification of barriers to caring for survivors of IPV, and formal education and educational needs in relation to IPV. Of the 251 nurses surveyed, 47% (n=119) had received formal education on IPV, with 51% (n=61) receiving this education via one or more units, and fewer than 25% (n=24) receiving this content through several lectures and tutorials in numerous units. Most of the nurses in this study concluded that they did not receive adequate education via their initial UG degree to adequately care for survivors of IPV (Glaister & Kesling, 2002).

Haggblom et al. (2005) found similar results in a descriptive-survey study examining nurses’ knowledge, training, and practices in relation to survivors of IPV. Of the 234 nurses working on the Aland Islands, Finland, only 22% had received training in IPV-related content during their UG degree. Most of these nurses (88%) were in favour of having more IPV-related content in the UG nursing degree (Haggblom et al., 2005). An earlier study by Chung, Wong and Yiu (1996), which involved 400 emergency nurses completing a questionnaire, found that 94% of these nurses had no formal education in IPV-related content, and 86.2% believed they had insufficient knowledge to adequately help survivors of IPV. In a United Kingdom (UK) focus-group study, Bradbury-Jones and Broadhurst (2015) found that while UG nurses and midwives understood the construct of IPV, they simultaneously lacked confidence to intervene or screen. This is despite the fact that the National Institute for Health and Care Excellence (NICE) recommends that IPV be integrated into the UK UG curriculum (NICE, 2014).
To add to this literature and close the research gap that exists in the context of Australian universities, the current study will research how prominently IPV-related content appears in the BN degree (research question 1), and if this content is included, whether it is integrated throughout the curriculum (research question 2). The study will further examine in which units this content appears, how such units are chosen by academics (research question 3), and exactly what is taught and how the content is taught (research question 4).

### 3.6.1.1 Number of hours

An additional dilemma observed in the literature is that when violence-related content is incorporated in the BN curricula, it is done so at a minimal level, usually including an average of two to four hours of coverage (Hinderliter et al., 2003; Ross et al., 1998; Woodtli & Breslin, 1996, 2002). Connor, Nouer, Speck, Mackey and Tipton (2013) surveyed nursing students in relation to their knowledge of and attitudes towards IPV, and examined the extent, content and sufficiency of IPV education these students had received prior to graduate school. Fifty-two nursing students from graduate (Doctor of Nursing Practice and Doctor of Philosophy) nursing programmes from Southern America were included in their study. It was discovered that 26 of the participants (51%) had received no IPV-related education before entering graduate school, and of the students who did receive IPV-related education before entering graduate school, 16 (31%) received only one to five hours of training (Connor et al., 2013).

Hinderliter et al. (2003) surveyed 553 nurse practitioners about the number of hours dedicated to teaching IPV in their BN or nurse-practitioner course, and the results demonstrated that only one to four hours were dedicated to this IPV-related content in the majority of cases (70%; n=152). Forty-three nurses (19.8%) reported receiving teaching of this content in five to ten hours, and 19 nurses (8.8%) reported receiving teaching of this content in more than 11 hours (Hinderliter et al., 2003). Woodtli and Breslin (2002) found that 211 schools of nursing (56%) of 374 provided IPV-related content in two to four hours of
classroom time, while 114 schools (30%) provided this content in one hour or via readings only.

Finally, Ross et al. (1998) surveyed 155 Canadian schools of nursing via a 35-item survey specifically designed for the study to determine the amount of violence-related content in the BN curricula. All schools of nursing included IPV-related content in their curriculum, but the time dedicated to the content was on average only 3.6 hours. When asked whether the School of Nursing believed IPV-related content was adequately addressed, 48% of the respondents answered ‘yes’, 28% answered ‘no’, and 24% answered ‘unsure’ (Ross et al., 1998). One of the limitations of this study is that the researchers failed to survey the people that teach the students. They surveyed deans, programme managers, curriculum coordinators, and chairpersons of curriculum committees. This is one limitation of the literature the current study will overcome by surveying and interviewing the lecturers that teach the content to the students. Further, as these studies are now at least 12 years old, the current study aims to provide up-to-date evidence of the number of hours Australian universities dedicate to providing IPV-related content to current nursing and other HCP students.

3.6.1.2 Content covered

The literature reveals that not only are inadequate hours being spent on teaching IPV-related content, but the content being covered is also quite narrow. Hinderliter et al. (2003) also examined the commonly covered content areas of IPV education. The most frequently taught topics were the cycle of violence and violence during pregnancy, with very minimal time dedicated to safety planning and legal issues surrounding IPV (Hinderliter et al., 2003). Again, these findings are now 12 years old and thus the aim of the current study is to provide up-to-date information on the type of IPV-related content that is being taught to Australian nursing students through answering research question 4.
Another study investigating students’ levels of exposure to and attitudes towards abuse of partners was conducted by Sword, Carpio, Deviney and Schreiber (1998). A convenience sample of 150 students was obtained from the McMaster University baccalaureate nursing programme to complete a number of survey instruments. In relation to the type of content covered, the most commonly covered topics were psychological effect (42.6%), why women stay or leave (39.3%), community resources (38%), child-protection agencies (36.7%), the relationship between power and violence (36%), and presenting problems (35.3%) (Sword et al., 1998). However, the students indicated their course covered limited content on violence in lesbian relationships (2.0%), the legal process associated with IPV disclosure (9.4%), how to deal with the abuser (12.1%), health-care costs (13.3%), involving police (14.0%), and developing a safety plan (14.0%) (Sword et al., 1998). It was also found that the following are the units into which this content is commonly integrated: psychiatric nursing (30.9%), maternity nursing (21.3%), adult health (16.2%), community health (10.3%), women’s health (10.3%) and medical–surgical nursing (10.3%) (Ross et al., 1998; Hoff & Ross, 1995).

There are a number of limitations to these studies. First, the age of the studies is problematic because they cannot be considered to represent current evidence. Second, these are international studies, which means that it is unknown whether Australian universities offer the same content coverage of IPV. Third, Sword et al.’s (1998) study was conducted only in one university. To address such limitations in the literature, the current study aims to provide current evidence through conducting an Australia-wide study that includes numerous Australian universities.

According to current EBP, theoretical content for teaching IPV should include information on definitions, prevalence, effects, prevention, risk factors, therapeutic approaches to assessment, questions used for screening, legal implications, and appropriate interventions (Daniel & Milligan, 2013, p. 25). The current study will examine whether Australian universities are adhering to EBP by examining the content that is currently being
provided through addressing research questions 4 and 5. This is the first known study to examine frontline academics’ attitudes and beliefs about the inclusion of IPV-related content in the UG curricula of nursing, midwifery and paramedicine degrees, and will therefore provide significant insight into this area.

3.6.1.3 Teaching methods

To overcome the scarcity of IPV-related content within the BN curriculum, a wide variety of teaching methods have been evaluated for their efficacy in integrating IPV-related content in BN curricula. Examples of such efforts include a DV learning module, a two-day immersion course, and a one-day DV-immersion activity. It was found that through these interventions, students began to understand the physical, psychological and emotional effects of IPV, and the negative connotations of common myths, judgements and stereotypes, while simultaneously gaining confidence with survivors of IPV (Belknap, 2003; Davila, 2005; Evans, Helton & Blackburn, 2001; Helton & Evan, 2001). Some of these efforts to include IPV-related content in curricula will now be explored.

Educating nursing students about IPV through a learning module was devised and evaluated via an existential phenomenological method by Helton and Evans (2001) at the University of Tennessee. These researchers incorporated a 22-hour learning module (which was completed in one week) in the psychosocial course of the BN programme. The learning module consisted of students attending circuit court, talking with judges, accompanying advocacy workers and attending group-therapy sessions with survivors and perpetrators of IPV. They evaluated the success of the programme via a pre- and post-test with 87 students between 1997 and 1998. An important finding of this study is that students were surprised with the pain, sadness, isolation and fear the survivors and the perpetrators of IPV experienced (Helton & Evans, 2001). It was also found that the programme broke down the stereotypical images of a survivor of IPV, and of the perpetrator. As one student commented, ‘The woman in the victim group looked just like me .... she was intelligent, had kids, a job’
Another student made the following comment about the perpetrator, ‘They looked like anybody I could have seen on the street … like my neighbour or fellow student’, while another stated, ‘I thought one of them was attractive. I guessed I thought violent men couldn’t be attractive … or somehow I would know that someone could be abusive’ (Helton & Evans, 2001, p. 51).

Further evaluation was completed on this learning module by Evans et al. (2001), which demonstrated that this module continued to affect positively the students involved. It empowered the students to disseminate information about IPV to other university students, they organised fundraisers to raise funds for a women’s shelter, and led brief in-services at their local hospitals. Additional findings included students experiencing decreased anxiety, increased confidence, improvement in communication skills, and assessment of potential IPV survivors (Evans et al., 2001, p. 87).

Belknap’s (2003) US study had consistent findings. This study incorporated a two-day immersion course in an UG BN programme, resulting in students’ beliefs being challenged and a conclusion drawn that IPV-related content should be incorporated in all UG nursing degrees. This two-day immersion course consisted of two all-day sessions, one-month apart. The first day of this course centred on developing knowledge about the extent of this type of violence, understanding women’s experiences, and understanding personal values and beliefs. The second day consisted of a visit to a shelter where students were able to explore the resources and interventions available to women who stay there (Belknap, 2003).

Unfortunately, this intervention was only minimally assessed by a brief post-test, which included five short essay questions. However, irrespective of how it was assessed, it too provided evidence for the inclusion of IPV-related content in this curriculum.

Davila (2005) delivered a one-day DV-immersion activity as part of a US baccalaureate psychiatric/mental-health nursing course, which incorporated a variety of educational material, including videos, nursing-care plans, shelter visits and screening tools. It
was the aim of the author to ‘maximise student comprehension, application and retention of formal DV classroom lecture content’ (Davila, 2005, p. 2). This activity resulted in students experiencing improved confidence about encountering patients currently experiencing or who have experienced IPV (Davila, 2005). Increased confidence was felt by students in their ability to screen for and problem solve IPV situations after implementing a joint annual workshop between the Alverno College Nursing Division and the Medical College of Wisconsin Department of Family and Community Medicine (Wielichowski, Knuteson, Ambuel & Lahti, 1999).

Although Davila’s (2005) one-day immersion activity consisted of excellent educational material, the author failed to assess its success via a pre- and post-test or a qualitative approach. It would have been beneficial to determine whether the students’ knowledge, beliefs and attitudes changed pre-intervention to post-intervention with this curricular effort. There were also validity problems with Wielichowski et al.’s (1999) study because there was no mention of the methodology used to arrive at their conclusion, which is a major limitation of the research. Irrespective of these methodological flaws, this research highlights the success of implementing IPV-related content within BN curricula.

A successful component of Helton and Evans’s (2001) and Belknap’s (2003) studies was the inclusion of clinical placement to a shelter or group therapy. This is currently a contentious issue among academics, with contrasting results in the literature. Hoff and Ross (1995) and Woodtli and Breslin (1996) discovered that clinical experience with survivors of IPV is rare for BN students while on clinical placement, with it usually occurring only by accident and thus is unplanned. In contrast, Woodtli and Breslin (2002) found that 31% of the Canadian schools of nursing they surveyed had planned clinical experiences within settings incorporating violence-related content. Likewise, 62% of the schools of nursing they surveyed had planned clinical experiences involving the assessment and treatment of survivors of IPV (Ross et al., 1998).
Nursing students gaining clinical experience with survivors of IPV is as great a necessity as them gaining experience with surgical patients. To be able to provide care and support to IPV survivors under the watchful eye of a clinical facilitator is essential so that nurses can enter their working lives with confidence and experience in working with IPV survivors (Ross et al., 1998). Clinical experiences do not need to be confined to a hospital. Women survivors of IPV attend multiple health-care sites, including emergency departments, prenatal clinics, women’s shelters, churches, home-health services, women’s health clinics, and the court system (Woodtli & Breslin, 1997).

The most current literature on the topic of teaching methods for IPV-related content highlights the importance of simulated laboratory experiences and service learning (Daniel & Milligan, 2013). Simulated laboratory experiences are a necessity for practising communication skills, exploring thoughts and feelings, practising IPV screening, and discussing possible barriers to screening (Daniel & Milligan, 2013, p. 25). MacDonnell, George, Nimmagadda, Brown and Gremel (2016) highlight how multidisciplinary-team-based simulation not only offers IPV education, but also allows team members to be a source of information for survivors, and for other HCPs in the health-care team to screen and intervene. In service learning, students learn about IPV while servicing members of the community. Service learning provides students with the opportunity to implement theoretical knowledge, and to help IPV survivors while improving competency in care and dissolving misconceptions about IPV (Daniel & Milligan, 2003, p. 25).

This research study will make important contributions to the very sparse and poorly understood literature on effective teaching methods for IPV. First, it will provide the first Australia-wide study on the teaching methods used to provide IPV-related content to current nursing students. It will examine whether schools of nursing are incorporating simulated laboratory experiences and service learning into the curriculum. Finally, it will provide
current evidence for this debate because most studies examining this issue are becoming outdated. Once again, research question 4 will provide the answers to these questions.

3.6.1.4 Contemporary issues in UG nursing education

A paradigm shift is currently occurring in the Australian health-care system from focusing on acute care to focusing on primary health care (Bennett, 2009). This shift has resulted from economic and political factors such as an increased cost of health care, an ageing population and an increased rate of chronic disease (Cooper, Cant, Browning & Robinson, 2014). Other factors resulting in this change to health care and thus nursing care include increased client acuity, advanced technology, HCP shortages, increase in health literacy as a result of the media and internet, and advanced surgical practices (Andre & Barnes, 2010; Kantor, 2010; Woods, 2010). Community health, population and global health, chronic-disease management and health promotion are now the areas of health care and workforce preparation that are now receiving the greatest amount of attention by key members of the tertiary nursing education sector (Kantor, 2010).

These rapid health changes and increased expectations of nurses will affect the nurses of the future because they will be adopting expanded traditional roles (Cooper et al., 2014; Kantor, 2010). To accommodate these changes in health care, changes need to occur in the preparation of nurses in their UG BN (Kantor, 2010; Parker, Gillham, Tucker & Kargillis, 2010). This re-examination of the UG curriculum will need to examine the traditional UG curriculum, which usually involves pathophysiology, pharmacology, generic nursing units (e.g., communication, leadership), and one unit on primary and preventive health care, and modify this to a more current evidence-based curriculum that includes stand-alone primary-care units, and integrates this content throughout the BN curriculum (Keleher, Parker & Francis, 2010; Mackey, Hatcher, Happell & Cleary, 2013). Traditionally, the nursing curriculum has been slow to change in response to socio-political factors, which then leads to knowledge gaps for nurses and adverse patient care (Carabez et al., 2015).
It is evident from the literature that IPV-related content should be taught in a BN through a more current evidence-based curriculum because it falls under the category of primary and preventive health care and health promotion. Indeed, in today’s society, where IPV is becoming a highly prevalent issue, it seems impossible that this topic would not be incorporated into BN curricula. Therefore, the current study aims to determine how prominently IPV-related content appears in the UG curricula of Australian nursing, midwifery and paramedicine degrees through addressing research question 1, as well as examining how it is integrated in these curricula if it is included (research question 2).

However, the researcher is aware that prioritising content in a BN degree is difficult because of the constraints of accreditation requirements (Birks, James, Chung, Cant & Davis, 2014), which means that an increase in the BN content will result in course saturation (Kantor, 2010). This course saturation risks increased tensions between educators who compete for their course content to be included (Kantor, 2010). Presently, there are advocates for the inclusion of more content in areas such as mental-health nursing, community-health nursing, and GLBTI-based nursing and alcohol-related education (Carabez et al., 2015; Cooper et al., 2014; Happell & McAllister, 2014b; Holloway & Webster, 2013; McCann, Lu & Berryman, 2009; Woods, 2010).

Advocates for including more content on mental-health nursing are facing the same challenges as those advocating for more IPV-related content to be included in BN curricula. According to the National Nursing and Nursing Education Taskforce (2006), there is an inadequate amount of mental-health content in Australian UG nursing degrees, and the timing and number of hours of coverage must be re-examined. In a qualitative exploratory study consisting of in-depth interviews with heads of schools in Qld, Happell and McAllister (2014a) discovered that the BN was not adequately preparing nurses to work with patients diagnosed with a mental illness. In addition, Ross, Mahal, Chinnapen and Rana’s (2013)
results demonstrated that BN students experienced increased confidence working in mental health following clinical placement either in a community setting or an in-patient setting.

Although there exists competition for content inclusion in the BN degree, it is essential that students graduate with comprehensive knowledge and skills-based practice (Birks et al., 2014). The aim of all BN degrees is for the graduate nurses to function in accordance with the Nursing and Midwifery Board of Australia’s (NMBA) National Competency Standards for the Registered Nurse (Birks et al., 2014). The inclusion of IPV-related content in the BN curriculum will now be discussed in relation to the NMBA’s competency standards, the Code of Ethics for Nurses in Australia, and the Code of Professional Conduct for Nurses in Australia.

3.6.1.5 National Competency Standards for the Registered Nurse

For nurses within Australia to gain and retain their registration to practice, they must adhere to the National Competency Standards for the Registered Nurse, which incorporates the four domains of professional practice, critical thinking and analysis, provision and coordination of care and collaborative and therapeutic practice. Within these national competency standards, there is no direct mention of the term ‘IPV’ or its alternative terms. However, there are competency standards that are relevant to the assessment and care of IPV survivors. For example, element 1.2 of the domain of Professional Practice states that nurses must fulfil their duties of care by performing ‘nursing interventions following comprehensive and accurate assessments’ (NMBA 2006a, p. 3). This element is significant for IPV practice because if nurses are not taught appropriate strategies to detect and screen for IPV, then they will be unable to provide appropriate nursing interventions, thus failing to fulfil their duty of care to IPV survivors (Gerlock et al., 2011). Another example from this domain is element 2.1, which asserts that nurses must ‘ensure that personal values and attitudes are not imposed on others; conducts assessments that are sensitive to the needs of individuals/groups; recognises and accepts the rights of others; and maintains an effective process of care when
confronted by differing values, beliefs and biases’ (NMBA, 2006a, p. 4). Meeting this competency standard in relation to IPV might be difficult for many graduating nurses because they may hold negative attitudes and stereotypes about IPV, and the ease with which such a relationship can be terminated (Reisenhofer & Seibold, 2013). Students that hold negative attitudes and stereotypes in relation to IPV must have their attitudes and beliefs challenged through education in their UG degree. They must also be educated that women have the right to choose to stay in a relationship if they wish, and their rights must be respected at all times (Trevillion et al., 2012).

Examples of competency standards that are relevant to the assessment and care of IPV survivors can also be obtained from the other domains of the National Competency Standards for the Registered Nurse. Without an education on the resources related to IPV available within the hospital system and the community, student nurses will be insufficiently prepared to refer women to appropriate resources, resulting in a lack of continuity of care (Alpert, 2015). This is in contradiction to the Provision and Coordination of Care domain, element 6.4, which states, ‘Identifies and recommends appropriate agency, government and community resources to ensure continuity of care and initiates necessary contacts and referrals to external agencies’ (NMBA, 2006a, p. 9). The final domain, Collaborative and Therapeutic Practice, also has competency standards that are relevant to IPV practice. For example, element 9.1 states, ‘demonstrates empathy, trust and respect for dignity and potential of the individual/groups and establishes rapport with individuals/groups that enhances their ability to express feelings and fosters an appropriate context for expression of feeling’ (NMBA, 2006a, p. 11). It is extremely important that nursing students learn in their UG degree how to develop a therapeutic relationship with survivors of IPV. They need to learn how to phrase questions, how to respond appropriately and respectfully, and how to ensure the safety of the survivor (WHO, 2014). Collectively, all these examples illustrate the necessity of including IPV-related content in the UG curricula of nursing degrees, and strengthen the significance of this
study, which aims to determine the content that is included in UG nursing degrees in Australia.

3.6.1.6 Code of Ethics for Nurses in Australia

The Code of Ethics for Nurses in Australia contains eight value statements and acts as a guide for ethical decision-making and practice for all nurses (NMBA, 2008a). Once again, connections can be made between IPV best practice and the value statements of this code. Value statement 2 expresses that ‘nurses actively preserve the dignity of people through practised kindness and by recognising the vulnerability and powerlessness of people in their care’ (NMBA, 2008a, p. 5). One essential nursing practice that is required when caring for IPV survivors is respect and dignity. Section 3.5.1 of this thesis states that such respect and dignity is often missing in the nurse–patient relationship (WHO, 2013b). Therefore, to act ethically when caring for IPV survivors, nurses should adhere to this value statement.

Another example of the connection between IPV practice and this code is seen in value statement 4, which states that ‘Nurses valuing non-harmful, non-discriminatory care provide nursing care appropriate to the individual that recognises their particular needs and rights. They seek to eliminate prejudicial attitudes concerning personal characteristics, such as race, ethnicity, culture, gender, sexuality, religion, spirituality, disability, age and economic, social or health status’ (NMBA, 2008a, p. 7). One basic need of IPV survivors is to be treated by nurses who are non-judgemental. Often, this is not the case because IPV survivors are usually confronted with stereotypical attitudes such as ‘why don’t you just leave’ (Reisenhofer & Seibold, 2013). By educating nurses on IPV-related content, prejudicial attitudes will be challenged and appropriate attitudes and beliefs adopted. These two value statements alone illustrate the necessity of educating nurses on IPV-related content, not only for the ethical practice of the nurse, but also for the quality patient care.
3.6.1.7 Code of Professional Conduct for Nurses in Australia

The Code of Professional Conduct for Nurses in Australia should be read in conjunction with the National Competency Standards for the Registered Nurse and the Code of Ethics for Nurses in Australia. This code has 10 conduct statements; however, the term ‘IPV’ and its alternative terms are not mentioned. Nevertheless, there are many conduct statements that are relevant to the care and treatment of IPV survivors. Some of these examples are now presented.

It is essential that nurses caring for IPV survivors ensure the safety of their patient by not engaging in any tasks that may increase their likelihood of harm. For example, this may mean that IPV survivors are not assessed for IPV unless it is safe to do so (Association of Women’s Health, Obstetrics & Neonatal Nurses, 2015). This is in alignment with conduct statement 2, which states, ‘Nurses’ primary responsibility is to provide safe and competent nursing care’ (NMBA, 2008b, p. 3). Additionally, for IPV survivors to disclose their abuse, a level of trust must first be established with the nurse. Once this trust is established, the survivor relies on their nurse to care not only for their physical health but also for their psychological, emotional and social health (WHO, 2014). This is in line with conduct statement 8: ‘Nurses take reasonable measures to establish a sense of trust in people receiving care that their physical, psychological, emotional, social and cultural wellbeing will be protected when receiving care’ (NMBA, 2008b, p. 6). As stated, the best means by which to ensure all nurses are educated in the necessity of these safe practices for IPV survivors is to provide this education in their UG degree. However, it must be determined what is and is not being taught in these UG degrees, and the thoughts and attitudes about the inclusion or exclusion of IPV-related content in the BN degree of the academics that teach these degrees must be assessed. The current study will examine these areas though addressing research questions 1, 4 and 5.
3.6.2 Midwifery curriculum

There is a scarcity of research on the inclusion of IPV-related content within midwifery UG degrees. This may be because stand-alone BM degrees are in their infancy. However, it is essential that this content is included in the BM degree because pregnancy is a characteristic that increases the risk of IPV, as outlined in Section 2.7.1.9 (Clements et al., 2011).

Only two research articles were found in relation to the inclusion of IPV-related content within the midwifery degree. One is the study by Bohn et al. (2002), which discussed the implementation process and success of the Midwives Domestic Violence Education Project in post-bachelor degrees. Although this article was based on postgraduate students it is relevant to this study because Bohn et al. (2002) concluded that integration of IPV-related content needs to occur in midwifery curricula both via the delivery of content and through clinical placements. The second article is a cross-sectional study of midwives at the Guy’s and St Thomas’ NHS Foundation Trust in South London that aimed to assess the prevalence of DV in pregnancy when midwives were trained to enquire (Mezey et al., 2003). A surprising finding of this study was that none of the midwives had received IPV-related training in their UG degrees. Therefore, Mezey et al. (2003) recommended that IPV-related content be taught in pre-registration degrees and continued in professional practice. This is essential for midwives to be able to screen sensitively for and respond to IPV survivors (Mezey et al., 2003).

As has been highlighted, there is a major research gap in the examination of BM degrees, and their inclusion of IPV-related content. The current study aims to close this gap by examining BM degrees offered in Australian universities to ascertain whether they include IPV-related content, and if this content is included, to ascertain whether it is integrated throughout the curriculum, the units in which it is taught, how it is taught and the exact content being taught. Additionally, irrespective of whether IPV-related content is included,
this study will examine how the academics who teach the courses explain the inclusion or exclusion, and whether Australian universities are adopting national and international healthcare organisations and committees’ recommendations and guidelines relating to IPV.

### 3.6.2.1 Contemporary issues in midwifery UG education

As stated, the BM is in its infancy here in Australia. Midwifery itself has undergone a dramatic change from a profession deeply embedded in nursing to a profession that has its own identity and values (Sidebotham, 2012). Midwifery now requires separate registration from nursing and has its own competency standards (Sidebotham, Fenwick, Carter & Gamble, 2015). The BM UG degree was first introduced in Australia in 2002 as a response to the midwifery professions’ changing political, economic and workforce needs, as well as to the expectations of midwives (Cutts et al., 2003; Glover, 1999; Leap, 2002). Midwifery practice has shifted ‘from the biomedical, hospital-centric focus of pregnancy to one emphasising a new midwifery based on a midwife-woman partnership and evidence-based practice’ (Seibold, 2005, p. 9). As with nursing, the midwifery curriculum requirements are dictated by AHPRA, and although the curriculum differs between universities, they must all meet the requirements on clinical and theoretical hours and specific skills (Carolan-Olah & Kruger, 2014).

However, the BM has certain problems. According to the literature, the follow-through experience, which is the ongoing relationship between a student and woman from the early weeks of pregnancy through to the weeks following birth, and the number of clinical hours associated with this follow-through needs refining (Licqvish & Seibold, 2013; McLachlan, Newton, Nightingale, Morrow & Kruger, 2013). It is believed by academics that this number of clinical hours is excessive and negatively affects the students’ university and personal lives. In relation to the students’ university experience, this requirement of clinical hours results in students missing lectures and tutorials, as well as some clinical-placement hours, and involves excessive amounts of time on-call and outside university semesters.
Personally, follow-through experiences interfere with paid employment and with family commitments (McLachlan et al., 2013). McLachlan et al. (2013) state that this is one challenge that midwifery academics need to address.

Another challenge that requires the attention of midwifery academics is the number of clinical hours that must be completed by BM students. In a study designed to explore BM students’ experiences of achieving competencies, Licqvrish and Seibold (2013) completed a qualitative study based on grounded theory with 19 BM students. Via interviews, field observations and students’ documents, it was discovered that competencies are difficult to achieve because of medical dominance and the limited number of clinical hours (Licqvrish & Seibold, 2013). Although midwifery academics are limited in clinical practice because of this medical dominance of obstetric wards, they are influential in the clinical-placement requirements of this degree, and therefore should complete a review and adaptation of these hours (Licqvrish & Seibold, 2013; Licqvrish, Seibold & McInerney, 2013).

The focus of the majority of literature on the BM curriculum is on the topics of follow-through experiences and clinical-placement issues. Minimal literature discusses the content of the BM degree. The principal article discussing the content is by McCann and Clark (2010). This exploratory study aimed to explore first-year BM students’ level of mental-health literacy at a Melbourne university. A questionnaire was completed by 38 students, revealing that students had lay-person informed perceptions of a woman with schizophrenia. For example, they believed that antipsychotic medications, cognitive–behavioural therapy and electroconvulsive therapy were less useful than physical activity and counselling (McCann & Clark, 2010). Further, these students were able to recognise the mental illness and the favourable outcomes that would occur if the woman received treatment, but they failed to understand the consequences of not receiving this treatment. The authors recommended a pedagogical approach be taken, in that the BM needs to include more mental-health theory and clinical-education subjects relevant to prepartum and postpartum women.
This should include mental-health first aid, prevention of mental-health-related problems prepartum and postpartum, and care of women with severe and persistent mental illness (McCann & Clark, 2010, p. 19).

Although there is limited literature discussing content inclusion in the BM degree, it is likely that there would be competition for content inclusion because course saturation has occurred as it has for the BN degree. Despite this course saturation, it is the researcher’s belief, as informed by the literature, that IPV-related content should be included in the BM degree because IPV is a highly prevalent issue among the female population, as outlined in Section 2.5.

3.6.2.2 National Competency Standards for the Midwife

The National Competency Standards for the Midwife are the standards by which midwives receive and retain their registration, and these standards have the overarching theme of woman-centred care (NMBA, 2006b). Unlike the National Competency Standards for the Registered Nurse, these competency standards refer to IPV and its alternative terms (e.g., ‘family violence’, ‘DV’) twice. The first mention is in the Legal and Professional Practice domain, where the cues for competency 1, element 1.2 states, ‘complies with legal policies and guidelines for example, occupational health and safety, child protection, family violence’ (NMBA, 2006b, p. 6). IPV is specifically mentioned the second time in competency 9, element 9.1 in the Midwifery as Primary Health Care domain. The cues for competency 9, element 9.1 states, ‘acts to address public health issues, including the promotion of breastfeeding, smoking cessation and responding appropriately in situations where there is DV, drugs or alcohol use’ (NMBA, 2006b, p. 11). Given that IPV is mentioned in these competency standards, its omission as a public-health topic in the curriculum is difficult to defend. The inclusion of IPV-related content in the BM curriculum would be consistent with the competency standards, and therefore, the current study aims to determine whether
Australian universities are adopting this national organisation’s recommendations for practices related to IPV.

The National Competency Standards for the Midwife outlines other competency standards that are relevant to the care of IPV survivors. For example, the cues for competency standard 6, element 6.1 states that midwives should ‘demonstrate an understanding of the particular psychosocial needs of the woman and her family where there are complexities’ (NMBA, 2006b, p. 9). IPV is one of the most complex situations a midwife might encounter professionally, and is a situation where caution and safety is paramount (Association of Women’s Health, Obstetrics & Neonatal Nurses, 2015). Therefore, it is essential for midwifery students to learn the knowledge and skills necessary to provide care that ensures the safety of the woman and her baby. One method of learning that could be used to teach BM students is a role-play to practice safe intervention (Daniel & Milligan, 2013). The final example of the connection between the midwifery competency standards and IPV is in the cues for competency standard 7, element 7.2, which states that midwives should ‘acknowledge, respect and advocate for the rights of the woman to be involved as an active participant in her care including her right to make informed decisions and maintain dignity and privacy’ (NMBA, 2006b, p. 10). Again, midwives need to be taught during their UG degree the rights women IPV survivors have in relation to their health care, their choice of whether they remain in the relationship, and the services they use.

3.6.2.3 Code of Ethics for Midwives

Similar to the Code of Ethics for the Registered Nurse, the Code of Ethics for Midwives has eight value statements to consult in relation to ethical decision making for midwives (NMBA, 2008c). As for RNs, it is extremely important that the BM curriculum prepares Australia’s upcoming midwives to provide care and support to women survivors of IPV ethically and respectfully. Value statement 2 of this code is applicable to the care and treatment of IPV survivors because IPV occurs as a result of a power differentiation between
partners (Kelly, 2011). The perpetrator of the abuse is in the position of power, while the survivor has a sense of powerlessness (Kelly, 2011). Therefore, value statement 2, ‘midwives actively preserve the dignity of the woman and her infant(s) through practised kindness and by recognising the potential for vulnerability and powerlessness of women in their care’ (NMBA, 2008c, p. 6) is important because it states clearly that it is the midwife’s role to recognise this powerlessness and build and promote power in the person, rather than contribute further to their feelings of powerlessness.

Finally, it is the midwives’ role to assess and identify social and environmental risk factors for the women in their care. In doing so, they may discover IPV in the woman’s relationship. If IPV is identified, it is necessary for the midwife to identify how this form of abuse affects the mother and her unborn baby or infant. This identification and care of women survivors of IPV is in accordance with value statement 8 of the Code of Ethics for Midwives, which proposes that ‘midwives are sensitive to and informed about, the social and environmental factors that may contribute to the health and well-being of each woman and her infant(s) and that may play a part in their midwifery care. Midwives take into account the economic and domestic circumstances of each woman and her infant(s) where these impact, positively or adversely, upon their maternity care needs and health’ (NMBA, 2008c, p. 12).

3.6.2.4 Code of Professional Conduct for Midwives

Once again, similar to RNs, midwives also have a Code of Professional Conduct but it includes no direct mention of the term ‘IPV’ or its alternative terms. Nevertheless, numerous conduct statements are applicable to the identification and treatment of IPV survivors, which supports the importance of the inclusion of IPV-related content in the BM degree.

This chapter has clearly demonstrated that midwives must ensure the safety of all women, but particularly those surviving IPV. It has also shown that midwives must assess for and provide treatment for IPV when it is safe to do so (WHO, 2014). Such assessment and treatment will not only ensure the women’s physical safety but also their social, emotional
and mental safety as well (WHO, 2014). This sense of security and safety can be connected to conduct statement 2 ‘midwives make midwifery judgements based on the woman’s capacity and with regard to her sense of security and physical, social, emotional and mental safety’ (NMBA, 2008d, p. 4).

Conduct statement 4 states, ‘midwives practice in a non-discriminatory way. This includes taking appropriate action to ensure the safety and quality of their midwifery care is not compromised because of harmful prejudicial attitudes about culture, ethnicity, gender, sexuality, age, religion, spirituality, political, social or health status, lifestyle or other human factors’ (NMBA, 2008d, p. 5). This statement is relevant to IPV treatment. As stated, IPV education is important for challenging prejudicial attitudes and beliefs of upcoming midwives so that stereotypical images and attitudes can be replaced with accurate informed attitudes and beliefs (Reisenhofer & Seibold, 2013; Trevillion et al., 2012). This challenging of attitudes can be achieved by incorporating IPV-related content into the BM curriculum and therefore, this study will assess Australian BM degrees to ascertain whether they include IPV-related content.

3.6.3 Additional national standards for the RN and RM

In addition to the competency standards, value statements and conduct statements, the ANMC outlines that RNs and RMs should be appropriately educated so that they can uphold research responsibilities and approach all patient-care situations with critical-thinking skills. Whether RNs and RMs are educated on IPV appropriately, and whether they are taught critical-thinking skills in relation to this topic is yet to be determined. For this reason, the purpose of this study is to examine the BN and BM curricula of all Australian universities to determine the amount and type of IPV-related content within these degrees. Addressing research questions 1 and 4 will answer the above questions.

Moreover, the BN and BM degrees have been designated as the minimum qualification for registration within Australia to ensure national consistency in the education
that Australian students receive (Australian Nursing and Midwifery Accreditation Council [ANMAC], 2012, 2014). This study aims to determine whether there is consistency across Australian universities in relation to the amount of IPV-related content students are being taught. Again, addressing research question 1 will provide the answer to this question.

According to the Registered Nurse: Accreditation Standards 2012 and the Midwife: Accreditation Standards 2014, the nursing and midwifery curricula should include national health priorities and contemporary issues in health care (ANMAC, 2012, 2014). It must be noted that injury prevention and control and mental health are both areas of national health priority for 2016 (AIHW, 2017). IPV can manifest itself in numerous ways, and therefore, can have devastating consequences physically, emotionally, psychologically, socially and economically, as outlined in Section 2.6. Therefore, the physical consequences of IPV can be categorised under the priority area of injury prevention and control, and the emotional and psychological effects of IPV can be categorised under the priority area of mental health.

Finally, IPV is a prevalent contemporary health issue in Australia, and should therefore be included in the BN and BM curricula as argued by the literature examined in this review. Given this situation, the current study will investigate whether these UG degrees incorporate the topic of IPV, thus fulfilling this criterion for accreditation. Research questions 1 and 6 addresses this issue, and thus will provide answers to these questions.

Apart from the ANMC, there are other organisations that are imperative to the education of RNs and RMIs. For example, the ANMF, and the Australasian College for Emergency Medicine. The ANMF endorses the education of UG nursing and midwifery students in DV, as well as the continuing education in IPV of RNs and RMIs (2016). The Australasian College of Emergency Medicine also has a policy on DV, which clearly outlines the need for all UG HCPs to be educated and trained in DV-related care (2016). Thus, it clear that several national organisations advocate the education of UG HCPs in IPV-related content, but to date, no research has examined Australian universities’ adoption of these
recommendations. The current study aims to resolve this gap in knowledge by being the first national study to examine Australian universities’ utilisation of these recommendations.

### 3.6.4 Paramedicine curriculum

The research conducted on the IPV-related content in paramedicine curricula is even more limited than it is for the curricula of BMs. In Australia, this can be attributed to the recent transition of the education of paramedicine into the university system. It is extremely important for paramedics to receive education on IPV because they also frequently encounter survivors and perpetrators of IPV, and are often the first responders to an IPV call-out (Sawyer et al., 2014), and sometimes, the only out-of-hospital agency with which IPV survivors have contact (Hall & Becker, 2002; Weiss, Kripke, Coons & O’Brien, 2000). Further, IPV survivors are more likely to arrive at hospital by ambulance than non-IPV survivors (Datner, Shofer, Parmele, Stahmer & Mechem, 1999).

Paramedics are in a unique and critical position to screen, report and manage IPV situations (Sawyer et al., 2014). Therefore, according to the Australian Medical Association (AMA), paramedics should receive IPV-related education (Sawyer et al., 2014), and given that this profession is now taught in the university system, this education must occur in the BP or equivalent degree. Sawyer et al. (2014) conducted a cross-sectional descriptive study to examine the level of basic knowledge and preparedness for IPV cases of 50 Australian paramedics who undertook a two-hour IPV and sexual-assault workshop. First, this study found that 90% (n=45) of paramedics had responded to at least one call related to IPV, with the average number of IPV calls being 3.66 (Sawyer et al., 2014). Moreover, less than one in four paramedics felt very prepared to attend to an IPV situation, while 50% (n=12) felt they needed additional training on IPV (Sawyer et al., 2014). Finally, 26% of the paramedics had received no training on IPV, while 44% had received continuing education at work. The researchers support conducting further research into paramedics’ level of knowledge of IPV (Sawyer et al., 2014).
In a letter to the editor of the Emergency Medicine Australasia journal, Dousek et al. (2012) stated that Australian paramedics are not well equipped to deal with IPV survivors or perpetrators, which again supports the importance of the current study. Dousek et al. (2012) believe paramedics need to be educated on appropriate attitudes, knowledge and skills related to this population of patients (Dousek et al., 2012). These recommendations were echoed by researchers in Canada. Mason et al. (2010) conducted an online, short-answer survey with 480 EMTs to assess their knowledge of and experience with IPV. The results revealed that 84.5% (n=321) of the EMTs wanted more formal education on IPV. Informal education (e.g., personal learning) was received by 58.3% (n=222) of the EMTs, 35.7% (n=136) attended conferences or continuing-education initiatives, while only 17.6% (n=67) received some formal education on IPV-related content (Mason et al., 2010). No education or training at all was reported by 13 of the EMTs. Mason et al. (2010) argue for the inclusion of IPV-related content in the core paramedic curriculum. These findings add strength and credibility to the current study because the ultimate aim of this research is to change the curricula in the education programmes of HCPs so that students learn about the multiple components of caring for IPV survivors.

3.6.4.1 Contemporary issues in paramedicine UG education

Over the past decade, the Australian paramedicine discipline has changed dramatically by moving from the transport model to the model of pre-hospital medical treatment/primary health and social care (Council of Ambulance Authorities [CAA], 2014; Williams, Onsman & Brown, 2010). Further, advances have been made in the range of clinical treatments and technology used by paramedics to provide care to the community (CAA, 2010).

This shift in models has resulted in the professionalisation process of paramedics, whereby the education of upcoming paramedics now occurs in the higher education sector (Williams et al., 2010). According to Reid (1994), this shift into higher education results in the establishment and maintenance of EBP, participation in collaborative research, and is the
hallmark of full professional status. However, there is very limited current research on the UG paramedicine curriculum. Research conducted on this curriculum and its content inclusion is at least six-years old, which may now be irrelevant because paramedicine has had time to adjust into the higher education sector. Therefore, new research needs to be conducted into the contemporary issues in the UG paramedicine degree. The current study will contribute to this knowledge base because it is one of the first known studies to examine the amount and type of IPV-related content within Australian UG paramedicine degrees. The connection between IPV-related education and paramedics’ professional conduct will now be explored by first examining their Professional Competency Standards.

3.6.4.2 Professional Competency Standards

The Professional Competency Standards for the paramedic written by the CAA (2010) provides current industry requirements and standards that must be met to gain employment with major ambulance services of Australia and New Zealand. In this document, there is no direct mention of the term ‘IPV’ or its alternative terms, but there are competency standards that are relevant to caring for survivors of IPV. Some examples of these competency standards will now be discussed.

In their professional role, paramedics are often unaware of the situation they will be entering. With IPV call-outs, they are unaware of the trigger of the violence, the past circumstances of the IPV relationship, and what future triggers may be. Therefore, to provide safety for themselves and the survivor of this abuse, they need to use their knowledge of IPV and their past experiences with IPV cases to provide the best care possible while maintaining safety. This behaviour is in line with the Professional Competency Standards’ competency standard 3.2, which states ‘assesses a situation, determines the nature and severity of the problem and calls upon the required knowledge and experience to provide a response that is in the best interest of the patient/s’ (CAA, 2010, p. 9). Another competency standard that is relevant to the care of an IPV survivor is 7.1, which states, ‘analyses the situation, gathers
appropriate information and selects and uses appropriate assessment techniques’ (CAA, 2010, p. 12). If paramedics do not receive education on the appropriate and sensitive assessment of IPV, it is difficult for them to know the appropriate assessment technique to use. Beginning an assessment for IPV in front of a perpetrator will not only result in a negative response to the questioning, but will also increase the chances of retribution once the couple is alone (Association of Women’s Health, Obstetrics & Neonatal Nurses, 2015). This situation could be avoided if education on IPV-related content were provided to paramedics in their UG degree.

Ensuring this safety mechanism can also be linked to competency standard 8.4, which asserts that paramedics should ‘conduct appropriate diagnostic or monitoring procedures, treatment, therapy or other actions safely: Maintains the safety of both patients and those involved in their care’ (CAA, 2010, p. 13). As stated, maintaining the safety of a survivor of IPV is paramount, therefore the only means by which it can be ensured they receive this knowledge is through their education. To ensure all paramedics are provided with the same content, this education should occur via their UG degree. Whether this is occurring presently will be determined by the answers to this study’s research questions.

3.6.4.3 Australasian Competency Standards for Paramedics

PA (2011), the peak professional body representing paramedics in Australia, New Zealand and the Pacific Region, has written the Australasian Competency Standards for Paramedics. These standards provide detail of the essential attributes of a paramedic and support the accreditation process and regulatory frameworks of paramedicine (PA, 2011). These standards are divided into three domains: Professional Practice, Clinical Practice and Professional Knowledge, and an example from each will be used to demonstrate their relevance to the care and treatment of IPV survivors (PA, 2011).

From the Professional Practice domain, 1.a.2 states that paramedics ‘practise in a non-discriminatory manner: Acknowledge the right of the individual to self-determine their care’
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As stated, it is important to acknowledge that the IPV survivor has the right to accept or refuse an HCP’s help and they have the right to return to their abusive partner if they wish. It is the HCP’s job to accept they have this right and respect the IPV survivor accordingly (WHO, 2014). Assessment is an essential clinical-practice skill in managing IPV, which is highlighted in the previously discussed Professional Competency Standards, and therefore, will not be discussed here. However, the following competency standard from the Clinical Practice domain 2.a.1, ‘gather appropriate information as it relates to the assessment of a patient’s health status: Undertake a comprehensive assessment of the patient which includes assessment of the psychological, social and cultural determinants of health’ (PA, 2011, p. 9) is relevant to IPV as a result of this essentiality of appropriate and thorough assessment of all patients dealing with IPV.

It is important for all paramedics to understand that there are many reasons why people do not access health services. This may be because of financial concerns, transport issues, embarrassment or fear of violence. Survivors of IPV often avoid accessing health services because of the negative attitudes they may encounter in the health setting or the lack of care they may receive (Reisenhofer & Seibold, 2013; Tower et al., 2006). Acknowledging these factors is important for paramedics, as competency standard 3.a.1 asserts, paramedics must ‘understand and apply key concepts and knowledge underpinning paramedicine practice: Understands determinants of health and factors which constrain an individual’s access to health care’ (PA, 2011, p. 11).

3.6.4.4 Code of Conduct for Paramedics

The third professional document for paramedics is the Code of Conduct (PA, 2014). The key principles of this code are integrity, respect, responsibility/accountability, competence, consent for patient care, confidentiality, research and ethical review (PA, 2014). All these principles are applicable to the care and treatment of IPV survivors. It is vital that all IPV survivors are treated with respect and dignity and that paramedics assume the
responsibility of ensuring the safety of IPV survivors while in their care (WHO, 2014). This means being accountable for the safe assessment and identification of IPV survivors, being competent in the treatment of the physical, emotional and psychological health problems related to IPV, and being accountable for the safe transfer of information to the survivor and the maintenance of confidentiality at all times (WHO, 2014). Finally, paramedics can ethically review their conduct with IPV survivors, and determine whether they need further education about this population.

Thus far, Section 3.6 has examined the literature on UG degrees of nursing, midwifery and paramedicine, and their inclusion of IPV-related content. It could be argued that this content does not need to be included in these degrees because the information could be provided through continuing-education programmes and in-services. Therefore, Section 3.6.5 will discuss literature on the education methods of continuing education and in-services and demonstrate why these methods are successful at reinforcing knowledge, but should not be used to impart new knowledge.

3.6.5 Continuing education/in-services

The current study does not argue against the value of continuing education or in-services for HCPs learning IPV-related content because these methods are an excellent means of providing this education for HCPs who have graduated with minimal IPV education, or are highly valuable for reinforcing IPV-related content learnt by HCPs through their UG degrees (Boursnell & Prosser, 2010; Johnson et al., 2009). However, continuing-education initiatives or in-services should be used only as a reinforcement education method rather than as a method of initiation of such knowledge because of the issues associated with this continuing education or in-services (Dienemann et al., 1999). For example, poor attendance as a result of ward priorities, staffing levels, inadequate notification and poor timing associated with only some of the HCPs being able to attend because of shift times (Dienemann et al., 1999).
Evaluation of continuing-education programmes or in-services on IPV has been conducted in a variety of settings such as paediatric hospitals and family practices, across a variety of hospital wards, family-planning clinics and primary-care practices. A variety of professionals also attend such programmes, including nurses, physicians, social workers, family-support workers, technicians and dentists/dental hygienists (Hamberger et al., 2004; Johnson et al., 2009; Knapp, Dowd, Kennedy, Stallbaumer-Rouyer & Henderson, 2006; Nicolaidis, Curry & Gerrity, 2005; Wong, Wester, Mol & Largo-Janssen, 2007). These programmes have mixed results.

When examining the Australian context specifically, there is a paucity of research on IPV continuing education. Davila (2006) created a 3.5-hour IPV in-service programme for nursing employees using the adult-learning theory as the theoretical framework. A two-phase, mixed-methods design was used, with phase one consisting of semi-structured interviews with seven nursing staff of a public-health department. Although these nurses had attended a workshop two to three years earlier, which taught them about incidence and prevalence rates, health consequences of IPV, characteristics of survivors and perpetrators, and screening processes, these nurses felt uneasy and inadequately prepared to screen and care for survivors of IPV (Davila, 2006). This could be because they had minimal time to practice and implement these skills, and were therefore unable to gain confidence in using these skills. This would be avoided if IPV-related content were incorporated into the HCP’s UG degree because students would have time to practice, implement and gain feedback on these necessary skills via simulated laboratory experiences (Daniel & Milligan, 2013).

For the quantitative component of this study, Davila (2006) developed a one-group, pre- and post-test design to evaluate the effectiveness of the in-service programme. The results indicated that no significant knowledge gain was achieved through the in-service programme, with a mean knowledge score before the in-service of 5.01, and only 5.09 after the in-service. However, there was a significant difference found between the mean skill
levels pre- to post-in-service. The mean skill level increased from 3.6 to 4.8 post-in-service (Davila, 2006). The non-significant result for the knowledge level was attributed to the fact that a mandatory workshop on IPV had been delivered two to three years earlier (Davila, 2006).

A more recent programme has been implemented by Boursnell and Prosser (2010) in Australia. These researchers initiated a 45–60-minute project to improve the quality of identification and care of IPV survivors entering the emergency department of an NSW health service. Via a pre- and post-test and file audit, these researchers discovered that the knowledge of staff increased following this training session. The percentage of nurses who felt they had no knowledge of IPV policies and procedures before the training session was 52% (n=25); however, one month after the training session, 95% now felt fully aware of these policies and practices. Likewise, at the six-month follow up, all nurses believed they had retained all knowledge of the policies and procedures (Boursnell & Prosser, 2010). The investigators also examined the nurses’ awareness of their responsibilities associated with a patient experiencing IPV. Prior to the training session, 52% (n=25) of the nurses were not aware of these responsibilities, but at the one-month and six-month follow up, only one nurse remained unaware of these responsibilities (Boursnell & Prosser, 2010). Another aspect of care that dramatically improved since this training session was referral to appropriate allied health professionals or services. Before the training session, 73% (n=36) of the nurses stated they did not know how to or where to refer patients. This percentage reduced to 27% (n=6) after the training session (Boursnell & Prosser, 2010). Although successful results were found, a 45–60-minute in-service is not sufficient to educate HCPs on all aspects of IPV as sufficient time is necessary to discuss the multicomponent aspect of this violence.

Further positive results have been obtained by other researchers (Johnson et al. 2009). Examining nurses’ knowledge, attitudes, behaviours and self-efficacy, Johnson et al. (2009) implemented an interventional, longitudinal study to investigate changes in these areas
following a 30-minute training session on IPV screening. An increase in self-efficacy scores and knowledge of resources available was found, as was a reduced fear of offending patients when screening for IPV (Johnson et al., 2009). A different approach to examining the effects of an IPV educational programme was adopted by Schoening, Greenwood, McNichols, Heermann and Agrawal (2004) through examining attitudinal change before and after the educational programme. The Public Health Nurses’ Response (PHNR) to Women Who Are Abused questionnaire was completed by 52 nurses, with an increased score indicating positive thoughts, feelings and behaviours towards an IPV survivor found after implementation of one-hour training programme for nurses who had previous IPV experience, and after a three-hour training programme for nurse who had no previous IPV experience (Schoening et al., 2004).

Continuing-education programmes have also been presented to interdisciplinary teams. Lia-Hoagberg, Kragthorpe, Schaffer and Hill (2001) implemented a one-day statewide, interdisciplinary, community-based educational programme in Minnesota for public-health nurses, RNs, social workers, protection workers, women’s advocates, corrections staff, family-support workers and paraprofessionals (n=238). The results illustrated an increase in knowledge and skill development in the areas of assessment and intervention, and increased community partnerships and collaboration (Lia-Hoagberg et al., 2001). An even larger study consisting of 752 HCPs (RNs, medical assistants, radiology technicians, laboratory technicians, social workers and physicians) from two hospitals in a Midwestern US city examined the effect of a three-hour IPV-training programme. Positive results were achieved immediately following this programme and persisted at the six-month follow up. This training programme resulted in an increase in self-efficacy, HCP comfort in treating IPV, the number of referrals made for IPV survivors, and the validation of this topic as important for all HCPs (Hamberger et al., 2004).

Knapp et al. (2006) implemented a two-hour IPV educational programme to paediatric nurses, physicians and social workers of the Children’s Mercy Hospitals and Clinics (Kansas
City), with positive results found immediately after this training, and persisting for at least six months after training ceased. Attitudes were found to have changed positively, and self-efficacy scores increased immediately after training, and at the six-month follow up (Knapp et al., 2006). Likewise, examining referrals to appropriate services or personnel, Brackley (2008) found that before an eight-hour training session including nurses, social workers and technicians, only seven of the 32 identified cases of IPV were referred to appropriate services. Following the in-service training session, chart audits revealed that the staff were well informed and would even call in legal personnel to complete Orders of Protection while the women were still in the health-care organisation. Remarkably, of the identified cases of IPV, 100% of these women received appropriate referral (Brackley, 2008). In the knowledge component of the Doepel Domestic Violence Survey Brackley (2008) administered, the percentage of correct responses rose from 47 to 65%, and there was also an increase in skill level from 5.4 to 6.4% (Brackley, 2008).

Bonds, Ellis, Weeks, Palla and Lichstein (2006) took a different approach to evaluating their programme. Instead of surveying or conducting focus groups with the HCPs that work in the health-care system of a particular state or country, Bonds et al. (2006) decided to conduct a pre- and post-cross-sectional telephone survey of female patients from primary-care practices in North Carolina. Each primary-care practice was to nominate two resource persons to undertake a one-day training session held by experts in the field of family violence, a 90-minute training session at their primary-care practice, lunch-and-learn sessions and a half-day refresher session. The investigators concluded that the training of primary-care practices was a success. In the pre-test survey conducted in 2002, 16% of the female patients stated they had been screened for IPV. In contrast, in the post-test survey in 2004, 26% of the female patients stated they had been screened for IPV, meaning the female patients were now 79% more likely to be screened for IPV than they were before the training sessions (Bonds et al., 2006).
Overall, continuing education and in-services presenting IPV-related education to HCPs have found to be quite successful. However, because of the limitations noted at the beginning of this section, this form of education should not be the only means by which HCPs are provided with education on IPV. For all HCPs to be educated thoroughly on this topic, IPV-related education should occur during their UG degree. As stated, one of the aims of the current study is to determine whether this is occurring in Australian universities. A further aim is to enquire whether universities are adopting national and international organisations and committees’ guidelines and recommendations on the inclusion of this content. National organisations and committees have already been discussed, thus international organisations and committees will now be presented.

3.7 International Organisations and Committees

The recommendations of the leading global health-care organisation, the WHO, are also significant for the argument to include IPV-related content in the curriculum of the health-care professions under discussion. The WHO recommends that HCPs receive training on how to provide effective and efficient care to survivors of IPV (Garcia-Moreno et al., 2005; WHO, 2013b). The WHO (2013b) states that such education should be provided at the pre-qualification level, such as the BN, BM or BP or equivalent, to provide first-line support to patients experiencing IPV. These upcoming HCPs need to be educated on the multicomponent aspects of IPV, including identification, safety assessment and planning, communication and clinical skills, documentation, and provision of referral pathways using interactive, practical techniques (WHO, 2013b, p. 35). It is hoped that such education will lead to an increase in the identification of IPV survivors and a change in the attitudes and behaviours of HCPs (WHO, 2013b, p. 33).

Further, the WHO (2010) advocates so strongly for the education of HCPs on the topic of IPV that it also has recommendations about what should be included in this education. The WHO (2010) states that the minimum component of this education should be to familiarise
and sensitise HCPs to the effects of IPV; for them to develop active listening skills and ways to screen patients for this violence, including the way to formulate the screening question; how to support the patient when they disclose such violence; how to follow the designated care pathways for this situation; and how to consider ethical issues, legal issues, and ensure child protection and appropriate documentation. An additional requirement of this education is to discuss and discourage issues of gender inequality because the community of the HCPs must ensure that they do not stigmatise such patients any further (Garcia-Moreno et al., 2005; WHO, 2010); and to provide multidisciplinary training so that different HCPs understand the roles and responsibilities of their colleagues, with the ultimate aim of providing care coordination and information sharing between different HCPs (WHO, 2010).

Finally, according to the WHO’s Global Campaign for Violence Prevention, every level of society needs to take action to increase awareness of IPV (WHO, 2008). At the educational level of society, this means a review of current curriculum to incorporate IPV assessment and interventions for all students enrolled in an HCP degree. By implementing such content and strategies, Australian HCPs will be at the forefront of promoting this important public-health initiative (Tufts et al., 2009, p. 42). In addition, the WHO (2013b, p. 43) recommends that research be conducted to establish the minimum content and duration of education on IPV-related content to improve HCP skills.

The current study addresses the WHO’s (2013b, 2010) recommendations in numerous ways. First, the WHO’s (2013b, 2010) recommendation on the need to educate UG HCPs about IPV-related content supports the ultimate aim of this research study to change the curricula of the BN, BM and BP (or equivalent degree) to include IPV-related content, and integrate this content throughout the curricula. The current study also addresses the WHO’s (2013b, 2010) recommendations on what should be included in this education by asking academics at Australian universities exactly what content they are currently teaching their students. In addition, the WHO (2013b, 2010) recommends a review of UG HCP curricula to
verify whether this content can be incorporated into the curricula, to conduct more research into the content that is included in the curricula, and to examine the appropriateness of the duration of this education. These recommendations encompass the two principal aims of the current study: to examine the curricula to determine whether IPV-related content is included and if so, the type, amount and means by which it is taught. Finally, this is the first national or international study to examine whether academics utilise national and international organisations and committees’ guidelines and recommendations in their teaching of IPV-related content and if so, how this is accomplished.

The inclusion of IPV-related content in the BN, BM and BP (or equivalent degree) is also supported by other key international health authorities. For example, in 2000, the American Nurses Association (ANA) (2000) recommended that all bachelor- and graduate-level nursing students receive theory and content related to IPV across the lifespan of a person and across all practice settings in which nurses are employed. In addition, they recommended the facilitation of clinical experience so that nursing competencies related to IPV assessment, treatment and prevention could be achieved (ANA, 2000). In 2000, the American Association of Colleges of Nursing (2000) also recommended that educational institutions providing UG HCP degrees include in their baccalaureate programmes factual information and clinical experience on DV. For paramedics, the American College of Emergency Physicians (2009) has recognised the importance of training all emergency personnel in the assessment, treatment and evaluation of IPV survivors. Table 3.1 presents a summary of the recommendations of key international organisations and committees on IPV-related practices for HCPs.
# Table 3.1

## Summary of Recommendations from Key International Organisations and Committees

<table>
<thead>
<tr>
<th>Committee/organisation</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHO</td>
<td>Include violence-prevention modules in medical and nursing schools’ core curricula</td>
</tr>
<tr>
<td>Joint Commission on Accreditation of Healthcare Organisations</td>
<td>Ensure medical facilities to provide IPV education and training to all HCPs, and universal screening</td>
</tr>
<tr>
<td>AACN</td>
<td>Include IPV theory and content in bachelor-and graduate-level nursing courses</td>
</tr>
<tr>
<td>International Association of Forensic Nurses</td>
<td>Include comprehensive forensic-nursing education at entry and advanced practice Levels</td>
</tr>
<tr>
<td>Canadian Panel on Violence Against Women</td>
<td>Ensure mandatory IPV education for all HCPs</td>
</tr>
<tr>
<td>Department of Health</td>
<td>Ensure all HCPs receive education on IPV</td>
</tr>
<tr>
<td>American Nurses Association</td>
<td>Ensure IPV reduction through education and Screening</td>
</tr>
<tr>
<td>American Medical Association</td>
<td>Ensure IPV reduction through education and Screening</td>
</tr>
<tr>
<td>American College of Obstetricians and Gynecologists</td>
<td>Ensure IPV reduction through education and Screening</td>
</tr>
<tr>
<td>Accreditation Council for Graduate Medical Education</td>
<td>Incorporate in curricula of internal-medicine training programmes education on vulnerable patients (including IPV survivors)</td>
</tr>
<tr>
<td>Emergency Nurses Association</td>
<td>Supports curriculum development, training and continued education in IPV for nurses</td>
</tr>
<tr>
<td>American Academy of Paediatrics Committee on Child Abuse and Neglect</td>
<td>Recommends universal screening of all female Patients</td>
</tr>
<tr>
<td>American Academy of Family Physicians</td>
<td>Recommends universal screening of all female Patients</td>
</tr>
<tr>
<td>American College of Nurse Midwives</td>
<td>Recommends universal screening of all female Patients</td>
</tr>
<tr>
<td>American College of Emergency Physicians</td>
<td>Recommends universal screening of all female Patients</td>
</tr>
<tr>
<td>American Academy of Nurse Practitioners</td>
<td>Recommends universal screening of all female patients</td>
</tr>
<tr>
<td>Centres for Disease Control and Prevention</td>
<td>Recommends systematic screening for IPV by HCPs</td>
</tr>
</tbody>
</table>

**Sources.** McGarry, Clarke, Landau and Cyr (2008); Roelens, Verstraelen, Van Egmond & Temmerman (2006); Yonaka, Yoder, Darrow & Sherck (2007)
3.8 Research Issues

3.8.1 Gaps in the literature

This chapter has provided a comprehensive review of the literature relating to including IPV-related content in the UG health disciplines of nursing, midwifery and paramedicine. Throughout the chapter, the way this research aims to bridge the gap in literature has been highlighted. To recount, this study will address the following gaps in literature:

- This is the first Australian study to examine Australian universities in relation to how prominently IPV-related content appears in the BN, BM and BP (or equivalent) degrees and if included, whether it is integrated throughout this curriculum. It will further examine in which units this content is taught, how such units are chosen by academics, and what content is taught and how.

- This is the first national or international study to examine the quantity and type of IPV-related content in the UG degrees of nursing, midwifery and paramedicine collectively.

- This is the first known study to examine frontline academics’ attitudes and beliefs relating to the inclusion of IPV-related content in the Australian UG curricula of nursing, midwifery and paramedicine.

- This is the first national or international study to examine the adoption of national and international organisations and committees’ guidelines and recommendations on the inclusion of IPV-related content in UG HCP degrees.

- This is the first national or international study to research the rationale related to adherence or non-adherence to these guidelines and recommendations.

3.8.2 Research problem

The identified gaps in the literature above reaffirm the necessity of this research, and led to the development of the following research problem:
How effective are Australian universities that offer UG nursing, midwifery and paramedicine degrees at incorporating IPV-related content into these degrees, and how can this content be more consistently integrated to bring about a more responsive workforce in health care? Further, are Australian universities utilising national and international recommendations on the inclusion of IPV-related content in UG degrees?

3.8.3 Research objectives

To solve the research problem stated in Section 3.8.2, the following five objectives were established:

1. To establish whether IPV-related content is included in Australian BN, BM and BP (or equivalent) degrees.

2. To examine the amount of IPV-related content included in Australian UG nursing, midwifery and paramedicine degrees and if there are any barriers to such inclusion.

3. To examine the type of IPV-related content included in Australian UG nursing, midwifery and paramedicine degrees and the type of units this content is included in.

4. To investigate if IPV-related content is being integrated throughout the BN, BM and BP (or equivalent) degrees.

5. To investigate frontline academics’ attitudes and thoughts in relation to the inclusion of IPV-related content in these degrees.

6. To discover whether Australian universities are adopting national and international organisations and committees’ guidelines and recommendations on the inclusion of IPV-related content in UG HCPs degrees.
3.8.4 Research questions

To address these research objectives, the following six research questions were developed:

Research question 1: How prominently has IPV-related content appeared in the curriculum being offered in the currently available Australian UG nursing, midwifery and paramedicine degrees?

Research question 2: How is this IPV-related content being integrated into the curricula of nursing, midwifery and paramedicine?

Research question 3: How are the units that contain IPV-related content chosen by academics and why are they the units chosen to include this content?

Research question 4: How is this IPV-related content being taught and what is being taught in relation to this content in the disciplines of nursing, midwifery and paramedicine?

Research question 5: How do academics explain their inclusion or non-inclusion of IPV-related content in their unit/s?

Research question 6: How are academics utilising national and international organisations and committees’ guidelines and recommendations in their teaching of IPV-related content?

3.8.5 Research propositions

Given that this is a case-study research project, propositions needed to be developed (Yin, 2014). The following six research propositions were developed for this study. The propositions were derived from personal experience and the literature review undertaken.

Proposition 1: It is the proposition after an extensive literature review that the amount of time spent on IPV-related content in the above
curricula will be minimal because of the barriers of a lack of awareness, an overcrowded curricula and a lack of support for this inclusion.

Proposition 2: The proposition for this research question is that there exists a lack of integration of IPV-related content into the UG curricula of nursing, midwifery and paramedicine and IPV-related content is only included in units when the unit coordinator (or equivalent) feels competent and passionate about this content.

Proposition 3: Units containing IPV-related content in the examined curricula will be those associated with mental health units and child and family units as this topic has been traditionally seen as a mental health issue and a family issue that occurs behind closed doors.

Proposition 4: IPV-related content is usually only delivered via didactic lectures and readings only, with minimal interactive class time and clinical experience. In terms of what is being taught, types, prevalence and effects is assumed to be taught more often than the appropriate screening, detection and care principles for survivors of IPV.

Proposition 5: It is the proposition that non-inclusion of IPV-related content into these UG curricula is because of the lack of expertise in this topic, the lack of understanding of its importance to be included in the UG curricula and negative attitudes/beliefs towards survivors of IPV.

Proposition 6: It is the proposition of the researcher that academics have little awareness of national and international organisations and committees’ guidelines and recommendations on IPV-related content and are thus not implementing any of these guidelines/recommendations into their teaching.
3.9 Chapter Summary

This chapter has presented the literature review on the relationship between HCPs and the care and treatment of IPV survivors. It illustrated that IPV survivors access more health-care services than non-IPV survivors, and therefore HCPs will inevitably have contact with this group of patients. Therefore, it is essential that HCPs have knowledge about how to screen patients appropriately and safely for the occurrence of IPV. However, the literature demonstrates that screening rates for IPV by HCPs remain low. The consequences of this screening were discussed, as was the need to change this process so that all patients are screened for IPV. Screening recommendations by a number of national and international organisations and committees were outlined. It was also demonstrated that HCPs’ responses and attitudes towards IPV survivors can be negative and traumatising for the survivor.

Recommendations for HCPs’ responses and attitudes were provided, along with the LIVES mnemonic, which assists HCPs in responding to IPV disclosure appropriately and respectfully.

The principal argument of the current study is the need to include IPV-related content in UG BN, BM and BP (or equivalent) degrees. Therefore, each one of these degrees was investigated, and it was concluded that there is minimal IPV-related content in these degrees, and that there exists a unanimous call from IPV specialists and researchers for such inclusion of this content in HCP degrees. The literature of the WHO and other key national and international organisations and committees was consulted to examine their recommendations for including IPV-related content in UG HCP degrees. There is substantial national and international support for such inclusion and therefore, the current study is examining the extent to which Australian universities offering BN, BM and BP (or equivalent) degrees adopt and utilise these recommendations. This study is the first of its kind to research this topic. Finally, this chapter provided information on the research issues under investigation,
including the gaps in the literature, and presented the research problem, objectives, questions and propositions.

Thus far, this thesis has provided an introduction to the current study, an overview of the context of IPV nationally and internationally, and an analysis of the literature available on HCP responses to IPV survivors, and the need to change the curricula of UG nursing, midwifery and paramedicine degrees to include IPV-related content. The following chapter provides details on the research methodology adopted for this study.
Chapter 4: Research Methodology

The thought of someone you love and who is supposed to love you back continuously
inflicting physical and emotional pain towards you is unthinkable—yet it happens all too
often throughout the world we live in.

4.1 Chapter Preamble

As highlighted in Chapter 3, research conducted on IPV has employed quantitative
and qualitative research methods, which indicates the value of utilising a mixed-methods
approach for data collection. The adoption of a case-study approach is a highly valid
methodological choice given that replication is possible, and that it allows mixed-methods
research to be conducted. These considerations led this research to employ the case-study
method utilising the principles of Yin (2014) to achieve the research aims. The objective of
this chapter is to provide the reader with an understanding of case-study research, including
when this design should be used in research, and the five essential components that need to be
met to employ this method. The types of case-study design will be reviewed, along with the
four tests that are commonly used to verify the quality of case-study research designs. Data-
collection techniques will be explained, integrating the three principles of data collection and
the limitations of case study design will be outlined.

This chapter is presented in 13 sections. Following the chapter preamble (Section 4.1)
and pictorial outline of Chapter 4 (Figure 4.1), the paradigmatic justification of the research is
presented, concluding with the rationale for why the realism paradigm was chosen for this
study (Section 4.2). Following this, the justification for employing a mixed-methods research
design (Section 4.3) and the case-study research approach (Section 4.4) is presented, and the
five components of case-study research are discussed and applied to the current study (Section
4.5). The types and quality of case-study research designs are explored (Sections 4.6 and 4.7),
along with the principles of case-study data collection (Section 4.8). The three phases of this
multiple-case-study design, documentation (phase one), cross-sectional study (phase two) and qualitative interviews (phase three) are explained (Section 4.9), followed by the case-study specific data-analysis techniques utilised in this study (Section 4.10). The chapter closes by outlining the limitations of case-study research (Section 4.11) and the ethical considerations of the study (Section 4.12). The chapter concludes with a chapter summary (Section 4.13).
Chapter 4

4.1 Chapter preamble

4.2 Paradigmatic justification of research
   • 4.2.1 Positivism
   • 4.2.2 Constructivism
   • 4.2.3 Critical theory
   • 4.2.4 Realism

4.3 Justification for mixed-methods research design
   • 4.3.1 Quantitative research
   • 4.3.2 Qualitative research
   • 4.3.3 Mixed-methods research

4.4 Defining and justifying the use of case-study research
   • 4.4.1 What is case-study research?
   • 4.4.2 Justifying the use of case-study research

4.5 Case-study research design
   • 4.5.1 Research questions and propositions
   • 4.5.2 Unit of analysis
   • 4.5.3 Connecting data to the propositions
   • 4.5.4 Criteria for interpreting a study’s findings

4.6 Types of case-study designs

4.7 Quality of case-study research design
   • 4.7.1 Construct validity
   • 4.7.2 Internal validity
   • 4.7.3 External validity
   • 4.7.4 Reliability

4.8 Case-study data-collection methods
   • 4.8.1 Principles of data collection
4.2 Paradigmatic Justification of Research

Numerous definitions of a paradigm exist in the literature. For example, according to Filstead (1979), a paradigm is a ‘set of interrelated assumptions about the social world which provides a philosophical and conceptual framework for the organised study of that world’ (p. 34), and Guba and Lincoln (1994) state it is a ‘basic belief system or worldview’ (p. 105) that deals with ultimates or first principles. Irrespective of the definition, a paradigm aids in creating avenues of enquiry, formulating questions, selecting methods to examine the questions, defining areas of relevance, and establishing and creating meaning (Kuhn, 1996; Ponterotto, 2005). A paradigm is comprised of the following three elements (Christie et al., 2000; Guba & Lincoln, 1994):

4. ontology—configuration and character of reality
5. epistemology—character and basis of knowledge or the nature of the relationship between the researcher and reality

6. methodology—procedures performed to examine or explore the reality.

For this study, Guba and Lincoln’s (1994) categorisation of research paradigms will be used. According to these researchers, there are four research paradigms: positivism, postpositivism/realism, critical theory and constructivism. These paradigms extend from objectivism (positivism) through to subjectivism (interpretivism), with the realism paradigm midway between these two extremes (Perry, 2013). Each of these paradigms differ in their three essential elements, and these are summarised in Table 4.1.
### Table 4.1

**Comparisons of Research Paradigms**

<table>
<thead>
<tr>
<th>Ontology</th>
<th>Positivism (Objective)</th>
<th>Realism (Subjective)</th>
<th>Critical theory (Interpretative)</th>
<th>Constructivism (Phenomenology)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Naive realism—real</td>
<td>Critical realism—real</td>
<td>Historical realism—</td>
<td>Relativist—multiple, constructed</td>
<td></td>
</tr>
<tr>
<td>reality but apprehensible; reductionist and deterministic</td>
<td>reality but only imperfectly and probabilistically apprehensible</td>
<td>virtual reality shaped by social, political, cultural, economic, ethnic, and gender values</td>
<td>realities; reality is subjective depending on the context, individual experience and perceptions, the social environment and interaction between the individual and the researcher</td>
<td></td>
</tr>
</tbody>
</table>

| Epistemology            | Dualist—the researcher, participant and topic are independent of one another; Objectivity—research can be conducted without bias if rigorous, standard procedures are followed; researcher has no influence on their participants; replicated findings are deemed true and provide evidence for theory verification | Modified dualist/objectivist—emphasis placed on external guardians of objectivity such as critical traditions and the critical community; replicated findings are probably true; researcher may have some influence on the research | Transactional and subjectivist—researcher and research interactively linked with the values of the researcher influencing the research; findings are therefore value mediated; aim is to transform the individuals so group empowerment and emancipation from oppression occurs | Transactional and subjectivist—researcher and research interactively linked; findings created as the research unfolds |

| Methodology             | Experimental/manipulative—verification of hypotheses; strict scientific methods and procedures; quantitative methods; experiments and surveys | Modified experimental/manipulative—emphasis on critical multiplicity (triangulation); collection of situational information in natural settings; utilisation of qualitative techniques, case studies and convergent interviewing | Dialogic and dialectical—dialogue between researcher and individuals must be dialectical to avoid ignorance; Transformative intellectual—changes the social world within which individuals live | Hermeneutical and dialectical—passionate participant; qualitative research methods (e.g., in-depth face-to-face interviewing and participant observation) |

*Source.* Adapted from Christie et al. (2000); Guba and Lincoln (1994); Ponterotto (2005)

A brief examination of each paradigm will now be presented to demonstrate the considerations undertaken to determine the most appropriate paradigm for this study.
4.2.1 Positivism

Positivism can be traced back to the Enlightenment period of the seventeenth and eighteenth centuries, with philosophers such as Descartes (1637–1968) and Locke (1689–1956) highlighting the objectivity of the world and the use of language as a way of conveying the truth. These ideas were elaborated in the nineteenth century by Mill’s (1843–1906) *System of logic* (Ponterotto, 2005, p. 128). This paradigm’s ontological stance is that of an objective reality with the ‘Humean conception of causality as a constant conjunction of events’ (Tsang, 2014, p. 175). The principal objective of positivism is the measurement and analysis of causal relationships between variables, and the verification of hypotheses that are accepted as fact or laws (Guba & Lincoln, 1994). These hypotheses are stated as quantitative propositions that can be converted into mathematical formulas (Ponterotto, 2005, p. 128).

Reality is viewed through a one-way mirror and thus has no influence over the phenomenon under investigation. Therefore, positivists are classed as ‘disinterested scientists’ (Guba & Lincoln, 1994; Healy & Perry, 2000). Epistemologically, the researcher is separate from the research process and the researcher’s values are excluded from this ‘value-free’ paradigm (Guba & Lincoln, 1994; Healy & Perry, 2000; Perry et al., 1999; Ponterotto, 2005). The mode of research enquiry for positivism is theory testing based on deduction (Perry et al., 1999). This hypothetico-deductive method allows for statistical generalisations (Christie et al., 2000; Easton, 2010). The primary data-collection techniques for this paradigm focus on outcome-oriented approaches such as controlled experiments and sample surveys (Christie et al., 2000; Perry et al., 1999). Positivist’s aim is to inform decision makers, policy makers and change agents to form, explain and justify actions and policies, and change proposals (Guba & Lincoln, 1994).

Positivism is an inappropriate paradigm for the current study, as this study involves human participants and real-life experiences. Positivism ignores the individual’s ability to reflect on a problem and act on it in complex and multidimensional ways (Robson, 1993;
Veal, 2005). Moreover, a value-free one-way mirror between the phenomenon under investigation and the researcher was not appropriate for this study. Finally, quantitative propositions fail to provide answers to ‘why’ questions (Easton, 2010). Data collected utilising a positivism paradigm support or reject hypotheses or provide explanations of phenomena rather than explaining why or how phenomena occur (Perry et al., 1999). As seen in Section 3.8.4, the research questions for this study are ‘how’ questions.

Social science research should not seek causal explanations because the constructs under investigation are not tangible or easily apprehendable, but are humans that learn and change behaviours (Perry, 2013). This complex reality needs reflection, with meanings formed and revised. Therefore, a non-positivist paradigm should be used for this research (Perry, 2013). On the opposite end of the objective/subjective spectrum is the interpretive paradigms of constructivism and critical theory.

4.2.2 Constructivism.

Constructivism can be traced back to Kant’s (1881–1966) *Critique of Pure Reason*, in which he stated, ‘human claims about nature cannot be independent of inside-the-head processes of the knowing subject’ (Hamilton, 1994, p. 63). Therefore, constructivism adopts a relativist ontology, whereby truth is conceived as a particular belief held in a particular situation or context (Perry et al., 1999). Truth is therefore considered subjective and created by individuals. Accordingly, reality is not an externally singular entity (Ponterotto, 2005), but consists of multiple realities that are ‘socially and experientially based, intangible mental constructions of individual persons’ (Perry et al., 1999, p. 6).

The researcher's values and lived experiences cannot be separated from their research in constructivism. As a result, the researcher needs to acknowledge, describe and bracket these values but not eliminate them (Ponterotto, 2005). The researcher must also reflect on how their research influences their life (Ponterotto, 2005). Consequently, researchers are classified as ‘passionate participants’ in the research process (Christie et al., 2000; Guba &
Meaning is also more important than measurement in this paradigm. Researchers aim to learn about the ideologies and values behind a finding and transfer knowledge from one setting to another via vicarious experience (Christie et al., 2000; Guba & Lincoln, 1994; Perry et al., 1999). These data obtained under this paradigm depend on the interaction between the researcher and respondent (Christie et al., 2000). These data are mainly collected through qualitative methodologies such as in-depth interviews and participant observations (Perry, 2013).

Constructivism is not appropriate for the current study (Perry et al., 1999). This is because in this paradigm, the researcher needs to be a passionate participant, facilitate the emergence of ideas, and act as an activist (Guba & Lincoln, 1994). In this study, the researcher remained objective and thus did not become an activist. Further, this study focused on a mixture of beliefs and constructs that were measured, and thus required a paradigm that had elements of positivism and constructivism.

4.2.3 Critical theory

Critical theory can be traced back to the Institute of Social Research at the University of Frankfurt in the 1920s, as well as to theorists such as Max Horkheimer, Theodor Adorno and Herbert Marcuse (Ponterotto, 2005). Ontologically, critical theory aims to critique and transform social, political, cultural, economic, ethnic, and gender structures that constrain and exploit humankind (Christie et al., 2000; Guba & Lincoln, 1994). The aim of critical theory is advocacy and activism so that restitution and emancipation occurs and informed insight replaces ignorance and misapprehensions (Christie et al., 2000; Guba & Lincoln, 1994). For critical theorists, reality cannot be separated from power relations or their social–historical context (Ponterotto, 2005).

The methodology adopted by this paradigm is dialogic and dialectical. This dialectical researcher–participant interaction has the goal of leading to egalitarianism, democratic change and transformation (Ponterotto, 2005). The researcher adopts the role of ‘transformative
intellectual’ in which they aim to change individuals by increasing their insights into a situation, and encouraging them to act on these new insights (Guba & Lincoln, 1994). Thus, an interactive link between the researcher and the participants exists in critical theory (Guba & Lincoln, 1994). Further, this paradigm is value dependent. The researcher’s values are central to the task, purpose and methods of the research (Healy & Perry, 2000; Ponterotto, 2005). Critical theorists partake in this interaction via long-term ethnographic and historical studies (Christie et al., 2000; Healy & Perry, 2000; Perry, 2013).

Once again, this paradigm was not consistent with the current study. First, this study is not a long-term study, thus collecting data via ethnographic or historical studies was not appropriate. Second, this study did not seek to influence directly the consciousness of the participants (Perry, 2013). Critical theory is most appropriate when intervening in the transformation of respondents (Guba & Lincoln, 1994). Finally, the researcher did not aim to be a transformative intellectual within a group in this study.

4.2.4 Realism

Realism, also known as critical realism, postpositivism and neo-postpositivism (Denzin & Lincoln, 1994; Guba & Lincoln, 1994; Huberman & Miles, 1985; Hunt, 1991; Manicas & Secord, 1983) began as a result of discontentment with some of the positivist views (Ponterotto, 2005). Reality is not considered in the same manner in realism as it is in positivism; realists aim to develop prior theory and move closer to the understanding of truth (Perry, 2013). However, realists assert that precise knowledge of reality will always remain uncertain (Perry et al., 1999). Further, a difference between critical theorists/constructivists and realists also exists in their understandings of reality. Critical theorists/constructivists believe in multiple realities, whereas realists believe there is only one reality with many perceptions of it that need to be triangulated (Perry et al., 1999). According to realists, reality is not easily and unproblematically apprehended, characterised or measured because individuals experience only a portion of it (Perry, 2013; Wynn & Williams, 2012, p. 790).
Another difference between the paradigms is that a realist researcher observes people through an open window, not through a one-way mirror as does positivism, nor as a co-researcher in interpretive research. Moreover, realism focuses on causal tendencies rather than on causal certainties like positivism does. Lastly, the realist researcher is neither objective nor isolated from the research like positivists, they are not an involved participant like constructivists and they are not transforming mental frameworks as critical theorists do. Rather realists are value-aware. They try to build rapport with participants in order for them to feel comfortable to express their perceptions of reality but they do this in a way that minimises their influence (Perry, 2004).

Bhaskar introduced the transcendental realist philosophy for the natural sciences in *A Realist Theory of Science* (Bhaskar, 1975). He extended this to the social sciences in *The Possibility of Naturalism* (Bhaskar, 1998). According to Bhaskar (1975), the world is comprised of mechanisms, events and experiences, and there are three domains of reality (as listed below). These domains are relevant to realism because realist researchers observe the empirical domain to discover knowledge of the real world. This is achieved by naming and describing the generative mechanisms that occur in the real domain and result in events that can be observed (Christie et al., 2000). The following lists Bhaskar’s (1975) three proposed domains of reality:

1. real domain—this is where the processes that produce events occur; this domain is in the form of generative mechanisms or causal powers that exist independently; the events that are produced in the real domain are observable under contingent conditions
2. actual domain—patterns of events occur in this domain
3. empirical domain—experiences are witnessed by direct observation.

Social phenomena can be discovered despite them being imperfect and probabilistically comprehensible (Guba & Lincoln, 1994; Merriam, 1988; Perry & Coote, 1994; Perry et al., 1997). The methodology employed to discover a social phenomenon is
qualitative in nature and usually involves case studies or convergent interviewing (Perry et al., 1999). A key feature of this paradigm is triangulation, which involves utilising a variety of data types and sources, analytical methods and theoretical perspectives (Wynn & Williams, 2012). By using triangulation, perceptual limitations are overcome. There are two other purposes of triangulation. First, many types of structures comprise reality, and these can be physical, social or conceptual (Wynn & Williams, 2012). Each of these structures has its own emergent properties, powers and tendencies. Different methods are needed for each of these structures to develop knowledge about them. Second, triangulation controls the biases that can occur in the research process (Wynn & Williams, 2012).

Realism is the preferred paradigm for the current study because it is congruous with the case-study research approach for several reasons. First, the research topics are usually contemporary and pre-paradigmatic, requiring inductive theory building (Perry, 1998) rather than theory testing and verification. This is achieved through making comparisons, seeking similarities and differences in the data, and developing future questions to be answered. Generalisability to other populations is not the focus and thus is not tested (Christie et al., 2000; Perry, 2004; Perry et al., 1999). Second, a thorough understanding of the phenomenon is being sought in the current study. Experiences and beliefs about this phenomenon can be acquired only by getting close to the phenomenon through in-depth interviewing (Perry et al., 1999). Third, case studies focus on underlying causal tendencies rather than on cause-and-effect relationships (Christie et al., 2000). Fourth, this research is characterised by a degree of researcher objectivity. Realists believe that an external reality exists but its complexities and the limitations of the researcher require data triangulation to refine the observations of the reality (Perry, 1998).
According to Christie et al. (2000), case-study methodology should be used within the realism paradigm under the following four circumstances:

1. The investigation of a particular event that focuses on a situation or context that has specific features. This is because of the focus of case studies on the richness and depth of phenomenon, which allows new ideas and interpretations of the phenomenon to arise. This allows the event to be defined broadly rather than narrowly (Eisenhardt, 1989; Perry, 2004).

2. When the social organisational settings are detailed and complicated, a case-study design is appropriate because case-study research examines intricacies, processes, roles and changes of an organisation, as well as the relationship between the person and the setting (Kaplan, 1986; Parkhe, 1993).

3. When the researcher is seeking contextual meaning within a bounded system, case-study research is appropriate because it examines a phenomenon as it occurs in its natural setting (Bonoma, 1985; Perry, 2004; Stake, 1978; Yin, 2014).

4. When the research aims for inductive theory building as previously discussed in this section.

Examining the extent of IPV-related content in the UG nursing, midwifery and paramedicine degrees, and their adoption of national and international organisations and committees’ guidelines and recommendations is a contemporary issue that requires inductive theory building rather than theory testing and verification. Additionally, given that this is a contemporary issue that has received minimal research attention, a thorough understanding of this topic is required, including creating understanding of the experiences and beliefs of the people at the forefront of this topic (academics teaching UG HCP students), along with the processes, roles and changes that are connected to the research problem. Given that this is the context of the research, the phenomena under investigation cannot be separated from their natural setting, and need to be examined within this setting. However, the researcher remained
objective as possible while remaining value aware (Perry et al., 1997). Finally, the current study focused on underlying causal tendencies such as the reasons and rationales that are connected to including or excluding IPV-related content in the HCP degrees discussed, and achieved an understanding of this information through the use of data triangulation.

This section has highlighted and discussed the four paradigms of positivism, constructivism, critical theory and realism. Each paradigm was discussed as it relates to the current study, arriving at the conclusion that the realism paradigm is best suited to this study. Quantitative, qualitative and mixed-methods research will now be discussed with justifications provided for this study’s adoption of a mixed-methods approach.

### 4.3 Justification for Mixed-methods Research Design

After having selected the realist paradigm for this study, the following step was to consider the study’s methodology. In health-care research, quantitative, qualitative and mixed-methods research studies have been conducted. Typically, there are two types of methodology: quantitative and qualitative, but a third methodological movement has now occurred; that being mixed-methods research (Tashakkori & Teddlie, 2003). This section will present the characteristics of quantitative, qualitative and mixed-methods research and will conclude by providing justifications for adopting the mixed-methods approach.

Quantitative and qualitative research methodologies have some aspects in common. They both rely on research expertise, ensure rigour in their studies and generate scientific knowledge (Grove, Gray & Burns, 2015). They also complement each other because they generate different forms of knowledge (Grove et al., 2015). However, there are many differences between these two methodologies, which are summarised in Table 4.2.
### Table 4.2

**Differences in Quantitative and Qualitative Research**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Quantitative</th>
<th>Qualitative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Philosophical origin</td>
<td>Logical positivism</td>
<td>Naturalistic, interpretive, humanistic</td>
</tr>
<tr>
<td>Focus</td>
<td>Concise, objective, reductionist; tests specific hypotheses</td>
<td>Broad, subjective, holistic; examines breadth and depth of phenomena</td>
</tr>
<tr>
<td>Reasoning</td>
<td>Logical, deductive</td>
<td>Dialectical, inductive</td>
</tr>
<tr>
<td>Basis of knowing</td>
<td>Cause-and-effect relationships; description, explanation, prediction</td>
<td>Meaning, discovery, understanding</td>
</tr>
<tr>
<td>Theoretical focus</td>
<td>Tests theory</td>
<td>Develops theory and frameworks</td>
</tr>
<tr>
<td>Researcher involvement</td>
<td>Control</td>
<td>Shared interpretation</td>
</tr>
<tr>
<td>Nature of study</td>
<td>Artificial, controlled conditions</td>
<td>Natural environment</td>
</tr>
<tr>
<td>Form of data collected</td>
<td>Numeric data using structured and validated instruments</td>
<td>Narrative data using semi-structured or unstructured instruments</td>
</tr>
<tr>
<td>Nature of data</td>
<td>Numeric variables</td>
<td>Words, themes, images and categories</td>
</tr>
<tr>
<td>Data analysis</td>
<td>Statistical relationships</td>
<td>Holistically identifies patterns, categories and themes</td>
</tr>
<tr>
<td>Results</td>
<td>Generalisability; general understanding of respondents’ viewpoint; researcher-framed results</td>
<td>Particularistic findings; in-depth understanding of respondents’ viewpoint; respondent-framed results</td>
</tr>
<tr>
<td>Final report</td>
<td>Statistical report including correlations, comparisons of means and statistically significant findings</td>
<td>Narrative report including contextual description, categories, themes and respondent quotations</td>
</tr>
</tbody>
</table>

*Sources*: Gerrish and Lathlean (2015); Grove et al. (2015); Johnson and Christensen (2004)

### 4.3.1 Quantitative research

Quantitative research, referred to as the scientific or empirical method, refers to a formal, objective, systematic process that emerged from logical positivism and operates on the rules of logic, truth, laws and predictions. For quantitative researchers, truth is absolute and a single reality exists, and can be defined by careful measurement (Gerrish & Lathlean,
This measurement is created in the form of numbers, and involves measuring variables that are qualities, properties or characteristics of persons, things or situations that change or vary (Jirojwong, Johnson & Welch, 2014). Quantitative researchers also control for variables that may introduce bias in the study. One such bias that can enter research and adversely affect the validity of results is the values, feelings and personal perspectives of the researcher. For this reason, the researcher must remain objective and not allow their values to enter the research process (Grove et al., 2015; Jirojwong et al., 2014). The aim of quantitative research is to test theory by describing variables (descriptive research), examining relationships among variables (correlational research), and examining cause-and-effect relationships between variables (quasi-experimental and experimental research) (Groves et al., 2015; Jirojwong et al., 2014). Quantitative researchers achieve this by manipulating the numerical data statistically to confirm or refute hypotheses (Gerrish & Lathlean, 2015). Consistent with the other methodologies, quantitative research has strengths and limitations. These are outlined in Table 4.3.
Table 4.3

Strengths and Weaknesses of Quantitative Research

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tests and validates existing theories</td>
<td>These data do not provide information on the participants’ understanding</td>
</tr>
<tr>
<td>Hypotheses are formed before data collected</td>
<td>Underlying theories might not be useful or reflect the understanding of the participants</td>
</tr>
<tr>
<td>Replication in different settings</td>
<td>Focuses on hypothesis testing, not hypothesis generation</td>
</tr>
<tr>
<td>Generalisation to larger populations</td>
<td>Knowledge may be applicable only to that particular setting, context or individual</td>
</tr>
<tr>
<td>Researcher can decrease confounding Factors</td>
<td>Studies what occurs under experimental conditions, rather than the real world</td>
</tr>
<tr>
<td>Theory can be generated deductively</td>
<td>Does not allow people to speak in their own Words</td>
</tr>
<tr>
<td>Data collection is rapid</td>
<td>Ignores the complex, contingent and context-sensitive aspects of social life</td>
</tr>
</tbody>
</table>

Adapts to various researcher abilities
Can study large numbers of people

Sources. Jirojwong et al. (2014); Hammersley (2013).

4.3.2 Qualitative research

Qualitative research derives from the interpretivist tradition in which truth is considered complex and dynamic and can be discovered only by studying people as they interact in their natural setting (Creswell, 2014; Munhall, 2012). Consistent with this tradition, qualitative researchers believe that multiple realities exist because each person has their own perspective on life and these perspectives can change depending on people’s experiences (Jirojwong et al., 2014). The central aim of qualitative research according to Jirojwong et al. (2014) is to develop ‘an understanding of how human beings construct and make sense of the everyday world in which we live’ (p. 99). Generating this understanding is more important than testing hypotheses to qualitative researchers. A flexible, inductive research design is thus needed, rather than the detailed plan that is developed for quantitative research. Unstructured data are collected in qualitative research in forms such as observations and field notes, rather
than through the counting, ranking or measuring that occur in quantitative research (Hammersley, 2013; Yin, 2014). Further, qualitative researchers understand the importance of multiple sources of evidence, rather than just relying on one source of evidence. This triangulation leads to creating converging lines of enquiry (Yin, 2014).

Contrary to what occurs with quantitative research, the personal and social characteristics of the researcher influence the research process, and the phenomenon under research is investigated as it occurs in its natural setting (Hammersley, 2013; Jirojwong et al., 2014). Further, qualitative research examines a small number of naturally occurring cases to conduct an in-depth examination, and obtain verbal descriptions and interpretations (Hammersley, 2013). The findings of these interpretations are presented in a literary style, and include the descriptions and expressions of the participants (Jirojwong et al., 2014). Examples of qualitative research methods include phenomenology, grounded theory, ethnography, historical research and case-study research (Grove et al., 2015). Qualitative research also has strengths and weaknesses, and these are summarised in Table 4.4.
Table 4.4

*Strengths and Weaknesses of Qualitative Research*

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants’ meaning constitutes these data collected</td>
<td>Lack of generalisability to other populations or settings</td>
</tr>
<tr>
<td>In-depth study of a limited number of cases can be achieved</td>
<td>Difficult to test hypotheses and theories</td>
</tr>
<tr>
<td>Can describe complex phenomena</td>
<td>Time-consuming data collection and analysis</td>
</tr>
<tr>
<td>Useful when limited prior research has been conducted</td>
<td>Researcher influences data collection and analysis</td>
</tr>
<tr>
<td>Examines dynamic situations</td>
<td>Results can be influenced by researcher’s personal biases</td>
</tr>
<tr>
<td>Explores patterns of change</td>
<td></td>
</tr>
<tr>
<td>Identifies contextual and setting factors that may influence the findings</td>
<td></td>
</tr>
<tr>
<td>Changes can occur during the research process</td>
<td></td>
</tr>
<tr>
<td>A course of an event can be determined</td>
<td></td>
</tr>
<tr>
<td>Generates theory inductively</td>
<td></td>
</tr>
</tbody>
</table>

*Source.* Jirojwong et al. (2014)

### 4.3.3 Mixed-methods research

As stated, Tashakkori and Teddlie (2003) class mixed-methods research as the third methodological movement. Mixed-methods research refers to when the researcher combines quantitative and qualitative data-collection and data-analysis methods in one study. This integration of approaches is the important factor of mixed-methods research (Gerrish & Lathlean, 2015; Jirojwong et al., 2014). Green, Caracelli and Graham (1989) identify the following five purposes of conducting mixed-methods research:

1. Triangulation—this refers to studying phenomena using different methods, which results in convergence and corroboration of results. Triangulation strengthens the validity of the study because the quantitative and qualitative methods both have strengths and weaknesses, but when used together, the weaknesses can be overcome, thus increasing the validity of the results.
2. Complementarily—this seeks elaboration, enhancement, illustration and clarification of the results from one method with the results of the other method. For example, conducting interviews to clarify or explain findings obtained via a survey (Jirojwong et al., 2014). This increases the interpretability, meaningfulness and validity of the constructs and results by capitalising on the strengths of each method and counteracting the weaknesses.

3. Development—this refers to using one method to inform or develop the other method.

4. For example, conducting interviews to help develop a survey (Jirojwong et al., 2014). This increases the validity of constructs and results by taking advantage of each method’s strengths.

5. Initiation—this refers to looking for paradoxical or contradictory findings, new perspectives, or redesigning the research questions. This increases the breadth and depth of the enquiry, results and interpretations.

6. Expansion—this refers to increasing the breadth and range of enquiry by using the different methods to examine different enquiry components. For example, qualitative methods can be used to examine programme processes, while quantitative methods can evaluate programme outcomes.

A great deal of research has examined the rationale behind combining quantitative and qualitative research. For example, Bryman (2006) discovered 16 rationales for mixed-methods research: triangulation; offsetting the weaknesses and promoting the strengths of each method; completeness of investigations; process of examining different aspects of the construct; different research questions can be asked and answered; greater explanation of phenomena; unexpected results can be explained by adopting another method; instrument development can occur; sampling enhancement; increased credibility; contextual understandings of the findings can be discovered; illustration of quantitative data by qualitative research; improvement of the usefulness of the findings; confirmation and
discovery occurs in one study; diversity of views are offered; and enhancement of results occur. Overall, mixed-methods research offers a richer explanation than either quantitative or qualitative research alone, and draws on the strengths of each method, while decreasing the weaknesses (Jirojwong et al., 2014).

Mixed-methods designs can be classified according to three criteria: 1) timing (sequence); 2) weighting (dominance) and 3) mixing (integration) of quantitative and qualitative methods (Gerrish & Lathlean, 2015). In timing, there are two designs: concurrent and sequential. A concurrent mixed-methods study refers to a one-phase study in which quantitative and qualitative methods are conducted simultaneously. The results of this concurrent mixed-method study are a combination of both methods (Jirojwong et al., 2014), as illustrated in Figure 4.2.

Sequential mixed-methods studies have two distinct phases conducted in different timeframes. One method is conducted before the next, and the first phase informs and shapes the second phase. One of phase one or two can be dominant, or they can be of equal status (Jirojwong et al., 2014). As these components are separate, they stay true to their own paradigm and methodology (Gerrish & Lathlean, 2015). The sequential mixed-methods design is illustrated in Figure 4.3.

**Source.** Adapted from Jirojwong et al. (2014)

**Figure 4.2.** Concurrent mixed-methods design.
For the weighting (dominance) design criteria, the researcher must determine whether one method will be dominant, and the other supplementary or complementary, or whether both methods will be equal in status (Gerrish & Lathlean, 2015). The final criterion, integration, adds value to the research. Integration can occur at one stage or in many stages of the research process. Data should be analysed separately but then integration should occur at the interpretation stage (Gerrish & Lathlean, 2015).

Although the principal advantage of the mixed-methods approach is counteracting the weaknesses of each method while promoted the strengths of each method, there is criticism of this approach. First, critics state that philosophical incongruity exists between positivism and its focus on objective truth and interpretivism and its claim of multiple realities. Second, critics believe that mixing methods only compounds the sources of error inherent in each strategy. Third, critics’ question how quality can be judged if competing traditions are used (Gerrish & Lathlean, 2015). To counteract these arguments, mixed-methods researchers acknowledge the challenges inherent in this approach, including the requirement of expertise and skill, the need for a multidisciplinary or interdisciplinary team, and the difficulties in maintaining quality in this type of research (Gerrish & Lathlean, 2015). A summary of the key elements of the mixed-methods approach is presented in Table 4.5.
Table 4.5

Summary of Key Elements of Mixed-methods Research

<table>
<thead>
<tr>
<th>Scientific method</th>
<th>Deductive and inductive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most common research objectives</td>
<td>Multiple objectives</td>
</tr>
<tr>
<td>Focus</td>
<td>Multi-lens</td>
</tr>
<tr>
<td>Nature of study</td>
<td>More than one setting or condition</td>
</tr>
<tr>
<td>Form of data collected</td>
<td>Multiple forms</td>
</tr>
<tr>
<td>Nature of data</td>
<td>Mixture of numeric variables, words and Images</td>
</tr>
<tr>
<td>Data analysis</td>
<td>Statistical and holistic</td>
</tr>
<tr>
<td>Results</td>
<td>Corroborated findings that may be Generalizable</td>
</tr>
<tr>
<td>Final report</td>
<td>Statistical findings with in-depth narrative description and identification of overall themes</td>
</tr>
</tbody>
</table>


To justify the adoption of the mixed-methods approach for this study, Green et al.’s (1989) five purposes of conducting mixed-methods research are used:

1. triangulation—this study adopts a three-phase study design, utilising quantitative and qualitative research approaches within a case-study design

2. complementary—the second phase (the online survey) is used to clarify the findings from the content analysis of phase one; the interviews in phase three clarify the findings of the online survey

3. development—the results of the second phase (the online survey) are used to help develop the probing questions of the third-phase interviews

4. initiation—each phase of this study, and thus each quantitative and qualitative method used, is conducted to find supporting or contradictory findings or new perspectives of the phenomena under investigation

5. expansion—the quantitative methods adopted for this study examined enquiry components such as the inclusion or exclusion of IPV-related content in the curricula of HCP degrees, the number of hours dedicated to teaching this content, the frequency
with which certain teaching methods are used and content areas are adopted. The qualitative method was then used to expand these findings by enquiring why academics include or exclude this content in their units, what their beliefs and attitudes are in relation to the inclusion of this content, and their knowledge of national and international organisations and committees’ recommendations and guidelines on the inclusion of IPV-related content within HCP degrees.

This section has presented the characteristics of quantitative, qualitative and mixed-methods research, and has described that after careful consideration, the mixed-methods approach was adopted for this study because it fulfils the five purposes of conducting mixed-methods research as stated by Green et al. (1989). In the following section, case-study research will be defined and justification for the selection of a case study as the research method will be provided.

### 4.4 Defining and Justifying the Use of Case-study Research

After the decision was made to adopt the realism paradigm and the mixed-methods research approach, the next decision was to determine the research design for the current study. A case-study design, with its ability to be both descriptive and exploratory, was selected as the method of choice for this research. The multiple methods of data collection that underpin this method are suitable to promote a full understanding of the chosen Australian curricula and how IPV-related content is presented in these curricula, thus allowing the phenomenon under research to be understood in its natural context (Yin, 2014). The principal objective of this research is discovery rather than confirmation, aiming to gain a holistic and meaningful coverage of the real-life event under investigation (Burns, 2000). This means that exploration is necessary to determine the extent of coverage of IPV-related content in the curricula under examination, to identify the units in which this content is covered, why or why not this topic is covered, how it is taught, and whether there is adherence to national and international organisations and committees’ guidelines and recommendations. As the
main questions of this exploration include ‘how’ and ‘why’ questions, the guidelines stipulated by Yin (2014) guide this research effectively. The features of this case-study design will now be presented, followed by the justification for its selection.

4.4.1 What is case-study research?

Case-study research is defined as ‘an empirical inquiry that investigates a contemporary phenomenon in depth and within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident’ (Yin, 2014, p. 16). Case-study research is conducted when a researcher cannot take the phenomenon away from its context because the context is paramount to understanding the phenomenon. This is in contrast to experimental research, which purposely separates the phenomenon from its context to manipulate the variables under study (Yin, 2014). In the current research, the IPV-related content in a degree cannot be readily distinguishable from the university in which it is delivered because each degree has a different curriculum at each university.

The strength of case-study research is that multiple sources of evidence converge in a triangulating fashion, subsequently forming a chain of evidence without losing the natural setting (Yin, 2014):

the case study inquiry copes with the technically distinctive situation in which there will be many more variables of interest than data points, and as one result relies on multiple sources of evidence, with data needing to converge in a triangulating fashion, and as another result benefits from the prior development of theoretical propositions to guide data collection and analysis. (Yin, 2014, p. 17)

Another advantage of case-study research is that it is not limited to one case study. Multiple case studies can be researched within the one study (Yin, 2014). Additionally, case-study research is not sampling research. Therefore, examining multiple cases such as all the nursing, midwifery and paramedicine degrees in all universities throughout Australia was
required because sampling one university is unlikely to create strong representativeness with other universities (Stake, 1995, p. 4).

According to Yin (2014), case-study research is not confined to the qualitative research or quantitative research methods. A mixture of qualitative and quantitative evidence can be collected in case-study research (Burns, 2000; Yin, 2014), making it consistent with employing the mixed-methods approach. Case-study research involves a rigorous methodological process, beginning with a literature review and the development of succinct research questions or objectives. Following this development, procedures are instigated to ensure the validity of the research, a chain of evidence is maintained and the exploration of rival explanations is performed (Yin, 2014). As Stake (2000) states:

Case study is not a methodological choice but a choice of what is to be studied. By whatever methods, we choose to study the case. We could study it analytically or holistically, entirely by repeated measures or hermeneutically, organically or culturally, and by mixed methods—but we concentrate at least for the time being, on the case (p. 435).

This method of empirical enquiry has been used to examine individual, group, organisational, social, political and other related phenomena, and has been used extensively in subject areas relevant to psychology (e.g., Hersen & Barlow, 1976), sociology (e.g., Hamel, 1992; Ragin & Becker, 1992), political science (e.g., George & Bennett, 2004; Gerring, 2004), social work (e.g., Gilgun, 1994), education (e.g., Yin & Davis, 2006), and public health (e.g., Pluye, Potvin, Denis, Pelletier & Mannoni, 2005). Given that the current study is related to HCP education on a major public-health issue, the case-study approach was an appropriate method to utilise (Stake, 1995, p. 1). It was also useful because the case-study method leads to an understanding about the development and circumstances of the entities (i.e., the HCP UG degrees) under study (Polit & Beck 2011).
4.4.2 Justifying the use of case-study research

Whether to implement a case-study approach to a research project can be determined by considering three conditions: 1) the type of research question; 2) the extent of control the researcher has over behavioural events; 3) whether the focus is on contemporary or historical events (Yin, 2014). This is highlighted in Table 4.6 below (the bold text emphasises why that particular research method was not selected for this study).

Table 4.6

Selecting the Appropriate Research Method

<table>
<thead>
<tr>
<th>Research Method</th>
<th>Type of Research Question</th>
<th>Requires Control of Behavioural Events?</th>
<th>Focuses on Contemporary Events?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experiment</td>
<td>How, why?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Survey</td>
<td>Who, what, where, how many, how much?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Archival analysis</td>
<td>Who, what, where, how many, how much?</td>
<td>No</td>
<td>Yes/No</td>
</tr>
<tr>
<td>History</td>
<td>How, why?</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Case study</td>
<td>How, why?</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Source: Yin (2014, p. 9)

4.4.2.1 Type of research question

Research questions can be categorised as ‘who’, ‘what’, ‘where’, ‘how’ or ‘why’ questions and the category of question can direct the researcher to the best type of research method to use. ‘What’ questions are usually used for exploratory studies or can be termed in another way, such as ‘how many’ or ‘how much’ to use survey or archival methods (Yin, 2014). Likewise, ‘who’ and ‘where’ research questions (or termed another way ‘how many’ and ‘how much’) favour survey or archival methods and are commonly used to describe the prevalence or incidence of a phenomenon. Explanatory methods are commonly employed when the research question is addressing the ‘how’ or ‘why’ of a phenomenon, and this type of research employs methods such as case studies, histories and experiments (Yin, 2014).
4.4.2.2 Extent of control over behavioural events and focus on contemporary events

According to Yin (2014), if the research question is designed as a ‘how’ or ‘why’ question, then the researcher must decide between the history, case-study or experimental approach. The extent of control over the behavioural events to be researched varies between these three approaches. Historical research is preferred when the researcher has no access to or control over the events under study. Usually, some people involved in a historical study are no longer alive, and the researcher must rely on primary and secondary documents, and cultural and physical artefacts as the evidence for their study (Yin, 2014). In contrast, in the experimental approach, the researcher aims to control and manipulate the behaviour under investigation ‘directly, precisely and systematically’ (Yin, 2014, p. 12), and focuses on contemporary events. Finally, the case-study approach also focuses on contemporary events, but fails to have control over the behavioural events under investigation. The case-study approach incorporates the same evidence as historical research (primary and secondary documents and cultural and physical artefacts) but also integrates direct observation of events, as well as interviews of the people directly involved in the behavioural event (Yin, 2014). Although these research approaches have been dissected as individual approaches, it is important to remember that multiple methods can be used within the same study (e.g., a survey within a case study) (Yin, 2014).

Therefore, it is best to use a case-study approach when three conditions are met (Yin, 2014):

1. a ‘how’ or ‘why’ research question is to be answered
2. no researcher control of the behavioural event is needed or wanted
3. the focus is on contemporary events.

The following are identified as the reasons other research methods were inconsistent with the aims of this research. The experimental design could not be used because it requires control over the behavioural events under investigation, which is not possible or relevant for
the phenomena under investigation in this research study. The survey and archival analysis approaches were not consistent with the research questions being asked because the research questions aim for higher level explanatory results, and are thus not phrased as a ‘who’, ‘what’, ‘where’, ‘how many’ or ‘how much’ questions, which are answered by these two approaches (Yin, 2014). Finally, the historical approach is not relevant because the phenomena under investigation are current trends in IPV-related content inclusion in nursing, midwifery and paramedicine curricula, rather than examining previous curricula (Yin, 2014).

This section has provided a definition of case-study research, as well as an explanation of the key strengths of this research design. Justifications for the use of case-study research were provided, including the relevance of the study asking of ‘how’ or ‘why’ questions, the fact that no control is required over behavioural events, and that the focus is on contemporary events. In the following section, the five components of the case-study research design are defined.

### 4.5 Case-study Research Design

Now that the use of the mixed-methods design and case-study approach has been justified, the components that constitute a case-study research design are now explained. In case-study research, the research design constitutes a plan that directs the researcher in the process of collecting, analysing and interpreting observations. This design allows the researcher to ‘draw inferences concerning causal relations among the variables under investigation’ (Frankfort-Nachmias & Nachmias, 1992, p. 77–78). The case-study research design adopted for this study is based on the principles of Yin (2014) because these principles are the most recognised for case-study research design internationally (Gerrish & Lacey, 2010). Based on Yin’s (2014, p. 29) principles, the research design consisted of five components:

1. research questions
2. propositions
3. unit of analysis
4. logical connection of the data to the propositions
5. criteria for interpreting the findings.

4.5.1 Research questions and propositions

According to Yin’s (2014) guidelines, the first component—the research questions—need to be framed as ‘how’ or ‘why’ questions. Second, the study should include propositions that are statements that direct the researcher and provide direction for the study (Yin, 2014). After an extensive literature review was conducted, six research questions and research propositions were formulated and can be found in Sections 3.8.4 and 3.8.5.

4.5.2 Unit of analysis

The third component of the research design is the unit of analysis or ‘case’, which should include what is and is not included in the research, and the specific time boundaries within which the factors will be examined (Yin, 2014). The unit of analysis or the ‘case’ in this study is the individual degrees at each university at which they are offered. For example, the BN degree at the Southern Cross University represents as case, as does the BM at the Australian Catholic University. The time boundaries of each case are from the beginning of the UG degree to the end of the UG degree, irrespective of whether the student is enrolled full time or part time. Additionally, the participating universities, and thus the cases, deliberately represented large and small universities that were geographically distributed across Australia.

Yin (2014) states that differences in the definition and actors, along with the components that pre-existed the formal designation need to be acknowledged (p. 30). Given the ‘case’ in this study is an UG university degree, this study acknowledges that during the data-collection phases, it was a possibility that curricula changes occurred from the old curriculum to the new curriculum, thus if this occurred, these changes were classed as two separate cases. For example, case one is the BN (old curriculum) at Southern Cross University, and case two is the BN (new curriculum) at Southern Cross University. Further,
mid-term evaluations of the curriculum might have occurred, and these are noted in the findings. Finally, a unit under examination may have had different unit coordinators (or equivalent) from year to year, again, this study is aware of this; however, as the phenomena under investigation were occurring in the natural setting, no control over this situation is possible.

4.5.3 Connecting data to propositions

This fourth component of Yin’s (2014) research design indicates the data-analysis steps in the case study. Linking the data to the propositions involves the use of analytic techniques, and according to Yin (2014), the following five analytic techniques can be chosen for case-study analysis: pattern matching, explanation building, time-series analysis, logic models, and cross-case synthesis (Yin, 2014, p. 36). The data-analysis techniques used in this case study were explanation building and cross-case synthesis.

Explanation building is an analytic technique used in this case study because the aim of the study is to build an explanation of why the UG curricula of nursing, midwifery and paramedicine are or were not including IPV-related content, and whether these degrees are adhering to the national and international health organisations and committees’ guidelines and recommendations on the inclusion of this content. The how and why research questions, which are essential for case-study research, enabled creating an explanation for ‘why’ or ‘why now’ this inclusion and adherence is occurring (Yin, 2014). According to Walton (1992), case studies ‘are likely to produce the best theory’ (p. 129). To analyse case-study data via the explanation-building approach, repetition of the process is key. For example, in this study, a proposition was developed for the research question, and then findings from the initial case were compared against this proposition. Revision of the proposition occurred and changes were made if necessary, and these remaining data from the initial case were then compared against this revised proposition. If this revised proposition was correct, then the remaining cases were then compared against this proposition; this cyclic approach continued as many
times as necessary (Yin, 2014, p. 149). To aid in this analysis, a case-study protocol (indicating the data to be collected) and a case-study database (which stored the entire array of data that were collected) were developed for each case and the chain of evidence was followed (Yin, 2014, p. 150).

The second type of analytic technique used in this case study was cross-case synthesis because multiple cases were incorporated into this study. This multiple-case-study method is discussed in Section 4.6. This technique treats each case as if it were its own study, and findings are aggregated across the series of individual cases to explain the phenomenon under investigation (Yin, 2014). This technique incorporates the use of word tables that display these data from each individual case in relation to the particular research question being examined. Not only was each research question examined across multiple cases using these word tables, but the entire collection of word tables was analysed to draw cross-case conclusions about the curricula of nursing, midwifery and paramedicine. This enabled the different curricula to be compared against each other to distinguish similarities and differences in the amount of IPV-related content included in the degrees, along with the teaching methods utilised, the content covered, and the units in which this content is included. Additionally, the way these disciplines adhere to the national and international health organisations and committees’ guidelines and recommendations for including IPV-related content in their curricula was also compared for similarities and differences.

4.5.4 Criteria for interpreting a study’s findings

It is also extremely important in case-study research to articulate rival explanations and address them to strengthen the study’s findings. Addressing these rival explanations becomes the criterion for interpreting the study’s findings (Yin, 2014). The more rival explanations that are developed and rejected, the stronger the results become. Specifying these rival explanations at the beginning of the study is important and should therefore be part
of the case study’s research design (Yin, 2014, p. 36). Therefore, as part of this study’s design work, the following rival explanations were developed:

Rival explanation 1: IPV-related content within the UG nursing, midwifery and paramedicine degrees will be minimal because of the higher percentage of female academics in academia and a lack of exposure to survivors or perpetrators of IPV.

Rival explanation 2: IPV-related content is integrated throughout the UG curricula of nursing, midwifery and paramedicine as this content is part of the core units rather than elective units.

Rival explanation 3: There will be no consistency in the units in which IPV-related content is included within as it will be at the discretion of the academic as to whether to include this content or not within the unit they are responsible for.

Rival explanation 4: IPV-related content will be taught employing a variety of teaching methods, including clinical placement, and students will be taught health-related practices related to IPV, including screening and detection methods and communication techniques.

Rival explanation 5: Academics who include IPV-related content in their units are those who are knowledgeable and passionate about this topic. Academics who fail to include this content will be those that fail to adapt their work to include current health priorities and public-health issues, and those that fail to incorporate content experts into their teaching team.

Rival explanation 6: Academics are aware of national and international organisations and committees’ guidelines and recommendations regarding the inclusion of IPV-related content in UG HCP degrees, and are as
such adhering to them by doing so into their units.

This section has highlighted the five components of a case-study research design, and provided details about how each of these components has been applied to the current study. In the following section, the types of case-study designs are discussed, and the design selected for this study is presented. Further, the replication process will be discussed and applied to the current study.

4.6 Types of Case-study Designs

Now that the case-study research design has been developed, the next step in the process is to decide on the type of design that will be used. There are four types of designs from which to choose. These will be discussed and the rationale for choosing a multiple-case (holistic) research design will be presented.

There are four types of case-study designs: 1) single-case (holistic); 2) single-case (embedded); 3) multiple-case (holistic); 4) multiple-case (embedded) (Yin, 2014, p. 50). Given that this research is a multiple-case-study design, the first two types of designs are irrelevant. This case study is a multiple-case (holistic) design because it has only a single unit of analysis, rather than multiple units of analysis, as outlined in Section 4.5.2. Further, this study examined each individual degree (case) holistically, which further highlights the holistic nature of this multiple-case-study design. Finally, given that one of the aims of this study is to compare IPV-related content inclusion across degrees, it needs to be a holistic design because the results from embedded designs cannot be pooled across cases (Yin, 2014).

The cases incorporated into a multiple-case-study design are chosen to either predict similar results to each other (literal replication) or to predict contrasting but expected results (theoretical replication). It is important for the replication process to develop a theoretical framework that states the conditions under which a particular phenomenon is likely to be found (a literal replication), and the specific conditions under which it is not likely to be found (a theoretical replication). This will allow for generalisation to new cases (Yin, 2014, p. 57).
This process of replication involves each individual case being classed as an entire study in which convergent evidence is sought; each case’s conclusions then become the information needing replication by other individual cases (Yin, 2014). In the current study, it was anticipated that multiple phases would need to be conducted to gather the information required to answer all the research questions, and to demonstrate whether the propositions were correct. By conducting multiple phases, this replication logic remained intact for the current study.

The results from multiple-case-study designs are considered stronger, robust and more compelling when compared to the results of a single-case design. However, they require extensive amounts of resources and time to complete (Yin, 2014). Therefore, a Doctor of Philosophy (PhD) degree was an appropriate degree through which to complete this multiple case study because four years were dedicated to acquiring the many resources and conducting the multiple phases of the case study.

This section has explained that there are four types of case-study research designs, and the one chosen for this study was the multiple-case (holistic) design. The replication process was discussed and applied to the current study. Finally, the benefits and limitations of multiple-case-study designs were emphasised. The following section discusses the quality of case-study research designs, as well as the issues of construct validity, internal validity, external validity and reliability.

4.7 Quality of Case-study Research Designs

To ensure case-study research is of the highest quality, it is essential to employ the following four tests that are commonly used to assess the quality of any empirical social research (Yin, 2014, p. 45): construct validity, internal validity, external validity and reliability. Each one of these is addressed with an explanation of the tactics that were employed by this study to ensure the tests were successful. Table 4.7 provides an overview of the case-study tactics for high-quality case-study research designs.
Table 4.7

Case-study Tactics for High-quality Research Designs

<table>
<thead>
<tr>
<th>Tests</th>
<th>Case-study tactic</th>
<th>Phase of research in which tactic occurs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Construct validity</td>
<td>Use multiple sources of evidence</td>
<td>Data collection</td>
</tr>
<tr>
<td></td>
<td>Establish chain of evidence</td>
<td>Data collection</td>
</tr>
<tr>
<td></td>
<td>Have key informants review draft case-study report</td>
<td>Data collection</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Composition</td>
</tr>
<tr>
<td>Internal validity</td>
<td>Use pattern matching</td>
<td>Data analysis</td>
</tr>
<tr>
<td></td>
<td>Use explanation building</td>
<td>Data analysis</td>
</tr>
<tr>
<td></td>
<td>Address rival explanations</td>
<td>Data analysis</td>
</tr>
<tr>
<td></td>
<td>Use logic models</td>
<td>Data analysis</td>
</tr>
<tr>
<td>External validity</td>
<td>Use theory in single-case studies</td>
<td>Research design</td>
</tr>
<tr>
<td></td>
<td>Use replication logic in multiple case studies</td>
<td>Research design</td>
</tr>
<tr>
<td>Reliability</td>
<td>Use case-study protocol</td>
<td>Data collection</td>
</tr>
<tr>
<td></td>
<td>Develop case-study database</td>
<td>Data collection</td>
</tr>
</tbody>
</table>

Source. Yin (2014, p. 45)

4.7.1 Construct validity

Construct validity is defined as ensuring the ‘correct operational measures for the concepts to be studied’ (Yin, 2014, p. 46). To increase the construct validity of this case-study research, three tactics were employed: using multiple sources of evidence to promote convergent lines of enquiry; establishing the chain of evidence; having key informants review the draft case-study findings and discussion (Yin, 2014).

4.7.2 Internal validity

The second test employed to ensure this case study was of the highest quality was internal validity. Internal validity is defined as ‘seeking to establish a causal relationship, whereby certain conditions are believed to lead to other conditions, as distinguished from spurious relationships’ (Yin, 2014, p. 46). This study increased its internal validity by having
rival explanations clearly articulated and addressed, by using multiple sources of evidence, by employing explanation building (Yin, 2014).

### 4.7.3 External validity

It is important for research to ask whether the results of a study can be generalised beyond the study to other settings. The test of external validity addresses this question. External validity is classified as ‘defining the domain to which a study’s findings can be generalised’ (Yin, 2014, p. 46). It is often stated that case-study research lacks generalisability, and that this is a major flaw of this type of research. However, critics are often referring to statistical generalisation, rather than analytic generalisation, which is what case-study research relies on (Yin, 2014). Analytic generalisation differs from statistical generalisation because it aims to generalise a particular set of results (obtained from the case study) to that of a broader theory. Therefore, analytic generalisation refers to theory building, rather than to theory testing (Healy & Perry, 2000).

To overcome any problems with external validity, it is extremely important for multiple-case-study designs to adopt replication logic. This refer to the theory under investigation being further tested by duplicating the findings in a second case, then a third case, then for as many cases as are involved in the study, with the same results being obtained (Yin, 2014). If the same results are obtained from these multiple cases, then the results provide strong support for the theory being tested and external validity is upheld (Yin, 2014). Therefore, the current study implemented replication logic in its multiple-case-study design.

External validity was further enhanced in this study through several techniques. Research issues were identified before data collection through conducting a comprehensive literature review that ensured the study was based on sufficient prior theory (Perry, 2013). How and why research questions were developed (Yin, 2014), cases were carefully selected, and the researcher was knowledgeable and experienced in the research topic (Sekaran, 2009). Further, an interview protocol was developed to provide data that would confirm or
disconfirm prior theory (Healy & Perry, 2000). Finally, the findings were assessed against findings from previous studies (Yin, 2014).

4.7.4 Reliability

The last test to ensure the quality of data collected in case-study research is that of reliability. Reliability demonstrates that the ‘operations of a study, such as the data-collection procedures, can be repeated, with the same results’ (Yin, 2014, p. 46). To ensure the reliability of a study, it is important to ensure that if another investigator completed the same study of the same cases, they would be able to repeat the procedures undertaken in the study and arrive at the same results. For this to occur, it is important to use a case-study protocol to clearly document the procedures undertaken and to develop a case-study database (Yin, 2014).

A case-study protocol is essential for a multiple-case-study research design because it provides a guide to data collection from each individual case involved. It ensures the researcher remains on the topic of enquiry and helps to identify potential problems with data collection before they occur (Yin, 2014). The case-study protocol should contain the following four sections: an overview of the case-study project; an overview of the field procedures; the case-study questions; a guide for the case-study report (Yin, 2014). A case-study protocol was developed for the current study to ensure reliability. A case-study database was also developed for the current study, and will be explained further in Section 4.8.1.2.

As stated, the four tests for quality case-study research designs were employed and adhered to in the current study. The tactics applied and the corresponding phases of the research in which they were used have also been highlighted. In the following section, common case-study data-collection methods are presented and the four principles of data collection are discussed. Each of these four principles relate to the construct validity and reliability of the case study.
4.8 Case-study Data-collection Methods

Given that the components of the research design have been determined, the type of research design chosen and the quality of the research design enhanced, the following step is the collection of case-study evidence. Case-study evidence may be obtained from a variety of sources; however, the six principal sources of evidence for this type of study are documentation, archival records, interviews, direct observation, participant observation and physical artefacts (Yin, 2014). Data-collection methods usually evolve as preliminary findings require further understanding (Yin, 2014). Before discussing the data-collection methods employed in this study, the principles of data collection according to Yin (2014) will be reviewed. Each of these principles has been adhered to in this study.

4.8.1 Principles of data collection

To counteract the issues of construct validity and reliability discussed in Section 4.7, the following four principles of data collection need to be adhered to when conducting case-study research (Yin, 2014):

1. use of multiple sources of evidence
2. creation of case-study database
3. maintenance of chain of evidence
4. exercise care when using data from electronic sources.

4.8.1.1 Use of multiple sources of evidence

Data triangulation refers to the use of multiple sources of data to obtain a thorough and clear overview of the phenomenon under investigation and a corroboration of the facts obtained (Yin, 2014). When multiple sources of data collection and thus evidence obtained support the events or facts of the cases under investigation, triangulation has occurred and the strength of such findings are greatly enhanced (Yin, 2014). Further, construct validity of the study is enhanced because ‘multiple sources of evidence essentially provide multiple measures of the same phenomenon’ (Yin, 2014, p. 121). A further consequence of
triangulation is that of *converging lines of enquiry* (Yin, 2014). This is in contrast to using multiple sources as part of the same study but addressing different findings. The difference between convergence of evidence and non-convergence of evidence is presented graphically in Figure 4.4.

**Convergence of evidence**

- Documents
- Archival Records
- Open-ended interviews

![Diagram of Convergence of Evidence](image)

**Non-convergence of evidence**

- Separate substudies
  - Site visits → Findings → Conclusions
  - Survey → Findings → Conclusions
  - Document analysis → Findings → Conclusions

*Source.* Yin (2014, p. 121)

*Figure 4.4. Convergence and non-convergence of multiple sources of evidence.*

4.8.1.2 **Creation of a case-study database**

A case-study database is the method of organising and documenting all findings from each case in a single-case-study or multiple-case-study research design (Yin, 2014). The findings should be documented in a way that allows another investigator to review the evidence directly if needed, thus increasing the reliability of the findings. Such documentation
will usually involve case-study notes, case-study documents, tabular materials and narratives (Yin, 2014).

4.8.1.3 Maintenance of chain of evidence

Another strategy to increase the construct validity and reliability of case-study research is through maintaining a chain of evidence (Yin, 2014). If a chain of evidence is maintained, then a reader of the case study will know precisely the source of all evidence from the development of the research questions to the conclusions drawn from the case study. This is a bi-directional effect because the reader should be able to follow each step of the process from research questions to the conclusion and from the conclusion to the initial research questions developed at the beginning of the case study (Yin, 2014). This bi-directional effect is presented in Figure 4.5.

Source. Yin (2014, p. 128)

Figure 4.5. Maintenance of chain of evidence.
4.8.1.4 Exercise care when using data from electronic sources

This principle relates to collecting evidence from online sources, for example, obtaining a document online, conducting an online interview or observing an event remotely via the use of Skype (Yin, 2014). Caution needs to be taken when obtaining evidence online, as this evidence may not be provided by credible sources (Yin, 2014). Sources should be cross-checked with other sources to ensure the accuracy of the information obtained (Yin, 2014). Further, Yin cautions against the use of social-media sites such as Facebook, Twitter, YouTube and individual blogs because of their lack of accuracy (Yin, 2014). In the current study, the only online sources used as evidence were the curriculum documents obtained directly from each university website, which constitute a reliable source of evidence. However, to ensure the accuracy of this information and to obtain further evidence on this topic, other sources of evidence were collected from the on-line survey and qualitative telephone interviews.

Case-study data-collection methods include creating and gathering documentation, archival records, interviews, direct observation, participant observation, and physical artefacts. The four principles of data collection encompass using multiple sources of evidence, creating a case-study database, maintaining a chain of evidence and exercising care when using data from electronic sources. In the following section, the case-study data-collection methods employed in this study are highlighted. These methods are documentation, surveys and interviews. In addition, the development of the survey and interview protocol is discussed.

4.9 Data-collection Methods Used in this Study

The common data-collection methods used in case-study research were highlighted in the previous section, as were the principles of data collection. This section presents the data-collection methods used for the current multiple-case-study research design; these were documentation review (phase one), survey (phase two), and interviews (phase three). Table
4.8 below summarises the nature of the data sources in each phase of the sequential case study and the research questions and propositions examined by each of the phases.
### Table 4.8

*Data Sources, Research Questions and Propositions*

<table>
<thead>
<tr>
<th>Research questions</th>
<th>Research propositions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How prominently has IPV-related content appeared in the curricula being offered in the currently available Australian UG nursing, midwifery and paramedicine degrees?</td>
<td>1. The amount of time spent on IPV-related content in the UG curricula of nursing, midwifery and paramedicine should be equivalent to all other public-health issues, and the barriers of a lack of time, an overcrowded curriculum and a lack of support should be overcome.</td>
</tr>
<tr>
<td>2. How is this IPV-related content being integrated into the curricula of nursing, midwifery and paramedicine?</td>
<td>2. IPV-related content should be integrated throughout the UG curricula of nursing, midwifery and paramedicine, and IPV-related content should be included in units irrespective of whether the unit coordinator (or equivalent) is passionate about this topic.</td>
</tr>
<tr>
<td>3. How are the units that contain IPV-related content chosen and why are they the units chosen to include this content?</td>
<td>3. IPV-related content in the examined curricula should be incorporated into a variety of units throughout the entire UG degree, and not pigeonholed into mental-health units and child and family units.</td>
</tr>
<tr>
<td>4. How is this IPV-related content being taught and what is being taught in relation to this content</td>
<td>4. IPV-related content should be delivered via a variety of teaching methods, including didactic</td>
</tr>
</tbody>
</table>
in the disciplines of nursing, midwifery and paramedicine? lectures, interactive tutorials, clinical simulation and clinical experience, and the content should represent the multicomponent nature of IPV, including screening, detection, care principles and safety management.

5. How do academics explain their inclusion or non-inclusion of IPV-related content in their unit/s? The reasons academics do not include IPV-related content in their units, such as a lack of expertise, a lack of understanding of its importance and negative attitudes and beliefs, should be eradicated to foster the inclusion of this topic in nursing, midwifery and paramedicine curricula.

6. How are academics utilising national and international organisations and committees’ guidelines and recommendations in their teaching of IPV-related content? Academics should have an awareness of national and international organisations and committees’ guidelines and recommendations on the inclusion of IPV-related content in HCP UG degrees and be implementing said guidelines and recommendations in their teaching.

4.9.1 Documentation—phase one

Documentation involved in a case study can take many forms, including letters, email correspondence, minutes of meetings, administrative documents, formal studies and news clippings (Yin, 2014). Phase one of this case study involved collecting documentation. The
Purpose of using documentation in this phase is twofold: first, to make inferences; second, to verify the typical terms used for the topic of study that relate to the cases under investigation (Yin 2014).

For this study, the first phase involved examining curriculum documents for nursing, midwifery and paramedicine degrees delivered at Australian universities. Given that the three discipline cases were regulated through AHPRA, and curriculum documents are central in the accreditation process and designed to specifically to demonstrate learning objectives and graduate capabilities, unit outlines and unit descriptions were considered to be the most suitable documents.

The collection of documentation is a very common source of evidence for case-study research, and is considered useful for a number of reasons. For this multiple case study, the first purpose of examining these documents was to verify correct use of terms used to denote IPV. The second purpose was to identify patterns of included or excluded IPV-related content, which led to inferences being made and the collection of evidence to confirm or disconfirm such inferences as a chain of evidence was established (Yin, 2014). Finally, this evidence was used to collaborate and augment evidence from other sources (Yin, 2014).

There are many strengths of documentation, including its ability to be reviewed repeatedly, its unobtrusive nature, its broad coverage, and its ability to be precise (Yin, 2014). Unfortunately, documents can be difficult to retrieve and access, and may contain reporting bias by the author of the documentation (Yin, 2014). The information (and the consequent amount of data that could be obtained) that could be obtained through the unit outlines and descriptions depended on the university’s policies on the amount of information the university was willing to release. However, irrespective of these limitations, the most significant contribution this documentation made was its ability to corroborate evidence obtained through other sources as evidenced in Chapter 5, and thus aid in building triangulation (Yin, 2014).
4.9.1.1 Design

The collection and analysis of documents is a typical form of data analysis employed in case-study research (Yin, 2014). Content analysis was chosen as the method of analysing documents because it provides a useful beginning point in the case-study process (Hesse-Biber & Leavy, 2011). Content analysis can be used to provide ‘new insights, a representation of facts and a practical guide to action’ (Elo & Kyngas, 2008, p. 108). The approach adopted for this phase of the case study was the directed content-analysis procedure adopted from Insch, Moore and Murphy (1997). Directed content analysis can help to focus a research question, or provide detail on the relationship or frequency of the variables under study (Hsieh & Shannon, 2005). The directed approach is structured, with concepts or keywords of interest predetermined. It is suited to summative analysis that identifies and quantifies text frequency to understand usage and content (Hsieh & Shannon, 2005). Figure 4.6 summarises the steps involved in the content analysis.

1. Identify questions and constructs involved
2. Identify texts and unit of analysis
3. Design coding scheme
4. Pre-test coding scheme
5. Refine coding scheme
6. Collect data
7. Analyse data

Source. Insch et al. (1997)

Figure 4.6. Schema for content-analysis process.

4.9.1.2 Study sample

Details on all UG degrees forming the three cases was sourced from the Australian Government website studyinaustralia.gov.au. At the time of data collection, there were 39
universities in Australia teaching the disciplines under research. The number of courses offered across these universities was as follows: nursing = 33, midwifery = 13, paramedicine = 11. Data were collected for each of the 39 universities that formed the case study. The public availability of the online documents meant that it was feasible to examine the entire set of curriculum documents for the three discipline cases across these universities, providing a high level of source validity in the sample (Insch et al., 1997).

**4.9.1.3 Inclusion criteria.**

In identifying the documents to be examined, source validity was established by ensuring the documents provided appropriate information for the constructs of interest, and were capable of addressing the research questions (Yin, 2014). University websites were individually searched for the disciplines under examination, and all unit outlines and descriptions were retrieved. Table 4.9 illustrates the types of documents included in the search. In total, 1,300 individual unit outlines and descriptions were located from the search of university websites. By discipline, the total number of unit outlines and descriptions retrieved was as follows: nursing = 766, midwifery = 281 and paramedicine = 253.

Table 4.9

<table>
<thead>
<tr>
<th>Details of Course Documents Included in the Search</th>
</tr>
</thead>
<tbody>
<tr>
<td>University documents</td>
</tr>
<tr>
<td>University information leaflets</td>
</tr>
<tr>
<td>University student handbooks</td>
</tr>
<tr>
<td>Topics pages</td>
</tr>
<tr>
<td></td>
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<td></td>
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<td></td>
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<tr>
<td></td>
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<tr>
<td></td>
</tr>
</tbody>
</table>

**4.9.1.4 Coding instrument**

Recording coding decisions is an important procedural component of content analysis (Krippendorff, 2012). A coding frame should be sufficiently detailed, and it should be ensured
that the meanings and semantics of language are sufficiently described to ensure the coding is
efficient and reliable (Patton, 2014). Formulating a coding frame provided instructions for the
coding process and ensured reliability in the coding. The unit of text analysis (Adler & Clark,
2015) was at the level of words and phrases because coding text at this level provided
substantially higher reliability (Saris-Gallhofer, Saris & Morton, 1978).

A common strategy utilised to improve the accuracy and reliability of coding in
content analysis is the use of content-analysis dictionaries, which provide categories and rules
for assigning words and phrases. Examples of such dictionaries include the *Harvard IV
Psychosocial Dictionary* and the *Lasswell Value Dictionary* (Insch et al., 1997). Given that no
content-analysis dictionary was suitable to use in this study, an assumed categories approach
at the explicit level was adopted for this study (Insch et al., 1997). The following categories
were employed during the coding process:

1. units with IPV-related content, and therefore, use the words ‘IPV’ and/or ‘DV’
2. units with possible alternative IPV-related content.

To devise a detailed coding frame, a literature review was conducted to identify
alternative words for ‘IPV’ and ‘DV’. For the search, eight electronic databases (Academic
Search Premier, Biological Abstracts, Cumulative Index to Nursing and Allied Health
Literature, Humanities International Complete, LGBT Life, Psych Info, and PubMed) were
examined for the calendar year 2011–2012. The following search terms were employed: IPV,
DV, psychological abuse, physical abuse, economic abuse, abuse, family violence,
interpersonal violence, family dynamics and trauma. The inclusion criteria for this search
were limited to full text, research, or literature reviews in English-language journals that
focused on the keywords. The search generated 680 articles, of which 136 were retrieved for
detailed examination. The final coding frame of alternative terms was derived from these
manuscripts.
4.9.1.5 **Pre-test of coding frame**

Conducting a pre-test of the coding frame was important to ensure a robust and reliable set of decisional rules to guide text coding (Bryman, 2008; Devi Prasad, 2008; Insch et al., 1997). Following Insch et al.’s (1997) directed content-analysis procedure, a two-step pre-test was undertaken to refine the coding frame. In the first step of the pre-test, to establish the suitability of the newly devised coding frame (Insch et al., 1997), ten statements and descriptions from the three discipline cases were randomly chosen and analysed employing the coding frame. This analysis identified that the first category and associated codes were free of error and ambiguity and suitable for use in data collection. However, the coding frame for the second category was too restrictive in the alternative terms used and thus needed to be adjusted to broaden the number of alternative terms used in the analysis. To find more alternative terms to use in the coding frame, another extensive literature review was conducted to establish other terms commonly used for IPV. Any terms used to refer to the acts of IPV were then entered into the sampling frame for category number two. The second step in testing the coding frame involved establishing semantic validity, which occurs when the principal researcher and third-party researchers agree that the words placed into each category are similar in meaning or relate in a similar way (Insch et al., 1997). To achieve this in the current study, two fellow researchers, who were both women’s health researchers with extensive knowledge on IPV, reviewed the categories and terms placed in each category, and concluded that they words within each category were similar, thus making the coding frame suitable for data collection.

4.9.1.6 **Coding process**

Coding is a crucial stage in the content-analysis process and involves the identification of repeated patterns in the text (Bryman, 2008). Coding text allows for the reduction and tabulation of sections of textual material into categories (Krippendorff, 2012). The following two approaches are commonly adopted for coding documents: explicit and implicit
interpretation of text (Sproule, 2010). Explicit coding refers to coding of visible, easily identifiable content, and provides higher reliability and replicability of the coding process (Sproule, 2010). In contrast, implicit coding refers to analysis of the underlying or latent meaning of the text; this approach allows more subjective coding that offers richer analysis (Sproule, 2010). This study adopted an explicit interpretation of text.

It is important to acknowledge single classification and exclusivity in coding. Single classification is a form of coding text to categories that are mutually exclusive, with words or phrases coded only to one category (Insch et al., 1997). Exclusivity in coding refers to the fact that categories must not overlap or that ambiguity between categories must be minimised (Sproule, 2010). An explicit single classification system was employed in this study because this classification system addressed the issue of exclusivity and provided increased validity (Weber, 1990).

4.9.1.7 Data collection

Utilising the coding frame, publicly available online curriculum documents at universities delivering programmes for the three discipline cases were searched for key words pertaining to IPV. For each retrieved document, relevant textual content was tabulated by discipline. This included terms employed, detail on the type of content and the type and name of the unit including this content. These data were then transferred to a Microsoft Excel spreadsheet for statistical analysis.

4.9.1.8 Statistical analysis

The data-analysis technique used in content analysis should correlate with the purpose of the study. There are four main types of analysis: 1) exploratory or descriptive; 2) trend analysis; 3) hypothesis testing; 4) comparisons to norms (Insch et al., 1997). Exploratory/descriptive analysis was employed in the current study. In this type of analysis, basic statistics and the results of different categories are sufficient. Descriptive analysis was achieved via the frequency counts of terms used (Insch et al., 1997).
4.9.2 Cross-sectional survey—phase two

The aim of phase two of the case study was to design, validate and conduct a survey for the purpose of data triangulation and corroboration, and refinement of the converging lines of enquiry in the overall case study (Yin, 2014). The current section outlines the methods employed in the survey phase (i.e., phase two). For the three HCP-discipline cases, the survey sought to identify whether the units taught in Australian UG HCP degrees contained IPV-related content, the nature of any IPV-related content, and the methods employed to teach this content. The survey also sought to establish academics’ beliefs and opinions about IPV-related content in curriculum and their educational preparation and knowledge on IPV.

4.9.2.1 Design

The online survey was hosted via the Qualtrics software platform, providing a cost-effective and readily accessible survey. This platform allowed access to a large, geographically dispersed population of academics and assured anonymous and confidential questioning (Adler & Clark, 2015; Fowler, 2009; Sue & Ritter, 2007).

4.9.2.2 Study population

Australian universities offering UG nursing, midwifery and paramedicine degrees (n=39) were approached to participate in the online survey, providing a purposeful sample of academics. Table 4.10 summarises the location of the universities included in the study.
Table 4.10

*Location of Universities Invited to Participate in Phase Two*

<table>
<thead>
<tr>
<th>Location</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queensland (Qld)</td>
<td>9</td>
</tr>
<tr>
<td>New South Wales (NSW)</td>
<td>11</td>
</tr>
<tr>
<td>Victoria (Vic)</td>
<td>7</td>
</tr>
<tr>
<td>Northern Territory (NT)</td>
<td>1</td>
</tr>
<tr>
<td>Western Australia (WA)</td>
<td>4</td>
</tr>
<tr>
<td>South Australia (SA)</td>
<td>3</td>
</tr>
<tr>
<td>Tasmania (Tas)</td>
<td>1</td>
</tr>
<tr>
<td>Australian Capital Territory (ACT)</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>39</strong></td>
</tr>
</tbody>
</table>

**4.9.2.3 Sample**

From the 39 universities that were initially approached, three chose not to participate in the study. The first was a multicampus university operating in Qld, NSW, Vic and the ACT, which declined because staff have already completed a large number of external surveys. The other two universities (located in Vic and NSW) provided no reason. In total, 603 academics were invited to participate in the online survey. Of these academics, 12 were on extended leave, one was on maternity leave and three did not teach UG degrees at the time of the survey. Therefore, the number of eligible academics that formed the possible survey sample was 587.

**4.9.2.4 Recruitment**

Initially, an email was sent to the heads of school/deans of all schools of nursing, midwifery and paramedicine, notifying them that a PhD student from the Southern Cross University would be contacting their staff asking them to participate in an online survey. In this email, it was stated that if there was a problem with contacting their staff to reply to the student to inform them of this. Academics in the three case disciplines employed at the participating universities were invited to participate in the online survey through their
workplace email. These were sourced from the Australian Universities website (www.australianuniversities.com.au/list/). Return of the survey was deemed implied consent and participation was voluntary and anonymous.

4.9.2.5 Inclusion/exclusion criteria

Academics listed as assessors or coordinators of units in the three UG degrees formed the sampling frame for the survey (Sue & Ritter, 2007). The exclusion criteria included casual academics and tutors, and academics who were assessors or coordinators of postgraduate units rather than UG units.

4.9.2.6 Measurement instruments

Given that no pre-existing validated survey was identified as suitable for this study, items for the online survey were derived from a comprehensive review of the literature and the emerging study propositions and their constituent components from the incomplete case in phase one.

4.9.2.6.1 Designing the instrument

To capture the complexity of the emerging study propositions, a number of Likert scales were developed. Likert items are suited to scoring respondents’ opinions and perceptions, with items providing scaled responses (Bishop & Herron, 2015). Employing Likert scales allowed the complexity of the emerging constructs to be captured without prematurely attempting to reduce this to a smaller set of underlying components (Asún, Rdz-Navarro & Alvarado, 2016). The inclusion of a large number of initial items ensured sufficient items remained following removal of poorly performing items (Tabachnick & Fidell, 2014).

4.9.2.6.2 Establishing clarity and face validity.

Following the development of the initial survey, an expert panel of five academics (Radhakrishna, 2007) who were unit assessors or coordinators of nursing, midwifery and/or paramedicine units from three universities provided feedback on the clarity, readability and
face validity of the survey. The following minor amendments were made based on the
feedback from this expert panel: rewording five items to improve clarity (items 7, 11, 15, 19
and 43) and the correction of typographical errors (items 36 and 37). Response categories
were also altered from a single response category to a multiple response category for two
items (items 10 and 14).

4.9.2.7 Survey content and structure

The final survey contained 51 items grouped into six sections. The structure and
content of the survey instrument and the alignment of the items with the study propositions is
summarised in Table 4.11. The detailed instrument is presented in Appendix A. The sixth
item of the survey included the option to volunteer for a follow-up interview on the topic of
IPV-related content within curricula. The following lists the six sections of the survey:

- section one: demographic characteristics (10 items)
- section two: exposure/training related to IPV (5 items)
- section three: inclusion of IPV-related content in academic’s unit (8 items)
- section four: awareness of national and international health-care organisations and
  committees’ guidelines and recommendations on IPV (9 items)
- section five: beliefs/attitudes pertaining to IPV (16 items)
- section six: recruitment of participants for phase three of the case study (2 items).
<table>
<thead>
<tr>
<th>Research proposition</th>
<th>Variable/construct</th>
<th>Question number</th>
<th>Structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The amount of time spent on IPV-related content in the UG curricula of nursing, midwifery and paramedicine should be equivalent to all other public-health issues, and the barriers of a lack of time, an overcrowded curriculum and a lack of support should be overcome.</td>
<td>Presence of IPV-related content</td>
<td>17</td>
<td>Dichotomous</td>
</tr>
<tr>
<td></td>
<td>Amount of IPV-related content</td>
<td>20</td>
<td>Dichotomous</td>
</tr>
<tr>
<td></td>
<td>Perceptions on adequacy of IPV in curriculum</td>
<td>23</td>
<td>Dichotomous</td>
</tr>
<tr>
<td></td>
<td>Reasons for non-inclusion of IPV-related content</td>
<td>24</td>
<td>Dichotomous</td>
</tr>
<tr>
<td>2. IPV-related content should be integrated throughout the UG curricula of nursing, midwifery and paramedicine, and IPV-related content should be included in units irrespective of whether the unit coordinator (or equivalent) is passionate about this topic.</td>
<td>Integration of IPV-related content into curriculum</td>
<td>18</td>
<td>Dichotomous</td>
</tr>
<tr>
<td></td>
<td>Clinical placements with IPV survivors</td>
<td>49</td>
<td>Dichotomous</td>
</tr>
<tr>
<td></td>
<td>Consequences of lack of IPV-related content</td>
<td>35</td>
<td>Dichotomous</td>
</tr>
<tr>
<td></td>
<td>Readiness to intervene in IPV situations</td>
<td>36</td>
<td>Dichotomous</td>
</tr>
<tr>
<td></td>
<td>Perceptions of the need for IPV-related content</td>
<td>38, 39</td>
<td>Dichotomous</td>
</tr>
<tr>
<td>3. IPV-related content in the examined curricula should be incorporated into a variety of units throughout the entire UG degree, and not pigeonholed into mental-health units and child and family units.</td>
<td>Category of unit in which IPV-related content is included</td>
<td>21</td>
<td>Dichotomous</td>
</tr>
<tr>
<td>4. IPV-related content should be delivered via a variety of teaching methods, including didactic lectures, interactive tutorials, clinical simulation and clinical experience, and the content should represent the multicomponent nature of IPV, including screening, detection, care principles and safety management.</td>
<td>Teaching types/strategies</td>
<td>22</td>
<td>Dichotomous</td>
</tr>
<tr>
<td></td>
<td>Type of IPV-related content</td>
<td>19</td>
<td>Dichotomous</td>
</tr>
<tr>
<td></td>
<td>Knowledge of IPV-related content</td>
<td>11, 44, 45</td>
<td>Dichotomous</td>
</tr>
<tr>
<td>5. The reasons academics do not include IPV-related content in their units, such as a lack of expertise, a lack of understanding of its importance and negative attitudes and beliefs, should be eradicated to foster the inclusion of this topic in the UG nursing, midwifery and paramedicine curricula.</td>
<td>Duration of training</td>
<td>13</td>
<td>Dichotomous</td>
</tr>
<tr>
<td></td>
<td>Location of training</td>
<td>14</td>
<td>Dichotomous</td>
</tr>
<tr>
<td></td>
<td>Level of clinical exposure</td>
<td>15</td>
<td>Dichotomous</td>
</tr>
<tr>
<td></td>
<td>Perceptions of role modelling to students</td>
<td>34</td>
<td>Likert scale</td>
</tr>
<tr>
<td></td>
<td>Consequences of failing to identify IPV survivors</td>
<td>37</td>
<td>Likert scale</td>
</tr>
<tr>
<td></td>
<td>Perceptions of scope of practice and IPV-related content</td>
<td>40</td>
<td>Likert scale</td>
</tr>
<tr>
<td></td>
<td>Beliefs on past experiences of IPV and treatment of IPV survivors</td>
<td>41, 43</td>
<td>Likert scale</td>
</tr>
<tr>
<td></td>
<td>Ability to empathise with IPV survivors</td>
<td>42</td>
<td>Likert scale</td>
</tr>
<tr>
<td></td>
<td>Perceptions of the maintenance of confidentiality and reporting of IPV</td>
<td>46, 47, 48</td>
<td>Likert scale</td>
</tr>
<tr>
<td>6. Academics should have an awareness of national and international organisations and committees’ guidelines and recommendations on the inclusion of IPV-related content in HCP UG degrees, and should be implementing these guidelines and recommendations in their teaching.</td>
<td>Awareness of national and international organisations and committees’ guidelines and recommendations</td>
<td>Qu. 25–33</td>
<td>Dichotomous</td>
</tr>
</tbody>
</table>
4.9.2.8 Conduct of the survey

As response rates to web-based surveys are generally lower than they are to mail surveys, a modified Tailored Design Method was employed to maximise survey response rates (Dillman, Smyth & Christian, 2014). Consequently, one month after the initial survey invitation, second email contact was made with a personalised thank you and reminder. Two months later, a third email invitation was sent that included the active hyperlink and positive cues to the respondent noting the completion time was short, thus increasing the likelihood of survey completion (Newell & Burnard, 2011). Adherence to this method generally yields improved survey response rates (Dillman et al., 2014). The online survey was available for completion for four months.

4.9.2.9 Statistical analysis

Data were downloaded from the Qualtrics platform and statistical analysis was performed using SPSS version 21 (IBM [SPSS], 2012). Figure 4.7 presents the methods of statistical analysis employed in this study in the order in which they were employed.

Source. Developed for this research.

Figure 4.7. Statistical-analysis sequence.
Cleanse data and assess normality

Initially, valid range and logical response checks were made to identify possible coding errors. Missing data were also examined to identify patterns that might indicate problems with the construction of items or completion of the survey (Field, 2013). On examination of the spreadsheet, there was no specific pattern in the missing data. To establish the most appropriate statistical tests to employ, the data were then examined for normality. A normal distribution is classified as a theoretical frequency distribution that has certain special characteristics such as its bell shape and symmetry. In a normal distribution, the mean, median and mode are equal and located in the centre, with observations clustered around the centre of the distribution, and few observations at the tails of the distribution (Jackson, 2016). Normality was examined via skewness and kurtosis outputs using SPSS (Pallant, 2013). Results demonstrated that the data formed a non-normal distribution. The final step in preparation of the data for analysis was reverse coding of five Likert-scale items to ensure consistency in the direction of responses across the entire set of the Likert-scale items.

Factor analysis

To remove poorly performing items and establish the validity and reliability of the survey items, principal component analysis (PCA) and then Chronbach’s alpha reliability analysis was performed. PCA with varimax rotation was undertaken to identify the underlying components measured by the Likert-scale items (Joreskog & Moustaki, 2001). PCA reduces the number of variables into a smaller number of factors or components based on linear combinations of correlations between the items. By summarising patterns of variance, PCA identifies groupings of items that form coherent subsets (factors) that are independent of each other. PCA is also a useful item-reduction process. Employing this form of factor analysis (FA) was appropriate because the aim of this procedure was to reduce the number of items
into coherent factors (Tabachnick & Fidell, 2014), and to facilitate descriptive and comparative analysis.

The guiding principles for the interpretation of the PCA were as follows: eigenvalues >1; interpretation of the scree plot to identify the number of possible factors; communalities >0.4; and consideration of the proportion of significant (>0.05) residuals in the reproduced correlation matrix. Applying these criteria, as noted in Table 4.12, three items were removed because of poor communalities <0.4. The Kaiser–Meyer–Olkin test for sampling adequacy indicated moderate results (0.751), confirming that the proportion of common variance was not high among the variables and the data were suited to PCA. Bartlett’s sphericity test was significant (p=0.000), confirming the variables were sufficiently related to each other to provide a meaningful FA.

Table 4.12

Items Removed During FA

<table>
<thead>
<tr>
<th>Items removed</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCPs who have a personal history of IPV can sometimes have emotional decompensation and experience sleep disturbances, panic attacks and flashbacks</td>
</tr>
<tr>
<td>Those with past experiences of IPV are more likely to provide objective health care of those experiencing IPV</td>
</tr>
<tr>
<td>No HCP should report IPV unless instructed by those experiencing it</td>
</tr>
</tbody>
</table>

The final factor solution contained four factors, accounting for 62.62% of the total variance (Appendix B). The structure was satisfactory, with two or more items per factor and minimal cross-loadings across the factors. The pattern matrix and item loadings for the final solution are summarised in Table 4.13.
### Table 4.13

**Pattern Matrix for the Final Four-factor Exploratory Solution**

<table>
<thead>
<tr>
<th>Factor items</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Professional IPV role acceptance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Academics need to role model that IPV is unacceptable</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Without IPV related content in the HCPs curriculum, IPV will remain undetected and untreated, with the cycle of violence remaining intact</td>
<td>543</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Students enrolled in a health care professional degree need to be ready, willing and able to identify and care for women survivors of IPV</td>
<td>809</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Failure to identify a woman experiencing IPV at her initial contact with the health care system will result in incorrect care</td>
<td>640</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. HCPs are in need of education to provide best practice when encountering IPV</td>
<td>808</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. For all HCPs to gain adequate IPV related knowledge, they must be educated on IPV during their initial undergraduate degree</td>
<td>532</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. All health discipline undergraduate students should have a clinical placement in a women’s shelter or planned clinical placement with IPV survivors</td>
<td>687</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Professional IPV role resistance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Health care practices related to IPV is not within the scope of practice for my discipline</td>
<td>620</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I find it difficult to empathise or understand those experiencing IPV</td>
<td>598</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Femicide is not related to IPV</td>
<td>608</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. IPV is not a health problem</td>
<td>619</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. This content is not necessary as it is easy for a women to leave an abusive relationship</td>
<td>695</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Beliefs on reporting IPV</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. All HCPs should report IPV to the police</td>
<td>840</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. No HCP should report IPV unless instructed by those experiencing it</td>
<td>-820</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Beliefs about survivors of IPV</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Interventions for woman survivors of HCPs should assess the mental health status of survivors of IPV</td>
<td>720</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Interventions for women survivors of IPV should remain confidential to ensure theirsafety</td>
<td>802</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Reliability estimates establish the degree of internal consistency in a measure, confirming the extent to which the items measure the same construct (Heale & Twycross, 2015). For a scale to be considered reliable, Pallant (2013) suggests that the Cronbach’s alpha coefficient should be ≥0.7, although lower alpha coefficients are acceptable when testing scales with a small number of items, and for newly developed scales (Cho & Kim, 2015; Kilic, 2016). Reliability analysis employing Chronbach’s alpha was calculated for each factor derived from the PCA. The results of this analysis are presented in Table 4.14. The analysis confirmed ‘Factor 4: Beliefs on reporting IPV’ was unstable; accordingly, these items were removed from further analysis. The FA and reliability analysis provided three reliable scales suited for further statistical analysis in exploration of the propositions and their constituent components.

Table 4.14

<table>
<thead>
<tr>
<th>Factor</th>
<th>Number of items</th>
<th>Cronbach’s alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Professional IPV role acceptance</td>
<td>7</td>
<td>0.780</td>
</tr>
<tr>
<td>2. Professional IPV role resistance</td>
<td>5</td>
<td>0.514</td>
</tr>
<tr>
<td>3. Beliefs on reporting IPV</td>
<td>2</td>
<td>-0.137*</td>
</tr>
<tr>
<td>4. Beliefs on survivors of IPV</td>
<td>2</td>
<td>0.492</td>
</tr>
</tbody>
</table>

* = unstable and not retained for further analysis.

Descriptive analysis

Descriptive statistical analysis was undertaken to identify trends in the data (Fisher & Schneider, 2013). Tests performed in this analysis included frequency (numbers and percentages), measures of central tendencies (mean, median and mode), and measures of variations (range and standard deviation) (Fink, 2009; Fisher & Schneider, 2013). Cross-tabulation was also used to categorise respondents based on more than one variable at the same time (Graziano & Raulin, 2010).
4.9.2.9.5 Comparative analysis

Further comparative analysis was undertaken for cross-case analysis and to validate or refute the propositions statistically (Field, 2013). As a result of the non-normal distribution of data, the decision was made to employ non-parametric statistical tests where normality was an assumption of the test (Field, 2013; Jackson, 2016; Pallant, 2013). Comparison of variables was made using the independent samples t-test for continuous variables and the chi-square test for categorical variables (Pallant, 2013). Statistical significance was set at the conventional p<0.05 level. Independence of observations was assumed for this independent samples t-test because it was assumed that the data from the survey were independent (Pallant, 2013). Homogeneity of variance, or equal variances, was another assumption assumed in performing a t-test. A further general assumption of this test was normal distribution of scores. Although this was not the case, this technique was still robust and thus tolerant of this violation (Pallant, 2013). For the chi-square test for independence, the effect-size statistic was the phi coefficient ranging from 0 to 1. This analysis employed Cohen’s (1988) criteria for examining effect size, thus 0.10 represented a small effect, 0.30 a medium effect, and 0.50 a large effect (Pallant, 2013). Between-groups multivariate analysis of variance was performed employing the non-parametric Kruskal–Wallis test (Field, 2013).

4.9.3 Qualitative interviews—phase three

While quantitative data in case-study research indicate relationships, and aid the researcher to condense a large amount of data, qualitative data assists in understanding these relationships or may suggest a theory to underlie them (Eisenhardt, 1989). Interviews are an important source of evidence in case-study research and represent guided conversations rather than structured queries (Yin, 2014, p. 110). The principal purpose of the interviews for this study was to corroborate and extend the findings from the online surveys conducted in phase two.
4.9.3.1 Conduct of qualitative interviews

These guided conversations were conducted via a telephone interview. This alternative to face-to-face interviewing is less time consuming because of the ability to conduct the interview in a variety of places, such as the workplace, at home or during the commute to work; however, it is essential for the researcher to listen attentively to what the participant is saying and to be attuned to tonal changes in voice and expressions such as inflections, emphases and pauses (Welch & Jirojwong, 2014). This meant it was crucial to record all telephone interviews to ensure all tonal changes were reported accurately (Welch & Jirojwong, 2014). Ethical approval was obtained to record all interviews.

4.9.3.2 Design and development of interviews

The guided-conversation approach adopted by case-study research results in an interview that has no complete list of questions for each participant. The verbalised questions posed to each participant differ depending on the participant’s responses (Yin, 2014). However, because of the short length of this type of interview, it is advantageous to follow an interview protocol that contains a subset of topics that are considered relevant to the purpose of the interview (Yin, 2014). Given that this protocol serves as a conversational guide, it is essential to have probes that address each of the research questions and propositions (Yin, 2014). Six main probes were developed for the interviews, and their connection to the propositions are identified in Table 4.15.

Table 4.15

<table>
<thead>
<tr>
<th>Interview probes</th>
<th>Research propositions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incorporation of IPV-related content into units that are taught; rationale</td>
<td>1. The amount of time spent on IPV-related content in the UG curricula of nursing, midwifery and paramedicine should be equivalent to all other public-health issues, and the barriers of a lack of time, an overcrowded curriculum and a lack of support should be overcome.</td>
</tr>
<tr>
<td>Interview probes</td>
<td>Research propositions</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>First thing that comes to mind when hear the words ‘IPV’</strong></td>
<td>2. IPV-related content should be integrated throughout the UG curricula of nursing, midwifery and paramedicine, and IPV-related content should be included in units irrespective of whether the unit coordinator (or equivalent) is passionate about this topic.</td>
</tr>
<tr>
<td><strong>Units that IPV should be taught in</strong></td>
<td>3. IPV-related content in the examined curricula should be incorporated into a variety of units throughout the entire UG degree, and not pigeonholed into mental-health units and child and family units.</td>
</tr>
<tr>
<td><strong>Teaching methods for this content</strong></td>
<td>4. IPV-related content should be delivered via a variety of teaching methods, including didactic lectures, interactive tutorials, clinical simulation and clinical experience, and the content should represent the multicomponent nature of IPV, including screening, detection, care principles and safety management.</td>
</tr>
<tr>
<td><strong>Barriers to the inclusion of IPV-related content</strong></td>
<td>1. The amount of time spent on IPV-related content in the UG curricula of nursing, midwifery and paramedicine should be equivalent to all other public-health issues, and the barriers of a lack of time, an overcrowded curriculum and a lack of support should be overcome.</td>
</tr>
<tr>
<td><strong>How to obtain information on IPV; guidelines and recommendations</strong></td>
<td>6. Academics should have an awareness of national and international organisations and committees’ guidelines and recommendations on the inclusion of IPV-related content in HCP UG degrees, and should be implementing these guidelines and recommendations in their teaching.</td>
</tr>
<tr>
<td><strong>Competence in caring for IPV survivors; passionate about this area</strong></td>
<td>2. IPV-related content should be integrated throughout the UG curricula of nursing, midwifery and paramedicine, and IPV-related content should be included in units irrespective of whether the unit coordinator (or equivalent) is passionate about this topic.</td>
</tr>
<tr>
<td></td>
<td>5. The reasons academics do not include IPV-related content in their units, such as a lack of expertise, a lack of understanding of its importance and negative attitudes and beliefs, should be eradicated to foster the inclusion of this topic in the UG nursing, midwifery and paramedicine curricula.</td>
</tr>
</tbody>
</table>
4.9.3.3 Sampling

Given that interviewing is a form of qualitative research, non-probability sampling was undertaken in this phase of the study. Purposive sampling was employed because it provides information-rich cases for the phenomenon under investigation (Lopez & Whitehead, 2013) by selecting participants that have the knowledge or experience required to answer the research questions and address the aims of the study (Lopez & Whitehead, 2013). As stated, participants were recruited via an online survey. Item 50 of this survey invited the respondents of the survey to volunteer to participate in an interview. These participants who volunteered met the three criteria for participation in qualitative studies. They had experienced the phenomenon under investigation because they are currently academics teaching an UG nursing, midwifery or paramedicine degree. Additionally, they were able to communicate their experiences because of being well-educated professionals and were willing to communicate their experiences because they volunteered to participate at the completion of the survey (Jolley, 2013). Data were collected from new participants until data saturation occurred. This means that data were collected from new participants until no further new data were being added to the analysis (Jolley, 2013).

4.9.3.4 Conduct of the interviews

Before the commencement of the interviews, correspondence occurred to organise the time of the telephone interview, and to fulfil the requirement of signing and receiving the consent form. Each interview commenced with an introduction of the researcher and the research study and thanking the participant for volunteering their time. The participant was then informed that they were not obligated to participate in the interview and that they could stop the interview at any time without penalty or coercion, and that they could refuse to answer any question/s. Additionally, each participant was informed that the interview was being recorded, and that confidentiality would be maintained at all times.
Following these formalities, the participants were informed of the purpose of the interview and its relevance to the overall case study. Demographic information about the participant was then obtained (e.g., age, gender, state/territory in which they taught, degree they taught, years they had been teaching, whether they had completed an UG degree and if they had any qualifications in IPV). The purpose of these questions was not only to obtain demographic information, but also to enable the participants’ time to relax and build a rapport with the researcher before answering the questions about the phenomenon under investigation.

After these demographic questions were posed, the interviews differed, depending on the responses of the participants. However, all interviews incorporated the seven interview probes outlined above. Clarification questions were also asked throughout the interviews to ensure the accuracy of information obtained and to keep the conversation on directed towards the propositions. In concluding the interview, a debrief occurred on what had been discussed, and the participant was asked whether there was anything else they would like to add to the conversation. Any questions were addressed, and the participant was thanked for their time.

4.9.3.5 Participants

The majority of participants were female, which is consistent with the gender distribution in academia. There was only one male academic interviewed in this phase of the case study. The majority of participants were aged in their forties (seven participants) and fifties (nine participants), with most residing and teaching in NSW and WA. Given that there are more UG nursing degrees than UG midwifery and paramedicine degrees, it is not surprising that interview 15 participants taught in the nursing degree, two participants taught in both the nursing and midwifery degree, one participant taught solely in midwifery, and two in the paramedicine UG degree. Finally, although 12 participants had a relevant UG degree in their profession, only two had qualifications in caring for survivors or perpetrators of IPV.
Further demographic information is presented in Table 4.16.

**Table 4.16**

*Demographics of Interview Participants*

<table>
<thead>
<tr>
<th>Participant number</th>
<th>Age</th>
<th>Gender</th>
<th>State/territory</th>
<th>Degree</th>
<th>Years teaching</th>
<th>Completed UG degree</th>
<th>Qualifications in IPV</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>45</td>
<td>Female</td>
<td>Qld</td>
<td>Nursing</td>
<td>5</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>2</td>
<td>35</td>
<td>Female</td>
<td>Vic</td>
<td>Nursing</td>
<td>4</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>3</td>
<td>41</td>
<td>Female</td>
<td>Tas</td>
<td>Paramedics</td>
<td>2.5</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>4</td>
<td>56</td>
<td>Female</td>
<td>WA</td>
<td>Nursing</td>
<td>14</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>5</td>
<td>50</td>
<td>Female</td>
<td>NSW</td>
<td>Nursing &amp; Midwifery</td>
<td>22</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>6</td>
<td>51</td>
<td>Female</td>
<td>NSW</td>
<td>Nursing</td>
<td>5</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>7</td>
<td>62</td>
<td>Male</td>
<td>NSW</td>
<td>Nursing</td>
<td>31</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>8</td>
<td>58</td>
<td>Female</td>
<td>NSW</td>
<td>Paramedics</td>
<td>29</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>9</td>
<td>42</td>
<td>Female</td>
<td>NSW</td>
<td>Nursing</td>
<td>7</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>10</td>
<td>47</td>
<td>Female</td>
<td>WA</td>
<td>Nursing &amp; Midwifery</td>
<td>5</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>11</td>
<td>57</td>
<td>Female</td>
<td>Qld</td>
<td>Nursing</td>
<td>19</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>12</td>
<td>51</td>
<td>Female</td>
<td>NSW</td>
<td>Nursing</td>
<td>7</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>13</td>
<td>45</td>
<td>Female</td>
<td>WA</td>
<td>Nursing</td>
<td>4</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>14</td>
<td>55</td>
<td>Female</td>
<td>Vic</td>
<td>Nursing</td>
<td>21</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>15</td>
<td>54</td>
<td>Female</td>
<td>Qld</td>
<td>Midwifery</td>
<td>13</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>16</td>
<td>49</td>
<td>Female</td>
<td>WA</td>
<td>Nursing</td>
<td>7</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>17</td>
<td>55</td>
<td>Female</td>
<td>WA</td>
<td>Nursing</td>
<td>2</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>18</td>
<td>47</td>
<td>Female</td>
<td>Vic</td>
<td>Nursing</td>
<td>3</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

### 4.9.3.6 Thematic analysis

To prepare the interview data for the case-study analysis, the general inductive principles of qualitative research were followed, drawing on the generic approach of thematic analysis (Whitehead, 2014). Thematic analysis is a common analysis technique used by qualitative researchers (Whitehead, 2014). It can be used as part of a wider methodological design or as a stand-alone design.
During the thematic analysis, the interview was transcribed verbatim, and then line numbering was implemented to help locate the text throughout the analysis stage. Subsequently, the verbatim transcription was printed out to facilitate analysis and review (Whitehead, 2014). Next, the text was read and re-read several times for researcher to become very familiar with its content, and after this, important, interesting and relevant data were recognised and noted. This is classified as ‘coding’, and is usually achieved by highlighting sections of the transcript (Whitehead, 2014). The amount of data highlighted depends on the individual situation to maintain the context of the situation or experience. After all the verbatim transcriptions were read and re-read and coding was completed, codes were reviewed and themes generated to capture the qualitative richness of the phenomenon under investigation (Whitehead, 2014). Theme generation can occur via three methods (Whitehead, 2014, p. 265):

1. Theory driven—where the researcher attempts to apply a theory to the data collected
2. previous research—where the researcher compares and contrasts themes from previous research to themes identified in the current research
3. inductively—where the researcher explores and generates themes without any ‘consciously expressed predetermined interest’.

The thematic analysis utilised the third method of analysing the data without predetermined interest. Themes and the development of relationships between themes were then refined through further reading and re-reading of the data (Whitehead, 2014). Quotations were used to illustrate the nature of each theme. Finally, the themes identified were interpreted against the theory previously discovered via the literature review. This thematic-analysis technique is an iterative and reflexive process, but is often presented graphically as a linear process (Table 4.17):
### Table 4.17

**Thematic Analysis**

<table>
<thead>
<tr>
<th>Stage</th>
<th>Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1</td>
<td>Multiple readings of the data to generate familiarisation</td>
</tr>
<tr>
<td>Stage 2</td>
<td>Recognising and noting important, interesting and relevant data</td>
</tr>
<tr>
<td>Stage 3</td>
<td>Generating themes to capture the qualitative richness of the phenomenon noted above</td>
</tr>
<tr>
<td>Stage 4</td>
<td>Refining of themes and development of relationships between themes through reading and comparison with further data</td>
</tr>
<tr>
<td>Stage 5</td>
<td>Interpretation of themes in the context of theory or conceptual framework</td>
</tr>
</tbody>
</table>

*Source: Whitehead (2014, p. 143).*

This section has examined the data-collection methods used in this study. The first phase of this multiple case study involved the review of documentation in the form of publicly available online university-curriculum documents, while the second phase involved an online survey targeted at academics who were unit assessors or coordinators of UG nursing, midwifery and paramedicine units. The third phase involved conducting qualitative telephone interviews with the survey participants who further volunteered their time to conduct and interview. This section also explained the data-analysis methods utilised for each phase. The following section explains the data-analysis techniques specific to case-study research and highlights the techniques used in the current study.

### 4.10 Data Analysis for Case-study Research

In the preceding section, the data-collection techniques and their corresponding data-analysis methods were reported. In this section, the data-analysis techniques specific to case-study research will be reviewed. Data analysis for case-study research involves examining, categorising, tabulating, testing and combining evidence to produce empirically based findings (Yin, 2014). Yin (2014) states that this data analysis can occur via the use of general data-analysis strategies and specific analytic techniques. Any of these strategies and
techniques can be used in combination. The strategies and techniques used for data analysis in this case study are now discussed.

According to Yin (2014), the following four general data-analysis strategies that can be used in case-study research: 1) relying on theoretical propositions; 2) working the data from the ground up; 3) developing a case description; 4) examining plausible rival explanations (Yin, 2014). This case study relied on theoretical propositions and examining plausible rival explanations. Relying on the theoretical propositions that guide the case study is a key strategy because these propositions are used to shape the data-collection process and thus yield analytic priorities (Yin, 2014, p. 136). As part of the development of the theoretical propositions in this study, rival hypotheses or explanations were also developed. This enabled evidence to be collected for other possible influences. There are many kinds of rival explanations, but the type focused on in this case study was rival-theory explanations (Yin, 2014). These explanations provide a theory other than the original theory to better explain the results (Yin, 2014, p. 141).

Referring to analytic techniques, Yin (2014) states the following five specific techniques that can be used for analysing case-study data: 1) pattern matching; 2) explanation building; 3) time-series analysis; 4) logic models; 5) cross-case synthesis (Yin, 2014). This study used pattern matching, explanation building and cross-case synthesis as the specific analytic techniques. Pattern matching is the most desirable analytic technique because it involves comparing an empirically based pattern (the findings) to a predicted finding made prior to data collection (the propositions) (Yin, 2014, p. 143). If these patterns match, the internal validity of the case study is enhanced (Yin, 2014). Explanation building is a specific type of pattern matching that aims to develop an explanation about the case, utilising the case-study evidence. It is connected to theoretical propositions because the best case studies have explanations connecting the propositions to the evidence (Yin, 2014).
explanation building is not well documented in the literature; however, Yin (2014, p. 149) describes this iterative process as involving the following:

- developing an initial theoretical proposition
- comparing the evidence from the initial case study with the initial theoretical proposition
- redeveloping the initial theoretical proposition if necessary
- comparing other evidence from the case with this revised proposition
- comparing the evidence from a second, third or more case with this revised proposition
- repeating this process as required.

The final analytic technique utilised in this case study was cross-case synthesis. This technique was employed because this study uses a multiple-case-study research design. Cross-case analysis enables the comparison of the commonalities and differences of the units of analysis. The benefits of cross-case analysis include increasing the researcher’s imagination, prompting the researcher to ask new questions, producing alternatives to the initial propositions, constructing ideas, seeking explanations, making sense of unique findings, and articulating the theories discovered (Khan & VanWynsberghe, 2008). There are many different tactics that can be used to search for cross-case patterns; however, the tactic used in this study involved the selection of categories and then the examination of the findings for within-group similarities and intergroup differences (Eisenhardt, 1989). This was achieved through the creation of word tables (Yin, 2014).

In this study, case-study data analysis occurred through employing general data-analysis strategies and specific analytic techniques. This study employed the general data-analysis strategies of relying on theoretical propositions and examining plausible rival explanations, and the specific analytic techniques of pattern matching, explanation building and cross-case synthesis. Although the case-study research approach was adopted by this
study, it is important to acknowledge the limitations associated with this design. The following section discusses these limitations.

4.11 Limitations of Case-study Research

Now that the adoption of a mixed-methods multiple-case-study design has been justified and the three data-collection methods, along with the data-analysis techniques have been discussed, it is important to acknowledge the limitations of case-study research. As with all forms of research design, there are limitations to case-study research.

One limitation of case-study research is its lack of rigour because of a lack of adherence to systematic procedures (Yin, 2014). However, supporters of case-study research state that case-study research does not lack rigour if it is conducted appropriately and systematically (Yin, 2014). Additionally, it has been suggested that researchers not familiar with case-study research may confuse case-study teaching with case-study research. With case-study teaching, a person is able to alter the content within the case study to fit more appropriately with the content they are teaching. Therefore, if researchers associate this strategy with case-study research, then they might believe that case-study researchers alter the content and thus, the research is less rigorous than other forms of research (Yin, 2014).

Another common stated limitation of case-study research is that it lacks scientific generalisation, particularly if a single case study is used. Nevertheless, supporters of case-study research state that it is similar to experimental research in that the results are generalisable to theoretical propositions, not to populations (Yin, 2014). Thus, the aim of case-study research is to expand and generalise theories, which is classed as ‘analytic generalisation’ (Yin, 2014). However, there continues to be an emphasis on ‘true experiments’ and the causal relationships that are discovered through such experiments, thus downgrading case-study research because it does not produce findings on causal relationships (Yin, 2014).
Some researchers believe that case-study research can be used only for the exploratory phase of research, and is thus unable to be used for the descriptive or explanatory phase of investigation. Yin (2014) disputes this claim, stating that every research method can be adapted and applied to the exploratory, descriptive and explanatory phase of an investigation, and highlights examples of case-study research being used for explanatory and descriptive research. Therefore, an individual researcher can decide whether they want to conduct an exploratory case study, descriptive case study, or an explanatory case study (Yin, 2014).

This section has discussed the following limitations to case-study research: lack of rigour, lack of scientific generalisation, and use for only the exploratory phase of research. Arguments against these limitations were also presented. However, irrespective of the type of study conducted, ethical approval must be obtained and ethical principles must be adhered to. The following section discusses gaining ethics approval and considering ethical principles.

4.12 Ethical Considerations

While designing this case study, ethical principles needed to be considered and adhered to. In this section, the process of ethical approval is outlined, and the ethical principles considered are discussed. These principles are informed consent, anonymity and confidentiality, data storage, nonmalefeasance, beneficence and justice.

Phase one of this case-study research involved the collection and analysis of publicly available published university documentation and was therefore exempt from ethical approval. However, phase two (online survey) and phase three (focused interviews) required ethical approval, which was gained from the Southern Cross University Human Research Ethics Committee (HREC) (approval number ECN-13-146).

For phase two, an element of this ethical approval involved respondents providing informed consent to participate in the online survey. Informed consent was implied by the respondent completing the online survey (Fawcett & Garity, 2009; Newell & Burnard, 2011). An introductory email (Appendix C) was sent to all potential respondents with a participant
information sheet attached (Appendix D) and a link to the online survey. In the information sheet, and reiterated in the introductory email, completion of the online survey would constitute consent to participate in the case study. Further, respondents were notified that anonymity and confidentiality would be maintained via the use of the Qualtrics software. Respondents who provided their email address on the survey were informed that their details would be destroyed once the interviews for phase three had been conducted.

In contrast, the focused interviews conducted for phase three required a consent form (Appendix E) to be signed by all participants. An introductory email that included the consent form was emailed to all participants who agreed to participate in the focused interviews via the online survey. Once the signed consent form was received from the participant, email correspondence was employed to organise a date and time for the interview. Anonymity and confidentiality were maintained because participants’ names were used only during the initial recruitment correspondence. Once recruited, study codes and pseudonyms were used to identify each participant. No participant names or any circumstances or descriptions that could identify participants appear on any data or results. Additionally, for phase two and phase three, the data collected were secured in a locked filing cabinet to be kept for five years from the date of publication as per the National Health and Medical Research Council (NHMRC) (2007) guidelines. The only person with a key to the filing cabinet is the principal researcher to ensure data security and storage (NHMRC, 2007).

Nonmalefeasance and beneficence were maintained in phase two and phase three given there was minimal risk associated with participating in the online survey and focused telephone interview. Psychological harm was minimal because the questions did not concern personal experiences with IPV or perpetration of such violence. The questions focused on teaching practices, attitudes and beliefs about IPV-related content being incorporated into the UG curricula under research. It was also anticipated that no social harm would occur as a result of participation or non-participation in this research because anonymity and
confidentiality were maintained at all times. Further, there was no economic harm or costs associated with participating in either phase of the research (Fawcett & Garity, 2009). Finally, justice was maintained because there was no selection bias because of race, gender, ethnicity, religion or socioeconomic status (Fawcett & Garity, 2008; Newell & Burnard, 2011).

4.13 Chapter Summary

This chapter has described the adoption of a case-study research approach to the research study investigating the amount and type of IPV-related content in the UG degrees of nursing, midwifery and paramedicine and their resultant adherence to national and international organisations and committees’ guidelines and recommendations on the inclusion of this content. The realism paradigm was discussed as the paradigm of choice for case-study research because case-study research can be descriptive, exploratory and explanatory, with its aim being to understand the phenomenon under investigation within its natural context.

Justification for a mixed-methods research approach and the employment of case-study research for the study topic was provided, and the five components of case-study research design were discussed. The chapter also presented the different types of case studies identified by Yin (2014), and it was clarified that the current case study is a multiple-case (holistic) design. It is also important to be able to test the quality of a research approach, and the concepts of construct validity, internal validity, external validity and reliability were discussed, along with the case-study tactics and phases of the research in which these tactics were implemented.

The four principles of data collection were reported and the data-collection methods employed for the three phases of this case study were stated and described. The general data-analysis strategies and specific analytic techniques utilised in this case study were communicated, and the limitations of case-study research and the arguments against these limitations were explained. The chapter concluded with a discussion on the ethical considerations required for the three phases of this case study. Phase one was exempt from
ethical approval; however, phase two and three required ethical approval by the Southern Cross University HREC. The following chapter analyses the data collected from the three phases discussed in this chapter, and presents the research findings.
Chapter 5: Findings

The thought of someone you love and who is supposed to love you back continuously inflicting physical and emotional pain towards you is unthinkable—yet it happens all too often throughout the world we live in.

5.1 Chapter Preamble

The previous chapter presented the multiple-phase, mixed-methods case study research methodology adopted for the current study. Following the principles of Yin (2014), data were analysed to address the research questions stated in Chapter 1, and the research propositions and rival explanations were tested. The aim of this chapter is twofold. First, it provides a description of the three discipline cases under examination in this case study. Second, it presents the evidence for each research proposition by presenting within-case analysis, examination of rival explanations, cross-case analysis and testing of the research proposition. This approach offers converging lines of enquiry (Yin, 2014) and a more detailed understanding of the factors that influence the inclusion or non-inclusion of IPV-related content in Australian UG curricula for nursing, midwifery and paramedicine degrees. Details of the findings from the documentary content analysis, online survey and qualitative telephone interviews will be considered sequentially in light of the relevant research propositions and rival explanations.

This chapter is presented in 5 sections. Section 5.1 provides a chapter preamble and pictorial outline of this chapter (Figure 5.1), while Section 5.2 provides a description of the three discipline cases. Section 5.3 provides the evidence for the six research propositions and the three phases of this case study. Unplanned findings that were collected but did not fit with any stated research question/research proposition will be presented in Section 5.4 and lastly, this chapter will conclude with a summary (Section 5.5).
5.2 Description of Cases

This section provides detail on the three cases utilised in the case study, including the nature of the curriculum documents reviewed and a description of the study respondents for the phase two online survey and the study participants for the phase three qualitative interviews. Table 5.1 summarises the details of the three UG cases.
Table 5.1  

*Case-study Profiles*

<table>
<thead>
<tr>
<th>Case</th>
<th>Discipline</th>
<th>Location</th>
<th>Phase one: degrees (n=)</th>
<th>Phase one: documents (n=)</th>
<th>Phase two: survey respondents (n=)</th>
<th>Phase three: interview participants (n=)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Nursing—BN</td>
<td>Qld, NSW, ACT, NT, WA, SA, Vic, Tas</td>
<td>33</td>
<td>766</td>
<td>BN =127 BN + BM = 17 BN + BP = 8 BN + BM + BP =7</td>
<td>BN = 15 BN + BM = 2</td>
</tr>
<tr>
<td>B</td>
<td>Midwifery—BM</td>
<td>Qld, NSW, Vic, ACT, NT WA SA</td>
<td>13</td>
<td>281</td>
<td>15</td>
<td>1</td>
</tr>
<tr>
<td>C</td>
<td>Paramedicine—BP (or equivalent)</td>
<td>Qld, NSW, WA, SA, Vic, Tas</td>
<td>11</td>
<td>253</td>
<td>9</td>
<td>2</td>
</tr>
</tbody>
</table>

The purpose of the documentary analysis in the first phase of the study was to gain preliminary information on IPV-related content in the curricula across the three cases. At the time of the data collection, 39 universities offered the case disciplines. In total, 1,300 individual curriculum documents were retrieved (Case A: n=766; Case B: n=281, Case C: n=253) from the programmes across the Australian states and territories. Table 5.2 summarises the details of the curriculum documents retrieved from the universities that formed the case sample.
Table 5.2

Curriculum Documents Retrieved by Discipline Case

<table>
<thead>
<tr>
<th>Document type</th>
<th>Case A (n=)</th>
<th>Case B (n=)</th>
<th>Case C (n=)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information leaflet</td>
<td>3</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Student handbook</td>
<td>6</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Course profiles or handbook</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Courses search documents</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Course outline or planner</td>
<td>6</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Course summary</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unit catalogue or outline</td>
<td>6</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Topics pages</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Course structure</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Subject search documents</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Subject database</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unit description</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Total documents retrieved</td>
<td>36</td>
<td>13</td>
<td>11</td>
</tr>
</tbody>
</table>

In the second phase of the study, an online survey was administered to Australian academics who were unit assessors or coordinators in the three disciplines under examination. From the total sample of 603 academics who were willing to participate in the survey, 587 academics were available at the time of survey. A total of 202 completed surveys were returned, providing a response rate of 34.9%. This is a typical response rate reported in the social sciences for web-based surveys, with an average response rate of 33% reported for online surveys, compared with 56% for paper-based surveys (Monroe & Adams, 2012; Nulty, 2008; Petchenik & Watermolen, 2011). Demographic details of the survey respondents are presented in Table 5.3. Most of the respondents were female (82%, n=161), compared to male (18%, n=36). Most were between 50 and 59 years of age (42%, n=82) and had completed a nursing degree (82%, n=155); 12% (n=23) had completed a midwifery degree and 6% (n=11)
a paramedicine degree. For years practising in their profession, the majority (n=114, 61%) had 21 or more years of experience.

Table 5.3

**Survey Sample Demographics**

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>N</th>
<th>Valid (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>161</td>
<td>81.7</td>
</tr>
<tr>
<td>Male</td>
<td>36</td>
<td>18.3</td>
</tr>
<tr>
<td>Missing</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20–29 years</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>30–39 years</td>
<td>27</td>
<td>13.7</td>
</tr>
<tr>
<td>40–49 years</td>
<td>74</td>
<td>37.6</td>
</tr>
<tr>
<td>50–59 years</td>
<td>82</td>
<td>41.6</td>
</tr>
<tr>
<td>60–69 years</td>
<td>14</td>
<td>7.1</td>
</tr>
<tr>
<td>70+ years</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Predominant occupation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>153</td>
<td>82.3</td>
</tr>
<tr>
<td>Midwife</td>
<td>22</td>
<td>11.8</td>
</tr>
<tr>
<td>Paramedic</td>
<td>11</td>
<td>5.9</td>
</tr>
<tr>
<td>Missing</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Highest level of educational attainment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UG degree</td>
<td>12</td>
<td>6.3</td>
</tr>
<tr>
<td>Master degree</td>
<td>118</td>
<td>61.8</td>
</tr>
<tr>
<td>PhD and postdoctoral degree</td>
<td>61</td>
<td>31.9</td>
</tr>
<tr>
<td>Missing</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Years practising in profession</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1–5 years</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>6–10 years</td>
<td>17</td>
<td>9.1</td>
</tr>
<tr>
<td>11–20 years</td>
<td>54</td>
<td>29.0</td>
</tr>
<tr>
<td>21+ years</td>
<td>114</td>
<td>61.3</td>
</tr>
<tr>
<td>Missing</td>
<td>16</td>
<td></td>
</tr>
</tbody>
</table>
In the third phase of the study, qualitative telephone interviews were conducted to corroborate and extend the findings from the phase two online survey. Participants were recruited via purposive sampling and selected based on their knowledge and experience in the phenomenon under investigation. Recruitment continued until data saturation occurred at the eighteenth interview.

Table 5.4

Interview Participant Demographics

<table>
<thead>
<tr>
<th></th>
<th>Nursing (n=13)</th>
<th>Paramedicine (n=2)</th>
<th>Midwifery (n=1)</th>
<th>Nursing and Midwifery (n=2)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35–45</td>
<td>4</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>46–56</td>
<td>7</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>57+</td>
<td>2</td>
<td>1</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>12</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Male</td>
<td>1</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td><strong>State</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NSW</td>
<td>4</td>
<td>1</td>
<td>–</td>
<td>1</td>
</tr>
<tr>
<td>Qld</td>
<td>2</td>
<td>–</td>
<td>1</td>
<td>–</td>
</tr>
<tr>
<td>Tas</td>
<td>–</td>
<td>1</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>WA</td>
<td>4</td>
<td>–</td>
<td>–</td>
<td>1</td>
</tr>
<tr>
<td>Vic</td>
<td>3</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td><strong>Years Teaching</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1–5</td>
<td>6</td>
<td>1</td>
<td>–</td>
<td>1</td>
</tr>
<tr>
<td>6–10</td>
<td>3</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>11–15</td>
<td>1</td>
<td>–</td>
<td>1</td>
<td>–</td>
</tr>
<tr>
<td>15+</td>
<td>3</td>
<td>1</td>
<td>–</td>
<td>1</td>
</tr>
<tr>
<td>Completed UG degree</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Qualifications in IPV</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>1</td>
<td>–</td>
<td>–</td>
</tr>
</tbody>
</table>
5.3 Results in Relation to Research Propositions

Having described the three discipline cases above, this section contains an analysis of the data in relation to each research question, its theoretical proposition and rival explanation. Within case and cross-case analysis will be presented under each research proposition. Following this, will be a section examining the unplanned or unexpected data that were collected but does not fit with any of the stated research questions/propositions.

5.3.1 Research proposition 1: predominance of IPV-related content

The predominance of IPV-related content was established through frequency counts, self-reported detail from the participants on the frequency of inclusion and the allotted time teaching this content. The second part of the proposition, which relates to barriers, was examined through self-reported perceptions about barriers and statistical analysis of the attitudinal survey scales.

Research question 1: How prominently has IPV-related content appeared in the curriculum being offered in the currently available Australian UG nursing, midwifery and paramedicine degrees?

Research proposition 1: It is the proposition after an extensive literature review that the amount of time spent on IPV-related content in the above curricula will be minimal because of the barriers of a lack of awareness, an overcrowded curricula and a lack of support for this inclusion.

Rival explanation 1: IPV-related content within the UG nursing, midwifery and paramedicine degrees will be minimal because of the higher percentage of female academics in academia and a lack of exposure to survivors or perpetrators of IPV.

5.3.1.1 Phase one—documentary content analysis

Descriptive analysis identified that the number of units containing the terms ‘IPV’ and/or ‘DV’ was minimal. In total, only 0.92% (n=12) of documents from the pool of 1,300
unit outlines retrieved specifically contained these terms. Case B (midwifery n=7) contained these terms the most, followed by Case A (nursing n=4) and Case C (paramedicine n=1).

Examination of the documents for alternative terms revealed possible relevant content across a range of subject areas (see Table 5.5).

Table 5.5

<table>
<thead>
<tr>
<th>Frequency of Alternative Terms in Curriculum Documents</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Trauma and trauma care</strong> (n=)</td>
</tr>
<tr>
<td>Trauma (11)</td>
</tr>
<tr>
<td>Trauma pathophysiology (1)</td>
</tr>
<tr>
<td>Traumatic emergency/ies (2)</td>
</tr>
<tr>
<td>Management and treatment of serious trauma (1)</td>
</tr>
<tr>
<td>Highest level trauma care (1)</td>
</tr>
<tr>
<td>Triage and trauma scoring (2)</td>
</tr>
<tr>
<td>Musculoskeletal injuries (3)</td>
</tr>
<tr>
<td>Specific types of injuries (3)</td>
</tr>
<tr>
<td>Major trauma (3)</td>
</tr>
<tr>
<td>Trauma management (3)</td>
</tr>
<tr>
<td>Traumatic injuries (12)</td>
</tr>
<tr>
<td>Emotional and social trauma (1)</td>
</tr>
<tr>
<td>Prevention injury/trauma (6)</td>
</tr>
<tr>
<td>Tissue injury (2)</td>
</tr>
<tr>
<td>Mechanisms of injury (1)</td>
</tr>
<tr>
<td>Long-term injury (1)</td>
</tr>
<tr>
<td>Non-accidental injury (1)</td>
</tr>
<tr>
<td>Serious and acute trauma (2)</td>
</tr>
<tr>
<td>Trauma care (3)</td>
</tr>
<tr>
<td>Effect of trauma (1)</td>
</tr>
<tr>
<td>Traumatic conditions (1)</td>
</tr>
<tr>
<td>Management of injury (1)</td>
</tr>
<tr>
<td>Harm to self and others (2)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Gender and family issues (n=)</td>
</tr>
<tr>
<td>Rape (1)</td>
</tr>
<tr>
<td>Sexual assault (2)</td>
</tr>
<tr>
<td>Gender-specific issues (2)</td>
</tr>
<tr>
<td>Intimate relationships (1)</td>
</tr>
<tr>
<td>Family violence (3)</td>
</tr>
<tr>
<td>Child and youth abuse (2)</td>
</tr>
<tr>
<td>Child abuse and neglect (1)</td>
</tr>
<tr>
<td>Child and family crisis (1)</td>
</tr>
<tr>
<td>Child safe environment (1)</td>
</tr>
<tr>
<td>Family health (1)</td>
</tr>
<tr>
<td>Family dynamics (1)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Risk assessment (n=)</td>
</tr>
<tr>
<td>Mandatory reporting (6)</td>
</tr>
<tr>
<td>Child protection issues (7)</td>
</tr>
<tr>
<td>Reporting abuse and neglect (1)</td>
</tr>
<tr>
<td>Risk assessment (1)</td>
</tr>
<tr>
<td>Signs of abuse (1)</td>
</tr>
<tr>
<td>Recognise and report abuse (2)</td>
</tr>
</tbody>
</table>
5.3.1.1.1 Comparative analysis by discipline case

Table 5.6 summarises the predominance of relevant content for the three cases identified from the documentary content analysis conducted in phase one. Cross-case analysis for each case confirmed the following:

- **Case A—Nursing:** The proportion of units containing identifiable IPV/DV content was minimal (0.5%). Units containing possible relevant content were in the subject areas of injury prevention, trauma, harm to self and others and gender-related issues.

- **Case B—Midwifery:** The proportion of units containing identifiable IPV/DV content was the highest across the three discipline cases, but still minimal (2.5%). Units containing possible relevant content were in the subject areas of physical abuse, sexual abuse, rape and family violence.

- **Case C—Paramedicine:** The proportion of units containing identifiable IPV/DV content was minimal (0.3%), appearing in one unit only. Units containing possible relevant content were in the subject areas of trauma, injury and injury plans, and legal aspects related to abuse of vulnerable members of society.

Table 5.6

*Documentary Analysis: Frequency of IPV-related Content by Case*

<table>
<thead>
<tr>
<th>Category of content</th>
<th>Case A n (%)</th>
<th>Case B n (%)</th>
<th>Case C n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Units with IPV-related content (using the terms ‘IPV’/‘DV’)</td>
<td>4 (0.5)</td>
<td>7 (2.4)</td>
<td>1 (0.3)</td>
</tr>
<tr>
<td>Units with possible alternative IPV-related Content</td>
<td>44 (5.4)</td>
<td>6 (2.1)</td>
<td>22 (8.3)</td>
</tr>
<tr>
<td>Units with no IPV-related content</td>
<td>718 (93)</td>
<td>268 (95)</td>
<td>232 (91)</td>
</tr>
<tr>
<td>Total</td>
<td>766</td>
<td>281</td>
<td>255</td>
</tr>
</tbody>
</table>
5.3.1.2 Phase two—online survey

Further detail on the predominance of IPV-related content in the three cases was identified from the online survey. Respondents who identified as being a unit assessor or coordinator (n=166) were asked to report detail on the content related to IPV in the UG units for which they were responsible. Across the three cases, a total of 32.1% (n=54) of units taught were reported to contain IPV-related content. Of the 54 respondents who reported that IPV-related content was included in their units, 72% (n=39) reported delivering this content in one to three hours, while 19% (n=10) reported delivering the content in four to eight hours.

5.3.1.2.1 Comparative analysis of content by discipline case

Cross-case analysis of the survey data for each case confirmed the following:

- Case A—Nursing: IPV-related content was reported to be included in 30.9% (n=42) of units. Most of this content was delivered in one to three hours (n=32), with fewer units (n=9) including four to eight hours of content. One respondent reported that IPV-related content was delivered in nine to fourteen hours.

- Case B—Midwifery: IPV-related content was reported more commonly in this case, with 52.9% (n=9) of units including this content inclusion. Most content was delivered in one to three hours, with one respondent reporting delivery time of four to eight hours, and one reporting 15 hours or more.

- Case C—Paramedicine: Only one academic reported inclusion of IPV-related content in their unit for this case. This content was delivered in one to three hours.

- As summarised in Table 5.7, comparative analysis between discipline cases employing a chi-square test for independence identified statistically significant differences (p=0.045) between the cases for the inclusion of IPV-related content, with midwifery containing a higher proportion than the other disciplines. Comparative analysis by other demographic characteristics (age, gender, years in the profession, religious
affiliation, ethnicity, marital status) did not identify any significant differences for inclusion or non-inclusion of IPV-related content.

Table 5.7

### Inclusion of IPV-related Content by Discipline

<table>
<thead>
<tr>
<th>Discipline Area</th>
<th>N</th>
<th>Yes</th>
<th>n (%)</th>
<th>n (%)</th>
<th>(\chi^2)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td>136</td>
<td>42</td>
<td>94</td>
<td>(30.9)</td>
<td>(69.1)</td>
<td>6.18 (2)</td>
</tr>
<tr>
<td>Midwifery</td>
<td>17</td>
<td>9</td>
<td>8</td>
<td>(52.9)</td>
<td>(47.1)</td>
<td></td>
</tr>
<tr>
<td>Paramedicine</td>
<td>11</td>
<td>1</td>
<td>10</td>
<td>(9.1)</td>
<td>(90.9)</td>
<td></td>
</tr>
</tbody>
</table>

5.3.1.2.2 Comparative analysis of perceptions about barriers to IPV-related content inclusion.

Proposition one asserts that barriers are influencing factors for the inclusion of IPV-related content in UG HCP curricula. To examine attitudinal barriers, the factors derived from the PCA reported in the previous chapter were employed to examine the participants’ self-reported attitudes about barriers to IPV-related inclusion. The factors used in this analysis were *professional role resistance* (five items: e.g., ‘Health-care practices related to IPV is not within the scope of practice for my discipline’) and *professional role acceptance* (seven items; e.g., ‘Academics need to role model that IPV is unacceptable’). Employing sum-scores, which are created by totalling scores for each item in the five-point factor scale for these factors, a Kruskal–Wallis test was performed. As reported in Table 5.8, *professional role acceptance* was statistically significant (p<0.001) in its association with inclusion of IPV-related content.
Table 5.8

**Kruskal–Wallis Test: Professional Role Resistance, Barriers to Inclusion of IPV in the Curriculum and IPV-related Content**

<table>
<thead>
<tr>
<th></th>
<th>Professional role acceptance*</th>
<th>Professional role resistance**</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean rank</td>
<td>$\chi^2$ (df)</td>
</tr>
<tr>
<td>Exposure to IPV survivors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>76.22</td>
<td>0.273(1)</td>
</tr>
<tr>
<td>No</td>
<td>81.43</td>
<td></td>
</tr>
<tr>
<td>Inclusion of IPV-related content</td>
<td>1(10.161)</td>
<td>0.001</td>
</tr>
<tr>
<td>Yes</td>
<td>60.53</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>85.18</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>66.40</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>91.36</td>
<td></td>
</tr>
</tbody>
</table>

*Notes. * Higher score indicates lower role acceptance; ** higher score indicates higher role resistance.

Further examination of individual scale items within the professional role resistance, professional role acceptance and curricula barriers to inclusion of IPV scales identified five items that had mean scores above 2.0. These are the items for which respondents demonstrated higher rates of disagreement or support (see Table 5.9).
Table 5.9

*Descriptive Analysis of Scale Items with Higher Frequency of Disagreement*

<table>
<thead>
<tr>
<th>Scale item</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>Agree (%)</th>
<th>Disagree (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All health-discipline UG students should have a clinical placement in a</td>
<td>159</td>
<td>3.17</td>
<td>1.051</td>
<td>25.1 (40)</td>
<td>67 (42.1)</td>
</tr>
<tr>
<td>women’s shelter or a planned clinical placement with IPV survivors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For all HCPs to gain adequate IPV-related knowledge, they must be educated</td>
<td>159</td>
<td>2.13</td>
<td>0.969</td>
<td>155 (68.6)</td>
<td>18 (11.3)</td>
</tr>
<tr>
<td>on IPV during their initial UG degree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Without IPV-related content within HCP curriculum, IPV will remain</td>
<td>160</td>
<td>2.17</td>
<td>0.992</td>
<td>108 (67.5)</td>
<td>18 (11.3)</td>
</tr>
<tr>
<td>undetected and untreated, with the cycle of violence remaining intact</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Failure to identify a woman experiencing IPV at her initial contact with</td>
<td>161</td>
<td>2.17</td>
<td>0.963</td>
<td>109 (67.7)</td>
<td>16 (9.9)</td>
</tr>
<tr>
<td>the health-care system will result in incorrect care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Femicide is not related to IPV</td>
<td>155</td>
<td>2.05</td>
<td>0.844</td>
<td>106 (68.4)</td>
<td>5 (3.2)</td>
</tr>
</tbody>
</table>

To examine the participants’ perceptions of structural and systematic barriers to IPV-related content inclusion, respondents were asked why they believed IPV-related content was not included in their curriculum. Analysis of these survey items confirmed the following perceptions as the main self-reported reasons for non-inclusion of this content: an already overcrowded curriculum (89.6%, n=138), followed by lack of academics confident and competent to teach in this area (55.8%, n=86), and a lack of support to include IPV-related content in the curriculum (39.6%, n=61). To further examine these perceptions, a variable suited for testing using the Kruskal–Wallis test was created by summing three items (i.e., curriculum is already overstretched, lack of academics that are confident, and lack of support) to create the sum-score item *curricula barriers to inclusion of IPV*. Comparative statistical analysis demonstrated no significant relationship between this variable and the inclusion of IPV-related content (see Table 5.10). Similarly, no statistical association was identified
between *curricula barriers to inclusion of IPV* and the inclusion of IPV-related content, discipline or gender.

Table 5.10

*Kruskal–Wallis Test: Curricula Barriers to Inclusion of IPV and Inclusion of IPV-related Content in Taught Units*

<table>
<thead>
<tr>
<th>Systemic barriers to inclusion</th>
<th>Mean rank</th>
<th>$\chi^2$ (df)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inclusion of IPV-related content</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>79.23</td>
<td>1(0.120)</td>
<td>0.730</td>
</tr>
<tr>
<td>No</td>
<td>76.72</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td>1(0.028)</td>
<td>0.929</td>
</tr>
<tr>
<td>Female</td>
<td>77.36</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>78.12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discipline</td>
<td></td>
<td>2(0.274)</td>
<td>0.872</td>
</tr>
<tr>
<td>Nursing</td>
<td>76.23</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midwifery</td>
<td>81.69</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paramedicine</td>
<td>73.25</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5.3.1.3 Phase three—qualitative telephone interviews

The inclusion of IPV-related content appeared more predominant when participants were interviewed. Of the 18 participants, 11 stated they include IPV-related content. The time spent delivering this content ranged from several minutes to a maximum of two hours. While six participants from Case A reported they included IPV-related content in their units, according to PT 14, this content was only mentioned briefly:

*At the present moment, I'm teaching an acute medical–surgical unit and it's mentioned only obliquely when we talk about patients presenting to the emergency department and alerting the students to be aware of considering whether the explanation given for the injury matches to the injury observed.*

Additionally, although IPV-related content was not included in their unit, one nursing academic (PT 11) realised through the interview that this content now could be included:
No, I probably should. I teach aged-care nursing. So, it probably could very easily go in there because we have the … because we look at culture and sexuality and all that stuff, so we could probably look, we look at elder abuse but I haven’t even. It’s something that’s never even talked about across the board, is it?

IPV-related content was included by three midwifery academics that were interviewed for this case study. When asked if they included IPV-related content in their unit, PT 10 stated, ‘I certainly do … it’s one of my topics. Unfortunately, it’s in along with abortion … so they get a choice of which topic they’re going to present on’. PT 5 made a similar statement that she includes it ‘whenever I can’ (PT 5). However, PT 5 indicated that she has never seen IPV as part of a curriculum document in the areas in which she teaches: ‘All the units I’ve taught, there’s never been any objective to look about … talk about violence in anyway’ (PT 5). The proximity of the midwifery profession to women was recounted by midwifery academics to provide midwives a unique opportunity to help women survivors of IPV, and therefore, should be an influencing factor in including IPV-related content into the BM curricula:

Yeah, I think so because you’re dealing with some … you know, you have such a great chance to influence, you know, change too, and encourage people to, you know, help people to leave situations where … be able to give them resources to deal with it and become aware of it. (PT 5)

In Case C, the two paramedicine academics who participated in the telephone interviews reported including IPV-related content in their units. However, similar to the other two cases, the content was only minimally covered: ‘Yeah, we talk about it, for maybe a half hour in class’ (PT 3). This participant recounted including IPV-related content as part of an assessment case, but was unable to estimate how long students spent learning the topic. PT 8 also reported this minimal coverage: ‘Currently it gets just, you know, sort of an acknowledgement … I would not like to put more than a couple of hours on it’.
Given that both paramedicine academics who participated in the interviews included IPV-related content, they were asked why they included this content into their units. They both stated they felt the need to provide students with the reality of what they are going to see out in the real world. PT 3 illustrates this point:

*I try to choose quite violent acts for the trauma unit because they need to realise it’s not just people falling off pushbikes and breaking an ankle. Sometimes, there are murders and sometimes, there are really nasty, horrible, yucky things where people have treated other people really poorly.*

The uniqueness of the paramedicine degree was also reported to influence the inclusion of IPV-related content, and the surface learning that occurs in that degree. This was noted by PT 3:

*There’s so many pieces of the pie that you need to try to insert into these poor students’ brains. There’s so many bits of information that have to be lodged in there to help them grasp paramedic practice. It’s so different to nursing, so different to medicine. We’re kind of a bit of everything, and we want to give them high value. But I do find that even the course as it is, you know, it’s a ... it becomes very surface learning. Because there’s so much to learn, and there’s no time to digest it.*

During the telephone interviews, participants were asked why they did or did not include IPV-related content in their units. A range of answers were given, but the most common answer was that IPV-related content did not ‘fit’ into the unit. One reason reported for nursing academics failing to include IPV-related content in their units was that it did not fit into the unit they taught. One nursing academic (PT 16) failed to see how IPV-related content could be incorporated into a skills unit and a chronic-care unit:

*It doesn’t quite fit in the units that I have been teaching, yes. I do a first-year skills unit, as in a semester one, and I’m in the process of writing a new unit in chronic care, so yes, it doesn’t fit.*
Other answers included a lack of support and a lack of confidence to teach this topic area. An already packed curriculum was noted by seven participants across all three cases. This was reported as the biggest barrier to including IPV-related content, and if IPV-related content was included in the curriculum, then students would become overloaded and the curriculum would lose its effect. The academics explained that students are already doing two-hour tutorials and two-hour lectures every week for eight to 12 weeks, and any more content would be too much for them. This was supported by midwifery academics, as explained by PT 5:

_I think yep, definitely it’s the overcrowded curriculum. I think too much emphasis is placed on clinical care and not on social and emotional wellbeing. Probably a lot of staff might not be schooled up in the area or committed or interested in it. I think one of the barriers, the main barriers, is that there’s too much in the curriculum and it’s too clinically focused._

Other significant barriers included budget and staffing constraints, industry practice partners not considering IPV a significant public-health problem, academics being frightened and feeling unconfident to present this type of material, and academics’ lived experience of IPV making it challenging to teach this content. Lack of support was highlighted by PT 13:

_I did spend a few years asking if I could have, information … I could have stuff on feminist theory, but the university was not interested. The School of Nursing was not interested in that, so, did I put much? I probably put a slide or two in it._

A significant barrier to the inclusion of IPV-related content that was not considered in the research propositions was the focus of the curriculum, in particular its focus on science and clinical skills. A nursing academic stated the following:

_I think one of the problems at the moment in nursing curricula across Australia is they’re becoming more and more hard science, more and more biosciences, more and
more pharmacology, more and more critical care. Because our degrees are only three years, that sort of time-expensive teaching is falling into disuse. (PT 7)

The participants identified focus on clinical care and acute medical–surgical nursing, and skills such as drug calculations and resuscitation, and less focus on areas such as health promotion, mental health, and social health and welfare as barriers to including IPV-related content in their units:

It’s actually easy to ignore [IPV] and to worry about the IV pump and the medications and the removing sutures because those are nice psychomotor skills which you can grasp easily and they do not challenge you emotionally or personally. And with the short stay that patients have, then one can conveniently say, well, there was not time to explore those issues with, with the person.

A similar sentiment was expressed by PT 3, who stated the focus is on ‘ECGs [electrocardiograms] and diagnoses of different types of respiratory conditions and management of different types of medication for conditions, rather than emotional points’. PT 8 elaborated on the focus on the biomedical model:

I think there is, you know, of course, the bias that, um, you know, really is supportive of a biomedical, problem-based kind of curriculum that’s around secondary acute medical–surgical nursing and, um, although there’s lip service paid to primary health care and these other areas, getting beyond a little foothold for something around mental health is really, um, you know, difficult. There’s some, yeah, some psychosocial stuff, but, yeah, it’s difficult.

Additionally, being competent and confident to teach the area of IPV was another factor influencing the inclusion of IPV-related content. Having someone with a wealth of
knowledge and experience on the teaching team enabled the teaching of this content to midwifery students. PT 15 illustrated this point:

*I think for maybe some educationalists, they do not understand the enormity of it and actually the overall effect, and I think what has brought it home in the UK for a lot of educationalists and a lot of clinicians was the confidential enquiry into maternal deaths, that actually had a whole chapter on DV and women that are murdered during pregnancy and in the perinatal period due to DV."

5.3.1.4 Examining rival explanation

In case-study research, it is important to consider rival explanations as the study unfolds. For research proposition 1, the rival explanation proposed that because of the higher percentage of female academics in academia and a lack of exposure to survivors or perpetrators of IPV, IPV-related content would be minimal.

Descriptive statistics conducted for the online survey found that gender influenced the inclusion of IPV-related content, but not in the direction stipulated by the rival explanation. It was identified that the majority of content was included by female academics (83.02%, n=44). Moreover, statistical analysis confirmed that attitudinal barriers to IPV-related content inclusion were gendered, with mean-rank scores on professional role resistance lower in female academics. No statistical association was demonstrated between gender and perceptions about curricula barriers to inclusion of IPV. Gender was reported as a barrier to including IPV-related content in the telephone interviews. For example, PT 5 explained the following: ‘I think it’s also still a really male-dominated culture, and maybe that might contribute to lack of awareness and, you know, a commitment to raising those issues’.

Evidence of the influence personal experience of IPV has on the inclusion of IPV-related content was minimal. In the online survey, eight respondents stated they had extensive exposure to survivors or perpetrators of IPV. Interestingly, four of these respondents included IPV-related content in their units, but four did not. Further, two respondents stated they had
no exposure to IPV survivors or perpetrators but still incorporated IPV-related content into their units. Similarly, exposure to IPV survivors or perpetrators was not significantly associated with variance in scores on the scales for *professional role resistance* and *professional role acceptance*.

5.3.1.5 **Cross-case analysis**

Evidence from the three phases of this case study was compared to test proposition 1 and is summarised in Figure 5.2. The common findings from all cases refer to the perceptions of the participants about barriers that prevent the inclusion of IPV-related content in the UG nursing, midwifery and paramedicine degrees. The two barriers most commonly perceived were an overloaded curriculum and a focus on clinical care/skills.

*Figure 5.2. Cross-case analysis for research proposition 1.*
5.3.1.6 Testing research proposition 1

In the first phase of this case study, it may be argued that content related to IPV may have been included in the UG nursing, midwifery and paramedicine degrees more than is reflected in this documentary analysis, as the documentation under review may not have been reflective of the actual UG curricula being delivered. However, the purpose of the first phase was to establish the prominence of IPV-related content included in the disciplines investigated in the case studies. The proposition that the amount of time spent delivering IPV-related content in the three disciplines’ curricula was confirmed as minimal, with less than 1% of curriculum documents across the three cases specifically containing IPV-related content. However, this phase does not address the factors for which this occurs. As per Yin’s (2014) guidelines, data collection can lead to further questions needing to be addressed. This was the case in this study, with phase two addressing the second part of research proposition 1. Obtaining this in-depth knowledge and confirming or disconfirming research proposition 1 required surveying the academics who taught units in these UG degrees.

The online survey conducted in phase two of this study provided evidence to suggest that the presence of IPV-related content was minimal in the UG nursing, midwifery and paramedicine degrees, with less than one-third of units incorporating IPV-related content. However, according to the interview evidence from phase three, 11 of the 18 participants included IPV-related content into their units. Nonetheless, this content was only delivered in several minutes to approximately two hours. Although 11 participants reported including this content, they may have been motivated to include this content and be involved in the interviews because of their interest in and passion for the topic.

The second half of research proposition 1 focuses on the barriers prohibiting the inclusion of IPV-related content in the UG curricula. The participants reported lack of awareness of IPV, an overcrowded curriculum, and a lack of support as resulting in the minimal inclusion of this content in their courses. Given that there was no statistical
significance found for the relationship between curriculum barriers to IPV and the inclusion of IPV-related content, the findings from the online survey do not offer support for research proposition 1. The barrier of a lack of awareness of the importance of including IPV-related content in the units was reported by nursing and midwifery academics, and an overstretched curriculum was reported across all three cases. The barrier of lack of support was reported only in Case A.

Research proposition 1 is only partially supported by the evidence obtained in this multiple-phase case study. It was found that there is a minimal amount of IPV-related content in the UG nursing, midwifery and paramedicine degrees in Australia and when this content is included, it is delivered only in several minutes to a couple of hours. The evidence pertaining to the second section of this research proposition, which refers to the barriers that prohibit the inclusion of IPV-related content in these units, was conflicting and thus further research needs to be conducted on this subtopic.

5.3.2 Research proposition 2: integration of IPV-related content

The premise of research proposition 2 is that integration of IPV-related content is demonstrated by inclusion into core units throughout the degree, including work-based learning and clinical-placement units. To address this proposition, data were collected from respondents on whether units containing IPV-related content were core or elective units. Academics’ competence was examined through items enquiring about the nature and extent of their IPV-related education, how academics rated their knowledge of IPV, and the academics’ level of exposure to IPV victims. Academics’ passion for the topic was examined through the scale *professional role acceptance* and participants’ narratives.

**Research question 2:** How is this IPV-related content being integrated into the curriculum of nursing, midwifery and paramedicine?

**Research proposition 2:** The proposition of this research question is that there exists a lack of integration of IPV-related content into the UG curricula of nursing, midwifery and
paramedicine and IPV-related content is only included in units when the unit coordinator (or equivalent) feels competent and passionate about this content.

**Rival explanation 2:** IPV-related content is integrated throughout the UG curricula of nursing, midwifery and paramedicine, as this content is part of the core units rather than elective units.

5.3.2.1 Phase one—documentary content analysis

Descriptive analysis identified that across the degrees examined, IPV-related content was almost exclusively included in core units (91%, n=49). Examining each case separately, for Case A, 37 of the 42 units that contained IPV-related content were core units (88.1%); for Case B and Case C, 100% of the units that contained IPV-related content were core units (see Table 5.11).

<table>
<thead>
<tr>
<th>Unit type</th>
<th>N</th>
<th>Case A n (%)</th>
<th>Case B n (%)</th>
<th>Case C n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core unit</td>
<td>47</td>
<td>37 (88.1)</td>
<td>9 (100)</td>
<td>1 (100)</td>
</tr>
<tr>
<td>Elective unit</td>
<td>5</td>
<td>5 (11.9)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>52</td>
<td>42</td>
<td>9</td>
<td>1</td>
</tr>
</tbody>
</table>

5.3.2.2 Phase two—online survey

To address the second component of this proposition, respondents were asked to what extent they agreed with the following statement: ‘All health-discipline UG students should have a clinical placement in a women’s shelter or a planned clinical placement with IPV survivors’. Most respondents (n=55; 34.6%) disagreed that UG students should have a planned clinical placement with IPV survivors, with only 7.5% (n=12) strongly agreeing with this statement.
Examination of the relationship between academics’ self-rated IPV knowledge and whether IPV containing units were core or elective was conducted using chi-square analysis. A statistically significant association was found between academics’ self-rated knowledge of IPV and inclusion of IPV-related content in core or elective units ($\chi^2 (3, n=168) = 16.08, p=0.001$). Academics who reported inclusion of IPV-related content had a mean of 2.80 for self-assessed knowledge, compared to a mean of 2.32 in the no group. While no significant association was found between the amount of training academics had received and inclusion of IPV-related content in core or elective units ($\chi^2 (3, n=53) = 4.907, p=0.077$). To further explore the influence of academics’ self-rated knowledge and training and the variables professional role acceptance and professional role resistance, a Kruskal–Wallis test was performed with the variables self-rated knowledge and amount of training received. This analysis demonstrated a statistically significant effect of self-rated knowledge ($F(11, 130) = 3.17, p=0.001$) and amount of training received ($F(11, 128) = 2.75, p=0.003$) on professional role resistance.

Employing the scale professional role acceptance as an indicator of passion, a between-subjects comparison was conducted employing a Kruskal–Wallis test to compare the effects of professional role acceptance on inclusion of IPV-related content in core or non-core units. There was a significant effect of professional role acceptance on the inclusion in core units of IPV at the $p<0.1$ level ($F(1) =5.518, p=0.019$), with a mean-rank score for professional role acceptance and inclusion in core units of 23.08 compared to 40.13 for non-inclusion.

### 5.3.2.2.1 Comparative analysis of inclusion by discipline case

A chi-square test for independence indicated the relationship between discipline cases was not significant for core or non-core inclusion of IPV-related content ($\chi^2 (2, n=52) = 1.32, p=0.52$). To further examine academics’ perceptions, a Kruskal–Wallis test was performed to examine the differences across disciplines in relation to the belief that students should have
planned clinical placement with survivors of IPV. There was no statistically significant
difference at the $p<0.05$ level in scores between the three UG disciplines: $df(2) = 1.357$
$p = 0.507$ (nursing mean rank 80.71; midwifery mean rank 67.72; paramedicine mean rank
75.23). The frequencies for each case are reported in Table 5.12.

Table 5.12

| Level of Agreement on Planned Clinical Placements with IPV Survivors by UG Disciplines |
|-----------------------------------------------|-------------------|-------------------|-------------------|-------------------|
| Strongly agree (n) (% | Agree (n) (%) | Neutral (n) (%) | Disagree (n) (%) | Strongly disagree (n) (%) |
| Case A (n=130) | 9 (6.9) | 20 (15.4) | 45 (34.6) | 46 (35.4) | 10 (7.7) |
| Case B (n=16) | 2 (12.5) | 5 (31.2) | 3 (18.8) | 5 (31.2) | 1 (6.3) |
| Case C (n=11) | 1 (9.1) | 2 (18.2) | 4 (36.3) | 3 (27.3) | 1 (9.1) |

5.3.2.3 Phase three—qualitative telephone interviews

Out of the 18 participants interviewed, 11 incorporated IPV-related content in their
units. Across the cases, inclusion was as follows: Case A = 6; Case B = 3; and Case C = 2.
Only two participants stated that their university integrated IPV-related content throughout the
curriculum. When asked if this content should be integrated throughout the degree, the
majority of participants provided an affirmative response to this question. The contrasting
view, that IPV-related content should be provided in one unit, was upheld by four of the
participants interviewed (Case A = 4).

The best example of integration was noted by a nursing academic (PT 7) who stated
that IPV or what the participant termed ‘DV’ was an intercurrent theme throughout that
particular nursing curriculum:

*It’s actually in primary health care and health promotion and education and it’s
covered there in terms of social determinants of health and community problems.*
To illustrate how integration occurred in the midwifery curriculum, PT 15 explained the following:

*We touch on it in the first year, what it is, because certainly in the first year, the students should not be working on their own, but they may look at the continuity of care in women from the first year. So, the outcome, what is the consequences of violence in a relationship in pregnancy, and then in the third year, I’m just about to go and do some work with the third years which will be about how to ask the question and respond appropriately.*

Another participant stated that IPV-related content could easily be integrated throughout the curriculum by incorporating it in a communication unit in first year, in an injury-type unit in second year, and then combined so the students receive the entire situation pertaining to IPV in third year (PT 14). PT 18 reported that an advantage of this type of integration was that the students would learn about IPV in a safe environment:

*Let’s do it in a sheltered, nurtured, safe environment where we’re encouraging the students to discuss these issues, rather than wait until they get in the clinical field and find it as a traumatic incident.*

Once again, the interview evidence corroborated the findings from the online survey in relation to the integration of IPV-related content into clinical-placement units. Twelve participants (Case A = 8; Case B = 3; Case C = 1) were against the idea of students having a clinical placement in a women’s shelter or a planned clinical placement with IPV survivors. However, one midwife academic (PT 5) believed that clinical placement could not occur in shelters for reasons of confidentiality reasons:

*I do not know about with refuge it might be a bit different, you know, treating it so confidentially. It’s … you know, the privacy’s too important, but definitely community-based women’s health services or mental-health services away from just clinical services, for sure.*
In nursing (Case A), it was stressed by PT 10 that no matter in which department or setting a nurse works, they are likely to have contact with IPV survivors during their career: ‘They go to a community mental-health placement, they go to community-health placements and they go to ED [emergency department]. And that’s the real life of nursing’. Two participants noted that clinical-placement hours are already limited, and including a clinical placement with IPV survivors would put too much pressure on placement timetables.

However, one nursing academic (PT 7) refuted this claim by stating the following:

*If you look at the current ANMAC [Australian Nursing and Midwifery Accreditation Council] stats, you have to have 800 hours of clinical minimum, but the definition of clinical is that you’re supervised by an RN, but you can do observational placements, in which case you haven’t got to be supervised by an RN, so if that could happen in a safe environment then yes, it would be a good idea.*

Two nursing participants thought that clinical placements incorporating the care of IPV survivors should be provided as an elective rather than as a mandatory unit. However, one midwifery participant believed that an entire clinical placement would be too much for students, but that a two-day visit would be beneficial. One nursing participant (PT 9) summarised the issues:

*It could be an elective, I do not know if it’s something that is everyone’s cup of tea … So, you know, forcing someone to do it, well, not so much forcing, but I guess, telling someone that that’s what they’ve got to do, I do not know if that, it could be like it’s a bit like a jail, really, not everyone is comfortable in that sort of environment.*

The participants cited numerous negative issues associated with IPV clinical placement. First, PT 2 (a nursing academic) believed students would not be able to cope with caring for such clients because it would be a challenging and stressful situation for them.
Therefore, screening tools would need to be completed to know which students to send to these clinical placements and which students not to send because of their personal situation.

However, another nursing academic (PT 14) rebutted these suggestions by stating that special consideration should not be given to IPV because the same could be considered for all conditions:

Well, you can say that about anything, can’t you? Additionally, only a limited number of services deal with IPV, thus all students could not gain placements in these services. But from a purely logistics point of view, I have 250/300 students in a year, so, I do not think that there’s an educational experience that we can provide.

One midwifery academic (PT 15) provided a solution to some of the negative considerations associated with clinical placements with IPV survivors:

I do not know if they would need a whole placement, but maybe a two-day visit, and I know in one of our courses, the students work with ... maybe they’re the students that have an interest and a passion in that particular field. But I certainly do not think it does ... would do any student any harm to go and just spend a day or two days with the agencies and see what amazing work they do with very limited funding.

Being passionate about IPV was common among the interview participants (n=11). Passion was most noticeable in Case B, with all three participants from midwifery describing their passion for this area. Similarly, both interview participants in Case C were passionate about the area. In contrast, only seven of the 13 participants from Case A were passionate about IPV. Four participants from Case A were very forthright in stating they had no passion or interest in either the topic of IPV or its inclusion in HCPs degrees. Another participant stated that they were not passionate, but understood the importance of the topic, while another stated that it ‘concerns me, but doesn’t excite me’ (PT 4).
On a positive note, participants involved in the interviews provided many reasons for their passion for this topic. One participant was passionate about the reduction of violence in general, while PT 18 described the following attitude:

_I would say I do have a passion, and I do have a sensitivity towards females and domestic violence. But I suppose, I would not go as far as to say passion, I would say I have a keen interest._

Personal experience was mentioned as a reason this topic was important for two participants. PT 11 explained how a negative experience with a doctor made her realise how little doctors know about this situation, and how she never wanted another woman to have to go through such a negative experience with an HCP:

_When I experienced violence, I was in my forties and I was pregnant, so I went to the doctor and the most shocking thing that I’d ever heard or seen about it was he said to me, ‘Um, Mrs X, do not worry about this’. And, because I’d gone to get some verification that it had happened, and as I was leaving my husband at the time, so I think that it just shocked and appalled me._

All interview participants in Case B reported being passionate about this topic. One participant (PT 10) used her passion to include IPV in the unit she teaches so that students would learn to consider how they would act and respond when faced with such a challenging situation: _‘I quite often use challenging scenarios like this to try and get students to think about how they’re actually going to do their job’._

In addition, the two participants in Case C were passionate about this topic and its inclusion into the curricula. One participant was using her passion for this topic to ensure it would be included throughout the entire new curriculum because the university was undergoing a curriculum review at the time of the interview. This participant wanted to ensure IPV was addressed in the mental-health unit and the trauma units, and that it was included in discussions about the social determinants of health and treatment approaches. The other
paramedicine participant (PT 3) held strong advocacy beliefs, and saw it as her role to advocate for all clients, including those experiencing IPV:

You know, it's something if I ... it doesn't matter whether it's a child, or the person is elderly, or a person with a disability, or a person who's of a different racial background. I think our job is to be an advocate for all people, so I'd say in terms of human rights, I'm probably equally passionate about all those things ... I'd say that I advocate the same for each of them in those categories.

When exploring the relationship between the inclusion of IPV-related content and passion, it was found that five of the six nursing academics from Case A who included IPV-related content were passionate about this area. Interestingly, two participants from Case A reported being passionate about IPV and its prevention, but failed to include this content in their units. In contrast, all participants from Case B and C included IPV-related content in their units and were passionate about this topic area.

Similar to the findings for passion for the health area of IPV, 13 participants involved in the interviews felt they were competent to teach IPV and the distribution between discipline cases was the same. In Case A, eight participants felt competent, and the three participants in Case B and the two participants in Case C felt competent in this area. In Case A, eight of the 13 nursing academics interviewed felt competent to teach IPV, and the remaining five did not. These five participants stated they had no specialised knowledge in IPV, and would need to do a lot more research and reading before feeling comfortable to teach this topic. However, of note, one participant (PT 17) explained they did not need to be competent in IPV as a nurse or an academic because the nurse’s role in relation to IPV is to refer them to the social worker:

It's not really a big part of mental-health nursing. We refer more to a social worker to make sure that they have everything they need legally and, ah, and benefit-wise and that sort of thing.
Perception of competence level in Case A ranged from feeling uncomfortable with teaching IPV as ‘it did not appear in my UG or postgraduate program’ (PT 18) to feeling competent in knowing the resources and services available to women survivors of IPV.

However, some participants felt extremely confident and competent in this area because they had extensive experience in this field. For example, PT 7 stated the following:

*If I go right back in my career, in emergency departments and then as, as a career mental-health nurse, there was a significant amount of inter-partner violence in mental-health clients, especially those with persistent and enduring mental illness ... and which really means, as you know, people with command hallucinations, that sort of stuff.*

All three midwifery participants interviewed as part of Case B felt competent in the field of IPV. To be more competent in a variety of health care conditions, another participant (PT 10) completed a Diploma of Psychology and she explains her reasoning for this:

*Um, I actually felt completely unable to provide a level of care for those patients, and the patients who had self-harmed and been put into an intensive-care unit. I went and did a Dip in Psychology, so that helped me a great deal in being able to at least empathise, I mean you can’t sympathise unless you’ve lived it, but at least I had a few more skills rather than just a physical capacity to help.*

Similar to Case A and B, the two participants in Case C felt competent as a result of their extensive experience and further-education opportunities:

*I’ve had a lot of experience. A lot of experience with sort of, minor ... I guess minor physical scuffles that are highlighted by neighbours, or whatever, and we’re called, but I’ve also been to quite a few cases where people have been murdered by their partner, in ... behind closed doors, but also in public places, so I’d say I’m pretty experienced with that kind of stuff.* (PT 3)
5.3.2.4 Examining rival explanations

The rival explanation for research proposition 2 is that IPV-related content is integrated throughout the UG curricula of nursing, midwifery and paramedicine because this content is part of core units rather than the elective units. This rival explanation was proven correct. For Case A, 88.1% of content was included in core units, and for Case B and Case C, 100% of the units that included IPV-related content were core units. This evidence was corroborated by the interview evidence because 11 of the 18 participants reported IPV-related content being taught in core units. Further, in relation to integration throughout the curriculum, two participants were already successfully integrating IPV-related content throughout their curricula, while 14 participants believed this integration should be occurring in all HCP curricula.

However, integration of IPV-related content into clinical placements was not supported by the evidence. As stated, 34.6% of respondents from the online survey disagreed that UG students should have a planned clinical placement with IPV survivors. Again, the interview evidence corroborated these findings with 66% of participants being against the idea of clinical placements specifically targeting IPV survivors.

5.3.2.5 Cross-case analysis

To conduct cross-case analysis for research proposition 2, evidence from the online survey and the qualitative interviews was explored across the cases. The similarities between the cases are presented in Figure 5.3.
5.3.2.6 Testing research proposition 2

The first component of the proposition was found to be incorrect because content was delivered almost entirely via core units across the three cases. Consistent with these findings, the qualitative telephone interviews performed in phase three identified that 11 participants included IPV-related content in their unit. All these units were core units. Additionally, one participant from Case A and one participant from Case B provided examples of how IPV-related content is integrated throughout their curricula. Integration of IPV-related content in
HCP curricula was considered favourable by 14 participants. Contrasting findings were found for clinical placements specifically with IPV survivors. The evidence from phase two demonstrated that a little under half of survey respondents disagreed that HCP students should have clinical placements specifically with IPV survivors. A similar sentiment was expressed in the telephone interviews.

The second part of research proposition 2 states that IPV-related content is only included in the units when the coordinator (or equivalent) feels competent in and passionate about this content. In the survey data, higher levels of professional role acceptance (passion) were associated with IPV inclusion. Thus, the part of research proposition 2 relating to competence as a factor influencing inclusion of IPV-related content was supported, with the findings confirming that academics’ self-rated knowledge of IPV was associated with the inclusion of IPV-related content. These findings provide insight into professional role acceptance as a factor influencing the inclusion of IPV-related content, while academics’ level of knowledge and training was an influencing factor in reducing professional role resistance.

Again, the interview data validated the online survey data. The inclusion of IPV-related content in HCP curricula was associated with passion and competence in relation to the IPV. All participants in Case B and Case C included IPV-related content in their units, and were passionate and competent in this area. One participant from Case A included IPV-related content in their unit, but was not passionate about its inclusion. Interestingly, two participants from Case A were passionate and competent in this area, but failed to include IPV-related content in their units. Thus, overall, the second part of research proposition 2 was supported. Finally, the rival explanation for this proposition was proven correct because IPV-related content was included in core units rather than in elective units.

5.3.3 Research proposition 3: types of units incorporating IPV-related content

The premise of research proposition 3 is that IPV-related content would be included only in particular units, specifically those associated with mental-health or child and family
health. To examine this proposition, data were collected from respondents on the types of units delivering IPV content, and the academics’ perceptions were examined through the interviews.

**Research question 3:** How are the units that contain IPV-related content chosen by academics and why are they the units chosen to include this content?

**Research proposition 3:** Units containing IPV-related content in the examined curricula will be those associated with mental-health units and child and family units as this topic has been traditionally seen as a mental-health issue and a family issue that occurs behind closed doors.

**Rival explanation 3:** There is no consistency in regards to the units in which IPV-related content is included within as it will be at the discretion of the academic as to whether to include this content or not within the unit for which they are responsible.

### 5.3.3.1 Phase one—documentary content analysis

Analysis of curriculum documents confirmed that mental-health and child and family units were the most common type of unit containing IPV-related content.

#### 5.3.3.1.1 Comparative analysis of content by unit type

- **Case A—Nursing:** The titles for the units including IPV-related content were Health Optimisation 2: Mental Health Nursing; Essential Forensics: An Introduction to Forensic Principles for Nurses; Family Violence: Implications for Health Practice and Mental Health.

- **Case B—Midwifery:** The titles for the units including IPV-related content were Challenges in Practice; Preparing for Birth and Parenting; Clinical Midwifery Practice 4; Mental Health in Pregnancy, Birth and Beyond; Healthy Mothers and Babies; Perinatal Mental Health; and Midwifery as Primary Health Care.

- **Case C—Paramedicine:** The titles for the units including IPV-related content were Trauma Care in Out-of-hospital Practice.
5.3.3.2 Phase two—online survey

Descriptive analysis of the types of units for which the respondents were responsible identified 20 types of units, which were further condensed into eight categories of units. The most common categories of units that contained IPV-related content were women’s health, primary health care and childbirth (see Table 5.13). Mental-health units were ranked as the fifth most common category of units that included IPV-related content.

Table 5.13

<table>
<thead>
<tr>
<th>Category of Unit</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women’s health and childbirth units</td>
<td>42</td>
<td>81</td>
</tr>
<tr>
<td>Primary and community-health-care units</td>
<td>37</td>
<td>71</td>
</tr>
<tr>
<td>Children and family units</td>
<td>19</td>
<td>36</td>
</tr>
<tr>
<td>Essentials of health-care practice</td>
<td>19</td>
<td>36</td>
</tr>
<tr>
<td>Mental-health units</td>
<td>13</td>
<td>25</td>
</tr>
<tr>
<td>Medical/surgical and acute/chronic nursing units</td>
<td>13</td>
<td>25</td>
</tr>
<tr>
<td>Clinical-placement units</td>
<td>8</td>
<td>15</td>
</tr>
<tr>
<td>Paramedicine units</td>
<td>4</td>
<td>8</td>
</tr>
</tbody>
</table>

Note. N = 52, missing = 2.

To establish whether there was a dependent relationship between the unit categories containing IPV-related content and the disciplines, a chi-square test for independence was conducted. This analysis identified a statistically significant association between the inclusion of IPV-related content and all units in the broad category of women’s health and childbirth:

- women’s health ($X^2(2, n=51) = 13.23, p=0.001, \text{phi}=0.51$)
- childbearing journey ($X^2(2, n=51) = 8.75, p=0.01, \text{phi}=0.41$)
- intrapartum care ($X^2(2, n=51) = 14.88, p=0.001, \text{phi}=0.54$)
- midwifery practice challenges ($X^2(2, n=51) = 29.31, p=0.00, \text{phi}=0.76$)
- prenatal care ($X^2(2, n=51) = 20.26, p=0.00, \text{phi}=0.63$)
• professional midwifery practice ($X^2 (2, n=51) = 31.73, p=0.00, \text{phi}=0.79$).

The results of chi-square tests of independence also confirmed that mental-health units had a significant association with the following types of IPV-related content:

• consequences of IPV ($X^2 (1, n=51) = 4.79, p=0.03, \text{phi}=0.31$)
• cycle of violence ($X^2 (1, n=51) = 6.20, p=0.01, \text{phi}=0.39$)
• risk factors ($X^2 (1, n=51) = 4.04, p=0.04, \text{phi}=0.33$)
• types of relationships ($X^2 (1, n=51) = 7.04, p=0.01, \text{phi}=0.42$)
• why the survivor leaves the relationship or stays in the relationship ($X^2 (1, n=51) = 5.01, p=0.03, \text{phi}=0.36$)
• therapeutic communication ($X^2 (1, n=51) = 6.20, p=0.01, \text{phi}=0.39$).

The following categories of units were also found to have a significant association with content areas of IPV:

• child and family health units had a large significant association with the IPV content category effects on children ($X^2 (1, n=51) = 11.17, p=0.00, \text{phi}=0.51$)
• primary health-care units had a medium significant association with the IPV content area health-care costs ($X^2 (1, n=51) = 8.61, p=0.00, \text{phi}=0.46$)
• community-health units had a small negative association with the IPV content area cycle of violence ($X^2 (1, n=51) = 3.88, p=0.05, \text{phi}=0.28$).

5.3.3.3 Phase three—qualitative telephone interviews

The interview participants were asked to describe the category of units that contained IPV-related content. For Case A, this content was included in the following units: one women’s health and childbirth; two primary and community health care; one medical–surgical and acute/chronic nursing; one mental health; one essentials of health-care practices. For Case B, the following three units included IPV-related content: one primary and community health care; two women’s health and childbirth. For Case C, the following two
units contained IPV-related content: one paramedicine practice unit; one mental-health unit. For the inclusion of IPV-related content into mental health units, one mental-health unit in Case A included this content, but the other did not. The mental-health unit in Case C included IPV-related content into its unit. No participants taught in child and family health units.

Participants were asked in which unit types they thought IPV-related content should be taught. Two participants from Case A stated that IPV-related content was already taught in the mental-health units of their curricula, and another participant stated it was already included in the child-health unit of their curricula. Additionally, two participants from Case A stated IPV-related content should be included in the child and family health unit but not confined to it, while two other participants from this case believed it should be featured in the mental-health unit, but not confined it to. PT 16 explained the following:

*I would say the first thing that springs to mind is mental health, but I would also be thinking units that are related to things like community care and critical care, looking at emergency-type nursing as well, so community, emergency and mental-health-type units.*

Most participants from Case A considered it detrimental to include IPV-related content in a mental-health unit because mental health is often labelled negatively. PT 18 expressed this as follows:

*I do not think linking it up to mental health actually does it any favours. I think more along the lines, it should be part of general nursing, as it would for anyone with any specific injury. So, if someone had a car accident, if someone had a suicide attempt, if someone actually had a medical illness, it should be treated as that type of condition, rather than try and pathologise it as a mental-health issue.*

Further, IPV was described as an issue relevant to the entire population by PT 11: ‘*I certainly do not think it’s just a mental-health issue. It’s a societal issue because it’s seen as acceptable and it’s been hidden for a long time*’. One participant who had previously taught
mental health also believed that IPV-related content should not be included in mental-health units: ‘I do not think it fits into mental illness, I actually taught mental illness, so I know mental health is diluted down’ (PT 17).

It was also the consensus that IPV-related content should not be categorised into a specific unit. Consistent with the findings of research proposition 2, participants believed it best to adopt an integrated approach, with IPV content included in health assessment and health management. PT 9 described how this integration could occur:

*I think it’s probably one that could be put across a curriculum in that you could sort of bring it up in like, communications, so how do you communicate with somebody that’s been abused? Um, then maybe in second year, the injuries, the like, it’s not just, um, fixing up what you can see, it’s fixing up what’s underneath as well and maybe, you know, ways that you can direct them without really directing them, as well as mental health? And in third year, sort of putting the whole picture of that together again, so this is how you talk to them, this is how you treat them, and how do you treat the partner or the perpetrator, um, when they come to visit and that kind of thing. So, it can be spread, um, but I think it probably could be embedded a lot better than what it is.*

The three participants interviewed from Case B reported including IPV-related content in their units. When asked into which units they thought IPV-related content should be incorporated, only one believed it should be incorporated only in mental-health units. However, even this participant expressed doubts:

*You can’t put everything in every unit. I mean, our guys who teach in our mental-health units, they, they are particularly good at addressing a whole pile of different psychosocial and mental-health issues. But it’s … where do you put it and how much time do you devote to it? I’m not saying it’s an unimportant thing, but, when you consider it amongst schizophrenia or bipolar disorder, or, you know, drug addiction*
and drug use, ah, it’s smaller then. That’s, um, that’s where it gets lost. Lost in translation. We try, we try and give it the most broad range as we possibly can but sometimes ... we can’t be all things to all people. (PT 10)

The other two participants from Case B thought integration was the key to including IPV-related content. PT 5 believed a separate unit focusing only on IPV-related content would be extremely unlikely:

*It probably should just be integrated. The way the curriculum’s structured, there’s ... I just do not think there’s any way that they would put a unit like that separately. I think it has to be [a part]. Yeah, maybe family health or community health or health promotion, some sorts of units, but it’s all changed now, so I do not ... maybe mental health, but the way mental health is taught, it’s so much from a, you know, medical model. I think it really needs to look at ... you need to look at mental health beyond that, the way that is ... I’m pretty disillusioned with the whole nursing and midwifery curricula.*

As with Case A and Case B, integration of IPV-related content and mental-health units were discussed with the interview participants in Case C. One participant believed that integration is the key to including IPV-related content in the BP (or equivalent) curricula. This participant believed that pigeonholing this content into one particular unit was detrimental to IPV survivors, and should thus be integrated throughout the course. In contrast, the other participant from Case C considered the mental-health unit as the best unit in which to teach IPV-related content because it can provide a multicomponent approach to including this content:

*Within the mental-health component for the paramedic programme, it’s just taking a diagnostic approach you know, a trauma-informed approach and, um, you know, looking at that as a, um, model that explains the phenomenology, the lived experience, um, mental-health issue. (PT 8)*
As stated, phase three of the study adopted a guided-conversation approach. Therefore, there was no complete set of interview questions for each participant. An interview protocol was followed, which included seven probing questions. However, these probing questions focused only on the main component of each proposition, and therefore did not include any questions about whether participants believed IPV was an issue that occurs ‘behind closed doors’. No participants mentioned this issue voluntarily; therefore, there is no interview evidence on whether this was part of the participants’ consideration in relation to research proposition 2.

5.3.3.4 Examining rival explanations

The evidence collected from the online surveys conducted in phase two and the qualitative telephone interviews conducted in phase three reveals that IPV-related content is included across a broad range of unit categories. This rival explanation was supported because there was no consistency in relation to the units in which this content was included. However, despite the lack of consistency, some categories of units included IPV-related content more often than others.

The evidence from the online surveys conducted in phase two demonstrated that IPV-related content was included in all eight categories of units: medical–surgical and acute–chronic nursing units, women’s health and childbirth, clinical placement, paramedicine, mental health, primary and community health care, children and family, and essentiality of health-care practices. However, the broad categories of units that included IPV-related content more however were women’s health and childbirth and primary and community health care.

The interviews revealed that IPV-related content was included across a variety of units. The evidence from the interviews revealed that IPV-related content was included in the following broad categories of units: women’s health and childbirth, primary and community health care, medical–surgical and acute–chronic nursing, mental health, essentiality of health-care practices, and paramedicine practice. The rival explanation that
there is no consistency in the units in which IPV-related content is included, and that this inclusion will be at the discretion of the academics, was supported.

5.3.3.5 Cross-case analysis

To conduct cross-case analysis for research proposition 3, evidence obtained from the online surveys in phase two and qualitative telephone interviews in phase three was compared across cases. Similarities between these categories for the three cases involved in this research are presented in Figure 5.4. Commonalities were noted between Cases A and B, Cases A and C, and Cases A, B and C. No similarities were noted between Cases B and C.
5.3.3.6 Testing research proposition 3

Research proposition 3 states that units containing IPV-related content in the examined curricula will be those associated with mental-health units and child and family care units.
units because IPV has traditionally been considered a mental-health issue and a family issue that occurs behind closed doors. First, the categories of units containing IPV-related content were examined. The most common categories of units that contained IPV-related content were women’s health and childbirth and primary and community health care. The child and family health units were ranked equal third with 19 out of the 54 units that included IPV-related content. Mental-health units ranked five out of the eight categories, with only 13 out of the 54 units being recognised as this type of unit.

Evidence from the qualitative telephone interviews in phase three also illustrated the distribution of IPV-related content across a broad range of categories of units. The 11 participants that included IPV-related content in their units revealed that only two of the units were mental-health units and zero were child and family health units. The remaining nine units that included IPV-related content were as follows: one essentiality of health-care practices; three women’s health and childbirth; three primary and community health care; one medical–surgical and acute–chronic nursing unit; one paramedicine practice.

Further, of the 18 participants involved in the telephone interviews, three believed IPV-related content should be included in mental-health units but not confined to these units, and two believed this content should be included in child and family health units, but not confined to these units. Most of the interview participants considered it detrimental to IPV survivors to include IPV-related content in mental-health units, and recommended it be integrated throughout the HCP curricula. Thus, the evidence from phase two and phase three proved the first section of research proposition 3 (that IPV-related content would be included more in mental-health units and child and family health units) is incorrect.

The second section of research proposition 3 states that IPV is a family issue that occurs behind closed doors, which is the reason it is included in child and family health units. Findings from the online survey confirmed the academics believe they need to role model to their students that IPV is unacceptable, and that if they do not include this content in the
curricula, IPV will remain undetected and untreated. Therefore, it was concluded that academics do not see IPV as a family issue that should not be included into UG HCP curricula and thus the second section of this proposition was not supported.

In conclusion, proposition three was not supported by the evidence obtained via the phase two on-line survey or the phase three qualitative telephone interviews. The rival explanation, however, was proven to be correct. IPV-related content is included across a wide variety of units and is thus not confined to only mental health and child and family health units.

5.3.4 Research proposition 4: teaching methods and specific content inclusion

The premise of proposition 4 is that IPV-related content is delivered through minimally interactive class time, with a focus on the effects of IPV, rather than on screening, detection and case management. To address this proposition, data were collected from study participants on the nature of IPV content and its predominant delivery methods.

Research question 4: How is this IPV-related content being taught and what is being taught in relation to this content in the disciplines of nursing, midwifery and paramedicine?

Research proposition 4: IPV-related content is usually only delivered via didactic lectures and readings only, with minimal interactive class time and clinical experience. In terms of what is being taught, types, prevalence and effects are assumed to be taught more often than the appropriate screening, detection and care principles for survivors of IPV.

Rival explanation 4: IPV-related content will be taught employing a variety of teaching methods, including clinical placement, and students will be taught health-related practices related to IPV, including screening and detection methods and communication techniques.

5.3.4.1 Phase one—documentary content analysis

Data collected from the documentary content analysis were not suitable to address research proposition 4.
5.3.4.2 Phase two—online survey

Descriptive analysis of data relating to the delivery of IPV-related content confirmed that IPV-related content was more commonly delivered via tutorials 85% (n=44), followed by lectures 75% (n=39), and online materials and readings 58% (n=30). Comparative analysis incorporating a chi-square test of independence indicated a significant medium association between the teaching strategy lectures and the coverage of community resources ($X^2 (1, n=51) = 4.22, p=0.04, \phi=0.33$). Table 5.14 provides further detail on the nature of the delivery of IPV-related content across the three cases.

The integration of IPV-related content into assessment items was reported for two content areas. A chi-square test of independence indicated a significant medium association between assessment items and the content area consequences of this violence ($X^2 (1, n=51) = 4.33, p=0.04, \phi=0.34$), and a small significant association between assessment items and the content area risk factors ($X^2 (1, n=51) = 3.88, p=0.05, \phi=0.28$). Only 15% (n=8) of units offered clinical placements specifically with survivors or perpetrators of IPV. Of note, only 6% (n=3) integrated IPV-related content into the mastery of clinical skills in clinical laboratories.

Table 5.14

### Teaching Types and Strategies by Discipline Case

<table>
<thead>
<tr>
<th>Teaching type</th>
<th>Case A (N=41)</th>
<th>Case B (N=9)</th>
<th>Case C (N=1)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td>Lecture</td>
<td>28 (68.2)</td>
<td>9 (100)</td>
<td>1 (100)</td>
</tr>
<tr>
<td>Tutorial</td>
<td>36 (70.5)</td>
<td>7 (77.8)</td>
<td>–</td>
</tr>
<tr>
<td>Online</td>
<td>23 (56.1)</td>
<td>7 (77.8)</td>
<td>–</td>
</tr>
<tr>
<td>Assessment item</td>
<td>12 (29.2)</td>
<td>2 (22.2)</td>
<td>–</td>
</tr>
<tr>
<td>Clinical placement</td>
<td>6 (14.6)</td>
<td>2 (22.2)</td>
<td>–</td>
</tr>
<tr>
<td>Clinical laboratory</td>
<td>2 (4.9)</td>
<td>–</td>
<td>–</td>
</tr>
</tbody>
</table>
Descriptive analysis of the type of IPV-related content taught in the examined UG HCP curricula illustrated type of violence/prevalence of violence was the most commonly included content (75%, n=40), followed by beliefs/attitudes/stereotypes (74%, n=39), effects on children (60%, n=32) and consequences of this violence (58%, n=31). Less than half of the units containing IPV-related content were reported to contain content on screening and identification (49.1%, n=26), while 35.8% (n=19) contained content on safety planning.

Table 5.15 provides a cross-case comparison of the more common IPV-related content areas addressed in the curricula.

Table 5.15

<table>
<thead>
<tr>
<th>Types of IPV-related Content Covered by Discipline Case (N=53)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of content</td>
</tr>
<tr>
<td>Belief/attitude/stereotype</td>
</tr>
<tr>
<td>Types/prevalence violence</td>
</tr>
<tr>
<td>Consequences of IPV</td>
</tr>
<tr>
<td>Effects on children</td>
</tr>
<tr>
<td>Community resources</td>
</tr>
<tr>
<td>Screening/identification</td>
</tr>
<tr>
<td>Effects of this violence</td>
</tr>
<tr>
<td>Therapeutic communication</td>
</tr>
<tr>
<td>Referral pathways</td>
</tr>
<tr>
<td>Cycle of violence</td>
</tr>
<tr>
<td>Safety planning</td>
</tr>
</tbody>
</table>
5.3.4.2.1 Comparative analysis of content type

- Case A—Nursing: Employed all teaching types.
- Case B—Midwifery: Employed all teaching types and strategies with the exclusion of clinical laboratories. A higher rate of inclusion of content related to the cycle of violence, safety planning and referral pathways.
- Case C—Paramedicine: Utilised only lectures to present IPV-related content. No content on beliefs and attitudes, screening or therapeutic communication.

5.3.4.3 Phase three—qualitative telephone interviews

Consistent with the evidence discovered in the online survey in phase two, tutorials/workshops were the most popular form of teaching strategy recommended for the teaching of IPV-related content. Of the 18 participants included in this phase, 12 participants recommended this teaching strategy, and only five participants thought lectures were an appropriate way to present this content. However, these participants stated that the lecture should be followed by a tutorial. Finally, only one participant from Case B included this content in a skills-based setting and another participant from Case C included it in an assessment item. Of the 13 participants in case A, nine thought an interactive approach was the best strategy to teach and discuss IPV-related content. Tutorials were discussed as the best option for providing practical understanding. PT 2 stated the following:

*It has to be interactive, it has to be engaging, it has to be, you know, realistic, otherwise, it’s a waste of time. Having a talk say at the beginning of the tutorial about thoughts, beliefs, um, you know. The other thing that comes to mind is in terms of ... and I know that we have done this in the past in terms of, um, sexual assault, and you know, reporting that. And ... and bringing up ideas around, ‘Well is it the woman’s fault or did they ask for it’. And ... and some of the conversation that you can get from those tutorials.*
Lectures were often seen as an inappropriate teaching method for this type of content. Only three nursing academics from Case A recommended this type of teaching strategy. One noted benefit of lectures was the ability to utilise guest speakers. Six participants discussed the benefit of the lived experience and the introduction of a survivor as a guest speaker in the lecture. For example, PT 7 stated the following:

> What I like to do is bring someone in who has had a stress-related condition and say, okay, share with us how you feel and, and what happened to you. And if you can get somebody who’s brave enough and is ... can be supportive enough to come in and say this is what, what it was like when my father hit me or this is what it was like when my husband hit me, and this is why, then I think that’s the most effective way. But in, in things like mental health and abuse, whether it’s parental or, or by teachers or sexual or emotional abuse or whatever, then I think it’s, it’s the personal experience which actually gets the message across to the student rather than a formal lecture.

However, other participants recommended the introduction of a counsellor or an IPV expert as a guest speaker in lectures. For example, PT 9 stated the following:

> Yeah, um, it would be good if you could put maybe someone with the lived experience, with a counsellor ... Um, but somebody to support them as well, um, and that they can probably get, ‘Okay, this is what happened to me’, and maybe coping mechanisms from the counsellor or suggestions that we [HCPSs] could help.

Interactive tutorials were the preferred teaching strategy for the three midwifery academics of Case B. PT 10 stated, ‘I quite often use challenging scenarios like this to try and get students to think about how they’re actually going to do their job’. Two of the midwifery academics recommended the use of tutorials in conjunction with lectures and skills-based
activities. Skills-based learning was then recommended for third-year midwifery students by PT 15:

*I would say the first year it’s a lecture, because you're just talking about what it is.*

*Practising asking the question, responding appropriately, referring on to other agencies, supporting the woman and doing a care plan around disclosure.*

For Case C, lectures were described as a waste of time because ‘students often do not read the lecture notes before they come’ (PT 3). It was recommended that case-based learning or problem-based learning within tutorials was the best teaching strategy to use for IPV-related content. Unlike in Case A and Case B, the use of assessment items was mentioned by one of the paramedicine participants. First, students were meant to refer to it as a risk factor in one of the assessment items and consider it in the next assessment on restraining a patient:

*Some of the assessment pieces have looked at practice protocol and the like, and um, the transport protocol for ambulance involves possible use of constraint, um, restraint, and you know, the possible re-traumatising, what that might mean if somebody’s got that background.* (PT 8)

According to the interview participants, a vast array of IPV-related content was covered in the UG curricula of nursing, midwifery and paramedicine. However, when participants were asked their views on the content that should be incorporated into their curricula, two participants had surprising responses. PT 4 stated ‘no idea sorry’, and PT 17 stated ‘this content should be included in psychology degrees more than nursing degrees’. Additionally, a teaching category that wasn’t included in this proposition was identified by PT 6; this being teaching about the lived experiences of survivors: ‘She survived, but she was severely physically abused and has had to have massive amounts of rehab, and really complex, so I tend to, to use that type of thing, so that the statistics have a face and are real’.

Several participants discussed how a real-life case scenario could be presented in tutorial classes, with students brainstorming on topics such screening and assessment,
discharge follow up, and steps that can be taken to protect victims from their abuser. One participant who discussed the integration of IPV-related content throughout the BN, explained how these different types of IPV-related content could be incorporated across the curriculum:

It’s covered in primary health care and health promotion and education, and it’s covered there in terms of social determinants of health and community problems. So, it is, it is everywhere but specifically it’s in the first two units ... two of the first three units are the non-clinical consolidation subjects before, before the students complete the course. (PT 7)

Beliefs, attitudes, stereotypes and the need to be non-judgemental and supportive were discussed only by participants from Case A. As stated by PT 12:

Students are reminded that as a health-care professional, it’s about ... not about making judgements, it’s about supporting people, and helping, you know, people find what they might need to find to help themselves.

The other type of IPV-related content that was raised only by participants in Case A was the need to refer patients within the health-care service for services and support:

Who can help these people? So, it’s just about ... being able to listen to them, let them talk, do not interrupt them, and then when they’re finished you can give them advice, support and education. (PT 2)

According to the three midwifery academics in the Case B interviews, only five categories of content were included in the BM. Two participants believed the effects of this violence should be discussed, while one believed only the types and prevalence of IPV should be taught. Similar to Case A, participants discussed the lived experience as a form of IPV-related content: ‘Personal experience and someone coming in telling their story is just so profound’ (PT 15). Case B interview participants also discussed the integration of numerous types of IPV-related content throughout the BM. For example, PT 15 stated the following:
We touch on it in the first year, what it is, because certainly in the first year the students should not be working on their own, but they may … I think the knowledge of the signs and indications of violence in an IPV relationship is really important and so they’re looking at the continuity of care in women from the first year. So, the outcome, what are the consequences of violence in a relationship in pregnancy, and then in the third year, I’m just about to go and do some work with the third years which will be about how to ask the question and respond appropriately.

The two paramedicine academics of Case C included five types of IPV-related content in their units. These types of IPV-related content were effects of this violence, types/prevalence of violence, legality of IPV, treatment of survivors and screening/identification. Screening and identification of IPV survivors was emphasised by these participants, with one participant focusing on a diagnostic- and trauma-informed approach, and the other focusing on a particular real-life scenario and the assessment associated with it:

It was of a woman who had petrol thrown over her by her partner—had an argument with him—and set alight. And there’s a picture of that, and they have to do a burns assessment talk about, you know, what they’re going to do about it, but more from a clinical point of view of assessment and treatment. (PT 3)

Finally, as with the other two cases, an example was provided of how one participant included a variety of IPV-related content into their unit:

I teach one unit which is the very first degree and it’s for paramedic practice specifically, and we do talk about things like, that we’ve seen, we talk about duress, we talk about appropriate behaviour for a paramedic and what is, sort of characteristics in that … in that sort of way. We talk about what’s legal and what’s illegal in terms of practice from a, sort of, broader scope of practice, and you know, if you witness something that not’s good, such as, you know, a child being injured or,
um, you know, something that’s going on that’s either criminal that it is your job of junior care to step forward and report those issues, or get someone of a senior nature to report those issues. (PT 3)

5.3.4.4 Examining rival explanations

The rival explanation for proposition four is that IPV-related content would be taught by employing a variety of teaching methods. Overall, in units where IPV-related content was included, the content was taught via a variety of teaching methods. To differing degrees, tutorials, lectures, online materials and readings, assessment items, clinical placements, and clinical laboratories were utilised to deliver IPV-related content. However, fewer participants (6%, n=3) included IPV-related content in clinical-skills mastery in clinical laboratories, and a small proportion of participants (15%, n=8) included planned clinical placements. When cases were examined individually, differing evidence was found. Case A and Case B included a variety of teaching methods, including clinical placements; however, Case C incorporated only one to two teaching types and strategies. Therefore, the first section of this rival explanation is partially supported. IPV-related content was taught via a variety of teaching methods; however, clinical placements were reported to be utilised very minimally by the respondents in the online survey and the participants in the telephone interviews.

The second component of the rival explanation considers the types of IPV-related content that is being taught. This rival explanation was largely unsupported. Health-related practices were not being taught by a lot of the academics according to the on-line survey and telephone interviews. Information on referral pathways and therapeutic communication was only being taught by 51% of respondents (n=27) included in the on-line survey, while screening/identification was taught by 49.1% (n=26). Lastly, safety planning was taught by 35.8% (n=19) and treatment of survivors by 24.5% (n=13). Through the interviews, the Case A participants represented the majority of participants reporting the inclusion of IPV-related
content. Therefore, the second section of the rival explanation was found to be incorrect. Thus, the rival explanation for research proposition 4 has been only partially supported.

### 5.3.4.5 Cross-case analysis

Cross-case analysis was performed on research proposition 4 by collating the evidence from phase two and phase three of the research. No similarities were noted between Cases A, B and C. However, 15 similarities were noted between Cases A and B, which included the delivery of IPV-related content and the types of IPV-related content. This cross-case analysis is summarised in Figure 5.5.
Figure 5.5. Cross-case analysis for research proposition 4.

- **Cases A & B:**
  1. Between 78 and 88% of respondents used tutorials to present IPV-related content
  2. Between 22 and 29% of respondents used assessment items on IPV-related content
  3. Between 15 and 22% of respondents organised clinical placements with IPV survivors
  4. Participants used tutorials to provide real-life case scenarios
  5. Lectures used to introduce IPV
  6. Between 61 and 67% of respondents taught effects on children
  7. Between 51 and 56% of respondents taught screening/identification
  8. Between 11 and 19% of respondents taught forensic evidence
  9. Between 44 and 49% of respondents taught risk factors of IPV
  10. 78% of respondents taught beliefs/attitudes/stereotypes
  11. Types of relationships included by between 33 and 38% of participants
  12. Screening/identification included by between 33 and 38% of participants
  13. Types of violence/prevalence included by between 31 and 33% of participants
  14. Lived experienced discussed by participants
  15. Could include a variety of content types throughout degree

- **Cases A & C:**
  1. Lectures seen as a waste of time
  2. Could include a variety of content types throughout unit

- **Cases B & C:**
  1. 100% of respondents used lectures to present IPV-related content
  2. 100% of respondents taught types of violence/prevalence
  3. 5 of the 18 types of IPV-related content included by participants

- **Cases A, B & C:**
  Nil similarities
5.3.4.6 Testing research proposition 4

The first part of research proposition 4 states that IPV-related content is usually delivered only via didactic lectures and readings, with minimal interactive class time and clinical experience. Evidence from both phases contradicts the first section of research proposition 4. Interactive class time via the use of tutorials was reported as the leading strategy used to deliver IPV-related content to UG nursing, midwifery and paramedicine students.

The qualitative telephone interviews from phase three corroborated the evidence from phase two. Providing practical understanding, discussions, examples, the ability to learn from others, and an expression of a range of opinions in a safe environment were reported as the advantages of incorporating IPV-related content into tutorials and workshops. In contrast, lectures were considered a waste of time because students often do not attend lectures, and can thus avoid the topic altogether. Skills-based learning was recommended by one midwifery academic, particularly for third-year students, while two participants used pre-readings as an adjunct to their tutorials. Therefore, evidence from both phases of this case study prove this first part of research proposition 4 to be incorrect.

The second section of this proposition states that the types, prevalence and effects of IPV are assumed to be taught more often than appropriate screening, detection and care principles for survivors. This part of the proposition was proven to be correct. Types and prevalence of violence was the most commonly included IPV-related content in the examined curricula, with 74% of the respondents (n=40) including this content into their units. The effects on children was covered by 60.4% (n=32), consequences of this violence by 58.5% (n=31) and the effects of this violence by 54.7% (n=29) of respondents involved in phase two. In contrast, 49.1% (n=26) included screening/identification in their units, while only 24.5% (n=13) of respondents included treatment of survivors.
Contrasting findings were found via the phase three telephone interviews. The leading type of content covered by these participants was screening/identification with seven participants covering this content, while only three participants included content related to the treatment of survivors. The types and prevalence of IPV was covered by six participants, the effects of this violence by five participants, and the effects on children and the consequences of this violence by two participants involved in the interviews.

Research proposition 4 is only partially supported. In the delivery of IPV-related content, this proposition was proven to be incorrect. IPV-related content was not only delivered via didactic lectures and online materials and readings as the proposition stated. The two phases differed in their findings for the second part of the proposition. According to phase two, the types, prevalence and effects of IPV were taught more often than the screening, identification and treatment of survivors. However, the interview evidence found that screening and identification of IPV survivors was the leading type of IPV-related content covered by participants; however, the interview participants also reported minimal coverage of treatment of survivors. The rival explanation for this proposition was only partially supported as outlined above.

5.3.5 Research proposition 5: expertise, understanding and attitudes/beliefs

The premise of proposition 5 is that inclusion of IPV-related content in HCP UG curricula is associated with the level of academic expertise and attitudes towards the importance of including this topic in the curricula. To address this proposition, data were collected from study participants via the online survey and interviews.

Research question 5: How do academics explain their inclusion or non-inclusion of IPV-related content in their unit/s?

Research proposition 5: It is the proposition that non-inclusion of IPV-related content in these UG curricula is because of the lack of expertise in this topic, the lack of understanding
of the importance of including it in the UG curricula and negative attitudes/beliefs towards survivors of IPV.

**Rival explanation 5:** Academics who include IPV-related content into their units are those that are knowledgeable and passionate about this topic. Academics who fail to include this content will be those that fail to adapt their work to include current health priorities and public health issues and those that fail to incorporate content experts into their teaching team.

5.3.5.1 Phase one—documentary content analysis

The documentary content analysis conducted in phase one did not address this proposition, and is therefore not discussed in this section.

5.3.5.2 Phase two—online survey

In the survey, a little under half of the respondents reported they had received no training in IPV (48.5%, n=98). Table 5.16 presents the detail on the amount of training in IPV reported by the participants, and whether there were statistical associations between IPV training and inclusion of IPV-related content. Participants who reported not including IPV-related content were more likely to have received fewer than five hours of IPV training, and to rate their knowledge as ‘some’ or ‘none’.
Table 5.16

Chi-square Difference Tests for Inclusion of IPV-related Content and IPV Knowledge.

<table>
<thead>
<tr>
<th>Training and Exposure</th>
<th>Inclusion of IPV-related content</th>
<th>n</th>
<th>Yes</th>
<th>No</th>
<th>$\chi^2$</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount of IPV training</td>
<td></td>
<td>81</td>
<td>6.366</td>
<td>0.001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;5 hours</td>
<td></td>
<td>41</td>
<td>13</td>
<td>28</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6–14 hours</td>
<td></td>
<td>20</td>
<td>13</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;15 hours</td>
<td></td>
<td>20</td>
<td>10</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of IPV knowledge</td>
<td></td>
<td>168</td>
<td>16.08</td>
<td>0.001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td></td>
<td>10</td>
<td>2</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some</td>
<td></td>
<td>84</td>
<td>17</td>
<td>67</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td></td>
<td>2</td>
<td>25</td>
<td>33</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extensive</td>
<td></td>
<td>16</td>
<td>10</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exposure to IPV survivors</td>
<td></td>
<td>167</td>
<td>19.65</td>
<td>0.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td></td>
<td>26</td>
<td>2</td>
<td>24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some</td>
<td></td>
<td>101</td>
<td>29</td>
<td>72</td>
<td></td>
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</tr>
<tr>
<td>Moderate</td>
<td></td>
<td>19</td>
<td>19</td>
<td>13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extensive</td>
<td></td>
<td>4</td>
<td>4</td>
<td>4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

To examine academics’ attitudes and beliefs, a variable suited for testing using the Kruskal–Wallis test was created by summing two items in the subscale *beliefs about survivors of IPV*. The analysis demonstrated significance at the p<0.01 level (F(1) = 0.878, p=0.024), suggesting academics’ attitudes relating to IPV survivors influence whether they include IPV-related content in their curricula. Cross-case comparison of mean scores on the subscale confirmed the following that midwives hold more favourable attitudes towards IPV survivors (M=3.2500) than nurses (M=3.4922) and paramedics (M=4.4545) (scale direction: 1 agree to 5 strongly disagree).
5.3.5.3 Phase three—qualitative telephone interviews

In Case A, numerous participants reported having extensive professional experience with IPV in various clinical environments, from general nursing wards in which survivors would disclose assaults by intimate partners, to working in a surgical ward with patients who had been assaulted by their intimate partner. Emergency departments and mental-health wards were also common hospital environments in which IPV survivors were encountered. For example, PT 7 stated the following:

Yes, I have. If I go right back in my career, in emergency departments and then as, as a career mental-health nurse, a significant amount of inter-partner violence in mental-health clients, especially those with persistent and enduring mental illness ... and which really means, as you know, people with command hallucinations, that sort of stuff. So, it is significant, I think.

Direct work experience in women’s organisations and support groups was reported by two participants. One participant worked with families experiencing all forms of ‘domestic abuse’ (PT 13), and PT 6 worked in numerous women’s centres in Victoria and participated in writing national documents:

When I was working at the Well Woman’s down in Melbourne, I was then a coordinator, supervisor, and I would take calls for the, um, Centre Against Sexual Assault crisis line. Just before I started here in, I wrote a document in aggression prevention and management ... Toolkit for Work Health Victoria, whatever it was called, Work Safe Victoria, and that has become a national document.

In Case B, only one midwifery academic had qualifications in IPV, and these were obtained via training programmes at women’s health agencies. Direct IPV experience in employment was reported by two midwifery academics, and thus both these participants felt
confident and competent in teaching IPV. PT 5 had extensive experience working with women survivors of IPV in a variety of hospital and community settings:

*I worked in refuge for a number of years and I was a ... then I was involved in court support of women who’ve experienced violence, and I was also ... acted in the role of domestic-violence counsellor for a little while. Actually, I’m—I’ve got a qualification in social-sciences welfare study, so we did a little bit of gender studies, which covered those sorts of issues, but not specifically, you know, related to domestic violence or anything on intimate violence, whatever it’s called now.*

Case C found one paramedicine participant that had obtained qualifications in IPV. Both paramedicine interview participants stated they were confident and competent in this area, but only one had direct employment experience in this area. The other stated, ‘if I had, it was by accident’ (PT 8). The participant with direct employment experience described experiences with minor physical assaults, as well as intimate-partner homicides:

*Certainly, going into paramedics that was a regular thing to come across. Whether that was verbal aggression or physical aggression or sexual assault, you know, physical assault, whether it’s known by someone ... the person is known by someone, or in a family situation, and whether it was at home, or whether it was something that happened out in the street. So, yes, it was not really until I was a paramedic that I came across a lot ... and a lot of it, you know. It’s a bread and butter part of our job.*

(PT 3)

Participants in the telephone interviews were not directly asked questions about their understanding of the importance of IPV; however, through the guided-conversation approach adopted for the interviews, numerous participants noted the importance of including IPV in their scope of practice as an academic and as an HCP. Of the 11 participants who included IPV-related content in their units, six recognised that IPV-related care was within their scope of practice, and thus should be included in their units. Three of the six nursing participants
(Case A) who included IPV-related content in the curricula believed that IPV care was within their scope of practice; all three midwifery participants (Case B) believed that IPV care was within their scope of practice; and no paramedicine participants (Case C) believed that IPV care was within their scope of practice. Given that the participants from Case C did not report their belief in the importance of including IPV-related content in their units, there are no data pertaining to this case. However, Case A and Case B will now be discussed.

The three nursing academics from Case A who included IPV-related content in their units because of their belief that IPV-related care is within their scope of practice as an RN stated that IPV care is something that an RN will come across irrespective the health-care environment in which they work. For example, PT 14 stated the following:

*I do not subscribe to that theory that it’s not part of what we, as nurses, should know because we are going to come in ... and, ah, it’s probably more prevalent than the statistics would indicate because of the reluctance of a lot of people to report, but certainly, no, I would not subscribe to the theory that it’s not part of what nursing should teach. To me, that’s like, say, as I said, mental health is not, you know, part of general acute nursing. It’s an argument I can’t subscribe to.*

Not only did these participants perceive IPV-related care as within their scope of practice, they also acknowledged that many academics fail to recognise this, and ‘live with their heads in the sand’ (PT 9). PT 7 noted that the focus on acute care and its cure means that including IPV-related content in the BN is difficult:

*I think because even though we, we, we preach that we’re very good at primary health care and we’re very good at, at, at tertiary care in terms of, of [unclear], we’re not, and we just want the, the acute-care issues. And if you could give a tablet which said cure, cure pain from intimate-partner violence, then nurses would, would embrace that enthusiastically, but there isn’t, but there isn’t one, so they can’t do that.*
Interestingly, another three nursing participants admitted that IPV-related content is within their scope of practice as both an academic and an HCP, but did not include IPV-related content in their units. One participant noted that IPV care was within their scope of practice, but some nurses are frightened to initiate a conversation about IPV because of a lack of skills in the area or are frightened to address the topic of IPV. Another participant stated that the characteristics of the RN workforce may prevent it from being implemented.

A characteristic noted by PT 11 was the age of the nursing workforce:

_Well, obviously, it’s affecting people’s health and that sometimes you think, you got to think too about the age of people and their experience from when they were growing up, about what was acceptable and what was not acceptable. Well, you’ve got to think about the dominant workforce in health care, and what age are they? I think that would be worth looking at because, you know, you, we’re still talking about the average age of a nurse is in her fifties, isn’t it? So, what was their experience growing up and what the social norm was._

Two other participants from Case A noted the concept of their scope of practice, but neither stated that IPV-related care was included in this scope. One participant stated that other care-related conditions were more important to include in the curricula, and that if an RN wants to specialise in IPV care, they should do so after graduation. The other participant in this category (PT 17) stated that once an IPV survivor is identified, the only responsibility the nurse has is to refer them to the appropriate person:

_I mean, that’s, that’s as far as it, it would go, really, to just see if you could identify it and then refer on rather than ... I’m, I’m not definitely on, on the board, except in, sort of, a very superficial way, but certainly they’re not on the ward long enough to have, um, you know, ongoing therapy. So, nurses, not, not so much._

All participants in Case B included IPV-related content into their units as they recognised the importance of its inclusion within their scope of practice as a RM. They did
identify, however, that academics have their own specialities and as such would be more passionate about them. An understanding of the need to gain further knowledge in order to provide appropriate care to IPV survivors was also mentioned:

> Well, no, it’s, it’s definitely a health-care problem but not in, not in, it’s not in quite a lot of people’s standard practice. I made it, I made it my business to learn more because I did not have the skills or knowledge to deal with it when I got slammed with it as a junior nurse. (PT 10)

Only one participant of all the cases explicitly noted their attitudes and beliefs in relation to IPV; this participant was from Case C:

> I would never put myself in a situation like that, and then I did find myself in a domestic [unclear], and I was absolutely gutted that I’d managed to get myself in that position and not stand up for myself. It’s kind of an interesting thing, you know, I do not think there’s any predetermined, um, sort of, set of rules, or age, or background that will end up in those situations. You’re, kind of like, a bit shocked, what am I doing in this situation, and how did I get here. (PT 3)

Further, this paramedicine academic provided an explanation for why some HCPs do not want to become involved in IPV situations:

> There’s a bit of, you know, well you’re not looking out for yourself so why the hell should I? Look sometimes you can go the nth degree with people, you can go the ... and do everything for them and they still go back to that partner. And that’s pretty hard to accept, but it’s also their choice, I suppose, in a way. I mean, they’re human, they’re allowed to make their own decisions about their life. And how they want to conduct it. But I think probably, clinicians feel a bit betrayed, at times, when that happens. (PT 3)
5.3.5.4 Examining rival explanations.

The first section of rival explanation 5, which states that academics who include IPV-related content in their units are knowledgeable and passionate about this topic, was addressed in part in research proposition 1 that confirmed that professional role acceptance was a significant influencing factor for the inclusion of IPV-related content in core units. For research proposition 5, academics’ self-rated knowledge was also an influencing factor for inclusion. Finally, the results of this proposition confirm that training influences inclusion of IPV-related content in the units. Additionally, a significant association was found between academics who reported exposure to victims of IPV and inclusion of IPV-related content.

The qualitative results found that 11 participants from phase three were passionate about this topic, and 13 participants felt competent and confident in teaching IPV. Of the 11 participants who included IPV-related content in their units, two had specific qualifications in IPV care, seven had direct work experience with IPV, and eight had confidence and competence in IPV. The results demonstrate that the first part of this rival explanation is correct.

The second part of this rival explanation is that academics who fail to include this content fail to adapt their work to include current health priorities and public-health issues and fail to incorporate content experts in their teaching team. This part of the rival explanation was difficult to prove or disprove with the evidence gathered. It was noted that nine academics recommended the use of guest speakers, either survivors or experts in the field, to present their experiences of IPV to students as a means of engaging them in the lecture. However, this part of the study found that the inclusion of IPV-related content is associated with the professional role acceptance of academics, their self-rated knowledge levels, their reported exposure to survivors of IPV, their competence levels and passion for this topic area. As this is the only evidence available for this section of the proposition, further research is required to confirm or deny this rival explanation.
5.3.5.5 Cross-case analysis.

Cross-case analysis of evidence from the online surveys conducted in phase two and the telephone interviews conducted in phase three is presented in Figure 5.6. Only three similarities were noted between the three cases.


**Figure 5.6.** Cross-case analysis for research proposition 5.

**5.3.5.6 Testing research proposition 5**

Proposition five asserts that non-inclusion of IPV-related content in the examined curricula is because of academics’ lack of expertise in the topic, a lack of understanding of the importance of including it in the curricula, and negative attitudes/beliefs related to survivors of IPV. This proposition will be examined in three segments: first by testing the level of
expertise, second by testing the level of understanding, and third by testing attitudes and beliefs in relation to IPV survivors.

Evidence showed that a lack of expertise was associated with the non-inclusion of IPV-related content in the three UG HCP curricula. This non-inclusion was associated with less than five hours of training and academics’ self-rated IPV knowledge of ‘some’ or ‘none’. Consistent with these findings, the interview evidence confirmed that among the academics that did not include IPV-related content in their units, only one had a qualification in IPV, three had direct work experience in IPV, and two felt confident and competent in the area of IPV.

The evidence from the online surveys and interviews also demonstrated that the academics’ attitudes and understandings of IPV were associated with the non-inclusion of IPV-related content. The surveys revealed that the inclusion of this content is associated with professional role acceptance. Further supporting this association, nine of the 18 participants in the interviews did not view IPV-related care as part of their scope of practice. Therefore, 50% of the participants in the interviews lacked understanding of the importance of IPV in their role as an HCP and as an academic.

Finally, it was found that academics’ attitudes in relation to survivors of IPV influenced the inclusion of IPV-related content in their units. Only one participant in the interviews discussed their beliefs and attitudes towards IPV. This paramedicine academic stated they believed IPV could occur to anyone, including an educated paramedic like her, but she understood how some HCPs feel betrayed when survivors return to their abusers after seeking help.

The results demonstrate that to include IPV-related content into a unit, the academic must accept their professional role and understand that the topic is in their scope of practice. The non-inclusion of IPV-related content in the UG disciplines of nursing, midwifery and
paramedicine is associated with a lack of expertise, a lack of understanding of the importance of the topic, and negative attitudes and beliefs in relation to survivors of IPV.

5.3.6 Research proposition 6: national and international organisations and committees

The premise of research proposition 6 is that IPV-related content is associated with academics’ awareness of national and international IPV guidelines and recommendations. To address this research proposition, data were collected from respondents via the online survey and participants involved in the telephone interviews.

Research question 6: How are academics utilising national and international organisations and committees’ guidelines and recommendations in their teaching of IPV-related content?

Research proposition 6: It is the proposition of the researcher that academics have little awareness of national and international organisations and committees’ guidelines and recommendations on IPV-related content and are thus not implementing any of the guidelines/recommendations into their teaching.

Rival explanation 6: Academics are aware of national and international organisations and committees’ guidelines and recommendations regarding the inclusion of IPV-related content in UG HCP degrees, and are as such adhering to them by doing so into their units.

5.3.6.1 Phase one—documentary content analysis

The documentary content analysis from phase one did not address this proposition, thus this stage of the research is not discussed here.

5.3.6.2 Phase two—online survey

Descriptive analysis of the survey data indicated that the majority of academics surveyed were unaware of a range national and international IPV-related guidelines and recommendations. Table 5.17 below summarises the level of awareness of these guidelines and recommendations.
Table 5.17

Awareness of National and International Guidelines and Recommendations

<table>
<thead>
<tr>
<th>Guideline/recommendation</th>
<th>N</th>
<th>Aware n (%)</th>
<th>Unaware n (%)</th>
<th>Not related to profession n (%)</th>
</tr>
</thead>
<tbody>
<tr>
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<td>57</td>
<td>98</td>
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<td></td>
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<td>(62)</td>
<td>(1.9)</td>
</tr>
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<td>Department of Health and Ageing guidelines/recommendations</td>
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<td>104</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>(35)</td>
<td>(65)</td>
<td></td>
</tr>
<tr>
<td>Australian Government guidelines/recommendations</td>
<td>163</td>
<td>59</td>
<td>102</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>(36.2)</td>
<td>(62.6)</td>
<td></td>
</tr>
<tr>
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<td></td>
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<td>89</td>
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<tr>
<td></td>
<td></td>
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<td>(55.6)</td>
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<td>16</td>
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<td></td>
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<td>(76.1)</td>
<td>(14.1)</td>
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<td>(60.9)</td>
<td>(1.2)</td>
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</table>

Chi-square analysis identified statistically significant associations between awareness of these guidelines and recommendations and the inclusion of IPV-related content in the curricula (see Table 5.18). Awareness of guidelines and recommendations was significantly associated with the inclusion of IPV-related content, with the exception of the Time for Action: The National Council’s Plan for Australia to Reduce Violence against Women and
Their Children 2009–2021 which was not found to be significantly associated with the inclusion of IPV-related content.

Table 5.18

Chi-square: Inclusion of IPV-related Content and Awareness of IPV Guidelines and Recommendations

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<th>χ²</th>
<th>p</th>
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</table>

5.3.6.2.1 Comparative analysis of awareness by discipline.

The cross-case comparisons are summarised below and presented in detail in Table 5.19

- **Case A—Nursing**: More than half of respondents in Case A were unaware of guidelines relevant to the discipline.

- **Case B—Midwifery**: A higher proportion of respondents from Case B (compared to Case A and Case B) were aware of all guidelines and recommendations other than those by Australian state or territory ambulance services.

- **Case C—Paramedicine**: A higher proportion of respondents from Case C compared with Cases A and B were unaware of guidelines and recommendations.
### Table 5.19

**Chi-square: Awareness of Guidelines and Recommendations by Discipline Case**

<table>
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<tr>
<th>Guidelines/Recommendations</th>
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<th>Case B N</th>
<th>Case C N</th>
<th>χ²</th>
<th>P</th>
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Table 5.3.6.3: Awareness of national and international organisations and committees’ guidelines and recommendations on the inclusion of IPV-related content in HCP curricula.

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<th></th>
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<th>Case A N</th>
<th>Case B N</th>
<th>Case C N</th>
<th>χ²</th>
<th>P</th>
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</table>

### 5.3.6.3 Phase three—qualitative telephone interviews

During the interviews, respondents were questioned about their awareness of nine national and international organisations and committees’ guidelines and recommendations on the inclusion of IPV-related content in UG nursing, midwifery and paramedicine degrees. One of the interview probes used during the guided-conversation interviews was how the participants obtain their information on IPV, and their awareness of national and international organisations and committees’ guidelines and recommendations on the inclusion of IPV-related content in HCP curricula. These national and international organisations and committees were known by only five participants of the 18 participants from the interviews. Thus, 13 participants were unaware of these guidelines and recommendations. Of the five participants who knew of the guidelines and
recommendations, three were from Case A, two from Case B, and zero from Case C.

When specifically analysing the awareness of guidelines and recommendations and the association of this awareness with the inclusion of IPV-related content, four of the five participants that knew of these guidelines and recommendations included IPV-related content in their units. Of these four participants, two were from Case A and two were from Case B. Thus, one participant from Case A knew of the national and international organisations and committees’ guidelines and recommendations on the inclusion of this content but failed to include it in their unit.

Participants from Case A who did not have awareness of these guidelines and recommendations provided numerous explanations for this. PT 6 cited a lack of time: ‘No, I do not know them … because I just do not have time to’; PT 16 attributed it to not teaching in this topic: ‘No, it’s not something I teach, so I do not need to know about them’. Two other participants from Case A stated they would need to complete research on the topic to find out about these guidelines and recommendations. For example, PT 9 stated the following:

I’d have to Google and find out, yeah, it’s not something … sort of there’s a really, yeah, like no one, I’ve never, I haven’t actually had to prepare anything for it.

As stated earlier, two of the three midwifery academics from Case B had awareness of these guidelines and recommendations. PT 5 from Case B was not aware of their existence, stating the following: ‘You can send me some if there are any’. When asked which sources they used to gain information on IPV-related content and its associated care, PT 2 stated, ‘I just Google it’, which was a common answer. Google and other websites were found to be the most common answer for which sources the participants consulted for such information. Eight participants used this method, five participants reported consulting national and international organisations and committees’ guidelines and recommendations, and another five reported consulting research journals. The next most common method for gaining such information was consulting women’s health clinics and organisations, with four participants utilising this
source, while four other participants used support groups to acquire information. A variety of other methods were used by other participants, including textbooks, experts in the field, librarians, newspapers and their own experiences.

Slight differences were noted by discipline case in relation to the most accessed sources of information. For Case A, the top four sources of information were websites, support groups, women’s health clinics, and national and international guidelines and recommendations. For Case B, the top four resources were national and international guidelines and recommendations, research journals, women’s health clinics, and websites. For Case C, the top four sources of information were research journals, websites, independent bodies, and their own experience.

5.3.6.4 Examining rival explanations

The rival explanation for research proposition 6 is that academics are aware of national and international organisations and committees’ guidelines and recommendations on the inclusion of IPV-related content in UG HCP degrees, and are adhering to these guidelines and recommendation by including this content in their units.

Data obtained by phase two and three of this case study provided conflicting evidence for this rival explanation. Most respondents were unaware of relevant guidelines and recommendations. The National Plan to Reduce Violence against Women and Their Children 2010–2022 was the most recognised source of guidelines and recommendations. Components of the interview evidence corroborate these findings, with five of the 18 participants reporting they were aware of national and international organisations and committees’ guidelines and recommendations. Thus, the majority of participants involved were unaware of these guidelines and recommendations. Therefore, the evidence provided thus far illustrates that over half of the respondents from the on-line survey and nearly three quarters of the participants from the telephone interviews were unaware of these guidelines and recommendations.
However, in contrast, there is evidence from both phases supporting the link between the awareness of these guidelines and recommendations and the inclusion of IPV-related content. A statistically significant association was found between the awareness of these guidelines and recommendations except for the Time for Action: The National Council’s Plan for Australia to Reduce Violence Against Women and Their Children 2009-2021 and the inclusion of IPV-related content. Furthermore, the interview evidence found that out of the five participants that were aware of the guidelines and recommendations, four of them included IPV-related content into their units.

There is some support for the rival proposition. Although most academics were unaware of relevant national and international organisations and committees’ guidelines and recommendations, a small number were aware of these, and included IPV-related content in their units, even if minimally.

5.3.6.5 Cross-case analysis

Evidence from phase two and phase three was collected and compared, as presented in Figure 5.7.
5.3.6.6 Testing research proposition 6

This research proposition states that academics had little awareness of national and international organisations and committees’ guidelines and recommendations on IPV-related content, and consequently, are not implementing these the guidelines and recommendations in their teaching. The survey data supported the proposition. Similarly, of the 11 interview participants who reported including IPV-related content in their units, only four were aware of these guidelines and recommendations.

5.4 Unplanned Findings

The guided-conversation approach adopted for the telephone interviews allowed participants to discuss topics and issues they felt were important, rather than being able to answer only questions posed by the interviewer. This allowed two important findings to arise.
that had not been considered by the researcher. These were the consequences for students if IPV-related content is integrated throughout the curricula, and the significance of this thesis topic.

5.4.1 Consequences for students

A common theme reported throughout the telephone interviews was the consequences of students if IPV-related content was integrated throughout or included in the UG curricula. The major consequence of this content inclusion noted by participants was an increase in awareness of this important societal and health-care issue. PT 10, a midwifery academic, stated, ‘it’s got huge implications’. Participants reported that including this topic brings IPV to the forefront of students’ minds and enables them to develop the ability to deal appropriately and sensitively with survivors of IPV, ensures higher a higher level of detection of survivors, and increases the ability of students to educate patients and potential perpetrators of violence. Further, PT 18 stated that it encourages students to think more comprehensively and conceptually about this health-care issue.

Another reported consequence of this content inclusion is an increase in the confidence levels of students to deal with IPV, which makes them empowered to manage this situation effectively as an HCP. This was described by PT 5 as follows:

*They’ll feel more confident about dealing with people who are experiencing these situations, and feel more confident about how to support them and what services are available. Yeah, I think it’ll … it can only enhance their careers and their personal and professional knowledge.*

Removal of personal judgements about survivors of IPV was also noted as a positive consequence of including IPV-related content in the UG curricula. Some of the specific topics to be addressed were reported as follows: ‘understanding why women do not leave, the lack of empowerment they’ve got. Um, and also the impact it has on the family’s health and the child’
(PT 13). One rationale given for why this content needs to be included to eliminate personal judgements was the characteristics of student cohorts:

* A lot of the students that we have are quite young: 17 to sort of 23, haven’t travelled, haven’t really been anywhere, just pretty much straight from school or home. And I think that they’ve never even heard of those things, or given it any consideration. So, I think it’s a starting off point to open that debate. (PT 3)

The only noted negative aspect of including this content in the UG curricula is the need to ensure counselling services are available to students, particularly given that the student cohort may contain IPV survivors or students who are currently in an IPV relationship. However, as explained by PT 15, caring for IPV survivors and perpetrators is part of the role as an HCP and therefore, students need to be prepared to care for them:

* As hard as that ... you know, I do not mean to sound callous, but I just think it needs to be seen as part of the role. It needs to be seen as part of just what a health professional does, part of the effect it has on health. So, if I’m thinking about midwifery, we have a lot of midwives who experience, you know, miscarriages, like miscarriages, stillbirths, sadly, you know, but those midwives still go on and function in their role and they still care for women who are experiencing those things that they’ve experienced. So, we have to think about domestic violence in the same way, and I think as long as students and clinicians are well supported when you’re doing this work and you have those mechanisms in place to keep them safe, it should be ... just be seen as any ... even though it’s more complex, we should all look at it as it’s just what we do.

5.4.2 Significance of thesis topic

The other unexpected finding of this case study was the acknowledgement of the important role this research will play in academic health education. The inclusion of IPV-related content in UG HCP curricula was seen by the participants as a valuable topic. For
example, PT 3 stated, ‘it is vital that we have these conversations on topics like this’. Further, it was reported as a topic ‘of great societal importance and community importance’ (PT 7), and as PT 18 concluded, ‘your PhD has sparked my interest now’. PT 4 raised the issue of ‘educating the educator’ to ensure important research like this can be included in health education. PT 15 noted the significant contribution this research will make to routine care:

*Well, I think with work like yours that will certainly help if we can start to educate students and make it just part of what they do when they’re providers, nurses and midwives, that’s what they’ll do. So, I think it’s a really good place to start.*

### 5.5 Chapter Summary

This chapter analysed the evidence obtained from the documentary content analysis conducted for phase one, the online survey conducted for phase two and the qualitative telephone interviews conducted for phase three, for the three discipline cases of nursing (Case A), midwifery (Case B) and paramedicine (Case C). This chapter began with a chapter preamble and pictorial outline of the chapter, followed by a description of the cases. Data analysis in relation to each research proposition was presented using within-case analysis, examination of rival explanations, cross-case analysis and testing of the research proposition. Unplanned findings were then presented followed by a chapter summary. Chapter 6 now presents the conclusions drawn from the research propositions, and the conclusions regarding the research problem for this case study.
Chapter 6: Discussion

The thought of someone you love and who is supposed to love you back continuously inflicting physical and emotional pain towards you is unthinkable—yet it happens all too often throughout the world we live in.

6.1 Chapter Preamble

The previous chapter provided the evidence obtained from the three phases of this multiple-phase mixed-methods case study for each research proposition. The purpose of this chapter is to offer a critical discussion of the evidence of this case study and to draw conclusions and responses to the research problem. Conclusions drawn from the research propositions will firstly be presented and discussed in relation to the gap in the literature this research fills, as well as their relationships to previous research and the contributions these conclusions have made to the body of knowledge. Lastly, conclusions on the research problem will be presented and the framework for the integration of IPV-related content will be outlined and discussed as a means to which IPV-related content can be successfully integrated throughout UG HCP degrees.

This chapter is presented in four sections. Section 6.1 introduces the chapter, and a pictorial outline of the chapter (Figure 6.1). Section 6.2 discusses the conclusions related to the research propositions, which address the amount and depth of inclusion and integration of IPV-related content included in UG HCP degrees, as well as the location of such content inclusion and delivery approaches of that content, and the real and potential drivers of academics’ choices relating to content inclusion and delivery. Section 6.3 provides a conclusion to the research problem. This chapter then concludes with a chapter summary (Section 6.4). A table of the contributions to the literature emerging from this study is presented in Appendix F.
6.2 Conclusions drawn from research propositions

This section presents the conclusions drawn from the six research propositions of this multiple-phase mixed-methods case study. This will provide the evidence necessary to address the research problem outlined in Section 3.8.2. The findings will be discussed in relation to the gap in the literature, and the relationship of the research to previous research. New knowledge obtained and unexpected findings will also be highlighted.

6.2.1 Amount and depth of IPV-related content inclusion and integration.

This study adds to the body of knowledge in the topic of IPV and health education by determining that IPV-related content is almost exclusively included in core units in the UG nursing, midwifery and paramedicine degrees in Australia, and that academics advocate for the integration of this content throughout these degrees. Previous research has not examined this topic in relation to IPV-related content, making this a significant finding and a high-level contribution to the literature on this topic.
However, a crucial finding from this research was that this IPV-related content is incorporated only minimally in Australian UG BN, BM and BP (or equivalent) degrees. These findings corroborate the recent scoping review conducted by Crombie et al. (2016), which also concludes that minimal IPV-related content is included in the BN and BM degrees in Australia. Further, these findings demonstrate that little progress has been made in the inclusion of IPV-related content in the BN degree because this study confirms research conducted in 1996 to 2005 (Chung et al., 1996; Glaister & Kesling, 2002; Haggblom et al., 2005; Woodtli & Breslin, 2002), which found a lack of IPV-related content in this degree.

Not only was the content inclusion found to be minimal, but where it is included, it is often delivered in several minutes to a couple of hours. This is inconsistent with the literature reported in Section 3.6.1.1, which states that the average duration of coverage for this content is two to four hours (Hinderliter et al., 2003; Ross et al., 1998; Woodtli & Breslin, 2002). An unexpected finding is that only two respondents from the online survey taught this content in nine to fourteen hours, and only one respondent taught it in more than 15 hours. This contrasts with Hinderliter et al. (2003), who found that 19% of nurses received IPV-related content in five to ten hours, and 8.8% received it in more than 11 hours. As the previous research conducted on this topic is more than 10 years old, the evidence from this case study provides current evidence on the duration of IPV-related content coverage.

The importance of placement experiences for the integration of theoretical learning is well established; however, no known research to date has examined academics’ attitudes and thoughts towards planned clinical placements with survivors or perpetrators of IPV. Overall, 42% of respondents disagreed or strongly disagreed with this planned clinical placement, and only 24.8% agreed or strongly agreed with it. Telephone interviews provided converging evidence, with 12 of the 18 participants also reporting to be against planned clinical placements with IPV survivors or perpetrators. Not only did the current study provide new insight into whether academics agreed with planned clinical placements in IPV, it also
provides qualitative evidence about academics’ beliefs in relation to these clinical placements. These beliefs include those relating to students not being able to cope with this challenging and stressful situation.

The only known research on clinical placements with survivors of IPV was conducted in Canada and the US, but this research examined only the number of schools of nursing that had such placements arranged (Wootli & Breslin, 2002; Ross et al., 1998). In these studies, 62% of schools of nursing in Canada and 31% of schools of nursing in the US had planned clinical placements with survivors of IPV (Woodtli & Breslin, 2002; Ross et al., 1998). Therefore, the findings of the current research make an important contribution to the literature on IPV-related content in HCP UG degrees in Australia by providing quantitative and qualitative evidence for the issues surrounding planned HCP clinical placements with survivors or perpetrators of IPV.

The first two research propositions also highlight key enablers and barriers to the inclusion and integration of IPV into HCP UG degrees in Australia, as reflected in the literature (Kassebaum & Anderson, 1995; Keeling & Birch, 2002; Hamberger & Phelan, 2004; Ross et al., 1998). However, the commonalities between the previous research and the current study are minimal in relation to the barriers. Only six common barriers were found that constitute a combination of professional and personal barriers. This study provides new knowledge on the barriers impeding the inclusion of IPV-related content because it discovered nine new barriers that have not been previously acknowledged.

These barriers are an overcrowded curriculum; a focus on hard science and clinical skills; a focus on the medical model and acute medical–surgical nursing; very limited focus on health promotion, mental health and social health and welfare, no mandate from the school to include this content; a lack of confidence and competence in teaching this topic; a lived experience of IPV; academics not being adequately prepared to react to students’ responses if they have experienced or are currently experiencing IPV; a focus on their own speciality area
and priorities; an inability to relate to an IPV situation; and gender, with males less likely to include IPV-related content in their units.

Despite these barriers, this study also provides new insights into the enablers to including IPV-related content in HCP UG degrees. The following four enablers were noted by participants in the telephone interviews: a high level of knowledge and experience in the teaching team; the proximity to women for midwives; the need to provide students with the reality of what they will experience as professionals; being female was also noted as an enabler. No previous research has been conducted on this topic, thus the current findings are unique, and the research reveals a gap in the literature that was previously not acknowledged.

Acquisition of new knowledge also occurred in relation to the connection between passion and competence and the inclusion of IPV-related content. Evidence obtained from the online surveys and the telephone interviews converged to illustrate that academics who are passionate about IPV and are competent and confident in teaching this topic area include IPV-related content in their units. Statistical significant associations were found between professional role acceptance and the inclusion of IPV-related content in core units, while academics’ self-rated knowledge was associated with the inclusion of IPV-related content. Further, 10 of the 12 academics who were passionate about IPV included such content in their units, while 11 of the 13 participants who were competent included this content. No previous research has been conducted on the connection between passion for and competence in IPV care, and the inclusion of IPV-related content in HCP UG degrees in Australia or internationally, thus illustrating the uniqueness of this enquiry. These findings provide an important contribution to the knowledge base of IPV-related content and curricula development.

6.2.2 Content location and teaching strategies for IPV

While previous international research has been conducted, this is the first known Australian study to examine the types of units into which IPV-related content is incorporated.
It is also one of the first known studies to examine frontline academics’ attitudes and beliefs in relation to the inclusion of IPV-related content in the UG curricula of nursing, midwifery and paramedicine.

The findings identified that when IPV-related content is incorporated into Australian UG nursing, midwifery and paramedicine degrees, it is done so through a variety of units. However, the most common categories of units containing IPV-related content are units on women’s health and childbirth and on primary and community health care. This contrasts with the previous literature outlined in Section 3.6.1.2, which states that the most common unit type incorporating IPV-related content is psychiatric nursing (Hoff & Ross, 1995; Ross et al., 1998). In the current study, mental-health nursing was ranked as the fifth most common type of unit to include IPV content (25% of the units that included IPV-related content are mental-health units). Additionally, three participants from the interviews taught in mental-health units, but only one incorporated this content.

Conflicting findings also occurred in relation to women’s health and childbirth units. In previous research, maternity nursing constituted 21.3% of the units incorporating IPV-related content, while 10.3% were women’s health units (Hoff & Ross, 1995; Ross et al., 1998). However, the findings of this study were different. Women’s health and childbirth units were the main units including IPV-related content, constituting 81% of the units. Further contradictory results between the current study and previous findings were found for units of community health and units of medical–surgical nursing. Once again, the inconsistency between the current study’s findings and previous research could be because of the age of the previous findings, with the older findings having less relevance. Additionally, these studies were conducted internationally, which means the differences may be because of the different countries’ compartmentalisation of IPV and its related health-care needs and priorities.

An interesting and unexpected finding arose from the qualitative telephone
interviews, which is that academics did not acknowledge IPV as a mental-health issue, but as a wider societal issue. The majority of participants believed it was detrimental to IPV survivors to include IPV-related content in mental-health units because mental health has problems with stigmatisation; these academics reported believing that teaching IPV-related content in more generic units would be more appropriate. This finding provides new insight into the perceptions and beliefs of frontline academics teaching in Australian BN, BM and BP (or equivalent) degrees, and provides unique and novel findings for the argument of including IPV-related content throughout UG nursing, midwifery and paramedicine degrees in Australia.

Having established the location of IPV content, this study also explored how such content was being delivered. The research found that academics felt strongly about the need to role model to students that IPV is unacceptable, with 71.6% of the academics strongly agreeing with this statement. Likewise, 67.5% of the academics agreed or strongly agreed that without IPV-related content in the HCP curriculum, IPV will remain undetected and untreated, with the cycle of violence continuing. Only 11.3% of academics disagreed with this belief statement. Therefore, the majority of academics involved in the online survey of phase two believe that role modelling the unacceptability of IPV, and breaking the cycle of violence as a serious issue, and an issue in which they can actively assist through teaching the healthcare topic of IPV. Again, no previous research has been conducted on this topic, and thus, the findings provide new insight into the beliefs and attitudes of Australian frontline academics.

This research also established that the most common method for delivering IPV-related content in Australian UG nursing, midwifery and paramedicine degrees was through tutorials and workshops. Tutorials were the most popular teaching strategy adopted by academics who responded to the online survey, with 85% of them using this teaching strategy, and 66% of interview participants using this strategy. While the review of the literature found the use of teaching strategies such as a DV learning module, a two-day immersion course and
a one-day DV-immersion activity (Belknap, 2003; Davila, 2005; Evans et al., 2001; Helton & Evans, 2001), no previous research had been conducted on the teaching strategies used to deliver IPV-related content in an UG HCP degree when IPV-related content is incorporated into individual units. Thus, this is one of the first studies of its kind to investigate the teaching strategies utilised to deliver this content, and consequently provides unique insight and knowledge contribution on the delivery of IPV-related content to UG HCP students.

Knowledge was further expanded by the current study by examining the use of clinical laboratories as a teaching strategy for delivering IPV-related content and health-care practices. Only 6% of the respondents of the online survey integrated IPV-related content into the acquisition of clinical skills in clinical laboratories. Similarly, only one of the 18 interview participants conducted skills-based learning to teach this content. While conducting the literature review for Chapter 3, it became evident that no research had been conducted on the mastery of clinical skills specifically related to IPV. The only literature discovered was in a literature review stating that simulated laboratory classes are a necessity for practising communication skills and IPV-screening techniques (Daniel & Milligan, 2013). The lack of clinical-skills practice in IPV-related care is a significant issue because it means a lack of connecting taught theory with interventions. As a result of the lack of research into this area, these findings offer important contributions to the existing knowledge and evidence on the education of IPV-related content to UG nursing, midwifery and paramedicine students.

An unexpected finding from this study was the strategy of using guest speakers during lecture presentations. Guest speakers, in the form of survivors and experts, were utilised by nine nursing academics involved in the telephone interviews. No information was provided by the online survey because this form of teaching strategy was not included in the options for the survey given that there was no acknowledgement in the literature of such a teaching strategy being applied to deliver IPV-related content. Therefore, this study provides another novel finding into the use of guest speakers as a delivery method for teaching reality of IPV to
UG nursing, midwifery and paramedicine students in Australia, and thus provides a high-level contribution to the literature on this research topic.

Evidence obtained from the online surveys conducted in phase two and the telephone interviews conducted in phase three converged to find that frontline academics are failing to teach Australian nursing, midwifery and paramedicine students health-related practices related to IPV. When specifically examining these health-related practices, only 51% of respondents of the online survey reported including information on referral pathways and therapeutic communication, while 49.1% included screening/identification practices, and 35.8% included how to treat survivors of IPV. Likewise, screening/identification practices were only included by seven of the 18 interviewed participants, while treatment of survivors of IPV was included by three of these participants, and safety planning, referral pathways and therapeutic communication by only two of these participants.

This research builds on the existing research conducted into the area of the types of IPV-related content included in university degrees reviewed in Section 3.6.1.2 by also finding a lack of teaching of health-related practices associated with IPV survivors. Several studies have concluded that content coverage of IPV is very narrow, with greater focus being placed on the basic issues of IPV, such as the cycle of violence, than on safety planning and treatment of IPV survivors (Hinderliter et al., 2003; Sword et al., 1998). Sword et al. (1998) found that among the most commonly covered IPV topics were the psychological effect of IPV, why women stay and leave, community resources, and presenting problems. However, limited coverage in the curricula was found for the development of a safety plan. Thus, health-related practices in relation to IPV were also covered minimally in the studied curricula. It is important to note that the previous research conducted in this area includes only two studies that are more than 14 years old, and are both international (Hinderliter et al., 2003; Sword et al., 1998). In addition, the research conducted by Sword et al. (1998) includes only the BN degree at one university.
This research also illustrates that Australian UG nursing, midwifery and paramedicine degrees are not adhering to numerous national and international organisations and committees’ guidelines and recommendations on the topics to include in the teaching of IPV-related content. For example, the WHO’s (2013b) recommendations state that HCPs need to be educated on all aspects of IPV, including identification of survivors, safety assessment and planning, communication and clinical skills, documentation, and referral pathways. Another WHO (2010) recommendation elaborates on this multicomponent aspect of IPV by stating that effects of IPV, active listening skills, screening, how to support survivors when they disclose abuse, how to follow designated care pathways, ethical issues, legal issues, child protection, documentation, gender inequalities and multidisciplinary training should be taught to all UG HCP students. Therefore, this study provides new insight into the lack of health-related practices being taught to Australian UG nursing, midwifery and paramedicine students and the disparity between what is currently being taught and what is recommended for teaching in these degrees. This study builds on existing research, and thus provides a medium contribution to the literature pertaining to IPV education.

6.2.3 Drivers influencing content inclusion and delivery

This study establishes that academics with a lack of expertise in IPV are less likely to include IPV-related content in their units in Australian UG nursing, midwifery and paramedicine degrees. The non-inclusion of IPV-related content was found to be associated with fewer than five hours of training and a knowledge rating of some or none on the online survey. Likewise, of the interview participants that did not include this content in their units, only one participant had qualifications in IPV, three had direct IPV work experience, and two felt confident and competent in IPV health care. These findings again highlight the value of this study in that no previous research has been conducted on the association between level of expertise and including IPV-related content in HCP UG curricula.
This research also confirms there are numerous barriers to the inclusion of IPV-related content other than a lack of expertise. The academics revealed a clear lack of understanding that IPV is within the scope of practice of all HCPs. Therefore, the non-inclusion of IPV-related content is associated with a lack of acceptance of professional role, and potentially a denial that IPV is within the scope of HCP practice. This research also contributed to the clarification of barriers associated with the non-inclusion of IPV-related content, with a perceived lack of understanding of IPV being one such barrier. This interplay between expertise in and understanding of IPV is further complicated by the finding on academics’ values and attitudes in relation to IPV.

These findings demonstrate that the inclusion of IPV-related content is influenced by frontline academics’ attitudes and beliefs in relation to IPV survivors. Two belief statements examined by the online surveys conducted in phase two were that HCPs should assess the mental-health status of survivors of IPV, and that interventions for survivors of IPV should remain confidential to ensure their safety. The data analysis conducted on these belief statements demonstrated that academics’ attitudes and beliefs in relation to survivors of IPV influence the academic’s inclusion of IPV-related content. Further, it was found that midwives had the most favourable beliefs and attitudes in relation to IPV survivors, followed by nurses and then paramedics. Only one paramedicine academic referred to their beliefs and attitudes in relation to IPV survivors, and these were positive in nature. By identifying the role and influence of academics’ attitudes and beliefs on the inclusion of IPV-related content, this study provides an important contribution to the literature. The gap in the literature on the examination of frontline academics’ expertise, understanding of, and attitudes and beliefs in relation to IPV has now begun to be closed as a result of the current study.

Numerous national and international organisations and committees’ have guidelines and recommendations on the inclusion of IPV-related content. These organisations and committees were outlined in Chapter 3, along with their guidelines and recommendations.
previous research has been conducted on the adherence to these guidelines and recommendations.

In the online surveys, respondents were asked if they were aware of nine of the national and international organisations and committees’ guidelines and recommendations, and the interview participants were asked about their awareness of these guidelines and recommendations. Findings from these questions illustrated that most frontline academics are unaware of these guidelines and recommendations, with up to 73.3% of respondents unaware of the guidelines and recommendations of the National Council to Reduce Violence against Women and their Children, and 65% were unaware of the guidelines and recommendations of the Australian Department of Health and Ageing. Further, 13 interview participants were unaware of any guidelines and recommendations in relation to IPV. This study enriches the literature on health education of IPV because it is the first to provide evidence of frontline academics’ lack of attention to health organisations and committees’ guidelines and recommendations in relation to teaching IPV, thereby demonstrating a reason for not including current EBP in their teaching.

This failure to incorporate EBP into curricula is further highlighted by the finding that the most common means by which frontline academics gain knowledge on IPV is via the Google search engine. Only five participants of the 18 interviewed searched databases to find current research articles on IPV and its related health-care needs. This research highlights that frontline academics are not incorporating peer-reviewed academic information into their teaching content and therefore, may not be providing the most accurate and current information to their students. These findings support previous research that has demonstrated that academics have little understanding of or expertise in IPV.

However, the association between the lack of awareness of national and international organisations and committees’ guidelines and recommendations and the non-inclusion of IPV-related content was unclear. While the evidence from phase two demonstrated a
significant association between awareness of these guidelines and recommendations and the inclusion of IPV-related content, the evidence from the interviews found that of the 11 academics who included IPV-related content in their units, seven were unaware of the guidelines and recommendations. This suggests that other factors such as academics’ values and beliefs influence the inclusion of this content. Further research into this topic should be conducted to gather further evidence on the association between awareness of guidelines and recommendations and inclusion of IPV-related content.

No previous research has been conducted on this topic, and therefore, this study provides preliminary evidence on how academics acquire their IPV knowledge and information. However, further research needs to be conducted to determine how academics’ IPV knowledge is obtained and the consequences this has on students’ knowledge and health-care practices.

6.3 Conclusion on the Research Problem

As stated in Section 3.8.2, the following research problem was addressed in this study: How effective are Australian universities offering UG nursing, midwifery and paramedicine degrees at incorporating IPV-related content into these degrees and how can this area topic be more consistently integrated to bring about a more responsive workforce in health care? Further, are Australian universities utilising national and international recommendations on this inclusion in the UG degrees?

This research problem was developed after identifying numerous gaps in the literature on the education of UG nursing, midwifery and paramedicine students in IPV-related content. The literature review confirmed the inadequacy of previous research completed on this significant public-health issue. As a result, six research objectives, research questions and research propositions were developed and a realist epistemology and a mixed-methods multiple-phase case-study design were adopted to address them. This study succeeded in bridging the gaps in the literature to provide a better understanding of the current situation of
teaching IPV-related content in Australian UG nursing, midwifery and paramedicine degrees. As presented in Appendix F, 20 contributions to the literature were provided by this study, thus providing comprehensive and useful insights into this significant topic. These findings are now synthesised to address the overall research problem of this study.

Overall, Australian universities are ineffective at teaching UG nursing, midwifery and paramedicine students the necessary content required to adequately care for survivors of IPV. Minimal IPV-related content is being incorporated into these degrees, and if this content is included in such degrees, it is usually done so using a brief amount of time. It is important to acknowledge why this situation is occurring in Australian UG HCP degrees and to determine what is stopping frontline academics from including this content in their units, and identify the enablers that can be promoted to encourage including this content. This is what this study set out to determine.

To integrate IPV-related content into UG HCPs degrees consistently, and thus provide a health-care workforce that is more responsive to IPV survivors, a framework for the integration of IPV-related content into UG HCP degrees has been devised. This model provides a new, comprehensive view of the inclusion of IPV-related content in UG HCP degrees and thus represents a further contribution to the literature. This model demonstrates that inclusion of this content can be achieved by focusing on the following three major components of integration: elimination of barriers, promotion of enablers, and acceptance of EBP (see Figure 6.1). Each of these three major components is now addressed.

Integration of IPV-related content into Australian UG nursing, midwifery and paramedicine degrees can occur only if barriers to this inclusion are noted and eliminated, and enablers for this inclusion are recognised and promoted. There are many barriers to the integration and inclusion of IPV-related content in these UG degrees, with 17 barriers identified in this study. All these barriers can be amended through education of frontline academics, heads of school, and deans of the faculty. This study also identified 11 enablers
for the inclusion of IPV-related content, and these are promotable through education of frontline academics, heads of school, and deans of the faculty.

Education of frontline academics, heads of school, and deans of the faculty on the importance and necessity of including IPV-related content in the curricula and on EBP in relation to the best methods to achieve this will not only eliminate barriers and promote enablers, it will also ensure this content inclusion is completed correctly when implemented. The education of key members involved in the inclusion and integration of IPV-related content in UG HCP degrees will be elaborated in Section 7.2.3 of the following chapter.

A key overall contribution of this study is the provision of EBP in relation to the best approach to incorporating and integrating IPV-related content in Australian UG nursing, midwifery and paramedicine degrees. As seen in Figure 6.1, there are four aspects of this EBP in relation to the inclusion of IPV-related content. First, IPV-related content needs to be integrated throughout the curricula across a variety of units, rather than be pigeonholed into one particular unit or type of unit. For example, it has been determined that including IPV-related content in mental-health units could be detrimental to IPV survivors because mental health is often stigmatised. Second, this content needs to be incorporated into core units throughout the UG degree, rather than into elective units, so that all UG students receive the same comprehensive, multicomponent information on IPV. Third, there is a need for planned clinical placements with IPV survivors and/or perpetrators. This is difficult to achieve for paramedicine students, as they are unable to plan with which clients they have contact. However, planned clinical placements are achievable for nursing and midwifery students. However, for this to occur, frontline academics must be challenged in their thoughts and attitudes in relation to such placements because overall, the academics involved in this study were against these planned clinical placements. It has been proven by previous research that clinical placements with survivors and/or perpetrators of IPV can be implemented and
conducted successfully (Ross et al., 1998; Woodtli & Breslin, 2002). Therefore, this success is also achievable in Australian universities.

Fourth, key people involved in curriculum development need to be informed that the most popular and effective teaching strategy for delivering IPV-related content is through tutorials and workshops because interactive participation is required for this teaching strategy. Discussions around case scenarios, the incorporation of role plays, examples of different IPV situations, the ability to learn from others and to appreciate other’s perspectives, as well as the expression of opinions, thoughts, beliefs and feelings can all occur in a safe environment during these tutorials or workshops. Further, IPV-related content and its associated health-care practices must be assimilated into skills-based learning during clinical-laboratory time. It must be stressed to these key people that if students are not given the opportunity to practise screening for IPV, communicating appropriately and respectfully to survivors of IPV, and managing referral of survivors in a safe environment such as a university clinical laboratory, it is very difficult for them to acquire competence in these skill areas. In addition to tutorials and clinical laboratories, lectures are a very effective strategy to employ to introduce the topic of IPV, and guest speakers can also be incorporated into lectures. It has been demonstrated by this study that numerous academics use guest speakers, both survivors and experts, as a means of providing a real-world perspective on the topic of IPV.

As can be seen in the model for the integration of IPV-related content (Figure 6.1), national and international organisations and committees’ guidelines and recommendations for the inclusion of IPV-related content has a priority position at the beginning of the model. This aspect of IPV care is at the beginning of the model because there are numerous national and international organisations and committees that have guidelines and recommendations on IPV-related content inclusion in HCP degrees, and it is therefore imperative for Australian universities to adhere to these guidelines and recommendations. A complete list of national and international organisations and committee’s guidelines and recommendations can be
found in Section 3.7. National organisations such as the ANMF (2016) endorse the education of all UG nursing and midwifery students in the topic of DV, while the Australasian College of Emergency Medicine’s (2016) policy on DV states that all UG HCPs should be educated and trained in DV-related care. Internationally, the WHO (2013b) advocates that all HCPs should receive training on the effective and efficient care of IPV survivors. Further international organisations advocating the education of UG HCP students include the ANA (2000), the American Association of Colleges of Nurses (2000) and the American College of Emergency Physicians (2009).

Australian universities are currently failing to adhere to these guidelines and recommendations on the inclusion of IPV-related content in their UG nursing, midwifery and paramedicine degrees. This is evident in the lack of IPV-related content included in Australian UG nursing, midwifery and paramedicine degrees. Not only are Australian universities not adhering to the guidelines and recommendations on the inclusion of IPV-related content, they are also not adhering to the recommendations for the inclusion of clinical experience as a teaching tool for these students. In the current study, only 15% of the units that incorporated IPV-related content in the online survey offered clinical placements as a teaching strategy, while clinical placements were not mentioned by the interview participants at all. This conflicts with the recommendations of the ANA (2000) and the AACN (2000), which state clinical experience as an important means for achieving nursing competencies related to IPV assessment, treatment and prevention. Finally, it was also found by this study that Australian universities are failing to adhere to the WHO’s (2013b; 2010) recommendations on the type of IPV-related content that should be incorporated into UG HCP degrees.

It is clear that Australian universities are not effectively incorporating IPV-related content into the UG BN, BM and BP (or equivalent) degrees, which means they are failing to adhere to national and international organisations and committees’ guidelines and
recommendations that strongly advocate the inclusion of this content. Further, this study confirms that Australian universities are also failing to adhere to the guidelines and recommendations on clinical experiences related to IPV survivors, and the type of IPV-related content that should be incorporated into HCP degrees. Finally, this study provides evidence on how IPV-related content can be more consistently integrated into Australian UG HCP degrees. To include IPV content most effectively in these degrees, this study recommends the following strategies: integrating IPV-related content throughout the degree; including IPV-related content in core units; ensuring clinical placements with IPV survivors; incorporating IPV-related content into tutorials/workshops and clinical laboratories; and inviting guest speakers to present lectures.
Figure 6.2. Framework for integration of IPV-related content.
6.4 Chapter Summary

Overall, this chapter has highlighted and discussed conclusions drawn directly from the findings of this study and in response to the stated research problem. A summary of the conclusions drawn from the research propositions were presented, examining the link between the research propositions and the existing body of knowledge, the gaps in the literature, and the contributions made by the research. The findings of this study have made a high level of contribution to the body of knowledge because it is one of the only Australian studies to examine the inclusion of IPV-related content in Australian UG nursing, midwifery and paramedicine degrees, and the adherence of Australian universities to national and international organisations and committees’ guidelines and recommendations on this inclusion. Conclusions were also drawn on the research problem and a framework was created to demonstrate how to integrate IPV-related content into UG HCP degrees. Chapter 7 will now provide the recommendations from this case study along with the implications for theory, policy, practice, methodology and future research.
Chapter 7: Conclusions and Implications

The thought of someone you love and who is supposed to love you back continuously inflicting physical and emotional pain towards you is unthinkable—yet it happens all too often throughout the world we live in.

7.1 Chapter Preamble

Chapter 6 provided a discussion of the findings from this multiple-phase mixed-methods case study in relation to the research propositions and the overall research problem. This study provided 20 contributions to the scant body of knowledge that exists in relation to the inclusion of IPV-related content in UG HCP degrees, and created a framework for the integration of IPV-related content. This framework is further discussed in the current chapter. The aim of this chapter is to draw the study to a conclusion. Recommendations developed from the study’s findings will be discussed, and the implications for research in relation to theory, policy and practice, methodology and future research will be outlined. Finally, the strengths and limitations of this study will be presented.

This chapter is presented in five sections. Section 7.1 provides the chapter preamble and the pictorial outline of this chapter (Figure 7.1). Section 7.2 outlines the four recommendations devised from a thorough analysis of the case-study evidence. Section 7.3 outlines of the implications for theory, policy, practice, methodology and future research arising from this study. The strengths and limitations of this research are summarised in Section 7.4. Section 7.5 concludes this research study.
7.2 Recommendations

A thorough analysis of the evidence presented in Chapter 5 led to four recommendations being devised. These recommendations have been formulated to provide a solution to the problem of the lack of IPV-related content being delivered in UG nursing, midwifery and paramedicine degrees in Australia. These recommendations are now discussed.

7.2.1 Recommendation one: IPV-related content should be integrated throughout all UG HCP degrees via the use of the framework for the integration of IPV-related content

Through the analysis of the documentation conducted in phase one, the online surveys conducted in phase two and the interviews conducted in phase three, this study concluded that there is minimal IPV-related content incorporated into current BN, BM and BP (or
equivalent) degrees in Australia (Section 6.3.1.1). This study recommends the inclusion of IPV-related content throughout these HCP UG degrees. The inclusion of this content should occur via the incorporation of IPV-related content at each year level of these degrees. This will ensure that students are exposed to aspects of this content each year of their degree, with all health content on this topic aggregated in semester two of the final year to provide students with overall teaching and practise of how to screen, identify, communicate, treat, refer and follow up IPV survivors.

This integration can occur and be successful through using the framework created by this research for integrating IPV-related content in UG HCP degrees (Figure 6.2). This framework illustrates that IPV-related content can be integrated successfully in UG HCPs degrees by focusing on the following three major components: elimination of barriers; promotion of enablers; acceptance of EBP. As part of this framework, guidelines will be developed and written by the researcher for the integration of IPV-related content on how to achieve the following:

- eliminate barriers
- promote enablers
- integrate content throughout the UG degree, particularly via core units
- accommodate IPV-related experiences into clinical placements
- teach IPV-related content, focusing on using tutorials, clinical laboratories and guest speakers.

Further, for integration to be successful, not only do guidelines need to be developed and written but also key members of curriculum development need to be led on these principles. Leadership by heads of school, deans of faculty, curriculum-development teams, and any other teaching and learning working parties will ensure the elements related to the integration of IPV-related content in their UG degrees are undertaken.
7.2.2 **Recommendation two: development of an IPV Tertiary Education and Research Centre**

The curriculum integration from recommendation one will be strengthened by a devoted research centre based on national and international guidelines for IPV education. The adoption of national and international organisations and committees’ guidelines and recommendations on the inclusion of IPV-related content in UG HCP degrees is a new topic in the IPV literature, and this research study provides a new theory for this adoption. Not only will this centre aid in the development and presentation of a national approach to the integration of IPV-related content in tertiary education, but it will also help with curriculum mapping and networking. A multidisciplinary approach to the development of IPV-related curricula and resources, and the dissemination of such content and resources will also occur through collaboration with state and federal governments and community groups. Furthermore, the incorporation of AHPRA, PA and the Council of Deans of Nursing and Midwifery into the discussion and dissemination of results and resources is paramount.

Additionally, this centre will provide the foundation for research into IPV-related content in UG HCP degrees and associated research areas. Therefore, this centre will continue to contribute to the body of knowledge on this content area and ensure that EBP is upheld. Finally, this centre will be responsible for the dissemination of these findings to Australian and international universities, professional bodies and to general society.

7.2.3 **Recommendation three: staff education—‘train the trainer’ sessions**

Through data analysis of the online surveys conducted in phase two and the interviews conducted in phase three, this research found that one of the greatest challenges to the inclusion of IPV-related content is academics’ lack of education on IPV, and their lack of awareness of how IPV relates to health care. Of the barriers noted to the inclusion of IPV-related content, the following four relate to a lack of education and awareness: inability to perceive how IPV-related content can be incorporated into a unit; academics fear of and lack
of confidence in teaching this content; academics’ lack of awareness of the gravity of the problem; academics’ lack of awareness of IPV-related health care’s connection to their scope of practice.

As a result of these identified barriers to the inclusion of IPV-related content in UG HCPs degrees, this research recommends that frontline academics be educated on IPV and its associated health-care needs. This is in line with the WHO’s (2013c) guidelines *Transforming and scaling up health professionals’ education and training*. According to these guidelines, universities need to design and implement ‘continuous development programmes for faculty and teaching staff relevant to the evolving health care needs of their communities’ (WHO, 2013c, p. 13).

By providing ‘train the trainer’ education sessions, academics will gain an understanding of the enormity of the problem of IPV in Australian society because such sessions will provide information on current statistics, different types of IPV situations, and the consequences of this violence. Additionally, by educating academics on the consequences of IPV, and the need for HCPs to screen, identify, communicate appropriately, treat, refer and follow up with survivors of IPV, it is hoped that academics will perceive teaching about this violence and its related health care as being within their scope of practice (Cohn, Salmon & Stobo, 2002).

Moreover, in the ‘train the trainer’ education sessions, frontline academics will also be educated on how IPV-related content fits into a wide variety of health-care units. For example, one of the units that a participant from the telephone interviews stated could not incorporate IPV-related content was a gerontological-nursing unit. However, through the ‘train the trainer’ sessions, academics would be educated on the fact that IPV can occur in any relationship at any age, and thus should not be excluded from this unit type because of the age of the target population. Skills units were also noted as not fitting with IPV-related content by the academics involved in this study; however, through this education intervention, academics
will be made aware that a large range of skills are required to be practised and developed to ensure competency in caring for IPV survivors. Finally, by participating in these educational sessions, frontline academics will feel less fear of teaching IPV, and more confident in incorporating IPV-related content into their units.

7.2.4 Recommendation four: employment of specialist IPV academics

The final recommendation formulated from the analysis of the case-study evidence is the employment of specialist IPV academics by Australian universities. This may be in a full-time capacity or via a joint appointment with a hospital or IPV service. This research illustrated that the principal systemic barrier to the inclusion of IPV-related content in UG nursing, midwifery and paramedicine degrees is a lack of academics that are confident and competent to teach this content. Further, knowledge, expertise, experience, competence and passion in relation to IPV were related to the inclusion of IPV-related content in the Australian BN, BM and BP (or equivalent) degrees. Therefore, employing specialist IPV academics who are knowledgeable, confident, competent and passionate in this area will aid in including IPV-related content in these degrees.

The practice of employing speciality-area academics has been successfully noted by mental-health researchers (Happell & McAllister, 2014a). Happell and McAllister (2014a) found that a strong presence of mental-health academics in Australian BN degrees resulted in the strong representation of mental-health nursing in these degrees, and concluded that curriculum content may be largely affected by position and influence rather than by EBP, national priorities, prevalence statistics, and burden of disease. Therefore, it is necessary for IPV specialist academics to be employed in the faculty of UG HCPs degrees to influence curriculum mapping and development.

This section has outlined four recommendations to help ensure the inclusion of IPV-related content in UG HCP degrees, and the adherence to national and international organisations and committees’ guidelines and recommendations on including this topic. The
following section of this chapter will examine the implications of this research. In particular, the implications for theory, policy, practice, methodology and future research will be discussed.

7.3 Implications of Research

Chapter 5 presented the findings of this case study; Chapter 6 discussed the contributions of this research to the body of knowledge in this area, and the preceding section presented the recommendations of this research. The implications of this research are now outlined, with the implications for theory discussed first.

7.3.1 Implications for theory

The current study has made several contributions to the theory of IPV, and specifically for theory relating to the inclusion of IPV-related content in Australian UG nursing, midwifery and paramedicine degrees, by identifying the issues and challenges that require the attention of the higher education industry (HEI). Previous literature concerning the inclusion of IPV-related content in UG nursing, midwifery and paramedicine degrees is scant in Australia and internationally, thus providing numerous gaps in the literature that needed to be closed.

A holistic picture of the inclusion of IPV-related content in Australian UG nursing, midwifery and paramedicine degrees was provided by this research. The overall principal finding of this study was a lack of IPV-related content in Australian UG BN, BM and BP (or equivalent) degrees. It was also found that if this content is included in units of these degrees, it is only taught for a minimal number of hours, thus not allowing time for adequate coverage of even the most basic content related to IPV and its associated health care.

The minimal literature available on IPV-related content inclusion in the BN degree addressed the barriers to such content inclusion (Kassebaum & Anderson, 1995). This research extends the literature by identifying further barriers to this content inclusion and by acknowledging that these barriers are of a professional and a personal nature for frontline
academics. Moreover, this research unexpectedly found numerous enablers to the inclusion of this content and is thus able to make recommendations for the promotion of such enablers.

This research is the first to reveal that IPV-related content is principally taught in core units, rather than in elective units, and finds that this should remain the standard because incorporating this content in the core units ensures that all students in the degree are receiving the same amount of content, which is necessary for the appropriate and effective care of IPV survivors. Further, by incorporating this content in the core units, it highlights to students the importance of the topic.

This research highlights that IPV-related content is and should be incorporated into a variety of units throughout the UG degrees, rather than being pigeonholed into one or two types of units, which contrasts with the findings of previous researchers (Ross et al., 1998). However, this research found that academics fail to incorporate IPV-related content into skills-based learning situations in clinical laboratories, and are against planned clinical placements with survivors of IPV. This is a severe deficit in the teaching of IPV-related content because HCP students need to be able to practise their communication, screening and treatment skills in a safe environment before employing these skills in the real world (Daniel & Milligan, 2013). Once this practice is achieved, HCP students would also benefit from clinical placements with IPV survivors.

The current study has laid the theoretical foundations for the exploration of IPV-related content in UG HCP degrees, not only in Australia but also internationally.

7.3.2 Implications for policy and practice

The previous section discussed the theoretical implications of this study. This section considers the implications for policy and practice of this study. These implications relate to professional role identity, curriculum mapping and time, confidence and competence in teaching IPV-related content, the theory–practice divide, the politics of representation in UG
HCP curricula, reluctance to claim an area of knowledge in UG HCP curricula, and lack of leadership in tertiary HCP education of IPV.

7.3.2.1 Professional role identity

This research has implications for the professional role identity of HCPs, particularly in relation to the expansion of HCPs’ role and scope of practice in the health-care system. In the current health-care system, historical professional role identity has been overtaken by new and exciting roles, and currently, HCPs are expected to be expert clinicians, educators, researchers, advocates, leaders, mentors, role models, collaborators and scholars (Kalayjian, Marrone & Vance, 2010). However, with the rapidly changing society and thus health-care environment, the scope of practice for HCPs continues to rapidly evolve (Nursing Council of New Zealand, 2016). Therefore, HCP roles, competencies, accountabilities and responsibilities have begun to overlap with those of other health professions (Nursing Council of New Zealand, 2016).

Expanded practice is defined as ‘areas of practice that have not previously been in one’s health profession realm or have been the responsibility of other HCPs’ (Nursing Council of New Zealand, 2016, p. 10) For example RMs’ roles have expanded over recent years, with an increase in the social support RMs provide, and an increase in the number of women with complex physical and social needs (Midwifery 2020 Core Role of the Midwife Work Stream, 2010). Another example in which the roles of HCPs are being expanded is in IPV. This is in contrast to how IPV should be perceived because it is a health-care matter that requires a thorough, effective and efficient health-care response.

This study has implications for policy and practice because HCPs’ professional role identity must be expanded and extended to include the prevalent social, public and health issues of IPV. In today’s society, nurses, midwives and paramedics need to acknowledge that they will inevitably have contact with IPV survivors and thus need to be knowledgeable in all health-related practices relevant to treating these patients. Additionally, this expanded role
needs to be acknowledged by Australian universities, who must ensure they include IPV-related content in their UG HCP degrees. Further, the Nursing and Midwifery Board of Australia and PA also need to acknowledge the expansion of professional roles and the need for the inclusion of IPV-related care in the scope of practice of their health-care professions. Each Australian state and territory health department must also acknowledge this. The researcher is hopeful that the findings of this study will motivate these decision makers to expand the professional role identify of HCPs, and incorporate screening, identification, treatment, referral and follow up of IPV survivors into all HCPs’ scope of practice.

7.3.2.2 Curriculum mapping and time

Another implication of this study is the need to map IPV-related content throughout the curricula of HCP UG degrees and to ensure adequate time is allocated to teaching all elements of this public-health issue. An overcrowded curriculum and thus a lack of time in the curriculum was found in the current study; however, this problem also occurs in other health-related disciplines and other fields of nursing, for example, mental health (Happell & McAllister, 2014a), gerontological nursing (Bardach & Rowles, 2012), palliative care (Palliative Care Curriculum for UGs Project Team, 2012), and pain education (Briggs, Whittaker & Carr, 2009). Academics lack knowledge of how to resolve this issue, believing that adding more content to the curriculum requires the removal of other content. Suggestions have been made by academics about increasing these UG HCP degrees to four years to incorporate all content that needs to be included. However, the current study illustrates this is not necessary.

No content or units need to be removed to include IPV-related content in UG BN, BM and BP (or equivalent) degrees. IPV-related content and health-related practices can be incorporated into case studies, clinical laboratories focusing on the assessment of a patient, and lectures examining reasons why certain injuries occur. However, for this successful integration to occur, IPV-related content needs to part of the curriculum with its own graduate
attributes, objectives and assessment items (Happell & McAllister, 2014b). Further, any changes to the inclusion of IPV-related content needs to be approved by the school board before any changes are made. This needs to occur to ensure that academics are not making active choices not to include IPV-related content or to write this content out of their units.

7.3.2.3 Theoretical/practical divide within IPV-related content

Overall, the academics in this study reported being against the idea of planned clinical placements with survivors and perpetrators of IPV (Sections 5.6.2 and 6.3.2.2) but agreed with the need to provide IPV-related content in the UG HCP degrees. This theory–practice divide was also noted in the type of IPV-related content being taught. Australian nursing, midwifery and paramedicine students are not receiving extensive information on health-related practices related to IPV survivors (Sections 5.8.2 and 6.3.4.4), but rather are receiving information on the theoretical aspects of the types of IPV, as well as its prevalence and effects. The implication of this study is that it unites this theory–practice divide in the IPV-related content by demonstrating that both aspects of IPV-related content can and must be integrated throughout UG HCP degrees.

7.3.2.4 Politics of representation in UG HCP curricula

This study highlights the existence of marginalised spaces in HCP UG degrees, and how certain experiences and population of people are represented in the discourses of nursing, midwifery and paramedicine curricula. These marginalised spaces exist because of an absence of an agreed professional framework that promotes engaging in the politics of social inequality, injustice and gender in UG HCP education. This is also reflected in the tension between ‘respectable’ technical skills and the ‘murkier’ spaces of emotional skills in the curriculum. According to Kagan, Smith and Chinn (2014, p. 9), social justice is entrenched in HCPs’ ontology, epistemology and ethics, and therefore, scholars are rallying for principles of social justice to be made explicit in core values for all HCPs (Boutain, 2005, 2008; Thorne, 2014; Yanicki, Kushner & Reutter, 2015). Academics worldwide are advocating for social-
justice information to be included in UG and postgraduate HCP degrees (Browne et al., 2009; Canales & Drevdahl, 2014). It is argued that not only theoretical knowledge, such as the socioeconomic inequalities influencing a person’s health, should be included in these curricula, but the practical skills to deal with local, national and global politics such as the skills of advocacy should also be included (Cuthill, 2016). This study highlights that in reality, UG HCP degrees have not been successful in addressing the inclusion of social-justice issues, and thus the curricula remain largely apolitical and biomedical. The key organisations involved in HCP tertiary curriculum development need to develop policies for inclusion of social-justice content in UG degrees.

7.3.2.5 Reluctance to claim an area of knowledge in UG HCP curricula

The findings of the current study imply that academics do not want to actively claim IPV as an area of nursing knowledge that is currently dominated by biomedical interventions that limit the interaction between HCPs and patients through depersonalising patients (Mazzotta, 2016; Proctor, 2000). For IPV to be considered a content area relevant to HCPs, health care must be based on a person-centred care model that focuses on the response to the disease process, and is oriented to the patient and family. Within this model, the patient and their family are guided throughout the health-care experience, and advocacy and caring are the driving forces of the HCP (IOM, 2011; Proctor, 2000; Sillars, 2015). According to the Australian College of Nursing’s (2016) position statement, person-centred care is determined by the attributes of the nurse, their practice and the care environment. Professional competence, highly developed interpersonal skills, self-awareness, commitment and strong values are key attributes of the nurse, while the acknowledgement of beliefs, preferences and rights, the empowerment of patients and the provision of holistic care are key practice elements. Finally, the care environment must have an appropriate skill mix and ensure transformational leadership (Australian College of Nursing, 2016). The vales of person-
centred care are conducive to the care and treatment of IPV survivors and thus need to be the
foundation of health care for IPV-related care to be considered a key area of HCP knowledge.

7.3.2.6 Lack of leadership in tertiary HCP education of IPV

Finally, the findings of this research illustrate an absence of leadership in HCP UG
education to advocate for the inclusion of IPV-related content in these curricula. This absence
of leadership is not only found in the university sector, but also in professional and regulating
authorities such as the Australian Health Minister’s Advisory Council, the Council of Deans
of Nursing and Midwifery, the Australian Nursing and Midwifery Accreditation Council
(ANMAC), the Nursing and Midwifery Board of Australia and PA.

7.3.3 Implications for methodology

The decision to adopt the case-study approach according to the principles of Yin
(2014) is a unique and valuable method of examining research problems related to health care
(Zucker, 2001). This research approach has failed to be incorporated appropriately and
extensively in health-care research because researchers often confuse case-study research with
either case-study teaching or the presentation of a case study to use as an example of a
particular illness state (Yin, 2014). Utilising the principles of Yin (2014) to ensure the
appropriate development and conduct of case-study research is recommended. By utilising
these principles, a successful well-conceived case study can be completed, providing unique
findings and insights into the phenomenon under investigation.

The use of a multiple-phase case-study design was successful because it enabled a
thorough examination of UG HCP degrees using multiple sources of evidence converging
through triangulation (Yin, 2014). Additionally, the use of the mixed-methods approach
enabled in-depth elaboration of the evidence obtained, and thus is appropriate for in-depth
examination of IPV-related topics.

It is indicated by Yin (2014) that the case-study approach should be utilised if limited
research is conducted on the research topic. This is one of the reasons it was adopted for the
current study. The body of knowledge on the inclusion of IPV-related content in UG HCP degrees is limited, and thus discovery rather than confirmation of previous findings was needed. Therefore, a case-study research design was the appropriate choice for exploring IPV-related content in these degrees.

There were two difficulties noted in conducting this case study. First, there was difficulty experienced identifying the unit of analysis, with multiple units of analysis contemplated before a decision was made. This is a common problem among researchers completing case-study research for the first time (Yin, 2014). Additionally, it was difficult to decide on the number of cases to use, and whether to have a holistic or embedded case study (Yin, 2014; Perry, 2013). Therefore, another implication from this study is that adequate time must be allocated to the decision-making process for selecting the unit of analysis and its associated elements. Second, more careful analysis of the replication logic was required for this case study. Replication logic refers to the selection of cases that either produce similar results to other cases (literal replication) or contrasting results (theoretical replication) (Carson, Gilmore, Gronhaug & Perry, 2001; Perry, 2013; Yin, 2014). Again, the researcher recommends that extensive thought is given to making decision about replication logic to allow for greater analytic generalisation (Yin, 2014).

7.3.4 Implications for future research

Since little to no previous research has been conducted on the inclusion of IPV-related content in UG HCP degrees, and the adoption of national and international organisations and committees’ guidelines and recommendations on this inclusion, this study lays the foundation for future research. There is opportunity for a vast amount of future research to be conducted on this topic. Some of these future research ideas are listed below:

- Replication of the study examining the IPV-related content inclusion in UG HCP degrees in other Western countries (e.g., New Zealand, US, Canada);
• Replication of the study examining the IPV-related content inclusion in other UG HCP degrees in Australia (e.g., social work, medicine, psychology, physiotherapy, dentistry, occupational therapy);

• Qualitative examination by the Heads of School and Deans of faculties from Australian universities, as well as of key members of key curricula organisations such as AHPRA, PA and the Council of Deans of Nursing and Midwifery to examine their knowledge, beliefs and attitudes towards the inclusion of IPV-related content within their respective UG HCP degrees and to examine their willingness towards such inclusion;

• Mixed-methods case-study approach to the examination of the moderating effects of professional role resistance and role acceptance on the delivery of IPV-related content with UG HCP degrees;

• Conducting focus groups to examine whether academics’ professional role resistance to IPV-related content inclusion is reflected by the professional role resistance of students studying in programmes taught by these academics; this is of interest because it has been argued that students role model the academics that teach them (Cohn et al., 2002);

• Further in-depth examination of barriers to and enablers of the inclusion of IPV-related content in HCP UG degrees needs to be completed to identify the exact mechanisms behind these barriers and enablers and to develop techniques to overcome the barriers and promote and enhance the enablers;

• Qualitative analysis of why gender influences the inclusion of IPV-related content. (In the online surveys conducted in phase two, gender was found to be a significant influencing factor for the willingness to include, and valuing including, IPV-related content. Male academics were more likely to espouse professional role resistance to this content inclusion. These male resisters were employed exclusively in nursing and
had graduated 10 to 20 years ago, most of them had graduated 20 years ago.

Therefore, it would be valuable to know why male nursing academics are more resistant to including IPV-related content in the BN degree. Such research could also examine whether male midwives are also resistant to including IPV-related content. In addition, seven male paramedics responded to the online survey, but none of the demonstrated having role resistance to including IPV-related content in the BP. It would be interesting to examine why this is so);

• In-depth case-study analysis of the universities that have are currently successful at integrating IPV-related content in their UG HCP degrees—a mixed-methods approach would be valuable in this research to examine documentation, attitudes and belief scores, as well as why these universities have been successful at this integration and why they are leading in health education; and

• Examination of the first integration of IPV-related content in an UG HCP degree in an Australian university utilising the framework for the integration of IPV-related content.

In conclusion, there are many future research projects that could be conducted on the inclusion of IPV-related content in UG HCP degrees. The list of recommendations for future research provides only several examples of these important research projects. This section concludes the implications of the current study. The following section examines the strengths and limitations of this research.

7.4 Strengths and Limitations of Research

The recommendations and implications arising from this multiple-phase case-study research have been discussed in the previous sections of this chapter. This section now presents the strengths and limitations of the study. First, the three principal strengths of this study are outlined.
The adoption of the mixed-methods approach was a strength of the current study. Mixed-methods research approaches allow for the limitations of quantitative and qualitative research methods to be counteracted and allow for a more in-depth examination of the phenomenon under investigation (Jirojwong et al., 2014). By implementing this multiple-phase mixed-methods case-study research design, this study was successful at addressing numerous gaps in literature, making 20 contributions to the body of knowledge, as well as the development of four recommendations. These significant outcomes demonstrate the success of the current study.

Some of the limitations of this study were addressed in Section 1.11, which discussed the delimitations of the research. The three delimitations identified were the focus on only Australian universities, the inclusion of only nursing, midwifery and paramedicine degrees, and the inclusion of only frontline academics. The limitations of case-study research were also noted in Section 4.11, which also provided arguments refuting these limitations. These arguments will not be repeated here but the other minor limitations of this study are now presented.

The limitations associated with the mixed-methods approach include the requirement of researcher skill and the need for an interdisciplinary team in relation to methodology as both quantitative and qualitative methods are used within the one study (Gerrish & Lathlean, 2015). The researcher overcame these limitations by conducting extensive research into how to employ the mixed methods used in this case study, and by involving a team of supervisors with expertise in a variety of research methodologies. There were also minor limitations associated with the documentary analysis conducted in phase one, which were the reporting bias in the documentation analysed, and the universities having different policies on the amount of information they make available to the public. Another minor limitation was noted in the qualitative telephone interviews conducted in phase three, which was that the participants’ personal experiences of IPV may be different to the experiences of academics
that did not participate in this study and as such may have differing views regarding the inclusion of IPV-related content into UG HCP degrees.

Overall, the strengths of the current study are more important than the minor limitations because these limitations do not detract from the strengths, but merely provide guidance for future research conducted on this research topic. All information important to this research has been presented. A summary of the current study is now provided.

**7.5 Summary**

IPV is a highly prevalent social and public-health issue in Australia and worldwide. It is a problem that causes severe physical, psychological, social and economic consequences for both the survivor and their dependents. It is inevitable that HCPs will provide health-care services to IPV survivors during their careers. However, it is not clear whether HCPs are adequately prepared to provide effective and efficient health care to these patients. This study aimed to determine whether the tertiary UG education of RNs, RMs and paramedics is adequately preparing these students to care for IPV survivors, and whether these degrees are adopting national and international organisations and committees’ guidelines and recommendations on the inclusion of IPV-related content in UG HCP degrees. Through a literature review, it was discovered that research in this area is scant, and extensive gaps in the literature remain.

To address these gaps, a multiple-phase mixed-methods case-study research study utilising the principles of Yin (2014) within the realist paradigm was conducted. Six research questions, research propositions and rival explanations were devised and multiple sources of evidence were collected to aid triangulation and converge lines of enquiry. Phase one of this case study employed a content analysis of documentation, phase two executed a quantitative online survey and phase three conducted qualitative telephone interviews. Additionally, data-analysis strategies specific to case-study research were used, relying on theoretical
propositions and examining plausible rival explanations and the specific analytic techniques of pattern matching, explanation building and cross-case synthesis.

A thorough analysis of the evidence demonstrated that minimal IPV-related content is included in Australian UG nursing, midwifery and paramedicine degrees, and when this content is included, coverage is very minimal and delivered in a short amount of time.

Further, it was determined that numerous barriers, both professional and personal, impede the inclusion of this content; however, there are personal enablers such as passion, competence, expertise, understanding and positive attitudes and beliefs that lead to the inclusion of IPV-related content in these degrees. It was found that when IPV-related content is included in Australian UG BN, BM and BP (or equivalent) degrees, it is usually included in a variety of core units, with the most common units being women’s health and childbirth and primary and community health care. The academics in this study do not pigeonhole this content in mental-health units because they do not perceive IPV as a mental-health issue, but as an issue relating to the entire population.

Tutorials and workshops were found to be the most popular teaching strategy when delivering IPV-related content; however, the lectures delivering this content most commonly involve the use of guest speakers such as IPV survivors and experts. However, it was found that the academics in this study do not include IPV-related health practices in clinical-skills practice in clinical laboratories, and are against the idea of planned clinical placements with IPV survivors. As a consequence of this lack of skills-based practice, students are not receiving extensive information on health-related practice relating to IPV survivors.

The second aspect of the research problem was whether Australian universities are adopting national and international organisations and committees’ guidelines and recommendations on the inclusion of IPV-related content in UG HCP degrees. First, this study found that a large percentage of academics are unaware of these guidelines and recommendations, and thus are not implementing them in their units. Second, it was
determined that Australian universities are not adopting these guidelines and
recommendations because it was found that there is minimal IPV-related content included in
Australian UG nursing, midwifery and paramedicine degrees.

In response to these findings, the researcher developed a framework for the integration
of IPV-related content to aid the integration of this content throughout UG HCP degrees and
to ensure Australian universities are adopting national and international organisations and
committees’ guidelines and recommendations on this content inclusion. This framework is
based on the following three major components of integration: elimination of barriers;
promotion of enablers via the education of academics, heads of school and deans; acceptance
of EBP. The research also developed four recommendations from the findings of this study
and the research implications relating to theory, policy, practice, methodology and future
research have been discussed. This study lays the foundation for numerous theoretical, policy
and practice changes in the field of higher education and the inclusion of IPV-related content
in UG HCP degrees. It is the first national or international study to examine extensively the
inclusion of this content, and thus sets the stage for discussions of the importance of
integrating this significant social and public-health issue throughout UG HCP degrees.
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Appendix A: On-line survey

Intimate Partner Violence and UG Curricula

(Developed by Lovi & Barr, 2013)

Demographic Information

1. Gender:
   - Female
   - Male

2. Age:
   - 20-29 years
   - 30-39 years
   - 40-49 years
   - 50-59 years
   - 60-69 years
   - 70 + years

3. Race/Ethnicity:
   - Caucasian
   - Indigenous/Torres Strait Islander
   - Asian
   - European
   - Other (please specify) ______________________________

4. Religious Affiliation:
   - Catholic
☐ Jewish
☐ Protestant
☐ Muslim Buddhist
☐ Agonist/Atheist
☐ Other (please specify) ______________________________

5. Current Marital Status:
☐ Single
☐ In a relationship but not living together De facto relationship
☐ Married
☐ Separated
☐ Divorced
☐ Widowed

6. What degrees have you completed?
☐ Nursing
☐ Midwifery
☐ Paramedicine

7. Highest Level of Educational Attainment:
☐ UG degree
☐ Paramedic non-tertiary qualification Masters Degree
☐ PhD
☐ Post-doctoral Degree
8. **What is the predominant current health system you work in?**
   - [ ] Nurse
   - [ ] Midwife
   - [ ] Paramedic

9. **Years practicing in this profession you noted in question 7:**
   - [ ] 1-5 years
   - [ ] 6-10 years
   - [ ] 11-20 years
   - [ ] 21 + years

10. **Bachelor degrees in which I currently teach (tick as many as are applicable):**
    - [ ] Nursing
    - [ ] Midwifery
    - [ ] Paramedicine

11. **My background knowledge of the subject of intimate partner violence:**
    - [ ] None
    - [ ] Some
    - [ ] Moderate
    - [ ] Extensive

12. **How much training have you received on intimate partner violence?**
    - [ ] None
    - [ ] Some
    - [ ] Moderate
If you have answered none to the above question, please skip to question 15.

If you have answered some, moderate or extensive, please complete question 13 and 14.

13. How many hours would this training have involved?

- None
- 1-5 hours
- 5-14 hours
- 14 + hours

14. Where did this training occur (tick as many that is applicable)?

- University within your UG degree
- University within your post-graduate degree
- Continuing education program/in-service held in a clinical setting
- Continuing education program/in-service held in a university
- Continuing education program/in-service held at non-government organisation (NGO)
- Other (please specify) ____________________________

15. Professional experience with survivors/perpetrators of intimate partner violence within your clinical work or via academia:

- None
- Some
- Moderate
- Extensive
Intimate Partner Violence Content and Knowledge

16. Does the unit/subject you are assessor/co-ordinator of contain content specifically related to intimate partner violence and/or domestic violence?

☐ Yes
☐ No

If you have answered no, please skip to question 22.

If you have answered yes, please continue with the questionnaire.

17. Is the unit/subject you are responsible for a core unit/subject or an elective unit/subject?

☐ Core unit/subject
☐ Elective unit/subject

18. What intimate partner violence related content do you cover in the unit/subject you are in charge of?

☐ Types of violence ☐ Cycle of violence
☐ Consequences of this violence ☐ Effects of this violence
☐ Effects on children ☐ Risk factors for this violence
☐ Health care costs ☐ Types of relationships
☐ Screening/identification ☐ Treatment of survivor
☐ Safety planning ☐ Legality of IPV
☐ Referral pathways ☐ Why women leave or stay
☐ Community resources ☐ Therapeutic communication
☐ Forensic evidence ☐ Beliefs/attitudes/stereotypes
19. How many hours of intimate partner violence related content would you cover in the unit/subject you are responsible for?

☐ 1-3 hours  ☐ 3-8 hours
☐ 9-14 hours  ☐ 15 + hours

20. Please identify the broad category which depicts the type of unit/subject you are responsible for. Please tick as many as are applicable:

☐ Medical/surgical  ☐ Mental health
☐ Child and family health  ☐ Community health
☐ Chronic illnesses  ☐ Acute illnesses
☐ Women's health  ☐ Science/biological science
☐ Clinical placement units  ☐ Exploring professional practice
☐ Indigenous/culturally appropriate care  ☐ Spirituality in health care
☐ Paramedicine practice  ☐ Health care ethics
☐ Childbearing journey  ☐ Pre-natal care
☐ Intra-partum care  ☐ Professional midwifery practice
☐ Midwifery practice challenges  ☐ Primary health care

21. Please tick the boxes that reflect the type of teaching/assessment types and strategies that you use in relation to this type of content:

☐ Lectures
☐ Tutorials
☐ On-line material/readings
☐ Assessment items
☐ Clinical placement
☐ Clinical laboratories
22. Do you believe intimate partner violence/domestic violence related content is adequately addressed within the curriculum of your particular health care profession?

☐ Yes
☐ No

23. Why do you believe intimate partner violence/domestic violence related content is not included more into the curriculum of the degree in which you teach in? Please tick as many of the below statements you believe are applicable:

☐ Curriculum is already over-stretched
☐ Lack of academics that are confidence and competent to teach this content
☐ Not within scope of practice of the health care professional
☐ Lack of support to include intimate partner violence/domestic violence into the current/planned curriculum
☐ Negative attitudes/beliefs of academics towards intimate partner violence/domestic violence survivors and perpetrators
☐ Personal discomfort in teaching about this type of violence
☐ Intimate partner violence/domestic violence is not a health care problem
☐ This content is not necessary as it is easy for a woman to leave abusive relationships

24. Please indicate if you are aware of the following in regards to intimate partner violence/domestic violence. Please tick not applicable (N/A) if you believe the guidelines do not relate to your profession.

Time for Action: The National Council’s Plan for Australia to Reduce Violence Against Women and their Children 2009-2021

☐ Yes  ☐ No  ☐ N/A

National Plan to Reduce Violence Against Women and their Children 2010-2022
Your state or territory’s guidelines/recommendations

☐ Yes  ☐ No  ☐ N/A

Australian government’s guidelines/recommendations

☐ Yes  ☐ No  ☐ N/A

State ambulance service’s guidelines/recommendations

☐ Yes  ☐ No  ☐ N/A

World health organisation’s guidelines/recommendations

☐ Yes  ☐ No  ☐ N/A

National council to reduce violence against women and their children’s guidelines/recommendations

☐ Yes  ☐ No  ☐ N/A

Australian nursing and midwifery council’s guidelines/recommendations

☐ Yes  ☐ No  ☐ N/A

Department of health and ageing guidelines/recommendations

☐ Yes  ☐ No  ☐ N/A
25. To what extent do you agree with the following statements?

Academics need to role model that intimate partner violence/domestic violence is unacceptable.

- [ ] Strongly Agree
- [ ] Agree
- [ ] Somewhat Agree
- [ ] Disagree
- [ ] Strongly Disagree

Without intimate partner violence related content within health care professionals’ curriculum, intimate partner violence/domestic violence will remain undetected and untreated, with the cycle of violence remaining intact.

- [ ] Strongly Agree
- [ ] Agree
- [ ] Somewhat Agree
- [ ] Disagree
- [ ] Strongly Disagree

Students enrolled in a health care professional degree need to be ready, willing and able to identify and care for women survivors of intimate partner violence/domestic violence.

- [ ] Strongly Agree
- [ ] Agree
- [ ] Somewhat Agree
- [ ] Disagree
- [ ] Strongly Disagree

Failure to identify a woman experiencing intimate partner violence/domestic violence at her initial contact with the health care system will result in incorrect care.

- [ ] Strongly Agree
- [ ] Agree
- [ ] Somewhat Agree
- [ ] Disagree
- [ ] Strongly Disagree

Health care professionals are in need of education to provide best practice when encountering to intimate partner violence/domestic violence.

- [ ] Strongly Agree
- [ ] Agree
- [ ] Somewhat Agree
- [ ] Disagree
- [ ] Strongly Disagree
For all health care professionals to gain adequate intimate partner violence related knowledge, they must be educated on intimate partner violence/domestic violence during their initial UG degree.

Health care related to intimate partner violence/domestic violence is not within the scope of practice of my discipline.

Those with past experiences of intimate partner violence/domestic violence are more likely to provide objective health care of those experiencing IPV/DV.

I find it difficult to empathise or understand those experiencing intimate partner violence/domestic violence.

Newly graduated health care professionals who have a personal history of intimate partner violence/domestic violence, can sometimes have emotional decompensation and experience sleep disturbance, panic attacks and flashbacks.
Femicide is not related to intimate partner violence/domestic violence.

- □ Strongly Agree
- □ Agree
- □ Somewhat Agree
- □ Disagree
- □ Strongly Disagree

Health care professionals should assess for mental health status of survivors of intimate partner violence/domestic violence.

- □ Strongly Agree
- □ Agree
- □ Somewhat Agree
- □ Disagree
- □ Strongly Disagree

Interventions for women survivors of intimate partner violence/domestic violence should remain confidential to ensure their safety.

- □ Strongly Agree
- □ Agree
- □ Somewhat Agree
- □ Disagree
- □ Strongly Disagree

All health care professionals should report intimate partner violence/domestic violence to the police.

- □ Strongly Agree
- □ Agree
- □ Somewhat Agree
- □ Disagree
- □ Strongly Disagree

No health care professional should report intimate partner violence/domestic violence unless instructed by those experiencing it.

- □ Strongly Agree
- □ Agree
- □ Somewhat Agree
- □ Disagree
- □ Strongly Disagree
All health discipline UG students should have a clinical placement in a women’s shelter or a planned clinical placement with intimate partner violence/domestic violence survivors.

Strongly Agree  Agree  Somewhat Agree  Disagree  Strongly Disagree

26. Regardless of whether you include IPV/DV-related content into your unit/subject, if you are willing to participate in a short phone interview with the researcher, please enter your email address below and he will contact you shortly:

________________________________________________________________________________________
________________________________________________________________________________________

27. If you would like feedback about this study, please provide your email address here:

________________________________________________________________________________________
________________________________________________________________________________________

Thank you for participating in this survey.

This survey is now completed
### Appendix B: Final factor solution – Total variance

#### Total Variance Explained

<table>
<thead>
<tr>
<th>Component</th>
<th>Initial Eigenvalues</th>
<th>Extraction Sums of Squared Loadings</th>
<th>Rotation Sums of Squared Loadings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>% of Variance</td>
<td>Cumulative %</td>
</tr>
<tr>
<td>1</td>
<td>3.794</td>
<td>31.613</td>
<td>31.613</td>
</tr>
<tr>
<td>2</td>
<td>1.606</td>
<td>13.385</td>
<td>44.998</td>
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<tr>
<td>3</td>
<td>1.215</td>
<td>10.123</td>
<td>55.121</td>
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<td>6.818</td>
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<td>5.946</td>
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<td>.686</td>
<td>5.719</td>
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<td>9</td>
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<td>4.231</td>
<td>90.338</td>
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<td>10</td>
<td>.445</td>
<td>3.709</td>
<td>94.047</td>
</tr>
<tr>
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<td>.378</td>
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</tr>
<tr>
<td>12</td>
<td>.336</td>
<td>2.802</td>
<td>100.000</td>
</tr>
</tbody>
</table>

Extraction Method: Principal Component Analysis.
Appendix C: Phase two – Introductory email

To Whom It May Concern

My name is Renee Lovi and I am completing a PhD in nursing at Southern Cross University. My study includes an on-line survey of academics that are unit co-ordinators/unit assessors or who are responsible for units within the UG disciplines of nursing, midwifery and paramedicine. It aims to examine the inclusion of intimate partner violence/domestic violence related content within these disciplines; how Australian universities are adhering to the national and international health regulating bodies in regards to the inclusion of this content; and how academics feel about such inclusion of content into their UG degree.

Participation in this on-line survey is voluntary and confidential and should only take 20-25 minutes to complete. Further information can be obtained via the Participant Information Sheet attached to this email including my contact details along with my principal supervisor’s details as well. The survey can be accessed via this link:

https://scuau.qualtrics.com/SE/?SID=SV_02KCMzgahJjUW8J

Thank you for considering this request for participation. Yours sincerely

Renee Lovi (PhD student; APA scholarship)
Appendix D: Phase two – Participant information sheet

Participant Information Sheet

My name is Renee Lovi and I am conducting research as part of my PhD degree in nursing at Southern Cross University. My research project is titled: Are Australian universities adhering to national and international guidelines? Intimate partner violence-related content within nursing, midwifery and paramedicine UG curricula. I am inviting academics who are unit co-ordinators/assessors or responsible for a unit/subject around Australia to participate in this study. This case study is examining the amount of intimate partner violence/domestic violence related content within the UG degrees of nursing, midwifery and paramedicine; the current guidelines and recommendations on the inclusion of this topic in these UG disciplines; and what academics believe about such inclusion of content into their discipline’s degree.

This research involves the completion of an anonymous on-line survey that can be accessed via the link at the bottom of the introductory email. Your participation is completely voluntary and confidential and the on-line survey will take approximately 20-25 minutes to complete. There are neither costs nor travel involved in this study. There is no consent form attached as consent is implied by the completion of the survey.

The results of this study may be published in a peer-reviewed journal and presented at conferences, however, no identifiable data will be published or presented. Only group data will be provided. All data obtained will be kept in a locked filing cabinet and will be retained for a period of 7 years as per Southern Cross University’s policy. After closure of the survey and analysis of results have occurred, participants will receive a final email thanking them for their participation and this will also include a document attached with the findings on it. Therefore, it then becomes the participants’ choice as to whether they look at the feedback or not.
This research has been approved by the Human Research Ethics Committee at Southern Cross University. The approval number is ECN-13-146. If you have concerns about the ethical conduct of this research or the researchers, the following procedure should occur.

Write to the following:

The Ethics Complaints Officer Southern Cross University

PO Box 157

Lismore, NSW 2480

Email: ethics.lismore@scu.edu.au

All information is confidential and will be handled as soon as possible.

If you have any inquiries regarding this research, please contact myself at

If you would prefer to contact my principal supervisor, Dr Jennieffer Barr, she can be contacted via email

Kind regards Renee Lovi
Appendix E: Phase three – Consent form

CONSENT FORM

Title of research project: Are Australian universities adhering to national and international guidelines? Intimate-partner violence-related content within nursing, midwifery and paramedicine curricula

Name of researcher: Renee Lovi

Tick the box that applies, sign and date and give to the researcher

<table>
<thead>
<tr>
<th>Statement</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>I agree to take part in the Southern Cross University research project specified above.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I understand the information about my participation in the research project, which has been provided to me by the researchers.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I agree to be interviewed by the researcher.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I agree to allow the interview to be *audio-taped and/or *video-taped.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I agree to make myself available for further interview if required.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I understand that my participation is voluntary and I understand that I can cease my participation at any time.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I understand that my participation in this research will be treated with confidentiality.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
I understand that any information that may identify me will be de-identified at the time of analysis of any data.

☐ Yes ☐ No

I understand that no identifying information will be disclosed or published.

☐ Yes ☐ No

I understand that all information gathered in this research will be kept confidentially for 7 years at the University.

☐ Yes ☐ No

I am aware that I can contact the researchers at any time with any queries. Their contact details are provided to me.

☐ Yes ☐ No

I understand that this research project has been approved by the SCU Human Research Ethics Committee

☐ Yes ☐ No

Participant’s name: _________________________________

Participant’s signature: ___________________________________

Date: ___________________________________
### Appendix F: Contribution to the body of knowledge

<table>
<thead>
<tr>
<th>Research question</th>
<th>Research proposition</th>
<th>Research objective addressed</th>
<th>Existing body of knowledge</th>
<th>Gaps in the literature</th>
<th>Contributions of this research</th>
<th>Contribution level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How prominently has IPV-related content appeared in the curriculum being offered in the currently available Australian UG nursing, midwifery and paramedicine degrees?</td>
<td>It is the proposition after an extensive literature review that the amount of time spent on IPV-related content in the above curricula will be minimal because of the barriers of a lack of awareness, an overcrowded curricula and a lack of support for this inclusion</td>
<td>➢ To establish if IPV-related content is included in Australian BN, BM and BP (or equivalent) ➢ To examine the amount of IPV-related content included in Australian UG nursing, midwifery and paramedicine degrees and if there are any barriers to such inclusion</td>
<td>The literature review identified a lack of IPV-related content in UG nursing, midwifery and paramedicine degrees in Australia and internationally. If this content was included, it was done so for an average duration of two to four hours. Furthermore, numerous barriers to this inclusion of IPV-related content was noted.</td>
<td>➢ It is the first Australia-wide study to examine the inclusion of IPV-related content in the UG degrees of nursing, midwifery and paramedicine</td>
<td>➢ Minimal IPV-related content is included in Australian UG nursing, midwifery and paramedicine (or equivalent) degrees</td>
<td>High</td>
</tr>
<tr>
<td>2. How is this IPV-related content being integrated into the curriculum of nursing, midwifery and paramedicine?</td>
<td>The proposition for this research question is that there exists a lack of integration of IPV-related content into the curricula of nursing, midwifery and paramedicine and IPV-related content is only</td>
<td>➢ To investigate if IPV-related content is being integrated throughout the UG BN, BM and BP (or equivalent) degrees ➢ To investigate front-line</td>
<td>No previous research has been conducted to determine if IPV-related content is included more into core or elective units within HCPs’ UG degrees. Furthermore, no previous literature was</td>
<td>➢ It is the first known study to examine front-line academics’ attitudes and beliefs regarding the inclusion of IPV-related content into the</td>
<td>➢ IPV-related content was included mostly in core units in the Australian UG nursing, midwifery and paramedicine degrees</td>
<td>High</td>
</tr>
<tr>
<td>3. How are the units that contain IPV-related content chosen and why are they the chosen units to include this content?</td>
<td>Units containing IPV-related content in the examined curricula will be those associated with mental health units and child and family units as this topic has been traditionally seen as a mental health issue and a family issue that</td>
<td>To examine the type of IPV-related content included in Australian UG nursing, midwifery and paramedicine degrees and the type of units this content is included in</td>
<td>Previous international research conducted into the types of units IPV-related content is incorporated into found that psychiatric nursing and maternity nursing were the two most common types of units including this content. Nil previous research has been conducted on</td>
<td>➢ First known Australian study to examine the types of units IPV-related content is incorporated into within the aforementioned Australian curricula</td>
<td>➢ IPV-related content is taught across a variety of units within Australian UG nursing, midwifery and paramedicine degrees, with the most common categories of units being women’s health and childbirth units and primary and community health care units</td>
<td>High</td>
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| included into units when the unit co-ordinator (or equivalent) feels competent and passionate about this content. | academics’ attitudes and thoughts on the inclusion of IPV-related content into these degrees | available on academics’ thoughts and attitudes towards planned clinical placements with IPV survivors or perpetrators. However, the literature review did identify that internationally, between 31% and 62% of the Schools of Nursing examined included such planned clinical placements. Nil previous research has been conducted examining the link between passion and competence and the inclusion of IPV-related content. | UG curricula of nursing, midwifery and paramedicine | ➢ Academics were against the idea of planned clinical placements with survivors or perpetrators of IPV | ➢ Being passionate about IPV and competent in this topic were linked with the inclusion of IPV-related content | High |
| Occurs behind closed doors. | Academics’ beliefs regarding IPV as a mental health issue or their beliefs and attitudes regarding role modelling behaviour and methods used to break the cycle of violence. | It is the first known study to examine frontline academics’ attitudes and beliefs regarding the inclusion of IPV-related content into the UG curricula of nursing, midwifery and paramedicine. | Academics fail to perceive IPV as a mental health issue, but an issue for the entire population. | High |
| Academic’s possess positive attitudes towards role modelling the unacceptability of IPV and towards the inclusion of IPV-related content into the curricula in order for IPV survivors to be detected and treated. | High |

**4. How is this IPV-related content being taught and what is being taught in relation to this content in the disciplines of nursing, midwifery and paramedicine?**

IPV-related content is usually only delivered via didactic lectures and readings only, with minimal interactive class time and clinical experience. In terms of what is being taught, types, prevalence and effects is assumed to be taught more often than the appropriate screening, detection.

To examine the type of IPV-related content included in Australian UG nursing, midwifery and paramedicine degrees and the type of units this content is included in.

The only previous research conducted for this research proposition was in regards to the type of IPV-related content covered in the BN degree internationally. Hinderliter et al. (2003) discovered that content coverage of IPV was very narrow, usually covering the cycle of violence and violence during pregnancy but failing to spend.

It is the first Australia-wide study to investigate the teaching methods used to provide IPV-related content to UG nursing, midwifery and paramedicine students collectively.

First known Australian study to examine the

In Australian BN, BM and BP (or equivalent) degrees, tutorials and workshops are the most popular teaching strategy used to deliver IPV-related content.

Australian academics failed to incorporate IPV-related content into the mastery of clinical skills in clinical laboratories in Australian BN, BM and BP (or equivalent) degrees.

High
and care principles for survivors of IPV.

adequate time on safety planning and the legality of IPV. Likewise, Sword et al. (1998) concluded that commonly covered topics in the BN degree were the psychological impact of IPV, why women stay or leave, community resources and presenting problems. The development of a safety plan was only covered minimally in the BN degree examined. Nil previous research has been conducted on the teaching strategies used to teach IPV-related content

type of IPV-related content included within Australian UG BN, BM and BP (or equivalent) degrees

Guest speakers, in the form of survivors and experts, are being used to provide the reality of IPV to Australian nursing, midwifery and paramedicine students.

Australian nursing, midwifery and paramedicine students are not receiving extensive information on health-related practices related to IPV survivors.

It is the proposition that non-inclusion of IPV-related content into these curricula is because of the lack of expertise in this topic, the lack of understanding of its importance to be included in the curricula and negative attitudes/beliefs towards survivors of IPV.

To investigate front-line academics’ attitudes and thoughts on the inclusion of IPV-related content into these degrees

Nil previous research has been conducted on academics’ expertise, understanding and attitudes and beliefs and their relationship with the inclusion of IPV-related content into UG HCPs degrees

It is the first known study to examine front-line academics’ attitudes and beliefs regarding the inclusion of IPV-related content into the UG curricula of nursing, midwifery and paramedicine

A lack of expertise in IPV-related situations is associated with the lack of IPV-related content inclusion within Australian UG nursing, midwifery and paramedicine degrees

An absence of understanding of IPV is associated with the non-inclusion of IPV-related content within Australian UG BN, BM and BP (or equivalent) degrees
| 6. How are academics utilising national and international organisations and committees’ guidelines and recommendations into their teaching of IPV-related content? | It is the proposition of the researcher that academics have little awareness of national and international organisations and committees’ guidelines and recommendations on IPV-related content and are thus not implementing any of the guidelines/recommendations into their teaching. | To discover if Australian universities are adopting national and international organisations and committees’ guidelines and recommendations regarding the inclusion of IPV-related content in UG HCPs degrees | Nil previous research has been conducted on academics’ awareness of national and international organisations and committees’ guidelines and recommendations on the inclusion of IPV-related content | It is the first national and international study examining academics’ adoption of national and international organisations and committees’ guidelines and recommendations regarding the inclusion of IPV-related content into HCPs’ UG degrees | A large percentage of academics are unaware of the national and international organisations and committees’ guidelines and recommendations advocating the inclusion of IPV-related content into UG HCP degrees | A lack of awareness of these guidelines and recommendations is not necessarily associated with non-inclusion of IPV-related content into Australian BN, BM and BP (or equivalent) degrees | Academics gain the majority of their knowledge regarding IPV from google rather than professional organisations | High |