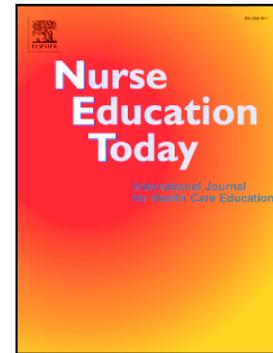


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Nursing STUDENTS' discourses on gender-based violence and their training for a comprehensive healthcare response: A qualitative study

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NURSING STUDENTS' DISCOURSES ON GENDER-BASED VIOLENCE AND THEIR TRAINING FOR A COMPREHENSIVE HEALTHCARE RESPONSE: A QUALITATIVE STUDY

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Nursing students' discourses on gender-based violence and their training for a comprehensive healthcare response: A qualitative study

Abstract

Background: Gender-based violence is a worldwide major public health issue with detrimental effects on the health of women. Nurses can play an essential role in its identification, management and prevention. Specific training is essential to be able to successfully address gender-based violence and accordingly, has been incorporated into many university's training programmes for nurses and other health care professionals. Research aimed at exploring attitudes and perceptions of gender-based violence in undergraduate student nurses following these new training programmes is scarce.

Objective: The aim of this qualitative study was to explore third- and fourth-year nursing students' perceptions and attitudes towards gender-based violence.

Design: A focus groups based qualitative study

Setting: A public University in Spain

Participants: Purposive sample of 42 nursing students who joined 7 focus groups

Methods: Focus groups discussions following a semi-structured interview guide. Discussions were transcribed and analysed following critical discourse analysis to identify interpretative repertoires.

Results: From the analysis, three interpretative repertoires emerged. The first, 'Gender-based violence is something serious', reflected participants' acknowledgment of the social relevance of this type of violence. The second interpretative repertoire, 'Men are defenceless!', related to the perception that national legislation on gender-based violence was discriminatory to men and the perception of a lack of social sensitisation toward intimate partner violence against men. The last one, 'Trained to address gender-based violence but still unprepared' encompassed participants' confidence in their ability to identify gender-based violence but uncertainty as to how to respond to gender-based violence exposed women in terms of professional practice.

Conclusions: Participants perceived that training has increased their knowledge and self-confidence in identifying cases. However, training should strongly challenge widespread myths about gender-based violence that could negatively affect their performance as nurses.

Key words:

discourse analysis, gender-based violence, nursing students, qualitative research

INTRODUCTION

Gender-based violence (GBV) in Spanish legislation is defined as any physical, psychological or sexual violence, including threats, coercion and deprivation of liberty, exercised by a male partner or ex-partner against a woman (Spanish Government, 2004).

GBV has been widely acknowledged as a global major public health issue and a human rights concern (García-Moreno, 2013) and the negative consequences to health of exposure to GBV have been extensively documented (Campbell, 2002; Sato-DiLorenzo and Sharps, 2007). Given this detrimental impact, the role of health care professionals in the identification, management and prevention of GBV becomes essential (García-Moreno, 2013). Besides providing appropriate medical services, health care providers can facilitate disclosure, offer emotional support, make referrals to social services where possible and conduct follow-ups (García-Moreno, 2013). Among health care professionals, nurses are considered to be in a privileged position to deal with GBV as in many health systems they are the 'first point of contact' for individuals seeking care (Beccaria et al., 2013; Tufts et al., 2009).

Nevertheless, health care providers' knowledge, perceptions and attitudes toward GBV can influence their professional management of GBV (Beynon et al., 2012; Colombini et al., 2013; Natan and Rais, 2010). Training in GBV can increase knowledge, improve self-efficacy and help health care professionals acquire skills to successfully respond to women exposed to GBV (Connor et al., 2013; García-Moreno, 2013; Murillo et al., 2017). Consequently, training in GBV has been strongly recommended for health care providers and undergraduate students in health care professions (Colombini et al., 2013, 2012; Damra et al., 2015; García-Moreno, 2013). In accordance with recommendations from the WHO, as well as national legislation and policies (Spanish Government, 2004), the University where this study was done included compulsory training in gender-based violence in the first year of its undergraduate nursing programme in 2011. The training includes basic theoretical knowledge about the psychological and physical health issues arising from exposure to GBV, early identification of cases, available local resources for referral, follow up and management of cases.

Research aimed at exploring attitudes and perceptions toward GBV in undergraduate student nurses that have received training in this topic is scarce (Bradbury-Jones and Broadhurst, 2015). Therefore, the aim of this qualitative study was to explore third- and fourth-year nursing students' perceptions and attitudes towards GBV. The knowledge generated will be essential for improving their training in successfully responding to GBV as health care providers.

METHODS

We followed a focus groups based qualitative methodology. Qualitative methodology has been found to be well suited to explore perceptions and attitudes of health professionals, which was the objective of this study (Pope, 1995).

Participants

Students in the last two years of a four-year nurse education programme at one public University in Spain were recruited via an invitation sent to their university email account. In this first contact, students were given a brief explanation about the aim of the research study and the kind of participation required, and asked if they would be willing to take part. As a result, 42 nursing students participated, divided into seven focus groups each containing five to seven participants. Two of the groups were composed exclusively of women, one of only men, while the remaining four groups were of mixed sex. In total 12 participants were men and 30 were women. Forty participants were in their early twenties and two were in their thirties.

Data collection

Data collection took place from December 2015 to September 2016. Focus group discussions began with a reminder of the aim of the study and an overview of the main points stated in the informed consent. The first author (A.M.) moderated all the focus groups following a semi-structured interview guide that included questions about participants' perceptions of GBV, training received on the issue during their nursing studies and their role in GBV management as future nurses.

Discussions lasted from 40 minutes to 1 hour and 30 minutes.

Data analysis

We followed the Critical Discourse Analysis approach, as we believe its theoretical premise concerning discourses not only reflecting what individuals think but also influencing and shaping their actions, is of special relevance in the field of health care professionals and GBV. With this aim, focus group discussions were first transcribed verbatim and then read several times. They were then coded with the support of Atlas.ti software. The developed codes and interviews were then read again in order to discern themes, as suggested by Jorgensen and Phillips (Jorgensen and Phillips, 2002). Finally, all this information was analysed to identify interpretative repertoires. This concept, developed by Potter and Wetherell (Jorgensen and Phillips, 2002), emphasises the flexibility and dynamism of discourses, acknowledging inconsistencies in attitudes and practices. Discourses from this perspective are flexible resources used in social interactions by people to construct their different versions of reality. In our study this translated into three interpretative repertoires reflecting three different identified constructions of GBV.

ETHICAL CONSIDERATIONS

Ethics approval for this study was granted by the Ethical Committee for Research with Human Beings of the University where the study took place (M10/2015/234).

Written informed consent was obtained from all the participants, and to ensure confidentiality all names were removed.

RESULTS

From the analysis, three interpretative repertoires emerged: ‘GBV is something serious’, ‘Men are defenceless!’ and ‘Trained to address GBV but still unprepared’.

‘GBV is something serious’

This interpretative repertoire reflected participants’ descriptions of GBV as something serious in two senses. On the one hand, GBV was described as severe, important and relevant. On the other, this ‘seriousness’ implied that to qualify as GBV the behaviour or incident between the couple also had to be something severe. In this sense, the label ‘GBV’ was commonly felt to be merited by events that should be reported to the police, i.e. physical violence, while control or psychological abuse was not considered worth reporting to the police.

Girl 7: ‘Jealousy or insults and you say, why am I going to report this? He’s just insulting me, it’s not that serious.’ (Group 2)

In this interpretative repertoire there was an inconsistency between participants’ acknowledgment of psychological violence as part of GBV definition and reluctance to label it as GBV. Words and expressions such as ‘is not normal’, ‘toxic relationships’, ‘is unhealthy’ or ‘is pathological’ were used instead of the term GBV. Highlighting the fact that they were not talking about physical violence was a common strategy to try to minimise the relevance of the examples they brought up.

Girl 7: ‘...I know a case, well, (...) I wouldn’t say it’s gender-based violence, because saying “gender-based violence” is somehow frightening because it’s (GBV) serious.’

Girl 1: ‘But it is (GBV). I know the case.’

Girl 7: ‘It’s a girl whose boyfriend mistreats her. I mean, he has never put a hand on her, he has never hit her, but how he treats her, not only when they are alone, he says terrible things to her, because he says really nasty things to her, he controls her a lot.’ (Group 2)

Physical violence was identified as the most visible form and the first thing one thinks of when hearing the term ‘gender based violence’. In this sense, media and prevention campaigns were pointed to as being somehow responsible for making physical violence much more visible or even the only visible type of violence. The perception of the participants was that violence only reaches the news when someone ‘has died’. Although one person criticised the terminology used in the media—like ‘found dead’ instead of ‘killed’—this was largely the terminology used by participants themselves.

Girl 2: ‘Then, when you hear on the news, you know it’s physical because you are not going to see “he’s insulting her” on TV. No. It’s in the news when there’s no way back and the woman is already dead. So, when you listen to a news story about gender-based violence you know someone has died.’ (Group 2)

Although they cited sexual violence as part of GBV, this issue was totally absent from the cases of violence between intimate partners of which they knew. The rape cases they remembered were those committed by unknown males during summer festivities and which had been made public in the news. The only case of intimate partner sexual violence mentioned was portrayed as an example of a false denouncement. In this case, according to the participants the girl had made up having been raped, even though the boy had been found guilty during the judicial process and was in prison.

Girl 2: ‘She made up a rape. (...) Of course, but because they had had sex, but there was no vaginal tear, nor anything else; there was no vaginal tear, and you think if there is no conclusive proof that

it has been forced sex why should you ... And he is in jail; he's already been there for three years and has not been released yet.' (Group 2)

Men are defenceless!

Participants' concern about violence perpetrated by women against men came out strongly during the group discussions. The perception was that violence exerted by men is more visible, but not more frequent. Participants justified lack of data on the prevalence of violence of women against men on the grounds of the difficulty to denounce due to gendered expectations (incredulity, shame, difficulty to identify) and inexistence of legal support for men.

Boy 1: 'I think boys against girls is more visible...I mean a girl is more likely to tell her friends about what he has done to her or how he treats her, maybe not to her parents but to her closest friends yes, while if it's a boy who goes to his friend and tells him "tsk, tsk, look at what kind of messages my girlfriend sends me", "look at what she is making me do" and so on, his friend is going to tell him "so, tell her something, you pussy!"...'

Boy 5: 'Assert yourself!'

Girl 4: 'And I am not going to tell her anything because they might think I am hurting her, you know?' (Group 4)

Women were portrayed as being frequent perpetrators of psychological violence, even if the examples and cases participants knew of were numerically overwhelmingly in favour of violence by men against women. When talking about perpetrating violence, the female participants frequently used the term 'we' (women) to refer to the type of violence exerted, while the men made it clear that the perpetrators were other men and not them.

Girl 3: 'Maybe threats over the mobile or control are the most frequent.'

Girl 4: 'We (women) go more for the psychological.' (Group 3)

Girl 5: 'I think so. Girls in that sense, we are more manipulative.' (Group 2)

There was a weakly supported competing interpretative repertoire stressing that the violence exerted by women and men was not comparable, either in magnitude or severity, or in the broader social context of support for each of them, in the sense that violence exerted by men was much more prevalent and with more severe consequences.

Girl 5: '(Violence) by a woman to a man is also violence, I don't think either is right, I mean no (laugh), of course not! But I get angry when they are compared, they (violence exerted by men and by women) are not comparable, socially they are not comparable.' (Group 7)

In relation to the concern about the position of men, false accusations of GBV were one of the strongest arguments for their vulnerability. The discourse about the high number of false denunciations was so strong that, as explained in the previous repertoire, even cases where the completed judicial process had resulted in the man being found guilty and imprisoned were presented as examples of false denouncements.

Girl 1: 'Yes, but I don't know. Maybe you have fallen and, let's say, you have a bruise or similar, and you have argued with your partner and you say "you'll see now!" and you report that it's been caused by the boy. What proof does he have to deny it? I mean it's really difficult to know.' (Group 6)

There was no competing interpretative repertoire to this idea of false denouncements being numerous. There was some reflection about the weight this argument should be

given in terms of abolishing the current law or questioning the relevance of violence by men against women.

Girl 5: ‘Yes, I mean, I think it (the perception about false accusations being numerous) incites you not to believe, not to believe a woman who comes to you telling you what she has experienced, like building barriers, and asking her: “how were you dressed?” And I don’t know, comments you can hear, I think it (the idea of false denounces being numerous) incites them. Then, I don’t care how she was dressed, even if it was she who invited him home, and then she didn’t want to [have sex] and he raped her. I don’t know.’ (Group 7)

When participants referred to the protection measures in the actual legislation there was a constant contradiction in their arguments. On the one hand, they described the law as being too strong, accessible and easy to progress in the case of false accusations. In consequence, women were described as feeling immune and taking advantage of that position while men were portrayed as being totally defenceless and at risk of being imprisoned solely because a woman had accused them without any other proof. On the other hand, and at the same time, they described the same protection measures as being very weak, inaccessible and unable to protect women who are genuinely exposed to GBV.

Girl 3: ‘And then, I lack information about this, but I have read that once reported to the police the pathway to progressing the accusation in the police station and with lawyers and so on is not easy at all.’ (Group 4)

Girl 6: ‘And so? How many have made an accusation and then been killed afterwards?’ (Group 2)

Trained to address GBV but still unprepared

Participants assumed that dealing with GBV was part of their scope of action as nurses. In consequence, they described it as being essential to have training on GBV in nursing curricula. This awareness of GBV could be seen in the ease with which participants recalled cases they had seen during their placements.

Girl 2: ‘In the emergency service I think there have been three cases of women, and I have only been there two months, you know? And they came in beaten, one woman even repeatedly.’ (Group 5)

Thinking about themselves as future nurses having to take care of women exposed to violence, for participants the ‘seriousness’ of GBV described in the first interpretative repertoire was related to this one in terms of the supposed consequences for a man who is falsely accused of perpetrating violence. Thus, although they were able to recall physical signs, symptoms and attitudes that might be associated with GBV, and were aware of the key role they might play, they reported feeling afraid of misidentifying cases. In this vein, the idea of false accusations being frequent was also relevant in their professional role as nurses, adding to the fear of misidentifying cases.

Girl 3: ‘Yes, but your interpretations sometimes... labelling it as gender-based violence. Goodness!’

Girl 5: ‘It’s a very serious issue to get wrong.’

Girl 2: ‘That’s right, you cannot make a mistake, because you can, you can screw up.’

Boy 5: ‘Because if you are wrong, the consequences for the man might be very bad for his life, and there have been cases ...’

Girl 2: ‘... that were a mistake.’

Boy 5: 'Or it's been a lie. She has said, "I have been maltreated" or "they have done this to me" and so on.'

Girl 2: 'And it's not the truth.'

Boy 5: 'And you have destroyed a man's life.' (Group 3)

Despite having received training participants stated that they did not know what to do when identifying a GBV case, and they felt that registered nurses they had worked with during their placements were in the same situation.

Girl 2: 'I heard about the case (of GBV), but the nurses said "well, yeah, she's come more times" but nobody was like, I mean, nobody did anything, I don't know if I am explaining myself.' (Group 5)

Boy 1: ' (...) when asking, "what about this case?" the answer was "no, no, let it go, let it go", like saying it's better for you not to get involved in such cases. So you don't have the support from your colleagues, nor from...(silence)' (Group 7)

In this sense, they mentioned the necessity for more training, more practical than theoretical, and for specific protocols that describe exactly what should be done, for example who they should phone, in this way trying to equate GBV with any other disease.

Girl 5: 'I, just yesterday, read, ok, I didn't read it entirely, but I had a look at a document about what to do in a case of gender-based violence. But it was extremely general, it didn't tell you what to do, and I can't recall anything of what was said because it didn't say anything. I mean, it beat around the bush and said nothing.' (Group 7)

Girl 2: 'There was a protocol, and in fact that was what we told our classmates, but it was somehow like what they tell you at university. But if you have to deal with it, I think I will feel lost, I mean, I wouldn't know what to do, what to tell her or ... I don't know. I think we are a little bit underprepared.' (Group 5)

Reporting a GBV case, citing the woman for follow up and referral were seen as essential elements of their role as nurses. Whether they could or should do anything else was a matter of discussion. In these discussions GBV was described as something private and thus trying to act a possible intrusion on people's privacy.

Boy 1: 'I think people are fearful of sticking their noses into other people's business, I mean, it seems like it's (violence) a domestic problem and maybe, if you are a friend you can get involved.'

Girl 3: 'But it could happen that they get angry with you and don't talk to you ever again, so you cannot help that person anymore.'

Girl 4: 'Exactly, and then yes, you have screwed up.' (Group 6)

DISCUSSION

The three interpretative repertoires identified in this study reflect how participants described GBV as something relevant that merits attention, their concerns about men's vulnerability under current GBV legislation and their fears and insecurities as future nurses having to deal with women exposed to this kind of violence.

Participants in this study considered GBV to be a serious social issue. They felt unanimously that managing GBV was part of their work as nurses and were aware of the

key role they might play in addressing the needs of women exposed to GBV. This finding shows a positive change in the perception of GBV as a relevant health issue compared with research findings in previous years (Coll-vinent et al., 2008; Murillo et al., 2017). Participants in this study felt confident in their knowledge in terms of being able to identify GBV. Given that research has found GBV identification by nurses to be strongly related to knowledge, this could have a very positive impact on improved screening for GBV (Murillo et al., 2017; Tufts et al., 2009; Valdés Sánchez et al., 2015), and consequently on the health care system's response to this type of violence.

However, the strong persistence of some of the myths about GBV puts these achievements in jeopardy. For this study's participants, false accusations made by women against men were common and very frequent in the field of GBV. Closely related to this idea was the belief that women's credibility in rape cases was conditional on them having physical injuries such as 'vaginal tear'. These myths, identified in the discourses of this study's participants, are part of a social emergence of new myths around GBV (Bosch-Fiol and Ferrer-Pérez, 2012). The belief that the majority of GBV accusations are false and the belief that men are exposed to the same levels of violence as women are part of the 'Negationist myths' described by Bosch-Fiol and Ferrer-Pérez (Bosch-Fiol and Ferrer-Pérez, 2012). In nurses, belief in these myths is likely to negatively affect their ability to identify cases and provide a comprehensive response to GBV. Questioning the credibility of a woman exposed to violence when disclosing to her nurse could have devastating effects on her (Damra et al., 2015). Therefore, it is of the utmost importance that undergraduate nurses' training begins with an extensive exploration of students' pre-understanding of GBV, myths and preconceptions in order to discuss and address these before embarking on their role as nurses. Although eliminating myths and changing attitudes is not an easy task, previous experiences show that it is feasible (Currier and Carlson, 2009; Schoening et al., 2003).

Participants identified a gap between their perceived knowledge and confidence in identifying GBV cases and insecurity about what to do afterwards. This finding coincides with those of other studies both of registered nurses and undergraduate students (Bradbury-Jones and Broadhurst, 2015; Nayak, 2000). Existing protocols were known to the participants but were regarded as being too general and vague to be useful. Participants asked for more detailed protocols that specified what to do step by step, as there are for other health issues; although, as previous studies with health care professionals have pointed out, responding to GBV is more complex than just following the steps of a protocol (Goicolea et al., 2015, 2013). More practical training, through activities suggested in the literature like standardised patient scenarios, peer education programmes, interviews with GBV survivors and placements in specialised social services for GBV, could help to reduce the gap between confidence in identification and case management (Gürkan and Kömürçü, 2017; Pana and Lesta, 2012; Tufts et al., 2009).

The desire to equate GBV with any other disease reveals a strongly biomedicalised approach to nursing during the university training programme, and echoes the current Spanish health care system's struggles to address health issues with social roots as well as biological ones, as described in previous research (Briones-Vozmediano et al., 2015). Hence, participants perceived that neither the health care system, nor the registered nurses whom they met during their placements, were supportive of a comprehensive response to GBV. According to the model developed by Colombini et al. (Colombini et al., 2012), training and guidelines are essential elements for a comprehensive health sector response

to GBV, but will not be sufficient from a long-term perspective if structural and organisational changes are not implemented. These structural and organisational changes remain a challenge for the Spanish health care system for the coming years (Goicolea et al., 2013).

Limitations

There are a number of limitations to this study. First, the researcher who moderated the focus groups was a former lecturer at the university for most of the participants. This might have influenced participants to respond in a way they thought was expected of them. Conversely, knowing the interviewer might have increased their confidence to discuss the topic openly. Second, the students who decided to participate in this study might have had a special interest in the research topic and different perspectives from those who did not. We addressed this possible limitation by organising new focus groups until saturation was reached and by reflecting the variety and nuances of the repertoires identified in the results section.

CONCLUSIONS

Nursing students' discourses reflected the perception that training has raised both awareness of GBV and its acknowledgement as a health issue, as well as having increased students' knowledge and self-confidence in the identification of cases. However, training in GBV should strongly challenge widespread myths about GBV that could negatively affect their performance as nurses. The inclusion of evidence-based, innovative methodologies into the training programme could encourage critical assessment of these myths and help students to develop skills to overcome their fear of intervening in GBV cases.

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Nursing students' discourses on gender-based violence and their training for a comprehensive healthcare response

- Participants felt confident in their knowledge to identify gender-based violence
- Discourses reflected the presence of strongly rooted myths
- Presence of myths might negatively affect how they address gender-based as nurses.
- Challenging myths should be considered in training design and implementation.

ACCEPTED MANUSCRIPT