The understandings, experiences, and practices of nurses and student nurses concerning domestic violence against women within healthcare encounters in Saudi Arabia: A hermeneutic phenomenological study

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Abstract

Background: Domestic violence and abuse against women (DVA) is a well-established public health issue and a violation of human fundamental rights. DVA is associated with numerous harms with detrimental health consequences on women. In the Saudi Arabian (SA) context, societal and cultural factors inhibit the expression of women's rights and limit the violence disclosure within marriage and families, further controlling the ability to access or receive appropriate healthcare and support. The experiences and practices of nurses and student nurses concerning care for DVA victims in SA remain unexplored. Therefore, this study aimed to address this gap and also intended to contribute to the nursing educational practice on DVA in SA.

Aim: To explore the practices, understanding, and experiences among nurses and nursing students surrounding DVA within the context of SA.

Methodology and Methods: This study used a qualitative hermeneutic phenomenology design (Heidegger, 1962). Study participants included nurses and student nurses from one of the city of SA, identified using convenience sampling. Data was gathered between October 2017-February 2018 through semi-structured interviews (n = 18). Data analysis was performed along the interview process to identify consistent themes, and transcripts were carefully evaluated to develop situated structures and a general structure.

Findings: The main concept explaining nurses' experiences was "being disempowered". Three themes that linked to this concept included: (i) being unequipped, (ii) being silent, and (iii) being constrained by social and religious contextual forces. Being unequipped with knowledge, training, and skills and lack of relevant care experience explain nurses' feeling of disempowerment in theme 1. Theme 2 relates to nurses' experiences of not speaking about DVA, which further associate with the organizational barriers, being unauthorized, experiencing dilemmas of reporting, and feelings of being unsafe. Theme 3 explains the social and religious contextual forces restricting nurses and/or victims from dealing with DVA including its normalization and acceptance, stigmatization and impacts of the guardianship role versus Saudi law.

Discussion: Nurses' disempowerment o undermines their ability to care for DVA victims. The themes stress the importance of nursing empowerment, approaching the barriers stemming from cultural, social, and religious norms and ensuring the availability of specific guidelines, policies, and procedures around protecting the privacy of victims, provision of care, reporting and support and safety of nurses as well.

Conclusions: This study contributes significant insights on nurses' experience in dealing with DVA and acknowledges the sensitivity and difficulty of addressing DVA in hospital settings, particularly in SA. Study findings can pave the way through effective and sensitive strategies, with required modifications in the curriculum, organizations, policy, procedures, and laws.

Keywords: abuse; battering; experiences; hermeneutic phenomenology; knowledge; nurse; perception; Saudi Arabia; student nurse; understanding; violence; women.

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List of Abbreviations

AMA	American Medical Association
ANA	American Nurses Association (ANA)
AWMI	Awareness of abuse among females with mental illness
BSN	Bachelor of Science in Nursing
CDC	Centers for Disease Control and Prevention
CEDAW	UN Convention on the Elimination of All Forms of Discrimination Against Women
CIA	Central Intelligence Agency
CLS	Clinical laboratory sciences
CNE	Continuous nursing education
CPD	Continuing professional development
DV	Domestic violence
DVA	Domestic violence and abuse
EBP	Evidence-based practice
ER	Emergency Room
FBO	Faith-based organization
G20	Group of 20 largest economies
GBV	Gender-based violence
GDP	Gross domestic product
IDVA	Independent domestic violence advisor
IPE	Inter-professional education
IPV	Intimate partner violence
JBI	Joanna Briggs Institute
MoH	Ministry of Health
NICE	National Institute for Health and Care Excellence
NIH	National Institute of Health
NFSP	National Family Safety Program

OCFS	Office of Children and Family Services
QoC	Quality of care
QoL	Quality of life
RC	Respiratory care
RCT	Randomized controlled trial
RIPLS	Readiness for Inter-Professional Learning Scale
RN	Registered nurse
SA	Saudi Arabia
SDG	Sustainable Development Goal
SES	Socio-economic status
STD	Sexually transmitted disease
VAW	Violence against women
VAWG	Violence against women and girls
WHO	World Health Organization

Chapter 1
Introduction

1.1. Domestic Violence Against Women (DVA) and Study Context

Domestic violence and abuse against women (DVA) has prevailed throughout history, and women have suffered physically and mentally in carrying out their reproductive roles throughout the ages. In recent times, this phenomenon has increasingly been recognized as a behavioural pattern rather than exceptional incidents in which the rights of women and girls are contravened, which is detrimental to their wellbeing and restricts their societal engagement (WHO, 2013, 2015). Frequently, domestic abuse goes unreported to the authorities (Office of National Statistics, 2019). DVA and intimate partner violence (IPV) are forms of gender-based violence (GBV), and are global concerns that affect individuals, families, and entire communities, across ethnicities, cultures, and socioeconomic groups (Penn and Nardos, 2003).

In healthcare environments, nurses are best situated to identify abuse victims and be their first point of contact, because among health workers, nurses spend the most time directly engaging with frontline patients (McGarry and Nairn, 2015). Healthcare settings may provide victims with the opportunity to confidentially disclose their abuse to someone in a position of trust, and as patient advocates within the modern healthcare paradigm, nurses are ideally placed to play this trust role (McGarry, 2014); hence, healthcare practitioners must be well-informed about DVA and its complexities. Most DVA occurs at home, so the onus is on those helping the victims to form strategies for intervention and prevention that both support the individuals and transform societies (Bennet, 2006). Important considerations relate to the complicated social and psycho-cultural aspects that may hinder victims from self-advocating (Jalal, 1991). Another obstacle is the social taboo of interfering in the privacy of others and the domestic sphere (Garcia-Moreno et al., 2003).

This thesis is about DVA in the Kingdom of Saudi Arabia (SA), exploring the practices, understanding, and experiences among nurses and nurses' students surrounding domestic violence and abuse within the national context.

This chapter provides some background information and discusses DVA and IPV in the context of SA.

1.2. Background

Domestic violence against women occurs in developed and developing nations globally. As most GBV involves males abusing females, GBV and violence against women (VAW) are frequently conflated. The 1993 UN Declaration defines VAW as GBV that causes physical, sexual, or mental damage to women, including threats, preventing freedom, and coercion, which can take place both publicly and privately (United Nations, 1993). GBV as a term emphasizes the gender divide, highlighting the correlation between females as societal subordinates and their higher probability of being victims of violence.

The UK government definition of DVA is any single occurrence or pattern of threatening, controlling, or coercive behaviour, abuse or violence between over-16s, who are current or past intimate partners or family members, without exception, due to gender or sexuality. This includes physical, sexual, emotional, psychological, and financial abuse (Home Office, 2013). Controlling behaviour is defined as a series of acts isolating a victim from their support system and resources, blocking any means of escape, and dictating their behaviour to cause them to become subordinate and/or reliant on the perpetrator. A coercive behaviour on the other hand is an incident or pattern of threats, assault, intimidation, and humiliation to harm, scare, or punishing the victim (Home Office, 2013).

The World Health Organization (WHO, 2015) notes the interchangeability of the terms "IPV" and "DVA", but observes that the latter can include other types of family violence (e.g. against children or the elderly). WHO has declared domestic violence (DV), which encompasses IPV and family violence, to be a leading public-health concern globally. Significantly, men, boys, and transgender people not identified under the traditional binary concept of "women" can also be victims of GBV and IPV, although violence against male and transgender people were not considered within the scope of this study. DVA can apply in both heterosexual and same-sex relationships. While women can be the perpetrators of DVA, they are overwhelmingly its victims (Dardis,

Dixon, Edwards et al., 2015). Typically, the abuser is known to the woman, and is usually a past or present intimate partner or other family members. Violence against women in many forms is prevalent in all areas of life (Ali, 2017). DVA with female victims is widely documented as an extensive public-health problem, associated with significant mortality rates and long-term morbidity (Lewis-O'Connor and Chadwick, 2015).

Because of the diverse cultural and legal concepts of DV, establishing a universal definition is problematic. VAW is acknowledged as a public-health issue globally, and a contravention of human rights (Watts and Zimmerman, 2002; Krantz and Garcia-Moreno, 2005). Abuse can be an isolated incident or an ongoing behavioural pattern, involving physical, sexual, financial, emotional, or psychological dimensions, or combinations of these.

This thesis concentrates on DVA encompassing IPV and family violence, utilizing the terms "domestic violence against women", and "DVA". Specifically, this research focuses on DVA that includes IPV, which occurs within a home, where abusers are typically husbands or intimate partners (Garcia-Moreno, 2006). From a sociological and psychological perspective, the term "family violence" refers to the abuse of any family member of any sex or age. Conversely, IPV is expressed as threatened or actual physical, psychological, or sexual harm by a former or current spouse or partner.

1.3. History of Domestic and International Action

1.3.1. First Stage: Shift from Private to Public

The UN Convention on the Elimination of all Forms of Discrimination Against Women (1979) mandated that countries report on active efforts to protect women from discrimination, and in 1980 the term "domestic violence" was introduced in official UN documents. The Second World Conference on Women (1980) in Copenhagen saw the commencement of the initial phase of reform of the international norms and standards of VAW, and specifically IPV. The term "intimate partner violence" is more specific than "domestic violence", and represents a sharpening of understanding and responses to such violence in public consciousness and policy, compelling governments to acknowledge

such problems and take action (Morvail, 2002; Kranick, 2015; Sprague, Hatcher, Woollett et al., 2015).

1.3.2. Second Stage: Legal Responses

The international community acknowledges DVA as a human rights violation for which governments carry responsibility. The 1993 World Conference on Human Rights was a pivotal moment in understanding it, as it was stressed that human rights for women must be prioritized. Concerning DV, it obliged governments to actively protect individuals' dignity, personal freedom and integrity, and right to live free of abusive actions. Most significantly, it was clarified that this applies even if a spouse or partner is the one violating these rights. WHO (2002) published the world's first global report on violence and health, in which it detailed the destructive and continuous impact of partner and sexual violence on females. This publicized the evidence and underlined the key role of healthcare systems in aiding DVA/IPV victims (Krug et al., 2002).

1.3.3. Third Stage: Establishing Norms

Government interventions to address DVA/IPV have increased, and it is now typical that governments establish policies, guidelines, and strategies and implement legislation with multidisciplinary input. Since 1979, each protocol and resolution has contributed to the body of work addressing women's rights (health, reproductive health, sexual, physical integrity, and freedom from abuse) (Morvail, 2002; Gerntholtz, Gibbs and Willan, 2011; Sprague et al., 2015). In most countries nowadays, DVA/IPV is illegal, and there are specifications for the authorities and the legal and justice systems to address it. Numerous social-welfare bodies such as shelters and other NGOs have been introduced to address the needs of victims and keep them safe from further abuse (Morvail, 2002). However, despite all the progress of the health sector and the process of universal screening, it still attracts controversy. In the hospital setting, particularly emergency department, physicians and nurses often consider screening necessary only in case if abuse is evident. This hesitancy might relate to the unpreparedness in terms of training and skills and the sensitive nature of the phenomenon, creating disagreement between the

procedure endorsed by regulatory bodies and the organizational guidelines and policies. Moreover, various domains of the patriarchal society consider DVA acceptable, normalizing the phenomenon and lack of appropriate laws make it an agenda of disagreement at the forefront (Morvail, 2002; Ramsay, Richardson, Carter et al., 2002).

1.4. Saudi Arabia's Protection from Abuse Law

In 2013, to highlight the issue of family violence, SA enacted the Protection from Abuse Law, which is the first national law to explicitly criminalize DV. It proscribes negligence and abuse (physical, sexual, and psychological) against any family member, and carries a maximum fine of SAR 50,000 (USD 13,000) and a one-year custodial sentence (BBC News, 2013). A DVA reporting centre was also established in 2016, along with 24 different social protection teams and units, and nine organizations to address reports and victims (Okaz News, 2019). In 2015 there were 8,016 spousal DVA cases recorded by the Ministry of Labor and Social Development, including 961 in one major city alone, including children and women deprived of basic rights, such as education, health care, and personal identity documents (Human Rights Watch, 2016; Musawah, 2018).

In addition, several national schemes are aimed at preventing DV and supporting both healthcare practitioners and women, including the National Family Safety Program (NFSP), established in 2005, which is connected to the National Guard Health Affairs' administration. It strives to promote family safety and unity and to be a centre of excellence by offering prevention and advocacy services, increasing awareness, and forging partnerships with various stakeholders to create a safe family environment in SA (Alquaiz, Almuneef, Kazi et al., 2017).

Another scheme is the establishment of a refuge for abused women and their children by the Ministry of Social Development, assigned the number 1919. It handles DVA complaints, and offers legal consultations and aftercare services (Ministry of Human Resources and Social Development, n.d.).

1.5. DVA Burden

1.5.1. Prevalence

WHO (2017) estimates that around one in three women, are victims of sexual and/or physical violence at some point in their lives. Approximately 1.3 million women annually in Britain suffer violence of same sort, particularly DVA (Office for National Statistics, 2016). García-Moreno et al. (2013) affirmed the high lifetime prevalence of partner violence against women, with 37.7% in Southeast Asia, and 23.2% in high-income regions. In low-income areas and middle-income areas, the rates were 36.6% for Africa, 29.8% for the Americas, 37% for the Eastern Mediterranean region, 25.4% for the rest of Europe, and 24.6% for the Western Pacific. It was found that male partner homicide against women ranged from 6% to 38%, with a global median of 13%. Bradley et al. (2002) examined national surveys in Canada and the UK and found that about a quarter of women suffered interpersonal violence.

DVA is a risk factor for psychological issues, injury, and death (García-Moreno et al., 2005). Policymakers, health professionals, and researchers should find ways to extend their understanding of DVA, while understanding victims' experiences around it (Bell, Cattaneo, Goodman et al., 2008). Abused women's self-efficacy might have to be increased by nurse-led counselling and intervention (Pallitto et al., 2016). Wellbeing is often affected by DVA, and a cycle of abuse through the generations can arise; nurse training and intervention can break this cycle, reducing health system and societal costs (aside from improving the immediate quality of care (QoC) for such vulnerable service users).

Spousal rape has not yet been criminalized in most Middle Eastern countries, and men are in charge of their wives' bodies (Al-Khalifa and Al-Khalifa, 2007; Krause, 2009). Although official statistics underestimate the prevalence of DVA, particularly in the Middle East, due to low reporting of such incidents, it is believed that many Saudi women are constant victims of DVA, with violence perpetrated by male "custodians" such as fathers, spouses, uncles, or brothers. These issues are discussed in detail in this thesis. Fareed (2017) was one of the few Saudi social activists who spoke out against violence

against women by male relations, but legislators, despite international campaigns, have generally ignored calls for reform.

Malik (2013) nevertheless highlights some attempts made to deal with DVA, citing the King Khalid Charitable Foundation and other initiatives patronized by members of the royal family. In 2013, a new law against DVA was put in place, as mentioned above. While DVA is frequently unreported, it is known to be associated with socio-economic status (SES) – women with higher SES often get more support from their families than those who are poor and with lower SES. DVA is not investigated sufficiently in most Arab countries, despite being common (Afifi, Al-Muhaideb and Hadish, 2011). Sahar (2015) stated that DVA is a hidden issue in SA, where a third of women are estimated to experience DVA (Kassaz et al., 2019).

Alhalal, Ta'an and Alhalal (2019) found that there has been no national Saudi study on spousal violence prevalence, and they carried out a systematic review of 16 studies of women in Saudi healthcare settings from 2002-2017 to identify prevalence as well as risk factors, outcomes, and help-seeking behaviour. One study was mixed-methods and the remainder were quantitative. IPV prevalence was estimated to be from 34.4% to 57.7%. The most common abuse was slapping, pushing, and shoving. Two of the studies found that there was a lifetime reporting of abuse for 9-44.5% of women, and 2-16% in the last year. During pregnancy and post-partum, the rates were 21-78%. The rates of sexual abuse were 9.7-12.7% for lifetime, and 48% for pregnancy. For emotional abuse, the lifetime rate was 22-32.8%, including 11% for the past year, and 7.5% in general. It was found that around 27.1% of women were psychologically abused in their lifetimes, which rose to 73% in pregnancy. 35.8% of women were found to suffer from verbal abuse, and 36.8% were the victims of controlling behaviour. About a third of women were the subjects of financial abuse while they were pregnant.

There are discrepancies in Alhalal et al.'s (2019) figures, which may be due to the range of definitions among reviewed studies, as well as a lack of evidence regarding the validity and reliability of measures used. Nevertheless, the paper showed that vulnerability to violence is influenced by relational, individual, and

sociocultural factors. Spousal violence has a negative impact on the health status (physical and mental) of Saudi women, and Saudi women do not tend to look for DVA support formally. It was also highlighted in the review that there is insufficient data as well as a lack of consistency in definitions and measurements of spousal violence. It was emphasized that there is a need for robust DVA research to create preventative and intervention programmes that work.

Jradi and Abouabbas (2017) found that out of 900 women in Riyadh, 41.7% did not report good wellbeing, or reported what was probably depression. Poor wellbeing is significantly connected to violence, poor conditions, and comorbidities. Abolfotouh and Almuneef (2019) researched 400 married women in Riyadh attending outpatient clinics aged 19 to 65. They discovered that DVA prevalence over a lifetime was 44.8%, of which 18.5% experienced physical abuse, 25.5% emotional abuse, 19.2% sexual abuse, and 25.3% financial abuse. Husbands only experienced a significant amount of emotional abuse, as opposed to the other types of DVA. There was more likelihood of physical violence in households with multiple women. There was a significant association between IPV and child abuse, as well as polygamy. It is essential to create customized national IPV prevention programmes.

1.5.2. Forms of DVA

There are many different forms of DVA. "Physical violence" involves the use of physical force against the victim to cause injury, pain, or physical suffering to the victim, encompassing acts such as hair pulling, kicking, and slapping, as well as some life-threatening acts, such as murder, strangling, and burning. "Sexual violence" involves forcing an individual to perform sexual acts against their will, including (but not limited to) having forcible sexual intercourse. "Psychological violence" is the use of various behaviours intended to belittle or insult someone, individually or in front of others, as well as intimidation and threatening someone (e.g. threats to take away children). "Controlling behaviours" involves isolating individuals and preventing or limiting their access to jobs, education, or medical care and financial resources, as well as tracking and observing their movements and making them feel vulnerable and

bullied. Different forms of abuse frequently occur simultaneously (WHO, 2012; Ali, Dhingra and McGarry, 2016).

1.5.3. Gender Role

The term "sex" primarily relates to biological traits that denote an individual as male, female, or intersex, considering material issues such as genitalia, hormones, genes, and chromosomes, whereas "gender" is a social construct referring to masculinity or femininity. Other than sex, the most effective indicator of attitudes in favour of VAW is gender role attitudes, which are convictions regarding the "proper" roles for males and females (McHugh and Frieze, 1997; WHO, 2012). It is easiest to consider gender role attitudes in terms of a continuum from traditional to egalitarian. People who hold traditional attitudes utilize stereotypical characteristics of their sex when interacting with others, while sex is not a factor in responses from people with egalitarian attitudes. Gender role attitudes are formed and passed through generations, as children's opinions are shaped by their significant role models, especially their mothers, and these subsequently determine their behaviours (Abouchedid, 2007).

Correlations have been identified between traditional gender role attitudes and negativity towards women. A study on religion, spirituality, and gender role attitudes as indicators of convictions about DVA found that the latter was the most effective predictor, although spirituality was also significant, among a sample of 316 White college students (Berkel, Vandiver and Bahner, 2004).

Conventionally, gender roles stereotype male characteristics as authoritative and dominant, while female characteristics are submissive and powerless, which creates a power imbalance. Regarding marriage and intimate relationships, this frames societal expectations that men should work and be the breadwinners of their families, while women should rear children, and maintain the household. Conversely, non-conventional gender-role expectations advocate equally shared responsibilities. Society and culture both significantly affect amending these stereotypes and perceived gender roles. Existing research indicates that people holding defined gender-role

expectations become stressed, angry, and aggressive when they encounter circumstances they perceive to conflict with their expectations (Ali et al., 2011).

The societal expectation of women to be submissive in marriage, even if it is against their basic rights, could be an underlying factor in DVA. Domestic abuse is more likely to occur when males with traditional gender-role opinions feel challenged, neglected, or ignored. Moreover, women with gender-equitable attitudes are at a higher risk of DVA, as they may be considered disobedient or too assertive (Haj-Yahia., 2000; Al-Rasheed, 2013: Eidhamar, L. 2017). Another possibility is that a person's gender-role expectations differ from their reality. Whilst there is an improvement, equality remains unattained, and gender-role expectations continue to be a factor in DVA. (Ali, 2017 and Ali, P., O'Cathain, A. and Croot, E.2016, Laeheem, 2017, and Abouchedid, 2007)

1.5.4. Health Consequences

The most severe consequences of DV are mortality and morbidity, including deaths due to both suicide and homicide (Dienemann, 2000; Coker, Bethea, Smith et al., 2002). Morbidity entails a low quality of life (QoL), poor health, and increased availing of healthcare services (Plitcha and Falik, 2001). Most abused women experience serious physical injuries and other extreme health issues (Coker et al., 2000), obesity (Alhalal, 2018), chronic pain (Barnawi, 2017), and psychological issues, suicidal thoughts, sleep disorders, drug abuse, and psychosomatic symptoms (Eldoseri et al., 2014). Frequently, the treatment offered in "healthcare facilities" does not detect the abuse of women, therefore victims remain at risk of further repeated abuse (Chibber and Krishnan, 2011; WHO, 2012; Dillon, Dillon, Hussain et al., 2013).

Oftentimes, DVA is associated with various immediate and long-term negative health impacts (Bosch et al., 2017). These include physical injury, chronic illness, functional disorders, mood disorders, suicidal ideations, gynaecological problems, negative pregnancy outcomes, and mortality (Campbell, 2002). Abused women are at high risk of unwanted pregnancy, miscarriage, and complications including low-birth-weight babies, premature membrane rupture, and induced abortion (Kaye, 2006). Another cross-

sectional study found that there is a lower probability of expert assistance during delivery if the woman has experienced IPV (Devries, 2010; Goo and Harlow, 2011). Physiological health problems (gynaecological, sexual, and gastrointestinal) are also prevalent (Feder et al., 2011).

DVA also causes relationships with friends and family to deteriorate, and financial problems. Victims have a higher likelihood of self-detrimental behaviours; for example, using alcohol and drugs, self-harm smoking and unsafe sexual activities (Dillon, Hussain, Loxton, & Rahman, 2013; Karakurt, Smith, & Whiting, 2014). DVA/IPV also harms productivity and has huge human and economic costs for victims, their families, and for the larger society (Karakurt et al., 2014). Furthermore, victims frequently have sexual and reproductive health problems. In addition to the abovementioned pregnancy issues, they are at a higher risk of sexually transmitted diseases, including HIV. The children of victims suffer, with higher rates of infant mortality and behavioural and developmental problems (WHO, 2013); the negative consequences may be ongoing throughout children's lives, including predisposing them to perpetrating or being victims of DVA (Krug et al., 2002; McGarry et al., 2011).

1.5.5. Risk and Protective Factors

Research shows that violence has no one single root cause. The socioecological model introduced towards the end of the 1970s includes many risk factors for both perpetrators and victims. Initially, this model was constructed to conceptualize child abuse and then youth violence, but more recently it has been applied to DVA (Krug et al., 2002). The socioecological model provides an effective framework that has the following four levels of risk, whose factors can cause violence:

- **Individual Level:** This encompasses the biological and personal aspects that shape individual behaviour (such as age, gender, education, income, childhood experience or witness of abuse, psychological issues, personality disorders, and drug or alcohol addiction). Prevention approaches include fostering opinions on behaviours that avert violence, such as conflict resolution and life skills.

- **Personal Relationships Level:** Personal relationships with intimate partners, friends, and family can influence whether an individual becomes a perpetrator or a victim of violence. The likelihood of being a perpetrator is increased by being raised in a highly patriarchal family, having violent friends, or conflict with an intimate partner. Prevention approaches include parent/family-centric prevention programmes, peer programmes, and mentoring.
- **Community Level:** This is the environment of social relationships (schools, neighbourhoods, workplaces). Influential elements include high crime and unemployment rates, drug or weapons dealing, lack of community action against DV, and insufficient victim aftercare. Prevention approaches include changing the social and physical environment through decreasing social isolation, enhancing economic and housing options, and school and workplace policies and environmental improvements.
- **Societal Level:** This encompasses the societal and cultural structures and systems and the extent of their acceptance of violence and inequality. It includes male dominance, poverty, or wider acceptance of violence. Other significant societal factors include the policies (health, economic, educational, and social) that contribute to enabling social and economic inequalities (Centers for Disease Control and Prevention [CDC], 2020).

As demonstrated by the socioecological model, the reasons why certain individuals or groups are at a greater risk of suffering or perpetrating domestic violence is not attributable to one specific factor. These complex and overlapping dimensions span many interrelated factors. At each level, there is both influence and prevention. Understanding the diverse factors can be of huge benefit to preventing DVA. However, it has been suggested that a primary limitation of this model is that the family is not treated with adequate significance (commensurate with its fundamental importance in most cultures) (Ali, 2016).

1.5.6. Nursing Role

Whether in a hospital or the community, licensed professional nurses are pivotal in early interventions for and prevention of DV (Peate, 2013). Nurses must maintain specific competencies and practice standards as established by their governing bodies. For instance, the College of Nurses Ontario (CNO, 2013) has seven practice standards of accountability, ethics, leadership, application of knowledge, relationships, knowledge, and continuing competence. Nurses are required to meet these standards and the healthcare organization is required to ensure nurses have the resources to do so. Regarding professional accountability, all UK-based registered nurses have a professional obligation to take all reasonable courses of action to protect vulnerable patients or those at risk of abuse, harm, or neglect (Nursing and Midwifery Council, 2015).

Although nurses are typically the healthcare workers expected to address DVA victims' care, all healthcare providers actually have a responsibility to do so. Nurses themselves typically believe that they have to care for female victims of DVA, including providing recognition, physical care, safety elements, advice, and support, and referring victims to designated services (Guruge, 2012). The latter is an important precondition of treating and caring for DVA victims, which could be improved by embedding standard DVA practice, but this is only safe and effective if there are a suitable intervention and follow-up (WHO, 2013).

Disclosure of DVA is estimated to be low (Taft et al., 2013), and although most healthcare providers have been trained for screening, they tend to ask about related issues sporadically (McCaw et al., 2001). WHO does not advocate universal screening for DVA except if not followed by the effective post-screening intervention; instead, it advises that healthcare providers are trained in appropriate responses and to recognise the physical and mental health indicators related to DV, and they should only query the patient if they detect indicators of DV (WHO, 2013). There is negligible supporting evidence for DVA screening policy, and three randomized clinical trials found no proof of decreased violence or enhanced health outcomes in response to such screening (Taft et al., 2013; O'Reilly and Peters, 2018). There is also the risk that healthcare practitioners become overwhelmed with such non-biomedical

and ancillary responsibilities, reducing their capacity to provide their expert healthcare services, while offering minimal benefits to women.

As per the guidelines of WHO and the National Institute for Health and Care Excellence (NICE, 2014), training for health workers should encompass how to: enable disclosure, check patient safety, provide support and referral, and administer medical aid and supplementary care. In-depth guidelines should be provided to all healthcare practitioners regarding the identification and addressing of DVA. Effective preparation and training is key, however healthcare practitioners also need expert support, particularly for challenging cases (WHO, 2016).

As healthcare practitioners operate in diverse environments, they can add to the knowledge by recognizing the signs of DVA and referring victims to beneficial resources (Ahmed, Ali, Rehman et al., 2016; Ali, 2017). They must be capable of providing support and empathy to victims to help them seek support. Nurses and other healthcare practitioners require the knowledge and skills to do so, which include active listening, a non-critical outlook, and steadfast ethical principles surrounding DVA. Nurses in leadership roles can also contribute by creating and implementing effective guidelines and policies, and informing legislation. Furthermore, the nature of nursing means that practitioners are in stressful situations, potentially caring for perpetrators of abuse while simultaneously dealing with victims of abuse, therefore it is beneficial to be self-aware, emotionally intelligent, and knowledgeable about professional codes of conduct. Another key function is identifying and aiding perpetrators of DVA who wish to change their behaviour and require support, which can be provided by referring them to suitable programmes.

DVA is a complicated issue that requires an integrated strategy, and healthcare professionals can be pivotal in its prevention. A meta-synthesis of qualitative literature indicates that women need healthcare practitioners to administer first-line support, which entails listening, asking about their needs, not pressuring them to divulge, ensuring their safety (and that of their children), and providing support, resources, and referrals (Feder et al., 2006). WHO advises that all healthcare providers are trained in this area and are respectful

of victims' decisions (WHO, 2013). The type of response and a precondition to accepting aid is that the victim recognises their abuse (Chang et al., 2010).

Education and training could generate improvements in training nurses and support for nurses while they work (WHO, 2019). The curriculum should endeavour to furnish healthcare providers with the fundamental skills for addressing DVA/IPV and sexual abuse against women. It should build skills and shape mindsets towards victims. Nurses should be informed about providing woman-centric clinical care, which entails identifying victims and administering first-line support via the Listen, Inquire, Validate, Enhance safety, Support (LIVES) approach, followed by administering medical care and informing service users about available resources and support. Compassionate and empathetic communication is stressed (WHO, 2019). The UK government published a *Domestic Violence Training Manual* (Department of Health and Home Office, 2006) and a *Resource Manual for healthcare Professionals* (National Assembly for Wales, 2001). Both publications acknowledge the key role of nurses and advise mandatory and continuous training and education.

Healthcare practitioners can provide continuous support and empower women to act. Evidence also supports other healthcare interventions, including supplementary training or expert partner violence advocacy (Rivas, Ramsay and Feder, 2005), and safety planning (McFarlane et al., 2002). The purpose of advocacy interventions is to directly help the victim through community resources, whereby they are typically connected with law enforcement, legal, financial, and housing services, in addition to psychological or psychoeducational support. Trials in developed countries have reported a decrease in DVA and potential mental health improvements (Tiwari et al., 2010).

Another function is a referral for DVA. Connecting healthcare practitioners with expert support or advocacy services raises the probability of screening and identifying victims of violence (Feder et al., 2011). However, studies have shown that there is often ambiguity surrounding referral avenues (Hegarty and Glasziou, 2011). Consequently, the Identification and Referral to Improve

Safety (IRIS) scheme was created and has performed well within the UK primary care environment (Feder et al., 2011). IRIS trains primary-care clinicians and other team members to identify, respond, and refer victims to expert advocates (Malpass et al., 2014). A study of IRIS effectiveness within one UK region determined that at a local level, both providers and users were affected, and found that a "whole team" strategy is key to the success of DVA schemes (McGarry, Hussain and Watts, 2019). IRIS is pivotal in aiding the effective responses of primary care professionals. In comparison to conventional approaches, IRIS was more pre-emptive and all-inclusive for women.

In all healthcare environments, particularly in emergency departments, nurses can identify and help DVA victims, however they must comprehend its different types, causes frequency, impacts, and indicators. Furthermore, nurses must have definitive individual standpoints on IPV, so that they can more effectively care for their patients (Ali, McGarry and Dhingra, 2016). Several studies have illuminated the potential obstacles for healthcare providers helping DVA victims, including a lack of knowledge, low professional confidence, and time restrictions (McGarry and Nairn, 2015).

WHO (2013) advises that in all nations, local policies and practices that clearly set out the roles, responsibilities, and practices must be created and implemented with adequate training and ongoing support. The basic professional education curriculum should include IPV and sexual assault training for healthcare practitioners who have the highest likelihood of dealing with such issues in reality. WHO (2013) prescribed minimum requirements that healthcare providers should have when screening for IPV: training on speaking to patients; a private location for talking; maintaining patient confidentiality; and a referral system. This has caused contention about whether and how healthcare practitioners in LMICs should address IPV in the absence of established policies and practices in the context of severe staff shortages and struggles in basic biomedical task completion (García-Moreno et al., 2015).

1.6. Biographical Sketch/ Rationale for the Study

I am a Saudi Arabian national and a qualified nurse with a master's degree in Community Health Nursing. This degree enables me as a graduate to assist registered nurses (RNs) to implement, develop, and promote nursing service programmes in deprived communities. Students are trained to identify high-risk populations, assess and improve health policies, and offer services for preventing diseases. In the past, I have worked as an internship-student in King Faisal Specialist Hospital and Research Centre, Riyadh (SA). This hospital offers high-intensity care across all clinical specialities. The major reason why I selected this topic is due to my previous experiences during the internship, when I witnessed women struggling to cope with the trauma caused by violence, and feeling uncomfortable or afraid to disclose their condition. The attitudes of nurses to DV is usually supportive and sympathetic, but they tend to lack the specific skills and knowledge necessary to discuss and identify key issues with their patients. In my view, nurses must have a stronger role in minimising the effects of violence on the well-being of women. My clinical experiences made me realise the importance of assessing women adequately on admission to hospital and after discharge, and provided me with first-hand knowledge of this.

While this study focuses specifically on DVA and IPV in the Saudi context, this topic is not currently part of the curriculum for nursing education in SA. I attempted to locate resources to back up my DVA knowledge, and whilst there is a vast body of literature and evidence on the subject, there are scant resources on Saudi Arabia to support the role, views, and understanding of nurses in addressing such issues to safeguard female patients. Nurses are the first point of contact for women in a healthcare environment; hence, it is essential to acquire an enhanced understanding of abuse against Saudi women. This includes a clearer understanding of district nurses' perspectives, role, the barriers they face, and other factors that could influence their practices. Therefore, I believe it is extremely important to initially examine nurses' experiences with/ understanding of DVA.

1.7. Significance of the Study

DVA poses a huge risk to social and economic development, as reported in the United Nations Millennium Declaration of September 2000, in which the UN General Assembly pledged to tackle all types of violence against women by enacting The UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (2017). DVA is a global problem that is a primary cause of poor health in women, recognized as an area ripe for progress. It is highly unlikely that any country will accomplish their Sustainable Development Goals (SDGs) without directly combating DVA (García-Moreno et al., 2005; Futures Without Violence, 2017). SDG Target 5.2 seeks to eliminate all forms of violence against women and girls, whereas the SDG Target 5.3 is aimed at eliminating all harmful practices, such as child, early, and forced marriage; and female genital mutilation. Furthermore, the SDG Target 16.1 is set to significantly reduce all forms of violence and related death rates everywhere, while SDG Target 16.2 aims to end abuse, exploitation, trafficking, and all forms of violence against children (García-Morenoa and Amina, 2016).

Internationally, DVA is constantly lowly prioritized in terms of planning, programming, and budgeting (García-Moreno et al., 2005). Approximately 40-70% of female murder victims worldwide are killed by their intimate partners. Although DV exists in every country, WHO (2014) conducted a global study and found that DV rates ranged from 15% in Japan to 71% in rural Ethiopia, confirming the widely different prevalence between countries, which suggests a significant role of prevailing cultural constructions of gender roles (USAID, 2010; Futures Without Violence, 2014). Approximately 2 million women are injured through DV annually, and 84% of women suffer spousal abuse. Undeniably, women of all ages remain at massive risk of DVA (USAID, 2010).

As mentioned previously, nurses are in the optimum position to be the first point of contact for female victims of abuse (Guruge, 2012; Cho, Cha and Yoo, 2015; McGarry and Nairn, 2015). Many victims of DVA go to hospital for medical attention relating to physical abuse they have suffered; in fact, in comparison to patients with no DVA background, female abuse victims are 50% more likely to avail of emergency department services, and 14-21% are

more likely to have had primary and speciality care visits (Davila, Mendias and Juneau, 2013). Typically, 84% of female victims will tell someone about their abuse (usually a friend or family member), and 21% will divulge to a nurse or doctor (Breiding, Chen and Black, 2014). This indicates the necessity for nurses to intervene, screen, assess and refer for DVA, to catch cases and help victims get to safety. All of this emphasizes the importance of healthcare providers, counselling, and preventative services in combatting DVA.

Existing literature signifies that nurses at all levels lack adequate knowledge and experience to effectively deal with DVA victims (Schoening, Greenwood, McNichols et al., 2004; Inoue and Armitage, 2006; Guruge, 2012; Cho, Cha and Yoo, 2015). Many sources stress the necessity to improve the awareness, knowledge, attitudes, education, and training in this area, to facilitate effective interventions and ensure that nurses have the confidence to manage such cases (Beynon, Gutmanis, Tutty et al., 2012; Al-Natour, Gillespie, Felblinger et al., 2014; Cho, Cha and Yoo, 2015; American Association of College of Nursing, 2016). Registered or specialist nurses should be capable of supporting and protecting their patients, and in conjunction with the wider community, their behaviour should gain public trust whilst improving and maintaining their professional practices (NMC, 2015).

SA has its own unique culture, traditions, and systems of belief, which is the backdrop for this study. A hermeneutic interpretive methodology is employed to analyse feedback from respondents to ascertain the experiences, practices that nurses and student nurses in community health nursing hold. This Ph.D. DVA study is the first of its kind in SA to utilize this methodology, and it can contribute to nursing educational practices and detect any relevant gaps in the care provided. Ultimately, the rate of DVA must be decreased, and this can potentially be achieved via effective prevention-centric education to influence public opinion.

Undeniably, DVA is a predominant social issue. Examining the ability of nurses to tackle it can highlight areas requiring enhancement, improve screening efficiency and communication, and offer better interventions to female victims. Hence, it is essential to assess the nurses' attitudes to incorporate the

appropriate material into nursing education, and to equip student nurses with more effective and appropriate knowledge and skills in this field.

1.8. Saudi Context

1.8.1. Saudi Arabia: Facts and Figures

With a land area of 2,149,690 km^2, the Kingdom of Saudi Arabia spans the majority of the Arabian Peninsula, with the Arabian Gulf to the East, and the Red Sea to the West. It shares land borders with the Iraq, Jordan, Kuwait, Oman, Qatar, United Arab Emirates, and Yemen (Appendix 1). The country's population boomed during the mid-twentieth century, with increasing life expectancy and high birth rates. While birth rates are now falling, they remain relatively high, and the country has an annual population growth rate of approximately 3.19%, with 4.3 births/ woman (Brown and Busman, 2003; Ministry of Health [MoH], 2011). In 2010, the estimated population was 27,136,977, and it is expected that the population will reach 36 million by the year 2020. The indigenous Saudi population is predominantly of Arab ethnicity, with a 10% naturalized population originally of African and other Asian ethnicity, and 37% of the population are temporary foreign workers (Index Mundi, 2018).

SA is among the group of the 20 leading global economies (G20), with a gross domestic product (GDP) of about USD 650 billion (Allmnakrah and Evers, 2019). The Saudi economy is heavily reliant on oil exports, which peaked in 1970. Saudi Arabia is by far the biggest oil exporter in the world. Oil accounts for up to 90% of its exports, and contributes approximately 75% of government revenue (Aarts and Nonneman, 2005). Almost half (45%) of GDP is from the oil industry, with the remainder coming from the private sector (Dincer, Hussain and Al-Zaharnah, 2004). Long-term economic growth plans were secured when the state acceded to the World Trade Organization (WTO) in 2005, which facilitated foreign investment in the economy (Aarts and Nonneman, 2005). According to the Central Intelligence Agency (CIA, 2016), the total population of Saudi Arabia was estimated to be 28,160,273 (as of July 2016). Table 1 shows the age structure of Saudi Arabia population concerning different genders.

Table 1: Age structure of Saudi population by gender

Age Group (yrs.)	Total Percentage (2018 est.)	Male	Female
0-14	25.74%	4,348,227	4,170,944
15-24	15.58%	2,707,229	2,447,519
25-54	49.88%	9,951,080	6,554,525
55-64	5.48%	1,112,743	700,553
65+	3.32%	586,606	511,687

Source: Index Mundi (2018)

1.8.2. The Saudi Healthcare System

Saudi Arabia began to have tentative modern healthcare services during the early 20th century, and in 1954 the MoH was established, enabling all citizens to receive free public healthcare services (Albejaidi, 2010). The MoH is the major healthcare service provider, and the majority of the population acquire their healthcare through its facilities. The MoH provides approximately 60% of healthcare services in SA, with a further 20% being provided by other government agencies, and the remaining 20% being provided by private sector organizations. The MoH offers its healthcare services at primary, secondary, and tertiary levels (Almalki, FitzGerald and Clark, 2011).

Saudi culture and mores are upheld in the nations' healthcare system; however, gender issues are an ongoing problem. The genders are separated in numerous ways; for instance, female nurses are usually preferred for female patients, and the majority of women will not accept male healthcare providers. Furthermore, in hospitals, females are admitted to female-only wards with female nurses, but the physicians could be either male or female (Alboliteeh, Magarey and Wiechula, 2017).

1.8.3. Nursing Education System

1.8.3.1 History of Nursing in SA

In SA, nursing has its roots in the early Islamic era when the Prophet Mohammad's female companions provided nursing on the battlefield. The earliest mention of a nurse in the early Islamic period is of Rufaida Al-Asalmiya who looked after injured soldiers, had a clinic to look after the general

population, and educated Muslim women to become nurses (Almalki et al., 2011). After the war, during peacetime, nurses began working as midwifes and cared for the dying and ill. They conducted basic procedures and provided emotional support and physical relief. It could be regarded as an early form of nursing where volunteers were taught through observation combined with practical training.

1.8.3.2 Nursing Education in SA

1948-1976

In SA since 1948, nursing has undergone numerous transformation and the profession is still in the phase of development. The Arabian-American Oil Company initiative led to the emergence of nursing education in 1948 with the launch of diploma program in nursing for males (Aljohani, 2020). However, the male dominance at the time led to the graduation of 256 Saudi and American male nurses for the company. Then, in 1958, the first formal nursing training was established in Riyadh's healthcare facility as a collaborative efforts between SA MoH and WHO for training of 15 male students for a year who had completed 6 years of elementary school.

After the success of this program, in 1962 two Health Institute Programmes were further established in the capital city Riyadh and in Jeddah. These institutes enrolled females for a one-year training program and they graduated as Nurse Aides (Almadani, 2017). The MoH then gradually established more institutes in various cities and extended the one-year program to three years. Also, then students with 9 years of secondary school preparation were recruited (Almadani, 2017)..

1976-1987

The MoHE took an important step in 1976 towards professionalizing nursing education by initiating the first bachelors of Science degree in nursing (BSN) in Riyadh. BSN was a 5 year program, with English as the teaching language and focus was on theory as well as practice. The program also offered incentives in the form of free text books, uniform and monthly allowance (Almadani, 2017). Subsequently BSN programmes were initiated at two more

institutes (King Abdulaziz University in Jeddah and King Faisal University in Dammam) in 1977 and 1987 respectively. With the passage of time and increase in population, the number of high school graduates increased and there were only limited institutes offering bachelors in health education particularly BSN. This called for a strict entry criteria for recruiting students in the programmes. However, more than 10 years after the establishment of these programs, only 117 female students had graduated from the mentioned three universities. This point towards the negative image that nursing held in SA (Almadani, 2017)..

1987-1992

During this period low participation of women was seen in nursing owing to the image that nursing had in SA. To address the situation, in 1987, King Saud University in Riyadh announced a master of science in nursing program to engage more women to pursue nursing as a career. With the passage of time 33 institutes had been established by 1990. Out of 30, 17 offered nursing education programmes for females and 16 for males (Almadani, 2017).. Progressively more health institutes were established in different cities that offered specialized facilities including pharmacies, laboratories, x-ray facility and nursing. The duration was of two years and language of teaching adopted was Arabic. To encourage more students to enter nursing profession incentives were provided. However, this period also marks the difference in the aim of MOHE and MOH where the MOHE was focused on improving the image of nursing while MoH focused on tacking the nursing shortage in the SA (Almadani, 2017)..

1992-2011

The criteria for recruiting in junior health colleges was upgraded to 12 years of education in 1992. During this period MoH was operating nursing education at two levels, one from the junior college and the other from the health institutes. This gave rise to establishment of 18 health institutes for males and 26 for females. A PhD scholarship Programme was introduced in 1996 where the Saudi nurse leaders and educators were provided importunity to study abroad (Tumulty, 2001) (Almadani, 2017) (Al-Shehri, 2013).

Furthermore, in 2008, Diploma programs in nursing offered through government shifted from MoH to MoHE and in 2010, the nursing diploma began to close and the criteria for entering in nursing practice changed to BSN (Lamadah and Sayed, 2014) (MoH, 2017).

The diverse nursing educational systems also created an overlap and confusion regarding job descriptions at different levels. Involvement of several providers in nursing education and lack of unified curriculum along with absence of regulatory bodies resulted in unsteady growth in the field (Aljohani, 2020). The lack of nursing leaders and reliable nursing workforce data in the past few years led to stunted maturity and lack of growth in the Saudi nursing field compared to the international nursing trends.

1.8.3.3 Male's involvement in Nursing

During 2006–2020, numerous universities started male nursing programs at both graduate and postgraduate levels. However, s nursing is regarded as a "female" profession, any Saudi men who chose nursing were criticised socially. In Saudi society, nurses are considered overemotional, uneducated, manual labourers, while nursing care is considered "dirty work" that foreigners should do. Opposite sexes mixing in the workplace is also prohibited by Saudi law as it "promotes immorality" (Al-Mahmoud, Mullen and Spurgeon, 2012). Cultural issues also restrict male students from receiving their training in the maternity unit or delivery room, making it more difficult for nursing schools to ensure that students receive advanced simulation laboratories for training male students.

On the other hand, no evidence shows that, for future nursing students, nursing schools must introduce gender quotas. The Saudi Commission for Health Specialties (SCFHS) report stated that, presently, nursing programs have 13,001 female and 4,084 male students enrolled. This report fails to specify the healthcare system's requirements, particularly regarding gender.

1.8.3.4 The current status of Nursing Education in SA

SA has two nursing bachelor programmes: the standard four-year nursing programme with a one-year internship and a two-year programme with six-month internship offered to nursing students with a diploma (Aljohani, 2020).

The latter programme was launched in September 2012 and led to diploma holders obtaining a bachelor's degree in their specialization field. This programme is applied by 18 government universities in SA (MoH, 2017). In terms of Bachelor's Programs in Nursing in SA, nursing education regulations have two pathways: the regular nursing program (RNP) and the bridging nursing program (BNP). RNP involves four years of academic study and one-year internship. The BNP is a two-year program with a six-month internship and is for registered nurses with a diploma. The National Commission for Academic Accreditation and Assessment (NCAAA), founded in 2004, oversees the bachelor's programs under the MoE governance (Aljohani, 2020).

1.8.3.5 Overview of the Nursing CurriculumThe first RNP year has two semesters where students learn the English language, communication, and general science courses. These courses are necessary for a bachelor's degree in nursing. The first year involves basic sciences courses; second year includes the core semester that is mandatory to undertake, the third and fourth years include nursing related subjects such as growth and development, pharmacology, nutrition, and microbiology. The necessary nursing courses include Nursing Concepts, Medical-Surgical Nursing, Foundations of Nursing, Psychiatric/Mental Health Nursing, Community/Primary Care Nursing, and Maternal- Child Health Nursing. Clinical practice takes place at the University Hospital and certain community hospitals, overseen by a nursing professor.A professional elective is also needed where the student selects from the clinical specialties in the last semester. Nursing management is one of the professional electives. The fifth year is an internship for improving nursing competence and helping develop self-confidence (Phillips, 1989).

1.8.3.6 Constituents of Internship

The university organises the internship and the internship training is provided by internship sites. Of the 52 weeks of internship training, there are four weeks of holidays, scheduled by the interns by coordinating with the clinical placement authorities. Nursing interns have rotations in different nursing departments such as intensive care, medical-surgical, emergency, maternity

(for female students only), and psychiatric, paediatric, and primary health care clinics. While male students cannot experience real practice in perinatal care, they are trained using high-fidelity simulation mannequins and equipment. Saudi universities typically implement a supervised practice internship model where a staff nurse supervises a student and the academic member works in liaison. To become eligible as a registered nurse, students must pass the Saudi Nursing Licensing exam either during or following their internship (Aljohani, 2020).

SA has different subspecialty nurses such as wound care, home healthcare, hematology, palliative care, and pain management. For specialist qualification, nurses have to complete the SCFHS 2-year diploma or certificate courses offered in various hospitals' training centres. However, these programs are not university-accredited. The number of advance practice Saudi nurses remains very limited and represents less than an estimated. (Alluhidan et al., 2020). Moreover, the current BSN syllabus does not include DVA as part of the education or practice, which must be the part of the nursing curriculum for increasing recognition and improving the care being provided to victims of violence (Stover and Lent, 2014). This explains the fact that no specialized training is therefore provided to support the DVA related theory and practice and hence there is also no domestic violence nurse specialist.

Another crucial concern with nursing is that there is no national nursing scope of practice, which is included in SCFHS' mandate. This is detrimental to nursing education development as it results in nursing schools implementing diverse international scopes, which can cause variations in learning outcomes. Moreover, it cannot be ensured that nursing graduates will practice their learning and training. These problems also affect Saudi nurses graduating from international nursing schools, such as advanced nursing practitioners who do not have a guidance regarding clear nursing practice regulations.

Nurses are generally taught to be empathetic when it comes to female victims of abuse and to offer effective care with no bias or stigma. Such nurses are crucial for caring for domestic violence victims because they are the first point of contact in the health services and can form strong, lasting bonds. Thus far,

however, little effort has been made in educating and training nurses in SA in this subject (Corbally, 2001; Bessette and Peterson, 2002; Herrera and Agoff, 2006).

1.8.4. Saudi Women and Culture

1.8.4.1. Family and marriage

The family is the core unit of all societies, albeit it takes different forms in different cultural contexts. Rooted in ancient tribal concepts, the extended family is certainly the most significant social institution in SA, and Saudis are extremely devoted to their family and self-identify with it above their country, ethnicity, or profession (Winter and Chevrier, 2008). In SA, personal and professional life are based on personal relationships between people; everything is based on an atmosphere of tribal patronage and personal favours, and the family-centric milieu shapes personal identity. Traditionally, the family unit has meant the extended family, however in recent decades; the nuclear family has become more of a focus due to increasing urbanization. Nevertheless, the family *per se* remains a core aspect of life and identity, and an underutilized resource with the potential to enhance Saudi healthcare delivery (Alabdulaziz and Cruz, 2020).

Families are male-led, with men making all major decisions, notwithstanding substantial transformations in Saudi society in a relatively fast time over recent years. Nevertheless, cultural norms dictate that men hold the power in both family and society. Tribal loyalties are generally respected, and socialization is centred on relationships and blood ties. Men are responsible for their families' income and security; hence, the expectation is that they will work to be adequate providers (Evason, 2019). However, women are increasingly enabled to establish businesses, make investments, and become property owners (Winter and Chevrier, 2008). There were never any legal restrictions to women establishing businesses, investing, and owning property in SA (as this would be contrary to sharia), although customary barriers and the guardianship system inhibited them from engaging in such economic activities and exercising their *de jure* sharia rights.

Polygamous marriage is legal in many Arabic and Islamic countries, including SA, where the legal status of unmarried, married, and widowed adult females is as wards of their male guardians (e.g. their fathers, brothers, husbands, and sons) (Westermarck, 2003). In the patriarchal and tribal society, women are often obliged or urged into marriages of convenience, and consanguineous marriages account for over 50% of all unions in SA. Although illegal under modern Saudi law and classical sharia, females under 16 might be forced to marry under tradition (Mobaraki and Sonderfeldt, 2010). Legally speaking women must be at least 18 to be married in SA, but the average of a woman at her first marriage is actually 25.

1.8.4.2. Patriarchal culture

SA society views women's primary roles as being wives and mothers. Whilst perceived acceptable Islamic behaviour is observable in all facets of society, women's roles are actually defined by tribal traditions, cultural norms, and local customs, iterated via the family structure (Yamani, 2000). As with much of Saudi culture, family and gender roles are rooted in the Bedouin culture of the indigenous people of the region, who remain an influential minority group. They hold the majority of judicial, religious, and National Guard positions in the country, and the government prioritises upholding their culture as a handle for preserving "national" values.

SA is also referred to as a "patriarchal belt" society, in which the law underpins the discrimination of women by heavily restricting their freedom. Both society and the law forbid women from becoming fully immersed in public life or the workforce. There is strict gender segregation, and the ideology of women's virtue as representative of the family honour is deeply entrenched. By controlling female family members, aided by intricate social conventions, men protect their family's honour by dominating women (Littrel and Bertsch, 2013). However, women who have held employment have fostered their own agency; rather than simply being a wife and mother, they participate in shaping their lives.

For instance, travelling abroad for higher education or actively pursuing employment has enabled increasing number of women to attain top-level

government positions that were once the sole domain of men. Notable instances of this include the appointment of 30 women to the consultative Shura Council, and 20 females winning municipal elections in 2015. In 2017, Princess Rima was appointed head of the Multi-Sport Federation, Fatima Baeshen was made a spokesperson for the Embassy of Saudi Arabia in Washington DC, Hind Al-Zahid was appointed the Executive Director of Dammam Airport, and Sarah Al Suhaimi was named head of the Saudi stock market (Al-Sudairy, 2017; Mustafa and Troudi, 2019).

1.8.4.3. Women's dress code

In many Muslim societies, veiling is common; however, it had always been enforced to an extreme degree in SA. As women's status has transformed, many have begun to resist it, and there are signs that enforcement is less stringent. In modern SA, many women still wear the *abaya* and hijab (black dress and head covering), but some no longer wear the niqab (face veil) (Quamar, 2016). Laws have recently changed to state that both citizens and tourists (female or male) should simply dress conservatively and decently (Al Arabiya, 2019).

1.8.4.4. Legal reforms

In 2019, women's rights in SA were dramatically reformed in a raft of laws referring to their business, status, and social conditions, after centuries of being heavily restricted compared to men, largely due to Saudi culture and some assertive religious dominance. The reforms caused SA to move up the rankings in the Forum's 2018 report, as the levels of educational achievements and equality in employment opportunities improved by 59%. Although SA was the last country to permit women to vote and stand in elections, this was rectified by King Abdullah bin Abdulaziz Al Saud in 2011, when he announced they could be appointed to the aforementioned Shura Council (in which they presently hold 30% of the positions), and take part in the 2015 municipal elections. Less than 20% of the workforce comprises of females, but the goal of Saudi Vision 2030 is to increase this to 30%, as discussed below. During King Salman's reign (since 2015), massive improvements have been made, including permitting women to drive alone in 2018, which had previously been

prohibited under the guardianship system (Lim, 2018). By the end of 2019, all genders over the age of 21 could travel without restriction, and women staying in tourist accommodation no longer required a *mahram*, which had been the case under the guardianship system (Aleqtisadiah Newspaper, 2018).

1.8.5. Saudi Vision 2030

Saudi Vision 2030 is a framework created by the Council of Economic Affairs and Development comprising 13 executive programmes and 96 strategic goals. It notes the importance of women to SA, highlighting that over half of all university graduates are female, and pledges to develop and invest in them. Increasing female participation in the labour market and drawing on the local female labour force will further establish women and foster economic growth. Undoubtedly, promoting female development and investing in women will assert their status in terms of decision-making positions and chains of command in their careers. Additionally, it will enable women to contribute to society and the economy. This is fundamental to both the National Transformation Program 2020 and Saudi Vision 2030 (Saudi Vision 2030, 2016).

1.8.5.1. Empowering women as key development partners under Saudi Vision 2030

There has been substantial progress socially, economically and politically in empowering women in SA. Education is being promoted, and women can now seek employment in numerous professions and be appointed to high-ranking positions, such as on the Shura Council. Furthermore, by 2030, the unemployment rate will have decreased from approximately 12% to 7% due to more women entering the workforce, which will have a positive effect on the nativist localization strategy, and will contribute to investing in, training, and qualifying individuals to meet the increasing demands of the Saudi market (Saudi Vision, 2030). Hence, Vision 2030 will enhance the status of females as citizens of the country. Consequently, women's agency will increase, and they will become more aware and determined to prevent DV, as they will no longer be dependent on men. Vision 2030 is in accordance with CEDAW (1993), which was ratified by SA in 2000. This guarantees gender equality in

line with the specifications of sharia. Prior to this, there were numerous types of gender inequality in the country, preventing women from being involved in politics or the economy, which were not in alignment with international or Islamic law, but which were merely tribal mores and cultural practices, such as the notorious and perplexing ban on women driving (Al-Rasheed, 2013). An interesting caveat is that women in rural regions have always typically driven, despite the generally stricter religious and cultural boundaries in such areas (Lim, 2018).

Saudi Vision 2030 was introduced in April 2016 and was positively received by many young citizens of SA, who considered it progress. It addressed significant socioeconomic areas, including healthcare, employment, the empowerment of women, and housing. To deal with internal issues such as inequality, vulnerability, and poverty, Saudi Vision 2030 and its associated programmes established several specific objectives, targets, and policies, including the management of female labour market issues, education and training incentives, and decreased social vulnerability. Furthermore, several bold programmes will be implemented that are highly focused on political integration, in a quest to achieve the Vision's goals and targets (Alsayyad and Nawar, 2017).

1.8.5.2. Healthcare transformation in Saudi Vision 2030

Healthcare in SA is presently undergoing a major transformation, which is largely attributable to population and economic growth, and patient-associated elements such as health awareness and disease prevalence. Saudi Vision 2030 recommends that improvements should be made to the standards of healthcare and education to meet national development requirements and international accreditation standards (Saudi Vision 2030, 2016). A primary objective of Saudi Vision 2030 is "Caring for our health", pursuant to which the health sector must raise the capacity of healthcare facilities and enhance the efficiency and effectiveness of the primary, secondary and, tertiary healthcare services offered (National Transformation Program 2020, 2015; Saudi Vision 2030, 2016).

Such huge changes will transform the structure and nature of the educational and healthcare systems in SA. Saudi Vision 2030 states the objective of having “an education that contributes to economic growth”; hence, there has been a shift towards an economy that is more knowledge-driven (Saudi Vision 2030, 2016). In 2018, more was spent on education and healthcare than any other sector by the government of SA (USD 192 billion), followed by the defence sector expenditure of USD 147 billion (Ministry of Finance, 2017). This is evidence of the commitment to realising Saudi Vision 2030’s socio-economic goals.

To accurately implement programmes, institutes of higher education must predict job market demand for various professions, which is also beneficial for students’ career decisions. The goal is to have at least five Saudi universities in the top 200 in the world by 2030. This has been accompanied by increasing privatization and international partnerships in the healthcare sector and the securing of related public and private partnerships (Saudi Vision 2030, 2016). Furthermore, innovative national healthcare programmes are being developed to foster interest in investment from international partners. This will contribute to the nativist employment strategy of Saudization (positively discriminating to promote employment of more Saudi nationals via quotas and fiscal penalties), with the healthcare sector having a particular dearth of Saudi nationals. Over 80% of all nurses in SA are expatriates, recruited from over 40 nations worldwide (Alsayed and West, 2019). Producing highly trained Saudi healthcare practitioners such as nurses would decrease over-dependence on foreigners; however, to accomplish this, nursing degree education standards must be implemented.

Another core component of Saudi Vision 2030 is expanding local industries, which will increase the production of healthcare products. The MoH and other bodies are collaborating to secure top global partners in numerous healthcare products, including medical and pharmaceutical supplies. This will appeal to domestic and international investors, thereby positively affecting the economy and implementing medical supply chain control, which safeguards an adequate basic medicine supply. The general strategic importance of this was highlighted in responsiveness to the COVID-19 pandemic in 2020, when many

healthcare systems had unacceptable shortages of personal protective equipment (PPE) and other resources for healthcare workers.

Saudi Vision 2030 demands government intervention to improve the healthcare sector in several areas, including information technology and digital transformation. It also requires a robust IT primary care infrastructure and greater accessibility to public health services that manage the major health issues, such as obesity and smoking. Additionally, emergency and urgent care departments require upgraded services before hospital admittance. Each of these measures is designed to enhance the QoL for citizens of SA whilst also decreasing the pressure on acute care facilities (Al-Dossary, 2018). Based on the above, Saudi Vision 2030 has opened a more panoramic scope for healthcare services in SA which can for the first time address hospital policies for nurses regarding DVA. In the context of education, this will entail developing a core syllabus for speciality nurses (e.g. DV and forensic nurses), and highlighting the functions and pivotal roles of nursing in multidisciplinary healthcare teams.

1.9. Religion, Culture, and Domestic Violence in Saudi Arabia

This section illustrates the status of women in Islam and provides an overview of the role of law, cultural, and patriarchal challenges faced by women in Saudi Arabia, particularly the guardianship system and Saudi law. This enables a fuller understanding of the Saudi context and the particular phenomena related to DVA in SA.

1.9.1. Islamic Context and Women

The Islamic religion was revolutionary in the comprehensive rights it accorded women 14 centuries ago, many of which would only be achieved in Western Europe by the 19th century, such as rights concerning inheritance, property investments, and other financial rights. It also emphasized and indeed mandated that women seek knowledge, promoting women's educational development as well as marriage and the right to have children, and the ability to contribute fully to society (Akhmetova, 2015). The privileges of females under Islam protected all parts of females' lives and secures their rights from the moment of birth. These rights specify that women and men are equal and

should be given equal discipline and reward. Women have additional rights inside their families, as well as in relational unions. Islamic law elevated the status of women and their sense of pride and self-worth. The Quran outlines women's rights, for example, in *Surah Al-Nisa* ("the Women"), one of the chapters of the Holy Quran.

Islam axiomatically prohibits discrimination on the basis of sex, colour, and ethnicity. The Prophet Mohammad (ﷺ) expressed:

> "All individuals are equivalent, as equivalent as the teeth of a comb. There is no claim of the value of an Arab over a non-Arab, or of a white over a black individual, or of a male over a female. Just God-fearing people give a good reason for a desire with God". (Az-Zubaidi, 1994)

God sees equality as being the most important precondition of the activities of the human race, and people should be treated equally regardless their colour, gender, and race (Muhammad, 1995). However, the *de jure* vision of Islamic egalitarianism and justice has been manifest with varying degrees of success and failure in fallible human communities and polities throughout history and in the present day, including its diverse interpretations and implementations in "Islamic" countries with very different cultures, such as Iran, Jordan, Morocco, Oman, Pakistan, and SA.

1.9.2. Religion, Culture, Law, and Domestic Violence in Saudi Arabia

Islamic law enjoins Muslims to show good manners and compassion. However, Saudi society, like most cultures, suffers from the existence of the phenomenon of violence that undermines the family unit and its foundations. Al-Badayneh (2012) noted that social and cultural customs influence DV; patriarchy, controlling conduct, and taboos all shape the Saudi context, such as women tolerating DV. Delays in reporting DVA, ongoing physical and psychological abuse, and sexual abuse were found in a cross-sectional study by Wali et al. (2020), with a convenience sample of 1845 respondents recruited to estimate the prevalence and risk factors of DVA in one city in SA. The results indicated that 97.2% of all abuse victims did not pursue help, potentially due to unawareness of the existence of assistance, as well as patriarchal

acceptance of abuse, or fear of disgrace in a conservative context. Thus, awareness should be improved and taboos challenged.

Numerous reasons exist for the perpetration and vulnerability of DVA, such as individual characteristics or cultural norms; the latter may shape social relationships. Individuals at the extreme poles of Saudi Arabia's socio-economic strata were most concerned with female honour according to Ghazal and Cohen (2002), typically suggesting that its transgression was the worst shame, rejecting female freedom and linking the honour of families (particularly of husbands and fathers) to their womenfolk's chastity. As Aldosari (2017) observed, DVA may be normalized as a conflict resolution and control mechanism for husbands faced with psycho-social stressors relating to interactions with women. In the modern Saudi context, 'protecting women's honour' is likely an umbrella concept for avoiding the total degeneration and anomie of Saudi society, feared due to the fast pace of irresistible globalization and the alienation of modernity (Smith, 1995).

Domestic violence remains common in Saudi Arabia and men often view violence as the solution to women's "misconduct" in the domestic sphere, which might include engaging in an alleged relationship with a man, leaving the house without male permission, or generally disrespecting male authority (Almosaed, 2004). Alsuwaida (2016) highlights that limiting women to the domestic environment and controlling them more broadly can be attributed to Saudi Arabia's patriarchal customs. One issue exacerbating DVA is when patriarchal cultural norms are given precedence over religious stipulations in Islamic jurisprudence (Al-Hibri, 2001). The Saudi community places strong pressure on individuals to protect their reputations, and awareness of community approbation is at the centre of most Saudis' self-identity and their decision-making processes about their own actions.

This includes *gheera* (protective modesty), which is seen as a praiseworthy quality whereby men exhibit jealous protection of the honour of womenfolk. This is widely associated with *crime passionel* and honour killings throughout the Arab and Muslim world. Islamic law openly prohibits such murders, which themselves traditionally carry the death penalty, but they are widely approved

and seen as socially conservative by many populist interpretations of modesty and the need to preserve "traditional values". Similarly, women tend to be singled out for such vigilante murders, while men are at least equally responsible for fornication, according to traditional jurisprudence (Evason, 2019). al-Hibri (1997) observed that individual interpretation (*ijtihad*) by Muslim jurists can often narrow the possible scope of sharia interpretations, unjustly confining women to the domestic sphere, purportedly to safeguard societal and female morality (Othman, 2006). The disputed understandings of faith, ambiguous interpretations of some Islamic principles (guardianship system), and Saudi Islamic law were explained below.

1.10. Guardianship System and Saudi Law

As per the Saudi constitution, national law comprises sharia, based on the Islamic sources of the Quran and Sunnah (van-Eijk, 2010). The legal system is thus based entirely on sharia law, interpreted by legal experts led by the Grand Mufti, who issue fatwas in response to particular issues and issue rulings in sharia court cases. Fatwas play a critical role in judicial practice, and although individual judges are theoretically free to apply their legal reasoning by interpreting the Quran and Sunnah, they typically follow approved national fatwas (van-Eijk, 2010). However, according to Vogel (2000), it is difficult to predict legal interpretations in Saudi Arabia, even in almost identical cases, because judges may use their own personal interpretation of the law.

This lack of uniformity in SA's legal and judicial processes is considered detrimental to women's rights and can also affect many areas of everyday life. Women's rights and gender equality are a challenging issue in Saudi Arabia, and those who campaign for progress on these issues are frequently met with hostility from both Islamic and legal actors, as well as from conservative members of the general public. Gender equality and women's rights advocates are frequently branded un-Islamic and pro-Westernization (Tønnessen, 2016).

Certain religious scholars are considered more open to reform than others, although few could be considered liberal in their attitudes to women's rights. The legal restrictions placed on women are frequently based on individual interpretations of the Quran and Sunnah; which are particularly notable in

personal status law, the latter of which regulates marriage, divorce, and child custody. One of the most notable examples of personal status law is the male guardianship system (Bier, 2011), an Islamic concept whereby the *wali* (guardian) provides assistance, health, happiness, and support to the people under his responsibility (a vulnerable group in the community), such as his *mahrams* (literally "people related by the womb", whom a Muslim cannot marry, such as his sisters, mother, daughters, and nieces) (Musawah, 2018).

Islam has specific requirements for this role for specific needs, such as a *wali* entrusted with the protection of an orphan child until he or she reaches adulthood; it should be noted while in general usage a *wali* is usually male, this is not always the case, and a woman can be a *wali* for her children. "*Mahram*" is commonly used to refer to a male relative who should chaperone a travelling woman. As discussed later in this thesis, some men misuse this role and use it to control or abuse women, using religion to justify the abuse of women in antithesis to the actual injunctions of Islam.

Mahrams or *walis* can restrict women's movements, subordinating them to their male guardians, whether this is their father, brother, husband, or son. Meanwhile, sexual violence falls between the guardianship law and criminal law. The notion that a wife must obey her husband negates the concept of marital rape or wife beating, while other forms of rape and sexual violence are covered by criminal law. These issues make the progression of women's rights an enduringly difficult issue in SA (Tønnessen, 2016). The *mahram* concept underpins the notion of women's obedience and prevents women from reporting violence to the police without permission, thus directly inhibiting the reporting of marital rape and domestic violence. The male guardianship system means that a woman needs the permission of her male guardian to work, travel, gain education or participate in politics, which covers women's rights in both the private and public domains, and Saudi women must seek permission from their husbands or father to undergo medical procedures (Tønnessen, 2016; Al-Amoudi, 2012; Musawah, 2018).

The *mahram* system in SA is ontologically based on the idea that there are fundamental biological differences between men and women whereby the

latter are too emotional and fragile to make their own decisions. The obedience aspect relies on verse 34 of *Surah an-Nisa* in the Quran, which uses the word "*qawwamun*" to describe the man, which some religious scholars have interpreted as meaning "male guardian". In contrast, Islamic feminists interpret the word as meaning "breadwinner", which gives a different interpretation and suggests caring for a woman financially, rather than giving men almost complete control over women's lives. This system means that women are likely to be charged for disobeying their guardian if they report them for abuse, so it can be seen that the *mahram* system puts Saudi women in a precarious legal position. Despite this, Saudi Arabia is modernising, and recent changes to the position of male guardianship and the permission for women to drive are two recent examples of this. Moreover, Saudi women are not powerless, and women's rights activism is increasingly prevalent across the country, with women at the forefront of negotiating for change by using Islamic religion to protect their rights (Tønnessen, 2016).

The guardianship system affects women's ability to seek healthcare and/or refuge or call helplines. It also is extremely difficult for victims to seek protection or obtain legal redress. Human Rights Watch research has found that women occasionally struggle to report an accident to the police, access social services, or access the courts without a male relative. Women who try to flee an abusive husband or family are arrested and returned to their families. If they flee or are referred to shelters, they are not allowed to leave unless they reconcile with family members or accept an arranged marriage. The shelters and the authorities do not facilitate women's ability to live independently. On the other hand, a 2014 law on medical ethics prepared by a government institution stipulated that a woman's consent must be sufficient to obtain health care. However, in reality, the requirement to obtain a guardian's permission depends on the hospital's internal regulations (Human Rights Watch, 2019). King Salman is leading a wave of reforms, and in April 2017 he ordered all government agencies to allow women to access any government service without a male guardian's consent.

One issue exacerbating DVA is oftentimes when patriarchal cultural norms are given precedence over religious stipulations in Islamic jurisprudence (Al-Hibri,

2001). The most egregious outcomes of this are seen in *gheera*-related honour violence, as discussed previously (al-Hibri, 1997; Evason, 2019), but even formal legal institutions can impinge on women's rights by adopting rigid and inflexibly interpretations (*ijtihad*) (Othman, 2006). Recently, there has been a clear effort from the government to re-interpret the elements of religion that have been used to justify violence. It is worth noting that in October 2017, the King ordered the establishment of the Complex of the Custodian of the Two Holy Mosques, King Salman bin Abdulaziz Al-Saud, for the Prophetic Hadith, to oversee the interpretation of the hadith (Asharq Alawsat International and Arab News, 2017). Subsequently, several laws were modified and delegated to support women, including in relation to child custody and the role of male guardians over women:

- The country has allowed women to drive and travel alone without a male guardian's permission.
- Early marriage (under the age of 18 years) cannot take place except with the permission of a court.
- Mothers can now be the guardians of their children and make decisions about important matters such as healthcare, education, and financial affairs with their children's fathers, including equal rights with men in registering births.
- Both husband and wife have the right to request family registration with the Department of Civil Status. The law has been amended to: "In the implementation of this scheme, the head of the family shall be the father or mother of the children".
- Termination of government entities requiring women to obtain the permission of their guardian to receive government services provides equality between men and women, such as in the requirements for obtaining passports.
- Mothers have custody of children up to the age of 15 years after divorce, but if they remarry they may lose custody.
- The Labour Law prohibits discrimination against women in hiring or wages.

These measures represent important steps in SA's conservative society to move toward improving equality for women, whereby:

> "citizens are equal in the right to work without any discrimination based on sex, disability, age or any other form of discrimination, whether during the performance work or when hiring or advertising". (UNFPA, UNDP, UN Women, ESCWA, 2018)

Chapter 2
Literature Review

2.1. Introduction

This chapter presents a previously published literature review concerning the study topic (Alshammari et al., 2018), with an updated section that critically analyses more recent additions to the evidence. This chapter concludes with an “implications” section where the key issues and gaps from all the existing evidence are highlighted – demonstrating the need for the current study. An in-depth integrative literature review that underpinned this thesis was published in a peer-reviewed journal in 2018 prior to undertaking the empirical research. The literature review helped me to formulate and justify the research question (Alshammari et al., 2018). This integrative review was undertaken to determine present knowledge and practices related to DVA and identify the gaps in the literature. Through analysis and synthesis of independent studies in similar subject areas, it was possible to identify relevant themes and to find the beneficial impact on care quality being delivered to the victims of DVA, and possible gaps in current knowledge and practice. The original published review has now been updated by collecting data from a variety of databases and bibliographic searches conducted from 2017 to 2020, building upon previous empirical evidence.

2.2. Original Published Review

2.2.1 Introduction and Background

The review’s introduction discussed about the IPV and DVA, its effects on different aspects of the health and its existing prevalence among the two genders. Also it sheds light on the role of nurses in the health care and explained how nurses are incompetent while dealing with abuse women victims. The review highlighted that nurses can work on the forefront to reduce the incidence of abuse however, their inability to address it raise concerns at various levels including nursing education and curriculum, training and presence of appropriately documented national and organizational policies. The review was undertaken to influence the future research and nursing

education as well as practice by identifying existing gaps in provision of care to women victims.

The background of the review deliberated the fundamental aspects in the form of nursing assessment. This section also highlighted that despite the endorsement of screening by various professional bodies, still nurses feel hesitant in undertaking it in actual routine in clinical settings. Moreover, the barriers that were probably the reason behind the hesitancy were also explored. Furthermore, the acknowledgement was made where nursing education and training were seen as the most prominent aspect of the DVA care provision.

2.2.1.1 Research Problem Identification and study aim

The Integrative review process begins with clearly identifying a problem from a gap in the literature. The concepts of interest related to the research problem need to be clearly defined. The development of the background and significance for the research problem provide justification for why the review is necessary or what is commonly referred to as the "so what" factor (relevance). Through the literature search the existing gaps came to light which helped in understanding the research problem, the variable of interest and the way forward. In light of the evidence, the review aimed to explore previous literature related to nurses understanding with regard to IPV/DVA against women and to identify the gaps in nursing education to use the findings as a baseline to inform potential intervention strategies, curriculum development in addition to outlining implications for future nursing practice.

2.2.1.2 Research Question

The formulation of research question was an important phase in the review and it was an iterative process. In order to develop one, the topic was defined and the literature was searched and reviewed to polish the topic. Also, the main components that were taken into account were the professional experience, educational background, personal interest, relevance, need and the existing gap that could be further addressed. Developing review question(s) and purpose is an interactive and inductive process that takes

place over time. It is critical that the review question and purpose are broad and well defined as it informs the search criteria and data collection procedures used in the review (Whittemore and Knafl 2005; Oermann and Hays 2016) The aim of this review was to synthesize and identify commonalities in the literature on the knowledge, attitude, perception and understanding of nurse students about domestic violence against women.

In order to refine the question, SPIDER framework was used. Based on the same principles as the PICO tool (Sample: Nurses and nurse's student; Phenomena of Interest: Domestic violence and/or Intimate Partner Violence against women; Design: Integrative Review; Research type: Evaluation) (Cooke, Smith and Booth, 2012). The framework helped in defining the study question which further helped in understanding the study.

2.2.2 **Methods**

2.2.2.1 **Study Design**

The study design considered appropriate to answer the research question was integrative review. The term integrative review is often used interchangeably with systematic review; however, there are distinct differences between them. The major differences are their purpose and scope, types of literature included, and time and resources needed to execute. An integrative review looks more broadly at a phenomenon of interest than a systematic review and allows for diverse research, which may contain theoretical and methodological literature to address the aim of the review. This approach supports a wide range of inquiry, such as defining concepts, reviewing theories, or analyzing methodological issues. Similar to the systematic review, it uses a systematic process to identify, analyze, appraise and synthesize all selected studies, but does not include statistical synthesis methods. Both integrative and systematic reviews follow systematic steps, including asking a review question(s); identifying all potential electronic databases and sources to search; developing an explicit search strategy; screening titles, abstracts, and articles based on inclusion and exclusion criteria; and abstracting data from selected literature in a standardized format. Both use critical appraisal methods to assess the

quality of each study, identify sources of bias, and synthesize data using transparent methods.

***2.2.2.2* Search methods**

Science direct, EBSCO host, PubMed Ovid Medline database and Social Science Index were the electronic databases that were searched to extract relevant studies. The search term included key word such as domestic violence/ Intimate partner violence combined with some other key terms such as "nurse", "abuse" "knowledge", "perception", "understanding" "integrative review", "education", "curriculum" and "women" and the phrases used included "nurses and domestic violence", "nurse education and domestic violence", "nurses training and domestic violence" and "relationship between nurses and abused women". Boolean connectors and truncation symbols "OR", "AND" were used to merge terms for focusing and broadening the search.

The inclusion and exclusion criteria to selecting relevant studies are provided in table 1.

Search Terms	'Nurse', 'battering', 'abuse' 'knowledge', 'perception', 'understanding' and 'women' and the phrases used included 'nurses and domestic violence', 'health care system and domestic violence', 'nurses training on domestic violence' and 'relationship between nurses and abused women'.
Databases	Science direct, EBSCO host, PubMed Ovid Medline database, and Social Science Index
Inclusion Criteria	1. Published papers written in English language 2. qualitative, quantitative and mixed method research studies 3. Articles published in last seventeen years January 2000 – January 2017 4. Articles focusing on nurses and nurse's student only (Excluding physicians and other health professionals) 5. Articles focusing on perception, understanding, attitude, knowledge, practice of nurses towards Domestic Violence against women only (Excluding men) 6. Articles focusing on curriculum, skills education, courses, training of nurses regarding DV against women

Table 1: Summary of integrative review databases, search terms, and inclusion criteria.

Studies fulfilling the eligibility criteria were included in the review. The review followed the title screening, followed by abstract screening. Studies who fulfilled the title and abstract criteria were screened for full text. Furthermore, the qualitative and quantitative studies were critically appraised for methodological quality using Joanna Briggs Institute (JBI) critical appraisal tool/Briggs institute checklist and mix method study using O'Cathain (2010) critical appraisal framework.

2.2.2.3 **Data abstraction**

In order to systematically break down relevant data into different components and to discuss how those related with each other, thematic analysis was conducted. for this the investigators read and accustomed themselves with the already collected data and evidence being examined. It was considered the most suitable approach because it is an aspect of moving closer to the extracted data and mounting even deeper appreciation of the content (Fink, 2010). Thematic analysis was done based on the content similarity in addition to patterns observed in the chosen articles.

2.2.2.4 **Data synthesis**

During data synthesis connections were established between the components identified during analysis. During this phase the investigators approached data as soon as it was assembled and synthesis was performed in a "step by step manner" to make the data more manageable. The final review yielded 17 studies including 8 quantitative studies, 2 mixed method studies and 7 qualitative studies. Moreover, themes were identified manually by the author. Figure 1 shows the schematic diagram of selection of included studies.

Schematic illustration of the selected studies

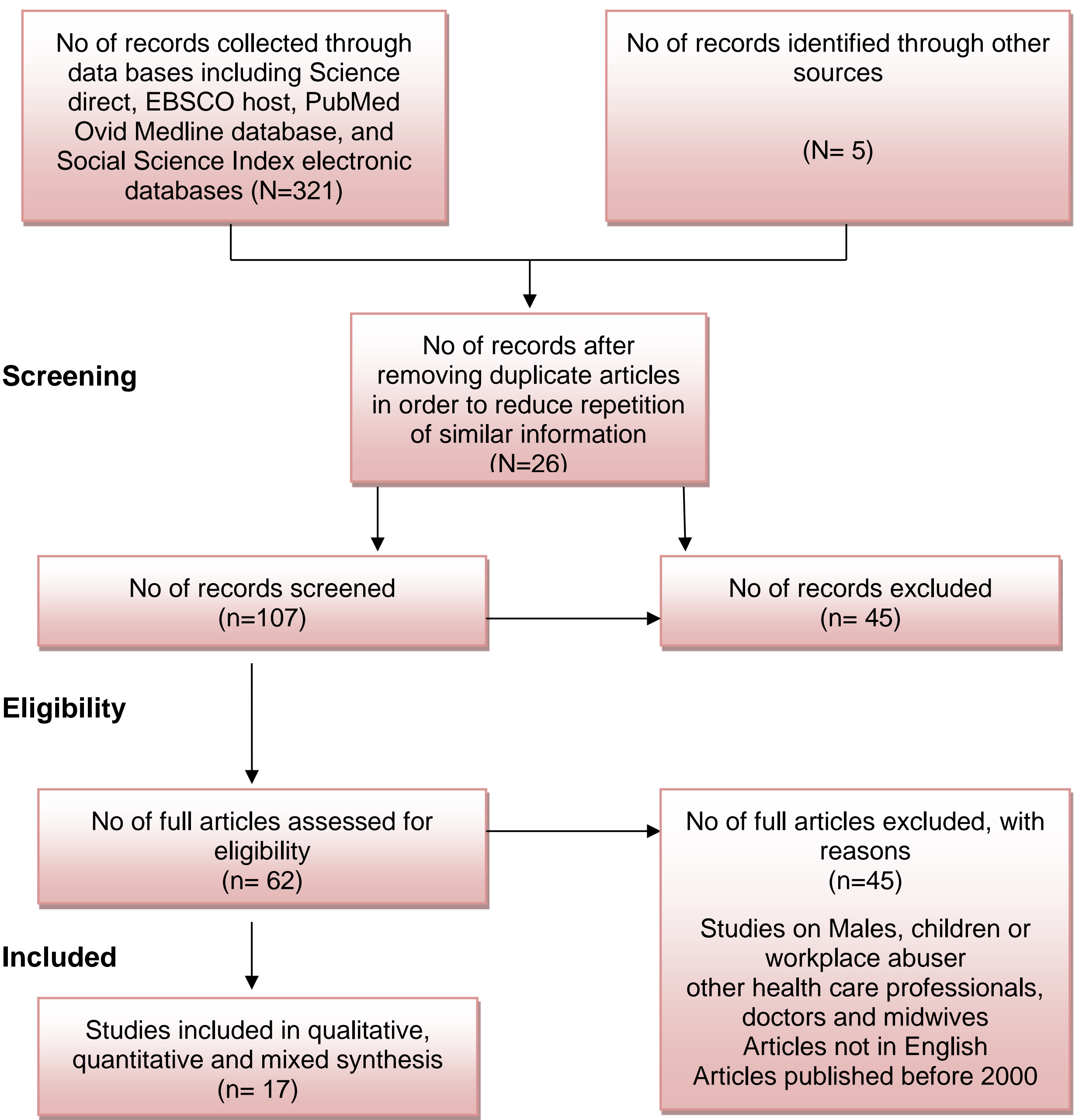

Figure 1: Schematic representation of the selection of studies for the integrative review of literature

2.2.3 RESULTS

Evaluation of those articles highlighted the limited body of evidence on nurse knowledge on IPV/DVA. The data were re-categorized as well as recorded as essential to fit under more suitable headings as well as eventually, the categorized data were aggregated into four themes: educational and training

experiences of nurses, identification of IPV/DVA, curriculum and communication skills of nurses.

2.2.3.1 Educational and training experiences of nurses

Participants in the majority of the studies demonstrated favorable attitudes towards the need of nurses for training and education on domestic violence during their undergraduate study (Bessette &Peterson, 2002; Cho, Cha, & Yoo, 2015; Glaister & Kesling, 2002; Guruge,2012; Inoue & Armitage, 2006; Schoening, Greenwood, McNichols, Heermann, & Agrawal, 2004). Nurses often need appropriate strategies as well as skills to respond to IPV/DVA to provide optimum care. Glaister and Kesling (2002) conducted a quantitative descriptive study with a random sample of 251 nurses indicating that DVA screening via routine inquiry is needed but should specifically be acquired by means of training and education along with guidelines development to aid the referral and identification in cases where domestic abuse is being disclosed. It is noteworthy for nurses to be aware that they are not required to be experts, however, they need to refer to some of the agencies. Multi-agency information sharing is crucial to ensure IPV/DVA, specifically, cases of repeated victimization are recorded so that it is possible to put care measures in place as well as conduct risk assessment. Schoening et al. (2004), undertook a quasi-experimental study to inspect the effects of educational program on nurse attitudes towards DVA. The research took place in an urban healthcare system and included a convenience sample of 52 nurses. The study aimed to investigate if a training support program (one or three hours education session), that mainly targeted the nurses to escalate the identification of women who have experienced DVA. The convenience sampling method is considered to be the weakest form of sampling approach and noticeably is not capable to represent the general population. The current knowledge of nurses were determined through scores identified from the “Public Health Nurses’ Response to Women Who Are Abused (PHNR)”, a standardized questionnaire that measures the reactions of nurses to IPV. Nurses expressed and supported the overall significance of education related to IPV/DVA for healthcare providers. A methodological strength of this study was the use of a pre-and post-test design that can efficiently examine the effects of the

educational intervention. Therefore, the nurses tend to lack domestic violence training and possessed limited knowledge, over and above were happy to get engaged with females experiencing IPV/DVA. Other studies such as Guruge (2012) in a qualitative interpretive descriptive study and Rigol-Cuadraet al. (2015) in a descriptive qualitative study focused on the training needs, desirable for the ongoing support of women who are living with a violent companion. Guruge (2012) recruited a convenience sample of 30 nurses so as to determine the intervention and screening practices, perceived educational requirements and knowledge of legal requirements about interpersonal violence. The results emphasized on an urgent need for a healthcare system to respond to the training needs and continuous education of nurses to undertake degree other than diploma programs.

2.2.3.2 **Identification of IPV/DVA**

The identification of girls and women who are subjected to IPV/DVA is considered to be a criterion for adequate care and treatments along with specialized referral to services. IPV/DVA identification in healthcare hospitals can be improved if women are inquired about it, whereas, it is safe and effective only if followed by a suitable response (Al-Natour, Gillespie, Felblinger, & Wang, 2014; Beccaria et al., 2013; Davidov, Nadorff, Jack, & Coben, 2012; Davila, 2006; Guruge, 2012; Schoening et al., 2004). This type of disclosure is relatively low to best predict the prevalence of IPV, while some studies indicate that in spite of training for universal screening, majority of the providers inquire about it selectively (Beccaria et al., 2013; Schoening et al., 2004). Studies indicate that nurses needs to be knowledgeable and trained sufficiently in a variety of ways to respond as well as be conscious about the physical health indicators related to IPV/DVA, together with inquiring about violence when observed (Bessette & Peterson, 2002).

Limited evidence reports about the universal screening policy. A qualitative focus group interviews conducted by Inoue and Armitage (2006) from 41 emergency nurses reported about the programs of screening showing limited evidence about the reductions in IPV/DVA, as well as health outcome

improvements. Furthermore, in countries or settings where prevalence of IPV/DVA is high and scare referral choices are found, maybe a universal enquiry bring around limited advantage for women along with overwhelming health professionals (Bryant & Spencer, 2002). Another study demonstrated that majority of women find queries regarding IPV/DVA tolerable (Schoening et al., 2004).Conversely, a study of 112 nurses, (between ages 19 and 35 years showed that they are less enthusiastic to carry out routine analysis or screening of women who are to be interrogated. Disclosure of DVA is more expected if females are inquired in a non judgmental or empathetic way, in an environment or may be private where confidentiality is to be protected and an individual feels safe. Nurses can be offered training on how and when to inquire, as well as how to offer a first line response comprising of support, patient's experience validation, empathetic listening, in line with a female's desire (Rigol-Cuadra et al., 2015). Hence, violence against women by their partners is an extremely stigmatized issue. Girls/ women often have realistic fears for their protection if they unveil the DVA, due to which some situations needs to be met. These circumstances indicates that women should be inquired about the issue safely, when the abusive partner is not there. The nurses are trained recurrently in how to respond and inquire while, the protocols, referral systems and standard operating procedures are in place.

2.2.3.3 **Curriculum**

Attitudes of nurses regarding domestic violence, IPV/DVA related curriculum and learning experience of nurse have been a subject of the studies reviewed (Dedavid da Rocha, Celeste Landerdahl, Ferreira Cortes, Becker Vieira, & de Mello Padoin, 2015; Duma, 2007; Rigol-Cuadra et al., 2015; Tambağ & Turan, 2015). The studies were mainly founded on the premise that an important approach for facilitating suitable care for women is via professional educational programs that prepares nurses who are skilled, knowledgeable and sensitive about the content linked to DVA. Moreover, it is urgently needed in any curriculum that prepares young nurses to practice. The studies principally focused on the possible impact of nurse feelings on the actions of nurses as well as questions the capability of a nurse to effectively intervene when some with a negative attitude forms the basis for the viewpoints of perpetrators and

survivors (Rigol-Cuadra et al., 2015). Woodtli (2001) conducted a qualitative study using interviews to elicit data that described and explored the nurses attitudes towards the perpetrators and survivors of DVA. An ecological Model for Health Promotion was used in the study as a valid holistic framework. A network sampling technique was used to recruit a purposive sample of 13 nurse participants. Ecological model for health promotion was used as a curricula framework for DVA linked to practice and education. The results suggest that nursing education should prepare the nurses with adequate skills and knowledge to intervene at different levels such as public, community, institutional, interpersonal and personal policy. The methodological strength of this study was the use of purposive sampling that mainly targets highly homogeneous sample and was therefore considered best to answer the proposed research question. Other studies Duma (2007) used descriptive qualitative case study and Dedavid da Rocha et al. (2015) used a descriptive exploratory qualitative research design to validate the relative significance of a certain topic that can be judged by its significance with regard to the basic curricula of nurse qualifying courses. Another study conducted by Rigol-Cuadra et al. (2015) and Duma (2007) provided several recommendations and suggestions regarding important curriculum content and necessary nursing skills proposed. However, these studies were qualitative and failed to draw on a rigourous scientific methodological genre such as ethnography and grounded theory etc.

2.2.3. 4 | Communication skills of Nurses

Communication skills of Nurses Beccaria et al. (2013) used a mixed method study design to survey 62 respondents and interview 27 nurse students. The study examined the understanding and perceptions of the undergraduate nurses towards DVA/IPV. Effective communication with women suffering IPV was also a statistically significant factor. The most required skill revealed by nurses was communication. The mixed method design used in the study included the benefits of both quantitative as well as qualitative approaches to research, often yielding better validity in the results. Conversely, Guruge (2012) conducted a qualitative interpretive descriptive design by recruiting a

convenience sample of 30 nurses from Sri Lanka. This study highlighted the barriers to offer care such as threats to patient safety, language barriers, lack of communication and association between different stakeholders in health care. Several limitations were found in this study that prevented the results from being generalizable. One included that the encounters with the women were not videotaped, which increased the likelihood of substantial non-verbal communication. Duma (2007) supported such an insight that women were more likely to disclose their DVA experience only, if staff used open ended queries and introduced the topic for probing further violence and by inquiring about the follow-up queries. This study also highlighted the need for an alternative clinical setting such as shelter for females suffering DVA.

2.2.4 | Implications for practice Education and research

The findings of this review shows significance for the nursing practice, as nursing staff caring for women suffering from DVA can be facilitated in developing a positive attitude towards the use of screening questions, better communication methods and advanced training during the course of their study. Nurses often have a duty of care towards their patients/clients, yet IPV/DVA is thought to be largely unreported or unasked, with many of the women going home with the DVA perpetrator. It is important to consider that nurses are professionals who are often involved with the care of patients, which may create a safe environment for a disclosure to happen. Hence, there lies a need for mandatory collaboration between secondary and primary health care along with trainings, liaising with some local agencies, to provide support to women who experience DVA. It is essential to include post-and pre-registration courses in nursing curriculum. Cooperative networking are required for establishing the multi-agency guidelines and trainings, all of which tends to influence the DVA identification. Referral channels and information sharing need to be established in secondary and primary sectors for providing assistance in this process. Training at multi-agency levels are needed to: raise awareness, identify, estimate risk levels, document as well as identify suitable intervention levels.

2.3 Updated Literature Review – New Studies

This section presents key characteristics and features of relevant papers published since 2017, which was the cut-off point for studies included in the original review (Alshammari et al., 2018). The characteristics and key findings of these more recent studies are presented in Appendix 8. An updated search using databases yielded 11 recently published research studies to explore practical issues that nurses may encounter when caring for females exposed to DVA. The 11 additional studies reviewed and critically appraised included both qualitative and quantitative primary research studies:

- 4 were cross-sectional studies (Gandhi et al., 2018; Sharma et al., 2018; Park et al., 2019; Alhalal, 2020) (the critical appraisal in Appendix 3).
- 5 were qualitative research studies, including focus group and interviews (Sundborg et al., 2017; Maquibar et al., 2018; Wath, 2019; Wyatt et al., 2019; Poreddi et al., 2020) (The critical appraisal in Appendix 2).
- 1 was a mixed-method study (Maquibar et al., 2019) (Appendix 5).
- 1 included RCTs (The critical appraisal in Appendix 6) and 1 observational quasi-experimental study (Sundborg et al., 2018) (The critical appraisal in Appendix 4).

Four of the studies were conducted in India, one in Saudi Arabia, one in South Africa, one in South Korea, two in Spain, two in Sweden, and one in the USA. The findings of the review of these more recent studies on the topic confirmed, expanded, and refined upon the themes identified in the published review. Both syntheses and their analyses were undertaken in detail, allowing knowledge accumulation on the topic addressed in this study. The results of this review suggest essential considerations for researching about the sensitive subject of DVA. The next section includes a brief summary of the studies reviewed along with the characteristics, drawing attention to novel aspects.

Collected evidences indicate that nurses during their education do not receive sufficient instructive training about DVA, in their advanced education curriculum, to permit them to deal with, recognize, and identify DVA in their

future specialized practice. Nurses usually lack confidence in responding to DVA, mainly due to limited training and educational experience, fear of offending, lack of effective interventions, and poor communication skills.

Study Characteristics

The themes generated followed the same four themes identified in my published review (Alshammari et al., 2018). The four themes were (1) Educational and Training Experience (2) Identification of DVA (3) Curriculum (4) Interviewing or communication skills

The papers were generally of high quality (included all). The strengths of the papers include its use of a wide range of methods and study designs, and covering several countries (both developed and developing countries). Therefore, the findings of these studies (educational and training experiences, identification of DVA, curriculum and communication skills of nurses) are applicable beyond their individual geographic locations where the studies were conducted (Gandhi et al., 2018; Sharma et al., 2018; Park et al., 2019; Alhalal, 2020,Sundborg et al., 2017; Maquibar et al., 2018; Wath, 2019; Wyatt et al., 2019; Poreddi et al., 2020, Maquibar et al., 2019, Sundborg et al., 2018, Poreddi et al. 2020). The major limitation in these studies is that none of them were conducted in a native, Saudi, nurses Muslim-dominated context where culture and way of life differ significantly. Consequently, this current study explores the issues of DV, using qualitative methods, in Saudi Arabia.

Emergent Themes

The more recent studies did not produce any new themes but added to the existing themes. Below, a table shows how the more recent studies contributed findings to the four themes:

Table 2: Common themes extracted from reviewed articles, 2017-2020

Study	Theme 1	Theme 2	Theme 3	Theme 4
	Educational and Training Experience	*Identification of DVA*	*Curriculum*	*Poor Interviewing/ Communication Skills*
Sharma et al. (2018)	✗		✗	
Gandhi et al. (2018)	✗	✗		
Maquibar et al. (2018)	✗		✗	✗
Maquibar et al. (2019)	✗		✗	
Wyatt et al. (2019)				
Alhalal (2020)	✗	✗		
Poreddi et al. (2020)	✗			
Poreddi et al. (2020)	✗		✗	
Wath (2019)		✗		
Sundborg et al. (2017)			✗	
Sundborg et al. (2018)	✗		✗	

The more recent studies did not produce any new themes but added to the existing themes. are elaborated above .

2.3. Implications of the Literature for Research Rationale and Aim

Overall, the reviews of evidence show that limited research has been published with respect to the nursing attitudes and practice towards domestic violence, therefore it is manifestly of interest to examine this concern in more

detail in many different care contexts. Further studies are needed to highlight the significance of education with respect to this topic, not just for nurses but for all professionals who encounter females exposed to violence. There is a need to further explore this concern deeply and to develop suitable training strategies for health professionals, and to incorporate relevant education and training in nursing curriculums.

Furthermore, such research may hold implications for design as well as training interventions along with relevant implementation to raise awareness and capacity with other sectors, for example the judicial system and social welfare departments. It is also significant to examine what the outcomes of diverse interventions and education for various types of service users. It is crucial to explore what types of intervention are required to modify deeply rooted attitudes toward DVA. There is a requirement to measure DVA myths among professionals who likely have contact with DVA victims. Additional research should explore the development of easy-to-use instruments to explore attitudes towards DVA, along with proposals on how to work for modifying unwanted misconceptions and attitudes towards DVA.

This PhD study mainly focuses on determining nurses' understanding, knowledge, and practices concerning DVA in SA, given that this topic is currently not a part of the national nursing curriculum. Therefore, relevant resources were located to back-up knowledge about DVA and to support the role, views, and understanding of nurses in SA. There is a need to understand the perspectives of district nurses, their roles, the barriers faced, and other factors that influence their daily practice. Therefore, I believe it is extremely significant to originally examine nurses' experiences concerning their understanding of DVA.

In Saudi Arabia, it is extremely hard for nurses to become proactive, as their own understanding is also shaped by traditional belief systems, and there are no readily available structures and policy to support their engagement with patients to provide holistic care in general. The nursing role is generally restricted to a physician-supportive role in biomedical task completion, which is the most fundamental barrier to the development of modern advanced

nursing practice in the country (Alghamdi and Urden, 2016). However, nurses are called upon to rapidly develop and advance their skills and the quality of services they provide.

With regard to DVA, the first necessary and urgent step is the provision of education to address understanding and to offer precise information about domestic violence and the roles of nurses to address it. The reviews show that there is inadequate evidence to scrutinize the competency of nurses in Saudi Arabia to deal with DVA and the ways through which the nurses' own beliefs and knowledge regarding DVA influence their behaviours in their engagement with culturally sensitive service users. Offering evidence about the practice, knowledge, and attitudes of nurses related to DVA will be useful for enacting obligatory reporting in the healthcare system, or developing or reforming policies to deal with the management and assessment of DVA.

Understanding nursing awareness as well as knowledge about DVA is also crucial for designing programmes manifesting evidence-based practice (EBP), which can emphasize preparing nurses across different clinical settings. Determining the degree to which nurses are familiar of DVA is essential to pave the way for future researches seeking to advance nursing care, and promote the wellbeing and safety of women, in addition to ultimately improving long-term clinical outcomes for women who suffer from DVA. The educational needs of nurses in SA are unknown or are not clearly described in this regard, despite research recommendations for educational and training experience needs and curriculum inclusion of DVA. Further studies are required to regulate effective approaches to DVA prevention among these groups.

The evidence has highlighted methodological issues with prevention and intervention assessments, such as a lack of analysis of appropriate programme length or curriculum, short follow-up, as well as limited comparison of different interventions. Some authors have noted the relative lack of DVA prevention work, specifically in the health sector. A spectrum of preventive measures can be identified from the literature, such as strengthening individual nurses' skills and knowledge, changing organizational practices, promoting community education, and influencing policy and legislation.

Accurate evidence regarding how often domestic abuse perpetration is identified, including the types and forms of abuse in nursing care is required. Experience, knowledge, and attitudes must be integrated with prevailing treatment and diagnostic models relevant to disclosure and the identification of domestic abuse in victims. This can shape how perpetrators are identified by nurses. Information on beliefs, attitudes, domestic abuse, and risks is often hard to quickly extract from patient records, which typically comprise basic biomedical history. Well-organized ways of information synthesis on risks are required, to facilitate greater information sharing among nurses and other healthcare professionals, and in interagency collaboration.

Gaps identified in relation to Saudi Arabia

The following are the salient gaps identified in the existing literature that this study seeks to address in relation to the study context of Saudi Arabia:

- DVA often goes unrecognized by nurses, who may find it hard to acknowledge or act on signs of DVA, being unclear about the effective and safe response to its victims.
- Interventions exploring sustained nursing clinical practice modifications regarding DVA are limited.
- Addressing and highlighting different contextual aspects may improve supportive nursing care practices for females experiencing DVA.
- There is very limited training and preparation of Saudi nurses to address and assess DVA.
- Understanding of nurses' educational needs concerning DVA is limited. Studying it further will be valuable for designing relevant educational programmes for nurses working in SA.

The reviews highlight that the phenomena of DVA has not been studied from the Saudi nursing perspective. Therefore, the goal of this study is to fill this gap and explore the understanding, experiences, and practices of nurses and student nurses about DVA. The review demonstrated that there is a dearth of literature using qualitative strategies to conduct research on DVA among nurses in Saudi Arabia. Hence, it is essential to commission suitable qualitative research to examine the broad spectrum of nurse experiences and attitudes

towards the same. A qualitative research approach is therefore important to obtain insights and develop new understandings of the phenomena DVA in the Saudi context from the perspective of Saudi nurses. Given the lack of both quantitative and qualitative research on the subject in SA, this study offers pioneering insights to help recognize the experiences of Saudi nurses endeavouring to provide quality nursing care to service users in their cultural and social contexts.

2.4. Research Question

What are the understandings, experiences, and practices of nurses and student nurses concerning DV against women within healthcare encounters in Saudi Arabia?

2.5. Aims and Objective

The aim of this study is to answer the research question (i.e. to identify the understandings, experiences, and practices of nurses and student nurses concerning DV against women in SA). This will be achieved by addressing the following research objectives:

- To investigate the understanding, experiences, and practices of nurses and student nurses about DVA
- To identify the barriers that may affect nurses in their subsequent professional practice.
- To identify the factors that may facilitate effective support and enhance nurse knowledge in the future.

Chapter 3
Methodology and Methods

This chapter provides a detailed account of the research design used in this study, and the underlying philosophical paradigm and methodology used to practically recruit participants, conduct ethical semi-structured interviews, and analyse data with reflexivity.

3.1. Methodology

3.1.1. Qualitative Research Design

To obtain profound insights and understanding about the topic, it was decided to use a qualitative research design, with the purpose of exploring ordinary occurrences as perceived by those involved (Weaver and Olson, 2006). A qualitative research design was chosen because the phenomena under investigation cannot be rigorously examined or measured in terms of quantity, intensity, or frequency. For instance, while quantitative methods could reveal the number of people that act a certain way, they cannot tell you definitively how or why they do so. In such cases, qualitative methods are more effective. Qualitative methods can answer questions about how and why an event happens, as well as provide other relevant details. A qualitative methodology mainly aspires for an understanding of the human experience by examining and collecting subjective data (Bowling, 2009; Creswell, 2012). The basic aim is to examine a phenomenon of interest that is a facet of the human experience. Whitehead (2007) suggested that qualitative methods are used to explore issues that primarily focus on human experiences, as this approach is germane to the exploration of subjective beliefs and attitudes.

In light of the evidence, I found that a qualitative research design fits well with my philosophical positioning, as well as the research objectives. Qualitative researchers posit that reality is socially constructed, and that the researcher intersects with these social constructs, which calls for the bracketing of relationships with the phenomena under investigation (as in Husserlian phenomenology, discussed below); or analysing and dealing with these perceptual legacies, such as potential biases (as in Heideggerian

phenomenology), thereby understanding the situational constraints that influence the investigation (Bailey, 1997). It is most appropriate to use a qualitative research design when attempting to generate an in-depth understanding of an unknown and intricate phenomenon. This paradigm thus applied to exploring nurses' experiences and understanding of caring for abused women and the little explored subject of DVA in SA.

3.1.2. Ontological and Epistemological Paradigm

The two archetypal philosophical research paradigms are positivism and interpretivism. Positivism is the essential philosophical stance of natural science, working with observable reality within society, leading to the construction of generalizations by experimental verification of hypotheses (Alharahsheh and Pius, 2020). Auguste Comte argued that the positivist paradigm relates to realism ontologically, whereby reality exists independently of the observer (Guba and Lincoln, 1994; Singh, 2007; Aliyu et al., 2014). Scotland (2012) stated that it aims to uncover true knowledge about the topic at hand. According to Rubin and Rubin (2012), positivism assumes that reality does not change, and that there is only one, quantifiable truth (and one, single external reality). This means that positivist research should be judged according to it is validity.

In contrast to positivism, interpretivism has its roots in anthropology (Ryan, 2018). Interpretivists argue that reality and knowledge are subjective, as well as culturally and historically positioned, based on experiences of people and their understanding of them. Researchers can never completely detach themselves from their own values and beliefs, hence these will certainly inform the way data is collected, interpreted, and analysed, thus pure objectivity is impossible (Ryan, 2018). Also, interpretivism shares a "relativist" ontological perspective which proposes that reality is only understandable through socially constructed meanings, thus there is no single shared "reality", only multiple interconnected "realities" (Ryan, 2018). Pizam and Mansfeld (2009) suggest that the goal of positivistic research includes explanations and reliable predictions, while interpretivism focuses on constructed understanding with less reliance on predictions.

Creswell (2009) argues that it is only possible to comprehend society and social phenomena from the perspective of those who are involved in it. Interpretivism attempts to bring hidden social forces and phenomena to light by understanding them from an individual's standpoint. They also aim to explore interactions between people in both a historical and cultural context. Within the interpretive paradigm, the focus in on understanding how individuals perceive and interpret the world around them and the things they encounter, as well as how they assign meaning to different objects and events (Scotland, 2012).

Interpretivism is based on the assumption that the social and natural worlds are not the same. The social world is based on human interactions, values, and consciousness, and how these affect perceptions of reality. When using constructivism, researchers attempt to explore these perceptions and meanings by exploring social interactions. When adopting an interpretivist paradigm, researchers take a holistic approach to exploring phenomena in their context. Typically, qualitative data are collected to generate a detailed understanding and to enhance knowledge. Research objectives are focused on understanding human experiences within the interpretivist viewpoint (Benton and Craib, 2011).

The epistemology of the interpretivist paradigm is embedded in subjectivism. In subjectivism, the world is considered to be separate from the existence of knowledge. Hence, knowledge is then interpreted, and reality can be understood. Interpretivists use naturalist orientations and focus on investigating aspects of real life. It is appropriate to adopt an interpretivist stance in the present research, since the researcher aims to create meaning and to understand human behaviours by interpreting the participants' subjective experiences and perspectives (Green and Thorogood, 2014). The epistemology of interpretivism adopts an approach to acquire knowledge by developing an understanding of phenomena through the deep level of investigation and analysis of those phenomena. Hence, their assumptions of what constitutes reality determine how they attempt to garner knowledge about such reality. In other words, their view of ontology affects their underpinning

epistemology, and subsequently their choice of methodology (Benton and Craib, 2011).

Within subjectivist ontology, the social world is considered to have multiple realities (Benton and Craib, 2011). It assumes that people interpret the world and experiences using their belief systems. Researchers aim to explore experiences and co-construct reality when adopting this philosophical perspective. Constructivism fundamentally posits that meaning is co-constructed by social actors, and that each participant creates knowledge based on their own experiences and opinions, by which they thus attach meanings to contexts (Rubin and Rubin, 2012). It is, therefore, suitable to implement an interpretive/constructivist paradigm in the present research. I considered several of these viewpoints and concluded that interprevistive paradigm was the best fit for this study, as explained above.

In light of the philosophical evidence, the research adopted an interpretivist perspective to explore, in detail, the rich lived subjective experiences of participants concerning DVA in SA. The interpretivist paradigm affirms the subjectivity of participants with diverse opinions, that are unique and different from others, and the researcher. It is based on the assumption that socially constructed reality is not objective, but is instead shaped by experiences of human and social contexts (ontology). Therefore, it can be best studied by integration of subjective interpretations of participants (epistemology) within socio-historic context (research methods for social sciences).

In choosing the research paradigm for my study, I examined the positivist paradigm and found that it is unable to address my research questions and does not fit well with the objectives of my research. Therefore, I took the interpretive position in this research to explore in-depth individual nurses' subjective accounts and their experiences and understanding about DVA to create a conceptual understanding of DVA and how it could improve nurses' education and practices and help identify significant research gaps

The methodology and methods of the research must be congruent with the philosophical positions through which the nature of knowledge is explored. As Mackey (2005) pointed out, philosophical standards and arrangements are at

the heart of research since they give continuity and soundness to its conduction and results. The choice of the research paradigm is determined by the research question and this, in turn, shapes the research design, data collection and analysis methods (Guba and Lincoln, 1994). Therefore, there is a congruence between the ontology and epistemology as well as the methodology adopted for the research.

3.1.3. Types of Qualitative Research Methodologies

There are various typologies of qualitative research methodologies that could have been used for this study, but they were not appropriate for my research questions. For this study, adopting ethnography, and particularly the participant observation method, may have limited my understanding of experiences and I would have to be physically present at the various hospitals to observe and record the actions and responses of the nurses relative to DVA (Dansig, 1985). It may also have narrowed the focus to the cultural influences at the expense of other factors that might be uncovered (Punch, 2009). Due to the time frame it was not feasible to observe the participants in real life, and it could have been potentially hazardous due to the difficulties of complete engagement in a sensitive topic (DVA). Furthermore, this was one of the first researches of this type to be conducted in SA, and there were no existing parameters to protect the participants and researchers, and the full disclosure of the research aims and methods was imperative for the safety of the researcher and participants. This study also did not use a grounded theory approach (Chenitz, and Swanson, 1986), because the aim of this study was not to develop a theory, but rather to understand the nuances of DVA and how nurses respond to this in their care provision.

The following subsection discusses phenomenology and provides a detailed account of why it was chosen for this study. Phenomenology seeks to explore a phenomenon as a lived experience that is best suited for qualitative and rich responses from participants. This was an appropriate approach to explore the perceptions and experiences of nurses and nursing students about DVA in SA, so that they could articulate their unique experiences directed at answering the questions of the research. Another important justification for this method is that it fits in my intention to raise awareness about domestic violence against

women, using the understanding and lived experience of participants. This research, therefore, has an increased potential of achieving progressive change in society, thereby contributing meaningfully to Saudi society and improving the QoC delivered to vulnerable and abused women.

3.1.4. Phenomenology

"Phenomenology" stems from the Greek "phenomenon", which means "displaying itself in-itself", and "reason", as described by Heidegger (1927/1962). Phenomenology is a philosophical approach that studies people's experiences of phenomena (Van Manen, 2016), guiding them to think about and understand experience and "meaning (Smith, 2008). The approach was developed by Edmund Husserl (1859-1938) and Martin Heidegger (1889-1976), and is used to understand the experiences of human life and how individuals and groups come to constitute meanings from them (Cohen, 1987; Smythe et al., 2008). The variation between these two philosophers is founded on how the results of the inquiry are generated and utilized to expand professional knowledge (Lopez and Willis, 2004). The phenomenologist maintains that there is an essence to every specific phenomenon, and that such essences can be understood (Bonomi, Allen and Holt, 2006).

Originally popular in anthropological research, phenomenology has increasingly been adopted within healthcare research (Matua and Van Der Wal, 2015), and as the choice of methodology for many nursing researchers (Mackey, 2005). The techniques of phenomenological research allow nurses to understand worldviews in a valuable way (Walters, 1994). In this study, I sought to investigate understandings, meanings, lived experiences, and existing knowledge about DVA. Therefore, this inquiry can be answered comprehensively with a phenomenological approach, which is highly congruent with the research question.

3.1.5. Different Schools of Phenomenology

Scholars divide phenomenology based on their respective perspectives into the two fundamental types: descriptive (Husserlian) phenomenology; and interpretive (Heideggerian) phenomenology, from which hermeneutic phenomenology emerged.

3.1.5.1. Husserlian phenomenology

Edmund Husserl is known for his work in philosophy and is regarded as the main founder of phenomenological philosophy (Husserl, 1927; Speziale, Streubert and Carpenter, 2011). Husserl proposed the concept of the interrelation between lived experience and the life-world, claiming that the life-world is not readily available, as it constitutes what is taken for granted (Mayoh and Onwuegbuzie, 2013). Husserl opined that the researcher should examine lived experiences by identifying their pure essence, without theorizing, explaining, or interpreting. His philosophy relied on the concept of the bracketing of cultural assumptions or beliefs – and indeed the subjective role and interpretation of the researcher – from a specific phenomenon, in order to understand it on its own terms.

Consequently, Husserl advised that researchers should attempt to leave behind their previous understandings and knowledge during the collection and analysis of data, in order to understand phenomena genuinely, as experienced. For my study, the bracketing concept is not deemed suitable because, as a nurse with experience of caring for DV, and as a member of the same culture and religious beliefs, the researcher cannot objectively remove previously understood experiences while conducting the research.

3.1.5.2. Heideggerian phenomenology

Heidegger, who was a student of Husserl, further developed phenomenology and the interpretation of phenomena to uncover hidden meanings that constitute knowledge (Van Manen, 2016). Heidegger was profoundly affected by Husserlian ideas, but he fundamentally departed from the claim that a person can realistically bracket their being-in-the-world. He stressed that it is unlikely to be possible to bracket all that the researcher knows and has experienced; conversely, Heidegger argued that the research can utilize these experiences in the interpretive process. “Heideggerian hermeneutic phenomenology” has been applied extensively to comprehend the significance of understanding phenomena in health research (O’Connor, 1998).

Interpretive phenomenology interprets and reveals the embedded meaning from a lived experience. Heidegger advised that the knowledge about the lived

world can merely occur by interpreting the grounded in the biosphere of individuals, things, language as well as relationships, because one is incapable of stepping “out” of the world. Hence, the interpretation of the meaning-making activities is consistently about the investigator’s viewpoint at a specific point in time (Smith et al., 2009). For this study, the Heideggerian approach was considered appropriate because it examines the process of interpretation of an understanding rather than just the description (Regan, 2012). Also, it allows utilizing the researcher’s knowledge and experience regarding the phenomena to give voice to Saudi nurses in this context.

3.1.5.3. Hermeneutic phenomenology

Hermeneutic phenomenology emerged from Heidegger’s claim that bracketing all presuppositions is not possible, and that researchers are bound to use words and language carrying *a priori* assumptions and constructs. Consequently, he attached great importance to the role of hermeneutics, and acquiring a clear sense of the meanings of words. Hermeneutic phenomenology is concerned with the “lifeworld or human experience as it is lived” (Laverty, 2003). The focus is toward revealing details and apparently all the aspects no matter how trivial those are, within experiences that may have been overlooked in our lives, with the aim of producing meaning and attaining a sense of understanding (Laverty, 2003).

Hermeneutic phenomenology constitutes “a qualitative research methodology that arose out of and remained closely tied to phenomenological philosophy, a strand of continental philosophy” (O’Connor, 1998). It is a philosophy of human understanding that examines human existence, the importance of human prejudices, human conversation, the nature of questioning, and the role of language (Devik, Enmarker and Hellzen, 2013). Hermeneutics is concerned with the interpretation and description of experiences. Cohen (2001) indicated that hermeneutic phenomenology is related to the understanding of texts. In this approach, an investigator aims to form a more in-depth and richer account of a specific phenomenon by focusing on intuition and revealing, rather than intensification and precision, to understand the impacts of previously held knowledge.

In utilizing this strategy, the problems of applying bracketing are acknowledged. Furthermore, one can accept the notion that there may be numerous perspectives on a particular phenomenon; for example, when a prism is turned, a certain part is visible while the other part is hidden. Hence, hermeneutics tends to avoid a prescribed technique for the sake of producing an applicable method and does not possess a systematic technique or analytic requirements (Smythe and Spence, 2012). Thus, the guidelines include recommendations for the vibrant interplay of six research activities: instigating a lived experience, commitment to a certain enduring issue, an oriented stance towards a query, consideration of parts or the entire specific phenomenon, and describing it by writing, and rewriting (Kinsella, 2006).

Hermeneutic phenomenology is considered congruent with the present research question and the view of the researcher regarding the phenomena. Hence, it is the most suitable methodology for this study in devising strategies to interpret the understandings of nurses and student nurses concerning violence. Hence, one may inquire how students/ nurses understand a phenomenon of DVA within the context of their pre-existing beliefs about this. This can be useful even if participants have not dealt with or experienced DVA, because, in a marital relationship, DVA is common, and is commonly understood within and across generations. Thus, this is founded on individuals' understandings.

Hermeneutics focuses on the fact that human beings are not only born into or develop within a linguistic environment while being subject to cultural, social, and historical forces, but they also change or reproduce this environment through their participation (Gadamer, 1975). Hence, the understandings of nurses and student nurses can be interpreted and perceived in terms of the language of their historical, cultural, and social contexts that influence these experiences, focused on their understandings of DVA. Additionally, this also relates to the dominant language spoken within their community and its relation to other factors such as education and training.

Hermeneutics postulates that there is no one single specific understanding of a certain phenomenon. Therefore, DV interpretation is not static, and

participants undertaking nursing practice are exposed to community, education, and socio-cultural influences that interact with each other and produce new interpretations, definitions, and understandings of DVA, which can be interpreted by employing open-ended questions to create discussion and dialogue about what DVA actually is. It is argued that there is a need to explore the understandings of DVA among nurses and student nurses to work towards the advancement of existing knowledge and nursing practice.

Thus, this study will use a hermeneutic phenomenological approach to gather first-hand knowledge (O'Connor, 1998) and data related to the nurses and student nurses' understandings and experiences about DV against women. Phenomenological interpretive data is obtained from human experiences, including participants and researchers, with the latter being engaged in interpretative association with the transcripts and data, using reflective records and notes (Smith, 2009).

3.1.6. Heidegger's Analysis of Being

Heidegger's philosophy centres on his analysis of "being", which is reflected in his emphasis on the important aspects of language, space, and time in providing context for researchers while understanding the lived experiences of their participants. When it comes to the world of nurses, nurses regularly meet with women, including their families. Women who have been abused are an example of the group in health institutions who are searching for care. Every day, nurses are tied up in the communities in which they live as well as the others' worlds. Heidegger argued that "being at things in the world" and "being with others" are both components of "being-in-the-world". According to Heidegger (1962), being on our own in the world, we are not capable of contributing to our being-in-the-world (*Dasein*) unless interactions occur with others. Therefore, it is not easy to separate ourselves from such interactions. Nurses are immersed in the world full of women who have been abused, the community they serve, and their professional lives, all of which interact.

Through being-in-the-world of abused women, nurses are existent and belong to the community's societal norms, comprising attitudes towards DVA. Furthermore, they must adhere to the profession's necessary codes and

competencies (Acosta et al., 2017). Individual understandings, therefore, originate from both professional and personal contexts and contribute to the "being" pre-existing experiences of nurses. However, being, the way Heidegger describes it, is often spatial and temporal (Gelvin, 1989), in certain circumstances, and with time, nurses vary in the means they work with and they ways they perceive abused women (Miles et al., 2013).

3.1.6.1. Temporality and spatiality (time and space) and language (Heidegger, 1962)

According to Heidegger's philosophy, the study of being connects the being-in-the-world with the idea of temporality and spatiality. To comprehend and understand what it "means to be", Heidegger valued the three elements of language, space, and time. These elements offer a perspective in which experiences take place, which relates to the way participants' narratives are completed by their contexts. Heidegger believed that lived experiences cut across some important life factors such as space, time, and cultural contexts in which lived experiences occur.

3.1.6.2. Space

The concept of "space" in Heideggerian philosophy reflects the real world through the experience of the participants and the researcher. It involves the culture and the routine engagement of the research participant with others, their culture, and the environment (Heidegger, 1926). To completely understand nurses' experiences and knowledge related to domestic violence, it is obligatory to know the context of their lives, beliefs, thoughts, and feelings while offering care for abused women. This is achieved by locating them in a specific country's context, while discovering how political issues, norms, culture, and religion play a crucial role in their practices and understandings associated with DVA.

3.1.6.3. Time

The concept of time transcends the past, present, and future of the worlds of participants. This concept shapes their experiences in describing the world around them within the context of research participants. It also influences their choices in making decisions when referring to the past and planning. In our

study, this relates to the exploration of nurses' experiences of barriers, training, education, community perspectives, and ways through which changes help in shaping the present understanding that, in turn, modifies the memories of the past. Future perspectives may also be coloured by present and past experiences. Such observations help the researcher to situate the reality within the primary focus of this research. This is the reason why concepts associated with Heideggerian phenomenology inform the current study.

3.1.6.4. Language

As a medium of communication (house of being), language provides a distinct way of transmitting information, which projects individuals' states of mind and moods (Heidegger, 1962). Thus, language offers the opportunity to understand the spoken and listen to the unspoken (silence). In directing language to address a problem (articulation), stories of participants are uncovered through the sharing of their experiences. For the revealing of the reality of nurses, the concept of language is essential in this study. The execution of the study was convenient because all participants were Saudis. Consequently, the researcher and the participants spoke a similar language, and interviews were conducted in Arabic. I was able to understand participants' expressions and experiences fully and comprehend the meanings of their silences, along with their body language in general.

3.1.7. The Choice of Heideggerian Hermeneutic Phenomenology

This research employs an interpretivist, subjectivist ontology, positing the perspective that a certain reality can have many truths derived from subjective individual experiences of nurses in SA. Moreover, the complex context of DVA in SA is comprehensively analysed. Heidegger emphasized "being" in forming an existential standpoint. Applying this with the Husserlian "how do we know what we know?" epistemological approach facilitates an evaluation of being human (Laverty, 2003).

Essentially, this study examines what it means to be a nurse caring for women who are abused in SA. From an epistemological standpoint, occurrences are viewed through the lens of social interactions. The researchers increase their knowledge socially and within their natural environment, in which

communication and listening between the researcher and participants are key. This means of data collection are sensitive and collaborative. In this way, the researcher can acquire nurses' views of DVA, and the influence of the associated cultural, religious, and social elements in SA, thereby producing new information. Furthermore, an appropriate methodological approach will be taken that fosters contemplations amongst the participants.

This research aim is to obtain a deep understanding of Saudi nurses' perspectives of DVA. Utilizing a hermeneutic approach, the researcher analyses their experiences. This research determines the surface and underlying meanings of their experiences. As a nurse with DVA experience, from the same culture and religion, the researcher's prior understandings and experiences cannot be objectively disregarded (my own ontological position); therefore, the Heideggerian phenomenological approach is selected rather than the bracketing (Husserlian) approach.

Optimally, a phenomenological hermeneutic method enables nurses to express their opinions and experiences "through nurses' voices "(Smith et al., 2013). My strategy is to investigate nurses' perspectives and understanding of DVA and to highlight and consider the meanings of their experiences to ascertain the deeper elements of the human experience in the subconscious, which can lead to improvements in nursing practices in this field. This study endeavours to comprehend reality as nurses perceive it in SA, which necessitates the researcher listening to their experiences and interpreting their meanings. The research concentrates on conveying the subtleties of their individual experiences rather than progressing existing predictive or prescriptive concepts.

Heideggerian hermeneutic phenomenology is suited to DVA research, as it centres on how meanings are attributed to lived experiences and attempt to grasp the deeper aspects of human experience. Nurses' views of their experiences and their comprehension of the impacts of socio-cultural factors on DVA greatly influence nursing practices. This study explores how their understandings and practices are affected by their nursing education, training, and socio-cultural factors. Heidegger emphasizes the significance of context

(personal, educational, and historical) in phenomenology and how it shapes understanding, facilitating an understanding of why the world is how it is (Maykut and Morehouse, 1994). Thus, hermeneutic phenomenology and the interpretivism paradigm were deemed most suitable for this research.

I sought to investigate the understandings, meanings, lived experiences, and existing knowledge about DVA. Therefore, my research question can be answered comprehensively with a phenomenological approach, which is highly congruent with the research aim. The objectives are focused on understanding human experiences within the interpretivist viewpoint (Benton and Craib, 2011).

Participant interviews were also used to collect data. In line with the subjectivist ontological viewpoint, I adopted an interpretivist epistemology, whereby such knowledge can be subjective, depending on the person's lived experience. The participants in the research were nurses and nursing students with very different experiences. Moreover, each participant interpreted their environment/ context through the lens of their belief systems and experiences.

3.1.8. The Hermeneutic Circle

The concept of the hermeneutic circle represents how individuals understand themselves and their surroundings (Heidegger, 1962). Michelfelder and Palmer (1989) opined that interpreters require some prior knowledge through which they can be guided with the respective pathways about the new information generated, and becoming part of such a circle can enable researchers to develop a complete perception (Heidegger, 1962). To acquire a full understanding of this involvement, one may endlessly pass between the parts of complete experience until an in-depth understanding is acquired from the generated information.

I developed my previous knowledge into novel findings after conducting interviews, which helped me to gain additional insight into their experiences and understanding. I believe that throughout this research process, my previous knowledge and experience of being a Saudi nurse and a native of the studied country context assisted me in reflecting on the transcribed data, allowing me an in-depth insight into nurse experiences. A shared social

practice underpins the social meaning of interpreting novel experiences (Heidegger 1927/1962). I noted the rich social context of Saudi nurses, and I was able to identify the meanings behind the context that might have been missed by an individual hailing from a different social context.

When I started interviewing nurses from Saudi and Arabic backgrounds, I viewed some of the perspectives of nurses regarding Arabic culture as normal, but my supervisory team perceived them as highly significant. For instance, these related to cultural tropes concerning the sanctity of the role of the husband, and the stigma of divorce for women, which contribute to the toleration and normalization of DVA. As a mechanism for safeguarding the complete exploration of all pertinent concerns, my research supervisor and I took account of all relevant concerns. This mutual review enabled us to highlight unique insights on the topic, since two different views were addressed during the collection of the data, thus maintaining the credibility of our study. Such discussion with my supervision team concerning the need to explain and explore how DVA is experienced gave depth to perspectives on DVA. This serves as a reflection on the research process, hence enhancing the credibility and trustworthiness of the study. Figure 1 displays my reflection on the hermeneutic circle to conceptualize my own understanding of the DV phenomenon.

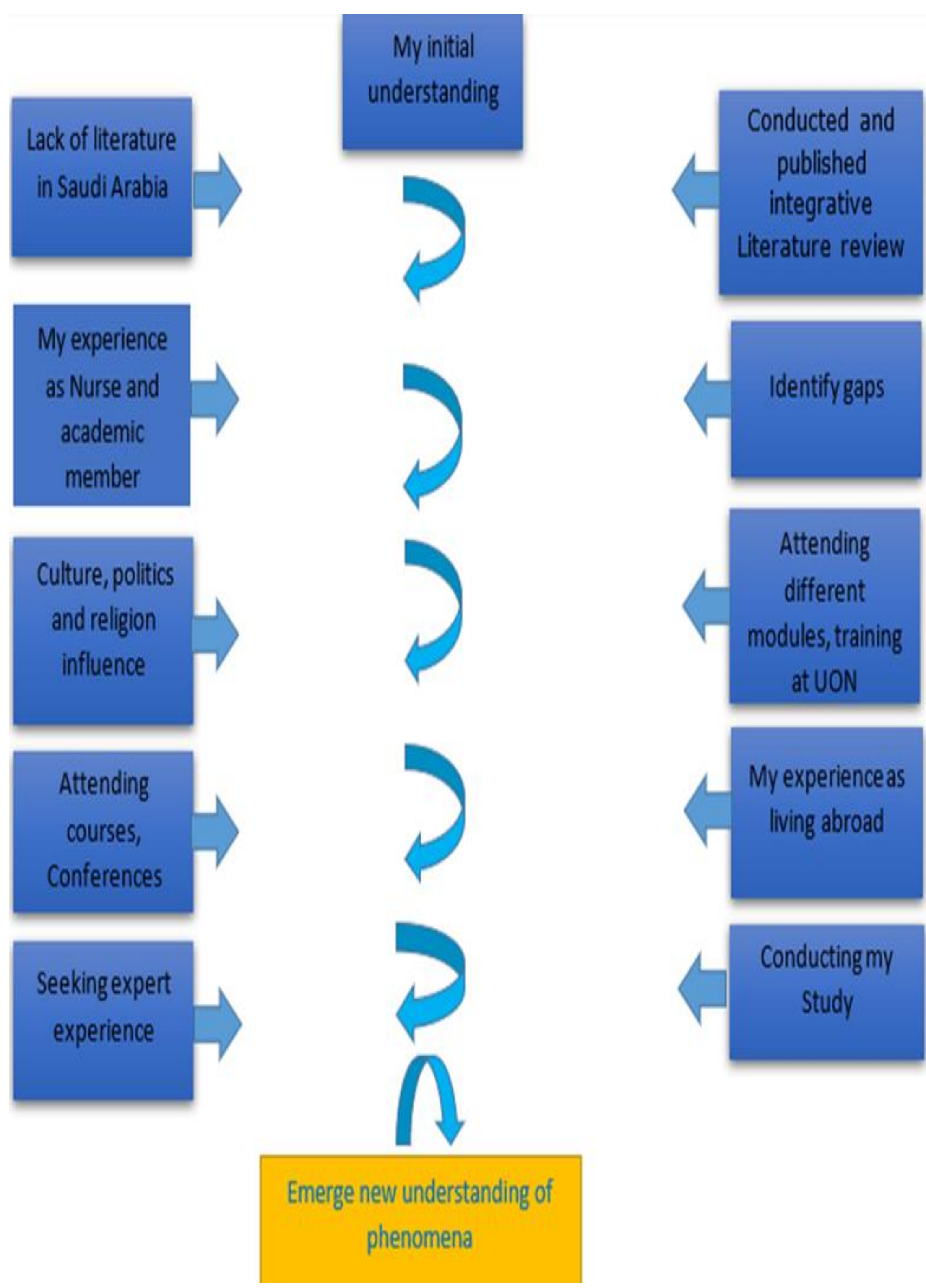

Figure 1: The hermeneutic circle: How is my understanding of the DV phenomenon shaped?

Having explained the rationale for selecting hermeneutic phenomenology as the underlying philosophy for the study methodology, the next section describes the methods used to conduct this study along with the justifications.

It begins by describing how study data were collected, and presents all details of the ethical approval process, study sites, recruitment process, sampling, interview procedure, access, and achieving trustworthiness.

3.2. Methods

3.2.1. Study Settings

The research took place in SA. There were two sites used for the research, which will remain anonymous to preserve confidentiality:

- Site A, an academic institution chosen to recruit local bridging nurses (qualified nurses with a diploma) and regular student nurses (BSN students), located in Riyadh, SA. This site was appropriate because it was the first university-level College of Nursing, established in 1976 by the Ministry of Higher Education. This institution offers a nationally and internationally accredited BSN (Tumulty, 2001). Many other nursing faculties in SA also follow their policies, nursing curriculum, and teaching strategies.
- Site B is a tertiary hospital located in Riyadh, SA, chosen to recruit qualified local nurses. It is an MoH hospital with a strategic location in the capital. This hospital features one of the largest and fastest-growing medical complexes in the Middle East, having 1200 beds, attended by an estimated 30,000 inpatients and 500,000 outpatients.

3.2.2. Study Participants

The study comprised a convenience sample of two categories of local nurses. The first category included seven nurses who had previously worked as nurses at Site A, but who at the time of study they were upgrading their diploma. Hence, although they were students, but they had relevant work experience ranging from 2.5-14 years. The second category included five BSN students from Site A studying in their final year, who were immersed in their core clinical practices and nursing theories and were ready to pursue future career in nursing. Similarly, six staff nurses working at Site B were recruited because they practiced in an evolving system of the health care. Their participation was likely to provide needed knowledge and evidence. The researcher took on

board the fact that broadening study samples by including qualified nurses would increase the richness and diversity of dataset. Table 3 describes the study participants' educational level, years of experience, and study site.

Table 3: Demographic characteristics of research participants

No.	Pseudonym	Education	Years of experience	Marital status
1	Hoor	Bridging-nurse[a]	4	Married
2	Muna	Bridging-nurse	8	Married
3	Sarah	Regular student[b]	None	Single
4	Amal	Bridging-nurse	9	Married
5	Nawal	Bridging-nurse	5	Married
6	Badoor	Staff nurse[c]	11	Married
7	Nouf	Staff nurse	2.5	Single
8	Assa	Bridging-nurse	6	Married
9	Yasmeen	Staff nurse	14	Married
10	Rasha	Staff nurse	10	Married
11	Rama	Regular student	11	Single
12	Hala	Staff nurse	14	Married
13	Nesrin	Staff nurse	2.5	Single
14	Sharifa	Staff nurse	12	Divorced
15	Zain	Regular student	None	Married
16	Tahira	Bridging-nurse	8	Single
17	Nour	Bridging-nurse	10	Divorced
18	Malak	Bridging-nurse	11	Single

[a] Nurses who have a diploma (3.5 years) and experience, now completing their BSN.

[b] Students studying nursing to earn a BSN without previous experience.

[c] Qualified nurses with a BSN working in a hospital.

The detailed Idiographic of the participants are provided below in table 4.

Table 4: Details about the study participants.

<table>
<tr><th>No.</th><th>Pseudonym</th><th>Education</th><th>Years of experience</th><th>Marital status</th></tr>
<tr><td>1</td><td>Hoor</td><td>Bridging-nurse[a]</td><td>14</td><td>Married</td></tr>
<tr><td colspan="5">Hoor was in the bridging course. She had extensive years of experience however she never got the chance to join in any DV training or courses during her education nor has ever dealt with DV cases during her care. She was moved by her friend's personal experiences as a victim during her pregnancy, and she stressed the importance of healthcare providers viewing this time as a critical period in Saudi women's life. As a result, all pregnant women should have compulsory screening. Hoor mentioned that one of the biggest challenges for nurses is that there is currently no law or code of ethics for SA nurses, and nurses could be part of the problem. Thus, nurses are disempowered.

Hoor detailed her encounters with abused women while working in the emergency room and previously in the southern part of Saudi Arabia, where she described numerous cases of rape. Nurses will be likely to remain silent even if they observe cases of DVA since they are not assigned to deal with or report violence as part of the routine and explicit regulations.</td></tr>
<tr><td>2</td><td>Muna</td><td>Bridging-nurse[a]</td><td>8</td><td>Married</td></tr>
<tr><td colspan="5">Muna had experience of working in the clinic. Through her experience she found that normalization of DVA extend into the hospital’s own cultures, particularly in the case of physicians. Although the traditional idyll of physicians is that they are friendly advocates of patients, When it comes to DVA, the majority of physicians and manger hide and normalize DV, and make it more acceptable, especially when the victim is a woman, because, in SA, the authorities are mainly for physicians, not nurses. As a result, nurses are able to avoid making a contribution to abused women's care. On the other hand, She cited either verses of the Quran or hadiths as evidence of women’s rights and the prohibition of abuse in Islamic instruction which should be followed in health care organizations. In her opinion, nurses should have appropriate knowledge regarding the identification of domestic violence and she should also support the victim to combat with this situation in addition to the command on communication skills and rapport building.</td></tr>
<tr><td>3</td><td>Sarah</td><td>Regular student[b]</td><td>None</td><td>Single</td></tr>
<tr><td colspan="5">Sarah didn't have any formal DVA training or education. She had experience of observed cases of DVA with preceptors. She noticed that a lack of awareness among nurses and women about DVA could impact nurses' practices. The participant feels that with nurses’ role as the first person women will meet in the hospital, the absence of awareness may have played a vital role in keeping the violence from being reported; that may also have assisted nurses and patients to become more reticent to report domestic violence.</td></tr>
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<tr><td>4</td><td>Amal</td><td>Bridging-nurse[a]</td><td>9</td><td>Married</td></tr>
<tr><td colspan="5">Amal illustrated how she had a lack of confidence in dealing with DV due to a lack of knowledge/ training that requires further education to overcome such feeling. This may reflect the reasons for keeping silent. Amal expressed the necessary skills nurses should be equipped with, such as being non-judgmental, that encourage women to talk about their situations.
From her experiences, Amal also stated that the ultimate authority was physicians, and the main nursing role was documentation, according to the hospital policy.</td></tr>
<tr><td>5</td><td>Nawal</td><td>Bridging-nurse[a]</td><td>5</td><td>Married</td></tr>
<tr><td colspan="5">Nawal had 5 years of experience in nursing but never had an opportunity to attend any course or training on the topic of DV however have encountered a few cases. She stated that DVA occurs most often because women are perceived as weak and poor. They are unaware of their rights and hence do not complain about DVA and also because of society's cultural impact. She also stated that DVA is a personal subject for them and that if it were me, I would not want others (include nurses) to know about my personal problem.</td></tr>
<tr><td>6</td><td>Badoor</td><td>Staff nurse[c]</td><td>11</td><td>Married</td></tr>
<tr><td colspan="5">Badoor was a nurse at X hospital with 11 years of experience. However she had not attended any structured training or education about the topic but has heard of it in media. The participant also shared experiences of patients who came to their emergency department and who were affected with DVA. They are then treated symptomatically and supported well. If the patient is agreed on reporting the case then the police are informed and that is all that they have done. She refused to take interest in cases of DVA as in her opinion she said since it is a social issue and so social workers or psychologists should be involved as she is unable to hear sad stories and so is not part of nurses’ role as they can only provide care and treatment.
Badoor shared her bad experiences of when she tried to help abused women, citing these as reasons she would not like to engage with DV cases again in future, mainly in order to safeguard her employment. There is nothing clear for nurses in the policy, thus they are often silent when facing cases of non-disclosure. Badoor had the same concern regarding the lack of clarity about the further consequences of reporting a case that might disempower nurses and exacerbate the lack of reporting</td></tr>
<tr><td>7</td><td>Nouf</td><td>Staff nurse[c]</td><td>2.5</td><td>Single</td></tr>
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<tr><td colspan="5">Nouf, a staff nurse, described her way in which to break nurses' silence so that the victim could speak out. These relate to building rapport with victims, which might help to break the ice and encourage them to speak up.

She usually asks the woman some normal questions about her life because they often do not speak out immediately and you need to start discussing something else, like their studies or degrees. You can then start to notice the signs and symptoms of the violence and determine whether she is upset about something or not. Sometimes I tell them about my mistakes and what I have done and as a result, they may start opening up and talking about their problems, so you can be rewarded for your patience and in time, they speak.

Nouf describe the common experience among nurses is that usually a husband holds the reins, and he says what the health complaint is on behalf of his wife and takes decisions relating to care. If the woman suffered from DV, it would be difficult to impart this without the abuser knowing. Nouf was savvy to this, and took steps to give women an opportunity to articulate their own healthcare needs, including potential DVA.</td></tr>
<tr><td>8</td><td>Kady</td><td>Bridging-nurse[a]</td><td>6</td><td>Married</td></tr>
<tr><td colspan="5">Kady appeared highly desirous and enthused about joining any course or training offered about DVA even if it was extra-curricular. She pointed out that limited knowledge exists concerning the cultural and social norms persisting within Middle Eastern societies, she mentioned what applies in Western society is not applicable for us, and our education and training programme must consider our norms as an Eastern society.

Kady also experienced silence in situations and withdrawal from dealing with or reporting cases of DVA and explained some obstacles and barriers to reporting DVA in terms of the nursing role and not being included in the nursing job description, as opposed to the role of a social worker, who has time and competence to deal with and follow up on, cases of DV. she also explained some of the barriers were related to cultural issues that prevent both nurses and women from disclosing DV to Saudi nurses and being silent.</td></tr>
<tr><td>9</td><td>Yasmeen</td><td>Staff nurse[c]</td><td>14</td><td>Married</td></tr>
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<tr><td colspan="5">Yasmeen had experiences of care for the abused girl who attempted suicide because she knew that her sibling would hurt her for her socially unacceptable behaviour (an honour issue). She had an understanding of the complications of DV and how associated stigmatization could drive victims toward negative beliefs and behaviour, including substance abuse and even suicide.
Yasmeen disclosed that some women’s recurrent hospitalizations due to attempted suicide (e.g. drug overdoses) or suicidal thoughts were associated with hidden signs of violence, which healthcare professionals have to consider when dealing with family violence
The important aspect regarding normalizing DVA uncovered by Yasmeen was how conservative some families can be.
Yasmeen highlights the complex contextual factors that can induce victims to not report DVA, increasing women’s vulnerability to DV.
She expressed that there was a lack of rehabilitation programmes that allow victims and abusers to be reintroduced to the community with positive attitudes toward their experiences. she felt that a positive impact in increasing the awareness of individuals and the community about DV and stopping its cycle</td></tr>
<tr><td>10</td><td>Rasha</td><td>Staff nurse[c]</td><td>10</td><td>Married</td></tr>
<tr><td colspan="5">The importance of being equipped with specific skills to deal with abused women properly was raised by Rasha, who cited that observation is one of the communication skills needed to detect DV cases, based on her previous experience: she mentioned that you can acquire it by practice. When she was new to the staff, she mixed up with the patients the first time, and she started to know gradually and see the first case and the second case, and she started to know. However, Rasha expressed her needs a long practice to know if the person in front of her is oppressed or not. she found it hard to know how to handle such cases.</td></tr>
<tr><td>11</td><td>Rama</td><td>Regular student[b]</td><td>11</td><td>Married</td></tr>
</table>

Rama was in the bridging course with 11 Year clinical experiences. She was that participant who had witnessed domestic violence at her home with her mother and she was thankful to God that she had not been a victim of this abuse by her husband. As per her, this abuse affected her mother who remained depressed and even her own psychological wellbeing and because of this she used to hate men and think that she will have to marry someone like her father. She was of the view that SA is society dominated by men and so they are not scared of punishments and they think that they can do whatever they want. She condemns the current culture of the society and compares it with the western world. She said that although the western world do not follow a 'shame' culture however they have strong laws and in our tradition, we follow shame culture, but we also follow religious rules; which is good but why don't we have strict laws from the government to restrict all this male dominancy which ultimately leads to various type of assaults. She assumed that this culture has a substantial impact on nurses' practice and that nurses were unable to act in this culture, both because of a lack of authority in their hands and because of the culture.				
12	Hala	Staff nurse[c]	14	Married
Hala although had years of clinical experience butshe felt scared and had lack of confidence to deal with cases of violence. She added that this affected her ability to reach her full potential. Hala turned to be a silent witness to DVA. She became concerned only when the victim presented with the physical injury at the hospital, regardless of the underlying DVA causes. It seems possible that such actions are due to a lack of confidence, proper policies, systems, and training and education. Also, there are many potential reasons why Saudi nurses become silent. Hala was open about the sensitivity within the Saudi community around DVA especially sexual abuse. In light of her experiences, Hala showed disappointment that only the most serious DVA cases had the opportunity to attend the emergency unit. In the absence of authorities, regulations, and laws, she found herself in a weaker position to assist those women, and she noticed a lack of clarity in nurses' roles while dealing with DVA at the hospital.				
13	Nesrin	Staff nurse[c]	2.5	Single
This participant had 2.5 years of experience but she had not attended any course or training about DV. She encountered a DVA patient and so thinks that she does not need any training however she has awareness of it. Moroever, the participant also declared the boundaries of her job as she is able to guide and support the DV victim and also can play a role in the referral of such cases. She also sent abused women to the social worker who have their own policy to deal with DVA case.The participant was more inclined towards the thought of the social worker helping the victim because in her opinion, nurses were the caregivers but it is the actual task that a social worker can do as she can give more time to the abused.				

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<tr><td>14</td><td>Sharifa</td><td>Staff nurse[c]</td><td>12</td><td>Divorced</td></tr>
<tr><td colspan="5">Sharifa compared her colleague's experiences in the UK health care system with what was done in SA. she mentioned how the Western model of advocacy for victims, which can be useful to the healthcare professionals in SA. Sharifa was very explicit about limited confidence to deal with tough situations, and how Saudi's nurses were left alone to deal with DVA and find their own ways to deal.. she expressed how it is difficult to detect other types of DV outside physical abuse without clear signs and symptoms, particularly in the absence of an assessment protocol and clear policy.</td></tr>
<tr><td>15</td><td>Zain</td><td>Regular student[b]</td><td>None</td><td>Married</td></tr>
<tr><td colspan="5">Zain was still doing her bachelor's but had no experience of working and also have had never attended any formal training or education regarding DVA. However, she did attend a workshop regarding DVA out of the curriculum. She found this topic extremely important and told that if a female with multiple fractures comes to the hospital and ifshe is crying or has many bruises, it may be due to some blood disease but she might have been abused as well.. However, she mentioned the important point that women should be made aware of their rights and should be encouraged to report DVA otherwise nurses are unable to act. According to her, nurses can play a very significant role in supporting and guiding the victim at the same time nurses should not inquire deep about their private information. Zain argued that if the society will become more aware of nurses' roles, it will help women to disclose DV situations and lead to empowerment of nurses. In her opinion there has to be some policy in hospitals regarding DVA and their management as this is a global issue so in her view, there should be some law against it in Saudi Arabia.</td></tr>
<tr><td>16</td><td>Tahira</td><td>Bridging-nurse[a]</td><td>8</td><td>Single</td></tr>
<tr><td colspan="5">Tahira raised concerns about the absence of DVA education or training, which limited their involvement in facing DV at hospitals. Tahira also mentioned how DVA training and education is neglected in hospitals, while they focused on and did periodic training for other areas like CPR, and emphasized the need to know the international guidelines for supporting abused women.

Tahira recalled an experience of escalating a case of DVA and pointed out that the authority accorded nurses only when hospitals dealt with serious cases where there were very clear about the signs and symptoms of abuse, which followed a compulsory report procedure by calling the police without the women's permission. In the absence of policy on non-disclosure cases, nurses are powerless to intervene.</td></tr>
<tr><td>17</td><td>Nour</td><td>Bridging-nurse[a]</td><td>10</td><td>Divorced</td></tr>
</table>

<table>
<tr><td colspan="5">Nour was a feminist. She was in the bridging course and with 10 years of experience but has not taken any courses on the topic under discussion. In SA, in her views, women are not legally or physically protected and so they easily become a victim of DVA. While nothing supports nurses in the hospital. Nour was explicit that nurses are obligated to report abuse and must follow guidance from nursing codes of ethics about their obligations to fight violence. Nour also expressed that reporting DV cases is part of the nursing role unless the nurse is merely looking to make money and is unethical.</td></tr>
<tr><td>18</td><td>Malak</td><td>Bridging-nurse[a]</td><td>11</td><td>Single</td></tr>
<tr><td colspan="5">Malak faced challenges of being disempowered due to the absence of relevant laws, lack of policies, lack of clarity in inter-professional working, and felt quite isolated in terms of other support that could help in caring for the victims. Malak stated that many things contributed to disempowering nurses and left them unequipped and alone, without a routine inquiry checklist or a compulsory screening tool, as a policy established by the hospital to support nurses’ roles and decrease the sense of loneliness they face in DV cases.

Malak further described that although she mentioned that victims should be seen by psychiatrist nurses or psychologists for their care. They mentioned that if victims visit ER with non-obvious psychological symptoms, it is almost impossible to know if they are victims and what they are going through. Also, the ER does not have trained and specialized DVA nurses to understand, assess, treat, and follow the situation, making care difficult for DVA victims in such specialties. Malak recognized the importance of experts dealing with DV in the field, such as forensic nurses, with sufficient policy and legislation to protect and support nurses’ roles as well as the human rights of victims</td></tr>
</table>

3.2.3. Eligibility Criteria

The participants were considered eligible to participate in this study if they were in their final (fourth) year of their programme. Since SA’s educational system is segregated by gender, the eligibility criteria for Site A included only female nursing students. The Saudi nurses from Site B were included based on segregation too.

3.2.4. Sampling Strategy

Sampling is the process of examining and selecting cases, situations, context, or participants who can provide rich account of the phenomenon of interest. There are various strategies that researchers use to sample their study participants. However, in qualitative research, the sampling is mostly

deliberate, and not random. In non-random sampling, not all participants have equal chance of being selected in the study. One of these deliberate sampling strategies is convenience sampling, which was used in this study. The important reason for choosing this strategy was to embrace participants with experience of the phenomenon under study (Moser and Korstjens, 2018). This study ensured that those nurses who were approaching their end of degree and who had likely had experience with DVA were enrolled, to achieve a rich and in-depth understanding of the phenomenon. Also, the sample recruited was limited to indigenous Saudi nurses, to understand the pure experience of nurses within the cultural, historical, and social context of SA.

3.2.5. Sample Size

There were total 40 students (bridging and regular students) who were invited to participate in the study, of whom 18 agreed and consented to participate. A total of 18 nurses were included in this study. The sample size for the study was considered taking into account various reasons.

Firstly, the type of study and its aim intends to offer a rich account of the nurses' experiences, therefore a large sample was not required to achieve the study objectives.

Secondly, a study with small number of participants does not indicate that the data attained is not credible. A smaller number of participants facilitate the researcher's close association with the respondents, and augments the validity of in-depth inquiry in natural settings (Crouch and McKensie, 2006). The intention of Heideggerian hermeneutic study is to generate rich description of phenomena and to interpret meanings embedded in experience.

Thirdly, in phenomenological study, the number of research participants is frequently small, as the approach generates voluminous and rich data (Van Manen, 1990; Greatrex-White, 2004; Tanyi et al., 2006). Researchers pursuing phenomenological studies typically use smaller sample sizes. Woodtli (2001) recruited 13 participants, Guruge (2012) recruited 30, and Corney (2008) utilized Heideggerian hermeneutic phenomenology and interviewed only two participants. Conversely, the point should be acknowledged that the findings from a small sample cannot therefore be generalized. However, the purpose

of qualitative research is not to generalize findings, rather the focus is on transferability.

Furthermore, theoretical saturation is not the aim of hermeneutic studies, since the temporality of truth is recognized. Additionally, the research question was deliberately broad, and a progressively intense focus on specific aspects of lived experience were not sought (Whitehead, 2004). In this study, a total of 18 nurses agreed to participate, and the sample size was deemed adequate to address the study objectives.

3.2.6. Access to Study Settings

Access to the study sites was possible due to various reasons. Firstly, I have been working in Site A as an academic staff member, which facilitated access to the study site. Site B was chosen due to the higher and advanced level of training and education provided at this hospital. I received my nursing training at this site during my undergraduate degree, which made me familiar with the environment, with awareness of the work that goes on there. Furthermore, when the researcher used to be an academic member in the Faculty of Nursing, she used to attend it, as this site provides several certified training programmes for preregistered nurses. This site is decisively endeavouring towards the Saudization of it is nursing (increasingly recruiting Saudi nurses) and technical staff, through rehabilitating the Executive Directorate of Academic Affairs to accommodate diverse programmes for training a huge number of trainees.

Gatekeepers for the recruitment of different groups

For recruiting the participants, an advertisement for the study was displayed on student notice boards within the College of Nursing to invite nominee participants at Site A. The nursing programme coordinator had advertised the research study to call only nursing students in their final (fourth) year. To gain more attention for the research study, I presented my research project and research objectives at the end of each lecture.

At Site B, recruited participants were staff nurses. The initial approach was from the Hospital Director, Nurse Manager, and heads of nursing in each department. Information about the research study was displayed in the

relevant clinical areas and nurses' lunchroom. The head nurses granted an extra break for chosen participants on the assigned day of the interview, allowing for more time for interview purposes. However, when I attended on busy days, I could not conduct any interviews because of the workload, and I thus had to rearrange the meeting time.

For all participants, the researcher gave a detailed participant information sheet (Appendix 9), and a contact details slip. Eligible participants who agreed to take part in the study were to complete the contact details slip and place it in a collection box, which was then collected by the researcher. The researcher contacted them within 24 hours to check their willingness to participate, and to arrange the time and place for interview. Recruitment strategies are shown in Figure 2.

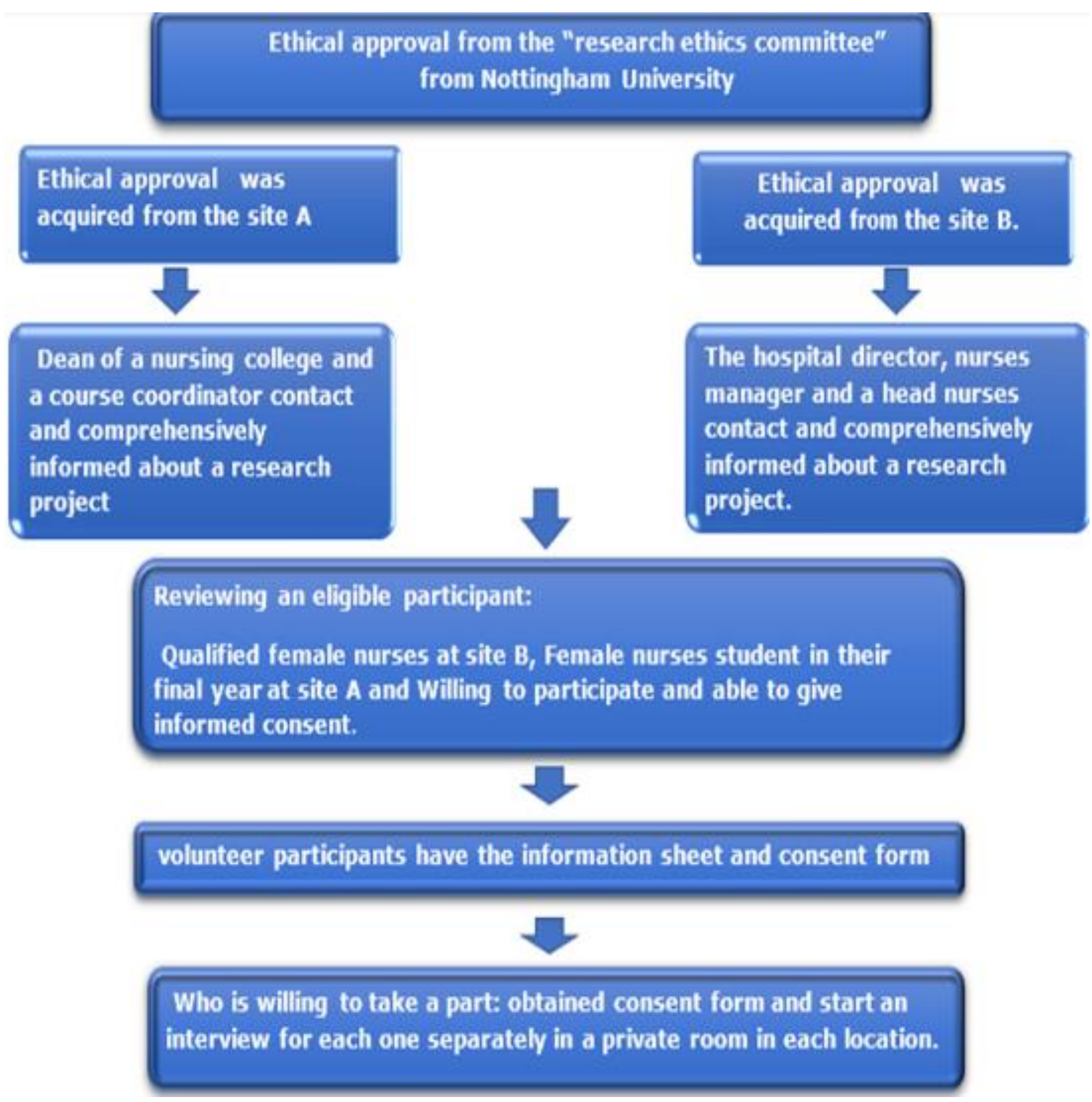


Figure 2: Recruitment strategies

3.2.7. Data Collection

Data were collected from study participants who are studying a final year at Site A and working in different departments of Site B. Data were collected during a period of six months, from October 2018 to April 2018. Data collection was conducted using individual qualitative interviews and through the flexible interview topic guide (Appendix 10). The duration of interviews ranged from 30 minutes to two hours. The amount of data collected was within my capacity to analyse, discuss, evaluate, and reflect. In hermenuetic phenomenological studies the aim is not to reach theoretical saturation, as the truth is revealed and recognized (Whitehead, 2004).

In many qualitative studies, the aim of the researchers is to achieve a sufficient sample size so that data saturation is achieved. However, the principle of interpretive (hermeneutic) phenomenology has a different stance, whereby data saturation is impossible, because there are experiences that exist beyond the reach of the study that are not always heard or revealed. There are a number of possibilities that cannot be confined in a designated sample size. Moreover, the interpretations that hermeneutic researchers offer are always regarded as uncertain, because absolute and bounded understanding is unlikely, as situations manifest ample meanings which offer myriad new possibilities for understanding (Ironside, 2006). Hence, small sample sizes reflect the philosophical underpinning of qualitative research, and focus on discovery and interpretation of the findings instead of proof.

3.2.8. Semi-Structured Interviews

Semi-structured interviews occupy the middle ground between structured and unstructured interviews. The interviewer developed a catalogue of questions based on the information they wish to gain from the interview. However, the interviewer might have strayed from the guide, depending on the interviewee's responses, to gain more in-depth, and more meaningful responses (Ryan et al., 2009) (see Appendix 10). Similar to other studies (De Juan Pardo, Russo and Roqué Sánchez, 2018), I used a guide to help the nurses reveal their experiences of being nurses to abused women, and to avoid short and shallow answers about sensitive topics (given the cultural context). However, after conducting my first interview, I realized that I might have prompted my participants to answer according to what I wanted or expected. Thus, I changed my interview approach to be more phenomenological-hermetic driven, and research questions were used to probe the participants further in order to gain more clarity about what they wished to convey, while ensuring that the objectives of the study were covered.

3.2.8.1. Rationale for choosing the interview method of data collection

Van Manen (2006, cited in Heinonen, 2015), suggested that the phenomenological interview should be utilized as a means to gather and explore experimental material. However, hermeneutic interviewing is used to

explore the interpretative meanings of material acquired from data sources or phenomenological interviews. When it comes to the hermeneutic understanding, one may emphasize the notion of the hermeneutic circle, and its dialectical back and forth movement between “the parts and the whole”, which leads to understanding. Hence, the hermeneutic cycle enables one to identify phrases and statements sharing commonalities, offering the basis for the establishment of essential themes and subthemes. The interviews, once finished, were transcribed with meticulous accuracy, including indications of laughs, pauses, speech dynamics, mistakes, and mishearing.

I executed a pilot interview with a nursing Ph.D. student, which played a significant role in honing skills to conduct and monitor interviews. Furthermore, I piloted a study with two real participants. I did not include the pilot interviews in my analysis (as participants).The primary purpose was to help in developing new interview techniques, and to acquiring insights on the understanding of nurses concerning domestic violence, to reflect on my propositions and assumptions. This kind of opportunity permitted me to expand my awareness about the different and in-depth interpretations of women’s experiences.

3.2.8.2. Field notes

I always kept a research diary with me, which I used after each interview to immediately document the critical points experienced. Moreover, I listened to the audiotape to note down my reflections on the topic. The diary comprised extensive notes I jotted down during the collection of data, including notes to reflect my personal interpretative comments to help assist me in analysing the collection information. Making field notes goes beyond merely recording data to begin the preliminary process of analysing it (Silverman, 2000).

The field notes included descriptive data for each of the nurses separately, along with informal conversation before starting to audio-tape, noting my ideas and thoughts. These notes supplied relevant data enclosing contextual information on each professional nurses and student nurses. Heidegger (1962) stated that the existence of an individual is often influenced by a person’s future, present, and past. To understand nurses’ knowledge and practices about domestic violence, one needs to understand their complete background.

This information was, therefore, provided to me using field notes along with providing me adequate assistance in interpretation and analysis processes. These were helpful during data analysis conducted over several months subsequent to the actual interviews themselves.

3.2.9. Location of Interviews

The interviews took place in a private room at each study site, to provide privacy and a relaxing atmosphere. Furthermore, the interview room was tagged with a "do not disturb" label to avoid interruptions. This area was extremely quiet, making it easy for the participant and interviewer to hear each other. To reduce power dynamic problems, the interview process ideally involved interactive dialogue, and utilized the core tenets of active listening and non-verbal communication tactics, while avoiding methods akin to interrogation.

Initially, the offices of the Nursing Administration and Nurse Manager were selected for interviews, but I felt that the nurses were not entirely comfortable with these places. Therefore, to decrease the power dynamics (given that the facilities were their workplaces), the location of the interview was changed to one of the rooms in the department where nurses usually work, or at their home in the department. In contrast, nursing students preferred to be interviewed in the university rather than the hospital where they receive their training, as they have long breaks in-between lectures in the former.

3.3. Ethical Considerations

Ethical approval for the study was sought and granted by the University of Nottingham (Faculty of Medicine and Health Sciences Research Ethics Committee reference number: 114-1709) (Appendix 11), and the ethical and organizational approval bodies of Site A and Site B (Appendix 12). Ethical approval from the University of Nottingham was received on 14th September 2017. Ethical approval was received from Site A on 1st October 2017. To get approval from the MoH and Site B, I completed the National Institute of Health (NIH) web-based training course called *Protecting Human Research Participants* on 2nd October 2017(Appendix 13). After that, ethical forms were submitted to MoH, and approval was received from Site B on 8th October 2017.

Written consent and recording permission were obtained from the interview participants prior to the interviews. Written consent was also sought for audio recording, and the participants' permission was audio-recorded. Participants' anonymity and confidentiality was ensured. The acquired data from participants were anonymized by providing pseudonyms and numbers to every consent form (Appendix 14). The documents and database also used gave pseudonyms. The researcher made a separate confidential record of each participant's name, position, and participant study number, to permit the identification of all participants enrolled in the study in case additional follow-up was required. Participants' anonymity was preserved by storing data in a locked cabinet and on password-protected computer files, accessible only to authorized personnel or the investigator. Electronic files and the audio-recording of interviews were stored on password-protected secure servers in Nottingham University web (via Z drive for PhD students; files.nottingham.ac.uk).

The disclosure of general details about the way this study will be conducted contributed to less anxiety and distress among the participants, who were informed that the research information would only be used for this study, and that the generated data will be stored for seven years following completion, and will then be destroyed, following the University of Nottingham's data storage policy. The data custodian is the Ph.D. researcher.

This study was considered low-risk, but there were some concerns revolving around potential emotional distress when the researcher prompted memories of difficult situations. However, participants were given up to two hours for the interviews as per their convenience, and refreshments were provided. Although the study did not seek nurses' personal experiences of violence, the sensitivity of the topic was always considered throughout the research. Participants may have felt that they were forced to volunteer; that their course progress could be affected (for nursing students); or that their positions or salary could be affected (for registered nurses).

The interview discussion might have created emotional responses or psychological distress among participants. To minimize risk, or identify and/or

respond to it, the counselling services of Sites A and B were contacted, and the Ethics Committee served as a resource by which to protect participants from psychologically disturbing/sensitive topics. I was fully conscious of any distress or unhappy feelings, and when I observed any participant distress signs, I immediately stopped the interviews, but all chose to continue the interview after a short break, and they did not require counselling. Thus, there was a low risk of harm to participants, and no coercion was involved.

All participants were provided with the information sheets and written informed consent with duplicates to be signed. The researcher provided one copy to each participant. The researcher also verbally informed participants in full about the nature of the study and their participation, including its wholly voluntary nature. It was explained that taking part, refusing to take part, or withdrawing would not affect their salaries, positions, grades, or academic achievement. They were also informed that they could withdraw from the study at any time. I made sure that the participants had enough time to consider participating, and answered any questions that the participants had concerning the study and their participation.

3.4. Rigour and Trustworthiness

The naturalistic paradigm of inquiry was proposed by Lincoln and Guba (1985). In this type of study, the researcher avoids the manipulation of results. In various fields relating to healthcare and other disciplines, a paradigm shift is underway, that is redefining diverse assumptions of research strategies and the roles of values, conceptualization of causality, potential for generalization, subject-object interactions, and the nature of reality. In this milieu, research guidance indicates that a naturalistic inquiry takes place; for instance, when trustworthiness is established during study design. Trustworthiness is determined by four components: credibility, transferability, confirmability, and dependability (Lincoln and Guba, 1985). These are described further below.

To improve data rigour, interviews were transcribed and tape-recorded. During interviews, participant statements were rephrased and summarized by the investigator. Tape-recording interviews permitted the researcher to take part

in the interview session with full concentration, leading to an increase in trustworthiness and accuracy in the process of data collection.

It was important to combine two perspectives for the interpretation of all meanings. After each interview, I also wrote memos noting overall impressions. In terms of the analysis process, I was aware of the significance of not merely applying my solo interpretation, and I also gave importance to the respondents' expressions and understandings. At the basic level, Heideggerian hermeneutic study encourages sympathy and discernment, by raising the awareness of nurses regarding how it feels like to be in a certain situation (Kearney, 2001). As a facilitator, my job was to acquire a complete explanation of the nurse's knowledge, understanding, and practices to inquire about further explanations. It was not only to execute my perspectives or interpretations.

3.4.1. Credibility

The first criterion of rigour is credibility. A study is thought to be credible when it presents a faithful interpretation and understanding of a phenomenon, when a reader recognizes it and relates it to their personal knowledge. Those people who have not encountered such a phenomenon may recognize it after reading about it through research findings. This also fits the second criterion of research rigour, which is termed "transferability". Credibility was augmented with the interview process and continued until the theme-building phase, where it came in line with the hermeneutic circle. Gadamer (1975) described it as a process that enhances the research credibility, the procedure of clarifying and reflecting during the interviews, and comparing specific parts of the texts to the entire concept. Using direct quotes to illustrate essential themes enhances the research credibility, making it consistent with the understanding and responses of the participants.

3.4.2. Transferability

A qualitative study usually takes measures to maintain the rigour and transferability of a study. Guba and Lincoln (1989) utilized the terminology of transferability, which is determined by the extent of similarity between two contexts. By describing socio-demographic details of participants and the

socio-cultural context of the study in sufficient detail, varying perspectives are offered to enable a reader to assess whether or not the findings have applicability in other contexts.

3.4.3. Dependability

Dependability is a systematic procedure for making decisions. A study and its findings are considered dependable when another researcher can trace the decision trail utilized by the researcher in the study (Whitehead, 2004). Koch (1995) also describes transferability as the ability to demonstrate how decisions were made using a clear audit trail of the research process. In this research, the clear statement of methods, methodology, and research question, as outlined served as an audit trail. The audit trail has been increased following all interviews, where an investigator has formed folders for all participants comprising of the summary of the interview session, memos, transcription of texts, and tape-recordings. The transcriptions were compared with each other to identify commonalities that eventually enabled the identification of important themes.

3.4.4. Confirmability

Confirmability is the extent of neutrality of the study, or the degree to which the participants shape the study results and focus of inquiry, independent of the researcher's bias. Confirmability is established when dependability, transferability, and credibility are fulfilled. De Witt and Ploeg (2006) suggested that philosophical inconsistencies demonstrate that credibility and confirmability are not suitable generic qualitative criteria to establish rigour in hermeneutic phenomenological studies. This was emphasized by Dahlberg et al. (2001), who stated that generated themes should reflect the experience of all participants to an extent. In this type of study, confirmability relied on a good presentation of data that the researcher provided. Confirmability showed where the interpretation emerged from the data, while ensuring evidence of scientific rigour.

This part has illustrated an explanation of the research methods used, with an explanation on the selection of research participants, study location, recruitment, sampling method, ethics, the process of data collection, and how

the trustworthiness was ensured, to correspond with the process of this research.

3.5. Data Analysis

Van Manen (1990) described phenomenology and hermeneutics as having "no method", but having a tradition, insight, growing body of knowledge, and an epistemological history. Fain (2004) suggested there is no single method for the methodology of interpretation or data analysis in phenomenology (Patterson and Williams, 2002). In this regard, I adopted some principles from previous studies, which stated that interpretive analysis in phenomenology is concerned with the detailed examination of human lived experience. Such examination is conducted in a way that enables the researcher to express the experience in its own terms, rather than in the predefined categories, connecting experiences with core ideas (Alase, 2017). Focus is on the views and understandings of stakeholders, rather than on the phenomenon itself (Van Manen, 2017).

In some cases, the data I generated showed richness in participant experience, and at some points the participants expressed their thoughts, understandings, feelings, and attitudes about phenomena of understanding DV. The data analysis involved thematic analysis that assisted in moving beyond description to discover an explanation. Thematic analysis is an approach as well as a tool that offers a rich, thorough, and complex account of the data (Ho, Chiang and Leung, 2017). Through this analysis, the researcher goes beyond description and engages in the process of recovering themes that are hidden, engaging in the meanings evolving through the data (Ho et al., 2017).

In hermeneutic phenomenology, theme identification is not about illuminating repeating patterns, but about recuperating the structure of meanings that live in human experiences (Ho et al., 2017). Also, in hermeneutic phenomenological analysis, a common interpretive technique to define themes in transcribed interviews is a thematic analysis (Benner, 1985; Van Manen, 2014). This type of analysis is regarded suitable for describing common meanings embedded in the transcribed interviews (Ho et al., 2017). In similar

contexts, building on the work of Greatrex-White (2004), thematic analysis was used by Altamimi (2015) in his doctoral thesis, using hermeneutic phenomenology to explore, understand, and interpret patients' perceptions, experiences, beliefs, and practices associated with the use of spirituality as a concept among end-stage renal failure patients in Jordan. Hence, this forms the basis of my decision to use the phenomenological analytic approach, which presents a complete match of the philosophical assumptions that underpin my study.

In interpretative phenomenology, analytic-reflective methods include thematic analysis, guided existential reflection, linguistic tracing, and exegetical reflection to identify and reflect on variant and invariant meaning aspects of the phenomenon as a starting point for phenomenological writing. I involved my self-reflection and acknowledged my being-in-the-world in understanding experiences, to comprehend the studied phenomena. In the hermeneutic interpretation strategy, the main aim was to discover the details of how participants make sense of their social and personal world. The real sense is hidden in the script, and it is the responsibility of the researcher to understand and disclose this meaning, instead of explaining the transcript (Heidegger, 1962). It is not a linear procedure, rather the researcher engages with participants' attempts to make sense of their world (Smith et al., 2009). This is why a hermeneutic researcher usually keeps a reflexive diary, to navigate such engagements and the emerging pictures of participants' realities.

Consequently, the knowledge, understanding, attitude, and practice of each nurse and student nurse was read and analysed separately, to gain a sense of the whole, and to determine similarities and dissimilarities between their understandings. Through the method I used for the analysis, I was able to discuss the reasons behind the participants' beliefs, understanding, and knowledge regarding their experiences. During the analytical process, I consequently tried to understand and define the thoughts of the participants. According to Smith (2004), this is a dynamic process, with which I tried to enter my interviewees' world more fully. The use of qualitative methodology allowed me to initiate my analysis from the first interview and continue throughout the whole process of interviews.

I also carried out transcription and translation side-by-side, using cross-cultural translation strategy, along with the identification of themes. Simultaneously, I also paid close attention to the distinctiveness of each nurse's individual experiences and knowledge, while grasping the essence. The thematic analysis of data was guided by the works of Van Manen (1990), Greatrex-White (2004), and Smith et al. (2009), following certain steps described below to make sense of the participants' answers.

3.5.1. Step 1: Transcription and Translation

Transcribing and translating interview data enables researchers to familiarize themselves with participants' perspectives and emerging themes (Van Manen, 1990).

3.5.1.1. Transcription

I familiarized myself with the data during the verbatim transcription of all the interviews in Arabic and subsequent translation into English. I listened to each interview with several iterations, to discover how nurses have shared their experiences and understanding regarding domestic violence. I found myself deeply involved in their conversation, identifying many similarities of thoughts and differences of opinions between participants during this process, and I made notes of these to help me in identifying themes and subthemes. By the end of the transcription process, I was able to select many meaningful units out of the data along with the finalization of the English version of the interviews. My level of understanding, interpretation, and unfolded meaning emerged about the phenomenon of DVA was through the transcription and engagement with it many times.

3.5.1.2. Translation

After transcription, I translated the Arabic transcripts into English personally, to maintain the confidentiality of participants and avoid misunderstandings, and checked other parts of the transcript with a bilingual academic. Similarly, professional translation of the specific concepts and sentences in Arabic was done wherever required, to assure me about the correct adaptation of the ideas generated by the participants.

In this way, my English transcriptions were compared and corrected for any errors or misinterpretations, and therefore I was confident that my transcripts and translations reflected the views of the participants. Following the recommendation of Beaton et al. (2000), a bilingual speaker (in Arabic and English) checked some translated copies, and suggested some minor corrections. Revisions were undertaken with discussed wherever inconsistencies appeared. For example, the Arabic terms *mahram* and *wali* were consciously used in many contexts rather than the closest English equivalents (e.g. “guardians”), to emphasize the particular local meanings in the Saudi cultural and legal context of nursing women at risk of domestic violence in SA.

While I was extensively reading and reviewing the interviews of the participants in English text, I also compared them with the notes that I took while listening to each interview. Therefore, after reading and re-reading the transcriptions many times, I found myself immersed in the data, and simultaneously I discovered a variety of meaning units and terms. Finally, I was able to list distinct items that denoted meaningful themes. I was able to capture the differences in the opinions, and to identify points of consensus. Hence, my transcripts were finalized in this way, and additionally, at this stage I also had many themes and meaningful units in hand. Later, I used NVivo 12 in order to manage and organize data, but not for analysis and interpretation.

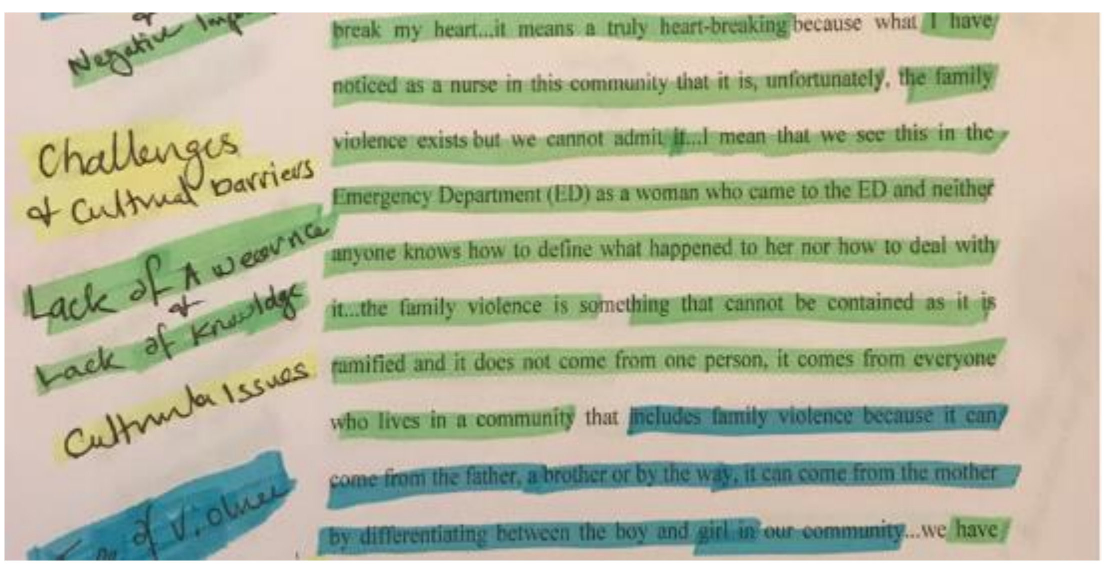
3.5.2. Step 2: Reading and Re-Reading

The thematic analysis adopted in this study involved a holistic approach and a line-by-line reading of transcript material while also attending to the meanings embedded in the text within (Van Manen, 1990). Data was read and re-read to achieve immersion (Smith, et al., 2009). This included intensive reviewing and reading of the transcripts after carefully listening to each and transcribing it. While reading and reviewing, presuppositions and judgments were suspended to focus on what is present in the transcripts, as per the practice of “bracketing” (Husserl, 1999), although this was not a fundamental aspect of this hermeneutic phenomenology study, as explained previously. I kept in mind the relevant questions like concerning nurses’ experiences, understandings, and obstacles and practices of DVA against women, and what it means to be a

nurse for abused women. Following my interest, I read each transcript as soon as possible after the interview, which aided me in achieving data immersion.

3.5.3. Step 3: Initial Noting

Initial notes were prepared on the printed copy of transcripts to explore semantic content, by writing margin notes. At this stage, I developed random notes that reflected initial thoughts that were arising in response to the text. For instance, it was said by one interviewee that society accepts male dominance, and that women are weak and cannot ask for their rights against domestic violence; by going through this statement, I urgently noted "community view, patriarchy" (drawing on the reviewed literature on the nature of Saudi societies and women's issues). This is important as it can influence the prevalence of the problem and psychological acceptance of domestic violence in society. This stage of analysis helped me to structure the data, to reduce a vast amount of descriptions that were not relevant or required, along with removing excessive and repetitive information, so manageable themes and sub-themes could be established. Figure 3 shows examples of some initial noting on the transcripts.



01:32 (P) the domestic violence against women is something really *break my heart*... it means a truly heart-breaking because what I have noticed as a nurse in this community that it is, unfortunately, the domestic violence *exists but we cannot admit it*... I mean that we see this in the Emergency Department (ED) as a woman who came to the ED and *neither anyone knows how to define what happened to her nor how to deal with it*	Feeling toward DV:" *break my heart*". accusing culture and community DV exist problem but neglect and hidden problem community deny أنكر vague and uncertain about her role, lack of practices and knowledge to deal properly with cases	Heart breaking + Negative impact Challenge & culture barrier a sense of being confused & uncertain Lack of awareness & knowledge Cultural issue
... the domestic violence *is something that cannot be contained as it is ramified* and it does not come *from one person*, it comes from everyone who lives in a community that includes family violence because it can come from the father, a brother or by the way, it can come from the mother ...	perceive the importance of domestic violence. Source of DV: father ,brother, mother	Frustrate!! Couldn't احتوى its out of hand هي غير قادرة على الاحتواء
by *differentiating between the boy and girl* in our community...we have been raised that the boy is not like the girl in terms of rights, so domestic violence *is like a ramified ring that is not compatible. it has many factors and many people who play*	Causes of DV: discrimination between girls and boys. التمييز بين الفتيات والفتيان. all people in the community were blamed	Cultural implications And women right Sense of accused culture

Figure 3: Examples of initial noting on transcripts

3.5.4. Step 4: Meaning Units and Developing Emergent Themes

The emerging themes were developed by focusing on transcripts and the notes, as well as by arranging the data into meaningful units. In this context, a "meaningful unit" means a part of a sentence or paragraph of any length which

presents a distinct item denoting a meaning or theme. While reading, identifying themes and subthemes, and interpreting the data, I constantly referred back to the original texts and asked myself about the phenomenon and relation of these emergent themes to the topic in discussion. This procedure is referred as an interpretive phenomenology by previous researchers, and it is practised to augment the quality of data and the research (van Manen, 1990; Greatrex-White, 2004, 2008; Smith et al., 2009). The construction of themes is by focusing on the text to find language/potency, time e.g. critical events, cultural context, polarization or tension and frequency, and significant statement (Smith, Flowers and Larkin, 2009).

Themes were generated from various paragraphs, pages, and even sentences. All the text was utilized for each participant in this way to identify what the individual was trying to say about domestic violence as per her knowledge and experience. Each theme was different from the others, and they contained subthemes. Proceeding in this way, I was able to find out a large number of meaningful themes using each interview, such as:

- Lack of policy
- Lack of education and knowledge
- Lack of preparation
- Being anxious
- Lack of authority
- Being unconfident
- Being confused
- The negative impact of family
- Cultural norms
- stigmatization
- Religious interpretations
- Lack of law
- Manhood ideology

Nevertheless, this was still grounded in the details provided by the participant. This reflects the hermeneutic circle (Pietkiewicz and Smith, 2012). After consulting my supervisor, I transferred my work from pen and paper to

software data organiser programme for organizing and viewing (but not to interpret it). I used software NVivo 12, which is a qualitative data management software for data organizing and viewing, but not for analysing and interpretations. Figure 4 shows an example of emergent themes using this software.

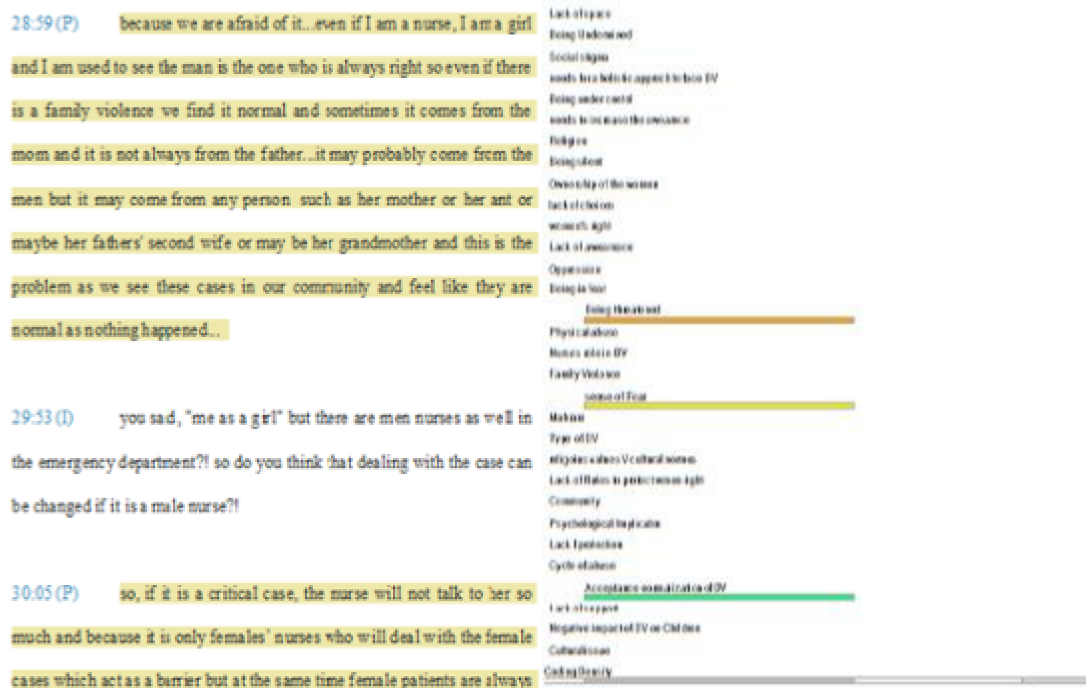


Figure 4: Example of emergent themes using NVivo 12

3.5.5. Step 5: Situated Structure Ordering How Nurses Understand DVA and Searching for Thematic Connections

The next stage involved looking for connections between the meaning units and emerging themes and grouping (clustering) them together as per their conceptual similarities, and then providing each cluster a descriptive label. When compiling themes, I had to drop a few themes as they did not fit with the emerging structure, or they had a weak evidential base (Pietkiewicz and Smith, 2012). While abstracting and integrating these themes, connections were searched across them. Using the identified themes, a structured classification of conceptual similarities was generated. Hence, the meaning units from the stages above were classified under certain categories based on the importance of the study's aim and objectives.

The emergent themes were clustered into various categories under nursing challenges in professional aspects, holistic approaches to facing DVA, and impacts of the surrounding environment, and impacts of culture and religion. The data was given meaning units and themes in a series of iterative steps by continuously revising and refining the emerging structure, along with the development of new insights, and elicitation of new relationships between the themes present in the nurses' comments.

During emergent structuring, each of the transcripts was again read line-by-line, highlighting the important points, abstracted key ideas, and sub-themes, and ultimately the themes. To ensure that my analysis was verifiable and systematic, interview guides, audiotapes of the interviews, and transcriptions, as well as detailed documentation of analytic decisions and changes in the themes, were used at all stages whenever required. In this way, all the in-depth interviews were manually analysed and initial comments and themes were created. A final list containing numerous superordinate themes and subthemes was achieved. Direct quotes of the respondents were used to understand the issues in context, and in the language and idiom of the ways participants thought and talked about the issues.

I moved on to the next transcript keeping in mind the previous themes, and also maintaining flexibility and space for the possibility of new emergent themes. To respect the individuality of each nurse participant and her own experience and understanding regarding domestic violence, I interpreted what she was saying about the phenomenon leaving (bracketing) the understanding of the previous participant. I also used participants' own words (direct quotes) wherever possible, as recommended by Higginbottom (2015), who found it essential for making categories, abstractions, themes, and for the understanding of participant's feelings in terms of idioms or phrases. These themes were evaluated for hidden meanings at all stages (Flick, 2004).

After codes and themes were identified in the data, the analytical process identified the most prominent as being that nurses were disempowered by their experiences. Three themes were linked with this concept, divided into three groups: nurses' challenges inside and outside the hospital, and the urgent

need for holistic approaches to address DVA; the environment's role in DVA; and the role of religion. I examined and identified similarities, differences, relationships, and contradictions across the themes and sub-themes, and compared these findings to the literature, research question, and objectives, and had consultations with experts on the topic, including my Ph.D. supervisors, and then renamed some thematic concepts.

The themes that emerged from the study pointed towards the barriers, which work together to stifle and disempower nurses and student nurses as they deal with DVA on three levels at three levels: the organizational level, such as remaining silent due to the lack of policy and nursing authority; the professional level, such as being unaware due to the lack of education and curricula; and the community level, such as the participants being constrained by social and religious aspects. These factors function as barriers that prevent nurses addressing DVA and contribute to the disempowerment of nurses, which was an overarching concept in this study. Thus, the themes and subthemes were derived directly from the findings, but I conceptualized them as barriers that can be tackled by facilitators and empowered nurses, which are elements that describe the nurses' experiences and understanding of DVA and contribute to disempowered nurses.

The main concept that explained nurses' experiences was "being disempowered". Three themes were linked with this concept and can be addressed under the following three main themes: (i) being unequipped (ii) being silent, and (iii) being constrained by social and religious contextual forces. Organizing the themes, collecting meaning units, situating structures, and reorganizing is a general structure of the phenomena that helped me to produce a further layer of understanding as the phenomena unfolded. Thus, the final themes and subthemes were found and reflected nurses' understanding of DVA.

3.5.6. Step 6: Moving Situated Structural Narrative to General Narrative

I looked into the common patterns and concepts across different verbatim quotes. As the participants belonged to the same profession, in many instances they shared familiar feelings, and had similar sorts of experiences

and limitations; hence it was easy for me to find patterns and idiosyncrasies among these interviews, whilst maintaining their individuality. This practice was also suggested by Greatrex-White (2008), who observed that a general pattern, displayed after the themes of each interview, can be collectively structured and analysed.

After doing the whole process, I initiated a write-up of the narrative for each theme, incorporating the subthemes and quotes of the participants. All of the interview data and field notes were taken into consideration. During this, I found out that participants had mentioned various aspects of domestic violence, thus a fruitful demonstration of the meaning of the concept could be achieved. This is one of Heidegger's central concepts, "understanding", which he describes as an interpretation, which varies from interpreter to interpreter. He emphasized that the same text interpreted by the same interpreter at a different time could produce differences in understanding. Thus, the "fore-structure" of understanding influences interpretation, which manifests in different interpretations of a text from one interpreter to another (Greatrex-White, 2004).

By referring to many authors and their publications and my supervisor's input, I was able to interpret the findings of my study with a close instinct. Understanding and portraying the depth of the feelings that the nurses showed towards the victims of domestic violence went along with adding their own experiences. New ways of understanding and unfolding meaning were present. Writing up a narrative report usually involves identifying the themes in the final form and then writing them up one-by-one. The narration needs to be exemplified and described, along with the extracts from interviews, followed by analytical comments (Table 4). Using interviewees' own words to demonstrate themes enabled me to justify my analysis, so that the reader can assess the pertinence of the explanations and determine that the voice of the participants' understanding and experiences has been retained, giving me an impetus to authentically portray their perspectives. The final write-up included the participants' versions of their experiences in their own words, and my interpretative commentary.

Table 4: Significant statements, formulated meanings, and themes

<table>
<tr><td colspan="3">"… the community says that she needs 'mahram', someone like her father or her brother… according to the law, it has been developed by the men, and the women did not participate in developing the laws in SA… I think that law is currently changing, but what I predominantly know that law is not protecting the women. For example, there are no women's organizations in SA, yet that may help the women to shine in the Saudi community… I know that women are studying and travelled abroad, but the law entitled her to be accompanied by a mahram, but what is this mahram for?! Is it because he needs to look after her, or what exactly?!!… or he is the one who could abuse her once she stops following the custom and traditions, for example if she wears something else than that 'abayya', what will happen?! if she speaks to other men, what will happen?! Do you get my point… ?! This is the family violence that I know… do you need more information… ?? {…} I didn't hear about mahram in Islam before… {…}".</td></tr>
<tr><th>Formulating meaning</th><th>Sub-themes</th><th>Theme</th></tr>
<tr><td>The community thought about a religious issue, law, wali concerning DVA</td><td>Guardianship role vs. Saudi law</td><td>Being constrained by contextual social and religious forces</td></tr>
<tr><td colspan="3">".. but I think they are not helping and encouraging woman so that she can complain about it with confidence, and will be more protected without any negative impact on her normal life… while she is losing many things like children or her reputation and many things which may prevent her from speaking out…".
" … she may have children that she wants to keep and raise them or she is alone in this life, therefore, I cannot accept that I can judge whether she can defend herself or not."..</td></tr>
<tr><th>Formulating meaning</th><th>Sub-themes</th><th>Theme</th></tr>
<tr><td>A sense of acceptance of DV to stay with children</td><td>Normalization and acceptance of DV in the community</td><td>Being constrained by contextual social and religious forces</td></tr>
<tr><td colspan="3">"I need to know that it will not affect my employment status, and I need to know that I am protected if I am to be more involved. I believe I need some numbers to contact if I need any consultation… but the most important thing I need is to feel safe and secure, this is especially true for nurses from abroad".</td></tr>
<tr><th>Formulating meaning</th><th>Sub-themes</th><th>Theme</th></tr>
<tr><td>Expressed concerns about personal and employability status</td><td>Being unsafe</td><td>Being silenced</td></tr>
</table>

To conclude, the data analysis started from the first interview and continued during transcribing and translating. Details of steps of thematic analysis are described in this chapter. The next step is to share the meaning of their dialogue and relate them to other participants' ideas. The important

perceptions, thoughts, examples, and sentences are quoted in the text in Chapter 4 to better understand the core ideas of participants' realities.

3.6. Reflexivity

Palaganas et al. (2017) posit that reflexivity enables researchers to recognise the changes they undergo throughout the research process, and consider how this has influenced the research. Researchers should pursue an embedded, interpretive approach when they self-reflect, recognising potential bias and assumptions. To answer my research question, I adopted a Heideggerian approach to reflect the ontological position (my being-in-the-world), formed by my experience as a qualified nurse who has studied Community Health Nursing and witnessed the impact of DVA on female patients. As a member of the academic staff at King Saud University, I teach students about nursing care, including women's care, for those who are at risk of health issues (other than DVA). Heidegger's notion of "being-in-the-world" from my perspective is formed by the background and cultural norms that I share with my participants. Reflexivity means self-reflecting and being aware of the relationship between the researcher and their environment (Lamb and Huttlinger, 1989; Dowling, 2006).

Personal factors can introduce bias into data collection and analysis; however, considering the research design and methodology, it is difficult to bracket all preconceptions. Hence these are not bracketed but are used intellectually in the process of interpretation of findings. Therefore, by associating my ontological position through Heideggerian philosophy, I was able to answer the research question. McGhee et al. (2007) indicate that self-awareness can be developed by recording and reviewing preliminary reactions; in this study, the reflexive diary was vital to establishing rigour. My reflexive diary supports Yardley's (2016) view that reflexivity maintains transparency by promoting critical thinking and recording all aspects of the study.

Smythe and Spence (2012) suggest that a researcher is positioned at the crossroads of their "fore-understanding". Conducting the literature review enabled me to find common themes in international nursing practise relating to DV, and to identify a gap in terms of Saudi nurses' experiences of this issue.

The use of Heideggerian hermeneutic phenomenology enabled me to engage with nurses at work, and enhance this with insight from personal experience (O'Connor, 1998). As a qualified nurse with a master's degree in Community Health Nursing, and having undertaken an internship where I witnessed women struggling with DV, I decided to investigate other nurses' experiences with this issue. The choice of research methodology is a pivotal decision for a student researcher, since it profoundly affects the findings.

As detailed in Appendices 15, 16, and 17, I completed courses in hermeneutics, phenomenology, data analysis and interpretation, and in DV. When reviewing the evidence, I discussed female issues in SA to better hear the voices of Saudi nurses. Greatrex-White (2004) and Crotty (2009) advise that in Heideggerian hermeneutic phenomenology, the researcher, being an insider position in their study, is better placed to understand the researched phenomena (Pringle et al., 2011; Hayman et al., 2012). That enabled me to understand phenomena, build rapport with participants, and discuss DVA with them, despite its sensitivity within Saudi culture. In contrast, there could be certain disadvantages of being an insider. Since I belonged to the same culture, research participants could have viewed me as an advocate instead of a researcher. Also, insiders can often overlook routine events due to a focus on dramatic events (Bonner and Tolhurst, 2002). However, the supervisors' input helped to mitigate this, as described previously with regard to identifying notable culturally specific themes.

Furthermore, Heidegger (1962) used "fore-structure" to understand the basis of interpretation, suggesting that interpretations generate familiarity with a real-world phenomenon, which Heidegger termed "fore-having". Prior knowledge of the topic when reviewing evidence allowed me to develop my research question (exploring nurses' understanding of DV). While contextual practices influence comprehension, "fore-conception" explains the predicted sense of what a researcher's interpretation will disclose. This helps in understanding and adding detail to the interpretation. This is also framed and shaped by certain background practices (Fitzpatrick and Wallace, 2006). In light of the hermeneutic circle, understanding cannot be achieved in isolation, rather it is

built upon previous understandings, giving new meaning to prior presuppositions (Figure 1).

During my research tenure, my reading decisions were shaped by “fore-sight”, and a sense of what authors and journals to use. Living in Europe had opened my eyes to cultural and religious differences among women, which influenced my interpretation of the phenomena, such as with regard to the privacy and normalization of a DVA within a family. Both Heidegger (1927/1962) and the ontological “fore-conception” I developed brought new dimensions to questions about nurses’ understanding of DVA in SA healthcare settings. Familiarity with the phenomena and shared experience enabled me to quickly form connections with the participants (Pringle et al., 2011).

Reflexivity allowed me to consider the impact of my presence and how my interactions with participants influenced the data collection (Finlay, 2002). I see my role as an interpreter of data, and understand how my development of the research question “shaped and fore [told]” how the participants answered it (Benner, 1994; Mackey, 2005). While Heidegger focuses on ontology, the epistemology is also of equal importance. It is concerned with the nature of the knowledge, which further paves the path for its scope, process, and limits, and the way knowledge can be acquired. It focuses on questions such as what actual knowledge is comprised of, what can be known, how it can be known, through what processes knowledge can be acquired, and how the validity of the subsequent reality can be ensured (Willig, 2019) Thus, reflecting on these assumptions, as indicated by McEwan and Wills (2007), epistemology establishes what we know and how we know it, which helped to give direction to this study.

The reflective diary not only documented my potential influence on the research process, but also how the research process influenced me. Witt and Ploeg’s (2006) concept of openness informed my reflective journaling, enabling me to consider experiences that may have influenced data collection and analysis. According to Creswell (2007), reflective journals are used in qualitative writing because of its interpretative nature, and I saw this as an opportunity to reflect on assumptions, rather than seeking to eliminate them.

Through this diary I was able to reflect on how participant interactions affected me, which was important in separating my thoughts from theirs. While including the researcher's subjective experience is important in qualitative research, I did not want my voice to overshadow those of the participants (Fine, Wei, Weseen and Wong, 2006).

The journey has been challenging and it provided numerous encounters of learning. The first challenge that I faced was regarding interviews. Conducting the interviews presented several difficulties for me where examining my skills in the process was a challenge However, in order to overcome that I executed pilot interviews with many nursing Ph.D. students, which played a significant role in honing my skills to conduct and monitor interviews. Furthermore, I piloted a study with two real participants. The primary purpose was to help in developing new interview techniques, and to acquiring insights on the understanding of nurses concerning DVA, to reflect on my propositions and assumptions. This kind of opportunity permitted me to expand my awareness about the different and in-depth interpretations of women's experiences.

The second challenge that I encountered was deviating from the research objective and aim. This challenge was twofold. First, often the participants share information which has not been asked or is not needed for the study. Second, the participants might be prompted by the researcher to get answers that she expected. Both scenarios pose challenge for the researcher. In order to ensure that the interviews produce the information that the study aimed to achieve the interviewer developed a catalogue of questions. However, the interviewer might have strayed from the guide, depending on the interviewee's responses, to gain more in-depth, and more meaningful responses. I used a guide to help the nurses reveal their experiences of being nurses to abused women and to avoid short and shallow answers about sensitive topics (given the cultural context). However, after conducting my first interview, I realized that I might have prompted my participants to answer according to what I wanted or expected. Thus, I changed my interview approach to be more phenomenological-hermetic driven, and research questions were used to probe the participants further in order to gain more clarity about what they wished to convey, while ensuring that the objectives of the study were covered.

Thirdly, owing to the sensitive nature of the phenomenon, The potential ethical issues that could have arisen during data collection might relate to potential emotional distress when the researcher prompt memories of difficult situations. But, this study was considered low-risk and participants were given up to two hours for the interviews as per their convenience, and refreshments were also provided. Although the study did not seek nurses' personal experiences of violence, the sensitivity of the topic was always considered throughout the research. Participants may have felt that they were forced to volunteer; that their course progress could be affected (for nursing students); or that their positions or salary could be affected (for registered nurses). The interview discussion might have created emotional responses or psychological distress among participants. To minimize risk, or identify and/or respond to it, the counselling services of Sites A and B were contacted, and the Ethics Committee served as a resource by which to protect participants from psychologically disturbing/sensitive topics.

Although the risk was low, I was fully conscious of any distress or unhappy feelings, and when I observed any participant exhibiting distress signs, I immediately stopped the interviews. However, they all chose to continue the interview after a short break, and they did not require counselling. Thus, there was a low risk of harm to participants, and no coercion was involved.

All participants were provided with the information sheets and written informed consent with duplicates to be signed. The researcher provided one copy to each participant. The researcher also verbally informed participants in full about the nature of the study and their participation, including its wholly voluntary nature. It was explained that taking part, refusing to take part, or withdrawing would not affect their salaries, positions, grades, or academic achievement. They were also informed that they could withdraw from the study at any time. I made sure that the participants had enough time to consider participating, and answered any questions that the participants had concerning the study and their participation.

Reflecting also on how the interview affected me, I felt horrible and it was stressful at times because of the personal stories of the participants. When I felt overwhelmed, I tried a variety of ways to cope, including consulting my supervisors and taking short breaks for few days.

To reduce power dynamic problems, the interview process ideally involved interactive dialogue, and utilized the core tenets of active listening and non-verbal communication tactics, while avoiding methods akin to interrogation. Initially, the offices of the Nursing Administration and Nurse Manager were selected for interviews, but I felt that the nurses were not entirely comfortable with these places. Therefore, to decrease the power dynamics (given that the facilities were their workplaces), the location of the interview was changed to one of the rooms in the department where nurses usually work. In contrast, nursing students preferred to be interviewed in the university rather than the hospital where they receive their training, as they have long breaks in-between lectures in the former.

Aside from the academic aspects of understanding my own relationship with the researched phenomena in more depth, the reflexive process helped me organize the practical aspects of conducting this research in relation to my other professional and academic activities. A note on the research budget is shown in Appendix 18, while generic research and personal development training courses undertaken and conferences attended are shown in Appendices 19 and 20. Appendix 21 shows professional memberships, and Appendix 22 shows publications undertaken during the course of this research journey.

3.7. Conclusion

In this chapter, I have discussed the use of phenomenological methodology, underpinned by ontological propositions of subjectivity. This informed the use of in-depth interview as a data collection method to explore the lived experience of Saudi nurses and nursing students about DVA. A hermeneutic phenomenology approach (Heidegger, 1962) was used to inform the study, because it was found to be the most suitable and congruent in answering research questions. Convenience sampling was used to identify study

participants, and data was gathered through semi-structured interviews with Saudi qualified and student nurses in one city in SA. Specifically, participants were recruited from two sites with which the researcher is familiar, which helped due to being an insider, with familiarity concerning the lived experiences participants shared.

The analysis was continuously performed throughout the interview process to identify consistent themes. The transcripts were carefully evaluated to develop situated structures and a general structure (van-Manen, 1990), The analysis was guided by the works of Van Manen (1990), Greatrex-White (2004), and Smith et al. (2009). NVivo 12 software was used to organize the voluminous data, but not to analyse it. The study identified the phenomenon of nurses' understandings and experiences of DVA, how they were manifested in each text, and how they came into being. Ethical principles and elements of trustworthiness were maintained throughout the study. The next chapter presents the findings of the study, and how the findings answers the research question.

Chapter 4
Findings

4.1. Introduction

This chapter presents the main findings of the research and explores how DVA was experienced and responded to by 18 nurses and student nurses in SA who agreed to participate and be interviewed, as described in Chapter 3. This chapter elaborates on how different types of DVA were conceptualized and understood in the Saudi context to provide the reader with guidance about how nurses recognise DVA, and what types of DVA the participants referred to in their interviews. It then illustrates the main concept that explained nurses' experiences of managing DVA in the workplace: "Being disempowered". Three themes were linked with this concept: (i) being unequipped; (ii) being silent; and (iii) being constrained by social and religious contextual forces (Figure 5).

The phenomenon of DVA is revealed to be multifaceted and complex in nature, strongly shaped by local cultural and religious norms. What emerges from these interpretations should be seen as a new level of understanding based upon the understandings of participants and the researcher (in conjunction with the research supervisors) of the phenomena under investigation. The new ways of understanding and unfolding meanings are presented in the following sections.

The findings of the study can clearly be viewed in the light of socio-ecological model. As the findings of this study took shape, it was evident that DVA is not an isolated event but an interplay of various factors that operate at the individual, organizational, community, and public policy levels. This study has articulated nurses' current experience as one of "being disempowered". The themes and subthemes were derived directly from the findings, but I conceptualized them as barriers that can be tackled by facilitators and empowered nurses, which are elements that describe the nurses' experiences and understanding of DVA and contribute to disempowered nurses.

The findings that this experience is underpinned by three main perceptions: "being unequipped", "being silenced", and "being constrained by contextual

social and religious forces”. All of the findings are equally important since they all work together to stifle and disempower nurses and student nurses as they deal with DVA. Approaches to tackle these barriers must be multifaceted and aimed at all levels.

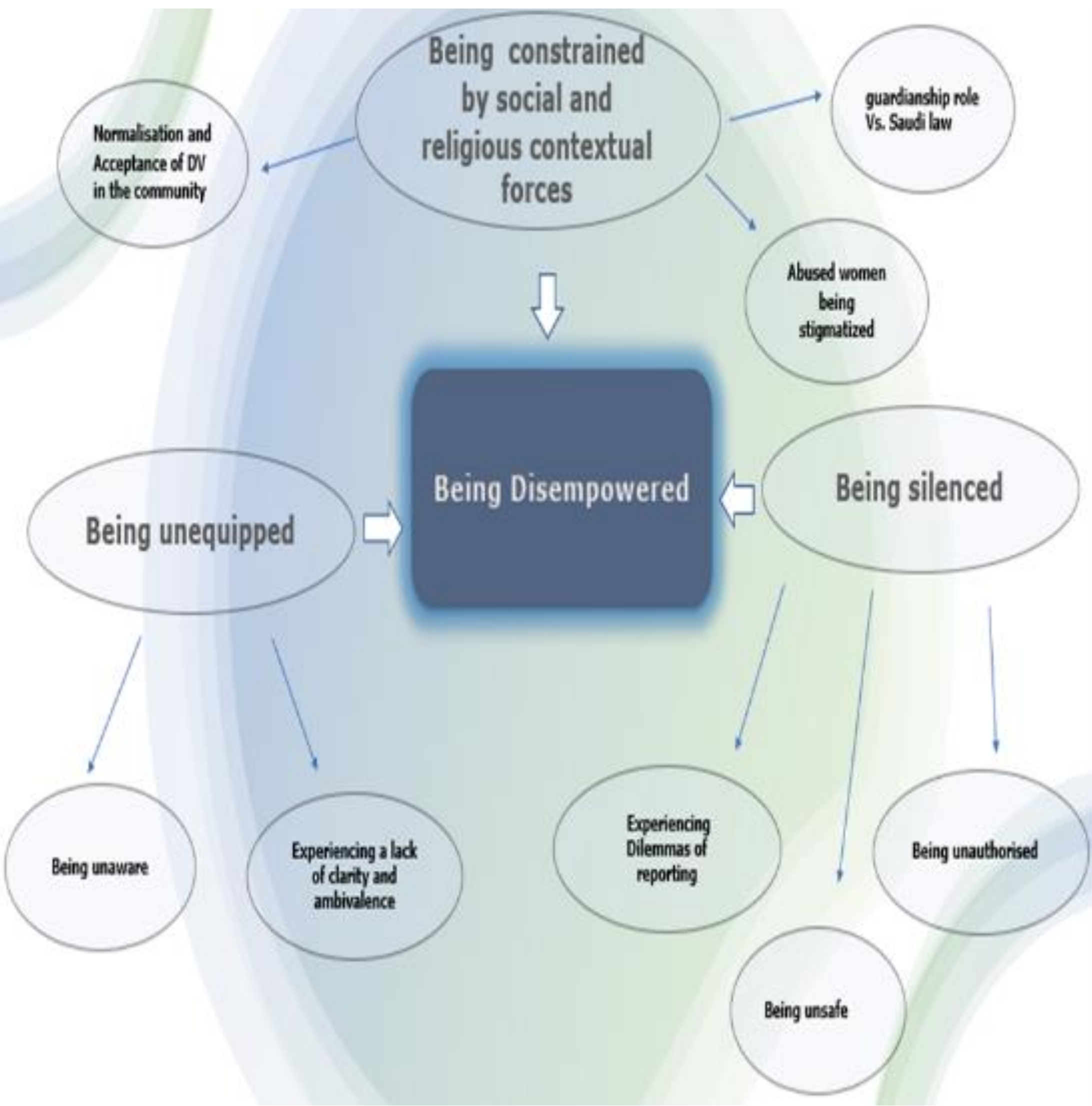


Figure 5: General structure of “being disempowered”

4.2. Understanding Types of DVA

This section describes how the participants defined their comprehension of abuse and the different varieties of it; there was also discussion around what is considered DV and whether this may be influenced by culture and religion. Their perceptions of DV were manifested in different ways, including how they defined different types of abuse, traditional victims of DV, and DV indicators. DVA was identified as encompassing a wide range of harms:

> *"It is anything that can change her mind or change her body; caused by a certain person within her family, it can be either violence by hand or through words in a psychological fight. It can be threats, bullying, hurting her through words or by stealing her money".* – Nesrin

While participants talked about different types of DV meaningful for them in the Saudi context, sexual abuse was only mentioned as a sideline in a discussion of sensitive issues, and participants did not like to elaborate more on this subject. Only Hala and Rama were open about the sensitivity within the Saudi community around sexual abuse, and reported illegal activities in terms of inappropriate behaviours such as incestuous kissing, hugging, and sexual engagement between first-degree family members, such as father and daughter or brother and sister. Nurses indicated that such activities may start from childhood and are often uncovered later when they become problematic during early adulthood. Nevertheless, nurses agreed about the negative implications of sexual abuse on individuals:

> *"Sexual abuse could be extreme, such as raping her and getting her pregnant, or maybe kissing her in a different way than a father or brother should. Here you can see that sexual abuse since childhood has a negative consequence on her future health; she feels that she cannot speak out, not only because they are her first-degree family members but also due to the disgrace if she becomes pregnant…".* – Hala

Zain mentioned other types of DVA, such as "forced marriage", and insisted that a woman must have the right to choose her husband; this is particularly

important in terms of empowering and encouraging women to ask for their right to either accept or refuse any future husband. Saudi culture is mostly conservative in nature, overriding the emphatic prohibition of forced marriage in sharia, with widespread prevalence of forms of forced marriage. Participants suggested that this might develop later to become a predisposing factor in family violence:

> *"Some parents do not take the opinion of the girl into account; they order her to marry this person and that's it… The husband has also been forced into marriage by his relatives, so he doesn't love his wife! This exists in our society…".* – Zain

It was clear therefore that in the first instance the participants were able to recall different types of abuse that resonate with conventional definitions and understandings. However, what was interesting is that issues emerged around culture, and religious issues in particular. There is some ambivalence about the concepts of women doing things "with their husbands' permission" (e.g. asking for a husband's approval to leave the house). Some of the participants felt that asking for a husband's approval to go out of the house is a unique contextual issue of SA, which does not automatically imply a violation of women's rights. Some participants expressed they regarded as a cultural requirement, which they did not perceive to comprise being included in controlling behaviour or violence

> *"You should ask your husband's permission. I feel you should ask, and if he is not satisfied, I will try to convince him… I try to convince him anyway… in our religion, violence is considered 'haram', not allowed".* – Rasha

The findings of the study suggest that participants perceived the domination of men to be culturally ingrained in the society, and they frequently tried to justify this by explaining that permission is not compulsory, but is part of good manners and respect. Generally, they do not see that the prevention and restriction of women's rights could be considered a form of abuse, so social custom and religious norms might have unconsciously affected the participants' views of "husband's permission":

> *"But the husband is not entitled to prevent his wife from seeing her family or to receive health treatment or follow-up and so on… either she persuades him or he persuades her through discussion. I mean to reach an agreement, it's not important who wins, but peace should be reached between husband and wife".*
> – Kady

Some participants had a different justification for husband's permission; Badoor considered that there is a mutual relationship between the wife and husband, and that this is part of the family connection, but she refused to accept that this was gender-discriminatory controlling behaviour, arguing that she had a reciprocal right to know where her own husband was going:

> "*Oh… my opinion on this subject? She is a human being and has rights. Actually, because we live with each other, I have to know where he is going and vice versa, but this is not to prevent me*".
> – Badoor

Meanwhile, Nasrin refuted the idea of "husband permission" and the need to consult with each other on everything. Some of the participants considered that controlling behaviour could be a form of abuse:

> "*Asking permission is also violence. Women have the right to come and go where they want in the same way as men. Men have duties and rights as well as women".* – Nasrin

Although Rama felt that religion was blameless, and mentioned how people misunderstood the concept of religion (as covered in more detail concerning the theme of disempowerment), she elaborated more about the control strategies involved in asking for husband's permission:

> *"Although in religion there is no such… I mean Islam does not support violence against women. Some men do that, but from my point of view, this is not his right, even if the notion of permission is allowed as part of the religion".* – Rama

Of all the participants, Rama alluded to asking permission as being part of religion, but indicated she was not happy to follow that. Most participants

converged on the concept that in SA there is a need for permission from husbands as part of cultural-religious etiquette, which was not seen as abuse *per se* by the majority.

In terms of identifying vulnerable groups, based on the cases the cases they have encountered in the hospital, participants identified that the traditional victims of DV are young and pregnant women. Yasmeen advised that the age of the victims can be problematic with regard to DV. The degree of domestic violence can be worse when the victim is from the younger generation, since this generally gives the abuser more control over the victims' rights:

> *"Violence can be physical, psychological or sexual abuse, particularly for younger age groups, while there may also be economic abuse, in which he does not allow her to practice her financial rights, or her opinion and movement…".* – Yasmeen

Similarly, some participants articulated how pregnancy was a triggering period for DVA. For example, Hoor recounted how her friend had been physically abused by her husband. The participants highlighted that this period should be seen by healthcare providers as a crucial period in the lives of Saudi women, and that further investigation should be carried out to assure that women in this period are safe and free from any abuse that might occur:

> *"I mean one of my friends is abused by her husband and she is too young, so, at first, she got pregnant and then she was beaten, but she could not talk because she was abroad. She thought he might change later on but he did not… So, he beat her again and she got a broken finger".* – Hoor

> *"I also worked at the antenatal clinic, where you can see that many pregnant women suffer from DV, but they don't disclose".*
> – Badoor

Some stereotypes are held around who is more likely to be a victim. Sharifa stated that housewives are more likely to be exposed to DV than working women, and justified this opinion by suggesting that housewives are

dependent on their husbands and do not have family support, whereas working women are more independent:

> *"We still see this in the community, especially among housewives because they are completely dependent on their husband and do not have a family member who can support them… Of course, we cannot generalize this {…} it depends on her, if she accepts the violence against her or not, but I mean that workers have more freedom to express their problems or go to court if they need to; they may be stronger than housewives, who depend on a man completely…".* – Sharifa

However, according to other participants, working women also still experience different forms of abuse, often financial abuse. It seems possible to suggest that the resemblance to domestic violence is probably not due to the enhancement of education or the employability of women. Taken together, according to these data, it can be inferred that there are other factors, some of which are explained later concerning the study themes:

> *"… I know some colleagues who are working and their salaries go to their brother or father. Once a woman is completely independent and can control her salary, she may have a higher chance of leaving the violent environment and be able to live alone… I mean if she is financially independent, family violence could be reduced".* – Nuof

This might be a hidden type of abuse that is largely undiscovered. Badoor and Hala support the idea that only the most serious DV cases had the opportunity to attend the emergency unit. The participants highlighted how DV can be interchangeable in a way whereby one type of abuse can lead to another; whenever the victim becomes silent, she is more likely to be exposed to different types of abuse, which later lead to negative implications, especially when such violence becomes unbearable. The nurses stated that types of DV cannot be separated from each other, and described how the type of abuse can vary along with its implications:

> *"I see cases in the ER* [Emergency Room] *where the woman knows she has to prevent this thing and stop him, because if she accepts it, she will complete the rest of her life as an abused woman. He will develop from verbal abuse to physical and psychological abuse, which can lead to another serious complication".* – Badoor

The most obvious type of abuse that the nurses recognized was physical abuse, but the participants indicated that other types of abuse could emerge as a consequence. Some participants mentioned that psychological and financial abuse might be less easily recognized by nurses, but these could also lead to serious harms. Women's rights are restricted, and their rights may be effectively inactive as a result of their cultural background and men's belief that the best place for women is in the home. In other words, there is an obvious dominance of man's role in the community, which may increase the incidence of DV:

> *"The abuse that I have seen in my workplace is mainly physical abuse, which leads to psychological abuse and may result in financial abuse. It is not clear for us as nurses in the hospital, but most of these cases are physical abuse, where women have been hit so extremely, up to a level where they sometimes need surgery… In terms of the causes, the man involved may be mentally ill and believe that she needs to be humiliated, that the only place she should be is at home, and whenever he needs anything, he wants it immediately".* – Muna

The above quote mentioned a more complex situation with nonobvious types of abuse ("financial and emotional"). Those hidden types or unclear indications of abuse would make nurses more predisposed to be silent, and to feel conflicted and unsure about what to do (as discussed in 4.3.2). Participants used the term physical violence to describe the obvious type of abuse that can be seen or noticed. It seems that all participants undertook physical assessments of the victims throughout their experiences and were able to identify the signs and symptoms of physical abuse:

"Physical examination helps to inspect bruises. We detect abnormalities and when patients are asked about it. They may not reveal their sorrows, but we can notice abnormal signs that indicate physical abuse". – Sarah

The above quote suggests that physical examination help the nurse to acquire a complete patient assessment, when they tend to inspect lacerations, abrasions, bruising, and trace evidence. Nurses are more willing to act in obvious cases of physical abuse, and respond to other types of abuse where such physical symptoms are present. It can be seen that the participants recognized the role that nurses play in addressing domestic violence through nursing assessment, and Rasha explicitly stated that nurses were in a fortunate position to identify such indicators. It is evident from the analysis that this identification of the signs and symptoms of DV can have a positive implication, empowering victims to open up and disclose more information to nurses:

"When a victim arrives at the hospital, we first observe her bodily injuries and look for signs of abuse. It is often clear from the bruises and her fears that the woman has been abused. We then make an effort to ask more questions and encourage them to take their rights". – Rasha

The participants were asked about the impact of DV on women's health and they described the consequences of DV as having the potential to lead to mental illness, which might lead to further health complications, psychological deterioration, and even suicide. This begins with a sense of being undermined, depressed, and isolated, with suicidal ideation, which also affects children, as several nurses reported:

"She may be depressed, psychologically deteriorated, and have troubles all the time… She may need psychological therapy or may attempt suicide, which could be dangerous and lead to isolation or to her violating her children… Violence should be stopped from the beginning, because it devastates and will become a huge problem in her life, producing major health

> *complications like abortions, some chronic diseases, hypertension and so on".* – Nasrin

Numerous participants understood that the consequences of DV are not only for the women themselves, but also extend to her children and the community. Effects could range from her withdrawal from school or decreased productivity as an effective member in society, through to drug abuse and becoming a burden on the community:

> *"It may affect her personally and make us lose our girls. She may stop her degree and become unable to be a good mum who is at the nucleus of the community… This may make her do something wrong that she sees as a right thing, {…} she uses drugs or alcohol and becomes an addict, or hides her actions and starts doing things behind her family's back… Perhaps even developing two personalities, or being diagnosed with a mental illness like schizophrenia".* – Hala

To sum up, participants were able to articulate quite clearly what DV means to them, and types of DV, including physical, verbal, financial, and sexual abuse, and forced marriage. Most participants declared that physical abuse is easier to recognise than other types of abuse within the healthcare setting. Several basic concepts were combined by the participants that mainly describe domestic violence as an abusive act that may violate human rights, excluding the notion of taking permission from husband, which is partly considered as a cultural or religious issue. There is a theory-practice gap' between how violent behaviour is being recognized or reacted upon in practice. Most respondents were unable or reluctant to act in response to DVA, because they felt disempowered during their practice. This feeling of disempowerment is discussed in detail in the next section

4.3. Being Disempowered

The overarching concept of "being disempowered" refers to combined components that prevent nurses from having power, authority, or influence against DV, despite their readiness to help abused women. This concept is

used to interpret and report participants' voices, views, and experiences. It illustrates a meaning unit of the phenomena of nurses' understanding of DV. Disempowerment is an overarching concept with several reinforcing components. Physical and structural components include a lack of systems or processes for reporting abuse within an organization, while more intangible contributors include a culture of silence that prevents or discourages nurses from voicing concerns. Placing nurses in a working environment such as a hospital with certain limitations of their professional authority causes them to lack in abilities, competency, skills, and attitudes to help such patients.

Consequently, actual professional capital is compounded by the morass of cultural and religious stereotypes concerning DV in SA, with issues around women remaining taboo and sensitive in nature, and very complex in their structural values. These factors all pose barriers to an effective nursing role in caring for abused women. The concept of disempowerment is an attempt to understand domestic violence and initiate dialogue from the understanding of nurses' experience. It is intended to identify the challenges, barriers, and perceptions that may affect their roles, and to offer a suggestion of strategies to promote their roles and performance in facing DV of women. The following parts of this chapter move on to describe in greater detail the disempowered status that participants highlighted as important challenges while dealing with DV, discussed concerning three main dimensions of nursing disempowerment: (i) being unequipped (ii) being silent, and (iii) being constrained by social and religious contextual forces. (Figure 5).

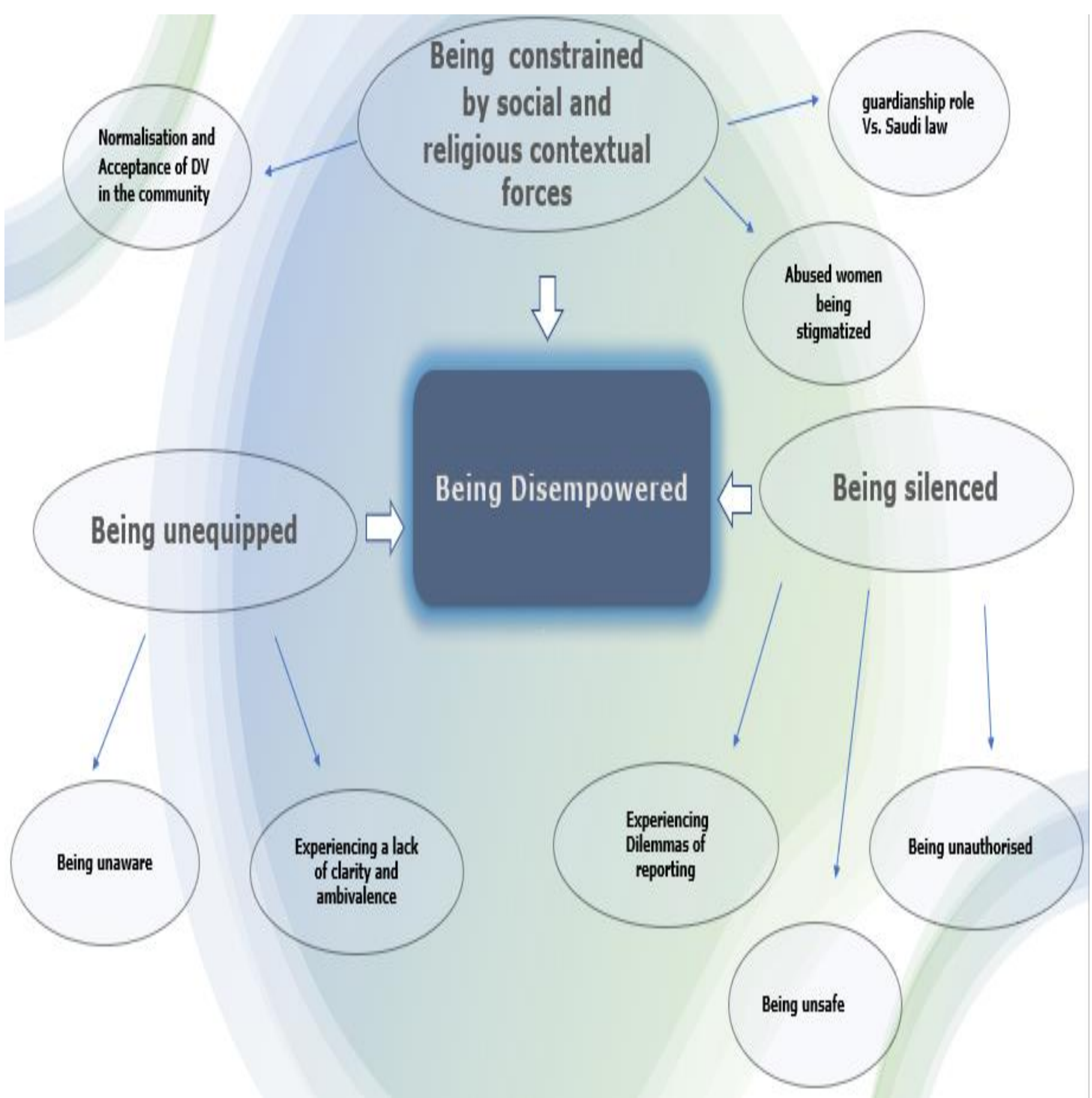


Figure 5: General structure of “being disempowered”

4.3.1. Theme 1: Being Unequipped

The concept of being unequipped refers to nurses feeling unprepared and unready or unable to deal with domestic violence, and experiences of being unaware for many reasons, including lack of education and training, which leads to feeling unconfident, powerless, and unsure (Figure 6).

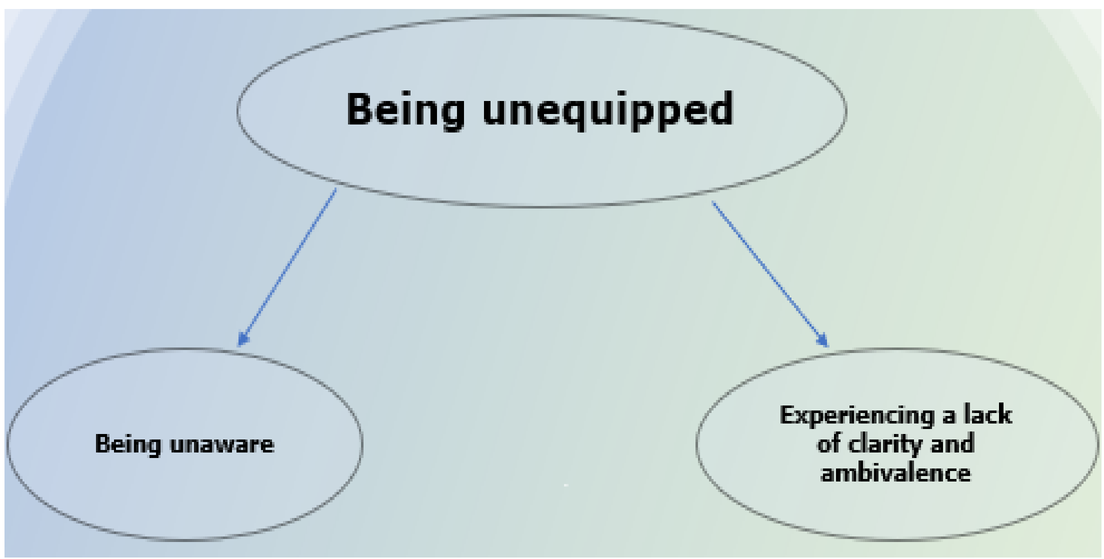


Figure 6: Theme 1 – Being unequipped

It also refers to nurses experiencing a lack of clarity, including a lack of clear policy, being left alone, and a lack of referral systems. Although education and training in facing DVA is highly important, respondents from this study experienced the absence of training in how to deal with domestic violence, which was evident throughout their interviews. Six nurses stated that they were unequipped in their position to deal with family violence, as exemplified by the following quote:

> *"Honestly, I don't know because I am not well-equipped, I personally feel scared and unconfident to deal with these cases… and I have no clue how to start with her and ask her about the conflict I can't behave".* – Hala

Hala stated that she felt scared and had a lack of confidence to deal with cases of violence. She added that this affected her ability to reach her full potential. Despite that, the participants stated clearly that nurses are in this position to stand for DV cases. Hala turned to be a silent witness to many other different types of abuse that were mentioned previously, and she became concerned only about the physical injury in domestic violence when patients presented at the hospital, regardless of the underlying DVA causes. It seems possible that such actions are due to a lack of confidence, proper policies, systems, and training and education. Also, there are many potential reasons why Saudi nurses become silent, as uncovered later in this chapter.

4.3.1.1. Being unaware

Regarding feeling disempowered, more than half of the research participants raised an important point about being unaware and having limited knowledge and training about DV. The participants stated that a lack of awareness about DV among victims may result in frustration and unmet expectations, leading to nurses feeling unconfident and powerless. Sarah stated that there should be healthcare improvements regarding the lack of awareness among nurses and women about domestic violence. The participant believes/feels that with nurses' role as the first people women will meet in the hospital, the absence of awareness may have played a vital role in keeping the violence from being reported; that may also have assisted nurses and patients to become more reticent to report domestic violence. Their lack of awareness of this matter was remarkably noticed in participants' interviews:

> *"Some of them* [abused women] *refuse to proceed in the complaint until they go back home, so it all depends on the nurse's understanding and awareness of this topic. I wish there were campaigns to increase awareness about family violence against women and educate and raise awareness of all frontline nurses on how to deal with this issue, and how to escalate the case to the related authority, or to educate anyone who may contribute to solve this issue in our community".* – Sarah

Most of the participants called for better education programmes that enhanced their understanding and increase their awareness about DV. Although extensive research has been carried out on the importance of educational programmes in confronting family violence, no single study demonstrated that a Saudi national curriculum was established to face such challenges at workplaces. The participants in this study raised such concerns as there was awareness of the absence of such education or training, which limited their involvement in facing DV at hospitals and elsewhere, as demonstrated by the following exemplars:

> *"I've never taken any education or training about it. How do I contact the patient and ask her about her situation… something*

> *like that if I'm not aware. Yeah… this is exactly what we need in our curriculum. In the DVA case, we need to be exposed and trained in the bachelor's degree somehow!".* – Tahira

> *"We need to have a small course in the foundation year, because we will need it after graduation… but what is happening is that we finish, and when we see an abused case we go and look for help…".* – Nour

Nour was curious and searching for information about DV from online sources or different books. However, she expressed that one of the main challenges that face nurses was the discrepancies between theory and practice (specifically, what they have read or learned and what they have witnessed in the hospital while facing DV cases). It appears to be very challenging to apply theory to practice. Although nurses and student nurses are encouraged to do their best in facing and solving patient care problems, this was not the case with DVA:

> *"How can it help us as nurses when I am reading from an international book or internet how to deal with violence but cannot apply it… as if it is forbidden to use it, which is pointless… it should be something that we need to learn about, and included within our assessment and curriculum with high visibility and applicability…".* – Nour

Some of the participants pointed out that limited knowledge exists concerning the cultural and social norms persisting within Middle Eastern societies, and disparities between different cultures:

> *"Bear in mind, what applies in Western society is not applicable for us, and our education and training programme must consider our norms as an Eastern society".* – Kady

The literature on how to incorporate cultural competence in practice is lacking. The true meaning of this is discussed in the following chapter. Cultural competence is considered to be an individual's core requirement for working effectively with culturally diverse people. Aziza narrated that a lack of

awareness about government support for domestic violence can increase or decrease DV, and misconceptions about it can lead to the acceptance of DV for both nurses and victims:

> *"She doesn't know if she is abused or not or that the government may protect and support her… I think that no one, not even nurses, know about this kind of support. The level of awareness is almost zero. You can ask any woman about it, and you will see that they don't know anything, and by time they thought it* [DV] *normal…".* – Aziza

The above quote demonstrates how a lack of awareness can implicate the acceptance and normalization of domestic violence for both victims and nurses, by misunderstanding the phenomena under investigation. Most of the participants disclosed their deep feelings about the need to raise awareness among nurses about the DV issues:

> *" – I feel one may need to know factors related to violence and respective solutions to tackle it… and as a healthcare professional, one may desire to explore how to interact with these cases being aware of the policies to follow, and respective centres that provide treatment to these violent cases, to signpost people in need…".* – Muna

Nour suggested that a different way to raise women's awareness is through brochures or educational classes offered by nurses:

> *"I wish we had an educational room to educate them about family violence and how they can deal with it, signs and symptoms, or excuses that abusers may use all the time… another idea is to give educational leaflets about violence and hotlines, and how we can help by referring to social services…".* – Nour

The participants called for raising awareness and overcoming DV by considering the social factors and collaborative work inside and outside the hospital, in terms of legislation, policy, platforms, and special programmes, etc. to empower nurses and abused women to overcome such situations. The

participants identified a need for a holistic approach to face family violence in SA. For example, many participants developed a sense that they can use schools as platforms to change the image of women and the traditional way women are treated. Also, the school may play an important role in educating children about women's rights, enhancing respect for nurses, and increasing awareness among children and the community about family violence. The following example illustrates their view on how schools might offer positive input concerning family violence:

> *"it should go through a holistic approach using social media, schools, mosques, healthcare centres, and shopping malls or leaflets talking about family violence, and she could deal with it… so, I don't think it will be difficult to spread the word and raise awareness…".* – Nuoaf

There are also many forms of being ill-prepared, such as the absence of in-service training in both universities and hospitals (and other forms of CNE) which lead to feeling left alone. Aziza thought to overcome such feelings through appropriate training programmes, especially considering that all the participants mentioned that they received nothing in terms of education/ training concerning DVA, as demonstrated in the following quote:

> *"If the hospital wants to improve services on this subject, they need to offer us some training programmes through violence organizations… and to teach us some statistics about it, how to deal with it and what to expect…".* – Aziza

The lack of hospital services, policy, and supportive training programmes about DV was also noted by many participants, in attempting to highlight the importance of caring for patients who suffer from violence holistically. Hospitals have to contribute more in improving the care for DV. Many participants in this study expressed a feeling of being left alone and unequipped with all the barriers they face in dealing with domestic violence cases. All of the participants replied that they had not received any formal training and education concerning such care, but Kady and some others appeared highly

desirous and enthused about joining any course or training offered about DV, even if it was extra-curricular:

> *"No, but there is a two-day training course. I registered, it is out of the curriculum and seems to be a conference on the mental health of the women… I will see if it includes violence of women. Really, I wish to get training on it".* – Kady

> *"We need a long practice to know if the person in front of you is oppressed or not. It's hard to know how to handle such cases".* – Rasha

It was suggested that several areas for student training should be utilized, not only hospitals, such as women's shelters and organizations, to support and raise nursing awareness, but they were not aware of any such facilities:

> *"They* [students] *can practice in associations or shelters that offer services to such cases* – *I don't know them".* – Nasrin

Based on the above findings, the nurses felt unconfident to perform well while dealing with the victims of DV. Nurses tend to play an important role in helping domestic violence victims. However, nurses in this study felt unaware and hesitant. Being well aware and feeling confident is basically a belief in oneself, in one's psychomotor skills, judgment, capability to think, and possession of knowledge to reach conclusions. However, in this study nurses often felt unconfident or hesitant to deal with or report suspected abuse cases, hence it is important to believe that reporting is not an accusation, rather it is considered as a request for an assessment or investigation. Many nurses illustrated how a lack of confidence in dealing with DV due to a lack of knowledge/ training requires further education to overcome such a feeling. This may reflect the reasons for keeping silent:

> *"I will not be confident in dealing with those cases unless I am well trained and educated on violence and how to deal with these cases, to feel fit that I can deal with these cases…".* – Amal

Most participants shared how unconfident they were, and the lack of structured learning compounded this. Some nursing students and practitioners claimed

that their lack of confidence stemmed not only from a lack of knowledge or education, but also from a lack of experience:

> *"I feel I am not professional enough to deal with cases. {laugh} I'm not confident enough… uh this interview makes me … this is the first time I am thinking out of the box in depth".* – Kady

Effective teaching / clinical strategies should be developed to promote self-confidence and increase nurses' awareness and acquired appropriate skills about DV. Also, some nurses experienced being unaware of the appropriate skills. There is a dire need for communication skills to ensure that nurses are providing appropriate care to abused women, and allowing them to open up, with strategies on how to respond to and deal with DV cases. Hoor, Rema, and Tahira emphasized the need for communication skills to help abused women to disclose their situation, and noted that the absence of such skills could put nurses in a dilemma of whether to report DV or not, as explained later in this chapter:

> *"I need to have good communication and a good manner in asking the patient questions and reassure her and try to build a trust relationship and to calm her down until she cools off…".* – Hoor

> *"…skills on how I can deal with her. I can convince her to tell us".* – Tahira

Amal expressed the necessary skills nurses should be equipped with, such as being non-judgmental, that encourage women to talk about their situations:

> *"… I expect that when the person is afraid, specific skills are needed to support them psychologically… possibly also nurses' behaviour; she* [the patient] *may not accept it because some nurses have a bad attitude! And they judge you* [abused women]. *It happens. Women might be afraid that their stories will be announced, and that the information will spread".* – Amal

The importance of being equipped with specific skills to deal with abused women properly was raised by Rasha, who cited that observation is one of the

communication skills needed to detect DV cases, based on her previous experience:

> *"The power of observation is the most important thing. You can acquire it by practice. When I was new to the staff, I mixed up with the patients the first time, and I started to know gradually and see the first case and the second case, and I started to know and so on".* – Rasha

Malak stated that nurses, by nature, have skills that enable them to do their work properly, including listening and building rapport, and there is no need for specific skills:

> *"I feel it is available in the nurses by nature. Listening skills and instilling confidence. The relationship you build between the nurse and the patient. Anyway, the patient gives you information, mainly about her sickness or herself and, if the patient accepted you, she will give everything. The first thing is trust".* – Malak

Thus, Nour suggested ways in which to break nurses' silence so that the victim could speak out. These relate to building rapport with victims, which might help to break the ice and encourage them to speak up:

> *"I usually ask the woman some normal questions about her life because they often don't speak out immediately and you need to start discussing something else, like their studies or degrees. You can then start to notice the signs and symptoms of the violence and determine whether she is upset about something or not. Sometimes I tell them about my mistakes and what I have done and as a result, they may start opening up and talking about their problems, so you can be rewarded for your patience and in time, they speak".* – Nouf

The power of having adequate education, knowledge, and training is that it leads the nurses to acquire confidence in their capabilities, given our finding that nurses felt unconfident because they did not have a strong educational and training background. Thus, to promote self-confidence, the curriculum of

nurses should be designed in a way that allows them to gain enough confidence to deal with such situations properly. Before proceeding further, it is important to notice that nurses in SA stressed the importance of education/ training and acquired skills.

4.3.1.2. Experiencing a lack of clarity and ambivalence

This sub-theme refers to a lack of clarity concerning nursing roles and tasks in caring for women who experience DV. Clarity implies the fact that they know what they are supposed to do, which includes policies and procedures and what is expected of them within the healthcare system. However, inconsistency exists at the level of the organization when women seek support. Many organizations have a clear policy for when women ask for support or have obvious injuries, but lack such procedures when voluntary disclosure is not made. The nursing role in DVA thus remains unclear, despite the organization encouraging holistic care for all service users. Under this situation, nurses find themselves in a weaker position to support those women in the absence of authorities. There are also policies and laws, but they remain unclear, unknown, and in abeyance. It was noted by other participants that a sense of clarity was missing from their roles while dealing with DVA at the hospital:

> *"We don't have to deal with it clinically, and don't have a policy that is trying to find some solutions regarding domestic violence; nurses' roles are not clear enough about what we should and shouldn't do! I will not be able to change anything as a single person. It is a big circle and everyone should cooperate to solve this problem".* – Hala

As a result of this, nurses expressed a sense of powerlessness in facing such situations. Finding a policy that supports participants' role may have a great impact on transforming their attitudes toward the care they can provide to victims. As described in the previous and following exemplars, nurses uncovered a sense of lack of clarity about their roles. However, a broader perspective was adopted by Hala, Nour, and Nawal, who argued in their interviews that without clear roles of nurses and actual collaboration from

everyone at the hospital, community, organization, and family levels in facing DV, nurses would not be able to deal with it at the hospital, despite the theoretical existence of policies. Nurses experienced a sense of difficulty in dealing with family violence and expressed the limitations of their abilities to provide support to victims:

> *"There is nothing clear for us as nurses in this issue! I meant in our practice. And there is nothing clear in our role; it's not stated clearly for us in our job description; we also don't have authority and there aren't any policies or services I know to facilitate my job… I feel that women organizations are still working in the dark as if it is a secret. And as I have said, no one tells you about those organizations. When I go to the hospital to receive treatment and she does not know what to do or whom to go to, such as the police or the court. All the different organizations must work together to support nurses. Therefore, it is very dull".*
> – Nawal

The above quote suggests a lack of clarity of the role of a nurse, and the limited policies on DV limit the capability of nurses to actualize the full scope of their professional responsibilities. Participants stated that everybody in the hospital environment should cooperate to solve a certain case of violence. Hala prompted and elaborated important aspects of nurses' performance while facing DV, indicating how nurses experience an isolated role that separated them from other teams in the hospital. Hala encouraged other nurses to get involved and be part of the team, especially with all of the other challenges faced, as illustrated below:

> *"It is like a normal nursing examination discussion, asking about the bruises and how they were done, and what happened, and I don't have to be informal, because other parties will start following their related issues. Therefore, I don't need to interfere in other things… all I need to do is to collect her medical history, and if there is something clear, I need to report it and propose a nursing care plan for her… so, we are all complementing each*

other's roles; police, social workers, or other healthcare teams. I don't think that nurses can do most of the process. An example is of an incident that happened before, where social workers convinced a woman who tried to disconnect all tubes that were connected to her daughter's body…". – Hala

As noted in the above quotes, nurses face challenges of being disempowered due to the absence of relevant laws, lack of policies, lack of clarity in inter-professional working, and feeling quite isolated in terms of other support that could help their role in caring for the victims. As a result, the majority of the participants expressed a sense of lack in roles to protect women that were participating in DV and they become part of it:

"I said to you that the nurse can do everything, and we have to be confident, but the laws and policy are controlling us. So, nurses being part of this circle… maybe". – Malak

"Currently, in light of having no law or ethics, nurses could be part of the problem because they have no other solutions, no specific role to perform…". – Hoor

As a result of the lack of clarity, most of the participants illustrated that, despite their fear of reporting, this was the main action they undertook while actively dealing with domestic violence. Undoubtedly the participants expressed disempowerment while facing DV, and their concern about their personal safety is explained under the next theme.

Muna reinforced the idea that clarity is skilfully tackled by creating a policy. Developing a policy that supports participants' role could have a great impact in transforming their attitudes toward the care they provide to the victims:

"Violence is still not clear. I feel if there is a certain policy it can help to deal with those cases and may lead to reduce violence as well". – Muna

Sharifa also mentioned the Western model of advocacy for victims, which can be useful to healthcare professionals to apply in SA, where the majority of participants stated they lack system support when facing family violence:

> *"they have… one of my colleagues went to the GP as she was pregnant, and the nurse practitioner in the UK asked her about a bruise she had, and told her that 'I will not discharge you unless you tell me where this bruise come from, or I will call the violence healthcare team to investigate'… you know that will support practices in Saudi".* – Sharifa

The participants revealed the importance of clarity in the process of protecting women's confidentiality within the healthcare system, such as how to report; there is a lack of guidelines, policies, and procedures around protecting the privacy of abused women. If a nurse goes the extra mile to report a case of abuse it may lead to a breach of patient confidentiality. Thus, protecting patient confidentiality without clear guidelines remains a challenge. Establishing a policy around victim confidentiality appeared to be important in reducing the indirect stigma that can be seen when reporting DV. Umm Hala suggested a similar approach to that used at hospitals when dealing with HIV:

> *"I don't know how to investigate the case, and all I know is that there are bruises, and I don't know about confidentiality. For example, we have a law that if a patient has HIV, we should not disclose any information or use a red pen, as well as protect the patient's confidentiality. We don't have these instructions applied to other things, such as family violence".* – Hala

Zain, on the other hand, argued that confidentiality is a basic nursing skill. Society becoming more aware of nurses' roles will help women to disclose DV situations and lead to empower nurses:

> *"It is nice that society knows the role of the nurse. For example, in dealing with these cases with high confidentiality".* – Zain

It can be implied that many participants felt that DV can sometimes be an issue to report. One main challenge nurses encounter was that the policies or systems that could help to report such cases easily and with confidentiality were inadequate and unclear. Nurses were reluctant and afraid to report cases because of the potential to breach patient confidentiality. The next section explains more about being silent.

Nurses expressed that being left alone makes them feel anxious, insecure, and depressed, which harms the patient, as it puts them in a high-risk situation, and makes them feel devalued. Sharifa was very explicit about limited confidence to deal with tough situations, and how Saudi's nurses were left alone to deal with domestic violence and find their ways to deal with domestic violence. Most of the nurses described being left alone to deal with challenging situations, disregarded after voicing concerns related to both patients and personal safety, with no clear directions or procedures to follow when such cases were witnessed. Thus, nurses should possess contemporary knowledge and training to categorize concerns and manage different types of patients properly. As one of the nurse participants responded:

> *"I don' t know which process should be followed when we witness abuse and we have no idea what we can do to be honest, and it all comes from our personal initiatives. Either to call the police or contact the hospital security, as we don't have a clear instruction to follow… so, nurses' role is not clear in these situations and if she did something, it comes from her heart…".* – Sharifa

The unique conclusion that emerged from the data of this study was that the participants followed their intuition, as stated from the proceeding quotes of Sharifa and other participants, when they do not know what to do exactly, without clear guidance or policy to support their work. Nasrin, as a new member of staff, also felt she was left alone and without clear direction, and she tried to find her way and what her heart-intuition told her to do, and she stated that there was no certain policy about DV when she encountered such a situation, so she learnt by experience:

> *"At XX hospital, nobody in the orientation days gave me information about these cases. I mean for me, if I didn't pass this situation, I would not know that there is a policy at XX hospital but I dealt like this … when I passed and I tried, this is from myself personal initiative, technically… I was alone". - Nasrin*

There is ambivalence on how hospital support and provision of quality care for all can be reconciled with informing new employees about policy related to

such issues as DVA. Nasrin stated that this had been neglected in the induction training for new staff, which should have explained the hospital policy and systems related to the topic, and familiarized staff with it. Nurses were left to fend for themselves in dealing with complex issues:

> *"Look, from the day I was hired here in the hospital, they never talked or explained to me what the policy or services are about violence, but when I asked a social worker, in this case, she told me that first I should call her, and she could communicate with the security in the hospital and make contact with the police outside the hospital, to take the necessary action. I asked and searched for services that might help these women… and hospital services need more and more development".* – Nasrin

Part of the policy is that the awarding or renewal of nurses' licenses require accredited hours and certification of passing CPR training; this is also offered for many other important courses, but this is not the case with DV. Tahira and Nasrin also mentioned how DV training and education is neglected in hospitals, while they focused on and did periodic training for other areas like CPR, and emphasized the need to know the international guidelines for supporting abused women:

> *"I guess if the hospital provides training courses, like periodic training and certifying CPR to be registered nurses, about DV {…} also, I need that. I didn't think about that before, but I want to know what is the procedure and process that we must follow, even if they are international guidelines".* – Tahira

> *"Here in the hospital, we have many courses and training that support other things rather than DV. There should be courses about violence…"*. – Nasrin

On the broader view, Umm Malek stated that many things contributed to disempowering nurses and left them unequipped and alone, without a routine inquiry checklist or a compulsory screening tool, as a policy established by the hospital to support nurses' roles and decrease the sense of loneliness they face in DV cases:

> *"It's a routine inquiry, if there is an available checklist for all women and other services in the hospital to support DVA cases".* – Malak

Some participants expressed their limited abilities to address the victims' psychological needs and to provide adequate psychological support. Nurses argue that it is difficult to detect other types of DV outside physical abuse without clear signs and symptoms, particularly in the absence of an assessment protocol and ambivalence in policy:

> *"I am not sure if I would be able to detect violence if there were no physical signs and if there were no tools to assess it…".* – Sharifa

Without enforced policy, Hala also mentioned that sensitive issues could face social barriers to enquiring about them, like sexual abuse (more explanation about social disempowered is explained later):

> *"We cannot say it frankly or talk clearly about sexual abuse, as I believe that it is not accepted in our community; for example, you cannot ask a man if he drinks alcohol or not, because they will not accept this culturally, due to the sensitivity of the topic {…} in the same way, if you talk about how to protect women from sexual abuse, they may not accept it…".* – Hala

Many nurses found themselves ill-equipped and excluded from dealing with serious cases of DV. Such results can be explained by the fact that the sensitivity around DV made nurses and student nurses excluded. It could be that the lack of confidence or awareness about DV and getting involved in such cases made them reluctant to take action to deal with or report it, and to be advocates for DV victims. However, this result raised the question of how nurses can be required to be in the frontline in facing violence, with no adequate training, education, policy support, or equipment. Participant accounts indicated a total dearth of adequate support at the workplace.

Nouf's narrative indicated how her knowledge and attitudes toward the victims of DV were influenced by a lack of referral system in challenging DV at work,

which was only concerned with physical issues. This was supported by Badoor, who expressed that they only treat symptoms:

> *"…we gave them paracetamol, a painkiller. The doctor comes and asks what the problem is. We usually try to end the issue by giving her essential care and discharging her out of the hospital".* – Badoor

A possible explanation for this might be being in an environment where physicians allocate tasks to nurses, instead of nurses taking the lead in providing care for the victims. It appeared that nurses waited until the physical assessments were finished before even taking basic action like providing painkillers. Others related such behaviour and action concerning family violence to the lack of support and hospital policy to facilitate nurses' roles. It seems possible that this reflects a lack of clarity about nurses' roles in dealing with domestic violence, as explained above.

Being unequipped was uncovered by research participants' experiences through a need for a referral system, which is also part of the policy. A referral system is deemed significant as it has positive implications. Through referral systems, women are able to receive prompt and immediate care from local authority services based on types of family violence. Moreover, some participants stated the importance of psychologist or psychiatrist involvement in DVA:

> *"We know that family violence has an impact and she* [the victim] *should be referred to a psychologist or psychiatrist to rule out any psychological problems and to investigate, treat and follow her…".* – Hala

However, Hala and Malak further described that although they mentioned that victims should be seen by psychiatrist nurses or psychologists for their care. they mentioned that if victims visit ER with non-obvious psychological symptoms, it is almost impossible to know if they are victims and what they are going through. Also, the ER does not have trained and specialized DVA nurses to understand, assess, treat, and follow the situation, making care difficult for

DVA victims in such specialties. Hala shared further views on this later in the interview:

> *"It is difficult and cannot be discovered unless she* [the victim] *comes to the ER shouting or stressed, especially that we don't have psychiatrist nurses in the department… all I know is that there are some psychological impacts…".* – Hala

Health and justice are mutual and have effects on people's lives. Malak recognized the importance of experts dealing with DV in the field, such as forensic nurses, with sufficient policy and legislation to protect and support nurses' roles as well as the human rights of victims:

> *"If we have a criminal nurses section, maybe there will be communication so that we do not influence the patient and have a guarantee that she* [the victim] *is protected, now and later, and keep the case highly confidential and secret. Plus, her children's future… and deal with the topic in our own way, and that makes her* [the victim] *relax and talk more. But since there's no such criminal nurse speciality, I could cause a bigger problem for the patient if she said anything or talked…* [decision makers] *should facilitate our role and deal properly with this case".* – Malak

Clearly, there is an enhanced feeling of being unequipped and disempowered through a lack of referral systems for victims. As a result of having a sense of self-blaming and powerlessness in the hospital when facing DV cases, Nouf added how nurses at her unit were chosen to call any security personnel at the hospital or the police to temporarily segregate abusers away from the victims. Participants thought that this was the ultimate action that they could provide victims. However, the question arises of what would happen after victims reunited with abusers again? Nouf stated that they still need to enhance the care for the victims, as she stated that the only thing they were providing at the time was a painkiller!

> *"We have someone called Mr Strong who is part of the security, and we call him once we feel the need to {…} we don't have a special team to deal with violence cases. So, her* [the victim's]

> *husband came and he hit her when she was alone, and then we called Mr Strong and the police and prevented the abuser from entering the hospital {…} the healthcare team has done whatever can be done and the child was treated as well, while the mother suffered from a bruise from that situation, and all we did was give her a pain reliever… all in all, once we call the police, we will not intervene further…".* – Nouf

The legal system of SA may at times is flexible with the abuser because of the guardianship concept, described in Chapter 1. This leads to the disempowerment of both nurses and women victims. Ten participants stated that they sensed a lack of support for women suffering from DV when they arrived at the hospital. In fact, participants stated that the laws are being used flexibly and in favour of abusers to legitimize their actions against women or children. For example, Nour explicitly emphasized that a lack of law supporting women made abusers unafraid of any further action that may be taken against them for further abuses:

> *"Yes, there is no adequate punishment for their actions as it is only a pledge signing… and does not support the abused woman, and she will be afraid from the abuser all the time as he may do it again…".* – Nour

Participants in this study reported a lack of disciplinary action against the abuser or even the one who tried to breach their roles to hide any DV:

> *"I don't think so, and most often these cases are handled by police who ask for the report, and that is why they return them to their families sometimes… what I know is that some of them go to jail, especially if they have done something wrong…".* – Hoor

Participants also feel quite isolated in terms of other support that they can access. The study sample suggested alternative ways in which they thought this might help and support the victims, and somehow help to reduce the cases of isolation, based on their experiences:

> *"We need laws and regulations from many authorities, such as the police, health organizations, family organizations, and counselling, to educate people, to limit the number of these cases… I mean, there should be an umbrella from the highest level to protect those cases. We need clear regulations for nurses on how to deal with and investigate those cases, and need to be trained* [practically]*, because the theory is not everything, and I need to know what I need to do, like if they need psychological support, and need to know what the ethical consequences will be if I could not refer those cases to receive psychological support… I mean that we need very big, updatable regulations to fit the requirements…".* – Hala

Concerning the understanding regarding DVA among research participants, the analysis demonstrated that most of the nurses expressed a feeling of powerlessness and perplexity regarding how care can be provided for DVA victims in the hospital. Nurses were well aware that ethically they were obliged to report the abuse, and if they did not do so, they were breaching the international code of ethics. However, they did not report due to lack of support, giving rise to the feeling of powerlessness. Thus, the feelings of powerlessness are reported to affect nurses' perceived ability and competence to provide quality care and also contribute to moral dilemmas:

> *"Personally, yes, I try to do my job properly to my best ability. But because there is nothing available to support my role, I cannot do it as it is affecting me as well and I feel bad about it. I feel apprehensive, frustrated, and I blame myself internally, but I cannot change anything, and I don't know too much about family violence… I know that I breached the ethical code of conduct, but it is already wide…".* – Hala

As reflected from the above experiences, the nurses of this study considered that their feelings of guilt, powerlessness, helplessness, and lack of understanding of DV were reasons that made them less involved in DV cases. Many participants narrated that there is a sense of powerlessness whereby

they witness domestic violence and do nothing about it, feeling unable to act, or unsure of how to act. In fact, this gives them a sense of a lack of clarity about their roles, as their main concern is physical care. As mentioned earlier, participants described having a lack of awareness, which makes them less confident about getting involved in family violence cases. Nevertheless, appropriate training in this regard can aid nurses in overcoming the feeling of guilt, powerlessness, and helplessness, as pointed out by participants. As a result of a lack of clarity, most participants illustrated that, despite the fear of reporting, this was the main action they undertook while dealing with domestic violence. Undoubtedly the participants expressed disempowerment while facing DV, and concerns about their own safety, as explained in the next section.

4.3.1.3. Summary

Nurses tend to play a significant role in serving the victims of domestic violence and abuse. Participants expressed having a lack of skills and formal knowledge concerning the key barriers that provide suitable care for females living with domestic violence, specifically lack of awareness about DV and ways to intervene. Nurses also experienced a lack of clarity regarding their roles, as they felt that they were not well trained or prepared to execute their job responsibilities well. They felt threatened that they were unaware of what the management wanted from them, and they had no clue of how to perform their tasks.

Many nurses found themselves ill-equipped, and excluded themselves from dealing with serious cases of DV, thus this section has attempted to identify factors that contributed to their apprehension, hesitancy, feelings of inadequacy, vulnerability, and frustration while dealing with domestic violence. These feelings were associated with being unaware because of a lack of education and training, and nurses experienced ambivalence and a lack of clarity concerning laws and policy. The analysis of nurse narratives revealed how these factors transformed their attitudes toward DVA. These issues combined to create a culture of silence, explored in the next section.

4.3.2. Theme 2: Being Silenced

Another theme that emerged from the experiences of nurses is the concept of "being silent", a key concept referring to a specific reaction, which may be external and internal factors that maintain the silence of a nurse towards a victim, whether nurses wish to help and or nurses have some control but choose to be silent (Figure 7). This involves nurses remaining intentionally or unintentionally quiet and not reacting, involving themselves in, or reporting a certain situation, such as DVA. This concept is explained under two interpretations. First, the nurses experienced that lack of clear policies and procedures and lack of education and training related to DVA led them to stay silent intentionally, exercising their control. However, the nurses also discussed that there were instances where they wanted to act constructively, but were silenced by external forces and factors which prevented them from taking corrective action. This theme has three sub-themes, as illustrated in Figure 7.

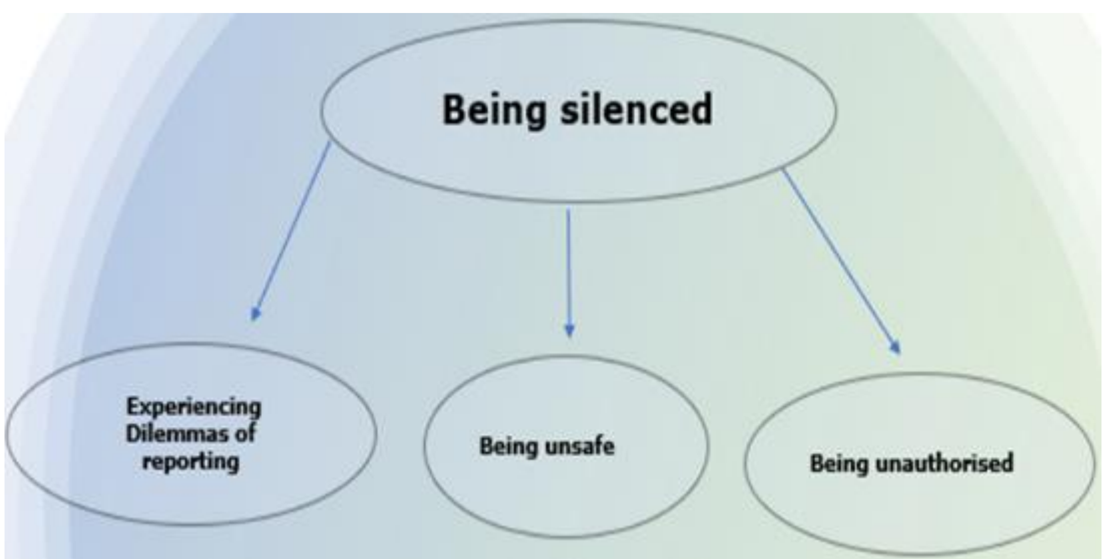


Figure 7: Theme 2 – Being silenced

In hospitals, most participants illustrated that being silent was the main action they took while dealing with DVA. Being silent manifested in different ways among different individuals, and included being unauthorized to report, being conflicted, and being unsafe. Participants displayed an apparent lack of empowerment when faced with cases of DVA. It is important to note that many of the nurses in the study were female nurses from SA, where being silent as

a woman is deeply embedded in the prevailing culture. As mentioned previously, participants expressed a sense of acceptance of domestic violence and normalized DVA when it was found in the hospital, which is the reason nurses were often silent about it. Conversely, nurses expressed a lack of support structures and clear policies and awareness regarding DVA. It could be argued that the cycle of abuse has been normalized in such a way that Saudi nurses did not see any point in getting involved in the process of reporting it:

> *"As nurses can see things that no one can notice… as nurses are always in the front line. But unfortunately, most of the nurses are keeping silent".* – Aziza

The participants were willing to encounter DV situations, but they felt frustrated when women gave up their rights, which led to nurses' reactions of being silent. More explanation about the effect of community impacts on abused women's decisions is provided later:

> *"She suffered from bleeding and, after her examination, she informed the doctor. A report was written about the situation and then her father came to support her, but she gave up her right and solved the problem peacefully and* [laughs] *I feel angry – he has to take the punishment! Anyway, I wouldn't help her again".* – Kady

4.3.2.1. Being unauthorized

Being unauthorized to report refers to a nurse's lack of legal power to make decisions, deal with DV, and report cases of DV within healthcare organizations. Thus, nurses lose their responsibility and obligation toward abused women and remain silent. In this study, when nurses are not assigned to report violence as part of routine and clear policies, they will be inclined to be silent even if they witness cases of DV:

> *"Yes, but you know because I am in a tertiary hospital and work in the Emergency Department, I don't see many cases of abuse other than those who are psychologically abused… the rape*

cases that I have seen were before, when I was working in the southern region… the rate of the rape there is higher than in other regions… what happens usually is that only police, supervisors, and physicians are engaged if rape has occurred". – Hoor

Amal also stated that the ultimate authority was physicians, and the main nursing role was documentation, according to the hospital policy:

"In my hospital, we don't have authority for nurses in DV cases {…} the doctor writes a case report, not nurses {…} there is no direct role. We just assess patients and write nurse notes, not reports". – Amal

Nour also stated clearly that she is not authorized to take action, and cited that nurses might need channels in the hospital to empower them, such as a hotline in the hospital, and some authority to report DV safely and quietly:

"We should have at least a hotline to call when I find an abused case, whether a woman or child, who can come immediately and quietly… nurses need more power or authority to act or at least to report. Nurses need them…". – Nour

Sharifa insisted on the activation of nurses' roles by giving nurses more authority, to enable them to make positive contributions by reporting cases of DV:

"Nurses know how to react with these cases and she can identify the physical signs, but you know we need to activate her role…"

R: what do you mean by activating her role?!

"Authorized to report; I mean that we need channels for nurses to progress with these family violence cases. For example, she can be connected with family physicians at hospitals who need to be responsible about it, or for example, a special committee in the hospital to deal with these family violence cases… they can contact that committee if a nurse or physician finds any sign

related to violence… so, there is no specific role for the nurse". – Sharifa

Some participants stated that they kept silent with regard to reports or dealing with DV because they did not have authority, and these roles were not included in a nurse's job description; otherwise, they would be ready to respond to cases of DV:

> *"You know, we do not report. We do not have the power and it is not included in our job descriptions. As we are not allowed to speak about the patients' conditions, hospitals usually refer these cases to social workers who have the power to speak or report about it directly while I cannot {…} because of the hospital policy that restrain us as nurses… {…} it is not my business".* – Aziza

Kady also experienced silence in situations and withdrawal from dealing with or reporting cases of DV, and explained some obstacles and barriers to reporting DV in terms of the nursing role in dealing with victims of abuse not being included in the nursing job description, as opposed to the role of a social worker, who has time and competence to deal with, and follow up on, cases of DV:

> *"Nurses have a role to provide care but the social worker knows more and can help. You know, I experienced withdrawal and I can't talk about abuse. The nurse can't play this role by discussing with the patient, finding out the reasons and discussing the possible solutions and following them up after the patient leaves the hospital. Because it is the nature of the social worker's job… uh… who is more effective in those cases".* – Kady

Some barriers were identified by some participants, such as not having enough time, the inability to follow-up cases later or offer immediate solutions, and their assumption that this is the social worker's job. In SA, social workers do rounds each day in all hospital wards to monitor the social needs of service users. Therefore, their main response was keeping silent and withdrawing from the

situation. However, some hospitals have policies for nurses in the case of child abuse, and Malak cited that they are only authorized to take action on behalf of people who are under the age of 18; otherwise, they are not authorized and will be silent:

> *"Nurse's authority here forbids that. Not allowed to interfere or act unless there are illegal things, for example, if there are girls that are raped and under the age of adulthood (18 years) we can interfere and take the necessary measures, and make an investigation, but if they were adults, we are not authorized to report without the patient's permission. We see many cases of abuse with blue bruises or broken legs, but I cannot do anything. The role of the nurse may be wider and bigger, but we are just able to hear, provide emotional support. That's all you can offer".*
> – Malak

Some of the hospitals often have certain policies or guidelines for any adverse or serious event occurring in the hospital. However, the roles of nurses are not included in these guidelines. More authority is accorded nurses only when hospitals deal with serious cases where there are very clear signs and symptoms of abuse, which follows a compulsory report procedure by calling the police without the women's permission. Tahira recalled an experience of escalating such a case:

> *""It's a crime, and he* [the abuser] *is a criminal {…} There is something clear in her* [the victim's] *eyes and it was the worst thing in my life… . .. My God, the hospital policy is not to let her go out with this extreme issue until we had completed the investigation and ensured that we provided her with care {…}. In this case, after completing the assessment sheet, the doctor sent her to the ICU. It's an urgent case. It was hard … the eyelid was completely black, and it was impossible to leave her. The police were informed and then the proceedings were taken and she was treated in the hospital. Honestly, after that, I don't know what the procedure is".* – Tahira

Participants narrated how they were silent witnesses because of the lack of authority to report cases. The analysis of participants' accounts showed that some medical staff and other senior hospital staff often attempted to hide and cover up any instances of DV. Rema reported:

> *" – I remember we were at the end of the day when I was working in the emergency clinic. .. at the end of our duty, a girl came in who had 'fainted'. She had a bleeding nose, her face was swollen, her father carried her – she had been abused. Unfortunately, the director of the health centre refused to report the incident because they had caught her meeting a man outside her home. However, the girl's nose was broken, she was unconscious, and she had bruises everywhere. Treatment was provided, but the director of the centre refused to report it, saying that her father would take care of it and maintain the family's 'honour'. When she started to regain consciousness, her father took her out. If I were in a managerial position, I'd have called the police. This is his responsibility as a manager in the primary centre. You know, I told him that we should report it but he hid this issue. He refused".* – Rema

The monopoly of authority by physicians and hospital managers takes the locus of healthcare away from the patient and toward society and wider concerns, which can entrench abuse, as in the above case. In this context, nurses are forced to be silent witnesses and to forego reporting cases of DV. However, Nasrin's religious beliefs forced her to do something for her patients and report cases even when she was not authorized to do so; she justified this personal initiative by stating that Islam forbids abuse:

> *"Do you know what happened that day? I called one doctor who is a 'consultant'. She said, 'don't interfere, it is not our business', but I did not listen to her because this is haram, which is not allowed in our religion, and ignores personal rights. I watched him [the victim's husband] nervous and not normal, and I found wounds on her body. I am being watched by God and this is my*

> *sincerity and honesty, so I connected with a social worker and - Haram!* [expression of sympathy] – *she must deal with her so that she could solve her problem. So, it is not a family matter, because if it was a private matter it would spread in the society and there would be no health and healthy environment even for a child growing up".* – Nasrin

Nasrin refused to be a silent witness, and she explained how she breached the passive authority of physicians because of her religious beliefs and personal conviction that she had a moral duty to help the victim. More explanation of this concept is explained under the Theme 3.

Overall, the participants feel that they are disempowered and forced to be silent witnesses, because they are not authorized to deal with or report cases of DV. Some of the participants expressed that reporting cases of DV was not required from nurses, and was not included in their job description. Furthermore, it is not required in their work environment, unlike for police personnel, doctors, managers, or social workers, where it is the core of their work. Therefore, this might be reflected in nurses' performance and perception, whereby they might not have the curiosity to detect and investigate cases of DV and thus prefer to keep silent. The ambivalence in hospital policy, as mentioned previously, and the limitation of nurses' authority, contributes to their being silent regarding DV.

4.3.2.2. Experiencing dilemmas of reporting

This subtheme refers to how the participants experienced the dilemmas of whether to report DV or not. Some of the participants do go on and take action, but recognize that it is very hard to decide what to do or report, given that women who come to the hospital can have complex circumstances and many signs and symptoms, and they may not tell the truth. For example, nurses are ready to report, but many factors mitigate against this, such as the reinforcement of silence because women might be reluctant to disclose DV, or their collaboration with their families and abusers to conceal the real story of injury provenance. This raises problems for nurses about the dilemma of

breaching ethical codes and the consequences of reporting cases. They may be constrained into silence by policy and practices.

As a result of a lack of authority, some participants expressed that they did not feel empowered when they are unable to report DV, and displayed a lack of engagement with the victims of DV when they came to the hospital. Some nurses can spot signs related to DV, but nurses do not ask about them because they feel there is little that they can do to help. Some participants stated that they are being silent and do not take action when the abused women are reluctant to disclose. The following quotes reflect nurses' attitudes towards undisclosed DV:

> *"Sometimes bruises can be very visible, and we can notice that the victim doesn't want to speak about them, as she thinks that she doesn't have the power to speak, or doesn't like to engage with other activities, and you can see this within her behaviours…".* – Aziza

> *"I can ask her what this is or what the reason behind it. But if I see that she has hidden it I will not convince her to speak about it".* – Badoor

Some participants illustrated some reasons why women did not disclose DV, which placed nurses in a dilemma and resulted in them being silent. Some of the barriers were related to cultural issues that prevent women from disclosing DV to Saudi nurses and being silent; more explanation about culture and community will be on the Theme 3:

> *"Some cases refuse to deal with Saudi nurses and seek treatment with any other nurses with different nationalities!"*

> ***R: In your opinion, what is the reason?***

> *"I don't have an answer, uh… as to why Saudi nurses! {…} It may be a kind of shyness or psychological or personal and cultural factors. I don't know why but it happens. Maybe because we share the same culture!"*. – Kady

The interpretation of this may be that a woman will be quiet because she feels that if everybody shares the same culture then nobody goes to report DV and nothing will be done, which leads to nurses being in a dilemma, with a lack of clear policy on whether to report or not without women's permission. Tahira and Nasrin stated that some other barriers could enhance silence for both nurses and patients. One barrier that could prevent international nurses from screening or reporting DV is the language barrier:

> *"However, foreign nurses have a language problem. Also, they perceive their role as one where they provide care and get the money, that's it. They may not like to have details because of language!".* – Tahira

> *"Filipino and Indian nurses at XX hospital cannot talk to the patient because they don't understand either the language or accent".* – Nasrin

Some participants felt it was very difficult and challenging to be enthusiastic in reporting any violence. Some participants expressed a sense of fear of reporting DV, which inhibits their ability to report it. Nurses experienced and felt conflict about whether they should or should not act on it, posing an ethical dilemma:

> *"I felt afraid to say that she was hit by her husband and that we needed to refer to this case. At that moment, I may have kept silent, and personally, I usually keep silent, because legally there is nothing to cover you, but ethically I don't know what to do and {…}. We have a code of conduct for nurses that states that we are responsible for most aspects, but it is ambiguous when you reach the aspect of ethics and family violence. I was afraid to inform that she was hit by her husband, as she did not want to disclose that she had bruises. These types of cases occur at the hospital frequently, and women will plead that you do not tell anyone, because they feel that they are not protected legally and that their family may not support them".* – Sharifa

The participants highlighted that one of the challenges in reporting DV in hospitals is that patients may insist on hiding the truth regarding their visits to the hospital. An implication of this is the possibility that patients express concerns and feel scared to report the abuser to the medical staff. However, Nour was explicit that nurses are obligated to report abuse and must follow guidance from nursing codes of ethics about their obligations to fight violence. Nour also expressed that reporting DV cases is part of the nursing role, unless the nurse is merely looking to make money and is unethical:

> *"I cannot see that there are reasons to not report those cases. I believe that nurses whom do this do are in gross misconduct of ethics and professionalism. Nurses are carers and should be merciful, otherwise she is only doing a job like any other job. Maybe she is more traditional and studied to earn some money, and is not doing nursing for the right reasons".* – Nour

A similar type of dilemma and conflict arises when nurses do not know what to do and how to respond to and recognize DV, thus they select to be silent. Nour felt conflicted and as mentioned above, and was unclear, unsure, and doubtful about her decision. The way families communicate with each other is a strong indicator of DV, but nurses are often unable to decide and follow their skills, feeling disempowered and unable to report because of lack of interaction:

> *"Nurses are the first people who meet the patients and their families and over time; nurses acquire the experience related to family dynamics. I mean… sometimes you know from how a family interacts with each other whether they have a problem with each other or not. For example, when the patient starts to talk, she may keep looking at her husband, and then once she says something, her husband will say the opposite, so I ask myself, who do I need to believe now?".* – Nour

The interaction between nurses and their patients is important in the experience of delivering or receiving care. Nour expressed that she was ready to act, but faced dilemmas in reporting because of a lack of interactions. Effective interaction and communication can help nurses identify cases of

domestic violence. Study participants felt that communication skills are the key to detecting cases of DV. However, they often felt unsure and doubtful of their own judgment due to the subjective complexity of caring for women in potential DV cases. Nurses are in a position where they must judge the relative empowerment of women who may be deliberately dissimulating and concealing the abuse they suffer, trying to understand the ways in which families communicate with each other. While certain features may be strong indicators of DV, nurses are often unable to judge and felt disempowered because of a lack of skills, causing a dilemma regarding nursing skills and being unequipped (as discussed previously regarding the Theme 1). They may then delivery poor QoC in their roles as nurses because of a lack of interaction. While certain signs are considered indicators of violence, a nurse's decision is also affected by perceptions of husbands' roles, as discussed regarding the Theme 3.

Some participants experienced dilemmas of reporting, and nurses also shared their experiences of being suspicious about the coherence and cohesion of patients' stories. Many participants believed that nurses are in the best position to identify DV in the hospital. However, nurses need to pay close attention to victims and share their experiences of being suspicious about the coherence and cohesion of patient narratives and explanations from a DV perspective. Nurses said that the obvious signs and symptoms are enough to arouse their suspicions, but they also advised that is necessary for abused women to admit or disclose the abuse to escalate the reporting of the case. The following response highlighted that one of the challenges of reporting DV is that in some cases nurses felt that it very difficult to report domestic violence because patients insisted on hiding the truth about hospital visits due to abuse-related injuries:

> *"In the Emergency Department, you need to know the story behind the injury and also the patient's past medical history. I studied critical care and emergencies and I know that some bruises are identifiable. In the case of head injuries, one may assume, but it is important to inquire from the patients… {…} I need to say that I cannot identify those bruises, and can*

differentiate them by assessment, but cannot confirm it unless the patient admits that it resulted from family-based violence. Some of them who don't want to tell the truth will make up any fake story…". – Hala

"Some of them display signs of hitting, and wounds, such as bruises on the body, but when you talk to them there is no correlation in the story. Sometimes the woman may look like a psychological patient: she can't talk, she worries, and doesn't want us to ask her these questions, so she usually ignores our questions and avoids eye contact. We observe these kinds of signs". – Malak

Furthermore, nurses revealed that they suspected the nature of injuries as being due to DV according to certain physical characteristics and psychological signals:

"Those signs might be around the neck, and if she has been beaten by a stick, I can see those signs, as it would be impossible for them to be there unless someone did it to her. She might be scared, and you can see this in her finger movements and her facial expressions when you speak to her. She may start shouting without any reason as a result of being stressed, violated, and not feeling safe". – Nour

Nurses are conflicted regarding whether to report or to ignore DV. There is nothing clear for nurses in the policy, thus they are often silent when facing cases of non-disclosure. Badoor had the same concern regarding the lack of clarity about the further consequences of reporting a case that might disempower nurses and exacerbate the lack of reporting. The ability to report requires more clarity on the process of reporting and its consequences, which could decrease resistance among nurses:

" – I cannot just report a case and neglect what will happen to her later! Where can she go? What will happen to her after that? Will she be in a safe place? And her kids, what will happen to them? I encourage her to report her husband and then what?! I

should know as a nurse what the process is and whether anything dangerous will happen as a result. Will she go to the street or home? I must know this and at the same time, I must be a qualified person to talk about this kind of thing and protect this woman. Therefore, we have to improve and find the best referral system between services in the hospital and outside of the hospital to ensure the patient is safe. We can engage in this issue without feeling guilty, because you know exactly what happens to the patient when you refer her". – Badoor

Nasrin also expressed the drawbacks of asking questions without having a solution to help:

> *"Ability to ask and seek for a solution, because what is the benefit of asking such a question if you don't have a solution? With the question, the nurse must be seeking a solution".* – Nasrin

The above quote illustrated that without support structures in place, speaking out may actually cause more problems for DV victims. Nurses emphasized the need for a hospital policy covering the whole issue to guide nursing responses. Nour also raised concerns about the further consequences of reporting DV, such as the lack of a safe and secure place available to protect abused women from their abusers. It could be argued that maintaining such places can protect and facilitate disclosure among the DV cases and make nurses feel more comfortable to proceed with reports:

> *"I don't know exactly what happened to my patient later – are they safe? What I know is that they take you to a care home for a period until they facilitate something else or find you another place. But mostly it is a very small number who can approach these care homes".* – Nour

4.3.2.3. Being unsafe

This sub-theme refers to the personal costs of reporting cases of DV, which are considered when nurses compare the benefits and drawbacks of deciding

to report cases of DV. These include the job security and personal safety of the reporting nurses.

In terms of job security, participants expressed concerns about their employability status and whether it would be affected by reporting DV. As mentioned previously, a lack of clarity in the process of reporting made the nurses feel unsafe in reporting family violence to the hospital or local authorities. The conflict felt about reporting DV and the subsequent refusal to report is understandable as it might have a huge impact on nurses' employability. This, according to Yasmeen, was more or less related to the nurses' nationality. If a nurse belonged to another nationality and reported local abuse, she was more likely to be in trouble in terms of potential impacts on her career. Yasmeen stated that terminating an international nurse is much easier to do, which may be why nurses from abroad chose not to be involved in the reporting process of domestic violence:

> *"I need to know that it will not affect my employment status, and I need to know that I am protected if I am to be more involved. I believe I need some numbers to contact if I need any consultation… but the most important thing I need is to feel safe and secure, this is especially true for nurses from abroad". –* Yasmeen

On the other hand, another participant cited that international nurses appeared to be more empowered in terms of reporting DV without any fears. This may be because international nurses receive more education and training on DV:

> *"I believe if she is a non-Saudi nurse, she will not keep silent as they are educated in this issue. Also, the ER is a very sensitive area, and whoever is working there has a strong heart. So, violent cases always attend the ER".* – Tahira

As mentioned previously, the lack of clarity on the process of reporting made the nurses feel unsafe to report DV to the hospital or local authorities, as they had concerns about their employability:

> *"The patient might deny the complaint she made, and this could cause trouble for all staff in the hospital".* – Nasrin

Badoor shared her bad experiences of when she tried to help abused women, citing these as reasons she would not like to engage with DV cases again in future, mainly in order to safeguard her employment:

> *"I tried to help the patient. She was scared and anxious. I gave her the treatment and then two days passed. Something happened that shocked me … uh… they called me from Patient Affairs – and said that someone was complaining about me and his wife also! God! I {…} Now I don't want to help anyone {laugh} I've had enough. I have to protect myself".* – Badoor

Another possible explanation for the lack of adequate reporting is the concerns that nurses raised about their personal safety. The study found that nurses expressed feelings of fear about being targeted after reporting DV in the hospital. The abuser might have friends and family who could facilitate any information in the hospital to be shared with him i.e. the person who reported the case. This could then lead to the nurse being targeted either inside the hospital or outside the hospital. This can cause nurses to be afraid:

> *"Nurses may be afraid of the abuser as he may target the nurse and cause her troubles inside or outside her work".* – Aziza

Many participants mentioned that reporting abuse could threaten their personal safety, and in general they felt that Saudi nurses were more at risk in this regard, due to living within the general communities of service users and being more integrated with them. Conversely, international nurses tend to live in highly secured compounds with limited access, and law enforcement confers relatively more protection on foreigners from violent crime. It is an important challenge to address how nurses in SA can be protected from violent reprisals when they report domestic violence and other forms of abuse in healthcare contexts. Overall, the picture was that foreign nurses are fearful of losing their jobs, thus they tend not to report DV when they encounter it and are *ipso facto* protected from violent repercussions. Conversely, Saudi nurses may be emboldened to report such issues, but in doing so they expose

themselves to more risk of harm from service users, both at work and in their communities:

> *"Yes, it may facilitate more. But I meant that Saudi nurses may get involved more and receive backfire, which I can handle in my country, while the nurses from abroad are more susceptible to be sent home, which is why they tend not to get involved, and stay away".* – Nour

Both Saudi and immigrant nurses were perceived to be vulnerable to different threats if they reported DVA, and the safety of themselves (and, by extension, their own families) was their foremost concern, before engaging in what were generally perceived as additional professional responsibilities (beyond biomedical care provision), like helping abused women, reflecting a basic psychological need. Sharifa expressed the feeling of needing to be safe and secure from the abusers when dealing with DV. Research participants suggested the need for new laws and regulations regarding the reporting process that can protect nurses at the hospital and outside the hospital, as well as concerning ethical issues such as patient consent:

> *"Yes… if she* [a nurse] *informed the authorities and the abused does not want to proceed with it, then troubles will be made… we need to have some guidelines to protect nurses, and we also need the abused* [person's] *permission to proceed with it, or a consent form that she wants to make a formal complaint…".* – Sharifa

4.3.2.4. Summary

It can be concluded that nurses have not been encouraged to report violence and therefore felt disempowered. Moreover, no action was taken to prevent similar incidents from happening in the future. Many participants felt that abuse can sometimes be a problematic issue to report, but the main challenge that caused most of them to be silent and not report DV was the inadequate authority given to nurses. Nurses were reluctant and afraid to report cases that they felt may cause ethical dilemmas if the women victims refused to endorse the complaint. These issues are further discussed in the following chapter,

including the sense of conflict around how to recognise DV and the need for nurses to feel safe. Nurses are often silent and consider such cases as routine or physical trauma. Being silent may be a result of cultural considerations and contextual factors such as cultural values, social norms, and religious values, which are all dimensions that shape their professionalism in practice, as explained further in the following section.

4.3.3. Theme 3: Being Constrained by Social and Religious Contextual Forces

This theme refers to how the participants' feeling of constraint can be due to social or religious factors, including norms, traditions, and/or religious concepts, which impose limits or restrictions that prevent nurses and/or victims from dealing with DV. This relates to the normalization and acceptance of DV, abused women being stigmatized in the community, and impacts of the guardianship role versus Saudi law, in a milieu of ambivalence and social transition. Some participants were ambivalent about the current situation, seeing some positive and negative aspects, and they were also uncertain of what they should do and how they should respond. Saudi society is in a profound transition, and hence multiple perspectives co-exist, which make the whole situation of healthcare delivery more complex.

In this study participants and victims identified numerous obstacles that prevented them from discussing or dealing with DV, including in the personal, household, community, and religious dimensions. The participants discussed how their communities viewed, judged, and dealt with victims and how this, as a result, may affect nurses' practices. Figure 8 displays theme 3 and its three sub-themes.

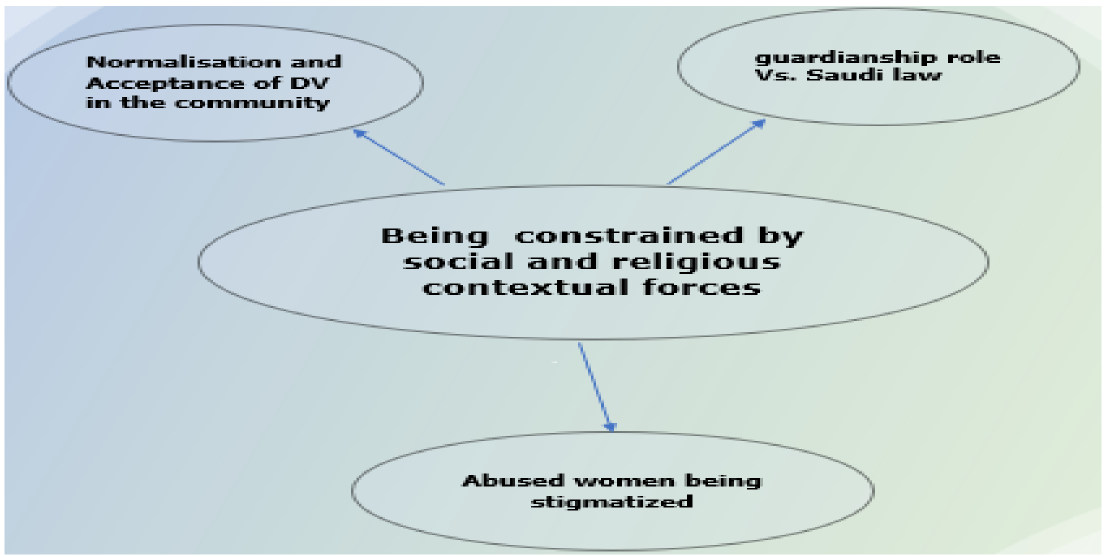


Figure 8: Theme 3 – Being constrained by social and religious contextual forces

4.3.3.1. Normalization and acceptance of DV in the community

The normalization and acceptance of DVA are in many instances an everyday part of family and community life, as most Saudi nurses perceived in this study. The participants expressed concerns that women themselves may believe that the idea that the abusive behaviour against them is a normal practice and part of life, and an accepted social norm. The participants of this study talked about this community view and how it normalized DV. However, they also reported that some families did not adopt this attitude, and were in fact very supportive in counteracting negative attitudes and actual abuse. The participants reflected how family attitudes and behaviour toward female members greatly affected their experiences to face DVA and to report this. They felt that the family can either empower or disempower female victim's rights. A supportive family can enhance female's right to voice their suffering and grievances when exposed to violence:

> *"It depends if the family supports the woman. Some say that if I find my family behind me, I will not hesitate to speak out and tell my family when he abuses me. While some don't have a family to support them, or they don't want them to interfere with their problems or they tell her that she must be responsible for her own decisions and actions…".* – Hoor

The above quote implies that females should be supported by their parents to reach their full potential. Abusive parents demanding respect for abusers and the status quo of accepting violence may negatively affect female victims and prevent them from disclosing their issues. Thus, care from a family member is important, which may lead either to enhancing or preventing DV occurrence. In some instances, the behaviour and attitudes of family members are quite aggressive with female victims of violence:

> *"I am used to seeing the man is the one who is always right, so even a family we find it* [DVA] *normal, and sometimes it comes from the mom, and it is not always from the father. It may probably come from the men, but it may come from any person, such as her mother or her aunt, or maybe her father's second wife, or maybe her grandmother, and this is the problem, as we see within the family, and these cases in our community, and feel like they are normal, as if nothing happened".* – Hala

Participants revealed how anger with a female family member was an indication of DV when abused victims come to the hospital, reflected in the way angry family members treated nurses analogous to the way they treat their own daughters, because they normalized abusive behaviours to any female member (given that the majority of nurses in SA are women). Nurses were reluctant to be involved with such families:

> *"It is a disrespectful action toward women, but the violence that we see as nurses is usually coming from… I mean, in several situations I have seen very angry families {…} If I am a nurse who is willing to discuss and argue with them, I will be in more trouble and will make the whole situation complicated…".* – Hoor

Participants need to protect themselves regarding this type of family, which makes nurses keep silent rather than helping the abused patient. The important aspect regarding normalizing DVA uncovered by participants was how conservative some families can be. The participants felt that conservative families are problematic when it comes to DVA, as a female member must obey commands from any male members within their families. The obedience

of these commands appears to give males the right to command females. It became a cultural norm whereby males and females do not have equal rights, especially with conservative families. With regard to DVA, this might disadvantage female members in such families, exposing them to different kinds of abuse mentioned earlier, and even the curtailment of simple, basic choices:

> *"I don't think we can treat human beings like that – it is not respectful at all… it is only for animals… and also when he waves by his hands* [gesticulating angrily]*, and tells her to move, she is neglected. So, I consider this as violence… I can remember now, there was an old lady who was walking with a 14 year old boy, and he was disrespectfully talking to her, saying 'go there', and 'sit there'… I was shocked. Why was he treating her like this?!!! I couldn't do anything for her".* – Yasmeen

This finding highlights the complex contextual factors that can induce victims to not report DVA, increasing women's vulnerability to DV. As well as nurses being uneducated and untrained with regards to DV, the lack of policy and clear guidelines means that nurses are unable to act with such types of DV. Such acceptance and normalization of family violence from the community was attributed to cultural values and traditional aspects that facilitated family violence as a normalized and accepted part of women's lives in SA:

> *"I believe that our culture facilitates this, due to the strong connection with our culture and tradition. They look at the woman as the one who should shut up and obey, so, in this case, even if you were humiliated, you need to tolerate it and be patient and not speak about it, which facilitates the violence, as the abuser is pretty sure that he has the right to do whatever he wants…".* – Nawal

Also, within backward/conservative families in the Saudi community, many factors enhanced and normalized DV, such as inequity between men and women, where a man can control and abuse a woman and she should obey:

> *"In our community, women are still not the same as men, and a woman can find difficulties in her life, especially among conservative families. We hear about many problems regarding this point, such as a woman being prevented from going to work or meeting her friends, and this could be done by her brother, husband, or father".* – Aziza

Some participants expanded further on how cultural elements favouring males over females played a vital role in domestic violence. They indicate how, culturally, it appeared acceptable to be abused:

> *"The community interferes with how children are being raised, and everyone says that males are always blessed, and women should always serve men, and men are not required to do anything… and this idea will be inherited for generations. That attitude could be noticed in the old generation among nurses, as they might accept violence; I think it would be better if old nurses were educated as well".* – Nour

Nurses illustrated how a family could favour males over females, which could be illuminating concerning the barriers and factors that lead to decreased nurses' motivation to investigate these cases. It should be taken into account that Saudi nurses sharing the same culture may unconsciously be affected by these attitudes in their way of dealing with DV and with normalizing abuse; Nour suggested raising the awareness of older nurses due to this perception.

The participants also disclosed how sibling abuse was traumatic in some cases, mainly in the form of causing pain or physical abuse. From a Saudi cultural perspective, the male is always dominant and is typically favoured by parents over female family members, the latter of whom are expected to obey any commands that are ordered from male members. Rearing children with this ethos is another form of normalization and acceptance of violence within the family:

> *"I feel that it is mostly the brother who always abuses his sister, and when it comes to the parents they feel that they are helping their son to grow and be a man, while at the same time, if*

> *violence came from the father, none of the mothers can speak or disagree with it… but, you know, I think this has been changed now, I was born in the 80s, and I lived these situations, and saw those people…".* – Yasmeen

The participants expressed their judgments about how families teach their children (especially males) regarding certain behaviours based on gender discrimination. This is strongly associated with social norms and culture; therefore, the ideology of masculinity may contribute to domestic violence and might normalize it, causing a lack of reporting DV. Those siblings will become husbands one day, and the cycle of abuse will continue. Thus, all participants disclosed how the community can play an instrumental role in normalizing DV, and this might result in a girl growing up without even recognising when she is being abused. That could disempower nurses and build a barrier to reporting abuse:

> *"Culture, habits, traditions and community have a strong relationship, because in our society the men have strong voices and domination {laugh} because he is a man!! A man has the authority to do anything and the woman is just a follower. Almost always, these things are the reason for violence. This idea gives them a right to violate a woman: of course, every person is independent by themselves, and he has no right to build my personality or abuse me. This is disgusting and unfair, but some girls grow up on violence and think that is normal".* – Tahira

It was uncovered that the notion of violence against females was embedded in the community itself, as it promotes abusive men over the female victims. There was nothing to name or shame the abuser; in fact, communities may collaborate in providing abusers with a second wife, with no references to his being an abuser in his previous marriage. Indeed, the community could even sympathize with abusers:

> *"He* [the abuser] *is raised with the notion of violence, as he is the man, and nothing can shame him no matter what he does, so*

> *there is no limit. And when she does something wrong, he may marry another woman regardless of his bad history".* – Nour

Normalizing a husband's abuse influences women. According to Saudi mores, a husband has a responsibility to provide for his wife financially, avoid mistreatment of her and her family members, and fulfilling her other demands and basic needs. This theme emphasizes the role of the husband, which was appreciated in the support of his wife and in providing all assistance that a wife needs. Participants reported how a husband playing this positive role in his family – namely, sharing responsibilities – helped to set a role model to other families who have suffered from family violence:

> *"Even I always imagined that one day I would marry someone like my father, and I hated all men and they were like my father. But then I got married and found my husband to be a 'gentleman' who is very kind to me. For example, when I was sick he worried and he kept calling me. I was surprized. I thought all men were a copy of my father. Really, I was surprized that there are men like him. He is a respectful and responsible man who practices the normal husband role".* – Rema

Furthermore, participants reported how the absence of such positive role models developed abusive or careless and selfish husbands, who did not share responsibilities with their families and abused their wives, with continuous threats and acts of violence being considered normal. These abusive and careless attitudes and behaviours from husbands had negative impacts on wives and children who witnessed domestic violence. According to participants' accounts, the negative role of the husband and his attitudes were reflected on the victims during their visits to the hospital.

Some victims were scared and developed a sense of fear to become pregnant again from such a husband. A possible explanation for this might be that another pregnancy could overwhelm the woman with extra responsibilities that could burden her to fulfil such commitments in the absence of a responsible husband, or an abused woman would be unable to follow-up and access care

during her pregnancy period, which was likely to affect her psychological state negatively:

> *"Some of them are scared or may be pregnant… She believes that she has to take the responsibility of two kids alone… while others don't want to proceed at all, and want to take over everything alone. But this may lead to a fear of getting hurt or losing her baby who is yet to come to this world".* – Hoor

Some participants explained how some husbands have been influenced by patriarchal community attitudes, and they assume that their wives should obey them; some husbands might abuse their wives based on their religious belief that their wives should obey them completely and literally, without contextual understanding of related religious concepts:

> *"According to the husbands who abuse women, it is a matter of fact that she must obey him literally, which is quoted from religion as they claim, and they use this fact to control her in all issues".* – Aziza

Nurses talking on behalf of women said it is hard for women to leave or report their husbands due to the religious belief that they would be sinning by doing so. This influences practices and responses to DV cases without a clear policy about dealing with a case where the victim does not speak up:

> *"Because we believe that if she reports her husband and he got any kind of harm it is exactly as if she harmed a holy human being… do you get my point?! Because he is considered a holy person and, by the way, this is our notion about the husband. So, if she stops him or reports him, it is exactly as if she made sin, because he got it as a superior member of that family, and this is also the core of the problem. The wife thinks that she should follow her man and cannot say 'no', and if she did he would beat her, and this becomes the norm. If she let her husband down, she may go to hellfire…".* – Hala

Participants explained some incidents that happened in the hospital relating to husband abuse, and how men normalized their behaviour, without guilt. However, there was no obvious reaction from nurses:

> *"I remember that, once, a woman came and her husband beat her. He left her at the hospital gate and left!! He didn't admit his guilt!!*
>
> ***R: what did you do?***
>
> *"I forgot, since it was a long time ago".* – Tahira

Participants elaborated on the husband's role, and how the community may normalize a husband's misbehaviour, indicating that it is crucial to know how healthcare professionals are prepared for such expected situations. Some of the participants said that they have an admission form which includes a general question, not specific to DV, from whose answer they might know if a female patient has been abused, as discussed concerning the previous theme with regard to policy ambivalence:

> *"Forms are a part of the admission procedure, and the cases must answer 'yes' or 'no'. If most of the answers are 'yes', we will move them to the safe side. If most of the answers are 'no', we inform the social worker. After completing the forms, the second step is a physical assessment {…} it's not about violence exactly. I mean, an indirect question like 'do your parents or husband support you like this?', and 'do you need a charity that helps?', and so on, can lead us to discover abnormal things".* – Nessrin

The participants illustrated the community view of the sanctity of the husband's rights, and the consequent social acceptance of any abusive behaviour (at the expense of the sanctity of the wife's rights). The common experience among nurses is that usually a husband holds the reins, and he says what the health complaint is on behalf of his wife and takes decisions relating to care. If the woman suffered from DV, it would be difficult to impart this without the abuser knowing. Nouf was savvy to this, and took steps to give women an opportunity to articulate their own healthcare needs, including potential DV:

"Once, as a nurse, I received a female patient whose husband started talking on her behalf aggressively, and I told them that I need to hear from the patient herself, because this is her right, and I always encourage this practice, because they are undermining her existence". – Nouf

However, nurses generally felt disempowered to overcome this problem, because when they encountered this type of husband, the lack of resources and referral system caused them to keep silent (as mentioned previously concerning Theme 1). This raises important questions for the local authorities and policymakers, who must create different ways of reporting DV in such cases, and support women in different ways. Participants highlighted a lack of family consultation services, because in many cases the next of kin (husbands' families) are complicit in the family violence. Family plays an important role in facing DVA. Participants disclosed that husbands' families could turn into abusers of the same victim, especially if they witnessed different types of abuse of the victim and did nothing. Hence, counselling clinics for husbands and families was revealed to be an important way to minimize this type of abuse. Further studies need to be undertaken to explore the role of husband's families and their awareness of abuse:

"It could be from the husband's family who will never abuse her unless he is abusing her, or they can see something wrong in her… we cannot change people, but they might dare to interfere sometimes because their son is not a real man, that is why we need channels for family consultations or attending family issues specialists". – Sharifa

Sharifa declared that the prevention of DV is not only the responsibility of nurses, and that community awareness should be raised and nurses should be provided with different resources, referral systems, and multi-disciplinary coordination to address abusers' behaviour and their families' attitudes. However, the normalization of DV was found to extend into hospital's own cultures, particularly in the case of physicians. Although the traditional idyll of physicians is that they are friendly advocates of patients, regardless of their

gender, the majority of physicians in SA are men, and men in general tend to be more tolerant of male abuse of women, particularly if they are more culturally traditional. When it comes to family violence, the majority of males hide and normalize DV, and make it more acceptable, especially when the victim is a woman, as elaborated in next subtheme:

> *"I mean, sometimes physicians can increase violence because they increase the stigma around women who are abused. Is this right?! In our community, we tend to cover it up. Most people are affected by their relationships with others, such as relatives or neighbours. For example, if the physician's sister got abused and they managed to cover it up, he may treat patients as well with the same behaviour, coming from previous experiences or other situations".* – Muna

Another important aspect that constrains nurses, making them unable to face DV, is that there is no benefit of reporting DV if there is a recurrence of the abusive behaviour. They expressed that there was a lack of rehabilitation programmes that allow victims and abusers to be reintroduced to the community with positive attitudes toward their experiences. Participants' accounts in this study showed a positive impact in increasing the awareness of individuals and the community about DV and stopping its cycle:

> *"First of all, there should be a rehabilitation programme for both of them, and someone should support her* [the victim] *in being an active member in her community, even if it is something very little. In the end, the abused woman lived so many experiences and will start and try to be more positive and productive and may affect others in the same way; on the other hand, a victim might have side effects, for example, she may treat others exactly as she has been treated or might send negative vibes…".* – Yasmeen

Rehabilitation programmes can have several benefits for women, especially in cases with recurrent abuse, enabling the close monitoring of victims and their families. Other potential benefits stated by participants included the

importance of mutual group support for victims and increasing community awareness about family violence. However, such support groups do not exist in the Saudi community, and their absence further disempowers nurses, as they cannot advise their patients to seek out such support, leaving them isolated and vulnerable:

> *"I may create a social group that consists of abused women to discuss their problems, to support each other without the presence of the abuser, such as the groups for alcoholic addicts, because they can empower themselves by knowing their peers, and it may include a psychologist. Furthermore, we can increase the awareness of the importance of reporting, or we can develop some workshops for couples…".* – Nouf

This combination of findings above provides some support for the conceptual premise that restricted nurses to deal with victims and victims being unable to report. Elements such as a sense of despair, social stigma, and considering DV as a private matter have collectively played an important part in the acceptance and normalization of the abuse of women.

4.3.3.2. Stigmatization of abused women

The concept of stigmatization fundamentally relates to community stereotypes and categorizations of certain people and behaviours, which in this context refers to undermining, labelling, and devaluing women who are abused, particularly those who disclose such abuse. As a result, an abused woman might be socially rejected and will hide DV, making nurses unable to help; it should also be noted that stigmatization can also be iterated by healthcare professionals, including when nurses blame women about their silence and fear of reporting.

The community often labels abused women and structures beliefs toward them (Overstreet and Quinn, 2013). This labelling can take form and construct an image of abused women being miskin, poor and weak, and also blaming them for being victims, declaring them responsible for their own situations. It should be noted that while "poor person" is a literal translation of the Arabic term used in this context (*miskin*), the latter connotes the general condition of

"wretchedness" in English, rather than "poverty" *per se*. The community itself might have a negative effect when a woman claims her rights; some participants observed that women who tried to fight for their rights and then got divorced usually suffered in all aspects of social life even more, due to the stigma, especially if they were left with no family support. Losing important support from the community and family has negative implications for women, ostracizing them from society, such as preventing them from engaging in normal social activities, resulting in them becoming socially isolated and withdrawn from the community, feeling humiliated, undermined, and burdensome:

> *"In our community, they look down on women who are divorced… I mean, men will always be respected… She will suffer from everything in her life… Reasons may be more social as she doesn't want anyone to talk about her, as the community may look at her as a poor abused woman who is suffering from violence…".* – Hoor

Similarly, it was also revealed that being divorced had deep implications in a woman's life in terms of being socially excluded even further, despite success and employability. Muna echoed the "poor women" stigma from the community about divorced women:

> *"Some people find violence normal and can practice it, while others clearly said it shouldn't be seen as normal… and I think that the community still look at the divorced woman negatively as a poor woman, and that is why she is afraid to complain about violence, in case he* [the spousal abuser] *decides to divorce her… and there is a stigma to be divorced, even if she is a manager or a successful worker…".* – Muna

A more general perspective was the lack of protection from communities and the sense of acceptance of any DV that each victim came across, at the same time developing blame when taking care of this type of women. Participants appeared to sense that those reasons might be behind keeping women from reporting any violence against them, as women might sense despair and

stigma from reporting violations of their rights. The participants cited feeling angry and blaming women about their acceptance of DV, unless they did not have support, or they stayed in abusive relationships for their children, which discouraged nurses from dealing with the abuse. Nurses blamed women for accepting their situation, which evokes the absence of nursing education and training discussed under Theme 1:

> *"I feel angry that they* [abused women] *don't speak and just accept the abuse. Nevertheless, she may have children that she wants to keep and raise or she is alone in this life, therefore, I cannot accept that I can judge whether she can defend herself or not… If there are factors in the community that facilitate woman's abuse, family violence and enhance the acceptance of violence against women among new generations, I feel that these factors are disappeared gradually in light of social media and the new transformation in the culture that can facilitate and increase awareness that both genders are equal. I think the abuser will be punished".* – Nouf

Badoor expressed her sadness about the plight of victims, but felt she would not be do anything for them unless they were prepared to help themselves, and she blamed women for not fighting for their rights:

> *"I feel sad for her, but I blame her because she didn't stop this violence, unless her circumstances are difficult. Anyone can think and find a solution for their problem"*. – Badoor

When nurses blame the victim, it may result in ignoring any DV in the future, or feeling that women are responsible for their own health issues, viewing them contemptuously, and thereby breaching the ethical expectations of treating patients with dignity. Nouf also mentioned that there is a community change in the current period, and that there is a higher chance the abuser will be punished, so she also blamed women for not taking their rights, as this also discourages nurses from deal with abuse issues. Put simply, nurses blamed women for accepting abusive situations. Most participants considered that both cultures and communities blamed women for the abuse they suffered,

ironically unaware of how this echoed their own victim-blaming, and they expressed the possibility of DV being triggered by women's behaviour or attitudes, as stated by Hala:

> *"They look at her as inferior and the one who causes a problem and a source of disgrace who should be punished… and in our community, if they want to blame someone they blame the woman more than the man {…} when she is beaten by her husband, no one will believe her and would say if she has not done a mistake she would not be beaten and they will be sure that she has done something wrong and will stigmatize her children, too"*. – Hala

Furthermore, other participants emphasized upon the negative impact of communities forcing abused women to show signs of acceptance of DV and consider it a private matter. There is a social stigma from the community towards the abused woman when she discloses the abuse:

> *"We have the stigma in our community towards any woman who talks about violence, as she needs to show that she is happy and satisfied, and to be patient, as it is fine and positive that she can hold the pain and keep it secret. Despite that, I am against it, as it seems very traditional to be patient and live with it, and tell her children to be like that as well…".* – Nour

The participants expressed that poor support from the community may lead to DV. Stigmatising DV, leading people to not admit the problem, and decreased access to healthcare and DV support may result in a woman being more vulnerable towards DV, and may cause her to be silent and not report the incident. With the ambivalence of policy, as mentioned concerning Theme 1, the nurses become inactive when trying to deal with non-disclosure DV. However, the majority of nurses felt that the stigma should be attached to the man and not the woman, but they perceived that abused women tended to blame themselves:

> *"Women always blame themselves and are scared from social stigma if they disclose this DV. You know, the stigma is on him not on you, but you have to speak up".* – Malak

As a result of being socially stigmatized, more psychological, social, and health consequences affect women's health. Participants stated their understanding about the consequences of DV, including that abused women may develop a sense of revenge toward their husbands, families, or communities. Some abused women tried to run away or developed adulterous relationships with others outside of their marriage (which are "illegal" in SA):

> *"It depends on the level of violence, whether it will change her* [the victim's] *feelings toward him* [the abuser]*, such as hating him or hating her father… and may lead to further family problems if it was her father, and as a result, she may think of running away from her family or develop another illegal relationship with someone… and the same thing if it was her husband who will turn her life into hell or any problem that may affect her and her children's state of health…".* – Nawal

The above quote suggested that women might refuse to continuously be abused, but rather than attempting to fight for basic rights, they might attempt to flee from their abusers, which does not offer scope for long-term solutions in Saudi society. A few participants disclosed that some women's recurrent hospitalizations due to attempted suicide (e.g. drug overdoses) or suicidal thoughts were associated with hidden signs of family violence, which healthcare professionals have to consider when dealing with family violence:

> *" – she took pills to commit suicide, as one of her brothers knew that she was speaking with someone and making a relationship… I can remember that I was working in the ER, and when I asked my colleagues about her, they told me that she tried to commit suicide".* – Yasmeen

Yasmeen mentioned that the abused girl attempted suicide because she knew that her sibling would hurt her for her socially unacceptable behaviour (an honour issue). The participants had an understanding of the complications of

DV and how associated stigmatization could drive victims toward negative beliefs and behaviour, including substance abuse and even suicide:

> *"She may think of suicide or live in isolation from people which will lead to psychological disturbances or she may turn into an addict… for example, in the long term, if I receive a woman who has been physically abused, she will be psychologically exhausted, and may think of suicide, or be a drug addict, only to bring some attention from others…".* – Muna

The concept of women raising their voices against abuse is contrary to prevailing "social and traditional norms" in SA. The sense of being unable to ask for one's rights or even to report any abuse was a phenomenon recurrently reported by the participants in this study, especially when the community becomes reluctant to provide victims with basic support. This was reported to have negative implications for women in this community, as they later developed a sense of fear of their abusers and the community. With regard to women's mental states, being unable to report or ask for help in this community was expressed as resulting in a sense of despair. Women were very concerned about the support system, which was dominantly geared to the support male abusers in family violence cases:

> *"A woman is seen as weak and poor from the community perspective, and is afraid of being looked at as a weak creature… if I was abused, and told one of my friends that I was abused, she would say that I am a poor person and cannot defend myself, so this what I mean by 'poor person', as I cannot take back my rights by my hand… this is maybe because of our community, as we were raised in a way where no one can know about our problems…".* – Nawal

The above quote from Nawal showed that one aspect of DV is the privacy matter, and being a "poor" person from the community's perspective made her more reticent to report or even ask about DV, preferring to remain silent (cf. Theme 2). She revealed later that it is culturally acceptable not to report what are perceived as "personal problems", including DV:

> *"I feel that we, as Saudis, don't like to be known for our problems. For example, if I am abused I wouldn't go and tell anyone or a nurse that my husband is hitting or abusing me, as I don't know how she will see me as a woman; she may say that I am poor and cannot defend myself, so I would try (from my perspective) to hide it from others as much as possible".* – Nawal

Nawal and other participants later elaborated more about what would happen if a woman chose to report her abuser. They stated the different levels of suffering that the victim may express, especially a sense of despair about losing her children. Children were revealed to be the only thing that any woman could hold onto, without any help and support from the community. Abused women could be traumatized physically (by their abusers) and mentally (from the community), and be left unable to find any alternative solution for their family violence situations:

> *"… for example, the woman before was afraid from a divorce. A woman might feel despair because she is deprived of her kids and have many problems, but now, she can go to court and take all her rights and custody of her children. I mean, it's not shaming to go to court. Now it's absolute, and now women prefer to be divorced rather than live with violence, but the majority don't know their rights, and stay for their children, and are scared of the consequences of divorce".* – Malak

Interestingly, participants identified social media as an important aspect in facing DV, which was uncovered to be a rich platform that can be used effectively to provide counselling and to share other experiences. Social media appeared to have positive impacts for women in terms of increasing their awareness and empowering their rights. All participants reported that social media can offer very powerful resources for victims to seek help and support. In fact, some of participants stated that social media can be used as a form of documentation, to indicate the abuse level within the community. Other participants stated that social media can prompt local authorities to take action against abusers, as manifest in their experiences:

"Social media informed people about several authorities that can be sought to solve violent conflicts. In addition, it offered a very rich platform, talking about related stories and consultations about women's rights, improving the ideology of women's image and violence or abuse… all this developed to reduce the level of violence, which I see as very effective… and you can see how it is fast to know about something that happened in the society when a video is uploaded to social media…". – Nawal

Participants reported that social media had an effective role in increasing women's awareness about DVA, and changing traditional images about women and abuse.

4.3.3.3. Guardianship role versus Saudi Islamic law

The participants clarified that "guardianship" in Saudi law is another main concept in this study that has a negative impact on the nursing response to DVA. The majority felt that this position was misused by some men to dominate or harass women. The participants felt restricted and unable to act due to these social, legal, and religious standards. They felt constrained and unable to act, as they had to respect the position of guardianship and wait for the husband/male guardian to disclose the health issue, or even the DVA. Nurses thought that disrespecting this position would place female service users and healthcare professionals at risk of exceeding their cultural and religious limitations. While nurses were already aware of the abuse of the guardianship system in the community, they were disempowered and unable to assist.

In this study, the participants expounded on the idea of guardianship in relation to *mahrams* and *walis* in relation to how the country applies some Islamic principles. Saudi law and the rules of some health organizations limit women's freedom, often seeking to justify these limitations on the basis that they are honouring such traditional concepts. Participants felt constrained and powerless to act due to these legal and religious norms. Some participants mentioned that the concept of *wali* is misused, and has become antithetical to its original purpose, becoming a tool of abuse when it was instituted as an Islamic concept to provide assistance, health, happiness, and support. The

participants explained how Islam puts specific requirements on this role on specific occasions e.g. a *wali* only protects an orphan child until they reach adulthood, and it can be a mother who plays that role for her children, while a *mahram* is only necessary to chaperone a woman who is travelling if she is scared to travel alone.

The participants explained how some men misuse this role and use it to control or abuse women, and that the DVA witnessed in modern days mimics the old cultural and traditional views of women. Patriarchy was traditionally practiced in the community through using religion to justify abuse, whereby it was more or less a community enterprise to systematically hinder women's rights. According to the participants, this was when people lacked religious values and beliefs with respect to women. Investigating the participants' perceptions of contextual factors of DVA is critical, because this allows them to identify their beliefs and values in relation to various forms of abuse, which increases their motivation to engage with DVA interventions. The community's perception of DVA is instrumental in barriers to remedies, and promoting effective, evidence-based nursing:

> *"Unfortunately, there is a misuse of religion and the building of decisions and laws depending on their misunderstanding of the religion and vague interpretations. I will give you a few examples of how our community manipulated religion, as I guess there is no single verses that say you have to respect/obey your husband, but Allah says, 'They* [your wives] *are a clothing (covering) for you, and you too are a clothing (covering) for them' – هُنَّ لِبَاسٌ لَكُمْ وَأَنْتُمْ لِبَاسٌ لَهُنَّ ' – That means we complete each other, however, that is socially unacceptable, plus the wali etc. But the community's patriarchal ideologies let men be more dominant under the name of religion, but actually the religion does not state that. The country policy formulated depends on that, but it seems to start to change now".* – Nour

When asked about their view regarding to the prevalence of DV in Arab and Islamic society, the participants argued that the community practices

inhumane behaviour against women and respects norms, culture, and tradition more than religion, but they had consensus that some people misunderstand religion or justify their abusive behaviour through religion. All participants agreed on how the Islamic religion honours women:

> *"Historically, Islam honoured women and prohibited any kind of humiliation of women, whether physical or verbal and developed women's rights".* – Nouf

The evidence reviewed here seems to suggest that nurses perceived a pertinent role for the religion in maintain and protect women rights that each woman should experiencing, but which they are often denied due to disingenuous misappropriations of religious concepts to entrench traditional abusive attitudes and behaviours. All participants cited either verses of the Quran or hadiths to as evidence of women's rights, and the prohibition of abuse, as exemplified by the following quote:

> *"Violence is not existent in Islam, and we all know how our Prophet* [peace be upon him] *was respectful to women, so imagine that we are humiliating her nowadays; so, if I was a male, and in a difficult situation, and felt the need to violate a woman, my belief and my religion should stop me from doing this and I should find another way to relief my stress because if we are more religious, it should stop us… and because we are a religious community, it should reduce the violence rate significantly…".* – Muna

With regard to DVA, participants from this study mentioned repeatedly their view that some members of society cherry-picked verses of the Holy Quran or interpretations of half-verses to wilfully misinterpret Islamic ethics toward women and justify abuse, in terms of how males should treat females in their families. Yasmeen gave an example of how half-verses give different meanings, and that God did not say that either men or women are better. What was perceived from the majority of participants was the opposite understanding to that of the points of view of some men, who cited only parts of the verses to justify abusing; some abusers know full well that what they are

doing is considered sinful in Islam, but they do it anyway because the community enhances patriarchy, as mentioned previously. The nexus of religious interpretations, community attitudes, and individual violence is complex:

> *"Religion doesn't support violence, but when they read 'Alrejal Qawamoon Ala Enesa'a'* ['men are the protectors/maintainers of women'] *and stop before the rest of the verse, they get it wrong and they just understand it the way they want…".* – Yasmeen

Some participants' accounts captured some important aspects that all Muslim women should be aware of. Some of the well-known hadiths listed by certain participants asserted that it is important to note that Prophet Mohammad (ﷺ) valued women and urged men to be as gentle in dealing with women as someone who is handling a flask that is fragile and easy to break. Hence, extra care is required, and violence is counterproductive (as well as prohibited). Showing genuine attention will make a woman feel that she is being protected physically, financially, and psychologically, which is the right of every woman under the religious values and beliefs of Islam. However, the participants felt that this ethos of genuine protection has turned into a paradigm of oppression against women due to the interpretations of the traditions of the culture they live in.

Aziza discoursed on the concept of *wilayah*, relating to the role of *wali* discussed previously. A *wali* in Islam is someone who has duties to provide protection, help, and assistance relative to needs and internal and external hazards. This is not necessarily about gender issues, as government officials may be referred to as *walis* (e.g. city mayors). In the context of this study, the position of *wali* as a legal concept relating to guardianship over woman in SA was perceived to be misused, and it had been misappropriated as a tool for abuse due to cultural norms antithetical to its original religious purpose:

> *"According to what I know about the Prophet's life when it comes to treating women, he emphasized that we need to avoid being violent with women* ['rafqan bel qawareer']*, 'be gentle with flasks', and* – خَيْرُكُمْ خَيْرُكُمْ لأَهْلِهِ وَأَنَا خَيْرُكُمْ لأَهْلِي – ['The best of you is the

> one who is best to his wife, and I am the best of you to my wife'], *and said also that whoever has two* daughters *and treats them very well will be his neighbour in paradise. So, Islam refused the notion of burying girls alive, and this can show us that Islam came to defend women where they were oppressed everywhere and treated badly… we know that Islam came to protect women through the 'wilayah', and not to oppress her, exactly as when you have a director in your work or a president in the country; therefore, the wali is there to look after her and not to control or beat her, and what has been practiced nowadays is mainly rooted in culture and traditions"*. – Aziza

The *mahram* system of male guardianship was seen by nurses as one of the key obstacles and most significant impediments to realizing women's rights. In SA, the life of a female is primarily controlled by a man until death. Every Saudi woman should have a male guardian, either a husband, father, brother, or son, who has the power to make a variety of critical decisions on her behalf. Furthermore, a woman may not be able to travel freely except if she is accompanied by a male guardian. Thus, participants stated that:

> *"I believe the problem is with the mahram… it is the man who helps and facilitates everything for her, but it seems that it has changed now; some of them see the mahram as the one who controls everything. For example, you need the mahram's approval when you want to issue a personal ID card; so the problem is not with the existence of 'mahram', but with how we define it in the community, as someone who grants the existence for the woman… so he is the one who approves bank cards or personal ID, or he may take the bank card and use it as well, and if she does not have a mahram she will suffer from losing the accessibility to all those facilities, including the healthcare system. Please, we are adults, and there is no evidence for this in religion. I mean she needs a mahram to be able to proceed in this life, and the problem is how we define the mahram in our community".* – Hala

In the above quote, Hala expressed the idea that the male guardianship system obstructs the realization of women's rights. She mentioned that there is no text in the Islamic law that requires a woman to be treated as a dependant rather than a capable adult; rather, it is a misunderstanding on how the *mahram* concept was defined, and how the law was formulated based on that.

Moreover, some of the participants felt that the responsibility of a *wali* was also misused by men, as they transformed their protective and caring roles for their women into restrictive, isolative, and oppressive roles against their womenfolk, as exemplified in the following quote:

> *"The actual wali is a legal person who can be responsible for and take care of the woman, while the forced wali is the one who can treat her as a slave and control whatever belongs to her, which is wrong"*. – Sarah

Participants also stated how the country's law supported and misused the role of *mahram*, and how they did not let it be optional; they perceived the importance of the role, even though it sometimes restricted women's freedom:

> *"I meant by this the notion of wali or waliyah, this can be seen when you travel, and they ask you about the wali's permission of travel. This can have advantages and disadvantages, but the disadvantages are very common in the community…".* – Aziza

Women previously required the permission of their *wali* for certain procedures in hospitals, such surgery; without the consent of their guardians they could be denied life-saving treatment, and the latter could carelessly or maliciously refuse to sign their consent. This policy was changed a long time ago, but women are still unable to self-determine whether they should get elective surgery or any procedure; consequently, even when policy changes *de jure*, people need time to change this ideology of guardianship *de facto*. Yasmeen cited how the healthcare services were affected by the *wali* role, and how the nurses were unable to ask even sexual questions that could affect the woman's health:

> *"some ladies wait for their walis to decide if they should undergo even minor procedures. And we have to wait a long time until they come and decides! She might be scared to do this, but it is part of the culture that the wife always seeks permission, even to explain her issues. According to the culture, wives are submissive to their husbands, and they go by what the husbands say. In maternity, we don't even ask about STDs, we just wait for them to say anything at all. They're so reserved, so I suppose the women still think they need a man to decide on their behalf; we should educate them to be honest. It was a policy to take guardian's permission about any procedure, but it has been gone a long time now".* – Yasmeen

As can be seen in the above quote, policymakers are responsible for formulating policies, and assessing how previous policies were formulated to serve a guardianship system which is different from the real concept. However, despite positive legislative and regulatory changes designed to increase women's autonomy and rights in healthcare, women still unconsciously seek permission from their *walis*, which delays their access to healthcare services and hinders nurses from performing their roles effectively, as in the example above of the inability to ask questions about sexual health and other sensitive issues for them. Thus, more education is needed to raise awareness of healthcare rights among Saudi women. There are negative interpretations and those who blindly follow what certain religious scholars say about women. This raises a question for the government about the criteria for issuing fatwas:

> *"Some scholars who didn't have a certificate in religious law said that a woman's place is her home, as a result of misinterpretation of some verses of the Quran, and that there is no need for education, and they do not have to go out except for emergencies, but now this has been changed; please stop following them. Before, these ideas were thought to have a religious basis… so when you talk to him as a man he will say 'no, I am the man and I will tell you what to do'… I mean the man's idea of how to treat the woman".* – Nour

As Nour stated above, some men formulated law and fatwas according to culture and traditions, and when someone discusses with them, their chauvinist ideology appears clearly, rather than an academic appraisal of sharia. Similarly, Hala thought that as law is formulated by men, there is an inherent discrimination against women, which appears in legal statements:

> *"We have two sides, the first is the community which does not protect the girl and the other side is that the law does not, either… the community and the law says that she needs a mahram, someone like her father or her brother. The law has been developed by men, and women did not participate in developing the laws in SA…".* – Hala

However, Sharifa elaborated the positive effects witnessed by the most recent amendments to the systems in SA, and how the government restated a clear regulation that protects the rights of Saudi women who suffer from parental control:

> *"The laws now are more dynamic and flexible and guarantee to protect women's rights. For example, previously, women could not do any procedures in courts without an agent (wakeel) or guardian (mahram), but now I recently read that there are some female lawyers that can be authorized to do everything for you, or even the notary can come to you to do the procedure… and you can even do it online by yourself…".* – Sharifa

Regardless of the above elements of family violence, it appears that SA has come very far in terms of women's rights, and participants highlighted the huge steps made by the current government, led by the Crown Prince Mohammad Bin Salman, to empower the female members of the community. Many of the participants of this study emphasized how this current government has helped in reconceptualising women's roles and rights in the community. Also, they highlighted women's rights for equal chances of free education and free health:

> *"Now the Crown Prince changed the system to allow women to manage their own travel by themselves, without any restriction on this. I feel there are some changes, and a recently activated*

> *Human Rights Department, starting with the issuing of driving licences for women, which not only empowered women but also changed men's perspectives toward the other gender… and now a little girl can say that she wants to become whatever she is dreaming of and has a chance, in contrast to the old days where she could improve only in certain sectors. Now they have equal chances to go abroad and study, so I feel that the government is trying to change, but it cannot be done without people's help…".*
> – Nouf

Nouf illustrated an important aspect regarding equal opportunities in education, both internally and externally. Previously, opportunities such as studying abroad were limited to certain circumstances that favoured males over females. However, the current changes have given each woman the opportunity to be able to continue their education. Also, the current government has enabled females to be active members in the community and tried to diminish the old traditional views about women's roles within Saudi culture. These days, the public is starting to notice a rising number of women's organizations that are scattered in almost every city and town, which play a great role in rehabilitating women and enhancing their roles in their families and communities. Seeing such improvement evoked a sense of empowerment concerning women's rights and a sense of comfort with the governmental changes.

Participants expressed a sense of relief when they disclosed their experiences of contemporary developments. They felt less pressured and more able to express their optimistic views in facing obstacles compared to previous generations. Hala disclosed how changes were occurring step-by-step:

> *"I don't know, because I am not knowledgeable about the politics but I can see that he* [Mohammed Bin Salman] *is standing next to women, and this may shed light on lots of aspects and change many policies which will indirectly protect women {…} moreover, this new government is encouraging changes in the culture, and this will help women to be able to speak up and discuss their own*

opinions. This will have great impact because it is the government, and not several individuals changing the norms. I will be able to issue my own bank card and so on, and this will reduce the financial and family violence gradually, through steps, and not by magic". – Hala

When queried about this, participants indicated that they wished to have more input from the governmental consultative body known as Majlis al-Shura, both in interpreting Islamic colloquial terminology and implementing discipline for those who have been committing family violence:

"I wish this issue could be taken straight to the Majlis Al-Shura in the country, to develop some channels to report violence, and laws to control this issue, either by interpretations or punishments". – Sharifa

From the transitional point of view, nurses in SA often express excitement concerning new changes that are brought up in Saudi legislation. This reflects a new generation who will advance the rights to report domestic violence in healthcare settings, and these changes will empower nurses, as they will feel more supported in their role. Participants in this study acknowledged the supportive role of the Saudi government, especially emphasizing the goals of the 2030 Vision, which empowers women to improve their wellbeing, and healthcare providers to provide optimal healthcare. This was also reflected in the practice of nurses, with policies and legislation for healthcare organizations, and the education of nurses, supporting women more than before, as discussed further in Chapter 5.

4.3.3.4. Summary

Most of the participants cited how families, husbands, and communities should be playing more supportive roles to open more avenues to support women, increasing their protection against DV. However, this appeared to be related to cultural domains that identify the superiorities of men over women within communities, thus normalizing DV. Also, stigma could indirectly affect nurses when providing care to victims, as well as women who are scared to

experience a social disapprobation and shame due to disclosing the abuse they suffer, causing them to remain silent rather than seeking help.

Nurses' narratives showed that in their experiences they could not separate their personal from their professional lives with regard to encountering abuse in the social and religious context. This reflects the contextual factors pulling people in different directions in terms of cultural and social norms and religious values, amalgamated in a way that is linked to both nurses' professional practices and their personal beliefs. Their accounts showed a sort of dissonance, with some kind of dialogue in their mind about what is right and what is acceptable in terms of what patients present with. To navigate these conflicting elements while providing nursing care, participants tried to understand how DV could be addressed, and this resulted in raising the important question of whether family violence can be addressed adequately by nurses only.

4.4. Summary of Findings

This chapter has explored the general structure of nurses' experiences and understandings of DVA. Saudi nurses are disempowered with regard to addressing domestic violence, as reflected in the participants' responses. The main concept that explained nurses' experiences was "being disempowered". There are several components that reinforce disempowerment, most of which are linked to three themes: being unequipped, being silent, and being constrained by social and religious contextual forces. Those elements reflect professional, organizational, and community barriers that contribute to disempower nurses.

The interviews about DVA uncovered multiple barriers and challenges that nurses face when providing care for the victims. The participants emphasized how being unequipped, such as lacking training and education; the lack of clarity around nurses' roles; ambivalent laws; isolated roles; being silent (e.g. the lack of reporting) and the personal cost of reporting DVA (e.g. losing employment or facing violence in the community); and being targeted and constrained by social/ religious forces all played important and interconnected roles in disempowering them. The analysis of the nurses' narratives showed

how these factors transformed their attitudes toward DVA. Clearly, these factors act as challenges and barriers to the role of nurses in addressing DVA and supporting victims in healthcare settings. Nurses were clearly found to be disempowered in this study, which was an important aspect of nurses' experience.

4.4.1 The interaction and Intersection of the study findings

This study produced insightful results around the understanding, experiences, and practices of nurses and student nurses around domestic violence against women within healthcare encounters in Saudi Arabia. All of the findings are equally important since they all work together to stifle and disempower nurses and student nurses as they deal with DVA. Approaches to tackle these barriers must be multifaceted and aimed at all levels. Which The three main themes that emerged from the study can be considered as the cornerstones since they picture the real experiences and understanding of nurses in the SA context. These cornerstones are guarded by various subthemes that explain and connect with one another at different levels. Each theme has not originated in silos but are part of the process. First theme that explains the feeling of being unequipped raise two important concerns, first lack of skills and training and second, lack of clear expectations, policies and procedures. Education and training regarding DVA is need of the time and is directly related to the disempowerment that nurses feel in their professional lives. This theme connects to another theme i.e. being silenced. Nurses are unable to raise their voice because they face the dilemma whether to report or not, they are not authorized to do so and also because they feel they are in a position that could do more harm than good to their employment and stance as nurse. In addition, since the nurses are ill-equipped these two notions can work together to further complicate the situation. Lack of skills and training along with lack of clear policies and procedures can surely mute the nurses in the crowded workplace. Similarly, when nurses are not in the position to raise their voice, it is the genuine sense if they experience feeling of being unsafe. In the alike manner the third theme sheds light on the grave situation that exists in SA. The religious and social constraints look like an iceberg. It is the only tip that we can see but it has strong and deep roots that are not visible at the surface.

Equally, nurses working in the clinical area come from the same culture and social context and follows the same religion. After performing the duty hours at the hospital setting, they have go back to their same culture and society. The culture and society that do not consider DVA as a crime and assault and doesn't encourage its reporting, how it would encourage the incorporation of DVA in the training and education of nurses? This portrays a vicious cycle with elements inter connected and the cycle repeats because there is lack of laws and policies to break it. This study beautifully showed the emergent issues and the lacking that make part of the implications and need to be addressed to break this vicious cycle.

Chapter 5
Discussion

5.1. Introduction

The overall aim of this thesis was to explore the understanding, experiences, and practices of qualified nurses and nursing students related to DVA within healthcare encounters in SA. Secondly, it also aimed to identify the barriers that may affect the nurses in their professional practice and the factors that may facilitate effective support and enhance nurses' knowledge and practices in the future. This chapter discusses in detail the findings of the study in light of the existing evidence, and reflects on how these findings contribute to the existing body of knowledge surrounding DVA and nurses' experiences of caring for those women. The findings of this study comprise critical learning, extending current understanding of DVA in the particular context of SA. Also, a significant connection has been discovered by this study between the implications for the education of nurses, and the development of policy and practices, and the need for increased awareness of DVA in the community.

Concerning the overall purpose of this research, it was found that the practices, understanding, and experiences amongst nurses relevant to DVA led them to feel disempowered, reluctant, and unable to act. Hence, this discussion begins by considering the concept of disempowerment in the context of DVA. Furthermore, the discussion proceeds to consider how disempowerment creates barriers to nursing practice, which are conceptualized in terms of three different levels that emerged from the findings. These barriers are related to the nurses' professional preparation; organizational structures and processes; and wider social, cultural, and religious fabric components. Those barriers and the findings of the study can clearly be viewed in the light of socio-ecological model.

As the findings of this study took shape, it was evident that DVA is not an isolated event but an interplay of various factors that operate at the individual, organizational, community, and public policy levels. The individual level factors are concerned with the skills, knowledge, and attitudes of individuals. The

interpersonal and the organizational factors shed light on the relationships of individuals with others in the context of social institutions. Similarly, societal and the public policy factors encourage or inhibit economic and social policies that play a role with other factors in the model (Krug et al., 2002) These factors, along with the barriers and possible implications, are discussed in detail. The discussion then goes on to describe how each of these barriers can be addressed, to facilitate effective support and enhance the knowledge of nurses in the future to improve the QoC they provide.

5.2. Nursing Disempowerment in Relation to DVA

The overarching concept that has emerged from this study is the disempowerment of nurses, the opposite of empowerment, which in this context refers to situations in which nurses feel unable and unsure of how to act when encountering DVA patients. This feeling of being unable to act relates both to the provision of care to the patients and to their ability to act as patient advocates. An important factor associated with nurses' empowerment is power, which is defined as having control, influence, or domination over something or someone; or more generally as the ability to get things done (Manojlovich, 2007). Benner (2001) defined power as caring practices by nurses that are used to empower patients. Nurses need the power to be able to influence patients, physicians, and other healthcare professionals, as well as each other. Conversely, nurses who lack power are ineffective, less satisfied with their jobs, and more susceptible to burnout and depersonalization (Benner, 2001).

Nurses' practice of power and ability to influence is dependent on their competence, along with healthcare organizational structure, and societal perception of the concept of nursing: the presence of support and nursing competence forges empowerment, while the failure to support and facilitate nurses leads to disempowerment (Andersson, Lindholm, Pettersson et al., 2017). Similarly, when nurses are empowered, this ultimately influences QoC and thus affects patient outcomes, as nurses are pivotal healthcare providers on the front line of care, including in providing support for violence victims and survivors (McGarry and Nairn, 2015; Karami et al., 2017; Horwood et al.,

2018). On the other hand, when nursing practitioners are disempowered, their patients suffer from the vacuum created in the support network. The empowerment-disempowerment effect is evident in the case of DVA Empowering nurses promotes a surge in confidence (Bradbury-Jones and Broadhurst, 2015), and whereby they engage more actively in decision making to improve patient healthcare (El-Demerdash and Obied, 2016).

In this study, the nurses deliberated various elements determining their experience of disempowerment while caring for DVA victims. Determination of disempowerment hinges on the comprehension of nurses' experiences, understandings, and knowledge of DVA against women. In addition to that, disempowerment also originates from the surrounding structures in which the nurses operate. Empowerment arises from social structures in the workplace that enable employees to feel satisfied and more efficient at their work (Kanter, 1988), and organizational systems provide strength and power for nurses (Manojlovich, 2007).

However, in this study, the nurses regarded the policy and practice of the organization as a barrier that contributed to their feeling of disempowerment. Nurses who stay silent often do so as a product of their working conditions, organizational policies, and situations, rather than due to their personal attitudes (Kuokkanen and Leino-Kilpi, 2000). Likewise, empowerment is also seen as a process of personal growth and development in which individuals' characteristics such as beliefs, views, values, perceptions, and relationships within the environmental context are key, interconnected factors (Thomas and Velthouse, 1990; Kuokkanen and Leino-Kilpi, 2000). Consequently, this study affirmed the literature in that nurses' values and beliefs were found to be derived from their education, community, and religion, all of which contributed to their feeling of disempowerment.

Empowerment eventually benefits the patients when nurses undergo the process of self-awareness and actualization to improve their professional competence and skills (Friend and Sieloff, 2018). Empowered nurses are better able to address patient needs, and their professional status and satisfaction improves as a result. In professional practice, empowering nurses

and students helps them take control by giving them more autonomy and accountability in their working environment (Espeland and Shanta, 2002). The key components that elicit empowerment include raising consciousness, developing strong positive esteem, and political skills needed to negotiate and change the organization, its legal and social structures, and the overall healthcare system (Glass, 1998). These concepts are instrumental in this study to assess the knowledge and experiences of nurses related to DVA, and hence in addressing the factors leading to disempowerment.

As clearly identified in this study, empowerment is essential in preparing nurses to be the change agents in the rapidly changing world of health care. When nurses are empowered, they also benefit by a sense of professionalism, which in turn increases their ability to meet patient needs in a holistic manner (Domino, 2005). Eventually, the benefits trickle down to the patients, who begin opening up in response to DVA, initiating the advocacy process (Wies, 2006). Empowered nurses can solve problems more effectively, ensuring higher standards of diverse types of holistic, person-centred care (Espeland and Shanta, 2001). Consequently, this raises nurses' self-esteem and motivation to learn, and inculcates positive feelings towards their placement.

In SA the concept of nurses' empowerment is often overlooked; put simply, nurses are not empowered to deal with issues of DVA. Empowerment of nurses is needed to improve their ability to deal with DVA and to prevent it. Simultaneously, they would be better able to recognize their obligations to provide care to abused women if they were empowered, as evidenced empirically by studies demonstrating the positive outcomes of empowerment for nursing practice (Manojlovich, 2007); nevertheless, the reality on the ground is that many nurses caring for DVA patients remain disempowered in SA and throughout the region. This experience of nurses and the barriers encountered in professional practice were explored in this study, indicating that nurse disempowerment in healthcare institutions and social signals comprise barriers to nursing professional development. Such obstacles could be addressed through strategies to support the empowerment of nurses and new insights for the advancement of quality nursing care to support abused women.

The first essential step towards empowering nurses is to identify the barriers that hinder their practice. The identification and assessment of such barriers helps inform the design of strategies to deal with the problem. This aim was articulated by this study, by revealing a range of inter-linked and over-lapping barriers, broadly categorized into three areas: barriers related to nurses' professional preparation; barriers related to organizational policy and practices; and barriers associated with wider social, cultural, and religious fabric components. Subsequently, addressing these challenges will help in realigning nursing professionalism, education, and practices to empower nurses. Assessment of these barriers regarding the defined categories enhances the chances of obtaining specific intervention measures relevant to the Saudi context.

As depicted in this study, disempowerment faced by nurses in dealing with DVA in the context of the Saudi healthcare system is multifaceted. The following subsections discuss various forms of disempowerment and barriers to empowerment identified by this study.

5.3. Barriers to Empowerment, Implications, Policy, and Practices

The nurses in the study discussed various barriers and factors that impede, discourage, or lead to disempowerment. Facing those barriers, nurses often end up being silent, and unable to act, having poor engagement with peers and patients, hesitation, reluctance to encounter problems, and reticence to report DVA, even when they wish to and feel that it is obligatory; all of these outcomes arise from disempowerment. Such barriers, intentionally or unintentionally, lead to reduced QoC for abused women, contributing to the exacerbation of the abuse cycle. Such barriers relate to how nurses are professionally equipped; lack of organizational policy and practices; and social, cultural, and religious factors. Each of these barriers must be addressed to facilitate effective support and enhance the knowledge and practices of nurses in the future.

5.3.1. Barriers and Implications Related to Nurses' Professional Preparation

The findings of this study show that the core barriers are intrinsic influences, caused by the lack of knowledge, training, inter-professional education, and CPD concerning DVA in both university and hospital nursing contexts. These barriers contribute to lack of confidence in nurses. The nurses in this study expressed the negative impacts of their lack of professional preparation, which made their experience of a sense of disempowerment unsurprising. A lack of empowerment due to insufficient training could be rectified by introducing relevant core DVA issues into the BSN curriculum. Again, adequate training and preparation, as well as continuing in-service professional training in the hospital, may lead to building up more confidence and enough assurance to discuss DVA (Alkorashy and Al Moalad 2016).

5.3.1.1. Being ill-equipped

Nurses in this study associated the feeling of disempowerment with not being adequately equipped. Nurses felt that they were ill-equipped in terms of their knowledge, training, skills, and relevant experience to care for women experiencing DVA. The literal meaning of ill-equipped is not having the equipment, power or capability, and ability to prepare that which is needed (Cambridge Dictionary, 2020). In the nursing context, a nurse who is not adequately prepared to care for patients coming with a particular complaint could be labelled as ill-equipped. However, the question arises of whether a nurse be ill-equipped when she has already completed her BSN; evidently among participants in this study the answer was "yes". Nurses were unaware and unconfident because they lacked requisite training and experiences in dealing with DVA in their workplace setting.

5.3.1.2. Education and nursing curriculum

A principal reason of disempowerment revealed by this study was a dearth of education and the shortfall of the nursing curriculum. Being unaware of the care provided to DVA women victims is a major area in which nurses need education. Nurses are not usually taught about DVA screening (Wyatt et al.,

2019), and possessing insufficient skills in general contributes towards nurses' disempowerment, as discussed previously.

This is connected to numerous studies which echoed that strengthening professional bonds with women who have suffered abuse, listening and communication abilities, as well as impartiality to promote women discussing their circumstances, are DVA-related capabilities that must be improved among nurses through proper education and training. Training and education are necessary in this regard (Crombie et al., 2017; Alshammari, McGarry and Higginbottom, 2018). Participant acknowledged that a lack of knowledge and skills was a key barrier to providing suitable care for women experiencing DVA. Nurses also highlighted their lack of awareness about DVA, its health consequences, and how nurses can intervene as barriers (Bessette and Peterson, 2002; Glaister and Kesling, 2002; Inoue and Armitage, 2006; Guruge, 2012; Cho et al., 2015; Alshammari et al., 2018).

Related to nursing knowledge, skills, and experience, the nursing curriculum is of prime importance. However, the literature supports that content has been scarce in the nursing curriculum related to domestic abuse and violence against women. This is also evident in this study, where nurses felt there was a deficit in the curriculum to address DVA in SA. These inadequacies led to an unclear understanding among the nurses, making them feel unaware about the type of care required by the affected victims (Crombie et al., 2017; Alshammari et al., 2018). Nurse students also brought realization in the form of unattained educational needs surrounding DVA. Together with the education needs of nurses, nursing students also need relevant education and training before they are expected to provide professional care for DVA women victims.

Many student nurses in the present study were acquiring their BSN after a nursing diploma. Research explains that in various settings, specific training to assist healthcare professionals with screening for domestic violence is usually provided for those who are employed by health services or organizations. Students who are still in the learning phase are often unable to access this training. Secondly, nursing students on their clinical placements might be

buddied with mentors who themselves lack proper skills to deal with abuse victims. This could lead to students not receiving the necessary mentoring and role-modelling support in undertaking screening in practice. In a similar context, Smith et al. (2018) reported that there is a lack of preparedness in screening for and responding to domestic violence among midwifery and nursing students, which could have an ongoing impact, as once registered, these personnel will not feel capable to support future students in developing these skills.

To address this challenge, a model was developed in UK, “for the systematic embedding of safeguarding knowledge, skills and attitudes within undergraduate pre-registration nursing curricula” (McGarry, Baker, Wilson, Felton, and Banerjee, 2015). The model focuses on the attainment of knowledge and skills for safeguarding vulnerable adults and children. Also, in light of the challenging and sensitive nature of safeguarding practice, ensuring that nurses feel professionally confident in responding to abuse is equally important. Therefore, taking into consideration the needs assessment, a core element of the course content is to incorporate the positive professional values and building of resilience and effective coping strategies among nursing students (McGarry et al., 2015).

Secondly, as safeguarding in practice requires a multi-agency approach, the course content was developed through extensive collaboration with a range of agencies, and included consultation with service users and carers, survivors of abuse and violence, and practice learning partners (McGarry et al., 2015). The safeguarding element of the curriculum involves multiple modes of delivery, and supports the needs of different learning styles with whole cohort lead lectures, self-directed online study, and small group discussion sessions with a facilitator. In addition to addressing the issues such as defining vulnerability, strengths-based working, and promoting autonomy balanced against the need for protection, the course content also facilitates developing learners’ professional independence throughout the course and during their transition to registrant status (McGarry et al., 2015).

This type of model, with some culturally sensitive variations, could be implemented in SA. It is integrative, and emphasizes the attainment of knowledge and skills to safeguard and protect vulnerable groups, including abused women. A core element of the model comprises of nurturing positive professional values and building resilience and coping strategies among nursing students (McGarry et al., 2015). These values are also needed by the nurses in this study. However, since DVA is not talked about openly, and the issue is not regarded as a concern owing to the strong cultural and societal norms in SA, its implementation can be difficult. Such a curriculum could be made part of nursing education for nursing students in their undergraduate years, and nurses who are already registered can be provided with short courses or workshops as part of CNE.

Another challenge that nurses face that was highlighted in this study is the discrepancies that exist between theory and practice, i.e. what nurses read and learn versus what they witness in the hospital setting while looking after DVA cases. The challenge is also apparent when theory has to be applied in practice in the context cultural and social norms persisting within Middle Eastern societies, and addressing disparities that exist between different cultures. This aspect of theory-practice integration is missing in nursing education and curriculums. However, various studies have tried to explain the concept of DVA within their respective geographical location and cultural milieu. One such effort was a systematic review by Ali et al. (2015), which aimed to comprehend IPV in Pakistan. It argued that there are several ways in which individuals interpret DVA within each culture and context; an act is not always considered violent in different societies, which can often be extended to other cultures.

Ali, O'Cathain and Croot (2016) attempted further to clarify the DVA phenomenon from the viewpoint of Pakistani people. Among many theories (including biological, psychopathological, feminist, and sociological perspectives) that explain the incidence of DVA, the nested ecological framework takes account of factors operating at various levels in the family, community, and society that describes violence in marital or intimate relationships. Ali et al. (2016) revealed that IPV in Pakistani society originates

from the daily life conflict between husband and wife, rooted in arguments and disagreements in daily life situations. These conflicts could be a part of normal life situation, but can turn into violence if spouses are unable to handle these issues constructively (Ali et al., 2016).

However, the ecological model has been criticized since it does not accommodate the immense significance of “family”, which takes different forms in different cultures, but which is nevertheless always an important element (Krug et al., 2002). The nurses in the current study also pointed out that limited knowledge exists concerning the cultural and social norms persisting within Middle Eastern societies, disparities between different cultures, and the significance of the family role in DVA. Thus, the development of specific curricula is necessary to address cultural connotations of violence, and to apprise nurses of real field challenges.

5.3.1.3. Training needs

In addition to education, the hands-on practice and skills building is of utmost importance for nurses and the absence of it is a barrier to empowerment. One of the ways of acquiring skills is through training. Nurses need appropriate strategies as well as skills to respond to DVA to provide optimal care (Davila, 2006; Crombie, Hooker and Reisenhofer, 2017; Alshammari et al., 2018). Since nurses are most frequently in close contact with patients, their recognition of abuse is essential to prevent these women from secondary victimization, which may result when these victims are mistreated by the health settings they access, and their vulnerability should be taken into account when they seek care in healthcare settings (Inoue and Armitage, 2006). The ability of the nurses to carry out a proper assessment is possible only with proper education and training. Likewise, as a means of increasing consciousness and determining appropriate interventions, cross-agency interactive educational opportunities that involve victims and provide DVA training are equally necessary for undergraduate nurses (Alshammari et al., 2018).

For planning and implementing a training programme that aims at improving the skills and knowledge of the nurses, it is also crucial to be aware of the myths and stereotypes that exist among them. Maquibar et al. (2018)

explained that critical analysis of such misconceptions, as well as tackling of anxiety relating to DVA, requires capabilities that can be nurtured through a training initiative, incorporating creative, evidence-based methods. The development of relevant proficiencies through training and education is required for all nurses (Maquibar et al. 2018). Training needs are equally essential for nurses and nurse students, as identified in this study. Students' experience in practice may differ from clinical placement to placement. Also, not all exposure in real-life practice is beneficial for adaption (Pollard, 2008; Smith et al., 2018). Since students may not have the ability to filter their experiences and decide what appropriate practice looks like (Pollard, 2008), they are the true candidates for training.

Nurse students can be exposed to experiential learning scenarios which is one way of addressing this lack of practice experience. Providing students with a demonstration of expected practice through the use of stimulus video clips and giving them supported time to practise responses can increase students' confidence in responding to disclosure of domestic violence. Giving students protected time for skills rehearsal provides great benefits and is an opportunity for them to synthesize how the knowledge they have learned at university informs their clinical practice. By the same token, interactive learning can be used to effectively bridge the transition from student to newly qualified professional (Kitson-Reynolds, 2009).

Forsetlund et al. (2009) suggest that interactive workshops are potentially one of the most effective methods to achieve moderately large changes in professional practice. With this in mind, an interactive workshops based around the authentic practice video can be developed and evaluated to increase students' knowledge and confidence levels in screening for and responding to disclosure of domestic violence in pregnancy (Smith et al., 2018). Another important factor in the empowerment of nurses, particularly nursing students, is the role of mentors. Supportive mentors are vital in the process of empowerment; likewise, the nursing profession needs to support those who undertake mentorship roles (Bradbury-Jones et al., 2007).

The model of empowerment proposed by Bradbury-Jones et al. (2010) in the "spheres of influence" model emphasizes the significance of knowledge and confidence in determining students' empowerment in clinical practice. It shows a range of factors that are directly associated with greater influence, which include being recognized as a learner, being part of a team, being respected as a person, having a supportive clinical mentor, and a high-quality placement, along with broader organizational and political influences. This model is empirically grounded in research with nurses. Its focus on knowledge and confidence aligns with the aims of this study, and it takes account the multiplicity of issues that might influence students' knowledge and confidence and thus their empowerment, regarding recognition and responses to domestic abuse. In the process of empowering, individuals, organizations and communities pursue maximal impact on their own life and eventual choices.

As the nurses and nurse students in this study highlighted a lack of training as a barrier, implementing the above-mentioned strategies would not only boost their confidence but would also prepare them for professional practice. These educational trainings would provide nurses as well as the students with a sense of clarity on how to begin with when the victim makes the disclosure and how to proceed with DVA assessment, which was evidently problematic for participants. This practice can be further strengthened if it is made part of the policies and guidelines of the healthcare organization. Thus, this can positively address the inconsistency between what is learnt in the classroom and what is experienced at the clinical site, leading to more clarity in the practices.

5.3.1.4. Continuing education and training in hospital for professional nurses

The nurses in the study described a lack of professional preparation as a barrier to empowerment. Professional preparation is not limited to undergraduate training, and learning and training needs are not limited to the classroom setting. The education that starts in schools of nursing should be continued during the course of the nurse career as part of CPD, to help nurses prepare for the appropriate and required nursing care and always provide the highest QoC with the best quality EBP. In addition, another aspect of disempowerment that has been identified in the present study is lack of "on-the-job hospital-based education", "continuing education", and "in-services

training for nurses", particularly with regard to DVA. Due to this deficiency, nurses could experience burnout, low satisfaction, and less engagement with the cases of DVA.

These findings corroborate those of Gassaz (2009), who studied Saudi nurses' perceptions of nursing as an occupational choice. She discovered that majority of the participants, including interns, staff nurses, as well as senior nurses, claimed that a lack of in-service support and in-role training was a significant factor in whether they would continue to work for an organization or not (Lamadah and Sayed, 2014). The same participants were motivated to progress via education and advanced training, which affected their sense of job satisfaction and continuation of a job with the organization.

Unfortunately, there is an inconsistency in the in-services and on-the-job support provided across different hospitals and sectors across SA. Staff nurses and senior nurses in the basic state sector and smaller private hospitals display more dissatisfaction and disappointment than their counterparts in more amply resourced tertiary hospitals in the military and security sectors (Lamadah and Sayed, 2014). Hence, education is the basic tool needed to influence the integration of routine screening in practical settings. Nevertheless, more than a third of nurses have been found to have no formal education on DVA (Crombie et al., 2017; Alshammari et al., 2018).

5.3.1.5. Lack of relevant experience

Coupled with the above-stated barriers, another significant aspect that nurses pointed out through this study is the lack of relevant experience. In addition to the need for education and training related to DVA, lack of relevant experience is another area that could lead to the experience of low confidence. In clinical practice, nurses assigned to care for women often experience violence, are novices, and do not have relevant experience. A study conducted with Japanese nurses to assess their understanding of DVA explained embarrassment as an attribute of resistance to the provision of care. When nurses encountered victims of DVA, they felt embarrassed, and tried to situate themselves in the similar situation, hence this feeling made them decide on not interfering, and thus withdrawing from the course of assessment and action

(Inoue and Armitage, 2006). Nurses admitted that they could never completely understand the feelings of victim women because of a lack of actual experience of being abused, therefore they were uncertain as to how they should act at that particular moment (Inoue and Armitage, 2006).

Similar sentiments and experiences were articulated by participants in this study. They felt that DVA is an essential area that they needed to engage with, but were unclear about how to deal with this. An exploratory study conducted in a UK university among third-year Bachelor of Nursing and Midwifery students revealed that the students recognized that domestic violence is an important issue, and they had comprehensive theoretical knowledge of the nature and consequences of abuse, but they lacked confidence in recognizing and responding to it (Bradbury-Jones and Broadhurst, 2015).

To be competent to provide the appropriate proven care, nurses must use the theory linked to best practices as well as deploying sensitivity to cultural and societal norms. The acquisition of relevant experience is significant for providing care with confidence, while a lack of the same can prove detrimental for students, nurses as well as for victims. Smith et al. (2018) assessed the confidence of midwives student to address the issues of DVA also found that student midwives had low levels of confidence related to screening for and responding to disclosure of domestic violence, with possible reasons surrounding lack of mentorship and role-modelling, the theory-practice gap, and a lack of exposure to dealing with women experiencing abuse.

However, following an interactive workshop focused on improving knowledge and building confidence in screening and responding to disclosure of domestic violence, Smith et al. (2018) reported significantly higher confidence levels afterwards. The findings of the present study highlighted that a lack of relevant experience affect nurses' capabilities and readiness to identify abuse and plan care. This could indicate that Saudi student nurses and registered nurses are not well trained to deal with the sensitive emotional issues concerning DVA, therefore they need appropriate exposures to build experience.

5.3.1.6. Different levels of awareness among nurses and victims

This study also shed light on the importance of awareness. Besides educating and training nurses and students, the acknowledgement of abuse by abused women is also equally important. Even if nurses are well trained and educated, abuse victims often do not want to disclose their painful experiences, recollections, and fears. In such cases, nurses are bound to respect the victim's decision of non-disclosure. A similar experience was shared by the nurses in this study. Under such encounters, victims should also be motivated to acknowledge their position, with awareness that they are in an abusive situation and that their experiences are crucial. However, victims blaming themselves and not wanting to reveal the abuse could arise in association with several factors relating to culture and social norms.

Perpetrator programmes can help women disclose and not feel blamed for their situation. These programmes are important elements of an integrated and comprehensive approach for preventing and fighting violence against women. They should be part of a comprehensive national policy. Working with male perpetrators of domestic violence and sexual assault can contribute to a wider process of cultural and political change towards abolishing gender hierarchies, gendered violence, and gender discrimination, as well as other forms of personal and structural violence and discrimination. In leading perpetrators to accept responsibility for their violence, perpetrator programmes are crucial to overcoming belief systems that tolerate and justify violence against women (Hester and Lilley, 2014). Such programmes would benefit nurses in Saudi Arabia too. The ingrained social and cultural norms need well planned and culturally sensitive strategies to make a change. Hence, nurses' feelings and experiences in this study opened a wide array of thinking process surrounding DVA.

This leads into the role of culturally appropriate and sensitive care that nurses are taught in their education to be incorporated in their nursing care plans. This concept is very much linked to the experience of nurses in this study, since Saudi Arabia is a distinct region with its own culture and norms. This notion is further explained under the organization barriers where the dilemma of reporting is concerned. Nevertheless, the key findings of this study shed light

on limited knowledge that exists and is published regarding the cultural and social norms persisting within Middle Eastern societies (Kulwicki, 2002). Literature concerning how to incorporate cultural competence about women's abuse in practice as well as for nursing education is lacking.

Cultural competence, particularly regarding DVA, is deemed to be a core requirement for nurses' effective work with culturally diverse people. Based on this view, Campinha-Bacote (2002) considered cultural competence to be a lifelong learning endeavour rather than an endpoint or static outcome, and proposed a model to develop cultural competence through an iterative and cumulative process of cultural awareness, knowledge, skill, encounter, and desire. These attributes are consistently identified in the literature as the main requirements for cultural competence (Almutairi, McCarthy and Gardner, 2014).

The framework used in this study proposes that a multicultural nursing workforce can become culturally competent through the development of five interdependent constructs: cultural awareness, knowledge, skill, encounter, and desire (Almutairi, McCarthy and Gardner, 2014). For the first time, this framework of cultural competence has tested the culturally diverse setting in SA, suggesting that the cultural competence of the nursing workforce in this setting warrants enhancement, which might best be achieved through CNE and training programmes at an individual level (Almutairi, McCarthy and Gardner, 2014). Moreover, there are differing levels of awareness between nurses and victims, which was considered a barrier by nurses in this study. Sometimes, the abused women might not recognize their own experiences, while health professionals are typically reluctant to ask women about their abusive situations (Baird, 2015).

The point to ponder is whether nursing staff should enact routine screening based on their suspicions, exploring if screening is an appropriate measure before forging a trusting and therapeutic relationship with the patient (LoGiudice, 2015). Williston and Lafreniere (2013) argued the significance of health care training to respond flexibly to sensitive situations. However, Ritchie et al. (2013) noted that improved practice and identification will not derive

solely from training alongside training to inquire about DVA used a purpose-designed family violence intervention form with risk assessment questions and a body map.

Al-Natour et al. (2015) argued that Jordanian staff nurses viewed screening as a risk to both staff members and patients; they also identified nurses' attitudes and beliefs as a barrier to screening. Nurses experienced emotions such as fear, anger, frustration, and guilt. Fear included fear for their own safety, victims' safety, offending victims, and losing their jobs. Anger was experienced by nurses with regard to the empathy they experienced towards women and the abuse women had suffered. Similarly, Jordanian nurses felt frustrated by not being able to assist victims through interventions, and not being able to understand their situation due to lack of knowledge of their roles and responsibilities (Al-Natour et al., 2015). Similar experiences were shared by the nurses in this study, who were frequently reluctant to inquire about abuse, knowing the fact that they could not do much for the victims, and that the necessary process and appropriate actions were unclear.

To tackle this situation, Bradbury-Jones et al. (2014) introduced an original approach for understanding the complexities of the disclosure procedure, entitled the "abused women, recognition and empowerment" (AWARE) model. Clinical practices about abused females, as well as an educational application for health specialists' instruction and training, may be derived from the model, although it requires additional empirical assessment and verification. The authors noted that improved practice and identification requires additional factors other than training, but DVA-related healthcare procedures may be improved through the AWARE model, in circumstances where the health professionals do not identify DVA yet the service user does; where both do not identify it; where the service user does not identify DVA but the health professional does; and when both parties identify it.

Bradbury-Jones et al. (2014) found that primary healthcare experts and abused females often express differing degrees of cognizance regarding the pervasiveness and kinds of abuse. They explored this concept through questioning 14 female survivors and 29 healthcare staff. Their investigation

forwarded the argument that the women had the desire to be questioned about abuse, suggesting that practitioners had the responsibility to enhance a dynamic, trusting, and therapeutic environment in which delicate issues can be freely discussed. This demands a careful approach and previous experience, with the more experienced staff being more likely to recognize and screen such cases for future appraisal. Accordingly, the model also takes into account disclosure and the process associated with it. The researchers state that the AWARE model may be adopted to strengthen women's ability to take safety and disclosure planning decisions, encourage transparent communication between women and healthcare providers, and offer nurses and broader health workers an educational technique.

Together with professionals and women, public awareness can also be enhanced through digital education platform online programmes such as Future Learn, which focuses on "Supporting Victims of Domestic Violence". This course was developed by one of the academic staff at the University of Sheffield (Ali, 2019). This concept may be feasible in Saudi Arabia since a similar online tool is available: "RWAQ is Gallery - The Arab Open Education Platform Free Academic Subjects in the Arabic Language in all Fields and Majors" (RWAQ, n.d.). However, there are no courses presently concerning DVA. Rectifying this concern is one of the conclusions of this study. This study has enhanced our comprehension of the significant issues relating to DVA in SA. It imperative to stress that merely raising awareness and improving training is not adequate. At the same time, nurses need the constant support of experts and mentors within the organization (Leppakoshi et al., 2014; McGarry, 2016), which is explored in detail in the next section.

In summary, education and training of nurses is necessary to improve their ability to deal with DVA, with adequate mentoring and training of students and continuing education and training for professional nurses. Nurses can thereby improve their skills and confidence, taking into account the cultural and societal norms that are some of the important findings generated under the theme of being ill-equipped. Being deficient in these factors can eventually result in the disempowerment of nurses, while being educated and trained to handle them can conversely empower healthcare professionals.

5.3.1.7. Implications for nursing professional preparation

Considering the barriers discussed by nurses related to professional preparation, various measures can be taken to overcome the challenges. This research therefore suggests that there is a need to design DVA-based training in a nursing curriculum that accords with the cultural requirements of SA. Thus, a key recommendation from the current study is to have a curriculum and guideline relevant to Middle Eastern society. Although extensive research has been carried out on the importance of educational programmes in confronting DVA, no research has demonstrated that a Saudi national curriculum was established to face such challenges at workplaces.

It is pragmatic to include women's rights in any curricula, and in the Saudi context this must acknowledge the Islamic approach to women's rights, as with the case of the 2016 establishment of a unit at the College of Medicine of King Abdulaziz University for Health Empowerment and Health Rights. The Unit had many aims and objectives, including the provision of education to healthcare providers about the various rules and regulations governing patients' rights as defined by the MoH, educating students about the *Patient's Bill of Rights*, and increasing community awareness in terms of the recognition of women, their health rights in the context of Islam, and the regulation of medical issues in contemporary and modern medicine. This new subject was included in the undergraduate medical curriculum and is still being evaluated to assess its impact (Al-Amoudi, 2017). However, this subject is not included in the curriculum of nursing and Applied Medical Sciences (El-Sobkey, Almoajel and Al-Muammar, 2014).

Although the medical curriculum includes this dimension of knowledge, Alshaeri et al. (2020) found that medical students still lack understanding and awareness regarding the provisions that exist. In a cross-sectional study conducted among medical students in Jeddah, only 65.1% of the students reported that a male guardian was not required for consent for hospital admission and discharge. Similarly, only 46.1% students were aware that a female patient can provide consent for a caesarean section. On the other hand, only 51.7% of the students had awareness about Saudi health rights, while 44.0% did not know about their codified existence. Only 25.2% had awareness

of sharia positions on abortion, and 51% students responded that male consent was not required around woman's right to attain contraception (only 25.7% of students stated that consent from a male guardian/partner is not required). The study highlighted that there is dearth of knowledge among medical students around health rights of patient populations in SA, which emphasizes the importance of health rights education in the medical curriculum.

A lack of awareness and dearth of education is one of the several barriers that may hinder the implementation of the *Patients' Bill of Rights* in SA (Alghanim, 2012). The omission of this topic in the nursing curriculum could have a significant impact on nursing self-identity and the obligation to advocate for patient rights. This could also strengthen hierarchical authority to grant enhanced responsibilities to doctors and medical students, entrenching the suppression of nurses and the development of advanced nursing in the healthcare system.

Presently, education, health, and research are well supported by Saudi Vision 2030, which aims "to empower women, improve education and the healthcare system". It is therefore a most opportune time to introduce DVA into the curriculum during nursing school. Furthermore, it is notable that the government attaches significance to health and education spending, which targets all segments of society as a means of developing human resources, raising the efficiency of health and educational services, and increasing the effectiveness of scientific research and creativity. Moreover, innovation and raising education and health personnel's skills should also result from such endeavours. The assigned budget for 2020 is SAR 193 billion for education, and SAR 167 billion for health and social development (Ministry of Finance, 2019). The government also supports higher education and research in a variety of disciplines.

Saudi universities have realized the importance of research and have awarded prizes, establishing requirements for the awards policy to ensure the heightened quality of work published. This can enhance nurses' readiness, abilities and understanding of DVA while ensuring high-quality standard care

for abused women. It is imperative to encourage DVA nursing education and research at this time. When DVA is not included in the curriculum, this could undermine the value that nurses place on the subject, and they will not consider it important to detect, identify, or deal with it. Consequently, nurses may prefer to stay silent when encountering DVA within healthcare contexts. This research shows the need to have DVA included in the Saudi nursing curriculum, to enable nurses to acknowledge DV's significance. To broaden the scope to consider pedagogical insights. Learner motivation is usually based on examination grades in Arab world contexts, which would emphasize the effectiveness of including this in the curriculum.

In light of the recent Saudi vision where the SA is undergoing significant national transformation. There is hope that there will be expansion of healthcare system with improved efficiency and with a focus on value-based healthcare. Also, the vision states that nursing force is the largest of the workforce and it is equally important for the reform of Saudi nursing to achieve success in this transformation. This avenue provides an incredible opportunity where the proposition for changes in the curriculum could be made. The current workforce would be more open to accept the changes that would be made through this transformation process instead of raising incorporation of DVA as an isolated issue (Alluhidan et al., 2020).

The new curriculum that I propose would include a theory as well as a practical course in 3rd or 4th year of the nursing programme. The later years have been selected because till then the base would have already been developed for the students and they can clearly understand the nuances of the nursing profession as well as the sensitivity of the DVA phenomenon. The curriculum would explain DVA and its type. Further each type would manifest through which signs and symptoms would be taught in detail. Moreover, the nursing assessment and care would be then be covered in enough detail with a proper sign off. This would also make a separate skill to be signed off at the clinical rotations. Guest speakers having extensive experience in caring for DVA victims would be invited to talk to the students as part of the classroom session. The pedagogy of this course would be interactive and students will be encouraged to open up and discuss their apprehensions, reservation and

questions since they all would belong to the same culture and society. In addition, an exam would also be conduetd along with nthe othwer courses that wouidl certify if the student has cleared the course.

If the proposition is accepted, efforts would then be followed to provide training to the nursing leaders on DVA and those nursing leaders would serve as the master trainers for the upcoming nursing force in SA. This would serve as breakthrough in the nursing curriculum.

Alongside nursing education and training, the implementation of inter-professional education (IPE) in Saudi universities is also imperative. The proposed newer strategy has been taken up by some Western universities in their undergraduate courses (Fallatah, 2016). For example, the University of Nottingham offers a four-week annual inter-professional education programme with the objectives of enhancing foundational future cooperation between professionals, delivering high-quality patient care, and ensuring the protection of vulnerable individuals. Undergraduate Health and Social Care students meet and discuss safeguarding vulnerable sectors within the local community, with women's issues being a high priority. In addition, several conferences are held during the learners' final year. This provides an opportunity to meet practitioners and develop responsibilities; share professional duties, and assess boundaries. The conference satisfies Level 1 Competence in Safeguarding certification, recognized by the General Social Care Council among other influential bodies.

Safeguarding vulnerable groups is the responsibility of all healthcare teams including midwives, nurses, and social workers, and they are accountable for recognition and response (Foster, 2018). Taking the concept in the context of this study, inter-professional education is identified as an important method of improving communication and interaction between healthcare providers, and it could be introduced into the nursing curriculum in SA to support the care of abused women, especially concerning the DVA issue already taught to professional social workers in the Saudi curriculum, though collaboration with specialists is imperative.

IPE has been studied in SA among medical health professionals and students. AlAhmari (2019) studied students of respiratory care (RC), nursing, and clinical laboratory sciences (CLS) to demonstrate the attitudes of students during their last semester prior to graduating, and the beginning of their IPE with the help of the Readiness for Inter-Professional Learning Scale (RIPLS) questionnaire. The results of the study found the lowest scores for nursing students compared to other specialties, and revealed the need to enhance nursing students' awareness of their professional roles and attitudes as well as the advantages of IPE.

Awan et al. (2018) examined whether fostering inter-professional instructional activities and promoting educational forum during undergraduate years at King Abdulaziz University could remedy the lack of collaboration observed in the workplace. Students from Medicine, Pharmacy, Nursing and Applied Medical Sciences were surveyed. The results found that students rated inter-professional collaborative learning as the highest category of IPE, followed by inter-professional self-improvement and inter-professional relationship. The study proposed the inclusion of a hybrid conceptual framework to address the issue of role clarification across all healthcare colleges at KAU, particularly in undergraduate studies, where students were not prepared thoroughly for professional collaboration. Hence, establishing inter-professional education centres in SA is essential, and this is a strong recommendation that has arisen from this present study.

Another significant aspect to discuss is absence of clear job responsibilities of nurses and Inter-professional collaboration. According to a study conducted among Saudi nurses, Bashehab, Mckenna, and Vanderheide (2018) recommended ProvidingThis nurses with clear job descriptions that define each nursing field‟s duties and roles to help nurses to save time and effort and focus on their work. The current study identified that many grey areas and organizational barriers caused a lack of clarity on correct and incorrect responses to DVA. The literature supports this concept, linking it to the patriarchal and traditional hierarchical power structure that exists in most organizations (Kuokkanen and Leino-Kilpi, 2000; Skela Savič and Pagon, 2008; Ameen, 2017). In most healthcare organizations in SA, patient care is

led by male physicians and the medical team, who do not always respect the boundaries between medical and nursing areas of responsibility (Al-Yami et al., 2018). This is a continued cultural norm that dates back to the Victorian household and conventional roles. The doctor/husband/father is one such role, and the female is usually a nurse/wife/mother and finally, the child/patient (Salvage, 2002). This model has therefore kept a certain amount of control of nurses (i.e. women) and kept the power in the hands of the doctors (men).

Other studies also found that control is exerted over nurses by the management structure of the medical profession. For example, there was a suggestion put forward by Brennan (2005), which stated that while the medical profession had developed “a legal monopoly over the control of caring interventions and health policy”, nursing had “became occupationally situated at the lower end of a hierarchy of control of care”. A potential means to address this system involve promoting inter-professional communication and collaboration within the healthcare organization (Al-Yami et al., 2018). Collaboration in healthcare organizations can be defined as the competency of every healthcare professional in a team to efficiently embrace complementary roles, work supportively, share problem-solving responsibilities, and make required decisions to articulate and implement plans for patient care (Busari et al., 2017).

Inter-professional collaboration between physicians, nurses, and other healthcare members increases the collective awareness of each other’s’ knowledge and skills needed for specialized patient care. Moreover, it enhances the QoC through continuous improvement in decision-making (Busari et al., 2017). Similarly, communication between healthcare providers is an essential element of competent care provision. Evidence shows that communication, collaboration, and teamwork do not always occur in clinical settings, and social, relational, and organizational structures contribute to communication failures. Poor communication can have devastating consequences for healthcare systems, including nurses and patients. However, effective communication can lead to improved information flow, more effective interventions, improved safety, enhanced employee morale, increased patient and family satisfaction decreased lengths of stay and overall

enhanced QoL (O'Daniel and Rosenstein, 2008). Therefore, communication and collaboration were deemed important by the nurses in this study, which provides several implications.

My findings also stress the need for nurse specialists and trained DVA nurses (see section 5.3.2.4), which is also endorsed by McGarry and Nairn (2015). Nurses are the cornerstone in the prevention, identification, and provision of treatment to abused women and referring them to appropriate facilities. Also, nurses hold a critical position to interact with, identify, and respond to DVA victims. However, due to multiple barriers related to care for abuse victims, such as lack of skills and knowledge, heavy burden of work, language barriers, danger to personal safety, hierarchy in healthcare, and lack of communication and teamwork between various healthcare professionals, nurses are unable to provide personalized care to DVA victims (Arrab and Ibrahim, 2018).

A productive way to plan for the care of DVA victims is the inclusion of specialized DVA-trained nurses in the health system. Such nurses could function independently within multidisciplinary teams when caring for abused women, catering to their needs on a priority basis, which is considered an urgent need for the healthcare system (Arrab and Ibrahim, 2018). Moreover, the need for DVA-trained nurses is also significant because training for addressing abuse is not consistent across the nursing curriculum and clinical areas (Wyatt, McClelland and Spangaro, 2019). This provides the opportunity for DVA-trained nurses to deploy an important set of skills and knowledge needed to cater the needs of abuse victims.

This point was also elaborated in a study that of important organizations in the USA such as CDC, Joint Commission, the American Medical Association (AMA), and the American Nurses Association (ANA), advocating screening for intimate partner violence. however researches conducted with registered nurses suggest that pre-licensure programmes infrequently include intimate partner violence screening methods in their curriculum (Tufts et al., 2009; Connor et al., 2013; Wyatt et al., 2019). Hence, low screening rates could be attributed to this, and DVA-trained nurses in the health system is deemed a significant factor.

In essence, this study has shown that nurses in SA have inadequate professional preparation, and this underlies the barriers and lack of intervention in the suspected/ proven cases of DVA within healthcare. Empowering nurses is a complex matter (Bradbury-Jones, et al 2010), which can be achieved through proper education and training to enhance the skills and confidence of nurses and student nurses. This study illuminates the need for an educational programme within a BA and CPD as a pre-register requirement for professional nurses. However, individual encouragement and preparation are inadequate in isolation to empower nurses. Organizational support is also required to inspire them to share the challenges they face in the workplace and provide systematic frameworks for improved QoC. The following section evaluates obstacles related to the organizational system.

5.3.2. Barriers and Implications Related to Organizational Structures and Processes

A key finding in this study was that nurses were silenced. The study demonstrated that there were many factors at the organizational level that contributed to nurses' reluctance to speak out surrounding DVA, including: being unauthorized, experiencing dilemmas of reporting, and feeling unsafe. This section of the discussion considers the range of organizational issues that may have contributed to silencing and considers strategies that may address this.

Nurses in this study discussed the experience of staying silent. Possible factors highlighted by nurses that could deter them from reporting included confusion over authority, a lack of clear policy or procedure to protect them, and a lack of clarity in reporting and the protection of confidentiality. Nurses in this study raised concern about how to report abuse, since there are no specific guidelines, policies, and procedures around protecting the privacy of abused women. While there is a policy regarding HIV patients, specially designed to protect their confidentiality, no such policy exists for women experiencing DVA. Apart from the lack of authority, nurses often stay silent due to their attitude of subordination attitude. Skela Savič and Pagon (2008) stated that subordination of nurses can be explained by the existing culture in healthcare organizations, level of personal involvement, and the level of education. Also, the

organizational factors such as hierarchy, control positioning, a lack of cooperation and collaboration and team-building between physicians and nurses, as well as insufficient inclusion in change implementation activities threaten the professional growth of nurses (Skela Savič and Pagon, 2008). Such factors apply to nursing in SA (Alghamdi and Urden, 2016).

5.3.2.1. Lack of policy on nursing authorities (nurses being unauthorized)

Nurses in the present study believed that they were unauthorized, particularly when the reporting of abuse was concerned. This perception and lack of involvement in patient care give rise to job dissatisfaction, which is the main driver of nursing turnover in SA (Al-Yami et al., 2018). In such scenarios, the significant role of effective nursing leaders in enhancing staff satisfaction and staff retention is valued and crucial. The innovative strategies to enhance this role includes generating an open communication channel to encourage staff to participate in decision-making processes. Furthermore, it is recommended that junior nurse managers are supported by their seniors and top management, so that nursing staff can be supported and empowered to offer improve QoC and professional satisfaction, which is a significant strategic component to enhance nursing retention (Al-Yami et al., 2018). In light of such endorsements, nurses would be able to communicate openly with the other healthcare professionals in the health settings and would be empowered to work effectively towards a common goal of providing quality, holistic care to abuse victims.

Another crucial stance mentioned in the study is the restrictions imposed on nurses to report DVA cases, signifying that nurses lack the authority to report and to initiate the plan of care. This often leads to frustration because there is no clear guidance on what to do with the information nurses receive from the abuse victims. Often the environment adds to the behaviour and attitude nurses exhibit towards abuse victims. For instance, abused women who attended an ED reported that staff had a “rushed and hurried approach” towards them, which further reinforced their reluctance to disclose the circumstances. Similarly, the organizational cultures of intense care contexts such as the Emergency Department are not germane to the disclosure of

abuse, due to a biomedical task-oriented approach focused on “workflow”, “rapid interventions” and an emphasis on the technological aspects of care.

Several other factors create hindrances for the ED staff in approaching domestic abuse victims, including fear of offending patients, frustration at an inability to address the problem or help survivors immediately, and a lack of training to address particular needs (McGarry and Nairn, 2015). These factors can be addressed partly by including nurses in decision making. Often nurses are not involved in making important decisions for their patients, and are only considered subordinates who follow physicians’ orders. These findings were prominently endorsed by nurses in this study. The Involvement of nurses in decision making can be defined as “the way of sharing decision making authority as well as the activities that manage nursing practice policy and the practice environment” (El-Demerdash and Obied, 2016).

This involvement can be classified as actual or preferred. Actual involvement explains the degree to which nurses have the autonomy and responsibility to make decisions, while preferred involvement means nurses’ desire to be involved and responsible for decisions other than care activity (El-Demerdash and Obied, 2016). Actual involvement helps nurses in taking autonomous and responsible steps for the care of the victims, while preferred involvement can be amended as per the individual situation faced by nurses. In the present study, the nurses’ perceptions of organization barriers and being silenced were related to not being involved in the decision making process. The lack of involvement is directly related to their feeling of disempowerment, which can be assessed by different indicators including nurses’ satisfaction with work, burnout, motivation level, and intention to stay in the organization for a longer duration.

Studies report various benefits of the involvement of nurses in the decision-making process. These benefits can be witnessed for patients and healthcare systems, as well as nurses themselves. Nurses’ participation in decision-making decreases conflicts with patients, hospitalization duration, patient complications, and mortality. Their exclusion from participation in decision making causes human resource problems such as low levels of control over

work activities, resistance to change, less flexibility , low motivation levels, and dissatisfaction with their jobs. (El-Demerdash and Obied, 2016). There is evidence that nurses are willing to be involved in decision-making processes, primarily about patient care, within the context of their practice setting (Van Bogaert et al., 2016). Such willingness was also depicted by nurses in this study. Despite the available evidence, in reality, nurses' involvement in decision-making is still restricted and their contribution in healthcare policy development is limited in the Saudi context. This is directly associated with disempowerment, hence leading nurses to stay silent (Havens and Vasey, 2005; Jaafarpour and Khani, 2011).

Another concern experienced by nurses is in the form of dilemmas faced while reporting the abuse. Nurses encountering women subjected to DVA in healthcare contexts could raise many uncertainties and concerns. As mentioned earlier, nurses are often not authorized to report abuse, hence there could be ambiguity in the decision of reporting violence when the system is not transparent, or does not empower nurses to take a stand for their patients. Nursing assessment is considered to be one of the most persuasive elements of communication with patients regarding DVA. Previous subjective experiences by nurses in different healthcare settings exhibits that victims often discuss their experience related to violence if inquired about it in a non-judgmental, empathic, and direct way (Alshammari et al., 2018). Nurses interviewed in a Western context revealed that they played a role in identifying abuse, taking care of patients' physical health needs, attending to their safety, making referrals, and providing support and advice (Grinspun, 2005Guruge, 2012); however, this milieu is not reflected in SA, and this study showed that nurses are not proficiently skilled to care for DVA women, and are even unauthorized to report such abuse.

Although the majority of nurses in SA are immigrants from many international contexts (Yeates, 2010), it is critical to note that all of the nurses in the study were female, which intersects with the particular Saudi gender constructs discussed previously, including marked subordination and submissiveness in the female cultural orientation of SA. Nurses thus tend to iterate the "being silent as a woman" culture that is deeply embedded in Saudi contexts, with no

supportive policy. The female-majority nursing profession, with its passive cultural constructs, has also been reported in Jordan, another Arab country (Saleh et al., 2019). Consequently, some study participants also expressed a sense of acceptance of domestic violence, and normalized DVA when it was found in the hospital, as a reason to stay silent.

On the other hand, nurses expressed a lack of supportive structures and transparent policies and awareness regarding how to deal with issues of DVA. It was highlighted in this study that the absence of a disclosure policy is another concern for the nurses. Under such circumstances, nurses felt conflict about whether they should or should not act on it. This finding relates to the study conducted by Ahrens (2006) with rape victims, which stated that the three main reasons rape victims remain silent are fear of undesirable reactions from professionals who handle such cases; similar reactions from close friends and family members, leading to feelings of self-guilt; and uncertainty and self-doubt about whether what they experienced constituted a rape, due to the negative reactions they receive from close people and professionals (Ahrens, 2006).

A seemingly positive outcome of DVA disclosure does not always meet the expectations of women, which is why they may be accept and acquiesce in the DVA (Trotter and Allen, 2009). 125 nurses and midwives were interviewed for the possible reasons for DVA non-disclosure during pregnancy by Githui et al. (2018). The reasons cited by the majority of nurses included victim willingness to stay with the abuser following disclosure, followed by the stigmatizing attitudes regarding DVA survivors within society. More than half of the participants mentioned that survivors were not fully aware of their rights regarding DVA, and that they viewed abuse as a normal state of life (Githui et al., 2018). Such circumstances are also discussed with regard to the social and religious barriers of this study (5.3.3).

Nurses should be aware of the additional consequences for their patients if their information is shared and communicated with the healthcare system, within inter-professional practices and collaboration. A study conducted that assessed nurses’ role in caring for women experiencing DVA in Sri Lanka explained that nurses mentioned lack of communication and lack of equal

sharing of information across various disciplines working within the healthcare system as barriers. With limited communication and follow-up, each group often ended up working within their individual bubbles. Many of the nurses perceived and felt that management was fully aware of the issues faced by nurses and patients, but had no interest in improving patient care, nurses' working conditions, or communication between multidisciplinary team members (Guruge, 2012).

In contrast, nurses in the study shared that despite knowing they cannot report, they still do their job, assesses victims, and try to encourage disclosure. However, in the situation where the victims do not disclose, the absence of clear policy in this situation creates the dilemma of whether to document or report the issue to their seniors, which would disregard the confidentiality they assured victims. Most of the time, nurses considered the existing situation of not being authorized, and felt they were not driven to perform their job with all the motivation.

Guruge (2012) also reported that nurses only interviewed patients if they actively revealed they had been abused, and other nurses said that victims would not disclose IPV even after being asked about it. Others believed that disclosure of abuse depended on the relationship between the patient and the nurse, which goes back to the trusting relationship and building rapport with victims. Also, nurses mentioned that they made an extra effort to develop a trusting relationship only if they suspected abuse. These findings suggest that despite screening all women for possible abuse, nurses perform selective screening, which leads to further selective reporting of the abuse cases. Such experiences and perceptions were also shared by nurses in my study. Guruge (2012) also supported that none of the nurses in the study suggested screening all patients for abuse, even though most of them believed the rates of DVA in the country were high.

Without any particular guidelines and policies in place, nurses often do not screen women even when they know or strongly suspect the women have been the victims of DVA. This pertains to the fact that once disclosure is made, there is little that they can do for the victims. Ramsay (2012) found that nursing

documentation was the most common action (70%), with no specific action carried out in abuse cases. Among victims, 30% were not provided with follow up material nor referrals, 47% were offered no supportive help, and 51% opted not to seek the help and advice of a domestic violence counsellor. Sundborg et al. (2015) argued that inadequate nurse training heavily influenced such high levels of non-disclosure. An empowered nurse can respond quickly and appropriately to DVA, which is highly dependent on the nurses' understanding of the limit of their responsibility.

Working together regarding patient safety issues is a vital point to consider. Similarly, in my study nurses felt lack of clarity about the referral system and further consequences of reporting a case in a sense that it could cause a problem for the victim. For instance, there is no safe place where women can be referred, and no facilities to care for their children in the absence of the women. There is limited evidence of women referrals after identifying DVA within or outside the healthcare organization (O'Doherty et al., 2015). Conversely, nurses also feel the fear of reporting DVA, which inhibits their ability to report it. It is an ethical dilemma, whereby some nurses thought silence comprises ethical misconduct, and they suggested making it obligatory to report abuse and follow guidance from nursing ethical codes about obligations to fight DV. Some found difficulty in deciding due to of lack of interaction between family in the hospital (e.g. different stories from different family members, and patients looking to their husbands). When women insist on hiding the truth, compounded with a lack of policy related to non-disclosure in protecting women, silence and inaction seems to be the inevitable consequence.

Nurses shared their experience that reporting the case is often not the personal choice of the abused care recipient. This study indicated that most patients were admitted to hospitals for physical injuries or health problems, so it was not surprising that most nurses thought taking care of physical health needs was a priority. However, there is a possibility that patients would not open up, given that they are vulnerable victims. Nurses in my study also mentioned the particular lack of policy on non-disclosure cases. Deficiency in policies can blur the situation, when nurses are not clear about the further consequences of

reporting a case, and whether reporting would cause a problem for themselves or for the victims.

Once disclosure is made, the process following it is very vague. There is a lack of safe places where the abused women can be referred with minimal risk of being victimized again. It is imperative that a key hospital policymaker should implement an assessment tool for all Saudi women, with reference to WHO guidelines (WHO, 2013). While there is limited evidence of uniform screening policy (Alshammari et al., 2018), and a validated approach must be used throughout the attainment of data for the target audience in assessing DVA (Dagher et al., 2014). It is equally vital that healthcare providers understand how to respond to positive screening appropriately, with safety planning and referrals being of paramount importance (Sutherland, Fontenot and Fantasia, 2014). Nurses can be trained regarding timely inquiries, and offering supportive responses such as empathetic listening, in line with patient needs (Rigol-Cuadra et al., 2015).

Once DVA is confirmed via screening, the patient's safety, both physical and mental, must be assessed, relevant resources administered, and referrals completed following the patient's wishes (Dagher et al., 2014). Women with positive DVA screens must be offered referrals to both local and national resources, to ensure their safety. This would be feasible in the context of SA. In the UK, antenatal clinic inquiry and screening regarding DVA is compulsory. This may be culturally appropriate in SA, and adapting this model, with reflection, is necessary. Being quiet and not empowered could implicitly mean that DVA has been considered normal and accepted in the Saudi culture. That might account for the reason why Saudi nurses are unforthcoming about abuse issues, and do not see the need to report DVA. Often the sign and symptoms of abuse are obvious yet nurses hesitate to report that because the victims do not disclose. This, therefore, calls for clear guidelines dealing with DVA reported or detected at hospitals, as these conditions lead to demotivation among nurses, who then tend to let go of abuse cases, without undertaking assessment or listening to service users due to the assumption that they cannot effectively report.

5.3.2.2. Lack of confidentiality policy and ethical code

Apart from the disclosure of the violence, another organizational barrier identified by nurses in this study is the lack of confidentiality policy regarding nurses' role in engaging with DVA cases. Mostafa Arrab and Shabaan Ibrahim (2018) stated that 70% of nurses perceived that the investigation of DVA was a breach of the confidentiality of abused women. Approximately half of the nurses sampled by Al-Natour et al. (2014) claimed that it was not their professional role to investigate non-disclosure cases. There is a low rate of disclosure without direct inquiry concerning DVA in healthcare settings (Taket et al., 2003). Recommendations to policymakers include introducing guidelines to support the role of nurses, and ensure confidentiality for both nurses and abused women, to facilitate confidential disclosure.

Nurses in the current study felt that they are part of the problem if they do not report DVA, placing them in a dilemma, with potential violation of the Code of Ethics. Nurses need to be fully aware of women's fear of disclosure, realising implications for both health and well-being, and genuine concern for child protection in the case of mothers. Raising this issue illustrates the culture in which women are fully aware of the impact of abuse, understanding there are means of support in place to access, even when choosing to stay in an abusive relationship. Women typically do not admit abuse when initially asked to disclose their plight, but opportunities for disclosure and referral to support agencies are often taken up subsequently, particularly if DVA was exacerbated during pregnancy (Salmon et al., 2015).

Nurses acknowledged in the current study that the failure to report DVA cases violates the Code of Ethics. Nurses' also experienced a lack of clarity and ambivalence concerning policy. Where there are some existent policies and laws potentially relating to DVA cases, they remain unclear, unknown, and unused. A qualitative study conducted in Brazil by Acosta et al. (2017) to examine nurses' understanding of the ethical and legal aspects of nursing care for abused women involved 34 nurses in two hospitals. It found that the nurses had both a lack of knowledge of legal competence and lack of knowledge of ethical competence, which they related to the need for confidentiality, advice, and privacy in the care process. Thus, there is a need for specific policy and

professional preparation. However, reporting DVA is an inherently sensitive and controversial issue.

The nursing staff members try to provide a safe haven for their patients, who are vulnerable and who expect privacy and confidentiality. Reporting suspected or acknowledged DVA to authorities may influence nurse-client relationships in terms of trust and faith. Grimley-Baker (2014) discussed ethical implications of mandatory reporting of violence, noting that nurses are particularly important in the reporting of DVA as the main caregivers who interface with vulnerable women, and they are usually fully aware of the benefits and risks of reporting. Although the fundamental intention of nurses is to protect patients, this may result in direct conflict with the ethical principle of non-maleficence ("do no harm"), along with provision 3 of the American Nurses Association (2001) *Code of Ethics for Nurses with Interpretive Statements*. This provision indicates that "the nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient". Following this provision, the nurses' role is to maintain confidentiality, safeguard privacy, and avoid loss of trust. Hence, nurses' grapple with legal consequences of non-compliance with legal consequences, as well as heartfelt concerned for the safety of their patients.

Mandatory reporting has potential benefits. It portrays a clear message that DVA is a criminal action, and that no individual should be abused. It also ensures that the abuser is accountable, allowing criminal justice to carry out its purpose. Victims may be more secure due to their identification, linking them to support services, having positive long-term support of family lives (Grimley-Baker, 2014). Thus, comprehensive guidance regarding a reporting protocol is required for healthcare professionals. This study highlights the need for support through policies and law regarding when and how to report DVA cases.

Furthermore, nurses in this study perceived being unauthorized in other ways too. Nurses reported a lack of authority to report and deal with DVA, because it is not included in their job description. Under this reality, there is a need to set out a clear plan for nursing authorities and a clear and consistent policy in this regard. Since it is not well stated and described in the job description,

nurses often consider caring for victims of DVA to be outside of their professional boundaries. The lack of authority contributes to an enhanced feeling of treating DVA as a private matter. This was shown in the current study, where nurses considered DVA to be a family issue beyond the scope of their healthcare service remit. Also, carrying personal attitudes and values about domestic violence, language barriers, cultural differences, fear of repercussions of obligatory reporting laws, frustration, history of personal exposure to abuse, low confidence in inquiring questions, fear of offending victims, lack of privacy, lack of knowledge and resources available for victims, time constraints, and a lack of training disincline nurses from providing more comprehensive personalized care (Alshammari et al., 2018).

Henderson (2001) reported that nurses' attitudes and values can present internal and external barriers to caring for women that are sometimes destructive to care goals, but a body of knowledge provided by women, about what they want from health professionals, provides opportunities to identify appropriate responses and actions that are not time-consuming, such as communication styles that make them feel they are not to blame for their situations (Tower et al., 2012; Usta et al., 2012). The experiences of nurses in the study present implications that can address the barriers associated with confidentiality and ethical codes.

5.3.2.3. Lack of organization policy supporting nurse safety

A significant barrier to empowerment identified by this study is the nurses' feeling of being unsafe. Caring for abused women can prove to be a threat to the nurses in addition to the victims (Guruge, 2012). Another important and non-negligible concern comes when there is a threat to nurses' safety (i.e. nurses being unsafe). Nurses are often the first point of contact in healthcare services, who frequently encounter women suffering from DVA. There is no doubt that DVA is a highly stressful and emotional issue for both victims and clinical staff (O'Malley et al., 2013) Thus, the weakness of the hospital's organizational policy, which does not ensure the safety of nurses, may lead to disempowered nurses.

Nurses in this study were highly concerned about their personal safety, which led them to be passive and non-communicative with abused women. This mirrors the warnings forwarded by Mezey et al. (2003) that these issues must not be ignored, and are paramount in the avoidance of dangerous and life-threatening altercations with violent partners, particularly after the abused women have sought advice and aid. These issues must be of the highest priority to local authorities and healthcare organizations.

The threats to the safety of nurses can be witnessed at different levels in the current study. These include threats to their job security if they report the abuse, and fear of being left alone due to the threat of repercussions. Under such scenarios, expatriate nurses working in similar working environments as Saudi nurses often have broader exposure and might be trained in a sense that makes them more empowered compared to Saudi nurses. Hence, they report the cases without as much fear, owing to their exclusive education and training, and their reduced vulnerability to potential hostility and retribution from within the Saudi service users' communities.

However, expatriate nurses are also more vulnerable to contract termination and have the fear of losing both their employment and right to live in SA, thus reporting abuse issues among privileged Saudi service users could result in the massive disruption and devastation of their lives, as mentioned by participants. The literature supports that the social conditions for expatriate nurses tend to be poor, and religious and cultural differences, social values, and language barriers between them and local patients tend to cause them to remain aloof from non-biomedical aspects of care (Al-Yami et al., 2018).

Our findings illustrate nurses' concerns concerning their employability status if they report DVA, contrary to the findings of general security reported by Abualrub and AlGhamdi (2011), utilizing a descriptive correlational approach with 308 Saudi nurses to explore the impact of leadership styles of managers regarding Saudi nurses' job satisfaction and intent to remain within their positions. They studied six MoH hospitals in SA and found that these health institutions were centralized, having several layers of management controlling work through maintenance of authority; hence, nurses were not afraid of

disciplinary measures, due to their limited scope for autonomy. Therefore, in public hospitals, nursing managers did not have the authority nor influence to affect job security nor salaries. Nurses may have a similar intention to stay on with their positions and ensure job satisfaction. These individuals may be ill-equipped to meet this challenge. Nevertheless, the question remains of whether nurses deal with or report DVA, and it is necessary to implement a supportive policy that protects nurses in public or private hospitals. Enhancing nurses' satisfaction and safety is the key concern identified by nurses in this study, in satisfying challenges of quality, patient satisfaction, and retaining staff. Further study is required to ascertain attitudes toward reporting DVA in relation to these dimensions.

Furthermore, the processes followed in healthcare settings are often unclear and lack transparency, therefore nurses feeling of being unsafe is truly justified. Specifically, in Saudi culture and tradition, the nursing profession is not valued commensurate with medicine, and nurses may be disparaged if they stray beyond biomedical tasks in attempting to provide holistic care (Lamadah and Sayed, 2014; Alghamdi and Urden, 2016; Alabdulaziz and Cruz, 2020). Often in general nursing profession faces the problem of workplace violence in ER, where the potential and actuality of violence from service users (including both patients and visitors) affects nurses (Ramacciati et al., 2018). In the context of violence, the lack of value attached to nurses can lead to them being targeted inside as well as outside the hospital, in their communities. Consequently, reporting abuse can entail significant risks for nurses in SA, who have no guarantees of security under such scenarios.

Given the existing actual and possible concerns about violence toward healthcare professionals, nurses in this study suggested other ways to address DVA other than relying on their individual moral obligations, such as the need for new laws and regulations regarding the reporting process that can protect nurses at the hospital and outside it in an ethical manner. Similarly, studies conducted among Jordanian nurses also revealed that personal safety was a concern when inquiring about DVA. Al-Natour et al. (2014) revealed that most nurses agreed that asking about IPV was possible without endangering themselves, but they were afraid of anger and violence when challenged by

abusers, and were also afraid of asking about IPV because of the potential to increase victims' risk. Social insecurity has also been reported as a barrier among health professionals in Serbia (Djikanovic et al., 2010).

Guruge (2012) documented a similar situation among nurses working in Sri Lanka, who mentioned personal safety as another concern raised in the context of working with women living with DVA. Nurses who lived in small towns or villages perceived threats to their lives arising from their professional responsibilities due to living among service users. Consequently, nurses said that they tried to talk to service users about violence issues, but generally avoided getting involved and confrontation because of potential threats to their safety. Likewise, some participants said that their nursing uniform acted as a sign of authority and provided a measure of safety, but that in small towns and villages it was easy to find out who they were and where they lived. Female nurses who lived alone said that they too might be at risk of harm from their patients' abusive husbands or male relatives.

Overall, hospital administrators were perceived as being unreceptive to the vulnerability of nurses, which led them to be silenced, since they were not empowered to report or take action in the safest way (Guruge, 2012). Similar themes emerged from the perceptions of nurses in this study. Being female, living in a patriarchal society, and pursuing the nursing profession together with immersion in the perception of the abuse of women being normative endangers the safety of nurses, and compounds professional passivity in response to DVA.

5.3.2.4. Implications to address organizational barriers

Nurses in this study discussed various barriers to empowerment originating from the organizational structure. To address these barriers, certain strategies need to allow assessment and care provision to victims, and prevent further victimization. Halliwell et al. (2019) suggested independent domestic violence advisors (IDVAs) within hospital settings. The main role of these advisors includes the provision of advocacy support for survivors who are at the highest risk of harm or fatality. These IDVAs assess risk, safety plans, and help survivors to access services. Meta-analysis highlights that advocacy for severe

IPV can improve the QoL of victims and reduce physical abuse over the short term, but long-term impacts on mental health have not been studied enough (Rivas et al,. 2005).

Halliwell et al. (2019) also reported that hospital IDVAs were more likely to engage with survivors at an earlier point in the abusive relationship, often when survivors and perpetrators were still living together. This demonstrates that hospital IDVA services may provide an opportunity for earlier intervention. A key component of the hospital IDVA role was to raise awareness of DVA services within the hospital community and provide training to healthcare professionals. Similarly, hospital IDVAs enabled a greater number of survivors to access ongoing health services (e.g. mental health and substance services) at the point of case closure (Halliwell et al., 2019).

Similarly, this study also stresses the need for organizational effort to support Saudi nurses in their roles. For this reason, specialized nurses who could support and empower nurses in their work is deemed important, which corroborates McGarry and Nairn's (2015) recommendation that DVA specialist nurses in the healthcare system can strengthen overall self-assurance, reduce anxiety, and promote further supervision among nurses, particularly in improving data accessibility. Leppäkoski et al. (2015) showed that improved identification of DVA stems from superior comprehension and collaborative work as well as from improved understanding and cognisance of DVA, which is linked most effectively in inter-professional education (5.3.1.7). A multi-location inter-agency or nursing specialist, as well as local guidelines and procedures, can underpin this work (Sundborg et al., 2012; Leppäkoski et al., 2015; McGarry and Nairn, 2015).

A similar strategy could also be adopted in the Saudi context. The Saudi Commission for Health Specialties provides higher training programmes for higher education in various health fields, and they supervise programmes and provide codified professional training opportunities for graduates of medical and health colleges (e.g. midwifery programmes). Also, most hospitals in SA also provide and tailor a special diploma programme to meet the specific needs of health professionals. For instance, the oncology programme offered for

nurses in King Faisal Specialist Hospital. King Fahad Medical City and military hospitals offer particular programmes based on the needs identified in their particular health settings.

In addition to such programmes, several national schemes are aimed at preventing DVA and supporting both healthcare practitioners and women. One such scheme is the NFSP, which strives to promote family safety and unity and to be a centre of excellence by offering prevention and advocacy services, increasing awareness, and forging partnerships with various stakeholders to create a safe family environment in SA (Alquaiz et al.2017). However, programmes that could address specific DVA victims' needs have not been developed. Hence, specialized nurses particularly trained for the assessment, screening, and provision of care could be a possible approach in the context of SA.

Likewise, nurses must emphatically encourage women to voice their opinions. It is also vital that inquiries are conducted within different levels of the healthcare system via differing healthcare staff, since there are discrepancies concerning the personnel to whom nurses should disclose violence issues. It is also essential to establish an independent complaints procedure. Sufficient time and attention would allow women to speak out and disclose violence; otherwise, they are reticent to express their feelings and experiences without feeling that it is safe to do so (Leskošek et al., 2017).

Henceforth, addressing the organizational barriers would provide nurses with more opportunities, self-assurance, and safety in providing professional care to the DVA victims. Given these points, the involvement of nurses in decision making can be increased by making them authorized to plan to care for their patients, and facilitating the reporting abuse when encountered according to the clear guidelines, without the fear of jeopardizing their job, dignity, and profession. This will help create a safer environment for nurses in and out of the hospital, and would play a significant role in empowering nurses now and in the future.

5.3.3. Barriers and Implications Related to the Wider Social, Cultural, and Religious Fabric Components

The third barrier to empowerment that emerged from the present study sheds light on an important aspect of care for women experiencing DVA. As discussed in the earlier parts, there are important aspects of empowering nurses towards the provision of quality care for abused victims. These include the professional and the organizational aspects. Under the professional aspect, education and training of the nurses are deemed important, while organizational aspects include clarity in guidelines, nurses' involvement in decision making, increased professional autonomy and authority to plan, and the provision of opportunities to report. However, an important constraint that can be encountered is social, religious, and cultural barriers that could restrict the work towards women being abused, from the healthcare professional and service user directions. Likewise, the third barrier explains various restrictions that influenced nurses in this study in the form of prevalent norms, traditions and/or religious instruction in the Saudi Arabia, which imposed a limit or restriction on caring for DVA victims.

5.3.3.1. Gender, cultural, and social norms

One fundamental problem highlighted by nurses in this study is the disempowerment faced largely due to cultural and social norms, which are rules or expectations of behaviour within a specific cultural or social group. Implicitly, these norms offer social standards of appropriate and inappropriate behaviour, dictating what is considered right, acceptable, and directing interactions with one another (WHO, 2009). These cultural and social norms persevere within society because individuals prefer to follow prevailing customs, in the anticipation that others will also do so. These norms are highly influential in shaping individual behaviour, including the use of violence (WHO, 2009).

Nurses in this study also discussed the established importance of such norms ingrained in the culture of SA. Norms can protect against violence, but they can also support and encourage its use (WHO, 2009). Cultural norms often differ from religious norms under different situations, including in particular

interpretations of religious teachings, a lack of knowledge and understanding of religion, and misusing it to guide and justify one's destructive deeds.

Nurses in this study highlighted that the norms rooted in Arab culture consider men to have inherent superiority over women (Oweis et al., 2009). Violence against women arises and continues mainly because of gender norms occurring at the societal and family levels, and this is seen in SA (Mobaraki and Soderfeldt, 2010). Patriarchal gender norms and values reinforce and sustain the low status of women in society, and increase the likelihood that men will perpetrate violence against women (Saeed et al., 2017).

Cultural norms entrench gender discrimination and attitudes, which was also a significant finding in this study of Saudi nurses. Gender attitudes and roles are usually learned in childhood by role modelling of norms regarding acceptable masculine and feminine behaviours and gender values observed in families. Research also documents that gender inequity and early subordination of females places adult females at greater risk of intimate partner violence (Hamid et al., 2010). In addition to Saudi culture, gender inequity is also common in other Islamic countries such as Pakistan, because of the prevalence of conservative cultural traditions based on male superiority (Niaz, 2004).

Ali et al. (2017) analysed baseline data collected for a cluster randomized trial among boys and girls in grade 6 in 40 schools in Hyderabad, Pakistan, to understand attitudes towards gender roles and violence against girls and women. The study found significantly higher levels of patriarchal gender attitudes among boys compared to girls. Women face continual discrimination and violence, with approximately 70-90% of Pakistani women being subjected to domestic violence, including physical, mental, and emotional abuse, with more egregious manifestations being honour killing, spousal abuse (including marital rape), acid attacks, and being burned by family members. The abuse inflicted by a spouse is rarely dealt with by the policy unless it takes an extreme form of murder or attempted murder, which could range from driving a woman to suicide or engineering an accident (frequently a gas explosion from a kitchen stove) (Ali and Gavino, 2008).

Secondly, young girls are raised to tolerate and accept DVA as a normal part of life (Ali et al., 2016), with over 50% of teenage girls believing that violence perpetrated against them is justified (Saeed Ali et al., 2017). Nurses in the current study also emphasized similar norms and attitudes towards gender in Saudi Arabia, stating that community values inhibit the recognition of DVA as a concern. Violence is a vicious cycle, perpetuated in varied forms. Evidence also shows that individuals experiencing victimization often report a lack of empathy towards others, and this eventually contributes to individual behaviour moving from victimization to perpetration (Saeed Ali et al., 2017).

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5.3.3.2. Normalization of DVA

The role of the family was found to be pivotal in this study, reflecting the fundamental importance of this institution worldwide, which in regard to DVA can create positive or negative impacts (Ali, O'Cathain and Croot, 2016). In the extended family system of Arab societies, particularly the tribal cultures of the Arabian Peninsula, the paterfamilias is considered the master of his own nuclear family, and the eldest male is generally the undisputed ruler of the extended family or tribe, with various forms of subordination and responsibility distributed through members of such confederations, extending to the level of national government (Almosaed and Alazab, 2015). Men are usually considered superior and dominant, which gives them the power to exert over women by controlling behaviours and acts. Often women cannot do anything without the permission of the significant men in their lives, especially their fathers or husbands, which was also depicted by nurses in this study.

DVA is frequently considered a private matter, since it occurs within families, therefore it is not considered an appropriate focus for assessment, intervention, or policy changes. There is a paradox relating to the strong extended family culture. On one hand, it can be protective, yet it can also

promote violence, prevent action, and maintain silence (Ali, Naylor, Croot and O'Cathain, 2015). Nurses in this study revealed that participants illustrated the positive role of the family in supporting women, with long-term familial relationships being deemed especially important. Aysa-Lastra et al. (2012) discussed the importance of family members as a collective protective factor against DVA. They found that Islam paved the way for good family relations and set several rules that should ensure welfare and peace within family environments, but due to the dominance of the male head of the family, abuse was commonly frequent but unrecognized.

This phenomenon was also shown in community-based research conducted in Jordan by Oweis et al. (2009), which highlighted that approximately a quarter of women are at risk of physical violence perpetrated primarily by husbands, fathers, and brothers, which makes DVA the most pervasive form of abuse experienced by women. Being surrounded by cultural and societal norms, beating a wife is widely considered acceptable behaviour under certain circumstances, such as the wife being unfaithful to her husband, or if the wife does not respect her husband's family or siblings. In this study, nurses talked on behalf of women who had been abused and spoke with them about the role played by the family (including their husbands and siblings) in domestic violence, and how it has become a regular occurrence. These practices have become commonplace for nurses and affect them both directly and indirectly, including with regard to issues of reporting and disclosure.

WHO (2017) outlined the risks at the root of violence against women associated with sexual abuse and IPV, including gender inequality and the acceptance of violence against women as a standard practice. The prevalence of such risks makes it difficult for nurses to intervene on behalf of abused women. By the same token, various internal and external pressures play a role in disempowering nurses by maintaining the cultural and social norms. Consequently, those who violate the norms face the threat of social disapproval or punishment, as well as feelings of guilt and shame (WHO, 2009). One of such influences is the normalization of DVA in Arab cultures.

A major sub-theme in this study alluded to by nurses is the acceptance of violence in society and victims' perception of tolerating it. Cultures that tolerate or promote DVA embed the acceptance of violence in society (Morrison et al., 2006). in a society where violence against women is acceptable, women are prone to accept such violence, and even to justify spousal abusive behaviours. Such justifications include violent acts of the husband being perceived as temporary lapses, beyond their husbands' control (Oweis et al., 2009; Eidhamar, 2017). Similarly, women also justify their husband's violence by blaming it on external forces, such as unemployment, not earning enough money to support the family demands, and coming from a broken family (Namy et al., 2017). While this is broadly in agreement with approaches to the treatment of violent offenders, it does not excuse the criminal behaviour of inflicting violence, nor help healthcare professionals in treating women who normalize violence through the act of tolerating such behaviour on the grounds of obeying their husbands and avoiding arguing with them (Oweis et al., 2009; Eidhamar, 2017).

The literature highlights that in the continuous cycle of tolerating and normalizing the experience of violence causes women to face repeated episodes, becoming passive, and paving a path whereby their husbands gain complete control over their lives. Women eventually became like robots and respond to their husband's orders and needs, to the extent that they always asked for forgiveness and frequently blame themselves for the violence inflicted on them, assuming responsibility for violent acts perpetrated against themselves (Oweis et al., 2009; Namy et al., 2017).

Evidence from the literature also states that on occasions when women considered violence too extreme, the perpetrator, as well as the victim, would justify it within a normative framework that rationalized the violence as an act of masculinity. As depicted in this study, and stressed in the literature, male aggression is largely normalized (by men who use violence, as well as victims of this violence) as a manifestation of the anger or shame linked to failed masculinity (Grace et al., 2019). Some women often considered this behaviour as "natural" or biologically determined (Namy et al., 2017). While DVA can be considered an expression of masculinity relative to social constructs, this does

not excuse such behaviour. Furthermore, the normalization of such violence perpetuates the cycle, and research shows that family members who witness violence as they grow up are more likely to perceive is as a normative and functional aspect of lives, and thus less likely to contest or report it (Hume, 2008).

Boys and men in patriarchal societies where violence is tolerated may learn that violence serves a purpose. Indeed, manhood and violence have been historically intertwined. Central to this notion is that men are taught from an early age to suppress emotion. Also, women are often blamed for violence among men, with many distorted beliefs considering women as blameworthy when they do not follow the expectations of their husbands and other men (Hume, 2008). A culture in which violence is normalized, and endurance and family reconciliation are promoted above individual health, is one in which women are forced into tolerance. This vicious cycle was apparent in the present study under the theme of being constrained by contextual forces, and the acceptance and normalization of the abuse in the society. These barriers give rise to disempowerment, since nurses alone cannot change societal perceptions and values. This also creates a hindrance in the provision of care, when women do not dare to disclose. These findings suggest that such behaviour should be directed by social transition and increased awareness, to change behaviours and practices at the grassroots level (Namy et al., 2017).

Furthermore, one of the key findings of this study, which is also a social barrier, is the role the husband plays in decision making in women's lives. Nurses perceived this existing reality as a challenge in addressing the situation of abuse, as women can be scared during healthcare encounters due to the presence and cognizance of their husbands. In patriarchal societies, women have limited autonomy to decide for themselves and their matters. Evidence suggests that even for accessing the maternal health services, instead of women deciding for themselves, these decisions are often made by their spouses or senior members of their family, such as their mother-in-law or father-in-law (Ganle et al., 2015). With those social barriers, the absence of nurse education on DVA, and ambivalent policy in hospitals and legislation in

general, Saudi nurses view the role of a husband as problematic in terms of detecting and reporting DVA.

5.3.3.3. Stigmatization

In the present study, a key finding related to social and cultural barriers is the negative impact of violence in the form of stigmatization. Stigma is a term that is not limited to diseases. It is a way in which society develops certain assumptions and demands associated with the identity of a person, giving rise to a virtual social identity, whereby those who deviate from certain parameters are held to have transgressed, and their actual social identity is subsumed in a stigmatized identity, which ostracizes stigmatized "others" (Goffman, 2009). Stigmatization was seen in this study in the way in which DVA within social contexts shapes how survivors judge themselves or are judged by the others, notably the experience of victim-blaming (Kennedy and Prock, 2018). Stigma can be defined as a powerful social process typified by labelling, stereotyping, and separation, leading to status loss and discrimination (Salifu et al., 2016, 2019).

Stigma is discussed widely om the literature with regard to victims of forms of social blaming, but in this research it also affected nurses and contributed to their disempowerment (Crowe and Murray, 2015). Evidence suggests that stigmatization, labelling, and discrimination have consequences for abused women. Overstreet and Quinn (2013) reviewed literature concerning the role of stigmatization, which may have a negative impact on behavioural help-seeking and psychological distress in terms of rejection and disapproval reporting, affecting decisions to disclose and seek help from others. Women who are stigmatized usually do not acknowledge and disclose their experiences (Bos et al., 2013).

Studies suggest that violence is very prevalent in Arab societies, with underreporting due to stigmatization associated with it, considering it as a taboo, due to a wish to protect the family's reputation and dignity. Low reporting is also associated with distrust of state institutions in some contexts (Haj-Yahia, 2000; Oweis et al., 2009). Other cultural rules mentioned by women in Jordan were the stigma of divorce and separation from the children. Women

stated that they could not end the type of life they were living out of fear, and if they were divorced, they would be deprived of their children (Oweis et al., 2009).

Women reported that they tried their best to avoid divorce because of the societal stigma associated with divorce . This was especially true for those who had no power or income independent of their husbands. Women also reported a lack of support from their original families, who would would not let them separate from their husbands, and would ask their daughters to cope with their relationships for the sake of the children. Although Oweis et al. (2009) did not directly address this aspect, the high prevalence of consanguineous marriages in the Arab world (including Jordan) mean than in many cases a wife's family are from the same extended family as their husbands (Mobaraki and Sonderfeldt, 2010). Oweis et al. (2009) noted that if women wish to return to their own family (paternal) homes, they were expected to leave their children with their estranged husbands, which is embedded in gender-based discrimination in family laws in many countries, and which also extends to the provision of government pensions and social security benefits.

Although the situation is not favourable for women, the laws have their shortcomings. The Penal Code has no specific provisions or laws that criminalize DVAs, and there are no restraining orders to apply in cases of abuse. Cases of DVA in Jordan are prosecuted under the Penal Code's general laws on assault and battery, but for women it is very difficult to prove such cases. Under sharia courts, the testimony of two male witnesses is required in these circumstances; the testimony of the wife alone is not accepted as sufficient evidence. Also, the police will not pursue cases in which the imposed injury causes an inability to work for 10 days or less without a complaint by the injured party. Women who are victims of violence are often discouraged from reporting the abuse to police because of the associated social stigma and shame, and a battered woman may be pressured by her family to drop the charges (UN Development Fund for Women, 2004; Oweis et al., 2009).

The situation is quite similar in Saudi Arabia, where the idea of divorce is also not welcomed, as it can bring stigma to women and their families. Also, if women file for a divorce, they would be more likely to lose custody of children (Zuhur, 2011). Given the disadvantages for women, often the couple decides to get separated without filing the actual divorce. This poses a further disadvantage for women because their estranged husbands are free to marry another wife (due to polygamy) while the woman cannot start her new life and marry a new partner. In Saudi society, the stigmatization of divorced women makes it relatively difficult for them to remarry. Such societal stigmas have a direct and profound impact on the lived experience of women, regardless of legislative developments.

Under Saudi law women and girls are protected by the Law on Protection from Abuse 2013, which covers criminal penalties for acts of DVA and establishes a process for people to lodge complaints and receive protection. Also, after divorce, mothers have custody of their children up to a certain specified age, but this is revoked if the women remarries. The President of the Supreme Council of the Judiciary No. 1049/C dated 20/06/1439 AH (2017) issued a verdict to regulate custody matters in relation to proof of custody of the mother, extending maternal custody up to the age of 15 years (UNDP, UNFPA, UNESCWA and UN Women, 2018).

Aside from societal stigmatization, a key issue identified in this study was the "blaming attitude" among nurses, and a tendency to stigmatize and accuse the victims of violence. The psychological conflict and interplay between the duty of care for abused women and a blaming attitude is one reason for the disempowerment of nurses. Negative stereotyping and rumours are inherent within societies, and some nurses nurture a cultural notion of stigmatization and prejudice against abused women. Several studies reflect the concept of the "battered woman", who is partially responsible for her state of affairs, involving herself in violent occurrences and voluntarily choosing a violent partner, or abusive living conditions (Marinheiro, Vieira and Souza, 2006; Taylor et al., 2013).

The findings of this study illustrate how many nurses have an attitude towards DVA that conceptualizes it as a private and social issue, rather than a health concern. Saudi culture may hide the DVA issue within private family lives (Butler, 2015), hence affecting women's rights to report abuse in the interest of family reputation and to avoid social stigmatization. The result is that a woman may remain silent, since the shared culture dictates that nothing is reported, thus nothing is done, which presents nurses with a dilemma over a clear procedure on whether to report the incident without the woman's permission.

5.3.3.4. Contested understandings of the religion, vague interpretations, and Saudi Islamic law

The study showed that religious doctrines were often misappropriated to read oppressive interpretations that excuse and enable DVA. A key finding of the study is that DVA was perceived to be routinely justified on religious grounds, which made it difficult for nurses to speak out against it. This eventually results in nurses' disempowerment, and they are unable to carry out their core practices. For example, Barlas and Majid (2002) argued that Islamic law has been misunderstood and misapplied, and the Quran's spirit – and even formal codices of sharia – have been misrepresented.

Progressive activism in Arab-Islamic societies has long acknowledged the possibility and the effectiveness of working with (and not against) Islamic religion, drawing on progressive ethics within Islamic doctrines, but Islam is commonly appropriated by social conservatism and retrograde attitudes towards women. Reflexive chauvinistic societal attitudes that are popularly conceived of as being "Islamic" are often directly opposed to Islam, such as honour killings etc., as discussed previously. In order to untangle such understandings, analysts typically distinguish between Islam as a "religion", and societal attitudes and practices as a "culture". Douki et al. (2003) declared that DVA is a result of culture rather than of religion, albeit common religious misinterpretations often legitimize such perspectives.

Saudi communities now face some major challenges in delivering Islamic teachings and being vigilant as to the influence on Saudi cultural norms.

Despite the inherent diversity among Muslims, most conventionally acknowledge that the Quran and hadith are the major sources of Islamic guidelines. Despite the condemnation of any kind of violence against women, spousal violence is often excused because of misogynistic misinterpretations (Al-Hibri, 2001). Perpetrators may cherry-pick some Quranic texts to create a religious "alibi" to justify spousal violence (Douki et al., 2003; Islam et al., 2018). It has been argued that many verses in the Quran are misinterpreted to justify men's superiority. This misinterpretation of religious beliefs together with socio-cultural norms put women in subordinate status, and increases violence against them (Rabbani, et al., 2008). The Islamic religion, which emphasizes compassion, justice, and liberation, can protect women from domestic violence (Flood and Pease, 2009). Islamic culture should be protective and should enhance self-worth, self-assurance, solidarity, and even hope for change (Niu and Laidler, 2015). However, there is hope for change in the region of Saudi Arabia.

This point was further supported by the difference in the religious interpretation between the Muslims of Indonesia and Norway as evident in a qualitative study by Eidhamar (2017) exploring the influence of religious factors and values held by local societies regarding DVA. The findings showed that most of the Indonesian respondents prescribed male leadership and had a lenient attitude on women's abuse, whereas in sharp contrast the Norwegian view of Islamic norms promoted women's equality and opposed abuse. Similarly, the ideology enforced that the husband should be blindly obeyed, while the case study of determining the boundaries of obedience to the husband from Islamic perspectives found that the man has no right to oblige his wife to comply with any order not recognized by sharia, especially if complying with it will cause her harm. In other words, from a sharia perspective, a woman must obey her husband in carrying out obligatory acts, which are obligatory upon her anyway by her own volition as a Muslim (e.g. if the husband "commands" her to breastfeed her child, which is generally enjoined for up to two years by the Quran) (Alabbady, 2018).

All these interpretations reflect on nurses' practices and their disempowerment, which impedes victims' help-seeking behaviour. On one

hand, women do not report abuse and seek help; on the other, the community views abuse as a normal practice (Oyewuwo-Gassikia, 2016). Therefore, it is necessary to develop treatment models and techniques that meet the cultural and religious needs of the victims. The barriers highlighted earlier demand the strategies to counter the prevailing norms, and investment in educating women about the resources and alternatives available when facing domestic violence, and how to access them (Sardaryan, 2017). Similarly, Afrouz, Crisp and Taket (2018) conducted a systematic review which explained that seeking help is not straightforward for female victims of abuse, and it might be a convoluted and drawn-out process. Muslim women, like other groups of women, may face various barriers to disclose abusive relationships and to seek help. It is important to identify these barriers and continually make recommendations for how they can be overcome.

In addition to the barriers related to social, cultural, and religious components discussed by nurses in this study, there is another aspect of nurses' disempowerment under the same theme. Saudi laws require a *mahram* as a close male blood relative who is a legal guardian carrying responsibility for major female decisions, such as accompanying her for the duration of her studies abroad (Musawah, 2018). As previously stated, women must obtain consent for medical procedures from their husbands or fathers. This legal role is an obstacle for women who intend to become a nurse. Women entering the profession while following this concept may could feel less confident and scared to disobey societal taboos and ingrained procedures. Al-Amoudi (2012) reviewed all the consent forms for breast surgery at King Abdulaziz Hospital and found that a male guardian had signed 85% of those in the 40-49 age bracket, and all of the rest, suggesting that not all female patients were aware of their right to consent for their health issues and surgery. This example demonstrates that while laws can change, practices may not. This shows that people do not quickly change their beliefs and attitudes, and therefore do not change their actions. Hence, it is also imperative to raise awareness about women's rights in Saudi Arabia.

The findings highlight the tension between the legal position and cultural norms. The organizational challenges in this study concern the lack of legal

clarification and assertive discipline in the avoidance of DVA, which is linked to cultural perceptions and considerations. In the similar context, Kulwicki (2002) provided some evidence on the domestic violence in the form of honour crimes in the Arab context. The study found that the rationale for honour killing in Arab countries is attributable to family structure, cultural norms related to gender roles and differences, and cultural values related to the sexual behaviour of males and females. In Arab culture, family honour and male honour is expressed by the generosity of its members, the honesty of its individuals, the manliness (courage, bravery) of its men, and the chastity of womenfolk, particularly the virginity of unmarried women. Any violation of the latter in such honour societies can incur violent and murderous retribution against female family members by any male relative, even when the latter are innocent victims of sexual assaults by third parties.

As discussed in Chapter 1, SA is seeing a massive governmental shift in support of women, including the criminalization of DVA in 2013. Social change can be slow, and it takes time to be accepted socially, hence it can be slower than the legal change. Therefore, public institutions and organizations such as healthcare providers can potentially play an important and leading role by signalling their support for desired changes. Nonetheless, this study has shown that one particular reason for nurses feeling disempowered is barriers related to social, cultural, and religious contexts; a lack of relevant legislation and regulations; and a lack of legal support regarding the activities of nurses.

Furthermore, the findings of this study suggested that how some people misunderstand/misinterpret religion and give legislation to the violent act. On various occasions, religion is often misinterpreted to justify DVA (Saeed et al., 2017). In reality, DVA is axiomatically un-Islamic. For example, according to Islamic doctrine, Allah Almighty considers men as the protectors of women, and orders them to live with their wives with kindness and equity. Indeed, the Prophet Mohammed (ﷺ) emphasized that a man should strive to be “best to his family”. However, the nurses in this study perceived that this meaning of religion has been lost somewhere, and men are frequently seen as the perpetrators of violence.

5.3.3.5. Implications to address the barriers to empowerment related to social, cultural, and religious components

Participants highlighted significant barriers that stem from the cultural, social and religious norms impeding their empowerment. Addressing these barriers is necessary through effective and sensitive strategies.

Firstly, this study showed stigmatization is one of the reasons nurses feel disempowered. Stigmatization falsely portrays abused women as guilty. Policy makers need to address this through training or other forms of information dissemination. People who work in Saudi healthcare settings must respond appropriately to victims of DVA. Many countries responded to this by offering support to teachers and healthcare workers, such as the UK *Guidance domestic abuse: A resource for health professionals* (GOV.UK, 2017). This training manual sets out the role of nurses in dealing with abuse as compulsory training.

Likewise, this study suggests spreading awareness regarding DVA through programmes in the communities. These programmes may help reduce the stigma associated with DVA and encourage women to identify and report circumstances. Many nurses in this study thought that they could use the educational brochures, social media, newspapers/ leaflets, educational classes, mosques, health centres, and shopping centres and schools as a platform to change the image of women and the conventional manner in which women are viewed and treated. Schools may also play an important role in educating children about women's rights, and increasing awareness of DVA for children and the community.

Furthermore, to reduce stigmatization, nurses could be empowered through education and training focusing on adapting the nursing attitudes to help abused women, rather than blaming them. Evidence from the literature provides insights that may influence nurses and other healthcare providers to more conscientiously extend their empathy to abused women, to understand that they are going through a difficult time in their lives, and to realize that they deserve the support of healthcare professionals and society. They also need to recognize that some of these women are not in a position to leave the

abusive situation, because of a lack of education and/or because of their financial dependence (Oweis et al., 2009).

Secondly, to overcome the cultural and societal barriers, it is best to understand domestic violence in the context of culture (Campbell, Moracco, and Saltzman, 2000; Hoff, 2001). This research demonstrates that the culture and norms of conservative Saudi society are disempowering nurses, and affecting their perceptions of domestic violence. There was an argument by Campbell et al. (2000) which stated that the study of violence demands an in-depth understanding of culture, surpassing cultural sensitivity and looking in-depth at group norms, beliefs, and lifestyles. It is important to note that cultural competency acknowledges that violence occurs in a gendered sociocultural context, and an understanding is required of the relationship between the practices surrounding violence and oppression. It also requires an awareness of the myriad cultural traditions and the accompanying attitudes, which construct – and which can deconstruct – domestic violence. Cultural competency is also advocated, warranting more cross-cultural research (Draucker, 2002).

Thirdly, the social and political influences on Saudi people need to be addressed. Life has been changing rapidly in SA for decades, and its traditional socio-political nature has provided a template for social stability that is premised on being overly "protective" of women, manifest in preventing them from driving, travelling, and working, and the guardianship system etc. This is also a natural consequence of collectivist cultures, where family honour is more important than individual wellbeing – thus causing the group to lose face by reporting personal suffering would be viewed with disapprobation in such cultures. Naturally this legacy will contribute in constraining women with social norms against reporting and openly discussing domestic violence. Being constrained by factors such as social, legal, and religious norms in Saudi Arabia needs to be addressed with clear policies for healthcare professionals, to allow nurses to be able to feel supported to discuss and deal with DV issues. Although the institutional positioning of the legal system has changed, changing people's attitudes is not easy, and practice requires time. This study calls for the root of the issue to be addressed, beginning with the education of

the community. This will give nurses the power to protect abuse victims who come forward to report without suffering any stigma and victimization. Again, there is a need for education and training for nurses to identify, manage, and coordinate with law enforcement agencies regarding DVA issues.

Another strategy is the development of helplines for DVA. Hotlines have an important role in helping informal supporters (family members) of abuse survivors. The help requested through the helplines is predominantly to equip and empower informal supporters so that they feel more skilful at coping themselves, whereby they are thus better able to offer support to survivors (Gregory et al., 2019). These strategies can be developed in SA within a context sensitive to cultural and religious requirements, which could sensitize survivors and their family members, paving the path to effective handling of abuse and increasing utilization of support by victims. Examples of this ethos might be naming such helplines after iconic women in Islamic history, and using normative Islamic terminology and phrases when in conversation with callers.

In addition to the policy and safety implications for nurses, the study also indicates the need to address the obstacles that stem from the victims of DVA themselves. To enhance efficiency in identifying victims of DVA, health workers must continuously encourage women to open up and freely express issues of potential or experienced violence, rather than masking their experiences and fears. Disclosure allows institutions to commence procedures protecting these victims against future harm.

Finally, another significant point to consider here is the role of laws and regulation. In the Saudi culture and tradition, the concept of guardianship is valued and followed. Guardianship entails the provision of assistance, health, happiness, and support to the people under one's responsibility, including the sustenance provided by the male breadwinner as *mahram* or *wali*. The important point to consider here is that nurses in this study reported the misuse of religion in a way that does not depict the actual teaching of Islam. Populist patriarchal interpretations of religion in socially conservative paradigms often subjugate women and do not treat them with respect and value, contrary to the

fundamental ethos of religions themselves, and the potential for more utilitarian and progressive interpretations. The Saudi government recognizes the problem of DVA and acknowledged the need for plans to be implemented to address it. This has been a notable concern of the Crown Prince Mohammed Bin Salman, as well as a feature of Vision 2030, which aims to empower women.

Major amendments to Saudi regulations have given women opportunities to compete in business and all practical and scientific fields, as discussed in Chapter 1. The participants in this study were aware of the support by the Saudi government, especially the goals established by Vision 2030, which aim to empower women in terms of healthcare and wellbeing. There are also more policies and legislation for healthcare providers and education, which support women more than ever before. This is in agreement with the WHO (2017) recommendation “to achieve lasting change”, and it is important to enact and enforce legislation and develop and implement policies that promote gender equality by ceasing discriminatory practices against women in terms of marital issues (including divorce and custody), property and inheritance, access to paid employment opportunities, and the development and support of national plans and policies addressing violence against women.

While some feminist activists and healthcare policy experts may find this inconvenient, the fact is that the Saudi community and its culture is strongly rooted in a faith tradition, and any efforts to achieve socio-economic reforms will meet with less resistance if they work with and not in opposition to this paradigm. Domestic violence is a serious concern both in a moral and spiritual context, and Islamic values can greatly support healthcare professionals in their unfamiliar foray into problems of Saudi domestic life. DVA is an affront to human dignity and violates the basic moral principles of all religious faith traditions.

Religious practices not only focus on bringing about healing in the world but also justice and sympathy as well. Islam fundamentally calls upon believers to be mindful of the rights of vulnerable individuals in society who lack power and privilege (e.g. widows and orphans are particularly emphasized in the Quran).

Manifestations of patriarchal violence and social conservatism are often cloaked in aspects or misappropriations of religion, but actual doctrinal and legal provisions within the Islamic tradition can be used to counteract negative and violent behaviours, attitudes, and beliefs toward women. For example, according to bn-Qudama, the Hanbali scholar, a woman is not obliged to be do housekeeping for her husband in sharia, If she had servants in her father's house, the husband is obliged to provide servants for her (Dar AlIfta, n.d.).

Faith communities can play a significant role in providing support for victims of domestic violence and in holding abusers accountable. Spiritual leaders are often the first place a person turns to in times of trouble and turmoil, and are in a position to provide counsel, support and safety. One area that has been the focus of many faith entities, and specifically faith-based organizations (FBOs), is GBV (Le Roux et al., 2016). In this arena of work, engagement with faith leaders is important as they are considered to be gatekeepers to local communities, with substantial influence on their beliefs and behaviours. Faith leaders are said to be ingrained in and are respected and trusted by the local community. They have a thorough understanding of local dynamics, which can influence developmental concerns and often have considerable power due to the size of their constituencies (Le Roux et al., 2016). DVA training at the community level under the religious framework can offer preventive measures, allowing free conversation and debate, conveying to both abusers and victims that this behaviour will not be condoned within their faith nor community. It can also act as a platform to present resources and support mechanisms, offering help when needed.

Likewise, communal faith leaders play a vital role in ensuring DV ceases, with clerics and spiritual directors having a responsibility to assist in combatting such occurrences. Particular faiths source such leaders for moral and spiritual guidance and advice as beacons of moral authority, supporting victims of DVA and assisting their needs. They can also hold abusers to account and influence national policy, supporting policy addressing DVA through private and public means. A report representing faith-based responses to violence against women and girls (VAWG) in the Asia-Pacific Region identified 58 FBOs responding to violence in the region (Le Roux et al., 2016).

The Office of Children and Family Services (OCFS) has witnessed such efforts in New York, where every county operates a licensed DV programme. They provide strongly necessary support for faith advocates, since they are trained to address a victims' legal and safety concerns. Faith leaders refer victims to these bodies who are experienced in DVA cases, exploiting their expertise to aid victims in their physical and spiritual healing process, when they are in their most vulnerable state, and in need of community support and understanding (The New York State Office for the Prevention of Domestic Violence, 2016).

DVA requires a whole-systems approach, including faith leaders, and implementing such a programme in SA requires collaboration with the Saudi Ministry of Islamic Affairs, Dawah, and Guidance. An important step will involve clear effort from the government to re-interpret the elements of religion that have been used to justify violence. It is worth noting that in October 2017, the King ordered the establishment of the Complex of the Custodian of the Two Holy Mosques, King Salman bin Abdulaziz Al Saud, for the Prophetic Hadith to oversee the interpretation of hadith (Asharq Alawsat International and Arab News, 2017), which led to numerous reforms and reinterpretations of gender issues, as adumbrated in Chapter 1. Culture is more influential than religion in fomenting DVA, with interpretations of religion based on social conservatism and patriarchal views being used to oppress women (Mir Hosseini, 2006). However, actual religious voices can overcome such cultural tropes and empower healthcare professionals to increase service user confidence in utilizing available healthcare resources and support in contexts like SA (Le Roux et al., 2016).

All in all, to empower nurses and to provide them with the opportunity to become change agents, there is a need to consider how to change the underlying acceptance culture in SA. While it is important to respect SA culture and its religious traditions in the provision of culturally sensitive and competent care, the abuse of women cannot be tolerated, and there needs change in how women are treated across the region, which can be facilitated by rooting progressive discourse in traditional Islamic ethics. The findings of this research suggest that this may involve policy revisions, community engagement, and a wider progressive social movement. There is a need to involve and build

collaborations with women's organizations, especially in the quest to develop special services for women, e.g. rehabilitation services for both abusers and abused women, safe places, and measures to ensure the safety of children. There should also be provision for a hotline to support women and raise community awareness about DVA. Women's law has indeed begun to change in SA, but there are still many patriarchal attitudes that harm both women and nurses.

Nurses are affected professionally by the beliefs they bring and imbibe from their normative culture, and the prevailing cultural mores of the society they inhabit. They may have conflicting views around what is professionally obliged, morally right, and socially acceptable, and whether there are policies in place to support them with what they need to do to help patients. Saudi nurses, as members of their communities, may share patriarchal ideas and/or conflicts between what they believe socially or religiously while dealing with abused cases. This situation would affect nurses' provision of care to abused women. Future study needs to assess the attitudes of immigrant nurses working in SA. This is not restricted to nurses – it is crucial that the ideology of domestic violence and abuse to prevent the perpetuation of these events. There is also a requirement for further research into the perceptions of men and male nurses towards DVA to address the root of the problem.

This study has revealed that frustration with patriarchal practices in the community is one of the factors disempowering nurses from dealing with or preventing violence against women in healthcare settings in SA. It is necessary to include feminist perspectives into nurses' education and practice concerning culture-religion view to make it acceptable and applicable. Nurses who truly value and accepts the individual will strive to focus on unique rather than stereotypical characteristics (Burton, 2016). Furthermore, the current study identified that nurses alone cannot overcome this problem, as it is not only a nursing problem; to solve the problem at its root, this study informs decision-makers in the country to provide adequate counselling and rehabilitation centres, hotlines, and platforms to raise people's awareness, especially in terms of schools and mosques.

Currently, the global COVID-19 pandemic is having massive impacts on healthcare systems, and it may have an impact on DVA in terms of access to healthcare and support available to abused women. Although precise data is hard to come by, it is clear that domestic abuse has surged worldwide under public health policies confining men and women to their homes, including in China, the UK, and the US (WHO, 2020). Confinement and unwanted restrictions have led to additional stresses for families, and the disruption of livelihoods can also increase the likelihood of DVA (Roesch et al., 2020). Evidence suggests that around 60% of Lebanese women became first-time victims of DVA during lockdown (Al Arabiya News, 2020). The situation could be similar in SA, although no clear statistics are available to support this assumption.

Consequently, the nurses should be aware of an increase in the prevalence of DVA during any type of emergency and crises. WHO (2020) recommends that healthcare providers need to be aware of the risks and health consequences of violence against women, and that they should help women who disclose by offering first-line support, which includes listening empathetically and without judgment, inquiring about needs and concerns, validating survivors' experiences and feelings, enhancing safety, and connecting survivors to support services and by providing medical treatment. Also, nurses are instructed to be aware of health facilities and should identify and provide information about services available locally (e.g. hotlines, shelters, rape crisis centres, counselling) for survivors, including opening hours, contact details, and whether services can be offered remotely, and establish referral linkages. Furthermore, during the situation of confinement, the use of mHealth and telemedicine in safely addressing violence against women must urgently be explored.

5.4. Key Identified implications and Actions Related to DVA

This research has shown that nurses' understanding of DVA is complex, and is shaped by inter-linked factors operating at different levels. Those factors have emerged as barriers to empowerment for nurses. This discussion has argued that actions to address the current situation required are multi-faceted.

Tables 5, 6, and 7 summarize the key study findings on DVA implications and remedial actions discussed related to nurses' professional preparation; organizational structures and processes; and social, cultural, and religious barriers, respectively.

Table 5: Key DVA implications related to nurses' professional preparation, and actions discussed

Nurses being ill-equipped: Education, curriculum, and training
Educational and training programmes that confront DVA: Introducing DVA into the curriculum during nursing school. A curriculum and guideline relevant to Middle Eastern society, including women's rights in all curricula, and the Islamic approach to women's rights. Inclusion of DVA-based training in a nursing curriculum that accords with SA cultural requirements. Student nurses preparation for role transition: appropriate mentorship. Experiential and interactive learning and demonstration. Inter-professional education: a way to prepare nurses professionally.
Continuing education and on-job training in the hospital
CNE: courses, seminars, workshops. In-services training. An educational programme within a BA and CPD as a pre-register requirement for professional nurses.
Lack of relevant experience
Increased exposure to DVA cases through simulation or clinical experience. Provision of continuous education and training programme. Mentorship and role-modelling, interactive learning, and demonstration, linking theory to practices with an emphasis on best practice concerning cultural and societal norms.
Different level of awareness among Nurses and Victims
Raising awareness among nurses and victims through education and training. Developing perpetrator programmes to help women disclose and not being blamed, to challenge the belief system and encourage perpetrator acceptance of responsibility for violence. Inclusion of such programmes in comprehensive national policy.

Table 6: Key DVA implications related to organizational structures, and processes and actions discussed

Nurses being unauthorized
A clear job description considering nurses code of practices and ethics related to DVA. Promoting inter-professional communication and collaboration within healthcare organizations. Generating an open communication channel to encourage staff participation in decision-making processes. Supporting junior nurse managers by their senior and top management. Involvement of nurses in decision making. Contribution in healthcare policy development.
Dilemmas of Reporting
Transparent policies in reporting cases of DVA. Formulation of clear policies on violence disclosure . Clear guidelines on dealing with the issues of DVA in case of disclosure and non-disclosure Policy confidentiality and ethical issues for nurses and victims. Calling for the introduction of legislation/ policy on women's screening for suspicious cases, and mandatory screening in an antenatal clinic. Clear guidance for nurses on caring for women experiencing abuse and not disclosing. Establishing an independent complaints procedure, to allow women to speak out and voice their opinions. Nurses' attitudes must be empathetic, enabling women to disclose violence. Investigation of inquiries within different levels of the healthcare system via differing healthcare staff. Clear guidelines on the referral of victims. Management taking ownership of staff working under their supervision. Inter-professional practices and collaborative information sharing concerning women. Specialized nurses who could support and empower nurses. Transparent processes in healthcare settings and clarification of consequences of reporting DVA. IDVAs for the provision of advocacy support for survivors who are at highest risk of harm or fatality. Development of helplines for DVA. Need for organizational effort to support Saudi nurses in their role. This study suggested specialized nurses particularly trained for assessment, screening, and provision of care could be a possible approach in the context of SA.

Table 6: Key DVA implications related to organizational structures, and processes and actions discussed

Lack of organization policy supported Nurses' Safety
Transparent processes in the healthcare settings related to nurses' safety (job and personal safety): Assurance of job safety for nurses. Nurse protection concerning disclosure and reporting DVA. Need for education and training for nurses to identify, manage, and coordinate with law enforcement agencies regarding DVA issues. Policymakers need to revisit the policies and lawmakers need to revisit the laws. Provision of support to healthcare providers addressing abused victims.

Table 7: Key DVA implcations related to social, cultural, and religious barriers, and actions discussed

Normalization and acceptance of DVA
Acceptance of the DVA as a concern in the society. Fostering good family relations by raising awareness, highlighting Islamic values. Social transition and increased awareness to change behaviours and practices. Provision of nursing education on DVA. Revisiting ambivalent and unclear hospital policies and legislation.
Stigmatization
Nurses' attitude towards abuse victims: education and training focusing on adapting nursing attitudes to help abused women. Practising empathy while caring. Awareness of the myriad cultural traditions and the accompanying attitudes affecting domestic violence (cultural competency). Embracing diversity and inculcating the cultural competence for the provision of culturally sensitive care. Addressing the root issues, beginning with the education of the community to report without suffering any stigma and victimization. Provision of support for abused women with strict confidentiality and provide a hotline. Introducing the awareness programmes to all slides of a community about DVA. These programmes may help reduce the stigma associated with DVA and encourage women to identify and report circumstances. Approaching general public through brochures, newspaper, educational material or educational classes offered, mosques, health centres, malls, and schools as a platform to change the image of women and the conventional manner in which they are viewed. Role of schools in educating children about women's rights, and increasing awareness of DVA for children and communities.

Table 7: Key DVA implcations related to social, cultural, and religious barriers, and actions discussed

Saudi laws and regulations surrounding DVA
Acceptance of the DVA as a concern. Enacting and enforcing legislation and develop and implement policies that promote gender equality by ending discrimination against women in marriage, divorce, custody, inheritance, and property laws. Developing and resourcing national plans and policies to address violence against women, and assertive discipline targeting the avoidance of DVA. Policy revisions, community engagement, and a progressive wider social movement. Need to involve and build collaborations with women's organizations, to develop special services for women, e.g. rehabilitation services for both abusers and abused women, safe places, and measures to ensure the safety of children. Provision of a hotline to support women and raise community awareness about IPV. Inclusion of Islamic feminist perspectives in nurses' education and practice, to make progress acceptable and applicable in the SA context. This study informs decision-makers in the country to provide adequate counselling and rehabilitation centres, hotlines, and platforms to raise awareness, especially via schools and mosques.
Religious interpretations and instructions
A significant role can be played by imams surrounding DVA. Faith communities can provide support for victims of domestic violence and hold abusers accountable. Development of treatment models and techniques that meet the cultural and religious needs of the victims. Formulation of strategies to counter the prevailing norms and to invest in educating women about the resources and alternatives when facing domestic violence and how to access them. DVA requires a whole-systems approach, including faith leaders, and implementing such programmes in SA requires collaboration with the Saudi Ministry of Islamic Affairs, Dawah, and Guidance.

5.5. Study Strengths and Weaknesses

The main strength of the study lies in pioneering the exploration of the experiences and understanding of nurses towards DVA in SA. Hence this study can be deemed useful for understanding DVA for Muslim communities and nurses in Muslim societies more widely. The methodology used, Heideggerian phenomenology, to explore the lived experiences of nurses

regarding the care of abused women victims is an important way of exploring and interpreting the essence of the experience. The findings of this study can be transferred and applied to other related contexts fulfilling the criteria of transferability.

The findings of the study generated important themes that depict the understanding and perception of nurses working at the particular study sites. However, we are not sure if the nurses working at the other healthcare facilities of SA, share similar understandings and perceptions. This could be a prospect of future exploration. Organizations must take serious steps, including nurse educators and nurse supervisors, to explore the phenomenon to achieve the insight into the grave matter of DVA in numerous Saudi healthcare contexts.

The limitations of the study include that nurses were able to share their experiences and understanding of DVA only from the health setting perspectives. The experiences and perceptions could differ among women being abused and living in the community while not seeking care. Another limitation includes the sample only being limited to female nurses. Male nurses' experiences and perception while caring for abuse are equally important and can be explored further. Also, hospital managers, physicians, and organizational perspectives can be explored to understand the phenomenon of DVA. One of the important areas that the study has not covered is the participation of the survivors. The experience of survivors would be an important step in understanding the graveness of the topic.

5.6. Future Research

The present study opens avenues for various areas of future research.

The present study has explored the scope of various possible interventions that could be adapted in the Saudi context for dealing with abuse. Existing interventions were primarily designed for an implemented in Western cultural contexts. Testing the effectiveness of such interventions in different contexts would be an important step towards generating knowledge and evidence that would guide future work and practice. Once the effectiveness is established, healthcare professionals, as well as the MoH, could work towards policy

changes in adapting those interventions in the local context. As the family is considered the fundamental unit of the society, exploring families' perceptions about violence and readiness to accept interventions could also be assessed in the future researches.

Future research should also investigate the role and perspectives of other stakeholders, survivors, and perpetrators, and general male views. Research focusing on survivors is necessary in order to explore the type of support they would like from the healthcare system and healthcare professionals. Similarly, exploring the domain of abuse through research on other healthcare professionals (e.g. physicians) and hospital stakeholders (e.g. management) is also important. Research on the perpetrators and men to identify DVA triggers, male attitudes and perceptions of DVA, and factors that prevent DVA is also necessary. DVA has only been explored among nurses in SA, with female victims. Since the cultural and societal norms discriminate by gender, it would be helpful to explore males' perceptions of violence as perpetrators. Exploring males' perceptions would help healthcare professionals as well as the policymakers in building a deeper understanding of the existing issue of violence.

Sharing the evidence of the study along with testing the effectiveness of interventions would provide policymakers sufficient groundwork to formulate new policies and guidelines. Those policies could be evaluated and monitored post-adoption, and could also include research to examine the best approach to educating nurses about DV and the best approaches to building confidence among nurses to engage with vulnerable patients and respond effectively to DVA.

Chapter 6
Conclusion

Violence against women is considered a major social, health, legal, and educational issue that confronts all segments of society across the globe (Oweis et al., 2008). Domestic violence does not discriminate; it crosses every socioeconomic level and is not limited to a particular race, ethnic, or age group. The present study as part of a PhD programme is a major contribution towards the limited literature that exists surrounding a significant yet neglected issue of DVA in Saudi Arabia. This study has articulated nurses' current experience as one of "being disempowered", finding that this experience is underpinned by three main perceptions: "being unequipped", "being silenced", and "being constrained by contextual social and religious forces". The discussion inferred from these findings that there is an interplay of interlinked and overlapping barriers that impede nurses' empowerment in three domains: barriers related to nurses' professional preparation; organizational policy and practices; and the wider social, cultural, and religious integral components. Each of these barriers has implications in the context of Saudi Arabia with its unique religious and cultural heritage.

This study contributes novel findings and highlights the key role of religion and culture in the interpretation and response towards DVA in SA. The findings of this study are likely to be transferable among nurses in the Saudi context and in the Middle East in general. Also, the recent developments that have taken place in SA in terms of changes in society and law that accord women access to more rights than hitherto, such as driving, mean that the insights of this research can provide a novel avenue for the government as well as for the civil society to address DVA through policy interventions.

Empowerment is a fundamental concept in the Arabic language and in Islamic religion, and this study offers serviceable insights for Islamic feminist discourse. For example, in the Holy Quran, the word "empowerment" is mentioned several times, referred to as *tamkeen*, with many meanings enacted in various instances relating to the following (Al-Khasawneh, Al-

Jammal and Hamadat, 2012; Al-Amoudi, 2017): authority (*Surah al-Kahf*); high-ranking positions endowed by the king (*Surah Yusuf*); preparation (*Surah al-Qasas*); acquisition of livelihood and wealth (Surah *al-Anaam*); and bringing peace in religion (*Surah al-Morsalat*). Varied definitions and understandings of empowerment pose important lessons for the nursing profession, healthcare organizations, and communities, which pertain to patient-centred, culturally sensitive modern healthcare service provision. In particular, there is a need to adapt a definition of empowerment rooted in Islamic ethics and narratives that is culturally situated, which can be used and endorsed by the nursing profession, organizations, and communities in the Islamic world, which can also be endorsed by and of utility to nurses in the performance of their nursing roles.

The empowerment of nurses is a subjective experience that has been described as freedom from oppression as well as increased autonomy and control over their work environment. Professional empowerment is also related to knowledge, and the power it gives is “exercised rather than possessed” (Bradbury-Jones, Sambrook and Irvine, 2008). Nursing empowerment benefits patients, when nurses progress through the process of self-awareness and actualization (Friend and Sieloff, 2018). Therefore, without nurses being empowered to deal with issues of DVA, this study has shown that nurses face several barriers to serve abuse victims. This study illuminates the professional, organizational, social/cultural, and religious barriers that lead to the disempowerment of nurses. Approaches to tackle these barriers must be multifaceted and aimed at all levels.

The importance of empowering nurses is evident when looking at individual benefits. Nurses can empower their patients when they identify opportunities in which the victims of abuse can be supported via all areas of nursing and the healthcare organization. When patients are empowered, there are positive outcomes for health, as well as in terms of decision-making, freedom of choice, acceptance of responsibility, increased trust in relationships, more informed choices, and overall improved QoC and life. It can be said that empowerment is an essential component for the promotion of health and the investigation and resolution of health problems, and therefore is vital for the strategic

progression of healthcare (Al-Amoudi, 2017). Patients' needs and the professional status of nurses both improve when nurses are empowered. This empowerment gives them more autonomy, accountability, and confidence in the work environment. To promote nursing empowerment, this study highlights avenues for nurses' education and training deemed significant for planning and providing culturally sensitive and individualized care to the women victims of DVA.

This study has provided enough evidence to guide nursing managers and healthcare leaders to rethink their health delivery model, with more emphasis on the inclusion of nurses in the decision-making process, enabling them to take an active part and to motivate them to pursue their careers with zeal.

The study has provided a basis to explain the difference between societal and cultural norms versus religious teachings, and how these attributes can be incorporated in a different way to provide safe and secure avenues for nurses as well as victims of abuse in SA. All these findings are equally important for nurses to be empowered enough to plan their care process and provide quality care to the vulnerable and suffering, taking into account the cultural and religious context.

The findings from this study have the potential to inform an understanding of DVA for nurses and other healthcare providers locally, regionally, and internationally. The Arab-specific cultural aspects of this study relate to other contexts in the Middle East, as well as among diaspora communities that maintains socio-cultural norms in other regions, particularly in Europe and North America. Hence, the knowledge generated through this study has the potential to provide nurses and other healthcare providers with the information needed in practice and decision making regarding interventions for patients from Arab culture. Also, this study could be useful for health professionals, social workers, policymakers, and legislators in Saudi Arabia and around the world for planning and implementing effective interventions and policies that are based on the needs of abused women themselves.

To conclude, this study explored the experiences and perception of nurses on how they deal with the issues of DVA in Saudi Arabia, where such

conversations are inherently difficult to broach due to many cultural factors. This study found that nurses' empowerment is constrained by three main interrelated and overlapping barriers related to nurses' professional preparation to deal with issues of DVA, as discussed in detail above with regard to the research findings.

The implications of the findings include the training of nurses on DVA care through conferences, workshops, and online-facilitated courses, through a medium such as Future Learn. This study also has demonstrated the glaring need to activate the Nursing and Midwifery Council of Saudi Arabia to consider including DVA in their pre-registration courses. It also implies that aside from passing supportive laws, the Saudi government must educate and empower citizens, including nurses, to feel comfortable to discuss issues about DVA, by actively engaging in raising awareness and consulting societal stakeholders in women's issues, as well as socio-economic development in general. These recommendations, with appropriate cultural and religious sensitivity, can increase Saudi Arabia's protection of its womenfolk and all citizens, as enshrined in the Holy Quran.

The study's implications and contributions

The thesis makes a significant contribution to the field of knowledge:

This Ph.D. is a major contribution toward limited literature that exists surrounding significant yet neglect topics such as DVA in Saudi. This study added to our understanding the complexity and sensitivity and difficulty of addressing DVA in hospital settings, particularly in SA, where nurses feel ill-equipped, and are silent or constrained by socio-cultural and religious factors. This study, therefore, provides an essential contribution to the existing body of knowledge in Saudi Arabia regarding DVA and the healthcare context.

This study further contributes novel findings and highlights the key role of religion and culture interpretation and response to DVA.

The findings also expands and extends understanding of DVA more widely for the Muslim community and nurses in Muslim society, as the findings may be broadly generalizable for nurses in other Saudi healthcare contexts and in the Middle East in general, particularly for contexts with similar religious, gender, family, and cultural norms.

This study contributes to inform nursing education

Support a DVA-nursing curriculum and training program for undergraduate nurses. I.e., Islamic approaches to women's rights that are applicable to SA and Middle Eastern cultures.

Alongside education and training, the study suggests that interprofessional education be incorporated into nursing curriculum and training.

This study contributes to inform nursing practices.

The current study has shown that despite health care organizations call for optimum care for all. There are still organizational barriers that disempowered and prevent nurses from conduction their care for abused women. Therefore, the study suggests :

- Routine screening should be considered as the standard of care.
- Support the need for continued education and in-services training in a hospital.
- It also suggests clear guidelines and policies related to protecting both nurse's and women's confidentiality. since one of the findings of this study is a safety issue.
- Transparent in the reporting process and its consequences for disclosure and nondisclosure cases, established an independent reporting system.
- This study can reflect on changing experiences who access services.

- The knowledge generated from this study has the potential to provide nurses with the information needed in practices and decision making regarding intervention for patient from Arab culture

• This study contributes significant insights into the sensitivity and difficulty of addressing DVA in hospital settings, particularly in SA, where nurses feel ill-equipped, and are silent or constrained by socio-cultural and religious factors. The implications of the findings include the training of nurses on DVA care through conferences, workshops, and online-facilitated courses, through a medium online platform such as Future Learn. This study also has demonstrated the glaring need to activate the Nursing and Midwifery Council of Saudi Arabia to consider including DVA in their pre-registration courses. It also implies that aside from passing supportive laws, the Saudi government must educate and empower citizens, including nurses, to feel comfortable to discuss issues about DVA, by actively engaging in raising awareness and consulting societal stakeholders in women's issues, as well as socio-economic development in general. These recommendations, with appropriate cultural and religious sensitivity, can increase Saudi Arabia's protection of its womenfolk and all citizens, as enshrined in the Holy Quran.

This study contributes to inform Researcher/ other professional and policy maker

This study has implication for professional/ researcher/ policy maker/ who want to understand and implement social, organizational, cultural, and religious change in relation to abuse and domestic violence. It could have implication broadly for action research aim at changing social and cultural way of doing things.

This study has implication for other researchers who are researching in areas what calls for education and creating awareness on a social problem such as DV since lack of knowledge was key finding in this study.

This study informs decision-makers in the country to provide adequate counselling and rehabilitation centres, hotlines, and platforms to raise people's awareness, especially in terms of schools and mosques. As the current study identified that nurses alone cannot overcome this problem, as it is not only a nursing problem.

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Appendix 1: Saudi Arabia Map

Source: Central Intelligence Agency (2021)

Appendix 2: JBI Critical Appraisal Checklist Qualitative Studies

Checklist	Maquibar et al. (2018)	Wyatt et al. (2019)	Poreddi et al. (2020)	Wath (2019)	Sundborg et al. (2017)
Is there congruity between the stated philosophical perspective and the research methodology?	Unclear	Yes	Unclear	Yes	Yes
Is there congruity between the research methodology and the research question or objectives?	Yes	Yes	Yes	Yes	Yes
Is there congruity between the research methodology and the methods used to collect data?	Yes	Yes	Yes	Yes	Yes
Is there congruity between the research methodology and the representation and analysis of data?	Yes	Yes	Yes	Yes	Yes
Is there congruity between the research methodology and the interpretation of results?	Yes	Yes	Yes	Yes	Yes
Is there a statement locating the researcher culturally or theoretically?	No	Unclear	No	Unclear	Unclear
Is the influence of the researcher on the research, and vice- versa, addressed?	Unclear	Unclear	Yes	Unclear	Unclear
Are participants, and their voices, adequately represented?	No	Unclear	Yes	Unclear	Unclear
Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?	Yes	No	Yes	Yes	Yes

Checklist	Maquibar et al. (2018)	Wyatt et al. (2019)	Poreddi et al. (2020)	Wath (2019)	Sundborg et al. (2017)
Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?	Yes	Yes	Yes	Yes	Yes

Appendix 3: JBI Critical Appraisal Checklist for Cross-Sectional studies

Checklist	Sharma et al. (2018)	Gandhi et al. (2018)	Alhalal (2020)	Park et al. (2019)
Were the criteria for inclusion in the sample clearly defined?	No	Yes	Yes	No
Were the study subjects and the setting described in detail?	Yes	Yes	Yes	Yes
Was the exposure measured in a valid and reliable way?	No	No	No	Yes
Were objective, standard criteria used for measurement of the condition?	Yes	Yes	Yes	Yes
Were confounding factors identified?	No	No	No	No
Were strategies to deal with confounding factors stated?	No	No	No	No
Were the outcomes measured in a valid and reliable way?	Yes	Yes	Yes	Yes
Was appropriate statistical analysis used?	Yes	Yes	Yes	Yes

Appendix 4: JBI Critical Appraisal Checklist for Quasi-Experimental Studies (Non-Randomized) Experimental Studies

No	Checklist	Sundborg et al. (2018)
1	Is it clear in the study what is the ‘cause’ and what is the ‘effect’ (i.e. there is no confusion about which variable comes first)?	Yes
2	Were the participants included in any comparisons similar?	Yes
3	Were the participants included in any comparisons receiving similar treatment/care, other than the exposure or intervention of interest?	Yes
4	Was there a control group?	Yes
5	Were there multiple measurements of the outcome both pre and post the intervention/exposure?	Yes
6	Was follow-up complete, and if not, was follow-up adequately reported and strategies to deal with loss to follow-up employed?	Yes
7	Were the outcomes of participants included in any comparisons measured in the same way?	Yes
8	Were outcomes measured in a reliable way?	Yes
9	Was appropriate statistical analysis used?	Yes

Overall appraisal: Include

Source: Schoening et al. (2004)

Appendix 5: Criteria for Assessing the Quality of Mixed-Methods Research

O'Cathain (2010) proposed a framework comprising of 44 appraisal criteria positioned within 8 quality domains: "planning quality, interpretive rigor, data quality, design quality, inference transferability, reporting quality, synthesizability, and utility". These domains and items are based on the work of Caracelli and Riggin (1994), Creswell (2003), Creswell and Plano Clark (2007), Dellinger and Leech (2007), O'Cathain et al. (2008), Onwuegbuzie and Johnson (2006), Pluye et al. (2009a), and Teddlie and Tashakkori (2003, 2009).

Critical Appraisal Checklist for Assessing the Quality of Mixed Methods Research

Domain with Quality	Items with Domains	Maquibar et al. (2019)
Domain 1: Planning Quality (Planning the study)	Foundation: Research questions and methods are based on sound examination of the relevant literature Rationale: Use of mixed methods approach is clearly justified and explained Planning: detail of intended design, data collection, analysis, and reporting is given Feasibility: Planned study can be completed with the available resources	✓
Domain 2: Design quality (Conducting the study)	Design transparency: design is clearly articulated and related to known typologies where appropriate. Design suitability: design is suitable to answer research questions, and fits with other stated features i.e. reason for use of methods, paradigm Design strength: Selection of methods minimizes bias and enables broader/deeper study than single method Design rigor: Implementation of methods is congruent with study design	✓
Domain 3: Data Quality (Conducting the study)	Data transparency: Detail is given of individual methods and their role in the study. Data rigor/design fidelity: Methods are rigorously implemented. Sampling adequacy: Selection approach and sample size are appropriate to method and context Analytic adequacy: Analysis is undertaken appropriately to the methods and questions Analytic integration rigor: Integration at the analysis stage, if conducted, is robust	✓

Domain with Quality	Items with Domains	Maquibar et al. (2019)
Domain 4: Interpretive Rigor (Interpretation of data)	Data transparency: Detail is given of individual methods and their role in the study. Data rigor/design fidelity: Methods are rigorously implemented. Sampling adequacy: Selection approach and sample size are appropriate to method and context Analytic adequacy: Analysis is undertaken appropriately to the methods and questions Analytic integration rigor: Integration at the analysis stage, if conducted, is robust	✓
Domain 5: Inference transferability (Interpretation of Data)	Ecological transferability: Inferences can be transferred to other contexts Population transferability: Inferences can be transferred to other populations Temporal transferability: Inferences are relevant to future contexts Theoretical transferability: Other data collection methods could be transferred.	✓
Domain 6: Reporting Quality (Dissemination of Findings)	Report availability: successful completion of study within planned/allocated time and resource. Reporting transparency: key aspects of study are reported appropriately to the mixed methods design Yield: mixed methods design yields greater insight than single methods	✓

Domain with Quality	Items with Domains	Maquibar et al. (2019)
Domain 7: Synthesizability (Real world application)	Qualitative element/ study has qualitative objective or question Qualitative element/study has appropriate design or method context for qualitative element/study is described Sampling approach and participants in qualitative element/study are described Approach to data collection and analysis in qualitative element/study is described Researcher reflexivity in qualitative element/study is discussed Sequence generation or randomization in quantitative experimental element/study is appropriate 'Blinding' in quantitative experimental element/study is appropriate Data sets are complete or largely complete in quantitative experimental element/study Sampling and sample is appropriate to quantitative observational study/element Choice of measurements in quantitative observational study/element is justified Confounding variables are properly controlled in quantitative observational study/element Mixed methods element/study is justified Mixed methods element/study combines qualitative and quantitative data collection methods and/or analysis techniques Mixed methods element/study integrates data or results from qualitative and quantitative elements	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓

Domain with Quality	Items with Domains	Maquibar et al. (2019)
Domain 8: Utility	Findings are useful to ‘target audience’ e.g. policy makers and consumers	

Overall appraisal: Include

Appendix 6: JBI Critical Appraisal Checklist for Randomized Controlled Trials

Items	Poreddi et al. (2020)
1. Was true randomization used for assignment of participants to treatment groups?	Yes
2. Was allocation to treatment groups concealed?	Yes
3. Were treatment groups similar at the baseline?	
4. Were participants blind to treatment assignment?	Yes
5. Were those delivering treatment blind to treatment assignment?	Unclear
6. Were outcomes assessors blind to treatment assignment?	Unclear
7. Were treatment groups treated identically other than the intervention of interest?	Yes
8. Was follow up complete and if not, were differences between groups in terms of their follow up adequately described and analysed?	Yes
9. Were participants analysed in the groups to which they were randomized?	Yes
10. Were outcomes measured in the same way for treatment groups?	Yes
11. Were outcomes measured in a reliable way?	
12. Was appropriate statistical analysis used?	Yes
13. Was the trial design appropriate, and any deviations from the standard RCT design (individual randomization, parallel groups) accounted for in the conduct and analysis of the trial?	Yes

Overall appraisal: Include □ Exclude □ Seek further info □Included

Appendix 7: The Published Paper

https://onlinelibrary.wiley.com/doi/full/10.1002/nop2.133

REVIEW ARTICLE

WILEY

Nurse education and understanding related to domestic violence and abuse against women: An integrative review of the literature

Abstract

1 | INTRODUCTION

1.1 | Background

Appendix 8: Table of Review – Newly Updated Research

<table>
<tr><th colspan="3">1. Sharma et al. (2018)</th></tr>
<tr><th>Purpose</th><th>Sample size & setting</th><th>Methodology</th></tr>
<tr><td>To assess the knowledge, attitude, practice, and learning needs of nursing personnel regarding women's health issues related to domestic violence.</td><td>100 nursing personnel, 25 each (3 PHCs), three maternal and child welfare (M&CW) centres/units, one general hospital, and one tertiary hospital in the National Capital Territory (NCT), Delhi.</td><td>Facility-based cross-sectional survey</td></tr>
</table>

<table>
<tr><th>Findings/ implications</th><th>Weaknesses and strengths</th></tr>
<tr><td>Two third of nursing personnel (67%) had moderate knowledge scores, and 27% had poor knowledge scores; 19% had favourable attitude scores towards DV; 57% had good practice scores; 44% reported moderate to the high need for learning and majority lacked preparedness to manage DV victims. The knowledge was significantly associated with younger age, single, graduate/ Postgraduates, B.Sc. Nursing degree holders, working in a tertiary hospital, as a staff nurse/public health nurse/sister in charge and those with lesser experience ($p<0.05$).

The present study confirms that there are considerable gaps in the knowledge, attitude and practices of nursing personnel, in Delhi too, and that they feel largely unprepared for addressing women’s health issues related to domestic violence. This shows a potential scope for imparting DVAW related pre-service and in- service training and ensuring relevant protocols in health care settings.</td><td>Data were collected through self-reports, rather than actual observations, especially for the practices which could lead to reporting bias. The cross-sectional design does not allow for making conclusions focused on associations. A small sample size of nursing personnel could have affected the generalizability of the study.</td></tr>
</table>

2. Gandhi et al. (2018)		
Purpose	*Sample size & setting*	*Methodology*
To assess novice nurses' perceptions of self- efficacy, educational preparedness and their role in this area.	Novice nurses (n=83) at a tertiary care centre using self-reported questionnaires	Cross-sectional descriptive survey

Findings/ implications	*Weaknesses and strengths*
A majority of the subjects were confident and had adequate knowledge in dealing with women who have experienced IPV. A significantly positive relationship was found between educational preparedness and self-efficacy and attitudes towards nurses' roles in caring for these women. There is an urgent need to integrate comprehensive training on IPV to improve clinical competencies, including how to refer women for further support.	Small sample size. Participants were selected using a convenience sampling technique and were recruited from a single tertiary care centre. A cross-sectional descriptive design was used.

3. Maquibar et al. (2018)		
Purpose	*Sample size & setting*	*Methodology*
To explore third- and fourth-year nursing students' perceptions and attitudes toward gender-based violence.	42 nursing students joined to 7 focus groups	Groups based qualitative study

Findings/ implications	*Weaknesses and strengths*
Implication: 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.	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.

4. Maquibar et al. (2019)		
Purpose	*Sample size & setting*	*Methodology*
To analyse training on gender-based violence that nursing students receive at universities in Spain	18 Training programs reviewed	Mixed-methods approach. Systematic review of public documents followed by in-depth interviews with university lecturers

Findings/ implications	*Weaknesses and strengths*
80% of the nursing education programmes included specific training in gender-based violence but with great variability in content among the universities.	Available documents for systematic review varied immensely in terms of the detail and extension of the information provided.

5. Wyatt et al. (2019)		
Purpose	*Sample size & setting*	*Methodology*
To identify if recently licensed associate degree prepared registered nurses screen for intimate partner violence, how they screen, which patients are screened, and how pre-licensure education and current workplace training has influenced these screening decisions and behaviours.	16 nurses	An exploratory qualitative design guided by Constructivist Grounded Theory was used.

Findings/ implications	*Weaknesses and strengths*
Six themes emerged from the interview data: Preparedness, Discomfort, Taboo, Disenchantment, Presumptuous, and Evolving Realizations. These findings suggest nurses are not being taught about screening for domestic violence., Findings also suggested work environment and peers influenced if and how diligently nurses screened. The findings point to an interpersonal or intimate nature to screening for domestic violence that is unique and may require highly interactive training throughout pre-licensure education and work orientation	Several limitations are identified. A geographical limitation with a small sample (n=16) from one large metropolitan area limits the findings from being generalized to nurses in other states. The sample was 100% female and 70% white, which may not represent the new licensed nurses as a group. Further, it is suggestive of the need to ex-amine healthcare workplace education regarding the need for screening for intimate partner violence among all patients, including males and individuals in same sex relationships.

6. Alhalal (2020)		
Purpose	*Sample size & setting*	*Methodology*
To investigate nurses' knowledge, attitudes and practices related to intimate partner violence among women in Saudi Arabian healthcare settings.	114 nurses from two hospitals in Saudi Arabia using a questionnaire.	Cross-Sectional Study

Findings/ implications	*Weaknesses and strengths*
There were gaps in nurses' perceived preparedness, knowledge, attitudes and behaviours. There was also limited training and preparation for nurses to assess and address intimate partner violence. The findings highlight that the lack of IPV education and training is a common matter. The study suggests the need for clear institutional health policies related to detecting, responding to, and preventing intimate partner violence. Guidelines about integrating intimate partner violence in nursing curricula and implementing in-service training should be developed and implemented. A multi-level intervention that enables nurses to respond to intimate partner violence is also needed.	The study is conducted in Saudi Arabia, and this might limit the generalizability of findings to nurses at global level. However, the sample had only 26.5% Saudi nurses with the rest being international nurses. As well, the use of a convenience sample might lead to selection bias; but the sample was similar to the nursing population in Saudi Arabia.

7. Poreddi et al. (2020)		
Purpose	*Sample size & setting*	*Methodology*
The aim of this study was to evaluate the impact of training on nurses' attitudes towards routine screening and confidence in implementing routine screening of violence among women with mental illness	The participants of this study were 68 nurses randomly assigned to either experimental or control group (34 in each group).	A randomized controlled trial design was adopted for the present study. The experimental group was provided eight interactive sessions based on a Nursing Module on abuse among women with mental illness. The assessments were done in both groups at baseline, after the intervention, at three months and at six months. All assessments were self-rated questionnaires to assess nurses' attitudes and confidence in implementing routine screening of violence attitudes

Findings/ implications	*Weaknesses and strengths*
The experimental group showed a statistically significant improvement in the attitudes and confidence in implementing routine screening of abuse in women with mental illness ($p < 0.05$) than the control group. Repeated measures of analysis also revealed statistically significant differences related to attitude and confidence in implementing routine screening of abuse between the groups and within the experimental group at different time points of assessment ($p < 0.001$). This study concluded that training based on a nursing module improved nurses' attitude and confidence to conduct routine screening of violence among women with mental illness. However, further studies are necessary to clarify whether the training is effective in implementing in nursing practice.	The use of cluster random sampling ensured a highly homogeneous sample to achieve the study objectives and follow-up assessment at third and at six months indicated retaining of the acquired attitudes to screen routinely and confidence to explore the sensitive issue. The nursing module was developed based on the findings of a qualitative studies conducted among nurses and abused women with mental illness. However, this study has certain limitations such as small sample size and study being limited to specific geographic area in a single university may limit generalization. In addition, there may be possibility of bias as assessment of all outcome variables in this study were dependent on self-reported questionnaires. However, this study did not assess the effectiveness of the Nursing Module among the end users (women with mental illness and victims of violence).

8. Poreddi et al. (2020)		
Purpose	*Sample size & setting*	*Methodology*
to explore nurses' knowledge, confidence, and learning needs in the identification and responding to disclosure of abuse in women with mental illness	nurses (N = 21) working in psychiatry units at a tertiary care centre	This qualitative study /The focus group

Findings/ implications	*Weaknesses and strengths*
Five dominant themes and fifteen sub-themes have emerged from qualitative analysis. The dominant themes include; Awareness of abuse among women with mental illness (AWMI), Experiences of recognizing and responding to abuse, Barriers for routine screening for abuse, Educational preparedness, and learning needs, and Prevention of abuse in women with mental illness. The identified barriers include personal related (personal discomfort, lack of knowledge, etc.), job related (Time consuming, not a nurse's job, lack of time, etc.) and organizational (lack of policies and administrative support, etc.). Most of the participants expressed that they lack confidence in the routine screening of women for abuse due to inadequate training. Therefore, it is critical to include a topic on domestic violence in the nursing curriculum and provide ongoing learning opportunities to the nurses through CNE programs, workshops, and conferences.	This qualitative study provided a better understanding of nurses' awareness, confidence, barriers for routine screening, and learning needs on domestic violence among women with mental illness. Therefore, the obtained information can be incorporated into the development and implementation of future educational programs to train nurses in the screening of women routinely and supporting them with early interventions. However, the sample of this study was limited to a single setting. Further, group dynamics such as participants were known to each other might have influenced the results. Therefore, the findings from this study are not generalizable and could be different from those in other locations.

9. Wath (2019)		
Purpose	*Sample size & setting*	*Methodology*
To uncover discourses that may help understand emergency nurses' responses towards women exposed to intimate partner violence	15 participants working at an emergency unit in a public hospital in South Africa	Qualitative study

Findings/ implications	*Weaknesses and strengths*
Four themes emerged from the focus group discussions: (1) strong women subject themselves to societal expectations and endure intimate partner violence (2) women are vulnerable and powerless against intimate partner violence (3) intimate partner violence is a private and secret phenomenon, and (4) emergency nurses have limited scope to intervene when they encounter women exposed to intimate partner violence.	South African population has ethnic and cultural diversity, nurses from different cultures not included.

<table>
<tr><th colspan="6">10. Sundborg et al. (2017)</th></tr>
<tr><td colspan="2">Purpose</td><td colspan="2">Sample size & setting</td><td colspan="2">Methodology</td></tr>
<tr><td colspan="2">To improve the understanding of district nurses’ experiences of encountering women exposed to intimate partner violence.</td><td colspan="2">11 district nurses in primary health care.</td><td colspan="2">Qualitative study</td></tr>
<tr><td colspan="3">Findings/ implications</td><td colspan="3">Weaknesses and strengths</td></tr>
<tr><td colspan="3">Several barriers to asking and factors that facilitated asking impacted the hesitation process. Under the influence of these factors, district nurses moved from being unaware that identifying intimate partner violence was their professional responsibility, to becoming ambivalent about asking, to starting to prepare themselves to ask about intimate partner violence. This study illuminates the importance of a supportive work environment in reducing district nurses’ hesitation to ask about intimate partner violence and to propose continuing education, training and supervision for district nurses regarding intimate partner violence.</td><td colspan="3">The theoretical model that resulted from the present study is a substantive theory applicable to the context from which it emerged; i.e., DNs working in primary health care in Stockholm, Sweden. The model must therefore be tested in each new context to ensure relevance.</td></tr>
</table>

<table>
<tr><th colspan="6">11. Sundborg et al. (2018)</th></tr>
<tr><td colspan="2">Purpose</td><td colspan="2">Sample size & setting</td><td colspan="2">Methodology</td></tr>
<tr><td colspan="2">To evaluate the impact of an educational intervention on the preparedness of district nurses at primary healthcare centres to encounter women exposed to inti- mate partner violence.</td><td colspan="2">Participants were divided into an intervention group (n = 117) and a control group (n = 204), both from the eastern part of Sweden. A group of nurses from across Sweden (the ‘national group,’ n = 217) was also recruited</td><td colspan="2">Observational quasi-experimental study.</td></tr>
<tr><td colspan="3">Findings/ implications</td><td colspan="3">Weaknesses and strengths</td></tr>
<tr><td colspan="3">The results indicate that the intervention had a low impact on district nurses’ preparedness. The educational intervention must be adjusted; a main focus of changes should be the addition of continuing post-intervention supervision and support. Pre-intervention preparedness was equal in all three groups. In the intervention group, preparedness related to the factor practitioner lack of control increased (p = 0.003), but a comparison of change between the intervention and control groups showed no significant intervention effect (p = 0.069).</td><td colspan="3">The equal pre-intervention scores of the intervention and control groups provided a good starting point for the educational intervention, but the study had several limitations. To estimate the long-term impact of the intervention, we chose to schedule the follow-up 1 year after the intervention was completed. This may have led to the high dropout rate that was the major limitation of the study. Because of this limitation, the results of this study cannot be generalised and should be interpreted with great caution. Recruitment of participants was also affected by several events during the study period that took a great deal of time and focus and may have drawn district nurses’ attention away from the current study</td></tr>
</table>

<table>
<tr><th colspan="4">12. Park et al. (2019)</th></tr>
<tr><td>Purpose</td><td colspan="2">Sample size & setting</td><td>Methodology</td></tr>
<tr><td>to examine the influence of gender-related perceptions and experiences on nursing professionalism among nursing students who grew up in a culture with strong gender norms.</td><td colspan="2">251 nursing student’s convenience sample of nursing students in South Korea</td><td>Cross-sectional study</td></tr>
<tr><td colspan="2">Findings/ implications</td><td colspan="2">Weaknesses and strengths</td></tr>
<tr><td colspan="2">Our findings revealed that gender-related perceptions were important factors influencing the perception of NP (nursing professionalism) among nursing students, with gender stereotyping and sexism being particularly meaningful factors.</td><td colspan="2">A limitation of this study was the convenience sample of one ethnicity with a limited number of respondents, which limited the generalizability of the results. Also, we used a self-report method to measure all study variables. This might present problems, as variables, such as gender violence experiences, might be less precise because of memory bias. Nevertheless,</td></tr>
</table>

Appendix 9: Participant Information Sheets

Student Nurses

Name of School & Department to be added

Participant Information Sheet
Final version 1.0: 5.9,2017)

Title of Study: Nurse's experiences and understanding of violence against women in Saudi Arabia
Study ID –
Name of Researcher(s): Kafi Alshammari

I would like to invite you to take part in my research study. Before you decide I would like you to understand why the research is being done and what it would involve for you. I will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask me if there is anything that is not clear.

What is the purpose of the study?

The aim of this research is to explore the practices, understanding, and knowledge among registered nurses and nursing students related to DV within the context of Saudi Arabia.

Why have I been invited?

I would like to speak to student nurses in the final year (4th year) in the King Saud University because they are ready to practice in an evolving system of health care. They have immersed themselves in core clinical practices and nursing theories and are ready to pursue a future career in nursing. They may also have experienced DV in practice. I would like to speak to student nurses in order to gain a broad perspective of their experiences

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What will happen to me if I take part?

You will be invited to take part in an interview. The researcher will explain all aspects of the study to participants. You will be given this information sheet to read and keep and will be asked to sign a consent form. The researcher is bilingual and therefore the consent forms and information sheets will be available in both Arabic and English languages. An in-depth interview up to 2 hours will be taken by the researcher. Interviews will be audio-recorded by the researcher using an audio recorder. Participation in the study is entirely voluntary and you may withdraw at any time. In the event of their withdrawal data collected so far cannot be erased, and we will seek consent to use the data in the final analyses, where appropriate.

Expenses and inconvenience allowance

We will not be able to pay you for taking part as this is research, I am undertaking as part of my doctoral studies, but will arrange the meeting so that you do not have to travel and will incur no expense.

What are the possible disadvantages and risks of taking part?

I do not anticipate that there are any disadvantages associated with taking part in the study. However, I acknowledge that this is a sensitive subject area and as such will provide information and support services should the need be identified.

What are the possible benefits of taking part?

The information I gain from your participation in this study may help women who access services in the future through the improvement of service support mechanisms and education and training in the undergraduate period. This could inform strategies appropriate to the particular context and needs in Saudi Arabia.

This will be the first study of its kind to look at the issues specifically within the context of KSA. Therefore, many of the issues that we uncover are likely to be able to support the better understanding of particular phenomena.

Will my taking part in the study be kept confidential?

We will follow the ethical and legal practice and all information about you will be handled in confidence. However, if you disclose a safeguarding issue I will be required to report this through the appropriate mechanisms.

If you join the study, some parts of the data collected for the study will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All information which is collected about you during the course of the research will be kept strictly confidential, stored in a secure and locked office, and on a password protected database. Any information about you which leaves the institution will have your name and address removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

Your personal data (email, and telephone number) will be kept for two years after the end of the study so that we are able to contact you about the findings of the study (unless you advise us that you do not wish to be contacted). All other data (research data) will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data.

We would also like to seek your consent so that the data may be stored and used in possible future research during and after 7 years– this is optional (please indicate you agree to this on the consent form).

What will happen if I don't want to carry on with the study?

Your participation is voluntary and you are free to withdraw at any time, without giving any reason.

What will happen to the results of the research study?

The study being a requirement for the award of a doctoral degree, it is anticipated that findings from the study will be disseminated at various stages of the study (from pilot to the conclusion of the main study) in appropriate scientific journal in open access journals for wider coverage, poster and oral presentations in KSA and at international conference. A copy of the findings will be available to you on publication and you will not be identified in any report/publication.

Who is organising and funding the research?

This research is being organised by the University of Nottingham and is being funded by the Saudi Arabian Cultural Bureau in London.

Who has reviewed the study?

All research in the University of Nottingham is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the Faculty of Medicine & Health Sciences (FMHS) Research Ethics Committee.

What if there is a problem?

If you have a concern about any aspect of this study, you should contact the Chief investigator Dr Julie McGarry Email:julie.mcgarry@nottingham.ac.uk or Professor Gina Higginbottom gina.higginbottom@nottingham.ac.uk**.** The full contact details of the research team are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you should then contact the FMHS Research Ethics Committee Administrator, c/o The University of Nottingham, School of Medicine Education Centre, B Floor, Medical School, Queen's Medical Centre Campus, Nottingham University Hospitals, Nottingham, NG7 2UH. E-mail: louise.sabir@nottingham.ac.uk.

Further information and contact details

Investigators		Email
Principal investigators	Kafi Alshammari	Ntxka17@nottingham.ac.uk
Chief investigators	Dr.Julie McGarry	julie.mcgarry@nottingham.ac.uk
	Prof.Gina Higginbottom	gina.higginbottom@nottingham.ac.uk

Registered Nurses

Name of School & Department to be added

Participant Information Sheet
Final version 1.0: 5.9.2017)

Title of Study: Nurse's experiences and understanding of violence against women in Saudi Arabia
Study ID –

Name of Researcher(s): Kafi Alshammari

I would like to invite you to take part in my research study. Before you decide I would like you to understand why the research is being done and what it would involve for you. I will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask me if there is anything that is not clear.

What is the purpose of the study?

The aim of this research is to explore the practices, understanding, and knowledge among registered nurses and nursing students related to domestic violence against (DV) within the context of Saudi Arabia.

Why have I been invited?

I would like to speak to registered nurses in the King Saud Medical City (KSMC) because a number of women who have experienced DV may access a range of hospital inpatient and outpatient services (McGarry 2014 & et al.). I would like to speak to both national and international registered nurses in order to gain a broad perspective of their experiences.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What will happen to me if I take part?

You will be invited to take part in an interview. The researcher will explain all aspects of the study to participants. You will be given this information sheet to read and keep and will be asked to sign a consent form. The researcher is bilingual and therefore the consent forms and information sheets will be available in both Arabic and English languages. An in-depth interview up to 2 hours will be taken by the researcher. Interviews will be audio-recorded by the researcher using an audio recorder. Participation in the study is entirely voluntary and you may withdraw at any time. In the event of their withdrawal data collected so far cannot be erased, and we will seek consent to use the data in the final analyses, where appropriate.

Expenses and inconvenience allowance

We will not be able to pay you for taking part as this is research, I am undertaking as part of my doctoral studies, but will arrange the meeting so that you do not have to travel and will incur no expense.

What are the possible disadvantages and risks of taking part?

I do not anticipate that there are any disadvantages associated with taking part in the study. However, I acknowledge that this is a sensitive subject area and as such will provide information and support services should the need be identified.

What are the possible benefits of taking part?

The information I gain from your participation in this study may help women who access services in the future through the improvement of service support mechanisms and education and training in the undergraduate period. This could inform strategies appropriate to the particular context and needs in Saudi Arabia.

This will be the first study of its kind to look at the issues specifically within the context of KSA. Therefore, many of the issues that we uncover are likely to be able to support the better understanding of particular phenomena.

Will my taking part in the study be kept confidential?

We will follow the ethical and legal practice and all information about you will be handled in confidence. However, if you disclose a safeguarding issue I will be required to report this through the appropriate mechanisms.

If you join the study, some parts of the data collected for the study will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All information which is collected about you during the course of the research will be kept strictly confidential, stored in a secure and locked office, and on a password protected database. Any information about you which leaves the institution will have your name and address removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

Your personal data (email, and telephone number) will be kept for two years after the end of the study so that we are able to contact you about the findings of the study (unless you advise us that you do not wish to be contacted). All other data (research data) will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all

precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data.

We would also like to seek your consent so that the data may be stored and used in possible future research during and after 7 years– this is optional (please indicate you agree to this on the consent form).

What will happen if I don't want to carry on with the study?

Your participation is voluntary and you are free to withdraw at any time, without giving any reason.

What will happen to the results of the research study?

The study being a requirement for the award of a doctoral degree, it is anticipated that findings from the study will be disseminated at various stages of the study (from pilot to the conclusion of the main study) in appropriate scientific journal in open access journals for wider coverage, poster and oral presentations in KSA and at international conference. A copy of the findings will be available to you on publication and you will not be identified in any report/publication.

Who is organising and funding the research?

This research is being organised by the University of Nottingham and is being funded by the Saudi Arabian Cultural Bureau in London.

Who has reviewed the study?

All research in the University of Nottingham is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the Faculty of Medicine & Health Sciences (FMHS) Research Ethics Committee.

What if there is a problem?

If you have a concern about any aspect of this study, you should contact the Chief investigator Dr Julie McGarry Email:julie.mcgarry@nottingham.ac.uk or Professor Gina Higginbottom gina.higginbottom@nottingham.ac.uk**.** The full contact details of the research team are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you should then contact the FMHS Research Ethics Committee Administrator, c/o The University of Nottingham, School of Medicine Education Centre, B Floor, Medical School, Queen's Medical Centre Campus, Nottingham University Hospitals, Nottingham, NG7 2UH. E-mail: louise.sabir@nottingham.ac.uk.

Further information and contact details

Investigators		Email
Principal investigators	Kafi Alshammari	Ntxka17@nottingham.ac.uk
Chief investigators	Dr.Julie McGarry	julie.mcgarry@nottingham.ac.uk
	Prof.Gina Higginbottom	gina.higginbottom@nottingham.ac.uk

Appendix 10: Topic Guide

- Thank you for agreeing to take part in my study
- Check participant has read information sheet and agrees to sign consent form.

This study aimed to explore your understanding about domestic violence. This interview will be anonymous. Your experiences and knowledge is really important for us. I determined the next question based on what was said to gain deeper understanding of the meaning inherent in a certain answer.

Ice breaker

- How you've found experience of studying in the King Saud University in general?
- What are positive and negative aspects of your study?
- **Scenario**

Knowledge of Violence against women

- How do you define domestic violence?
- Did you get a chance to join in any training/internship during your educational year?
- Can you identify the most common symptoms that is usually presented by the victims of violence?
- Can you tell me about types of DVA?
- How you can define it?
- what the reasons behind it?
- What do you think might be the effects of DVA on women health?

Nursing education

- What do you see as the nurse role with regards to violence against women?
- Depending on response to this question further prompts may be why? Or how?

- Are issues related to the “violence against women” covered in your curriculum?

Skills and competencies

- Have you ever heard or deal with cases experienced any type of violence while you have been on this course? If so ask:
- How did you feel at the time?
- How did the qualified nurse act – for example, make referrals?
- Were you worried about what you might say to the victim? Then,
- How did you resolve this?
- What skills do you think nurses need to deal and to identify a women in a violent situation?

If not, then ask:

- How do you think you would you act and make referrals, as future nursing professionals?
- Do you get worried about what you might say to the victim? Then,
- How do you go about resolving this?
- What skills do you think nurses need to deal and to identify a women in a violent situation?

Thank you.

Appendix 11: Ethical Approval from University of Nottingham

Email: FMHS-ResearchEthics@nottingham.ac.uk

Faculty of Medicine & Health Sciences
Research Ethics Committee
c/o Faculty PVC Office
School of Medicine Education Centre
B Floor, Medical School
Queen's Medical Centre Campus
Nottingham University Hospitals
Nottingham, NG7 2UH

14 September 2017

Kafi Alshammatri
PhD Student in Nursing Studies
c/o Dr Julie McGarry
Associate Professor/Deputy Director
Postgraduate Research and Environment
School of Health Sciences
B Floor, South Block Link
Queen's Medical Centre Campus
University Hospitals Nottingham
NG7 2UH

Dear Kafi

<table>
<tr><td colspan="2">**Ethics Reference No:** 114-1709– **please always quote**</td></tr>
<tr><td colspan="2">**Study Title:** Nurses' experiences and understanding of violence against women within healthcare encounters in Saudi Arabia: A Hermeneutic phenomenology study.</td></tr>
<tr><td colspan="2">**Short Title:** Nurses' experiences and understanding of violence against women in Saudi Arabia.</td></tr>
<tr><td colspan="2">**Chief Investigator/Supervisors:** Dr Julie McGarry, Associate Professor/Deputy Director, Postgraduate Research and Environment. Professor Gina Higginbottom, The Mary Seacole Professor of Ethnicity and Community Health</td></tr>
<tr><td colspan="2">**Lead Investigators/student:** Kafi Alshammatri, PhD in Nursing Studies</td></tr>
<tr><td colspan="2">**Type of Study:** Qualitative Interviews PhD study</td></tr>
<tr><td>**Proposed Start Date:** 01/10/2017</td><td>**Proposed End Date:** 30/04/2018 6mths</td></tr>
<tr><td>**No of Subjects:** 11-15+</td><td>**Age:** 18+years</td></tr>
<tr><td colspan="2">**School:** Health Sciences</td></tr>
</table>

Thank you for submitting the above application which has been considered by the Committee at its meeting on 11 September 2017and the following documents were received:

- FMHS REC Application form and supporting documents version 0.1: 29.08.2017

These have been reviewed and are satisfactory and the study has been given a favourable opinion subject to submission of the approval letters from Research Ethics Committee at the Nursing College, Kind Saud University and King Saud Medical City, Riyadh, Kingdom of Saudia Arabia.

A favourable opinion is given on the understanding that the conditions set out below are followed:

1. That all appropriate ethical and regulatory permissions are respected and followed in accordance with all local laws of the country in which the study is being conducted and those required by the host organisation/s involved.

3. You must notify the Chair of any serious or unexpected event.

4. An End of Project Progress Report is completed and returned when the study has finished (please request a form).

Yours sincerely

Professor Ravi Mahajan
Chair, Faculty of Medicine & Health Sciences Research Ethics Committee

Appendix 12: Ethical Approval from A+B Sites

Kingdom of Saudi Arabia
Ministry of Health
King Fahad Medical City
(162)

المملكة العربية السعودية
وزارة الصحة
مدينة الملك فهد الطبية
(١٦٢)

IRB Registration Number with KACST, KSA: H-01-R-012
IRB Registration Number with OHRP/NIH, USA: IRB00010471
Approval Number Federal Wide Assurance NIH, USA: FWA00018774

October 8, 2017
IRB Log Number: 17-348E
Department: External
Category of Approval: EXEMPT

Dear Kafi Alshammari,

I am pleased to inform you that your submission dated October 4, 2017 for the study titled **'Nurse's experiences and understanding of violence against women within healthcare encounters in Saudi Arabia: A Hermeneutic phenomenology study'** was reviewed and was approved according to ICH GCP guidelines. Please note that this approval is from the research ethics perspective only. You will still need to get permission from the head of department or unit in KFMC or an external institution to commence data collection.

We wish you well as you proceed with the study and request you to keep the IRB informed of the progress on a regular basis, using the IRB log number shown above.

Please be advised that regulations require that you submit a progress report on your research every 6 months. You are also required to submit any manuscript resulting from this research for approval by IRB before submission to journals for publication.

As a researcher you are required to have current and valid certification on protection human research subjects that can be obtained by taking a short online course at the US NIH site or the Saudi NCBE site followed by a multiple choice test. Please submit your current and valid certificate for our records. Failure to submit this certificate shall a reason for suspension of your research project.

If you have any further questions feel free to contact me.

Sincerely yours,

Prof. Omar H. Kasule
Chairman, Institutional Review Board (IRB)
King Fahad Medical City, Riyadh, KSA
Tel: + 966 1 288 9999 Ext. 26913

F M C
Approved
08 OCT 2017
I R B

المملكة العربية السعودية
ص.ب 642 الرياض 11421
www.ksu.edu.sa

جامعة الملك سعود (034)
هاتف 4693631 11 966+
فاكس 4693630 11 966+

كلية التمريض
مكتب العميد

سعادة الملحق الثقافي في سفارة خادم الحرمين الشريفين سلمه الله

المملكة المتحدة، لندن

السلام عليكم ورحمه الله وبركاته،،،

بداية نتقدم لسعادتكم ولجميع العاملين لديكم بسفارة خادم الحرمين الشريف في لندن بوافر الشكر والتقدير لدعمكم ومساندتكم الدائمة للطلاب السعوديين المبتعثين في بريطانيا وعلى وجه الخصوص طالبات كلية التمريض بجامعة الملك سعود في سبيل نجاح مهمتهم التي ابتعثوا من أجلها، ومن هذا المنطلق ونظراً لحاجة المبتعثة للحصول على درجة الدكتوراه في التمريض ...

المبتعثة : كافي بنت فريح الشمري

جامعة الابتعاث : **The University of Nottingham**

للقيام برحله علميه للمملكة العربية السعودية لجمع المعلومات والبيانات اللازمة لبحثها المعنون بـ :

"Nurse's experiences and understanding of violence against women within healthcare encounters in Saudi Arabia: A Hermeneutic phenomenology study"

عليه فإننا نفيد سعادتكم بأنه لا مانع لدينا من قيام المبتعثة الموضحة بياناتها أعلاه للقيام برحلة علمية للمملكة العربية السعودية لجمع المعلومات والبيانات اللازمة لبحثها للحصول على درجة الدكتوراه في التمريض، علما بأن المبتعثة ستقوم بجمع المعلومات والبيانات اللازمة خلال فترة وجودها في المملكة تحت اشراف وكالة الكلية للدراسات العليا والبحث العلمي بكلية التمريض بجامعة الملك سعود .

ولسعادتكم فائق الود والاحترام ،،،

عميد الكلية

د. أحمد بن عيسى أبوشايقة

Appendix 13: Certificate of “Protecting Human Research Participants”

Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **kafi Alshammari** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 10/02/2017.

Certification Number: 2503410.

Appendix 14: Consent Forms

Student Nurses

(Form to be printed on local headed paper)

CONSENT FORM

Final version 1.0: 27.8.2017

Title of Study: Nurse's experiences and understanding of violence against women in Saudi Arabia.

REC ref: ***(to be added after approval given)***

Name of Researcher: Kafi Alshammari

Name of Participant:

Please initial box

1. I confirm that I have read and understand the information sheet version number …………dated…………………………………… for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. This will have no negative consequences on my future course of study. ☐

3. I understand that relevant sections of data collected in the study may be looked at by responsible individuals from the University of Nottingham, the research group where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐

4. I understand that the interview will be audio recorded using a digital device and that anonymous direct quotes from the interview may be used in the study reports. ☐

5. I understand that information about me recorded during the study will be kept in a secure database. If data is transferred to others it will be made anonymous. Data will be kept for 7 years after the results of this study have been published and then destroyed. ☐

6. **Optional**: I understand that the information collected about me will be used to support other research in the future, and may be shared anonymously with other researchers. Any data used will be anonymised, and I will not be identified in any way. ☐

7. I voluntarily agree to take part in the above study. ☐

______________________	__________	______________
Name of Participant	Date	Signature
Name of Person taking consent (if different from Principal Investigator)	Date	Signature
Name of Principal Investigator	Date	Signature

2 copies: 1 for participant, 1 for the project notes.

This sheet should be stored separately from the consent form and other project documents.

STUDY NUMBER [ ]

Name: ……………………………………………………………………………………………………..

Address:
……

Telephone number: ……………………………………………………………………………

Optional: I agree to my contact details being stored for the purpose of being invited to participate in future research studies:

Signature: ………………………………………………… **Date:** ……………..……………………

Information below to be completed by one of the named investigators:

I confirm that I have fully explained the purpose of the study and what is involved to:

Name:……………………………………………………………………

I have given the above named a copy of this form together with the information sheet.

Investigators Signature: ………………………………………………………………

Name: ……………………………………………………………………………………

Ethics Code: ……………………………………………………………………………

Study Number: ……………………………………………………………………………………

Registered Nurses

(Form to be printed on local headed paper)

CONSENT FORM

Final version 1.0: 27.8.2017

Title of Study: Nurse's experiences and understanding of violence against women in Saudi Arabia.

REC ref: ***(to be added after approval given)***

Name of Researcher: Kafi Alshammari

Name of Participant:

Please initial box

1. I confirm that I have read and understand the information sheet version number …………dated…………………………… for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐

3. I understand that relevant sections of data collected in the study may be looked at by responsible individuals from the University of Nottingham, the research group where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐

4. I understand that the interview will be audio recorded using a digital device and that anonymous direct quotes from the interview may be used in the study reports. ☐

5. I understand that information about me recorded during the study will be kept in a secure database. If data is transferred to others it will be made anonymous. Data will be kept for 7 years after the results of this study have been published and then destroyed. ☐

6. **Optional**: I understand that the information collected about me will be used to support other research in the future, and may be shared anonymously with other researchers. Any data used will be anonymised, and I will not be identified in any way. ☐

7. I voluntarily agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person taking consent (if different from Principal Investigator)	Date	Signature
Name of Principal Investigator	Date	Signature

2 copies: 1 for participant, 1 for the project notes.

This sheet should be stored separately from the consent form and other project documents.

STUDY NUMBER

Name: ....

Address:
....

Telephone number: ....

Optional: I agree to my contact details being stored for the purpose of being invited to participate in future research studies:

Signature: .... **Date:** ....

Information below to be completed by one of the named investigators:

I confirm that I have fully explained the purpose of the study and what is involved to:

Name:...

I have given the above named a copy of this form together with the information sheet.

Investigators Signature: ....

Name: ....

Ethics Code: ....

Study Number: ....

Appendix 15: Hermeneutic Phenomenology Methodology Courses and Symposium

HERMENEUTIC PHENOMENOLOGY METHODOLOGY COURSE

'To put oneself on a journey, to experience, means to learn'
(Heidegger 1971, p. 143).

(Monday 3rd–Wednesday 5th, April 2017)

AGENDA

Introduction

This course is aimed at post-graduate research students, researchers and academics who are new/novices in this theoretical and methodological approach. During the course, participants will receive an introduction to, and beginning experience in, designing hermeneutic phenomenology studies, collecting and analysing data, and reporting themes, qualities and patterns.

Learning outcomes

- Appreciation of the background into the philosophical underpinnings of hermeneutic phenomenology
- Gain insights into key philosophical notions described by key philosophers (Heidegger, Gadamer, etc.) and how these can be applied within health care and human science based research
- How to design and conduct hermeneutic phenomenology research
- How to collect data for hermeneutic phenomenology (e.g. interviews)
- How to analyse, interpret, and report data (theses/dissertations and publications) in a way that is congruent with this methodology

Timing and refreshments
The sessions will run from **9.30-4.30pm** each day and mid-morning/afternoon tea/coffee (not lunch) is provided.

Overview of focus/aims

Monday 3rd April, 2017 – ***Introductions and beginnings***

- Welcome and introductions
- What is hermeneutic phenomenology - how it has evolved/key influences
- Entering the mood and space of hermeneutic phenomenology
- Ontic and ontological differences
- Introducing key Heideggerian terms

- Notion of 'truth'
- Challenges and critique

Tuesday 4th April, 2017 – ***Reflexivity and engagement in the hermeneutic circle***

- Methodology and methods in hermeneutic phenomenology
- Fore-structures of understanding
- Explicating pre-understandings and biases
- Developing the research questions
- Research participants
- Reviewing the literature in a hermeneutic phenomenological study
- Achieving 'rigour'

Wednesday 5th April, 2017 – ***Crafting the stories to illuminate and draw forth***

- Working with the data – ways not works
- Coming into the clearing / making the interpretive leap
- Drawing on philosophical concepts to illuminate meanings
- Engaging with wider literature
- Practicalities and defending the approach

Delegate engagement

On each day a one-hour slot has been set aside (3.30pm-4.30pm) for you to present, and discuss your research, questions, interpretations (please see welcome letter for further information to book a slot)

HERMENEUTIC PHENOMENOLOGY SYMPOSIUM
THURSDAY 6TH APRIL, 2017

08.30 Arrival/registration

09.00 Welcome – Dr Gill Thomson/Professor Susan Crowther

09.10 **Dr Bridget Taylor – Sobell House Hospice, Oxford**
Using Heidegger's philosophy to understand experiences of sexuality and intimacy in life-limiting illness.

10.00 **Dr Lesley Kay – Kingston University and St. Georges University of London**
Engaging with the 'modern birth story' in pregnancy: everydayness, absorption and the 'idle talk' of birth.

10.50 Break - Tea/Coffee

11.10 **Dr Lesley Dibley - King's College, London**
Kinship stigma in inflammatory bowel disease (IBD): Challenges of enacting hermeneutic phenomenology.

12.00 **Dr Fiona Work – Robert Gordon University, Aberdeen**
Language of death: the significance of words.

12.50 Lunch (provided)

13.50 **Dr Maria Healy, - Queen's University Belfast**
Solicitude of postnatal care.

14.40 **Dr Karen Wright - University of Central Lancashire** *Using Merleau Ponty's existentials in a study on patients with eating disorders and their care workers*

15.30 Break - Tea/coffee

16.00 Panel discussion – hosted by Dr Gill Thomson/Professor Susan Crowther

17.00 Close

Appendix 16: Getting Great Data – Supporting Analysis in IPA

Thursday 6th of September, 2019

Getting Great Data – Supporting Analysis in IPA

Thursday 6th of September

University of Derby, Enterprise Centre, Bridge Street, Derby, DE1 3LD

9:30am-4:30pm

Agenda for the day

9:00am	Registration, tea and coffee
9:30am	Introductions
10:00am	Review of analysis stages
10:30am	Break
10:45am	Group analysis on student sets
12:30pm	Lunch and networking
1:30pm	Q&A
1:45pm	Individual sessions with facilitator and analysis discussions with peers
3:15pm	Break
3:30pm	Reflections from activity 2
4:00-4:30pm	Whole group Q&A

Appendix 17: Certificate of Course Completion – Supporting Victims of DVA

Certificate of Achievement

kafi Alshammari

has completed the following course:

SUPPORTING VICTIMS OF DOMESTIC VIOLENCE

THE UNIVERSITY OF SHEFFIELD

This course is designed to help practitioners who come into contact with victims of domestic violence and abuse to recognise the signs and symptoms of abuse and be able to provide them with effective support.

3 weeks, 3 hours per week

Dr Parveen Ali
Senior Lecturer in The School of Nursing & Midwifery
The University of Sheffield

Appendix 18: Research Budget

This study is self-funded.

Appendix 19: Generic Research/ Personal Development Training

Course name	Date	Credit hours
Researcher Information Skills for Medicine & Health Sciences	07 Dec 2016	1.0
CELE Consultation - David	15 Dec2016	0.0
CELE Consultation - David	24 Jan 2017	0.0
Research ethics and the ethics review process for doctoral research	07 Feb 2017	1.0
Microsoft Word: Creating and Managing Long Documents	16 Feb 2017	2.0
Further qualitative research	28 Feb 2017	2.0
Planning your research	03 March 2017	1.0
Writing an Impact Statement (Medicine and Health Sciences)	14 March 2017	0.0
Systematic Review: literature searching	23 March 2017	1.0
Poster session	29th March 2017	0.0
CELE Consultation - David	28 March 2017	0.0
Introduction to Endnote for Researchers	31 March 2017	1.0
Hermeneutic phenomenology methodology courses	4 April 2017	4 day
Preparing for your confirmation review	25 April 2017	0.0
Creative Problem Exploration in Research	11 May 2017	2.0
An introduction to Atlas.it qualitative data analysis software workshop	27.4.2017	1.00
Follow up to the introductory workshop on Atlas data analysis	16.May 2017	2.00
Masterclass – Systematic Reviews	28-29 Nov 2018	
Qualitative Systematic Reviews. This is running on **13th December 2018** between**11.30** to **13.30** at **The Medical School.**		
Masterclass – Systematic Reviews 1:0 Qualitative Systematic Reviews 1:0 Critical Appraisal of scientific literature 1 (non-clinical) 1:0 Writing Scientific Abstracts 1:0 Preparing for the viva 1:0		

PhD Lunch	Date
Orientation	29.9.2016
Doctoral lunch session (Getting started on writing: putting your literature review together	01.11.2016
Doctoral lunch session (Which epistemology? Can you justify your project and call it scientific)	15.11.2016
End note training	02.02.2017
Pebble pad training	02.02.2017
Learning community forum (LCF)	18.10.2018

Appendix 20: Conference Attendance

1. **HERMENEUTIC PHENOMENOLOGY METHODOLOGY SYMPOSIUM -** Held on 6TH 2017 at **UCLAN University.**
2. **How to create an effective academic poster.** Held on 5th of March 2017 at **university of Nottingham. Organized by Saudi society Club.**
3. **Saudi scientific forum in Nottingham. Organized by Saudi society Club.** Held on 25th of Feb 2017 **at university of Nottingham.** (Attended and organizer).
4. **Tropical medicine conference.** Held on 26th of Nov 2016 at **university of Nottingham.**
5. **BSP Annual Conference 2018 Annual Conference in the Theory and Practice of Phenomenology. Held at the University of Kent, Canterbury from July 23-25 2018.**
6. **The Getting Great data – Supporting Analysis in IPA workshop.** Held on 6th of September **2018 at The University of Derby.**

Appendix 21: Membership

- Active official member in Saudi Society in Nottingham University 2017
- Member in British Society for Phenomenology

Appendix 22: Publications

1- Alshammari, K., McGarry, J. and Higginbottom, G. (2018) Nurse education and understanding related to domestic violence and abuse against women: An integrative review of the literature. **Nursing Open** 5(3): 237-253. https://doi.org/10.1002/nop2.133

2- Alshammari, K. (2019). Oral presentation: Nurses' understanding of domestic violence and abuse (DVA) against women in Saudi Arabia. RCN International Nursing Research Conference and Exhibition 2019. Sheffield Hallam University

Ali, T. S., Krantz, G., Gul, R., Asad, N., Johansson, E., & Mogren, I. (2011). Gender roles and their influence on life prospects for women in urban Karachi, Pak0istan: a qualitative study. *Global health action, 4*(1), 7448.

Aljohani, K. A. S. (2020). Nursing education in Saudi Arabia: history and development. *Cureus, 12*(4).

Alluhidan, M., Tashkandi, N., Alblowi, F., Omer, T., Alghaith, T., Alghodaier, H., . . . Hamza, M. M. (2020). Challenges and policy opportunities in nursing in Saudi Arabia. *Human Resources for Health, 18*(1), 1-10.

Almadani, N. (2017). *The implications of nursing degree education for future workforce planning in Saudi Arabia: a case study.* University of Salford.

Dillon, G., Hussain, R., Loxton, D., & Rahman, S. (2013). Mental and physical health and intimate partner violence against women: A review of the literature. *International journal of family medicine, 2013*.

Karakurt, G., Smith, D., & Whiting, J. (2014). Impact of intimate partner violence on women's mental health. *Journal of family violence, 29*(7), 693-702.