A Cross-Cultural Comparative Study of Undergraduate Health Care Professional Students’ Knowledge, Definitions, Education, and Training Experience of Domestic Violence in Northern Ireland and Jordan

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Abstract

The purpose of this study was to examine the cross-cultural differences in the knowledge, definitions, and current training and educational experiences of domestic violence (DV) among third-year undergraduate nursing, dental, and medical students from two distinct universities in Northern Ireland and Jordan. A convenience sample of 774 undergraduate students was recruited. Analysis was based on gender, culture, and educational speciality, as seen through the integrated lens of a social ecological and feminist theory model. The results showed that a substantial percentage of all participants had never received any education or training on DV in their undergraduate programs. The majority of participants had good knowledge about DV, and half of the participants believed that DV is “common” in their respective countries. Significant gender and cultural differences in the definition of DV were also revealed, with Northern Irish students and female students in both cultures more likely to regard a range of behaviors as a form of DV. The research findings suggest several potential directions for change, emphasizing the importance of establishing a systematic evidence-based multidisciplinary and interagency approach to teaching and learning for student health care professionals on the topic of DV in their undergraduate programs.

Keywords
domestic violence, health care professional, knowledge, education and training, definition, culture, gender

Introduction

Violence against women (VAW) is a significant global health and social problem affecting all societies, but often it goes unrecognized and unreported and in many countries, it is still accepted as part of normal behavior (Gracia, 2004; World Health Organization [WHO], 2005). Even though domestic violence (DV) is now recognized as a major public health concern, many health and social care professionals have been slow to respond to address the issue. Evidence suggests that health and social care professionals, who are equipped with the relevant knowledge and skills, can play a key role in the development of strategies and resources to combat DV (Feder, Hutson, Ramsay, & Taket, 2006). However, research illustrates that primary health care professionals are uncovering abuse, such as DV, at much lower rates than that being reflected by the prevalence estimates reported in the literature (Kahan et al., 2000; Rabin et al., 2000). These low detection rates have been attributed to inappropriate attitudes of primary health care professionals toward victims of violence and abuse, together with a general lack of information and training regarding DV (Peckover, 2003).

Literature Review

One of the most common and dangerous forms of violence is DV, or domestic abuse. DV is a serious health problem that is common to all societies and is linked to immediate and longer term health, social, and economic consequences (Goodwin, Hoven, Murison, & Hotopf, 2003; Krug, Dahlberg, & Mercy, 2002). A lack of reliable statistical data (Johnson, Haider, Ellis, Hay, & Lindow, 2003; Richardson et al., 2002) and the variance in definition of this violence and abuse make it difficult to estimate the true extent of the problem (Marchant, Davidson, Garcia, & Parsons, 2001). It is often hidden, secret, and undisclosed as well as a primary cause of gender-specific inequalities (Lazenbatt, Thompson-
Cree, & McMurry, 2005), which in turn can form significant barriers to women receiving effective and equal health care (WHO, 2000). DV may be a combination of physical, sexual, emotional, or psychological abuse, resulting in various health consequences ranging from physical injury to death. Most consequences can lead to an increased use of medical services and resources (Brokaw et al., 2002; Jewkes, 2002). The ongoing underidentification and lack of understanding about DV call for a closer look at undergraduate primary health care professionals’ knowledge, education, and training needs to deal with this serious public health issue.

**Definitions and Terminology**

Discussion of DV in general, and in specific contexts in particular, calls for a thorough examination of the meaning, attributed to the term violence (Winstok, 2007). There is little consensus among researchers on exactly how to define the terms violence and abuse. However, these terms are used differently, by different disciplines, and also by lay persons (Walker, 1999; Winstok, 2007).

The terms violence against women and gender-based violence are used in this article and both stem from the following definition as provided by Article 1 of the UN Declaration on the Elimination of Violence Against Women (DEVW, 1993), which defines the term violence against women as:

“Any act of gender-based violence that results in, or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.”

There is a significant discrepancy among different cultural definitions of what constitutes “DV” (Sokoloff & Dupont, 2005); there appears to be no universally accepted definition of DV as definitions used internationally and nationally can vary substantially (Bradley, Smith, Long, & O’Dowd, 2002; Verhoeck-Ofstedahl, Pearlman, & Coutu Babcock, 2000; WHO, 2002). The collective understanding of the behaviors that are associated with DV and the driving forces underlying those behaviors reflect considerable variation across cultures (Malley-Morrison, 2004). Cross-cultural investigations of DV are urged to carefully consider the language used, as it may be inadequate to allow for a full exploration of the relevant issues around DV (Fernández, 2006).

For the purpose of the study, “DV” is defined as:

“any violence against women which includes not just physical, but verbal, psychological, emotional, economic, and sexual patterns of behaviors, by their male partners, whose aim is to control, threaten, isolate, and/or exploit women.”

**Integrated Social Ecological and Feminist Theory**

Two interlinking theoretical frameworks—the social ecological theory and the feminist theory—are adopted in this study to explain the approach of primary health care professionals toward DV (see Figure 1). The social ecological theory conceptualizes DV as a multifaceted phenomenon grounded in interplay, between individual, family, community, and societal factors, and is best visualized as concentric circles (Bronfenbrenner, 1979; Heise, 1998). Feminist theory, on the other hand, attributes women abuse to the fundamental issues of unequally distributed power and culturally based gender relational patterns and patriarchal social patterns (Dobash & Dobash, 1979; Smith, 1990).

This approach is helpful in explaining the differences between the modernized societies such in the United Kingdom and Northern Ireland (NI), and more traditional Arab and Jordan societies, in which these cultures have different social, cultural, legal, and political structures.

Recently, there has been an overall international trend toward a more unified theoretical perspective, leaning heavily on an integrated feminist understanding of the social construction and dynamics of power relations (Muhlbauer, 2006). Feminist scholars believe that the patriarchal nature...
of society, through its emphasis on traditional gender role socialization, plays an important role in the prevalence of DV (Smith, 1990). In this sense, feminist theory does not limit causes of DV to psychological and microsociological factors but considers society’s explicit and implicit rules that legitimize violence under certain circumstances (Abraham, 1995). Accordingly, men’s power, domination, and privileges over women inherent in any society are considered as a cause of domestic abuse. Hence, ending this abuse would require a basic restructuring of the nature of the power relations between men and women in society (Dutton, 1998).

The importance of an integrated social ecological model and feminist theory is that “it views behaviour as being affected by, and affecting the social environment” (McLeroy, Bibeau, Steckler, & Glanz, 1998). For primary health care professionals, this view is important because it provides an opportunity to design a range of health promotion strategies targeting multiple levels within the social environment. The holistic view of behavior, proposed by integrating a social ecological model with feminist theory, permits primary health care professionals to focus their attention to different types of social influences and power dynamics, for which they can develop appropriate interventions to modify health-related behaviors (Little & Kantor, 2002).

Prevalence and Incidence

Worldwide, 1 in every 3 women suffers from DV, has been beaten, coerced into sex, or otherwise been abused in her lifetime (Heise & Garcia-Moreno, 2002; WHO, 2002). In the United Kingdom, the British Crime Survey (2004/2005) indicated that 1 in 20 women have experienced one or more incidents of partner abuse in the last year (Walby & Allen, 2004). In NI, 1 in 5 women have experienced DV (Department of Health, Social Services and Public Safety, 2005).

In Arab countries, many forms of VAW exist and are perpetuated by the deep-rooted sociocultural factors. In Jordan, although there are no studies on the rates of DV, the National Institute of Forensic Medicine states that around 750 women per year visit a forensic medical clinic in Amman, after suffering DV (Amnesty International Jordan, 2004). However, it is estimated that the actual number of victims could be 10 times higher. Worryingly, less than 10% of abused women are identified by professionals within health care settings (Council of Europe, 2002; Mirrlees-Black & Byron, 1999).

Primary Health Care Professional Approaches to DV

The health care system is often the first place outside of friends and family to which victims of domestic abuse turn, thus placing health care professionals in a central role of assistance and support (Ramsay, Richardson, Carter, Davidson, & Feder, 2002; Wathen & MacMillan, 2003). Yet, most primary health care professionals, including nurses, dentists, and doctors, have traditionally received little professional preparation on how to intervene and support women living with DV (Bacchus, Mezey, & Bewley, 2003; Hägglom, Hallberg, & Möller, 2005). These professionals have also received limited education or training in this area during their undergraduate training, or continuing professional development (Lazenbatt et al., 2005). Therefore, core competencies in screening, recognizing, and treating the short- and long-term manifestations of domestic abuse are increasingly expected as the standard for health care professionals. However, to assess and intervene appropriately, primary health care professionals must have current evidence-based knowledge about DV, including communication skills, and attitudes necessary to ask enquiring questions; the ability to offer appropriate information for intervention and referral; and to make referrals to support networks and community resources (Paluzzi & Houde-Quimby, 1996).

Although the evidence base is rapidly expanding on protocols for the identification and management of women suffering from DV, there is no published work on the identification of undergraduate university students’ knowledge, definitions, and education and training regarding domestic abuse, particularly those from a primary health care background (Sugg, Thompson, Thompson, Maiuro, & Rivara, 1999; Thompson et al., 2000). There is also some evidence to suggest that these undergraduate primary health care students do not receive enough educational training about DV (Naumann, Langford, Torres, Campbell, & Glass, 1999), within the higher education curriculum, to allow them to recognize and deal with domestic abuse in their future professional practice. For these students to enter their professional practice feeling confident that they have an important role in the supportive treatment for DV, they need to receive comprehensive, integrated, multidisciplinary education during their university undergraduate programs.

A need exists to build up the international evidence base surrounding university primary health care professional students’ knowledge, education, and training experiences. Investigating the training experiences of undergraduate health care students from NI and Jordan will enable the development of a culturally sensitive program. This will allow the development of health professionals who will be able to adopt a knowledgeable, evidence-based, and realistic manner with regard to the management of women who have experienced DV across countries that are diverse in terms of culture, economics, and sociopolitical development.

Method

Design

A cross-sectional, comparative survey design is used to provide evidence of differences in terms of culture, gender, and their educational speciality.
Sample. A convenience sample consisting of 774 students (NI = 322, Jordan = 452) with response rate of approximately 80% completed the questionnaire. In all, 63% (n = 484) were nursing, 15% (n = 112) dental, and 23% (n = 178) medical students. The age of the participants ranged from 18 to 45 years. In all, 64% (n = 493) of the participants were female; and 87% were single, 8% married, and 4% were divorced, widowed, or cohabiting at the time of the study. With regard to the religious affiliation, 58% of the participants were Muslims, and the remaining 38% were Christians. The majority of the participants were Jordanian (84%) for the Jordan sample and White (98%) for the NI sample (Table 1). Both cultural groupings (NI and Jordan) were surveyed in large classes; however, neither of these groups is expected to be representative of the population at large nor of students as a whole.

Instrument

A self-administered questionnaire “Students’ Knowledge and Attitudes of Violence and Abuse Scale” developed and based on the following items was used to measure the different variables of the study.

Demographic variables. This includes questions on the sample demographic data, such as age, gender, religion, ethnicity, marital status, place of residence, university, and school attended.

Students’ definition of DV. This section included one question utilizing a checklist, describing the various evidence-based behaviors indicated as examples of DV. Participants were asked to tick the behaviors that they felt indicated DV or abuse.

Students’ training and educational experience of DV. This section consisted of five questions designed by the researcher to measure the participants’ previous education and training with respect to DV against women. First, students were asked four questions: “whether they had attended any courses/seminars that had addressed DV within their undergraduate program,” “whether these were part of their undergraduate program,” “whether they had attended any courses/seminars that had addressed DV outside the university,” and “whether they had listened and/or watched media coverage program,” using “yes/no” as answers. Second, the students were asked to identify the extent of DV material being taught in their current curricula, using a rating scale format of “a great deal,” “occasional mention,” “very little if any,” “unsure,” and “not at all.”

Students’ attitudes toward primary health care professionals needs for education and training on DV. This section consisted of a 4-item scale, designed to assess participants’ attitudes toward the need for education and training of primary health care professionals in their undergraduate program. Responses to these items were based on a 4-point Likert-type scale (from 1 = strongly agree to 4 = strongly disagree).

Students’ knowledge of DV. This section included two parts: The first consisted of 12 questions developed by the researcher, and based on the evidence-based literature, to assess students’ knowledge of DV. The questions were focused on the impact of the DV on women’s physical, psychological, and reproductive health status; the common cited risk factors; and the impact of DV on children’s physical and emotional health. Responses to these questions were based on true/false/don’t know format. The second part included one question to assess participants’ knowledge of the prevalence and the extent of DV in their home country, using a rating format of “very common,” “common,” “rare,” “very rare,” and “don’t know.”

Translation and piloting of the questionnaire. The questionnaire was first constructed in English and used in its original form for data collection in NI. After the English version was developed, checked, and revised, it was translated into the Arabic language and used for data collection in Jordan. The questionnaire was pilot tested on undergraduate primary health care professional students in NI and Jordan and, on the basis of the pilot test, the wording of the questionnaire was revised to enhance readability and content validity.

Table 1. Demographic Characteristics of the Sample

| Variables                      | Category | NI (n = 322) | Jordan (n = 452) | Total (N = 774) |
|--------------------------------|----------|--------------|-----------------|-----------------|
|                                |          | n (%)        | n (%)           | n (%)           |
| Gender                         | Male     | 44 (13.7)    | 237 (52.4)      | 281 (36.3)      |
|                                | Female   | 278 (86.3)   | 215 (47.6)      | 493 (63.7)      |
| Age group                      | 18-24    | 217 (67.4)   | 427 (94.5)      | 644 (83.2)      |
|                                | 25-34    | 73 (22.7)    | 23 (5)          | 96 (12.4)       |
|                                | 35-45    | 32 (9.9)     | 2 (0.4)         | 34 (4.4)        |
| Educational speciality         | Nursing  | 251 (78)     | 233 (51.5)      | 484 (62.5)      |
|                                | Dental   | 37 (11.5)    | 75 (16.6)       | 112 (14.5)      |
|                                | Medical  | 34 (10.6)    | 144 (31.9)      | 178 (23)        |

Note: NI = Northern Ireland; n = number of participants; (%) = percentage of participants.
Table 2. Differences in the Definition of Domestic Violence Between Culture and Gender

| Behavior               | NI (n = 322) | Jordan (n = 452) |
|------------------------|--------------|------------------|
|                        | Male (n = 44) | Female (n = 278) | Significant chi-square | Male (n = 237) | Female (n = 215) | Significant chi-square |
| Verbal abuse           | 84%          | 97%              | $\chi^2 = 12.9, df = 1, p = .001^*$ | 73%          | 87%              | $\chi^2 = 13.2, df = 1, p = .001^*$ |
| Physical abuse         | 100%         | 99%              | $\chi^2 = 0.319, df = 1, p = 1$ | 86%          | 91%              | $\chi^2 = 3.3, df = 1, p = .07$   |
| Emotional abuse        | 93%          | 98%              | $\chi^2 = 3.9, df = 1, p = .08$ | 84%          | 91%              | $\chi^2 = 4, df = 1, p = .048^*$  |
| Sexual abuse           | 91%          | 94%              | $\chi^2 = 0.55, df = 1, p = .45$ | 65%          | 74%              | $\chi^2 = 3.8, df = 1, p = .052$  |
| Financial abuse        | 71%          | 84%              | $\chi^2 = 4.5, df = 1, p = .032^*$ | 52%          | 64%              | $\chi^2 = 6, df = 1, p = .01^*$   |
| Intimidation           | 91%          | 95%              | $\chi^2 = 0.93, df = 1, p = .30$ | 55%          | 66%              | $\chi^2 = 4.9, df = 1, p = .02^*$ |
| Threatening behaviors  | 96%          | 97%              | $\chi^2 = 0.19, df = 1, p = .65$ | 64%          | 70%              | $\chi^2 = 2.1, df = 1, p = .16$   |
| Controlling behaviors  | 82%          | 97%              | $\chi^2 = 16.9, df = 1, p = .001^*$ | 58%          | 70%              | $\chi^2 = 6, df = 1, p = .01^*$   |

Note: NI = Northern Ireland.

*p < .05.

Data Collection

Data were obtained by a means of the self-administered questionnaire as it allows complete respondent anonymity. The researcher distributed the research materials, including the questionnaires, consent forms, information sheets, and other informational pamphlets to the student cohort. Upon their arrival at class, the students were informed that participation in all parts of the study was voluntary and that they could discontinue their participation at any time, without penalty. The students were provided with information packs within sealed envelopes that included contact numbers, self-help groups, anonymous phone lines, and addresses of local psychological support services or crisis centers for anyone who may be exposed to DV.

Ethical Considerations

Prior to the onset of the proposed study, ethical approval was sought from the Office of Research Ethics Committee of Northern Ireland (NI-OREC) to pursue the current research in NI. In Jordan, approval was sought by the researcher who approached each faculty before conducting the study. Participants in this study were treated according to the standard of ethics committee for conducting research.

Data Analysis

Data from each questionnaire was coded and entered into a database. Statistical analysis was carried out using SPSS for Windows 14.0 version software package, and included descriptive, chi-square tests, $t$ tests, and two-way ANOVA.

Results

Primary Health Care Students’ Definitions of DV

Significant differences were found between the two cultural groups when asked to define DV. Table 2 shows the percentage of respondents for each culture and gender who indicated that the illustrated behaviors indicated an example of DV. For all behaviors listed, there were significant differences between the two groups. Students in NI were more likely than Jordanian students to label DV with all the listed behaviors. For the most part, there were significant differences between females and males in each culture. An important difference between genders is that female students in NI were significantly more likely than male students to view verbal abuse, financial abuse, and controlling behavior as a form of DV. In Jordan, female students were significantly more likely than male students to view verbal abuse, emotional abuse, financial abuse, intimidation, and controlling behavior as a form of DV.

Educational and Training Experience

Eighty-nine percent of all participants ($n = 692$) reported that they had not attended lectures or seminars related to DV at university. Only 11% of all participants ($n = 82$) stated that they had attended lectures or seminars at university, and of those respondents, only 7% ($n = 55$) indicated that these lectures were part of their undergraduate program. Although, 85% of all participants ($n = 658$) never attended lectures or seminars outside of the university, 88% of them had watched or listened to media coverage program about the topic of DV. There were significant differences observed among students who had attended lectures outside of their university. This reflects the fact that Jordanian students were more likely than NI students to attend lectures or seminars outside the university as illustrated in Table 3.

Significant differences were also revealed among students who reported attending lectures at university as a part of their undergraduate program, $\chi^2 = 15.05, df = 1, p = .001$, lectures attended by NI students ($9%, n = 28/30$) were more likely to be part of their undergraduate program than by students in Jordan ($6%, n = 27/52$). With regard to educational specialties, the results showed that nursing students were more likely than medical or dental students to attend lectures...
at university, $\chi^2 = 24.8, df = 2, p < .05$, and for these to be part of their undergraduate program, $\chi^2 = 25.68, df = 4, p < .05$. Moreover, nursing students showed greater exposure to the topic of DV through media programs rather than medical students or dental students, $\chi^2 = 13.52, df = 2, p = .001$. When the students were asked about the extent of DV being taught in their undergraduate education programs, 44% of all the participants reported “very little if any,” 40% “not at all,” and 20% “occasional mentions,” and only 3% of all participants reported “a great deal.” Significant differences were observed between the two samples, $\chi^2 = 15.47, df = 3, p = .001$, with NI students reporting “very little if any” more frequently than students in Jordan as shown in Figure 2.

**Primary health care professionals’ attitudes to the need for education and training on DV.** Almost all participants showed favorable attitudes toward the need of primary health care professionals for education and training on DV within their undergraduate programs ($M = 7.12, SD = 2.07$). Ninety-four percent of the students strongly agreed, or agreed, with the statement that “primary health care professionals need education on the topic of DV,” 85% strongly agreed that “DV against women as a topic should be integrated into nursing, dental, and medical undergraduate programs,” and 94% strongly agreed with the statements that “training on recognition of DV should be included in undergraduate programs” and “training on the management of DV should be included in undergraduate programs” (see Table 4).

Among students in Jordan, two-way ANOVA revealed only significant main effect for the educational specialty, $F(2, 444) = 5.05, p = .003$. Post hoc tests revealed that nursing students differed significantly from medical students. This indicated that medical students had more favorable attitudes ($M = 6.2$) than nursing students ($M = 6.95$). All other group comparisons did not reach statistical significance.

**Primary health care students’ knowledge of DV.** With respect to the knowledge that students had on the topic of DV, on average, all students demonstrated a good knowledge ($M = 8.73, SD = 2.14$). The results showed that 75% had answered 10 out of 12 questions correctly, and half of the participants (50%) answered at least 9 questions correctly. More specifically, 73% of all participants believed that DV at home causes more physical injury to women than violence by strangers, with 82% believing that women evaluate emotional abuse as worse than physical abuse. With regard to the question “when is DV against women likely to stop,” 60% of all participants believed that DV is unlikely to stop during pregnancy and postnatally, and 53% believed that it is unlikely to stop even after the woman leaves her abusive husband. Furthermore, 93% and 83% of all participants believed that alcohol and substance abuse, and long-term unemployment, respectively, were used as an excuse for DV. Moreover, 87% of all participants believed that psychological stress was often used as an excuse for DV.

Moreover, there were significant differences revealed between genders in NI ($t = −2.13, df = 320, p = .033$) and in Jordan ($t = −4.37, df = 450, p < .05$). The results showed that female students in both cultures had greater knowledge of the topic of DV than their male counterparts (see Table 5). However, there were no significant differences in the knowledge between genders across cultures. In relation to educational specialty, the only significant differences were
found among dental students ($t = -2.52$, $df = 110$, $p = .013$). Dental students in Jordan had significantly higher scores in knowledge than dental students in NI.

The two-way ANOVA test revealed a significant main effect of speciality, $F(2, 314) = 3.44$, $p = .03$, of students’ knowledge among the NI cohort. As the post hoc tests revealed, nursing students ($M = 8.18$) had higher scores in knowledge than dental students ($M = 7.68$).

Among students in Jordan, the results revealed significant main effects of gender, $F(1, 444) = 17.43$, $p < .05$, and educational specialty, $F(2, 444) = 3.06$, $p = .04$, on students’ knowledge. The results indicate that female students ($M = 8.67$) had higher scores in knowledge than male students ($M = 7.68$). In relation to educational specialty, post hoc tests revealed that nursing students ($M = 8.5$) differed significantly from medical students ($M = 8.0$), demonstrating that medical students had lower scores in knowledge than nursing students.

**Primary health care students’ knowledge of prevalence of DV.**

Of all participants, 49% ($n = 379$) reported that the prevalence of DV in their respective countries is “common,” 25% “very common,” 12% “rare,” and only 6% stated “don’t know” as illustrated in Table 6. Significant differences were observed between the two samples, $\chi^2 = 21.63$, $df = 5$, $p = .001$, with female students more likely than male students to report the prevalence as “common.” Moreover, medical students (38%) in both cultures were more likely than nursing students (19%) to report the prevalence as “very common”; however, dental students (31%) were less likely than medical students to report “very common.”

**Discussion**

This study explained the undergraduate health care professionals’ approaches to DV and abuse through the lens of the social ecological model and feminist theory. In this study, students’ definitions of DV, their knowledge about the severity, prevalence of DV, and their training and educational experiences were tested.

From the social ecological perspective of health care professionals’ approach to DV, numerous studies have shown that the disposition of health care professionals involved in assessment and identification of abused women is largely influenced by their definition of the problem (Gerbert et al., 2002; Sugg et al., 1999). Moreover, the cultural differences in the definition of DV revealed by this study are consistent with the results of previous studies which have shown that
cultural orientation and values shape the definition of DV (Kim & Motsei, 2002; Torres, 1991). Torres (1991) concluded that Mexican women’s definitions of DV were strongly shaped by Hispanic cultural beliefs about the roles of men and women in their society. Likewise, the female and male students in Jordan defined DV to reflect their patriarchal beliefs about women and VAW.

Although this study shows that the student health care professionals’ definition of DV reflected their considerable awareness of the problem and of various patterns of VAW, their responses also included indications that they are not always willing to consider acts of violence as DV. Overall, the vast majority of the participants in NI and Jordan defined many of the behaviors as DV; however, as physical and sexual violence were likely to be viewed as DV, verbal abuse, psychological/emotional, financial abuse, intimidation, and controlling behaviors were less likely to be perceived as DV particularly by male participants.

In this study, female students in both cultures had clearer and broader definitions of DV and were more likely than male students to include a range of behavior as a form of DV. Consistent with the findings of this study, a study among male and female nurses (Kim & Motsei, 2002) found that, unlike the males, females frequently described DV in terms of emotional or psychological abuse, and economic abuse was also only raised by women.

In this study, findings indicate that very few of all respondents think DV is uncommon; in fact, it is somewhat surprising to find that health care professionals’ students are as aware of the prevalence of DV as they are, which is inconsistent with other research that has shown that health care professionals often underestimate the rate of DV in their populations (Lazenbatt et al., 2005; Rabin et al., 2000).

### Table 6. Differences in Reporting Prevalence of Domestic Violence Across Cultures and Gender

| Variable | NI (n = 322) | Jordan (n = 452) | Total N = 774 (%) |
|----------|--------------|-----------------|------------------|
|          | Gender Male (n = 44) | Female (n = 278) | Male (n = 237) | Female (n = 215) | |
| Common   | 41%          | 53%             | 44%             | 51%             | 49 |
| Very common | 13.6%       | 16%             | 31%             | 33.5%           | 25.2 |
| Rare     | 20.5%        | 15%             | 9%              | 10%             | 12 |
| Unsure   | 9%           | 7.6%            | 7.2%            | 6%              | 7 |
| Don’t know | 16%          | 7%              | 8.4%            | 0%              | 6 |

Note: NI = Northern Ireland.

### Conclusion

Student health care professionals are ideally placed to recognize and detect ongoing DV, and to offer care, support, and information to the woman involved. The greatest limitation inherent in this study is the inclusion of primarily
third-year undergraduate health care professionals’ students. This aspect of the study is likely to result in a limited generalizability to the general population and to undergraduate students in particular. Therefore, it will be necessary for future studies to include more diversity relative to age, ethnicity, educational level, religious background, and population setting.

This study suggests that student health care professionals need to learn a more comprehensive global operational definition of DV and abuse (e.g., physical violence, sexual assault, emotional/psychological violence, and economic abuse). It appears that a more uniform and universal definition of DV must be derived to allow for overall comparison between studies and to allow multiprofessionals to view DV from the same perspective. This study supports the need for student undergraduate health professionals to receive significant training and education on VAW in their university training and educational program. In addition, regular continual professional development updates should be available for all health care professionals. By this, the present research study recommends that student health care professionals should be empowered with a joined up approach that includes an understanding of evidence-based research in the area, clear knowledge of support agencies, and interagency networks and refuges to allow them to give ongoing and appropriate information that will in itself empower and support women to make their own informed choices.

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