

ABUSED WOMEN'S SHELTER AS A CLINICAL LEARNING SETTING

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ABSTRACT

Background: Family violence is one of the major public health problems in South Africa and worldwide (WHO 2002). However, it is not yet viewed as an important curricular topic in nursing education to warrant dedicated clinical teaching and learning. Where it is addressed in the curriculum, it is usually at theoretical level, with few or no opportunities for clinical learning experiences.

Objectives: This descriptive qualitative case study was conducted to describe how family violence was integrated into the undergraduate nursing curriculum by using a shelter as a clinical learning setting.

Methods: Participant observation, document review and interviews were used as data collection methods. The following themes were identified from data analysis: commitment to partnerships between the nursing school and the shelter, commitment to service learning, provision of a conducive climate for learning, enabling students to learn how to deal with role conflict, sharing of students' personal experiences of intimate partner violence or family violence, learning to deal with prejudicial attitudes and refraining from blaming battered women.

Results: The findings were organised into the following two major themes:

- Those related to the clinical learning experiences gained by the undergraduate student nurses at the shelter for abused women, such as: learning to deal with role conflict, learning through sharing of their own personal experiences of intimate partner violence or family violence, learning to deal with prejudicial attitudes and learning to refrain from blaming battered women for their circumstances.
- Those related to the nature of the partnership between the shelter as a clinical learning setting and the university, such as: commitment to partnerships between school and shelter, commitment to service learning and the creation of a climate conducive to learning.

Conclusions: The findings of this study highlighted the usefulness of the shelter for battered women as a clinical learning setting for students to learn about nursing interventions related to *family violence*.

Keywords: case study, clinical learning, family violence, nursing education, public health, shelter for abused women.

INTRODUCTION

For nursing education to be relevant to the public health problems of the 21st century, it is imperative for nurse educators to be familiar with current public health problems facing their country. This calls for innovative curricular changes of undergraduate and postgraduate education programmes to produce nurses who are responsive to such problems while ensuring that the curriculum is not overloaded.

This article presents the findings of a study that was conducted to explore and describe the clinical learning experiences gained by undergraduates at an abused women's shelter, and the nature of the partnership between the university and the shelter in terms of providing a clinical learning setting learning opportunities for students.

Literature review

According to Alpert, Shannon, Velonis, Georges and Rich (2002:746), family violence includes intimate partner violence, child abuse and neglect as well as abuse of the elderly and people with developmental disabilities within families. Intimate partner violence (IPV), on the other hand, is defined as a pattern of violence where one partner (usually a man) in an intimate relationship controls the other (usually a woman) through force, intimidation or threats of violence such as physical, emotional and/ or sexual assault. Additional abusive and violent behaviours that often accompany intimate partner violence and woman abuse include psychological coercion, degradation, financial deprivation and the refusal to use condoms or contraception (Campbell 2002:1331).

Nurses and midwives are in the forefront of primary health care services where victims of family violence or abused women present with their health care needs. Yet, research demonstrates that nursing interventions or health management interventions with the victims of intimate partner violence are consistently inadequate (Campbell, Smith-McKenna, Torres, Sheridan & Landenburger cited in Campbell & Humphreys 1993: 248). A general observation is that family violence, as a newly described public health problem, is not viewed as an important curriculum topic in nursing education. Therefore it has not received dedicated clinical teaching and learning status equivalent to other common public health problems. If it is addressed in the curriculum, it is usually offered theoretically, with limited or no clinical application in clinical learning settings.

The literature also points to a lack of expertise on family violence among nurse educators, and a shortage of competent health professionals able to provide a health service

for survivors of family violence. These observations imply that there might be no role models for students in common clinical settings such as hospitals and clinics. Cohen, De Vos & Newberger (1997: 72) stated that these are compounding factors in the clinical teaching of family violence interventions.

Alternate settings, such as shelters for abused women and other community-based settings, have been identified as ideal clinical learning settings where students can learn about women's and children's health, health promotion and nursing interventions with women who are residents in the shelter following incidents of intimate partner violence (Ryan and King 1998:36–41).

There has been some response to the epidemic of family violence in some of the developed countries in the past decade. For instance, experts on family violence from the fields of nursing, medicine and dentistry met at a conference in Oklahoma in 1994 (Brandt 1997:S51-S58). A set of curriculum principles for health professionals' education about family violence was developed at that conference. These included identification of specific goals in knowledge, skills and practices that should be taught to all health professionals. It was proposed that a family violence component be integrated into existing courses and clinical experiences such as mental health, primary health care, community health, emergency care and maternal, child and elderly health. With regard to experiential learning, it was recommended that students spend time in clinical settings to acquire firsthand comprehensive experience of victims of family violence and all their problems. This was intended to prevent them from acquiring distancing attitudes that inhibit effective intervention. Specific settings that were recommended for clinical learning were shelters for abused women, hotlines, police stations and courts of law (Brandt 1997:S51–S58).

The current shift towards the community-based and primary health care approach in nursing education is a driving force for the increased utilisation of alternative communities for learning purposes. While family violence is a common occurrence in South African families, it is not always safe and feasible for students to learn about family violence nursing interventions in affected families within the community. It is crucial that safe, relevant and appropriate clinical settings be identified where students can learn from multidisciplinary professionals. Shelters for abused women promise to be an ideal clinical learning setting for students to learn about family violence interventions. It was recognised that the identification of and participation in programmes that already use shelters as part of their clinical learning programme was a strategy that could be adopted and adapted in South Africa.

Background to the study

A South African nurse educator who was registered as an international graduate student at Johns Hopkins University School of Nursing, majoring in family violence as a public

health issue and forensic nursing in gender-based violence, first outlined a curriculum that focused on family violence interventions. The family violence course required students to identify a family violence intervention strategy that could be adopted by and adapted to their own area of work. Students were allowed to participate in ongoing family violence intervention programmes that already existed at their school after submission of a full proposal to the course convenor.

Problem statement

The decision to study the shelter as a clinical teaching and learning site was influenced by the following observations:

- In South Africa, family violence is not yet a curriculum topic in nursing education.
- There is a lack of nurse educators with expertise in family violence.
- There is a lack of competent health professionals to provide service to victims and survivors of family violence, and therefore no role models for students and newly qualified nurses in this field.

In her capacity as a postgraduate student in a family violence clinical learning programme, the researcher chose to conduct the study at shelter for abused women in Baltimore, Maryland, in the United States of America.

The purpose of the study

The study was undertaken to identify and describe a family violence programme that could be adopted and adapted to South Africa.

The objectives

The objectives of the study were:

- to explore and describe the clinical learning experiences gained by undergraduate student nurses at the shelter for abused women
- to explore and describe the nature of the partnership between the shelter as a clinical learning setting and the university with regard to learning opportunities for student nurses.

The intention was to utilise the study findings to influence curricular changes that would integrate a family violence component into the undergraduate nursing programme in South Africa.

Research methods

A descriptive qualitative case study that utilised participant observation, document review and interviews as methods of data collection during February to May 2003 was used. A case study approach was selected because, according to Bowling (1997:359), it is a method that focuses on circumstances, dynamics and the complexity of a case. Its aim is to understand the selected case. It is also a common method used by nursing researchers when they need more knowledge about a particular case (Holloway & Wheeler 2002:221). A case study approach was selected because the researcher wanted to gain a holistic overview of the context under study, namely the learning that occurs during clinical placement in a shelter for abused women, its arrangement and its explicit and implicit rules (Miles and Huberman 1994:6).

The setting

The setting was a specific shelter for battered women in Maryland, USA. This is a comprehensive residential programme for women and children who are victims of family violence. The Johns Hopkins School of Nursing provides the clinical nursing services at the health clinic located within the shelter. In return, the school then utilises the shelter as a clinical setting for undergraduate student nurses. Nursing services rendered included health assessments, health care and referrals. The clinic was run by two registered nurses employed by the university. Students were allocated to the shelter with along with a nurse educator twice a week for a period of seven weeks.

Population

The population for the study comprised all the students in the community health nursing class of the undergraduate nursing programme, and their teacher. Students were divided into six small groups of eight. Each group was assigned to a different community learning site based on their selected elective module. The group that selected family violence as a public health issue were placed at the shelter for abused women. Others could select other elective modules such as forensic nursing within their community health nursing year.

Sampling

Purposive sampling was used to select one group of eight students who had selected family violence as their elective module. The nurse educator assigned for clinical accompaniment to the shelter was also included in the sample as a key informant.

Ethical considerations

Permission to conduct the study was granted by the Dean of the School of Nursing, the

programme convenor of the family violence modules and the director of the shelter after the presentation of the proposal. The status of the researcher as an international student was known to the students and they were informed about her intentions to learn from them as part of her research project. They all verbally consented to share the content of their reflective learning journals and to discuss their learning experiences with her. The proposal was presented to the nurse educator assigned to the shelter. She verbally consented to participate in the study, to assist the student as a clinical mentor and to oversee the research process.

Data collection methods

Participant observation was selected as the best method because it allows the researcher to stay close to the natural profile of the community being studied. It also allows the researcher extended contact with the community for day-to-day events, including unusual events; direct or indirect participation in local activities, where care is taken to describe local peculiarities; and the researcher is able to focus on individuals' perspectives and interpretations of their "worlds" (Miles & Huberman 1994:8).

Other data collection methods included the grand tour interviews and document reviews. These were carried out at different stages during the research process as discussed in the following section.

Grand tour interviews

The grand tour interviews were done at the end of February 2003 so the researcher could familiarise herself with the shelter before the actual data collection with the students commenced. The grand tour interviews were used to construct a map of the shelter and to elicit a broad picture of the participants. According to Fetterman (1989:51), the grand tour interview or questions provide an overview of the physical setting, universe of activities, and help the researcher to focus on and direct the investigation to meet the research objectives.

The grand tour interviews were conducted in two phases. Phase 1 was conducted with the key informant, who was a nurse educator responsible for the accompaniment of students in the shelter. This took the form of an informal interview with semi-structured questions using conversational interviewing and dialogue techniques. This approach was intended to encourage the informant to express her views on the use of the shelter as a clinical learning setting, teaching and learning objectives for such a clinical placement and methods used to encourage students to learn in the shelter. This approach was first patterned by Moustakas as cited in Smith (1997:402). Her responses to questions were handwritten as field notes immediately after the interview. This was done because, according to Burns and Grove (1993:355), the interviewee may have difficulty responding if note taking is obvious during the interview process.

Phase 2 was conducted with the director and case managers at the shelter for abused women. The same method of semi-structured interviews and note taking was used. The grand tour included an orientation to the shelter and all its facilities that are used by residents, staff and students for clinical learning purposes.

Participant observation

This was done from March to April 2003. Since the students were familiar with the researcher, gaining access to the group was easy. As a participant observer, the researcher attended all the clinical learning sessions at the shelter with the students and their teacher. Participant observation occurred while the researcher participated in the pre-clinical conference, group (students and case managers) management of abused women assigned to them, and during post-clinical conference sessions with students and their teacher.

Field notes of observations were written during all sessions, while other observations were either noted as they were observed or written immediately after the session in order to avoid interfering with or disturbing interviewees. Other observations were made during students' and women's interactions at the women's homes ??or at the clinic when they came for health care consultations.

Document review

The learning journals of some of the students were also reviewed. This was done at the end of this clinical placement. Students were reassured that the information in their reflective learning journals was going to be used for research purposes only, and not to judge them in any manner whatsoever. These were read and analysed according to significant incidents related to intimate partner abuse or any form of family violence, those related to clinical nursing skills and those related to other competencies as highlighted by the students in their reflections.

Trustworthiness

Trustworthiness in qualitative research is a concept that was coined by Guba and Lincoln in 1989, cited in Ulin, Robinson, Tolley & McNeil (2002:31,) as an alternative to the criteria of reliability and validity that are used in quantitative studies. It refers to the truth value as well as the methodological soundness and adequacy of the research, which is judged through the criteria of credibility, conformability, and transferability (Holloway & Wheeler 2002: 250; Ulin *et al* 2002:31).

For trustworthiness of data interpretations, member checking and verification of data was done with the nurse educator and students during clinical placement sessions.

Credibility is often referred to as the truth value. Its focus is on the confidence in the truth of the findings. It relates to how participants can recognise the meaning they gave to a situation. This includes how the researcher's interpretation of data is compatible with the perceptions of the study participants (Holloway & Wheeler 2002: 256; Ulin *et al* 2002:31). The researcher undertook this with the nurse educator in a formal discussion of findings and report writing prior to the submission of the project report. According to her, the findings were a true reflection of what happened in the shelter for abused women, as a clinical learning setting for undergraduate student nurses.

Conformability refers to the way in which the findings and conclusions of a study achieve its aims. It does not result from the researcher's prior assumptions and preconceptions. It requires the researcher to maintain a clear distinction between his or her personal values and those of the participants through the use of reflexivity (Holloway & Wheeler 2002: 256; Ulin *et al* 2002:31). Reflexivity is the researcher's acknowledgement of his or her role in and influence on the research project (Carolan 2003:7).

The researcher explained her role as a participant observer and a student who was interested to learn as much from the participants as possible. Everybody was aware of her international student status as well as her researcher status and how these might show up in the type of questions she asked.

Transferability refers to the transfer of study findings from one context to similar situations or participants. According to Ulin *et al* (2002: 32), transferability also refers to the application of lessons learned from one qualitative study to other contexts, if the sample has been selected carefully to represent the experiences that reflect the key issues in the research problem. The research setting and the findings in relation to the setting and the context of the setting are described so that anyone wishing to transfer the findings will understand the actual circumstances under which this study was conducted.

Data analysis

Data analysis occurred concurrently with data collection during different stages of the research process. Data collected through the different data collection methods and periods discussed above were then sorted, ordered and organised into one manageable data source or document. Collaizzi's six-stage process of data analysis (Collaizzi, cited in Holloway & Wheeler 2002:171) was adopted and adapted for final data analysis because of its simplicity and logical steps.

Data analysis included the following:

- reading all descriptions of grand tour interviews, observations made during different interactions with participants and when reviewing the student nurses' reflective learning journals in order to acquire a feeling from them and make sense of them
- returning to each description and extracting sentences or phrases that directly per-

tained to the phenomenon under study, such as learning about family violence or nursing interventions during clinical placement at a shelter

- formulating meaning out of these phrases
- organising such meaning into clusters of themes
- integrating the results into an exhaustive description of the investigated topic
- identifying the fundamental structure of the investigated phenomena.

Results

The identified themes were organised structurally and reported according to the objectives of the study as well as emerging themes:

- Those related to the clinical learning experiences gained by the undergraduate student nurses at the shelter for abused women included:
 - learning to deal with role conflict
 - learning through sharing of students' personal experiences of intimate partner violence or family violence
 - learning to deal with prejudicial attitudes and refraining from blaming battered women.
- Those related to the nature of the partnership between the shelter as a clinical learning setting and the university:
 - commitment to partnerships between school and shelter
 - commitment to service learning
 - conducive climate for learning.

Learning to deal with role conflict

The analysis of the observations made during the first few days of clinical placement at the clinic and of the reflective learning journals of students revealed frustration among students. This frustration was ascribed to the role of being a nurse in a shelter setting. The students stated that they felt frustrated about the role of the case manager versus the role of the nurse in the management of abused women's problems. This is demonstrated in the following abstract from one participant's reflective learning journal:

I felt limited and helpless as a nurse because, for all my care plans with the abused woman and her family I had to involve the case manager or refer to her for legal advice. I am so used to just give nursing care accordingly without having to validate everything with the case manager. After some time at the shelter, and through Mrs X (the nurse educator) answering my questions and discussions we had about the case manager and nurse's role, I am comfortable with working with another person who is not a nurse.

Another participant also reported a similar experience of role conflict in her reflective learning journal:

In the past two years of my nursing training, I was never told about the role of the case manager; I learnt that if there is anyone who can co-ordinate patients' care within the multidisciplinary team, it is a nurse and not the case manager; a social worker. At the shelter; however; I learnt that the case manager is 'the' co-ordinator of abused women services. I guess I am okay with it now after I have been made to understand her role and my role as a nurse in the holistic care of abused women and their children

Learning through sharing of personal experiences of intimate partner violence or family violence

Data analysis of formal and informal group discussions during debriefing sessions revealed that the experience at the shelter helps students to learn through sharing their own personal experiences about intimate partner violence. During these group discussions, students shared their own experiences about intimate partner violence. This facilitated further group discussions. These discussions of sensitive matters were encouraged by the ground rules of confidentiality and the supportive services that were available to any student who wanted to have private discussions about her experiences of intimate partner violence with the nurse educator.

One student shared the following with the group:

When I saw Mrs M for the first time, I saw myself before I left my abusive boyfriend. I was always wearing heavy make-up to hide bruises. I had no confidence; I just wanted to hide away from the rest of the world. I know I was fortunate to realise very early that in order to be myself again, I needed to run far away from that monster. I did just that and for the first three months I could not even let my mother know where I was because I knew that he was tormenting them. So when you guys [classmates] blame women for returning to their abusive partners, I think you do not yet understand. It takes time, and nobody can tell you to leave or not to. It has to come from you. As nurses we need to understand that too!

Another student reflected as follows:

Having spent the time with my client, exploring her reasons for wanting to return to her husband, I realised how it must have been for my mother to stay with my abusive father for so long. It was only until myself and my youngest sister went to college that mom initiated divorce process and that was about three years ago. It must have been difficult for her to leave, not knowing where she could keep us [sic]. I will personally make sure that people are aware of the shelter for abused women as a place where women and their families can stay together. And what a difference it can make.

Learning to deal with prejudicial attitudes and blaming battered women

Data analysis of field notes on comments made by participants during the informal discussions revealed the following:

- prejudicial attitudes
- social and racial distancing
- blaming of abused women.

Most of these observations were from participants who said they had experienced intimate partner violence at some stage in their lives and those who knew someone who had experienced it. The following statement attests to these attitudes:

If I could get out of it, how come she can't just leave him? I had nothing, no job, no money when I left him, but I knew that I had to leave, otherwise he was going to kill me if I did not kill him first! This is how I felt throughout my first few sessions at the shelter. But the way the case manager explained things to me and the discussions with Mrs X [nurse educator], I am learning to understand this woman's reasons for staying and I am ashamed of myself for the anger and attitude I had towards her in the beginning.

Another social distancing and blaming statement was the following: “How come she always ends up with an abusive partner, there must be something wrong with her.”

Another student stated: “I feel sorry for them really, but surely they could have got out of such relationship earlier before it gets worse [sic], I just don't get it why they stay.”

Later on this student wrote the following in her reflective learning journal about her social distancing attitude:

After listening to the group discussions and some of my white friends in class, I have since realised that intimate partner violence can happen to anyone. It is not a problem for poor people or minority groups (African Americans, and not others). It was an eye-opener. I have always thought that it is not our thing.

Commitment to partnerships between the school and the shelter

Clinical placement of students at the shelter was a joint venture between two partners, namely the school and the shelter for abused women. The director of the shelter highlighted the mutual benefits of the partnership in the following statement:

We have a mutual relationship with Hopkins [School of Nursing] which benefits our residence in many ways. For instance our residents get appropriate health care to their health need [sic] before their social insurance can be sorted. The students from Hopkins benefit from the readily available families from our residences.

The key informant highlighted the commitment of the school to the partnership in the following statement:

The school of nursing employs qualified nurses who work at the clinic and render clinical nursing to the residents of the shelter; I also provide service to the clinic for specified hours per week. In that I can demonstrate community health clinical nursing skills to

the students. At the same time, we get to addressing family violence problems in a safe environment. We (the school of nursing and the shelter for abused women) are both committed to the success of the clinic because we all benefit from our partnership.

Conducive climate for learning

Data analysis from all participants and the researcher's observations revealed the shelter for abused women to be a safe, relaxed and conducive climate for learning about the families of abused women. Students were allocated to families according to the language or culture they shared with the women. One participant (of Hispanic origin) highlighted the point of a conducive climate for learning in the following statement: "For the first time since I came to Baltimore, I am working with a family who share my beliefs in bringing up of children. I am confident in giving advice that I know are [sic] well understood by both the mother and her child."

Another participant stated the following during the debriefing session: "I like the idea that the care plans are drawn up with the woman and her case manager. We are not rushed to come up with care plans that are sometimes not accurate to the needs of the woman."

Commitment to service learning

The key informant reported that the shelter offers students experiential learning opportunities where they can apply academic knowledge and critical thinking skills to address community needs:

Students learn and develop through active participation [giving them] experience which meets the actual residents' needs and that to us is a community. All clinical skills learnt here provide students with time to think, talk, and write about what they learnt during the shelter placement. They can also use newly acquired skills and knowledge in real life situations.

Discussion of results

The joint venture with the shelter can be an important tool for promoting service learning principles. The Wisconsin Department of Public Instruction (1994:1) defines service learning as a form of experiential learning where students apply academic knowledge and critical thinking skills to address community needs. Students learn and develop through active participation in clinical experiences that meet the actual community needs, are coordinated in collaboration with the school and community and are integrated into each student's academic curriculum. This included clinical experiences that provide students with time to think, talk, and write about what they learnt during the service project, and with opportunities to use newly acquired academic skills and knowledge in real-life situations. The women and their families are part of the community of

the shelter, so the health service rendered by the students is said to meet the actual needs of the community.

The shelter for abused women is an ideal placement for undergraduate student nurses to learn more than mere basic clinical nursing skills such as history taking and physical assessments. The teacher can facilitate learning from the new experience and assist the students to learn to deal with their attitudes and some common myths towards victims of family violence. Campbell (1992:464–470) is of the opinion that having an experienced nurse educator available at the shelter helps the students to process new experiences in family violence so that the myths can be defused.

Learning from students' own experiences of intimate partner violence is encouraged in the literature, but certain precautions have to be taken to safeguard those students who are bold enough to share their experiences with the group for learning purposes. Alpert *et al* (2002:746) suggest setting up ground rules and discussing these with students during the first group session as well as offering supportive discussions with any student who wishes to make use of the offer at the end of learning sessions.

Shelter placement provides students with the opportunity to integrate both theoretical and practical knowledge in caring for the women and their families in a safe community-based setting. This supports Feenstra's proposal of a nursing programme that gives students theoretical and practical knowledge in caring for individuals, families and communities through community-based and community-focused nursing care. This would increase the number of nurses in community-based settings able to focus on meeting both individuals' and families' health care needs (Feenstra 2000:155).

The shelter provides students with a safe, relaxed and conducive climate and institutional culture to practise family and community health nursing interventions. This is a climate characterised by shorter waiting times, personalisation of the conversation, and a woman-focused attitude as opposed to a time-focused attitude. It is a climate characterised by culturally sensitive care that enhances the woman's willingness to admit to abuse (Pakieser, Lenaghan & Muelleman 1998:19).

Role conflict among health professionals working with victims of family violence has been reported in literature (Alpert *et al*, 2002:746; Campbell 1992:464–470; Campbell & Humphreys 1993:165). At the shelter, the leadership and coordination role is assumed by the case managers and not by the nurses. In clarifying such role confusion, Newberger, cited by Campbell & Humphreys (1993:25) proposed that at least one health professional should coordinate the varied interventions of the multidisciplinary team caring for the victims of family violence.

Because family violence is a prevalent public health problem, it was not surprising to find that almost all students knew someone close to them who was in an abusive relationship. Some students themselves had previously been in abusive relationships. Such

findings were also reported by Alpert *et al* (2002:746) at the Boston University School of Public Health when they initiated a course on family violence. It is also reported by Campbell (1992:464).

Limitations of the study

The major limitation of the study was time constraints. The observations and interviews took place during the day only, while the clinic operated until 10 pm and at least two students managed the clinic and the help-line phone services in the evenings. Observations that could have been made during the evenings were not recorded. Data collection was completed when the students were preparing for examinations, therefore verification of data was only carried out with the key informant. This could affect the scientific rigour of the report.

Conclusions

The findings of this study highlighted the usefulness of the shelter for battered women as a clinical learning setting for student nurses to learn about nursing interventions related to family violence. In order to maximise the community-based clinical learning settings for undergraduate nursing programmes, nurse educators should be innovative and think of alternative clinical placements such as shelters for abused women.

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