A MIXED-METHODS RESEARCH PREDICTING INTENTIONS AND PERCEPTIONS ABOUT INTIMATE PARTNER VIOLENCE SCREENING AMONG NURSING STUDENTS AND NURSE EDUCATORS IN THAILAND

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DEDICATION

To my wonderful family who have been there to provide unending support and encouragement throughout this PhD journey. To my grandmother who inspired me to be a good nurse. To my colleagues and friends who inspired to be a good nurse scientist. To my participants and intimate partner violence survivors, who inspired me to be a good violence researcher and advocator.

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ABSTRACT

IPV screening in healthcare settings is an effective secondary prevention strategy for IPV that can reduce negative consequences IPV survivors may experience. However, healthcare providers have not tended to screen patients or women who may experience IPV. Additionally, the curriculums of health professionals' students, particularly in the nursing curriculum, do not adequately prepare future healthcare providers for IPV screening. However, little research has addressed IPV screening or barriers to such screening regarding healthcare providers in global, particularly Thailand. This study was to examine the attitudes, subjective norms, and perceived behavioral controls of senior Thai nursing students to manage IPV and intention to perform of IPV screening. In addition, it also was to explore the perceptions of IPV screening in nursing education among senior-nursing students and nurse educators in Thailand. The Theory of Planned Behavior (TPB), which is a strong theory to predict intentional behavior, was used in this study as a theoretical framework.

This study was conducted a mixed-methods, with primary data collection involving online surveys and focus groups with senior nursing students in Thailand and individual interviews with Thai nurse educators. The quantitative study was recruited by nursing students who were in the last years of nursing program and passed at least one nursing clinical practice course. The qualitative study, there were nursing students and nurse educators. The inclusion

criteria were: nursing students who were in the last year of their nursing program and passed at least one nursing clinical practicum course: nurse educators who have at least ten years of experience in education and live in a province in Northeast Thailand. Nursing students who were studying in their first, second, and third year, and did not pass any nursing clinical practicum were excluded. Nurse educators who have less than ten years' experience were not recruited. The instruments of screening were developed by using attitudes, subjective norms, and perceived behavioral controls. There were 36 relevant items on a 5 Likert scales. The instruments were developed by previous studies and five experts. Two bilinguals experienced IPV experts did the forward-translation of the original English versions of the instruments into Thai. Institutional Review Board (IRB) was approval from University of Missouri and one of Boromarajonnani Colleges of Nursing in Northeast Thailand with waiver of documentation of consent. Analysis data as percentages, frequency, and standard deviation were described demographic data and attitudes, subjective norms, perceived behavioral control, and intention of IPV screening. Bivariate relationship as Spearman's Rho, Chi-square correlation, and Logistic regression were used to identify relationships between the variables. Content analysis with the Dedoose program was used. Categories were described.

Totally 639 participants with nearly 60% have ever trained regarding IPV and 89.84% of participants has intended of screening. There was a medium positively significant correlation between the attitude, subjective norm, perceive behavioral control and intention ($r = 0.43$-0.46). Gender, GPA, experienced of IPV training, having screening tool at the clinical site, have seen screening, experienced of screening, experienced abused, and experienced family abused were significantly associated with intention of screening, but number hours of training was not associated. Mediation was tested and attitude and subjective norm were mediators of the

relationship between having a tool at clinical site and intention to screen, but perceived behavioral control was not a mediator. Moreover, attitude and subjective norm were predicted intention by 33%.

The findings from qualitative research explained that participants perceived that IPV is a critical issue in Thailand, but it is difficult to identify because of the cultural consideration. Participants feel not well-prepared by school in terms of knowledge and training experience. Nurse educators also feel not confident in supervising. Addressing IPV into the nursing curriculum was highly recommended. This study is the first study to specifically explore the perceptions of IPV in nursing education in Thailand. The findings contribute to improving the nursing curriculum regarding IPV. More research is related to prepare nursing students to deal with IPV issue would be required.

CHAPTER ONE

INTRODUCTION

This chapter provided an overview of the significant global problems of IPV, including the context in Thailand and addressed the importance of healthcare providers regarding IPV screening. Additionally, this chapter also provided detailed descriptions of the aims, research questions, and hypotheses used for this study.

Intimate Partner Violence (IPV) is defined as physical, psychological, or sexual harm by a spouse or current or former partner (Breiding, Basile, Smith, Black, & Mahendra, 2015). IPV has gained prominence around the world as a serious violation of human and legal rights (World Health Organization, 2017) and is associated with negative physical and psychological health (Al-Natour, Gillespie, Felblinger, & Wang, 2014; Djikanovic, Celik, Simic, Matejic, & Cucic, 2010). The majority of violence against women takes place in intimate relationships and husbands or partners are often reported as the perpetrator (WHO, 2013). IPV is everywhere; the group of countries where women experience the most physical and/or sexual partner violence at some point in their lives are African, Eastern Mediterranean, and Southeast Asian countries (WHO, 2013), including Thailand, where IPV is prevalent (WHO, 2005, 2013).

IPV screening in healthcare settings is an effective secondary prevention strategy for IPV (García-Moreno et al., 2015) that can reduce negative consequences IPV survivors may experience (WHO, 2013). However, healthcare providers have not tended to screen patients or women who may experience IPV (Barthel et al., 2015). Several studies have found that healthcare providers feel unprepared and lack confidence to screen women for IPV (Barthel et al., 2015). Additionally, the curriculums of health professionals' students, particularly in the nursing curriculum, do not adequately prepare future healthcare providers for IPV screening

(Bradbury-Jones & Broadhurst, 2015). However, little research has addressed IPV screening or barriers to such screening regarding healthcare providers in global, particularly Thailand.

This proposed study begins to address this gap, exploring IPV screening-related attitudes, norms, perceived behavioral control, and intentions, among a convenience sample of Thai nursing students and nurse educators. This study will allow for better understanding of IPV screening barriers in Thailand, particularly those specific to preparation of new healthcare providers. This knowledge is critical for helping policy makers and nurse educators better prepare nursing students, who will be working for the frontline position in the future, to manage IPV and increase IPV screening.

Background of the Problem

IPV has a high prevalence; globally; about 30% of all women will have experienced physical and/or sexual violence by their partners in their lifetime (WHO, 2013), and 35% of female homicides around the world are perpetrated by intimate partners (Strömbäck, Malmgren-Olsson, & Wiklund, 2013). While operational definitions of IPV vary across studies, the group of countries where women experience the highest lifetime prevalence of physical and/or sexual partner violence are African, Eastern Mediterranean, and Southeast Asian countries (WHO 2013). In population-based data in Spain, for instance, the lifetime prevalence of IPV is 24.8%, with no significant differences by education or employment status, although women with the highest income have less risk for physical violence (Ruiz-Perez et al., 2017). Research in Nigeria has demonstrated a lifetime prevalence of 25.5% of IPV among women over the age of 18, with 16.7% currently experiencing IPV (Olayanju et al., 2016). IPV during pregnancy is particularly serious; For instance, in Asia, research has shown 7.7 % of Chinese women experience IPV

during pregnancy in their lifetime (Wang et al., 2017) and 53.7% of pregnant Thai women reported psychological abuse and 26.6% reported physical abuse (Saito et al., 2013).

IPV is strongly associated with numerous negative physical and psychological health consequences for women, including injuries, migraine, depression, stress, fear, low self-esteem, and homicide (Bloom, Glass, Ann Curry, Hernandez, & Houck, 2013; Gold, Spangenberg, Wobil, & Schwenk, 2013b; Jeha, Usta, Ghulmiyyah, & Nassar, 2015; Kalokhe et al., 2017). Additionally, there are positive associations between physical or psychological abuse, psychological distress, and suicide attempts (Jeha et al., 2015). Negative consequences of IPV specific to pregnancy include increased risk for abortion and preterm birth (Amemiya & Fujiwara, 2016), low birth weight, premature rupture of membrane (Abdollahi, Abhari, Delavar, & Charati, 2015); depression, and low self-esteem are also possible outcomes (Fonseka, Minnis, & Gomez, 2015).

IPV screening is a vital secondary preventive response for the healthcare setting (García-Moreno et al., 2015). Evidences show that screening is more reliable than usual care in identifying victims of IPV in both pregnant and non-pregnant women (Chisholm, Bullock, & Ferguson, 2017). IPV screening is beneficial because it has been linked to improved self-esteem, increased awareness of supportive services and initiated conversations for preventive actions (Anderzen-Carlsson et al., 2017; Chang et al., 2010). For example, IPV screening can improve the birth outcomes of pregnant women, reduce IPV for new mothers, reduce pregnancy coercion and rapid repeat pregnancy (Chisholm et al., 2017; Nelson, Bougatsos, Blazina, 2012; El-Mohandes, Kiely, Gantz, & El-Khorazaty, 2011), and reduce depression symptoms and episodes of violence (Chisholm et al., 2017). However, even though IPV screening has been suggested,

the IPV screening rate is still low, especially in Thailand (Boonnate, Tiansawad, Chareonsanti, & Thungjaroenkul, 2015; Thananowan & Heidrich, 2008; Thananowan & Vongsirimas, 2014).

Healthcare providers play a crucial role in addressing IPV by providing a safe environment to women experiencing IPV. However, research consistently suggests healthcare providers are unlikely to screen women for IPV (Barthel et al., 2015). They may feel like they are not well-prepared, and they need more training and practice with this issue before practicing with women who have experienced violence (Barthel et al., 2015). In addition, they may have confusion about whose role it is to take care of and identify women experiencing IPV; the dispute is whether this is the job of a nurse, doctor, or social worker (O'Doherty et al., 2015). Healthcare providers are also uncertain how to respond to IPV survivors and unaware of existing tools or referral systems (Eustace, Baird, Saito, & Creedy, 2016).

Nurses spend a tremendous amount of time with patients, and are in unique positions on the frontlines of the healthcare system in screening and supporting women experiencing IPV (Bermele, Andresen, & Urbanski, 2018). Nurses may encounter individuals in healthcare settings who experience IPV, and they have an important role in supporting these people by providing person-centered care (Ali & McGarry, 2018; Bullock, Sandella, & McFarlane, 1989). Nurses can identify women experiencing violence and refer them to advocacy resources. If women, who are experiencing IPV, have not seen nurses or lose some processes to meet nurses, those women have less opportunity to be screened for IPV and lack the opportunity to get supports and helping resources for IPV (Ali & McGarry, 2018; Anderzen-Carlsson et al., 2017; Ferranti, Lorenzo, Munoz-Rojas, & Gonzalez-Guarda, 2017). Importantly, nurses should also be aware of their knowledge about IPV and the challenge of disclosing IPV for the victims, which can affect nurses' ability to identify and support those who experience IPV (Ali & McGarry, 2018).

Therefore, it is important to offer education about IPV to the nurses prior to implementing a routine of asking about IPV in the healthcare setting (Anderzen-Carlsson et al., 2017).

Research shows that student health professionals (e.g., nursing students) feel like they lack knowledge of IPV during their undergraduate education and are unprepared for IPV screening (Beccaria et al., 2013; Bradbury-Jones & Broadhurst, 2015; Doran & Hutchinson, 2017). It can be predicted that this information will decrease their ability to screen and manage abused women in their nursing practice. It can also be acknowledged that undergraduate study in nursing is a critical time to develop positive skills and attitudes to intervene in IPV (Natan et al., 2016). Research supports that nursing students' intentions to screen for IPV is affected by their knowledge, beliefs, subjective norms, and perceived behavioral control, as well as by their instructors' opinions of IPV and IPV screening (Natan et al., 2016).

Research has extensively documented a high prevalence of IPV in Thailand. The Multi-Country Study on Women's Health and Domestic Violence against Women by the WHO reports that 23-34% of Thai women in Bangkok and Nakhonsawan provinces between the ages of 15-49 years old have experienced physical violence and about 30% have experienced sexual violence from an intimate partner (WHO, 2005). Another survey study, which is asked 421 pregnant women at 32 weeks gestations or later in antenatal clinics at tertiary hospitals in rural Thailand, shows that 53.7% of Thai pregnant women reported psychosocial abuse over their lifetime, 26.6% reported physical abuse, and 19.2% reported sexual abuse (Saito et al, 2013). Additionally, a cross-sectional study conducted with 488 young age between 16 and 25 years old in a suburban community of Pathumthani province states that physical partner violence is common for Thai adolescents (Chaopricha & Jirapramukpitak, 2010; Jirapramukpitak, Harpham,

& Prince, 2011); with 15% experiencing physical violence and 12% experiencing sexual violence (Chaopricha & Jirapramukpitak, 2010).

IPV has also been linked with negative consequences in Thai people. Depressive symptoms are a common symptom for married Thai women experiencing IPV (Devries et al., 2013). Peltzer and Pengpid (2017) examined the relationship between severity and different types of IPV and symptoms of depression and suicidal behavior among adult women, in antenatal care clinics and general outpatient clinics in nine randomly-selected hospitals in the central region of Thailand. In this sample, 49.3% of women who screened positive for past-year IPV were positive for depression, and 17.6% reported attempting suicide. Additionally, sexual violence has been significantly associated with depressive symptoms among Thai women (Peltzer & Pengpid, 2017). Negative consequences for Thai women experiencing IPV also include social stigma (Arpanantikul, 2010), diminished sense of self and safety, and husband and family' negative image; Thai women have been teaching to keep their family picture and status well and also keep their husbands good looking because he is the head of family (Rujiraprasert, 2009). Thai women responded to these consequences by covering, isolating, silencing their stories (Rujiraprasert, 2009).

Additionally, Thai cultures may contribute to the severity of IPV by constraining women's access to resources. Thai women are reluctant to disclose any information related to IPV to authorities and do not want their lives disrupted by a criminal investigation (Sriyothin & Maneesri, 2017). They choose to keep quiet and not report IPV events (Han & Resurreccion, 2008; Sricumsuk, 2006). The general view of Thai people is that IPV is a private and family issue, and that those outside of the immediate family should not interfere (Sricumsuk, 2006). If the problem of IPV is exposed to outsiders, it will cause loss of face and a certain amount of

shame for the woman affected by IPV (Costa & Matzner, 2002). Therefore, the actual numbers and root causes of IPV in Thailand are difficult to assess.

To address IPV and provide resources to abused women, the Thai government has operated the One Stop Crisis Center (OSCC) since 1999 and passed the Domestic Violence Act in 2007. The primarily hospital-based OSCC services provide comprehensive services for victims of violence, but Thai women still fall through gaps due to a lack of IPV screening and providers' knowledge (Grisurapong, 2002). Although IPV screening is one of the key strategies to identify women experiencing violence, connect them with available services, and reduce negative health consequences in Thailand (Saito et al., 2013; Thananowan & Vongsirimas, 2016), policy makers do not provide standards or specific IPV screening tools, especially in healthcare settings. In addition, education and opportunities for increased awareness healthcare providers, such as IPV training, are not widely provided. Specific to nursing training, the curriculum of the Thai nursing curriculum at the undergraduate level has not mentioned IPV as one of the modules in nursing professional courses (Sadkong, personal communication, February 22, 2018).

Natan et al. (2016) examined Israeli nursing students, who completed at least one years of nursing studies about their knowledge and beliefs about IPV to predict intention of IPV screening, and found knowledge, attitude, subjective norms, and perceived behavioral control of students towards IPV was significantly associated with intention to screen. The Theory of Planned Behavior (TPB) model predicted the intention of IPV screening by 32%, with subjective norms the most significant predictor. In addition, Aluko, Beck, and Howard (2015) did interviewed by exploring medical students' attitudes, subjective norms, and self-efficacy and perceived behavioral control about screening female patients for IPV by using the Theory of

Planned Behavior and social cognitive theory (Aluko, Beck, Howard, 2015). The findings found that participants felt IPV screening could identify IPV survivors, but could also offend patients. They perceived that barriers of screening were time and negative reactions from patients. In addition, receiving IPV training and provision of IPV screening are perceived facilitators.

As previously noted, healthcare provider responses to IPV is one of the barriers for healthcare provisions to the victims. Research is needed in Thailand to review and revise how healthcare systems and service provisions about IPV should be and how to advocate for women experiencing IPV. While there are significant gaps of knowledge related to IPV in Thailand, the extant literature supports these conclusions: (1) Thailand has a high prevalence of IPV, but it is rare to report and screen; (2) Thailand has a violence center (OSCC) and the Domestic Violence Act, but there are gaps between policies and policy implementations; (3) IPV has serious health effects on Thai women, including increased risk for injuries and depression; (4) Thai healthcare providers, particularly nursing professionals, are not well prepared for managing IPV; (5) Thai people still generally perceive IPV as a private issue and disclosure to others is embarrassing; (6) and there are no prior studies exploring beliefs of IPV in healthcare providers and student health professions, particularly nursing students.

Significance to nursing

Although multiple health care practitioners are in a position to screen for IPV, it is likely that nurses have the best opportunity to screen because nurses interact the most closely with the patients (Ali & McGarry, 2018). Nurses also can develop safety plans and facilitate access to assistance and support women experiencing violence.

However, a number of barriers arise that may limit screening, including nurses' knowledge, attitude, and norms about IPV screening. Prior studies examining the attitudes, beliefs and knowledge of qualified health professionals, such as nursing, about screening for IPV have reported inadequate knowledge about this form of violence (Ramsay et al., 2012). Reports from several studies indicate that educational preparation of nurses is inadequate for assuring sensitive, quality, and effective nursing care to those who have survived IPV. Despite receiving education in nursing school about screening for violence and existing hospital screening policies, there are gaps between knowledge and actual practicing at the clinical sites Connor et al., 2013. Notably, none of these research studies have been conducted in Thailand.

Therefore, the aims of this study were to examine and explore the attitudes, subjective norms, and perceived behavioral controls of Thai nursing students to manage IPV and predict their intention to perform IPV screening in healthcare settings. These findings will be a baseline to inform appropriate curriculum development and tailored interventions to increase IPV screening among Thai nurses.

Purpose of the study

The *overall goal* of this mixed-methods study is to examine and explore a convenience sample of Thai nursing students in order to describe key variables related to nursing students' perceptions and experiences with IPV screening, including their level of exposure to IPV screening (exposure to IPV training, experiences caring for patients experiencing IPV, experiences of seeing nurses screening for IPV, and own/family experience of IPV), behavioral antecedents of intention (attitudes, subjective norms, and perceived behavioral controls around IPV screening) and intentions to screen for IPV, and to identify predictors of students' intentions to screen for IPV.

Specific aims were as follows:

1) To describe participants' level of exposure to IPV training and screening (including experiences with patients experiencing IPV, experiences of seeing nurses screening for IPV, and exposure to IPV training), own/family experience of IPV, their attitudes, subjective norms, perceived behavioral control regarding IPV screening in healthcare settings, and their intentions to screen for IPV in their own clinical practice. (Quantitative research)

2) To explore the associations between participant demographics, level of exposure to IPV training and screening, personal/family experiences of IPV, attitudes, subjective norms, and perceived behavioral controls around IPV screening, and the intention to screen for IPV. (Quantitative research)

3) To identify the strength of the relationship between participant demographics, level of exposure to IPV training and screening, personal/family experiences of IPV, attitudes,

subjective norms, and perceived behavioral controls around IPV screening) and the intention to screen for IPV. (Quantitative research)

4) To explore the perceptions of IPV screening in nursing education (Qualitative research)

5) To describe how well a mixed methods design is to enhance interpretation and understanding of the perceptions of IPV screening.

This study hypothesized that the relationship between attitudes toward IPV screening, subjective norms regarding IPV screening, and perceived behavioral controls around IPV screening and intention to screen for IPV and personal experiences with patients who are abused were following:

- Positive attitude toward IPV screening predicts intent to screen for IPV.
- Positive subjective norms that support IPV screening predicts intent to screen for IPV.
- Positive perceived behavioral control around IPV screening predicts intent to screen for IPV.

Definitions of Terms

Intimate Partner violence is defined as any behavior within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship, including acts of physical aggression, sexual coercion, psychological abuse, and controlling behaviors.

Physical violence is defined as the intentional use of physical force with the potential to cause death, disability, injury, or harm.

Sexual violence is defined as a sexual act that is committed or attempted by another person without freely given consent of the victim or against someone who is unable to consent or refuse.

Psychological violence is defined as aggressive acts that are not physical acts of violence, and in some cases may not be perceived as aggression because they are covert and manipulative in nature.

Nursing students is defined as students who are studying nursing at the undergraduate level in Thailand.

Nurse educator is defined as nurses who are teaching nursing students at school of nursing in Thailand.

Perceived Behavioral control is defined as the perception of the amount of influence that an individual perceives he/she has over their actions.

Attitude is defined as a person's favorable or unfavorable evaluation of being able to perform the behavior in question.

Subjective norm is defined is the perceived social pressure to perform or not to perform the behavior in question.

Intention is defined as the extent to which someone is ready to engage in a certain behavior or the likelihood that someone will engage in a particular behavior.

Urban area is defined as an area where there is a high population density and infrastructure a built environment. It will include cities, towns, conurbations or suburbs.

Rural area is defined as the area, which is located outside towns and cities and has a low population density and small settlements.

Conclusion

This chapter was described the important of IPV screening and the reasons of this topic has been conducted. Intimate partner violence screening is the shared responsibility of all healthcare providers, particular nursing professional. This research study focused on Thai nursing students' attitudes, subjective norms, and perceived behavioral control about IPV screening in an effort to predict intention and explore nursing students and nurse educators regarding IPV screening. Nurses are encouraged to take an active role in developing and implementing programs and practices designed to increase IPV screening. These efforts have the potential to interrupt the healthcare responses as healthcare providers supporting of violence and prevent violence before it occurs in women.

CHAPTER TWO

REVIEW OF LITERATURE AND CONCEPTUAL FRAMEWORK

The purpose of this review is to examine the existing literature related to IPV, IPV screening, health-care-response to IPV, and IPV in Thailand. In addition, it discusses the Theory of Planed Behavior as a theoretical framework of this study.

Definition of IPV

There are many terms and definitions of violence defined by different sources. For example, the Center for Disease Control and Prevention defines IPV to include "physical violence, sexual violence, stalking and psychological aggression (including coercive tactics) by a current or former intimate partner (i.e., spouse, boyfriend/girlfriend, dating partner, or ongoing sexual partner)" (Centers for Disease control and Prevention, 2015). An intimate partner is a person with one has a close personal relationship which may be characterized by the partners' emotional connectedness, regular contact, ongoing physical contact and sexual behavior, identity as a couple, and familiarity and knowledge about each other's lives (CDC, 2015). The UN defines violence against women as any act of gender-based that results in, or likely to result in, physical, sexual or psychological harm or suffering to women (United Nations, 2012). In another definition, domestic violence is "any act of physical, sexual, psychological or economical violence occurring in the family or domestic unit, or between regular or occasional partners or cohabitants, regardless of the fact that the authors of these acts shared or still share the residence with his victims" (Convention on Preventing And Combating Violence Against Women And Domestic Violence, 2011). For this study, the definition of IPV in this study was similar to the CDC definition and included physical, sexual, and psychological violence by a current or former intimate partner.

Prevalence of IPV globally

Intimate partner violence (IPV) has gained recognition around the world as a grave violation of human and legal rights (WHO, 2013). Globally, the global lifetime prevalence of IPV among ever-partnered women is about 30.0% - 35% (WHO, 2013). The majority of violence in women takes place from intimate relationships, and their husbands or partners is reported as the perpetrator (WHO, 2013). African, Eastern Mediterranean, and South-East Asia are the group of countries having the highest percentage of women experiencing physical and/or sexual partner violence at some point in their lives (WHO, 2013). However, the prevalence of IPV is lower in the high-income region such as the European and the Western Pacific Regions (WHO, 2005, 2013; Table 1).

IPV affects millions of women in Africa (Oduro, Deere, & Catanzarite, 2015; WHO, 2013). It is estimated that a woman is killed by her husband/partner every 6 hours (Kimani, 2007). In addition, 50% of women in Tanzania and about 70% of women in Ethiopia's rural areas have experienced beatings or other forms of violence by their husbands (Kimani, 2007).

Table 1. Lifetime prevalence of physical and/or sexual intimate partner violence among ever-partnered women by WHO region (WHO, 2013).

Region	Prevalence, %	95% CI, %
Low-and middle-income regions:		
Africa	36.6	32.7 to 40.5
Americas	29.8	25.8 to 33.9
Eastern Mediterranean	37.0	30.9 to 43.1
Europe	25.4	20.9 to 30.0
South-East Asia	37.7	32.8 to 42.6
Western Pacific	24.6	20.1 to 29.0
High income	23.2	20.2 to 26.2

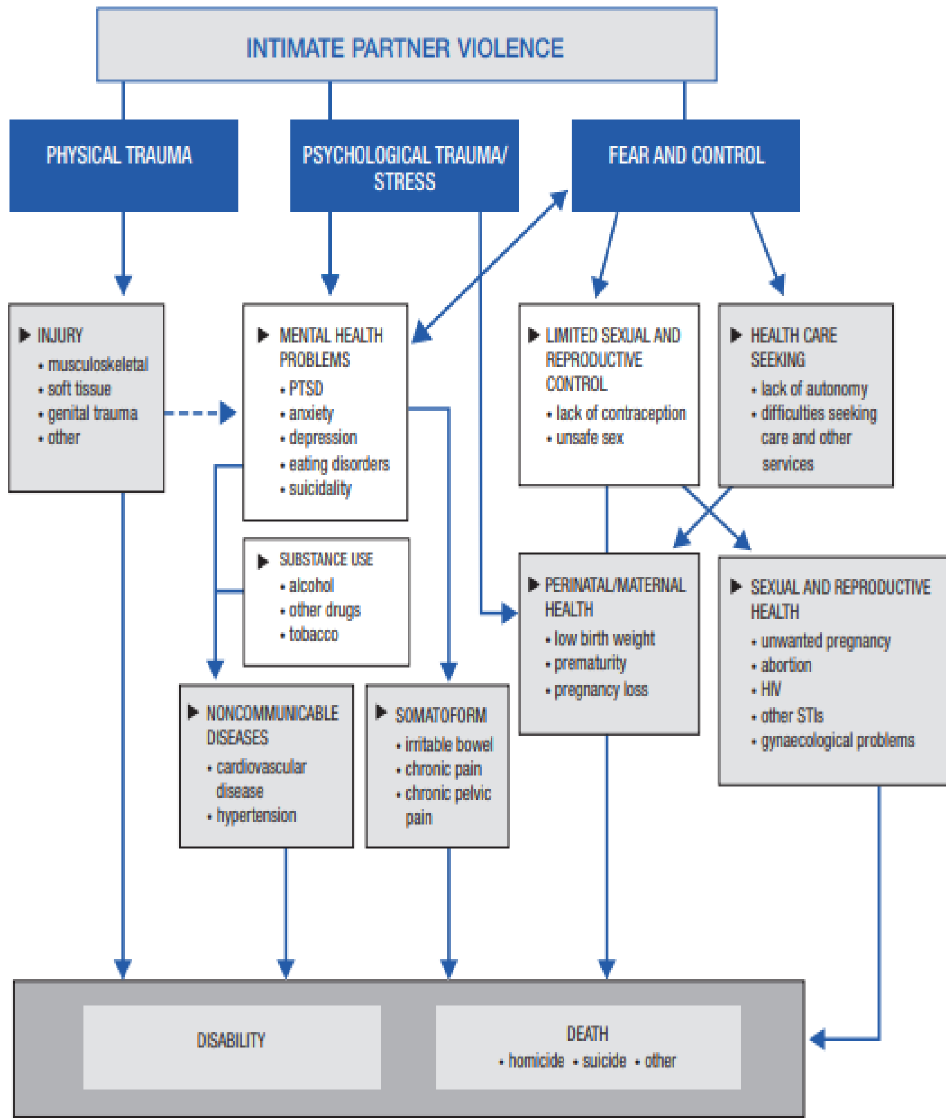
CI = confidence interval

Negative consequences of IPV

IPV (including physical, psychological, and acts perpetrating fear and control) has well-documented adverse consequences to women's health, as illustrated in Figure 1. These include include injury, depression, stress, fear, low self-esteem, and homicide (WHO, 2013; Gold, Spangenberg, Wobil, & Schwenk, 2013a; Jeha et al., 2015; Kalokhe et al., 2017). Physical or psychological abuse has been associated with suicide (Jeha et al., 2015). Negative consequences of IPV is also associated with adverse maternal-child health consequences, including abortion and preterm birth (Amemiya & Fujiwara, 2016), low birth weight, premature rupture of membranes (Abdollahi et al., 2015), and maternal depression or low self-esteem (Fonseka et al., 2015). For example, one study found 12% of pregnant women in Ghana reported current physical violence, and that women with unwanted pregnancy had a 17 times greater risk of

reporting an incident of significant physical violence (Pool, Otupiri, Owusu-Dabo, de Jonge, & Agyemang, 2014).

Figure 1. Pathways and health effects on IPV by the World Health Organization (WHO), 2013.



Factors associated with IPV

The exact causes of IPV are unknown, but there are many factors associated with IPV such as age, social vulnerability/marginalization, alcohol consumption, and cultural factors, although much of this research in low and middle-income countries is cross-sectional in nature. Older age is associated with a decreased risk for IPV, with the peak seeming to occur early in late adolescent and young adulthood (Capaldi, Knoble, Shortt, & Kim, 2012). Various factors in the adolescent period have been examined in terms of in dating or young adult IPV (Capaldi et al., 2012). For example, a cross-sectional study from Tanzania found being married at a young age was significantly associated with physical and/or sexual violence (Mahenge, Likindikoki, Stockl, & Mbwambo, 2013). Additionally, during pregnancy, women who also report higher general stress and lower social support are more likely to report IPV (Jackson et al., 2015).

Additionally, socioeconomic status is commonly discussed as associated with IPV in developing countries. In some research, women with lower incomes had significantly higher experiences of violence (e.g., Abdollahi et al., 2015; Gebrezgi, Badi, Cherkose, & Weldehaweria, 2017). For example, a study from India found the odds of IPV were greater for women living in the poorest quintile (Das et al., 2013). However, a Ghanaian study found women who reported physical violence during pregnancy were actually wealthier and had a higher parity than those who did not report physical violence during pregnancy (Pool et al., 2014).

It is important to know more about unique cultural factors contributing to risk of IPV, especially in developing countries. These factors include such things as desiring children of a specific gender, dowry payment, and women living with the husband's family. Some countries in developing countries believe that the son will take care of the parents when they grow old and, if

women do not have a son, then this reflects bad karma on them and their families (Priya et al., 2014). Another cultural belief is that when a woman gets married then she belongs to the husband's family. The woman has an important role in producing a son for her husband's family (Priya et al., 2014). A qualitative study from Nepal found identification of fetal gender increased the experiences of physical violence at the prenatal stage and sexual intercourse during pregnancy is perceived to increase the chances of conceiving the boy child that the husband desired (Deuba, Mainali, Alvesson, & Karki, 2016).

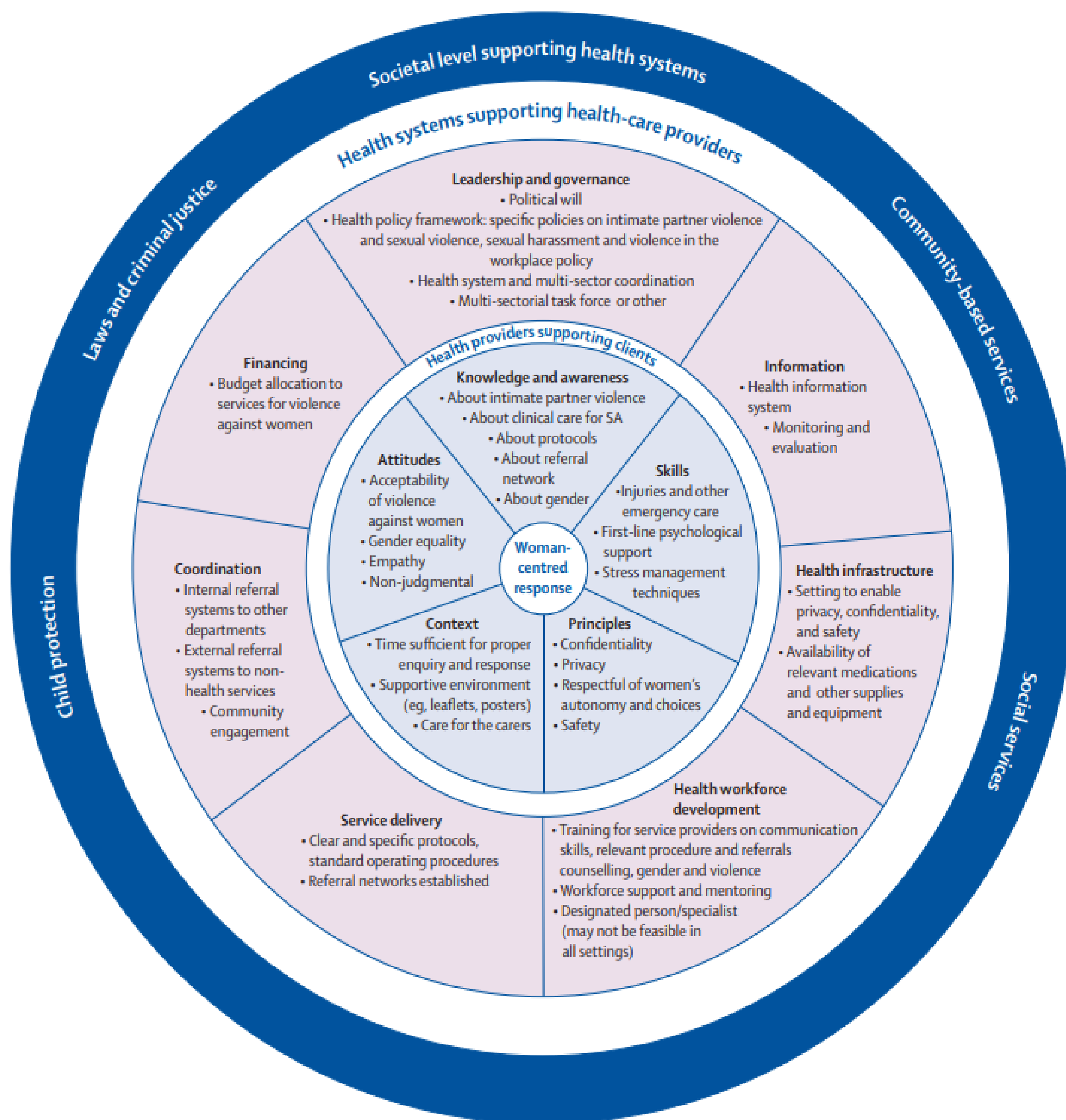
The healthcare-systems response to IPV

Healthcare systems play a critical role in responding IPV by providing a safe environment to women experiencing IPV (Alvarez, Debnam, Clough, Alexander, & Glass, 2018; García-Moreno et al., 2015; Swailes, Lehman, Perry, & McCall-Hosenfeld, 2016). The main role of healthcare systems for women, girls, and children who are facing violence is providing supportive care and a safety plan (Alvarez et al., 2018; Swailes et al., 2016). O' Campo et al (2011) describe the supportive care that can contribute into three levels of preventions; primary prevention, secondary prevention, and tertiary prevention. The primary prevention level includes advocacy/awareness raising, home visitation/ reduce harmful alcohol consumption, and data collection. The secondary prevention includes identification of violence, acute care for healthcare problems, long-term care for health including mental health, and referral to legal support services, and data collection. Finally, tertiary prevention includes rehabilitation, long-term mental health, support with other needs, and advocacy for supervisors in the criminal justice system. O' Campo el al (2011) also suggest that implementation of healthcare policies at each

level should be comprehensive approach to create consistent and sustainable change (O'Campo, Kirst, Tsamis, Chambers, & Ahmad, 2011).

It is important that healthcare providers or health policy makers understand the whole healthcare systems' concepts and recognize the basic needs of service provisions for managing violence against women. Colombini, Mayhew, Ali, Shuib, and Watts (2012) create a wheel for supportive systems response that includes elements of the health systems and healthcare response necessary to address violence against women (Colombini, Dockerty, & Mayhew, 2017). (See Figure 2). The wheel model includes elements of service delivery, health workforce, health information, infrastructure and access to essential medicines, financing, and leadership and governance. Additionally, the wheel model delineates the core elements/abilities healthcare providers should have to work with women experiencing violence. These include knowledge and awareness, attitudes, context, principles, and skills. It is important to point out that all of core elements in the wheel focuses on supporting women who have experienced or may be experiencing IPV.

Figure 2. Elements of the health system and health-care-response necessary to address violence against women by Colombini et al, 2012.



Healthcare providers' responses to IPV

Healthcare providers have to recognize IPV is an important health issue (Kamimura et al., 2015; Saberi et al., 2017; Swailes et al., 2016). In the wheel of elements of health systems and healthcare response necessary to address violence against women by Colombini et al (2012), they describe how healthcare providers are important people to support healthcare responses to violence against women (Colombini et al., 2012). Healthcare professionals should not fix all health problems of IPV, but can explore the psychological and emotional spheres and the social context in order to best respond to her/his health needs (Goicolea et al., 2017; Gupta et al., 2017; Swailes et al., 2016). However, hierarchies concerning the IPV issue are considered when working on a multi-professional team. For example, a study of *N*=160 primary healthcare professionals working in 16 primary healthcare centers in Spain found the current management of the health system (workload, weak supervision and little feedback, misdistribution of human and material resources, etc.) does not facilitate the sustainability of such an approach in women experiencing IPV (Goicolea et al., 2017). This research found IPV initiatives are commonly and primarily implemented and sustained through the personal interest and commitment of a group of professionals, usually headed by a social worker. If the key people retired or moved to another center, then the initiatives were often discontinued.

Healthcare providers have not been widely provided with clinical guidelines to address IPV, and they tend not to screen women for IPV (Barthel et al., 2015; Swailes et al., 2017). Many healthcare providers feel like they are not well prepared from professional schools, and they need more training and practice with this issue before practicing with women who have experienced violence (Barthel et al., 2015). In addition, they are often confused about the roles of nurses, doctors, social workers, and police officers in taking care of and identifying the victim

(O'Doherty et al., 2015). Moreover, healthcare providers are often uncertain how to respond to IPV, and noted few existing tools, or referral systems (Eustace, Baird, Saito, & Creedy, 2016).

IPV screening

IPV screening is a secondary prevention measure in the healthcare response to IPV (García-Moreno et al., 2015) recommended by the World Health Organization (WHO), the U.S. Preventive Services Task Force, American Medical Association, the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, the American College of Emergency Physician, and the American Academy of Nurse Practitioners recommend (Hill & Ousley, 2017; Todahl & Walters, 2011). Evidence shows that screening is more reliable than usual care in identifying victims of IPV, including both pregnant and non-pregnant women (Chisholm et al., 2017). In addition, IPV screening is generally seen to be beneficial as it has been linked to reduce negative consequences of IPV, increased awareness of supportive services, and initiated conversations for preventive actions (Anderzen-Carlsson et al., 2017; Chang et al., 2010). For example, IPV screening can improve the birth outcomes of pregnant women, reduce IPV for new mothers, reduce pregnancy coercion (Chisholm et al., 2017; Nelson, Bougatsos, Blazina, 2012; El-Mohandes, Kiely, Gantz, & El-Khorazaty, 2011), and reduce depression symptoms and episodes of violence (Chisholm et al., 2017).

Despite the widespread prevalence of IPV and high recommendation of IPV screening, the screening rate remains low (Chisholm et al., 2017; Hill & Ousley, 2017; Wolitzky-Taylor et al., 2011). The rate of informal disclosure by survivors (e.g., to friends/family) is considerably higher than the rates of formal disclosure (e.g, to healthcare providers, violence advocates, police, etc., Sabina & Ho, 2014). During pregnancy, about 10-40% of women disclose abuse when screened by primary care providers, and 31% of them were exposed to violence by their

partners (Fonseca-Machado et al., 2015).

However, IPV screening is not consistent with clinical screening of survivors (O'Doherty et al., 2015) and evidence still is lacking to support whether healthcare providers should implement universal screening or routine enquiry under specific circumstances. Nelson et al (2012) indicated that there is minimal harm to IPV victim as a result of screening, however, the points of concern are discomfort, loss of privacy, feeling depress, concerning about being judge by providers, and increased violence (Nelson et al., 2012). Moreover, there remains a lack of consensus regarding which screening tools may be the effective for women in different contexts (Chisholm et al., 2017).

Nurses' response to IPV

A nursing professional is an important and natural leader as first healthcare professional to meet women as a frontline position (Bermele et al., 2018). Nurses may encounter individuals in healthcare settings who experience IPV, and they have an important role in supporting these people by providing person-centered care (Ali & McGarry, 2018; Bullock et al., 1989). It is important that nurses understand the complex issues involved in IPV, including those related to its presentation and effects on physical and psychological health (Ali & McGarry, 2018). Nurses can identify women experiencing violence and refer them to advocates and resources. If women have not seen a nurse, they may lack opportunities to connect with advocacy and resources (Ali & McGarry, 2018; Anderzen-Carlsson et al., 2017; Ferranti et al., 2017). However, it is important to offer education to the nurses prior to implementing a routine of asking about intimate partner violence in the healthcare setting (Anderzen-Carlsson et al., 2017).

Even though a nurse professional is a natural leader to address IPV, there are barriers that challenge nurses working on IPV. For example, in low- and middle-income countries, in the

absence of IPV guidelines, nurses employed interventions characterized as counselling, ascertaining abuse, and referral (Sprague, Hatcher, Woollett, & Black, 2015). Nurses' actions are motivated by fear for patients' survival, and patients' expectations of receiving treatment (Sprague et al., 2015). Importantly, nurses should also be aware of factors such as lack of knowledge among healthcare professionals and the challenge for some individuals of disclosing IPV, which can affect nurses' ability to identify and support those who experience IPV (Ali & McGarry, 2018). However, a randomized controlled trial in Mexico City shows that enhanced nurse intervention is not more effective in reducing IPV; it may offer short-term improvements in addressing safety planning and mental quality of life (Gupta et al., 2017).

Nurses are inadequately prepared to screen for IPV effectively. Midwives, doctors and nurses have considered the IPV issue, but they feel like they are minimally prepared and unsupported (Eustace, Baird, Saito, & Creedy, 2016; Taylor, Bradbury-Jones, Kroll, & Duncan, 2013). Other core factors that nurses are concerned about include a sense of responsibility, worries about encouraging women to disclose without clear processes and resources to support the victims, and the presence of a partner at appointment (Connor et al., 2013; Eustace et al., 2016). Studies highlight that nurses are reluctant to talk to women who experiencing violence, lack of time, lack of training, language/cultural practices and partner presence (Beynon, Gutmanis, Tutty, Wathen, & MacMillan, 2012; Eustace, Baird, Saito, & Creedy, 2016).

Furthermore, studies show that nurses' knowledge, perceptions, beliefs, and attitudes are largely related to their ability to identify women experiencing IPV (Connor et al., 2013; Roush & Kurth, 2016; Sawyer, Coles, Williams, Williams, 2018). A study from South Korea surveying emergency nurses about the recognition of violence and attitude toward domestic violence finds that 60% of emergency nurses saw patients where they suspected violence was occurring in the

home, but the screening/reporting rates are low (Barthel et al., 2015). Nurses state that they lacked education about IPV during their undergraduate education; it has affected their self-efficacy in identifying and taking care of abused women (Beccaria et al., 2013; Connor et al., 2013). Undergraduate study in nursing is a critical time to develop positive skills and attitudes to intervene IPV issue (Connor et al., 2013). A study supports that nursing students' knowledge, beliefs, subjective norms, and perceived behavioral control affect their intention to IPV screen as well (Natan et al., 2016), and nursing instructors' s opinions about IPV and IPV screening are the most significant for nursing students' intentions (Natan et al., 2016).

IPV in Thailand

Thailand, a male-dominance society, ranked 36th among 75 countries in acts of physical violence and 7th among 71 in sexual violence ("Violence against women in Thailand on the rise: Study," 2014). Documentation of IPV in Thailand is increasing, with cases where either the husband attacks the wife or the wife attacks or kill husband in self-defense; reported cases have increased from 20,000 in 2012 to 31,966 in 2013 ("Violence against women in Thailand on the rise: Study," 2014). A research study in 2009 found 48% of Thai women age 25-45 experienced IPV perpetrated by the husband/cohabitating male (Chuemchit & Perngparn, 2014).

IPV has been also linked with negative health consequences in Thailand; especially the association relationship between IPV and incident depressive symptoms (Devries et al., 2013). For example, Peltzer and Pengpid (2017) examine the relationship between severity and different types of IPV and symptoms of depression and suicidal behavior among adult women in antenatal care clinic and general outpatient clinics in nine randomly selected hospitals in the central region. They found IPV accounted for 49.3% of depression and 17.6% of suicide attempts in the

past 12 months. Sexual violence was significantly associated with depression (Peltzer & Pengpid, 2017).

Moreover, Thai cultures may contribute to IPV severity. Thai women are reluctant to disclose any information related to IPV to authority and do not want their lives disrupted by a criminal investigation (Chuemchit & Perngparn, 2014); between 37%-46% of physically-abused women in Bangkok and Nakhonsawan never told anyone about the violence they had experienced (WHO, 2005). Thai couples are likely to try to manage problems by themselves. Furthermore, survivors conceal abuse to protect the family/husband reputation (Chuemchit & Perngparn, 2014). IPV is still a private and stigmatized issue in Thailand; the victim has to keep silence and often isolation. Because of these contexts, IPV reporting and identification in Thailand are low (Chuemchit & Perngparn, 2014).

The government of Thailand has established nationwide hospital-based one stop crisis centers (OSCCs) to address IPV and train healthcare providers (Grisurapong, 2002). The OSCC model has been established since 1999 to provide comprehensive services for victims of violence, and to collect data on cases of violence against women i.e. regarding the forms of injuries and treatments and the relationship between victims and perpetrators (Grisurapong, 2002). In Thai, the OSCC is called Pueng-Dai center.

Chuemchit and Perngparn (2014), investigating records of women visiting One Stop Crisis Center (OSCC) in hospitals in Bangkok, found 83% experienced physical violence; 9.1% psychological violence, and 5.9% sexual violence. Injuries (e.g. abrasions and bruised, sprains and dislocation) have been reported from physical violence (WHO, 2005). However, OSCC staff typically only record one type of IPV in the patient record (Yaowarat, M., personal communication, November 21, 2019), and other research in has found psychological violence is

the most common type reported (Saito et al., 2013, Sriyothin & Maneesri, 2017; Xiaohe, Kerley, & Sirisunyaluck, 2010). More research is needed to understand the patterns of IPV among survivors seen in the OSCC. The OSCC also forms a community network with NGOs and service providers; these networks play a vital role of violence's protection, prevention, awareness-building and correction on domestic violence in local communities (Grisurapong, 2002).

Domestic violence was made illegal in Thailand in 2007, with the release of the Act on the Protection of Victims of Domestic Violence B.E. 2550 (Thailand: Act on Protection of Domestic Violence Victims, 2007). The Act defines domestic violence as "any act committed with an intention to cause bodily, mentally or healthily harm of, or an act committed intentionally in a manner that may cause bodily, mentally or healthily harm of, a family member or any coercion or undue influence conducted with a view to make a family member to do something, refrain from doing something or accept any act illegally, but not including an act committed through "negligence" (Thailand: Act on Protection of Domestic Violence Victims, 2007). A complaint under the Act can be made not only by the victim, but also anyone who has seen or has information regarding domestic violence. The police will have to investigate the complaint immediately and the public prosecutor has to file the case before the court within 48 hours (Thailand: Act on Protection of Domestic Violence Victims, 2007).

However, even though Thailand has policies, legal protections, and OSCC centers to support and help the IPV victims, IPV prevalence remains high and there are substantial barriers in terms of healthcare systems providing health provisions to the victims, according to OSCC experts in Thailand (personal communication, November, 2017). These include: (1) IPV is still not a policy priority; (2) professionals are still working separately within the multi-professional

environment, even though the policy encourages working together; (3) the monitoring and supervising system between experts to practitioner needs to be evaluated; (4) there is a high OSCC staff turnover rate and a lack of motivation or reinforcements to continue working with violence; (5) effective IPV protocols and guidelines in the health sector are lacking; (6) IPV training standard curriculum for providers and new providers are needed: (7) and more research and researchers in violence field are needed. It is also critically needed to create tailored IPV interventions for Thai people.

Research of IPV in Thailand between 2009 and 2018

A systematic review was conducted aimed to summarize past empirical literature and to provide a more comprehensive understanding of the phenomenon relating to IPV in Thailand.

Search Strategy

The search was conducted by researcher and utilized the following databases: PubMed, Medline, CINAHL, OVID, and PsycINFO, using search terms as shown. Key words used in the search included domestic violence AND Thailand, domestic violence in Thailand, intimate partner violence AND Thailand, intimate partner violence in Thailand, spousal violence AND Thailand, women abuse in Thailand, and violence against women in Thailand. A search was also conducted using Google and Google Scholar to identify studies not published in indexed journals. In addition, the reference list of each article was scrutinized to identify studies that may not have been listed in the searched databases.

The search period selected was the 10 years between 2009 and 2018, a time span large enough to find sufficient articles and then to reflect on the state of current literature. Next, author screened titles and abstracts for eligibility, removing duplicates and studies not available in full text. The inclusion criteria for selected studies included: (1) the aim of the study focused on the

IPV in Thailand; (2) an independent study, including case study; (2) the participants in the study are Thai women or men who have between 15 and 60 years; (3) the setting of the study was Thailand; (4) the study was heterosexual or homosexual relationship; (5) the literature was published in English between January 2009 and March 2018; and (6) the English language was used in the literature. Exclusion criteria were: studies conducted in cross-counties or multiple countries; published in languages other than English; aimed to focus on IPV in child age under 15 years and elderly age above 60 years; focused on sex worker or trafficking; focused on workplace violence or political violence; cross-country studied; and published in the Thai language. The final step was reading the citations and reviewing the abstracts. Finally, 20 full text articles were reviewed and determined to be eligible for inclusion in the systematic review.

Study Selection Process

A total of 300 articles were retrieved through databases (PubMed (99); Medline (133); CINAHL (63); PsyINFO (5)), and 275 were identified after the removal of duplicates, and 104 were identified for screening. In all, 20 articles were considered eligible for full-text screening, and 20 articles included inclusion criteria and were reviewed.

Results

Key features of Studies

The critical findings from each part are summarized which is including 20 studies. The majority of the studies (n=14) were quantitative and use cross-sectional designs; five were qualitative design, and one adopted case study. Study results were analyzed to summarize IPV in adolescent, married women, and pregnant women. IPV studies in married women is the most amount of number, fourteen articles; IPV in pregnancy is five articles; and IPV in adolescent is the least number of articles, three articles. The number of articles in each year between 2009 and

March 2018 is between one and four articles. However, we have seen 6 articles in 2015, but they did not meet inclusion criteria.

IPV in adolescents in Thailand

There are 3 studies that met inclusion criteria of IPV in adolescents in Thailand (Table 2). It consists of studies between 2009 and 2011; two quantitative study and one qualitative study. The sample ages are between 16 and 25 years. Settings of studies are only the community in central part of Thailand.

Physical violence is the most common for adolescents in Thailand (Chaopricha & Jirapramukpitak, 2010; Jirapramukpitak et al., 2011): 15% of physical violence and 12% of sexual violence (Chaopricha & Jirapramukpitak, 2010). The factors are associated with IPV in adolescents, including experiences of abuse, low level of parental education, friends who were involved with health risk activities and having no close friends (Chaopricha & Jirapramukpitak, 2010). In addition, IPV in adolescents is strong associated with adverse mental outcomes (Jirapramukpitak et al., 2011). Moreover, there is one study explored perceptions of dating violence (Thongpriwan & McElmurry, 2009); physical violence is the most frequently described in perceptions of dating violence and sexual acts rarely were included in the defining of dating violence. The cause of dating violence is including individual characteristics and circumstances; situations related to the relationship; and open communication).

The studies suggested three main practice and policy guidelines for reducing IPV in adolescents: (1) a need assessment of the families with history of IPV and levels of family and social supporting systems (Chaopricha & Jirapramukpitak, 2010; Jirapramukpitak et al., 2011); (2) a need to identify and prevent negative impacts to adolescents (Jirapramukpitak et al., 2011);

and (3) needed to develop the educational programs to promote healthy relationships since it is limited educational programs (Thongpriwan & McElmurry, 2009).

IPV in pregnant women in Thailand

There are five studies that met inclusion criteria of IPV in pregnant women in Thailand; four quantitative study and one case study. See Table 3. The ages of sample in the studies are between 15 and 49 years old. Three studies collected data with pregnant women in antenatal care clinic, one study collected data from women who reported a pregnancy with the past two years, and one study collected from women who were six weeks postpartum. There are several parts of Thailand where research was conducted; three studies from Northeast region, one study from central region, and one study from Thai-Burma Border.

IPV victimization during pregnancy in Thailand is strongly related with pregnancy complications; 16% reported symptoms related to pregnancy complication (abortion and stillbirths) (Falb, McCormick, Hemenway, Anfinson, & Silverman, 2014). Psychological abuse is the most percentage of IPV type during pregnancy in all quantitative studies (Falb et al., 2014; Peltzer & Pengdid, 2017; Saito et al, 2013). In addition, about 50% of IPV during pregnancy have positive scored for depression and 17.6% reported attempt suicide (Peltzer & Pengdid, 2017), and Sexual IPV is associated with depression (Peltzer & Pengdid, 2017). A case study interviewed IPV pregnant women, they said IPV had pervasive consequences on their health and well-being and contributed to their low self-esteem, helplessness, fear, social withdrawal, suicidal ideation, and self-harm (Saito, Cook, Creedy, & Chaboyer, 2009). Furthermore, IPV in Thai culture is related to power of men exerting control over women, and women continue living with IPV because of stigma and blame towards women (Saito, Cook, Creedy, & Chaboyer, 2009).

Screening is a leading recommendation for identifying IPV during pregnancy (Saito, Creedy, Cooke, & Chaboyer, 2012, 2013), and assess women reporting IPV for depression and suicidal behavior are crucial practices (Peltzer & Pengdid, 2017). Moreover, respectful and culturally sensitive questioning and early intervention are important for early identification of victimization (Saito et al., 2013).

IPV in adults

There are thirteen studies conducted IPV in adult women in Thailand, between 2009 and 2018; seven studies of quantitative research and four studies of qualitative research, and one case study. See Table 4. In total, twelve studies include several settings in Thailand, central, north, northeast. However, Bangkok, central region in Thailand is the greatest number of studies: six studies. The sample age is between 15 and 65 years, and it included women with cancer, women in refugee camps, married women (Buddhist and Muslim), and parents.

IPV in Thailand has high prevalence in adult age, including physical, psychological, and sexual violence. IPV is significantly positively associated with stress, depressive symptoms and cervical cancer, but negatively correlated with social support and self-esteem (Thananowan & Vongsirimas, 2016a). Psychological violence is the highest kind of violence reported (Sriyothin & Maneesri, 2017; Xiaohe, Kerley, & Sirisunyaluck, 2010), but sexual violence is a strong predictor of depressive symptoms and social support (Thananowan & Vongsirimas, 2014).

Several factors may contribute to IPV. Experiencing conflict victimization since childhood is associated with current experience of IPV (Laeheem & Boonprakarn, 2016; Sriyothin & Maneesri, 2017), and belief that men are dominant (Laeheem & Boonprakarn, 2016). Alcohol is a strong factor linking IPV and family relationships (Ezard, 2014; Laeheem,

2016). In addition, education level, region, drug abuse, jealousy, and income were also related to IPV (Falb, McCormick, Hemenway, Anfinson, & Silverman, 2013; Xiaohe et al., 2010).

IPV in Thai adults is linked to negative consequences that prevent women leaving from IPV, including fear of social stigma (Arpanantikul, 2010), sense of self and safety and husband's image (Rujiraprasert, 2009). Thus, women responded to these consequences by covering, isolating, silencing or revising (Rujiraprasert, 2009).

However, there are two intervention programs that have been demonstrated to reduce IPV: Happy Muslim family activities and counselling (Laeheem, 2017; Sawangchareon, 2013). Families participating in Happy Muslim family activities experienced less IPV after the program, and counselling the victims by trained nurses is improved self-esteem and health status of IPV victims (Sawangchareon, 2013). The intervention programs to reduce the negative effects of women who have experienced violence should incorporate other forms of violence prevention (Falb et al., 2013), and the programs are needed to empower and increase the self-esteem of women (Arpanantikul, 2010). In addition, according to alcohol is also linking between IPV and family relationships in refugee camps, therefore, interventions to promote gender equality through gender-based empowerment may be needed in refugee camps setting (Ezard, 2014). A study conducted in Muslim women state that giving children knowledge of the religious principle in the belief and ethic training can reduce individuals' violence behavior (Laeheem, 2017). Training nurses in counselling can help improve the health of abused women, raise their self-esteem and encourage them to use the proper coping strategies (Sawangchareon, 2013). Training programs for health professionals should address IPV issues (Thananowan & Vongsirimas, 2014; Thananowan & Vongsirimas, 2016b). Finally, IPV screening is

recommended and treatment of IPV should be related psychosocial factors (Thananowan & Vongsirimas, 2016a).

Table 2 IPV in Adolescent. N=3

Author	Study design/Tool	Sample/setting	Results	Practice/Policy/Research
Chaoprich. & Jirapramukitak T. (2010).	*Design*: cross-sectional study. *Tool:* The Conflict Tactics Scales (CTS); Diagnostic Interview Schedule (DIS), Alcohol-Use Disorder Identification Test (AUDIT), sexual risk behavior screening test, modified Youth Risk Behavior Survey Questionnaire.	*Sample*: 488 young aged 16-25. *Setting*: Suburban community of Pathumthani Province.	• Childhood physical abuse was the most common form of abuse (15%) while sexual abuse was the second most common (12%). • Factors associated with having health risk behaviors: male gender, older age, experiences of abuse, low level of parental education, friends who were involved with potential health risk activities, and no close relatives.	• Needs assessment of the families with history of domestic violence. • Knowing the children' s needs and the levels of family and social supporting systems would help to prevent re-abusive experience and health risk behaviors in the future. • Parent training programs and enhancing good parents-child relationships may be more important than encouragement of parents spending purposeless time with their children or just doing family activities together.
Jirapramupitak, T., Harpham, T., & Prince, M. (2011).	*Design:* cross-sectional study. *Tool:* Conflict Tactics Scales: Clinical Interview Schedule-Revised: Diagnostic Interview Schedule: and Alcohol Use Disorder Identification Test.	*Sample:* 1,052 young residents, aged 16-25 years. *Setting:* a community in Bangkok.	• Exposed Domestic Violence (EIPV) and physical violence were highly likely to report IPV. • Strong associations were found between exposure to each form of the violent experiences and the adverse outcomes. • Those who had been exposed to the three types of violence, compared to none, were most likely to report all the adverse outcomes (odds ratios ranged from 4.3 to 17.3).	• Need to identify and prevent these experiences and their impact on children and young people. • Next step should be to move beyond looking at simple relationships between types of family violence in childhood and adulthood and between abusive experiences and adverse outcomes. • Longitudinal studies are needed to examine the

Author	Study design/Tool	Sample/setting	Results	Practice/Policy/Research
				biological, psychological and social mechanisms which may prevent or contribute to the development and course of subsequent violence and psychopathology.
Thongpriwan, V., & McElmurr, B. J. (2009).	*Design*: Qualitative study. *Tool*: interview guide.	*Sample*: 24 students who have aged 15 and 17 years. *Setting*: a secondary school in Bangkok	• Parents' negative attitudes toward adolescent romantic relationships or lack of parental recognition of daughters' relationships. • The majority of participants described two types of violent acts: (a) physical violence (e.g., hitting, slapping, pulling down, punching, and throwing an object at a person), and (b) emotional or verbal abuse (e.g., threatening, scolding, insulting, degrading, disrespecting). • Sexually violent acts rarely were included in the definition of dating violence. • Causes of dating violence: (a) individual characteristics; (b) situations related to the relationship; and (c) raised in a family in which parents used physical, emotional, or verbal violence to solve disagreements.	• Development of educational programs to promote healthy relationships and advocate for the human right to be safe from violence is important. • Limited educational programs exist to guide their social and cultural evolution, and in this absence traditional norms continue to be perpetuated, namely the double standards of dating, gender, and sexuality.

Table 3 IPV in Adult. N=12

Author	Study design/Tool	Sample/setting	Results	Practice/Policy/Research
Arpanantiku, M. (2010).	Design: qualitative study (Heideggerian phenomenology).	*Sample:* 18 middle-aged (45-55 years) Thai women, who had unfaithful husbands. *Setting:* Bangkok	• Unfaithful husbands were found to be an invisible family relationship problem, with many of the women trying to solve the problem by themselves. • Women tended not to speak out about their problem because of fear of the social stigma associated with the issue.	• Importance of nurses supporting women with unfaithful husbands and assisting them in the development of their own well-being. • Further study is needed regarding the effects of stress and depression on women who have an unfaithful husband. • Need for development of realistic interventions to empower and increase the self-esteem of women with an unfaithful husband.
Ezard, N. (2014).	*Design:* Qualitative research	*Sample:* 97 women who have aged 15 years and over. *Setting:* Mae La, a long-standing refugee camp on the Thai-Burma border.	• Alcohol use is subject to strongly gendered social controls; alcohol use is changing under the pressures of displacement. • IPV is an emergent alcohol-related harm. • Relationship between IPV and alcohol is complex. • No participant thought that alcohol alone was sufficient to cause violence.	• The feasibility of these interventions in a refugee camp setting like Mae La where most alcohol is already illicit may be limited. • Efforts to promote gender equality through gender-based empowerment and livelihoods programs may have some impact on alcohol-related IPV. • Further economic, epidemiological, and social science research to improve understandings of common causal pathways is required as a basis for identifying

Author	Study design/Tool	Sample/setting	Results	Practice/Policy/Research
				and implementing complex interventions.
Falb, K. L., McCormic, M. C., Hemenway, D.,Anfinso, K., & Silverman,J. G. (2013b).	*Design:* cross sectional study *Tool:* Reproductive Health Assessment Toolkit for Conflict-Affected Women	*Sample:* 861 women. *Setting:* 3 primarily Karen refugee camps (Umpiem Mai, Nu Po, and Ban Don Yang) along the Thai-Burma border.	• Experiencing conflict victimization was associated with religion and the husband or partner's level of education. • Majority (62.7%) experienced only 1 form of conflict victimization, while 20.5% experienced 2 forms of violence and 16.9% experienced 3 or more forms of victimization.	• Interventions to reduce the negative effects of conflict victimization should incorporate other forms of violence prevention, including IPV. • Longitudinal research is needed to discern pathways through which these experiences are related.
Laeheem, K. (2017).	*Design:* Experimental study (Randomized Controlled trial) *Tool:* The screening questionnaire for domestic violence risk behaviors; Happy Muslim family activities; Normal	*Sample:* 40 married Thai Muslim couples *Setting:* Satun province	• Before participation-- in happy Muslim family activities had violent behaviors against their spouses than those in the control group who participated in normal community activities. • After participating in the happy Muslim family activities, those in the experimental group used significantly less domestic violence against their spouses when compared	• Help Islamic and governmental organizations in forming good policy and concrete strategies for promoting and supporting married couples with violent behavior to return to being individuals with behavior according to social norms and the Islamic way. • The happy Muslim family activities should be considered as the first and principal ways in the development and promotion of the prevention and solving of domestic violence in a more concrete way

Author	Study design/Tool	Sample/setting	Results	Practice/Policy/Research
				and implementing complex interventions.
Falb, K. L., McCormic, M. C., Hemenway, D.,Anfinso, K., & Silverman,J. G. (2013b).	*Design:* cross sectional study *Tool:* Reproductive Health Assessment Toolkit for Conflict-Affected Women	*Sample:* 861 women. *Setting:* 3 primarily Karen refugee camps (Umpiem Mai, Nu Po, and Ban Don Yang) along the Thai-Burma border.	• Experiencing conflict victimization was associated with religion and the husband or partner's level of education. • Majority (62.7%) experienced only 1 form of conflict victimization, while 20.5% experienced 2 forms of violence and 16.9% experienced 3 or more forms of victimization.	• Interventions to reduce the negative effects of conflict victimization should incorporate other forms of violence prevention, including IPV. • Longitudinal research is needed to discern pathways through which these experiences are related.
Laeheem, K. (2017).	*Design:* Experimental study (Randomized Controlled trial) *Tool:* The screening questionnaire for domestic violence risk behaviors; Happy Muslim family activities; Normal	*Sample:* 40 married Thai Muslim couples *Setting:* Satun province	• Before participation-- in happy Muslim family activities had violent behaviors against their spouses than those in the control group who participated in normal community activities. • After participating in the happy Muslim family activities, those in the experimental group used significantly less domestic violence against their spouses when compared	• Help Islamic and governmental organizations in forming good policy and concrete strategies for promoting and supporting married couples with violent behavior to return to being individuals with behavior according to social norms and the Islamic way. • The happy Muslim family activities should be considered as the first and principal ways in the development and promotion of the prevention and solving of domestic violence in a more concrete way

Author	Study design/Tool	Sample/setting	Results	Practice/Policy/Research
	community activities.		with those in the control group.	through the use of socialization in the activities found by this study.
Laeheem,K, & Boonpraka, K. (2016).	*Design*: Qualitative study	*Sample:* 60 (20 parents and 20 relatives of the spouses). *Setting:* Pattani province	• Married, Thai, Muslim couples experiencing domestic violence had had a strict upbringing, experienced violence in witnessing their parents quarreling and beating each other. • Believed that women have an inferior status to men, and that men are dominant.	• Preventing and reducing domestic violence, especially where parents can apply them to improve their parenting styles positively because when children are raised and trained correctly and creatively, they will behave properly. • Socialization according to religious principles by giving children knowledge of the religious principles in the beliefs, practice, and morals and ethics, and training in religious practice in suitable environments and in line with the religious principles can reduce individuals' violent behavior.
Laeheem,K. (2016).	Design: cross sectional study *Tool*:	*Sample*: 1,920 Thai-Muslim married couple. *Setting*: Satun province.	• 34.3 percent of Thai Muslim married couples had domestic violence risk behaviors. • Factors affecting domestic risk behaviors with statistical significance consisted of six variables, namely jealous wives, suspicious wives, drinking husbands, drug abusive husbands, being not ready to have one's own family,	• The individuals and organizations concerned must cooperate to promote happy family life, campaign against domestic violence, and assist couples who regularly quarrel by providing them with socialization, mental health rehabilitation, meditation, etc.

Author	Study design/Tool	Sample/setting	Results	Practice/Policy/Research
			and lack of time for discussions.	
Rujirapraset, N., Sripichyaka, K., Kantaruksa, K., Baosoung, C., & Kushner, K. E. (2009).	Qualitative research (grounded theory)	*Sample:* 16 women who have abused. *Setting:* women's shelter in Northeast.	• Women concealed their abuse by covering, isolating, silencing or revising, in order to protect their sense of self and safety, and their husbands' image or family well-being in spite of repression, fear or psychosomatic symptoms resulting from keeping a secret. • Following disclosure, some women had negative experiences, including shame and guilt, as well as being blamed, revictimized and/or gossiped about. • Positively, some of the women felt relieved, had increased self-worth and obtained support.	• Approaching the women with a respectful and non-revictimizing manner is an initial step in empowering them to raise their voice for further assistance and service accessibility. • Further research should be conducted with abuse women who disclose and seek out medical services or social agencies. • Research should be conducted among other groups of women experiencing violence against them (e.g., rape, dating violence).
Sawangchareon, K., Wattananukulkiat, S.,	*Design:* Intervention study *Tool:* The abuse indicator screening questionnaire;	*Sample:* 17 women who have experienced partner violence. *Setting:* a primary	• After receiving counseling, abused women showed better self-esteem ($t = -4.80$, <0.001) and improved health status ($z = -3.09$, $p<0.01$).	• Nurses trained in counseling can help improve the health of abused women, raise their self-esteem and encourage them to use the proper coping strategies. • continued research should be done to follow up on abused women after

Author	Study design/Tool	Sample/setting	Results	Practice/Policy/Research
Saito, A. S., Nanakorn,S., Doasodsai, S., Baba, M., Takemoto, H. (2013).	The violence questionnaire; The Thai version of the general health questionnaire; Rosenberg's self-esteem scale; The coping strategies evaluation form.	care unit, and a drug treatment center, in Northeast region	• Participants felt the need to use less avoidance coping strategies ($z = 9.19$, $p < 0.01$) with a better approach to coping styles ($z = -2.59$, $p < 0.01$).	3 to 6 months and then a year in order to see discover whether or not levels of violence have decreased.
Sriyothin, S., & Maneesri, K. (2017).	*Design:* Cross sectional study *Tool:* Abusive and Supportive Environments Parenting Inventory (EASE-PI), Experiences in Close Relationships-Revised (ECR-R), Adult Attachment Questionnaire, and the Revised Conflict Tactics Scales (CTS2).	*Sample:* 556 female, who have age over 18 years or were currently in a relationship with a heterosexual partner for at least 6 months. *Setting:* 2 provinces from each northern, northeastern, southern, and central region.	• Abusive childhood experiences affected perpetration and victimization directly and indirectly. • 76.87% of males and 75.72% of females reported that they had perpetrated against their partners at least one or more times in the past 12 months. • Prevalence of victimization, 74.23% of males and 69.78% of females reported that they had been perpetrated against by their partners.	• The implications for the abused partner are the necessities of leaving from violent situations, being aware of sexual equality, and having a right to make accusations against perpetrators. • Social services were approached to deal with violent situations, which they dealt with by; giving counsel to the partners, restoring male perpetrators, promoting sexual equality, and developing multidisciplinary teams to solve the violence problems. • Reducing physical assault; for example, throwing things at, hitting, or beating children can protect adults from emulating this

Author	Study design/Tool	Sample/setting	Results	Practice/Policy/Research
			• Psychological aggression scores were highest, followed by physical assault, sexual coercion, and the lowest score was for injury.	behavior towards their future partner.
Thananowan, N., & Vongsirimas, N. (2016).	*Design:* cross sectional study *Tool:* The Abuse Assessment Screen (AAS) and the Index of Spouse Abuse (ISA), The Stress Test, the Multidimensional Scale of Perceived Social Support, The Rosenberg's Self-Esteem Scale (RSE), The Center for Epidemiologic Studies Depression Scale (CES-D).	*Sample:* 532 Thai women aged between 15 and 65 years, currently lived with a recent partner or separate from intimate relationship with gynecological problems. *Setting:* university hospital in Bangkok	• 21.1% of participants reported any type of IPV (e.g., physical, sexual, or emotional violence) in the past year and 22.2% had cervical cancer. • IPV was significantly positively associated with stress, depressive symptoms, and cervical cancer but negatively correlated with social support and self-esteem. • Psychosocial factors were mediators of the relationship between IPV and cervical cancer.	• Health care protocols for abused women should include screening for and treatment of IPV-related psychosocial factors. • Interventions that provide social support and protect self-esteem should reduce stress and depressive symptoms among abused women. • Future research might consider the use of multiple data collection methods, including salivary cortisol when appropriate.
Thananowan, N., &	*Design*: Cross-sectional design.	*Sample:* 532 Thai women who were inpatient ward with	• The prevalence of IPV in this study was 21.1% and 17.3% reported physically	• Women with gynecological problems should be screened for

Author	Study design/Tool	Sample/setting	Results	Practice/Policy/Research
Vongsirimas, N. (2014).	*Tool:* The Abuse Assessment Screen, the Index of Spouse Abuse, the Stress Test, the Center for Epidemiologic Studies Depression Scale, The Rosenberg's Self-Esteem Scale, and the Multidimensional Scale of Perceived Social Support.	gynecological problem diagnosed by gynecologist and have aged between 15 and 65 years. *Setting:* two gynecology wards of a large university hospital in Bangkok.	abuse, 11.5% sexual abuse, and 13.2% emotionally abuse. • Abused women reported significantly higher stress and depression and had lower self-esteem and social support than non-abused women. • Women who experienced emotional violence had significantly higher stress and depression but lower self-esteem and social support than those experiencing physical and sexual violence. • Sexual violence was the strongest predictor of depression, self-esteem, and social support. Physical violence had no effect on mental health.	mental health issues and asked about their history of IPV. • Routine assessment for IPV must be standard care for all women with gynecological problems. • Training programs for health professionals, including nurses, in hospitals and educational institutions should address issues such as common definitions, statistics regarding IPV, the cycle of violence, the health impact of IPV, how to screen for IPV, how to deal with IPV in the health care setting, and how to work with existing resources.
Xiaohe, X., Kerley, K. R., & Sirisunyaluck, B. (2011).	*Design*: cross sectional study *Tool*: Conflict Tactics Scale (CTS2),	*Sample*: 770 married women. *Setting*: Bangkok cluster sampling procedure).	• 62% of wives reporting psychological violence, 34% of physical abuse, and 15% of physical injury. • Psychological and physical domestic violence increases if the wife has less income as compared	• This research is an important step toward elucidating the causes of IPVAW in this unique Buddhist society in Southeast Asia. • Future research should include the linkages between gender traditionalism and IPVAW in urban

Author	Study design/Tool	Sample/setting	Results	Practice/Policy/Research
			with couples who have equal incomes. • Physical violence against wives increases if the wives have more years of education than their husbands as compared with their counterparts who have an equal educational status.	Thailand, both wives' and husbands' measures.

Table 4. IPV in Pregnant women. N=5

Author	Study design/Tool	Sample/setting	Results	Practice/Policy/Research
Falb, K. L., McCormick, M. C., Hemenway, D., Anfinson, K., & Silverman, J. G. (2014).	*Design:* cross-sectional design *Tool*: Reproductive Health Assessment Toolkit for conflict Affected Women.	*Sample:* 337 refugee women aged 15–49 years who reported a pregnancy that resulted in a live birth within the past 2 years. *Setting*: Thai Burma Border.	• 16% reported symptoms related to pregnancy complications (abortion, stillbirths. • Almost 1/6 women reported experiencing any forms of violence throughout their lifetime. • Conflict victimization was strongly linked with heightened risk of self-reported symptoms associated with pregnancy complications.	• Continue expanding multi-sectors effort to address the health and psychosocial needs of conflict-affected women in protracted refugee setting. • Consideration the long term and indirect impacts of conflict-related victimization from a programmatic, public health policy and human right perspective in relating to maternal health outcomes.
Peltzer, K., & Pengpid, S. (2017).	*Design:* cross sectional study *Tool:* the "Severity of Violence Against Women Scale," "Edinburgh Postnatal Depression Scale," "Danger Assessment Scale,"	*Sample:* 207 adult women and pregnant women. *Setting:* antenatal care clinic and general outpatient clinics in two provinces in the central region.	• 49.3% scored positive for depression, and 17.6% reported suicidal threats or attempts in the past 12 months. • Sexual violence was significantly associated with depression, whereas psychological abuse and femicide risk or danger was correlated with suicidal behavior. • The overall proportion of physical violence was 67.1%, sexual violence 27.5%, psychological abuse 82.1%, and danger 72.0%.	• Need to assess women reporting IPV for depression and suicidal behavior. • Increasing severity of IPV and increased danger are associated with poorer mental health needing safety planning and mental health services in conjunction with IPV care

Author	Study design/Tool	Sample/setting	Results	Practice/Policy/Research
Saito, A., Creedy, D., Cooke, M., & Chaboyer, W. (2013).	Design: cross sectional study. *Tool:* SF-12, psychological Maltreatment of Women Inventory-Short Form (PMWI-SF). Severity of Violence Against Women scale (SVAW)	*Sample:* 421 pregnant women at 32 weeks gestation or later and have aged at least 18 years. *Setting:* 2 hospitals in Khon Kaen province, Northeastern	• 53.7% is reported for psychological abuse; 26.6% of threats, acts of physical abuse, or both; and 19.2% of sexual abuse. • Women abused during pregnancy had poorer health compared with non-abused women, in role emotional functioning, vitality, bodily pain, mental health, and social functioning.	• Routine screenings by maternity services is urgently required. • Respectful and culturally sensitive questioning and early interventions are important to obtain early identification of victimization and prevent further harm. • Health care professionals need to be aware of the impact of IPV on the functional health status of childbearing women and recognize signs of ongoing violence when women present to hospital or health care clinics.
Saito, A., Creedy, D., Cooke, M., & Chaboyer, W. (2012).	*Design:* cross-sectional design *Tool:* Short Form 12-Item Health Survey, Psychological Maltreatment of Women Inventory, and Severity of	*Sample:* 274 postpartum (within 6 weeks) women who have aged between 18 and 45 years. *Setting:* two government funded tertiary hospitals in Khon	• Abused postpartum women had lower well-being than non-abused women. • 25.2% (n = 69) of the women were exposed to psychological violence. • 35.4% of women (n = 97) exposed to overall psychological abuse after childbirth. • Psychological violence had a significant impact on the physical functioning.	• Routine screening for intimate partner violence by maternity services is urgently needed. • Studies with large, representative samples of postpartum women are required.

Author	Study design/Tool	Sample/setting	Results	Practice/Policy/Research
	Violence against Women scale.	Kaen province, northeastern.		
Saito, A. S., Cooke, M., Creedy, D. K., & Chaboyer, W. (2009).	*Design:* Case studies	*Sample*: 2 pregnant women. *Setting:* Antenatal clinic, a hospital in north east Thailand	• IPV had pervasive consequences on their health and well-being and contributed to their low self-esteem, helplessness, fear, social withdrawal, suicidal ideation, and self-harm. • IPV in Thai culture is centered on the power of men exerting control over women. • Abused women continued to live with their partner because of stigma and blame towards women, which they perceived as prevalent in the Thai culture.	

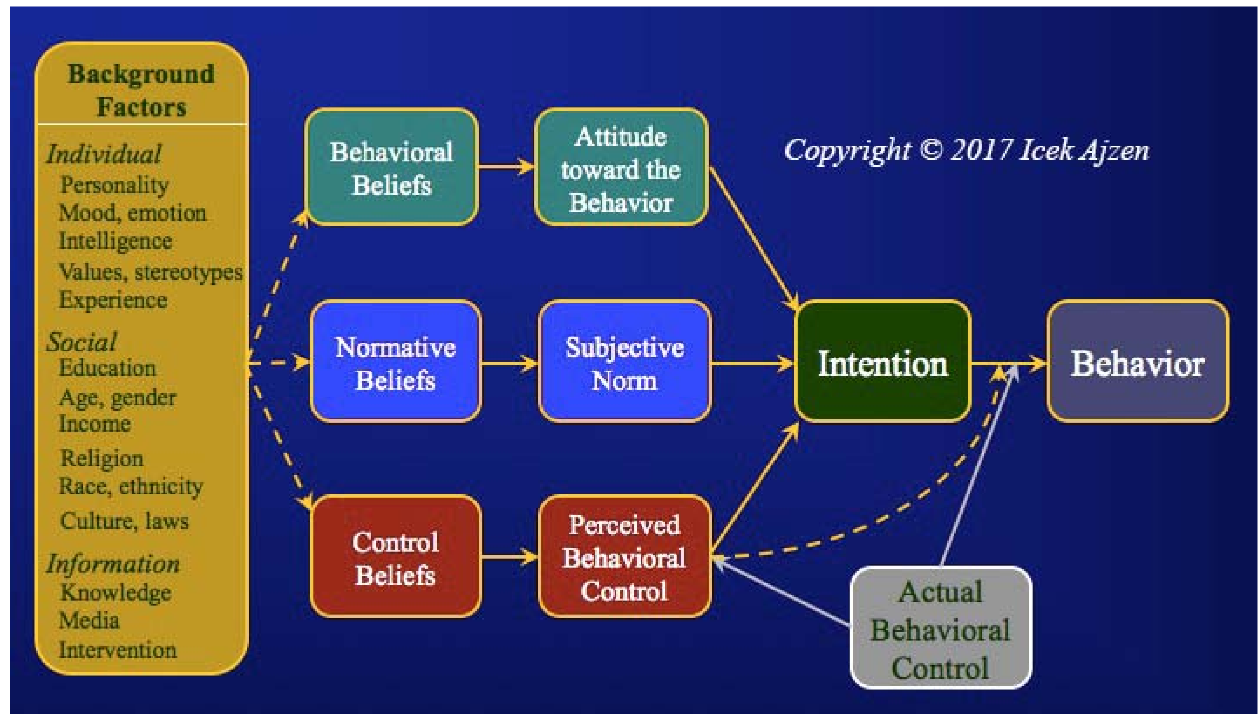
Theoretical framework

The Theory of Planned Behavior (TPB), which is created by Ajzen, is a promising framework to examine IPV screening and referral to advocate services (Ajzen, 1985). A theory of planned behavior was developed from the Theory of Reasoned Action (TRA), which first proposed in a joint paper between Ajzen and Martin Fishbein in 1980.

The concepts of TPB believe that intentions are the precursors of behavior (Ajzen, 2006). Ajzen (2006) explained that TPB determines attitudes, subjective norms, and perceived behaviors of people. See figure 3. The ultimate outcome of the theory is predicting behavior. The behavioral beliefs can produce attitudes toward a behavior, normative beliefs can produce subjective norm, and control beliefs will produce perceived behavioral control. If the independent variables, which are attitudes, subjective norms, and perceived behavioral control, are strong, a person should have a high intention to perform the behavior (Ajzen, 2006). Moreover, Ajzen (2006) stated that if a person can produce the high degree of actual behavioral control, it will result in a behavior.

The perceived behavioral control, which is the one added from the TRA, refers to the degree to which person believes that they control any given behavior. The TPB suggests that are much likely to intend to enact certain behavior when they feel they can enact them successfully.

Figure 3. Theory of Planned Behavior



Attitudes are perceptions of how pleasant or unpleasant or enjoyable or unenjoyable a recommended behavior is perceived to be (Ajzen, 2006). An individual is likely to have a positive attitude about a behavior (e.g., affirmative sexual consent) if they believe that it will lead to positive outcomes (e.g., will enhance their overall sexual experience) and prevent negative outcomes (e.g., prevent unwanted and/or nonconsensual sex).

Subjective Norms refer to the belief that important (referent) others in one's life think they should or should not perform a behavior (Ajzen, 2006).

Perceived Behavioral Control refers to the extent to which an individual believes that they are capable of performing a behavior, and whether they perceive that they are, or are not in control of performing the behavior (Ajzen, 2006).

Intentions are "the indications of a person's readiness to perform a behavior" (Ajzen, 2006). The relative contribution of each of these three constructs (i.e., attitudes, norms, and perceived control) on one's intention to perform a behavior may differ depending on the specific population being studied, and the particular behavior of interest (Ajzen, 1985, 2006).

Application of TPB

The TPB has been used as a framework for a number of behavioral interventions targeting, with regard to IPV specifically, studies have shown that the TPB is predictive of IPV behaviors of male perpetrators (Kernsmith, 2005), and the intention of female victims to leave or stay in a violent relationship (Edwards, Gidycz, & Murphy, 2015). While these studies use the TPB to predict behaviors among perpetrators and victims of IPV, Schoening et al. (2004) applies the TPB to assess the changes in attitudes toward IPV following trainings for hospital nurses (Schoening, Greenwood, McNichols, Heermann, & Agrawal, 2004).

The TPB has been used to examine nursing students' intention to screen domestic violence in Israel (Natan et al., 2016). The results show that the TPB can predict 32% of students' intention to screen and 28% of intention to report domestic violence. According to the TPB model, intention to screen women for IPV is affected by the following factors: Normative beliefs, subjective norms, behavioral beliefs, perceived control, and knowledge, with the factor of normative beliefs being the most significant (Natan et al., 2016). Additionally, Abildso et al, (2017) evaluate the impact of IPV behaviors (screening, making referrals, and safety planning) using the theory of planned behavior by surveying 125 home visitors in West Virginia. They were conducted before and after a

daylong IPV training. The results showed that IPV training has a positive impact on intention to perform the three behaviors of interest, with the greatest impact on the intention to conduct IPV screenings (Abildso et al., 2017).

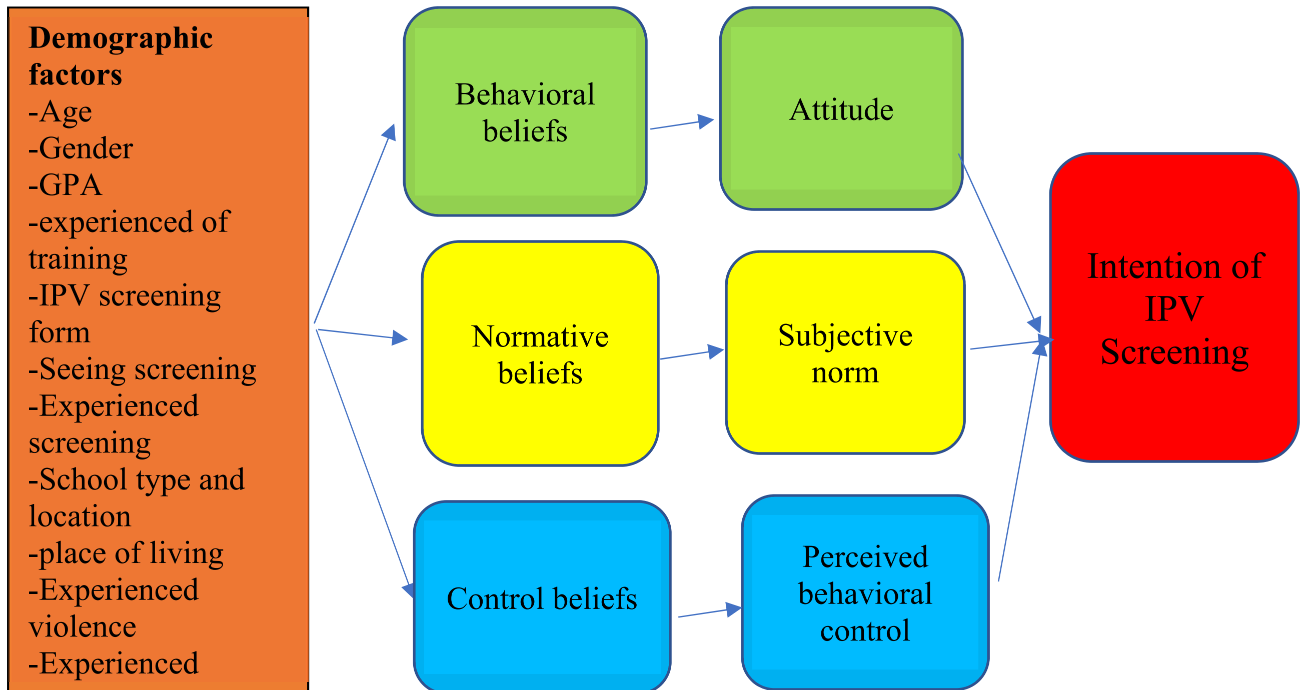
The intention is a key to determine behavior that it is valuable for researchers to design interventions to promote behavior change (Bandura, 1999; Locke & Latham, 1992; Maddux & Rogers, 1983). Research has supported that intention can translate into actual behavior. For example, one study examined drinking patterns among sorority member students, it was shown that behavior was predicted by intentions ($B=0.76$, $p<0.01$) and perceived behavioral control ($B=0.22$, $p < 0.01$) (Huchting, Lac, & LaBrie, 2008). In addition, a meta-analysis of research using the Theory of Reason (TRA) and the Theory of Planned Behavior (TPB) showed that these models explain the variances of intention between 40% and 50%, and the variances of behavior are between 19% and 38% (Sutton, 1998). Therefore, the cognition of someone intends to do something seems to translate and they do so.

The reasons for choosing the TPB as a theoretical framework in this study were included; (1) The TPB is one of the theories that can describe the intention of people from beliefs and background factors that is match with research questions of this study: (2) There are many evidences that support the TPB as a good theory for predicting intention, particularly intention to screen violence for women: (3) and tools of measuring intention of the TPB have validated from many studies and also several countries (developed and developing countries). Therefore, the TPB was suitable for prediction intention to screen IPV for women from nursing students in Thailand.

Framework for the study

Thai nursing students' intentional behavior of IPV screening was the outcome variable for this study. *Attitudes* were conceptualized to be the attitudes of nursing students related to performing IPV screening. *Subjective norms* were conceptualized to be the social references that nursing students apply to performing an IPV screening. *Perceived behavioral control* was conceptualized as the perceptions of ease or difficulty that nursing students assign to IPV screening. *Intentions* were conceptualized as the nursing students' motivation to carry out IPV screening. For this study, the application of the TPB was illustrated in Figure 4.

Figure 4. TPB Framework as a conceptualized framework for this Study of IPV screening



Conclusions

This chapter discusses the definitions of IPV, IPV prevalence, IPV screening, healthcare response to IPV, negative consequences of IPV, and IPV in Thailand. In fact, IPV is prevalence in global, especially in low-and middle-income countries and IPV has been linked with not only physical health consequences, but also psychological health consequences. Healthcare providers play an important role to prevent IPV, especially about nursing professional. The highlight of information of healthcare providers response to IPV is shown in the wheel of elements of health system and health-care-response necessary to address violence against women by Colombini et al, 2012. Nurses spend the most time with patients and they are working as a gate keeper as well. However, even though there are the guidelines of healthcare providers address to IPV, there are a lot of gaps between healthcare policies and implementations by providers. One of the gaps that the literature mentioned is knowledge and confidence of healthcare providers to response to IPV, additionally, student health professionals have not well-prepared for dealing with IPV and IPV screening.

In addition, this chapter reviewed IPV in Thailand and barriers of IPV screening with two components; policies and providers. First, resources, available resources of IPV is needed, such as IPV shelters and hotlines. This problem would make healthcare providers feel uncomfortable to screen women for IPV because they do not know how to do if they found positive IPV case. In addition, the government lacks policy about IPV training for healthcare providers, the training will be found in some hospitals in urban areas but it is not covered in all areas now. The policies of training will increase providers' awareness. Second, there is no research published regarding Thai healthcare

providers' perceptions or knowledge about IPV. Hence, there is a lack of knowledge and understanding regarding Thai providers' perspectives on IPV screening.

CHAPTER THREE

METHODS

The purpose of this chapter was to describe methodology employed in this study, including the research design, participants, sampling, measurement, data collection, data analysis, and ethical considerations.

Design

This study was conducted as a mixed-methods research, with primary data collection involving online surveys and focus groups with senior nursing students in Thailand and individual interviews with Thai nurse educators. The aims were to 1) describe nursing students' demographic (age, gender, GPA, religious, place of living, region of living, experiences of seeing nurse's screening in intimate partner violence, experiencing IPV, and experience of IPV training) data and attitudes, subjective norms, and perceived behavioral controls about IPV and intention of IPV screening, 2) examine the relationship between attitudes, subjective norms, and perceived behavioral controls and intentional behavior in IPV screening, 3) examine the strength of the relationship between demographic data (age, gender, GPA, religion, place of living, region of living, experiences of seeing nurse's screening in intimate partner violence, experiencing IPV, and experience of IPV training) and attitudes, subjective norms, and perceived behavioral controls predicts intention to screen for intimate partner violence, 4) and explore the perceptions of IPV screening.

Mixed methods research combines between qualitative and quantitative research approaches for deep understanding (Johnson et al., 2007). The goal of using mixed methods design is to cover more content than either method alone (Morgan, 2013). A

mixed-methods convergent parallel design was particularly conducted in this study. Convergent parallel designs are performed independently by the quantitative and qualitative strands of the research; the results are brought together in the overall interpretation (Creswell & Plano Clark, 2011) and both qualitative and quantitative research methods are equal in performing the study (Creswell & Plano Clark, 2011; Tashakkori & Teddlie, 2009). The strand results are integrated into meta-inference after separate analysis are conducted; related QUAN and QUAL research questions are answered of the same mixed research questions (Teddlie & Tashakkori, 2009). A main advantage of convergence design in mixed methods design is to enhance the credibility of the research results by minimizing the chance of biases (Denzin (1970).

Quantitative research involves the collection of data at a single point in time from a sample drawn of specified population (Polit & Beck, 2016). A cross-sectional study was fitted to the research questions of this study, which describes "What are the relationships between the independent variable and dependent variable" and "How much can IPV screening intentions be predicted?" The answers from these questions will be best expressed quantitatively. A cross-sectional survey offers the opportunity to assess relations between variables and differences between subgroups in a population (Robins, Fraley, & Krueger, 2009).

A qualitative research method with focus group and individual interviews explored Thai nursing students and nurse educators' perceptions to IPV screening, and also validated the results from the quantitative method. This design used an exploratory approach to understand a particular perception within its context or setting when little is known about the problem (Polit & Beck, 2016).

Participants

The quantitative study. The study participants included nursing students from schools of nursing: public universities and private universities across Thailand by using an online survey. The inclusion criteria were: nursing students who were studying the fourth year of bachelor's degree; passed at least one nursing clinical practicum course; and all gender orientation. Nursing students who were in their first, second, and third year of study were excluded.

The qualitative study, there were nursing students and nurse educators. The inclusion criteria were: nursing students who were in the last year of their nursing program and passed at least one nursing clinical practicum course: nurse educators who have at least ten years of experience in education and live in a province in Northeast Thailand. Nursing students who were studying in their first, second, and third year, and did not pass any nursing clinical practicum were excluded. Nurse educators who live outside a province in Northeast and have less than ten years' experience were not recruited.

Sample and Setting

In Thailand, there are about 2,000 students studying in Thai nursing colleges as public nursing colleges nursing schools under Praboromarajchanok Institute for Health Workforce Development (PIHWD), public universities, and private universities (Thai Nursing Council, 2019). The samples were generated by convenience sampling, with the aim of representing nursing students working in diverse settings across Thailand. The sample size was calculated by using the Power Analysis and Sample

Size software (PASS) (PASS 2019 Power Analysis and Sample Size Software, 2019). A logistic regression of a binary response variable (Y=intention)) on a continuous, normally distributed variable (X = attitude, subjective norm, and perceived behavioral control) with a sample size of 295 observations achieves 80% power at 0.05 significance level to detect a change.

Nurses make up 70% of the health care personnel in Thailand (Srisuphan et al., 1998), and 70% of them graduated with a Bachelor of Nursing. There were 65 nursing colleges in Thailand: fifteen nursing schools, which are under Ministry of Education, 29 nursing schools are under Ministry of Public Health, one under the Royal Thai Police, one under the Red Cross, and ten private nursing schools (Bureau of Policy and Strategy, Ministry of Public Health, 2005). The author, who is a Thai nurse and a nursing school faculty member, leveraged her personal and professional connections to reach Thai nursing colleges and students to recruit survey participants.

Measurement

Sociodemographic variables. Investigator-developed questions were measured the following: participant age; gender with male, female, or not identified; GPA with the range: 2.00-2.50, 2.51-3.00, 3.01-3.50, >3.5; place of living, rural or urban; religion: Buddhist, Muslim, Christian, and other.

Exposures to IPV training, and IPV screening. Investigator-developed questions were measured participants' experiences of seeing a nurse's IPV screening with YES or NO; how much IPV training there is in nursing school (none, watched a video, attended a lecture or talk, attended a skill-based training or workshop, and other (specify); estimated total number of hours of IPV training in school (none, 1-5 hours, 6-15 hours, and more

than 15 hours); own exposure to IPV ("have you ever experienced physical, sexual, and emotional violence in an intimate partner relationship, yes or no") and exposure to IPV among family members, ("have you ever witnessed physical, sexual, and emotional violence directed toward a family member: yes or no.)

Attitudes, subjective norms, perceived behavioral control, and intentions related to IPV screening. The instruments to evaluate intentional behaviors of IPV screening were developed by using an established measure of IPV attitudes, subjective norms, and perceived behavioral control from O' Malley (2011) and Natan, Khater, Ighbariyea, and Herbet (2016). The instrument from this study is called Intimate Partner Violence Screening Instrument for Nursing Students (IPVSI-NS). Attitude and perceived behavioral control measures were adapted from O' Malley (2011), which explains conducting violence assessment practices of pediatric emergency department nurses and physicians in the U.S. The questionnaires were created by the researcher and Ajzen, who established TPB, who was a consultant for the questionnaires. The Cronbach's alphas of attitude and perceived behavioral control are 0.54 and 0. 68 respectively. In addition, the questionnaire about subjective norms was adapted from Natan, Khater, Ighbariyea, and Herbet's (2016) study that they conducted about nursing students' intention to screen women for domestic violence following by using the Theory of Planned Behavior (TPB). However, the validity and reliability of these questionnaires are not mentioned in the original paper. See example questions in Table 5.

The participants in this study indicated their attitudes, subjective norms, and perceived behavioral controls, and intention on a 5-point adjective scales. The Likert scale was following Fishbein and Ajzen (2010), including, extremely agree, agree,

neutral, disagree, and extremely disagree. There are 36 relevant items; the total score is 180. There were 2 questions for intention: intention and not intention. There were eight reverse-scored items. The questionnaires were included as Appendix.

Table 5. Examples of questions by TPB construct

Construct	Number of questions	Example of question
Attitude (Outcome evaluation + Behavioral beliefs)	14	1. Assessing women, I can help provide safety to women. 2. Assessing women for IPV I can offer more complete health care to survivor.
Subjective norm (Motivation to comply + Normative beliefs)	9	1. My clinical preceptor supports screening women for IPV. 2. The opinion of my clinical preceptor concerning screening women for IPV is important to me.
Perceived Behavioral Control (Power of control + Control Beliefs)	13	1. It takes extra time to assess women for IPV 2. The reasonable patient load can facilitate assessment of women for IPV.
Intention	1	1 I intend to screen all women for IPV when they present to the hospital,

Construct	Number of questions	Example of question
		healthcare community, or healthcare services for treatment for any reason.

Because Thai-language versions of these measures do not currently exist, instrument translation and content validity testing with five experts were provided. Two experienced bilingual IPV experts did the forward-translation of the original English versions of the instruments into Thai. Back-translation was used to determine the equivalence of the original and translated versions. A first draft of the questionnaire was piloted with 45 Thai nurses and nursing students. The overall Cronbach alpha was 0.76.

The qualitative measure. Based on the previous studies (Oluwatoni E Aluko et al., 2015; Natan et al., 2016b), the author has developed a draft version of a semi-structured interview guide, with open-ended questions addressing the study aims (e.g., perceptions of IPV screening, attitudes, subjective norms, and perceived behavioral control about IPV screening, etc.). Examples of questions in the semi-structured interview guide for nursing students and nurse educators were as follows: Attitudes: *Is intimate partner violence a problem in Thailand? What do you think about screening women for IPV (advantages/disadvantages)? Do you think a nursing career is an important career for screening women for IPV?* Subjective norms: *Do you think opinions of nursing instructors, nurses, or policy at the clinical sites can support or encourage you to screen women for IPV?* Perceived behavioral control: *what are the barriers of screening women for IPV in Thailand? How does nursing school prepare you for screening women for*

IPV? Is screening IPV for women easy or difficult? Have you been trained? If you are a nurse educator who can provide or manage courses regarding IPV into the nursing curriculum, how should you start to prepare future nurses and promoting IPV screening (only nurse educators' participants)?

Data Collection

Quantitative study

The author sent the questionnaire link to nursing students' emails, nursing school's websites, Facebook, or any school's social media that the author found. In addition, the author sent the questionnaire's link to student groups' emails and Facebook, and asked them to share the link to their friends and colleagues. Rates of return were important in online survey research since a higher response rate would decrease the risk of bias (Robson & McCartan, 2016). Therefore, the boosting online survey was used to increase responding rate: repeated reminder emails to nursing students in every two weeks; posted the questionnaire's link to Facebook, Twitter, or any social media every week; using hashtags, which were representative in the research project in social media such as #IPVsurveynursingstudents, #Thainursingstudents, and #IPVinThailand.

The questionnaire took an average of 10-15 minutes to complete. Participants were asked to read a one-page instruction online describing the study aims and protocols, and containing the author's contact information and go to the instrument if they accepted to participate. All information was password protected when accessing the data, only author could access to the data, when answering the questionnaire participants could leave from the survey anytime when they feel uncomfortable. Data collection occurred within 12 months from June 2018 to June 2019. There was no incentive cost for

participants in this study. However, to encourage participants to take questionnaire, two iPads were provided as incentives and chosen by lottery; participants could choose to complete a separate webform (unlinked to their de-identified survey responses) at the end of survey completion to provide their contact information to be entered into the iPad lottery.

The author recorded data in the data collection that the participants submitted online directly to the author. To assure the integrity of the data entry process, validation options in Microsoft Excel spreadsheets were used so that only data values within allowable ranges were accepted. If someone was not included by the inclusion criteria, the system did not accept it and kicked it off.

Qualitative study

For both focus groups and individual interviews, the author distributed the research project by sending the official invitation letters to directors and deans of nursing schools within a province in northeast Thailand attaching the research flyers, and asked them to distribute the project to nursing educators and nursing students who may be interested. The flyer included the aim of research, date, time, and the author's contact information. When the participants responded to the author and agreed to participate, the author arranged all focus group and individual logistics (space, food, transportation, needed supplies). Upon participants arriving to the focus group or interview location, the author again described the study and its voluntary nature to participate.

The author (an experienced qualitative researcher) conducted all focus groups and interviews in the Thai language. Focus groups/interviews began with an informed consent process and were estimated to take 60-90 minutes. Participants have been compensated

for their time (approximately $7 USD), and food was provided; the amount and type of incentives were consistent with cultural norms and usual practice for data collection in Thailand.

Data analysis

A p-value of < 0.05 indicated statistical significance. Demographic data was generated in the form of frequency and percentage was generated. The author recorded data from the Qualtrics software and then imported to SPSS for analyzing. To assess the reliability of instruments, internal consistency was used with Cronbach alphas.

Research question 1: How did nursing students' demographics (age, gender, GPA, religious, place of living, region of living, experiences of seeing nurse's screening in intimate partner violence, experienced IPV, and experienced of IPV training) and describe attitudes, subjective norms, perceived behavioral control, and intentions? This question used descriptive analysis data, including percentage, frequency, and standard deviation.

Research question 2: What was the relationship between attitudes toward IPV screening, subjective norms regarding IPV screening, perceived behavioral controls around IPV screening, intention to screen for IPV, and personal experiences with patients who are abused? The independent variables were demographic data (age, gender, GPA, religious, place of living, region of living, experiences of seeing nurse's screening in intimate partner violence, experienced IPV, and experienced of IPV training), and attitudes, subjective norms, and perceived behavioral controls. The dependent variable was intention to screen women for IPV. Bivariate relationship as a Spearman's Rho correlation, Chi-square, and Fisher's exact test were used to identify relationships

between the variables.

Research question 3: How strong was the relationship between the demographic data (age, gender, GPA, religious, place of living, region of living); exposures to IPV training, and IPV screening (experiences of seeing nurse's screening in intimate partner violence, and experienced of IPV training), own/family exposures to IPV, and attitudes, subjective norms, and perceived behavioral controls in predicting the intention to screen for IPV? To test mediation, this study used PROCESS (available at http://www.afhayes.com). Mediation models were tested through a series of logistic regression, which yield unstandardized path coefficients for the total, direct, and indirect effects (Hayes, 2017). It was hypothesized that the indirect effect of demographic data (X) on intention of IPV screening (Y) through the TPB components (attitude, subjective norm, and perceived behavioral control) (M) as moderators. The independent variables were the demographic data and the logistic regression (predictive model) will be used to predict intention. Age variable was a control variable. To interpret and presenting these results from the logistic regression, the author looked at the data from the variables in the equation table (constant, slope, significant, and confidential interval), Model Summary (R Square). After that, the author created the equation and odds ratio to predict intention.

Research question 4: Exploring the perceptions of IPV screening regarding nursing education. Content analysis was used. All focus groups and individual interviews were recorded using two digital tape recorders and transcribed by the author from Thai to English, with codes replacing participant names to ensure anonymity. Transcribed data were coded by using the qualitative software package DeDoose, and employed a qualitative descriptive analysis approach, a low-inference, low-abstraction method of

analysis appropriate for use in health research and intervention development. The data from focus groups and individual interviews were analyzed separately.

There were two cycles for analyzing data in this study following Saldana (2015). The first cycle used In Vivo methods for coding to find the core meaning words or sentences that would be represent meaning of sentence or paragraph. The second cycle coding, which was done to group the same meaning and a word's feeling or purpose together and created the new word to represent that group, used two difference methods were focus and selective coding.

There were five steps performed in analyzing data. Firstly, the transcripts were read several times, keeping the research question in mind. Secondly, each sentence or paragraph was coded and marked using In Nivo coding to identify the main idea of the sentence or paragraph. Thirdly, the data was read several times again and then started to create tentative labels for chunks of data. Fourthly, codes with the same meaning and in the same sense were grouped together and relationships were identified among the focus codes and connections were made among the codes. Fifthly, the words that identified each group were identified, words to code were recalled, and transcripts were read again to make sure that the words can represent the whole story.

Categories and theoretical themes of analysis consisted of attitudes, subjective norm, and perceived behavioral control toward intention of IPV screening. Identified categories and themes were discussed with the research team until a consensus was reached regarding thematic findings. Any potentially identifying data within the transcriptions were redacted, and audiorecordings were destroyed following the transcription process. See Table 6.

Table 6. Example of content data analysis to categories

Citation	Meaning unit	Code	Sub-category	Category
"…We asked her how is going on; she was silent for about 2 mins and cried after that. We let her breath and asked her again. She told us that her husband hit her for years…"	Asking women about their intimate relationship, it may know their abusive experienced	*Identify survivors*	Positive attitude	Attitude
"I believe that IPV is most related to social work more than nursing work; nursing work can work on this issue when social work asks for help. We did not train for this issue"	Screening women for IPV may not be the nurse work.	*Not recognize in nursing work*	Negative attitude	

Research question 5: The mixed-methods question: Do the quantitative measure uphold the prominent themes discovered in the qualitative data? To what extent does the qualitative data contribute to an enhanced interpretation and understanding of the

relationships discovered among the quantitative variables? Mixed-methods data analysis of this study was comprised of combining the data of quantitative and qualitative methods for meaningful interpretation (Creswell & Plano Clark, 2011; Tashakkori & Teddlie, 2009). The steps of mixed methods data analysis were followed by Creswell and Planand Clark (2011). Quantitative and qualitative data were collected simultaneously then analyzed independently. After independent analysis was finished, the findings were further examined to determine how they will be compared. Polished the data of both quantitative and qualitative to join interpretation in answering the research question of mixed-methods research, and then compare both data. Next, a frequency table of emerged codes in qualitative method including focus groups and individual interviews and a cross-tabulation table of quantitative continuous variables and qualitative categories were created and developed. This method of analyses was considered to be the most direct similar of displaying in both sources of data (Creswell & Plano Clark, 2011). Lastly, a hierarchical categorization of IPV screening's perceptions was created to achieve a deeper understanding. The hierarchical categorization represented all data from survey online, focus groups, and individual interviews. Merged findings were used to answer the research question meaningfully (Creswell & Plano Clark, 2011). See Figure 5.

Trustworthiness of data for quantitative study

A descriptive cross-sectional study design with an online survey is not as effective in controlling threats. However, to maintain rigor, the investigator adhered to the epistemological standards of power and reliability, and also meet with assumptions of statistical analysis. Every effort was made in this study to control potential bias.

There are a number of ways to examine the sample size in quantitative research. This study explored a sample size by using G-Power analysis based on effect sizes from previous studies. This study sample size was 295, but the participants was 639, thus assuring adequate power.

In addition, this study recruited participants across Thailand, distribute and weight data covering all geographies of nursing schools and participant characteristics were also considered. During the first two months of data collection, the author primarily recruited through the author's professional contacts. It met minimum sample size, but found most participants were from northeast Thailand and nursing schools under PIHWD (where the author, a nursing school faculty member, is best-connected). Therefore, to reduce the bias of results, the author submitted an IRB amendment to recruit more widely via social media and substantially increased the geographic and nursing school diversity in sample.

As the tool would be used in Thailand, which has not used this tool before, the developed content needs to be culturally appropriate by five experts was conducted. Reliability of the tool was assessed using Cronbach′s alpha for internal consistency. Pilot testing with 45 participants was performed for purposes of validity and reliability. Support for reliability is considered acceptable when Cronbach′s alpha is greater than 0.7. The Cronbach′s alphas of major variables were from 0.78 to 0.89: a*ttitude* (α = .0.78), subjective norm (α = .0.89), and perceived behavioral control (α = .0.85). Overall the co-efficient is 0.91. It is a high level of internal consistency and overall reliability. Normality of data and other assumptions of medication and logistic regression were also tested before analyzing. Data was normalized and all statistical assumptions were met.

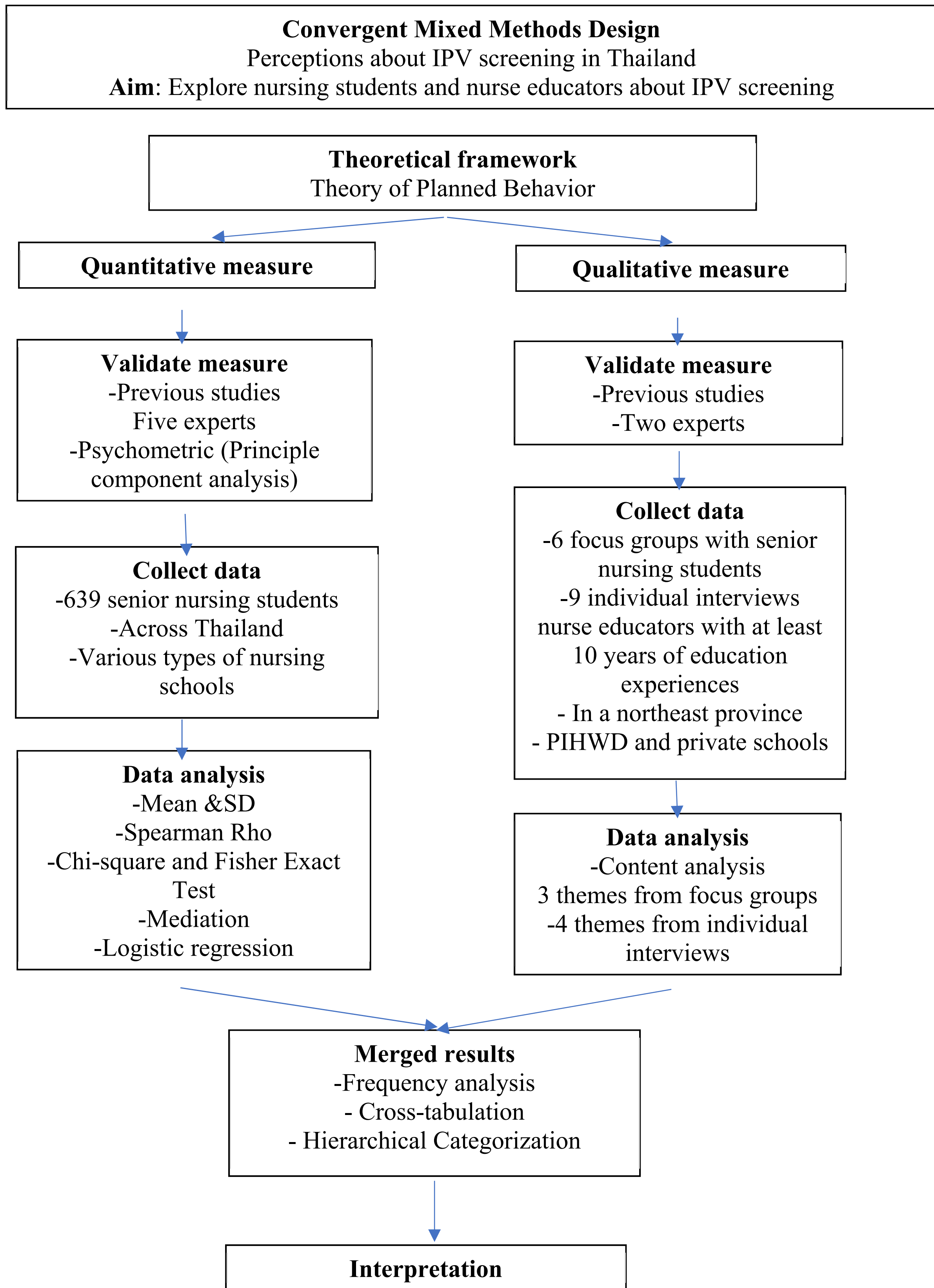
Trustworthiness of data for qualitative study

Credibility: The study participants were chosen through a purposive strategy to achieve a diversity of data in terms of nursing schools: PIHWD and private, thus increasing credibility. Moreover, before finishing a group discussion and individual interview, the author summarized the discussion to participants, who could confirm or recommend removal of portions of those for the accuracy of data. The process of content analysis especially transcribes verbatim, codes, and categories was back-translated into English to investigate issues concerning missed information. The process of building categories and themes was created by authors with experience in IPV, nurse educators, and qualitative research method. *Transferability:* The author can give suggestions and recommendations, but it is up to the reader to decide whether or not these findings are transferable to another setting. The researchers believe this study can provide valuable insight into Thai senior- nursing students perceptions and intentions about IPV screening. *Dependability*: The data analysis process was consistently followed, and the authors were open for dialogue and judgments about similarities and differences of the content that were consistent over time until agreement about the data was reached. *Confirmability*: The researchers checked and reviewed the purposes, methods, and procedures to enhance the rigor of research findings.

Trustworthiness of data for Mixed methods research

Methodological triangulation or validation of findings were verified through combining qualitative and quantitative methods. The merging and interpreting of quantitative and qualitative findings afford the researcher a more robust analysis of the phenomena.

Figure 5. Methodologies of mixed methods research in this study



Protection of Human Subjects

The author submitted the IRB to the University of Missouri-Columbia, Health Sciences Institutional Review Board requesting full board review and they approved of the study with appropriate consent forms and HIPPA Authorizations. All participants were volunteers and took part in an informed consent process, including a waiver of documentation of written informed consent. This informed consent process included informing them that they can withdraw at any time and for any reason, and study participation was not a requirement of their school program, nor will their data be shared with nursing instructors or others. While the data was collected, they were anonymous participants.

The quantitative method, to assure participants' rights to privacy, raw data was kept in files of a computer which only the author has a password to log in to view those files. Names and other possible identifiers were not used. Raw data was printed and stored at the separate file in the computer; the author only could open it.

Confidentiality was maintained first in recruitment by having interested potential participants indicated their assent. All the findings reported were anonymous and in aggregate form. Participants' right to beneficence was protected by ensuring that all have an equal chance of participating in the study.

Participants' right to veracity was respected by ensuring that they have completed information about the study so as to be able to make a truly inform by online consent. All study procedures were explained to participants including the data to be collected and their rights as participants via instruction of study that showed in the first page of the

questionnaire online. The author also shared this information with participants upon their request only.

There was minimal risk of being in the study. While participants were taking part in the answering the questions, the participants may remember or think about abuse of women that participants have experienced or seen. That could be upsetting. The study questions were about participants' professional opinions. Participants could decide not to answer any question they didn't want to answer and they could decide to stop being in the answer anytime, because being in this study was voluntary.

If participants agreed to take part in this study, there were no direct benefits to them. Participants may expect to benefit from being in the study by knowing that they are contributing to science and future knowledge about how best to help other people.

The qualitative method

This study obtained IRB approval from University of Missouri and Boromarajonnani College of Nursing in a Northeast Thailand. All participants took part in an informed consent process, including a waiver of documentation of written informed consent, using a consent form translated into Thai. We were not asking them about their own experience with IPV because we recognized that it was possible there may be IPV survivors among the participants. However, if participants felt uncomfortable and needed resources, they could connect to available local services or leave from the group anytime. All information was anonymous, code numbers were used to identify the group of focus group and individual interview, and it could not refer to or identify participants' information. Any potentially identifying data within the transcriptions were redacted, and the audio recordings were destroyed following the transcription process.

Conclusion

Chapter Three discussed about the quantitative method, qualitative method, and mixed methods designs. Quantitative and qualitative data were collected, analyzed and combined for meaningful interpretation specific to the research questions. In accordance with a positive deviance sampling plan, the participants for this study were purposely selected. Data were collected via survey online questionnaires, a focus group and individual interviews. Survey questionnaires were carefully chosen to measure the perceptions of IPV screening to predict intention of IPV screening based on the TPB components. Quantitative data were deductively analyzed using descriptive and inferential statistics, while qualitative data were inductively analyzed using a content data analysis to code data and emerging categorize findings. After independent analysis was completed, the findings were merged for joint interpretation in answering the mixed-methods research question. Quantitative and qualitative data was compared by frequency codes, cross-tabulation analysis, and hierarchical categorization of IPV screening's perceptions.

CHAPTER 4

RESULTS

This chapter presents the findings of this study to address each research question. First, a description of quantitative method, including the demographic data of participants, the correlations of TPB components, the associations between TPB components and intentions, mediation of variables, and predicting of intention. Second, this chapter describes the findings from focus groups and individual interviews by each category. Lastly, the results of mixed-methods are described.

Results for Research Question 1

What was the participants' level of exposure to IPV training and screening (including experiences with patients experiencing IPV, experiences of seeing nurses screening for IPV, and exposure to IPV training), own/family experience of IPV, their attitudes, subjective norms, perceived behavioral control regarding IPV screening in healthcare settings, and their intentions to screen for IPV in their own clinical practice?

Participant characteristics

A sample of 740 nursing students were recruited online for this study and 639 participants were screened eligible. Participants were mostly female; nearly half were from nursing schools (PIHWD) (44.8%) with the rest split fairly evenly between private and public universities (see Table 7). Approximately four in ten reported they had never experienced training or discussion regarding IPV. Of those who had received IPV training, nearly 70% had received between 1-5 hours of training, with about half (46.9%) experiencing a lecture or classroom discussion, and a third (32.9%) shown a video. See

Figure 6. About half (48.4%) did not know if their nursing school provided IPV screening tools for students, and 50% did not know if IPV screening tools existed in the hospital or community. See Figure 7. About half (49.3%) did not know whether health professionals screened for IPV in clinical sites and 26.3% said health professions did not screen; 24.3% had seen screening performed, and 17.7% had experienced screening women for IPV. See Figure 8. The majority (82.3%) had never screened a patient for IPV themselves. Approximately one in six participants had experienced physical, sexual, or emotional violence or threats of violence from an intimate partner or witnessed it directed towards a family member or friend. Moreover, about 90% of participants intend to screen women for IPV but about 10% not intend to screen. See figure 9.

Table 7. Demographics of participant sample.

Variables	N	Freq (%)
Gender	639	
Male	24	3.8%
Female	594	93.0%
LGBTQ	20	3.1%
GPA	626	
Less than 2.50		
2.50-3.00	280	49.1%
3.01-3.50	249	43.5%
>3.51	42	7.3%
Ever trained in or discussed IPV	639	
YES	377	59.2%
Video or discuss	210	32.9%
Lecture or discuss in classroom	300	46.9%
Training/Workshop	24	3.8%
Other	6	0.9%
NO	260	40.8%
Estimated total number of hours of IPV training in nursing school	378	
Less than 1 hr	95	25.1%
1-5 hours	260	68.8 %
6-10 hours	20	5.3%
11-15 hours	2	0.5%
>15 hours	1	0.3%

Variables	N	Freq (%)
In your nursing school, is there an IPV screening tool provided	639	
YES	70	11.0%
NO	260	40.7%
Do not know	309	48.4%
Is there an IPV screening tool in the hospital or community clinic	638	
YES	110	17.2%
NO	209	32.8%
Do not know	319	50%
Do other health professionals screen women for IPV in the hospital or community clinic while you practice	639	
YES	156	24.4%
NO	168	26.3%
Do not know	315	49.3%
While you practice in hospitals or community clinics, have you had experience screening women for IPV	638	
YES	113	17.7%
NO	525	82.3%
Religion	639	
Buddhist	591	92.5%
Muslim	25	3.9%
Christian	20	3.1%
Other	3	0.5%
Place of living	638	
Rural	290	45.5%
Suburb	210	32.9%
Urban	138	21.6%
Your nursing school	639	
PIHWD	286	44.8%
Public university	179	28.0%
Private university	174	27.2%
Have you ever experienced physical violence, sexual violence, emotional violence, or threats of violence in an intimate partner relationship?	639	
YES	105	16.4%
NO	534	83.6%
Have you ever witnessed physical violence, sexual violence, or psychological violence directed towards a family member or friend?	637	

Variables	N	Freq (%)
YES	117	18.4%
NO	520	81.6%
I intend to screen all women for IPV when they come for healthcare services for any reason	638	
Intention	563	89.84%
No intention	75	10.16%

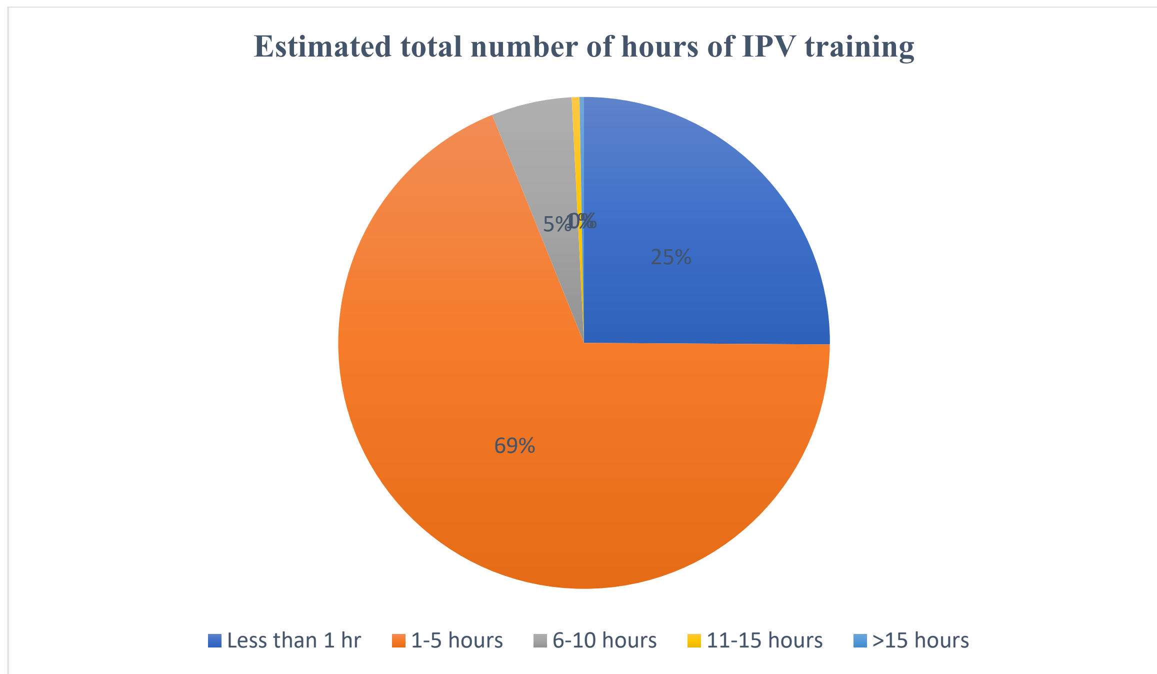


Figure 6. Estimated total number of hours of IPV training

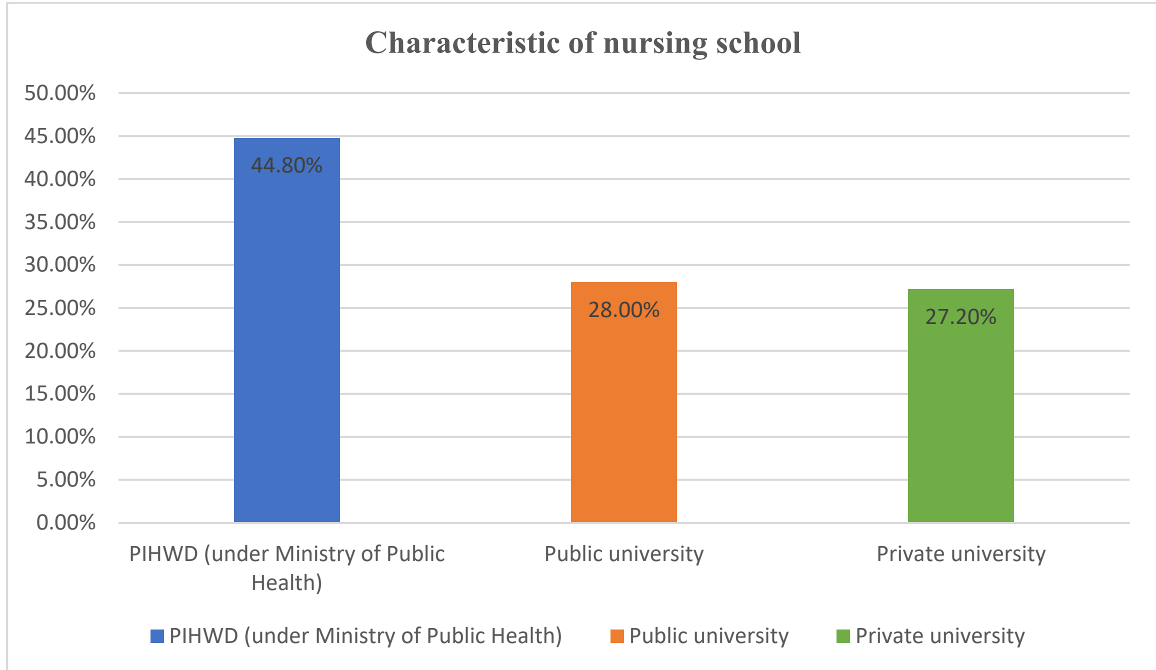


Figure 7. Characteristic of nursing school

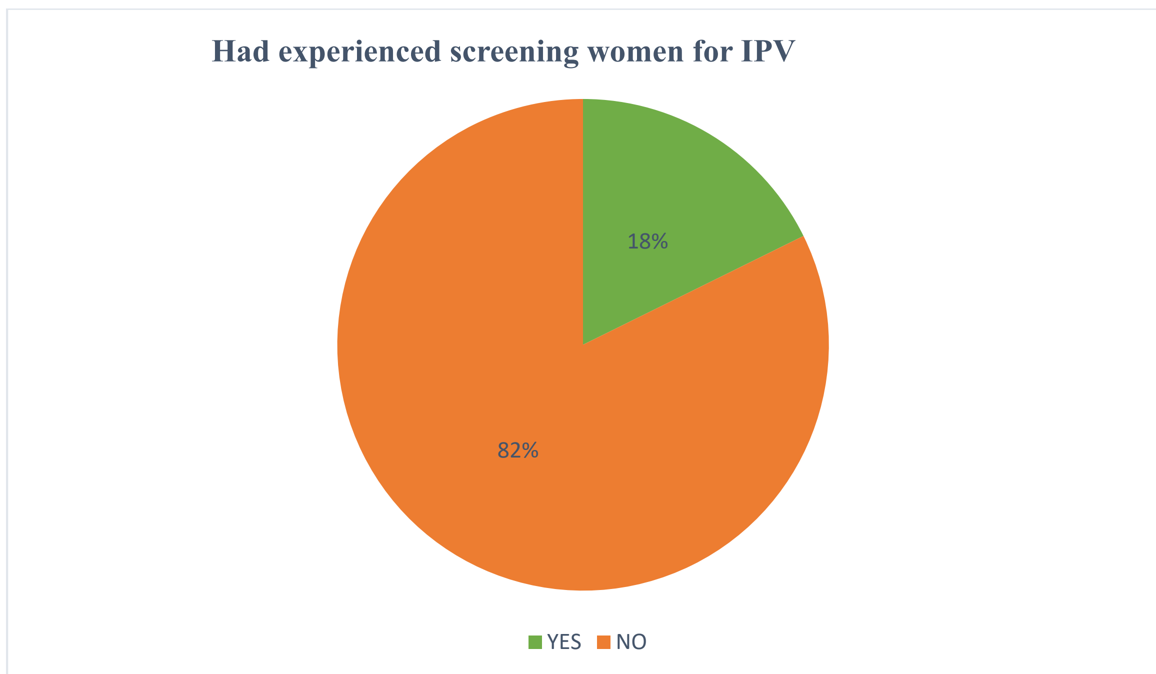


Figure 8. Had experienced screening women for IPV

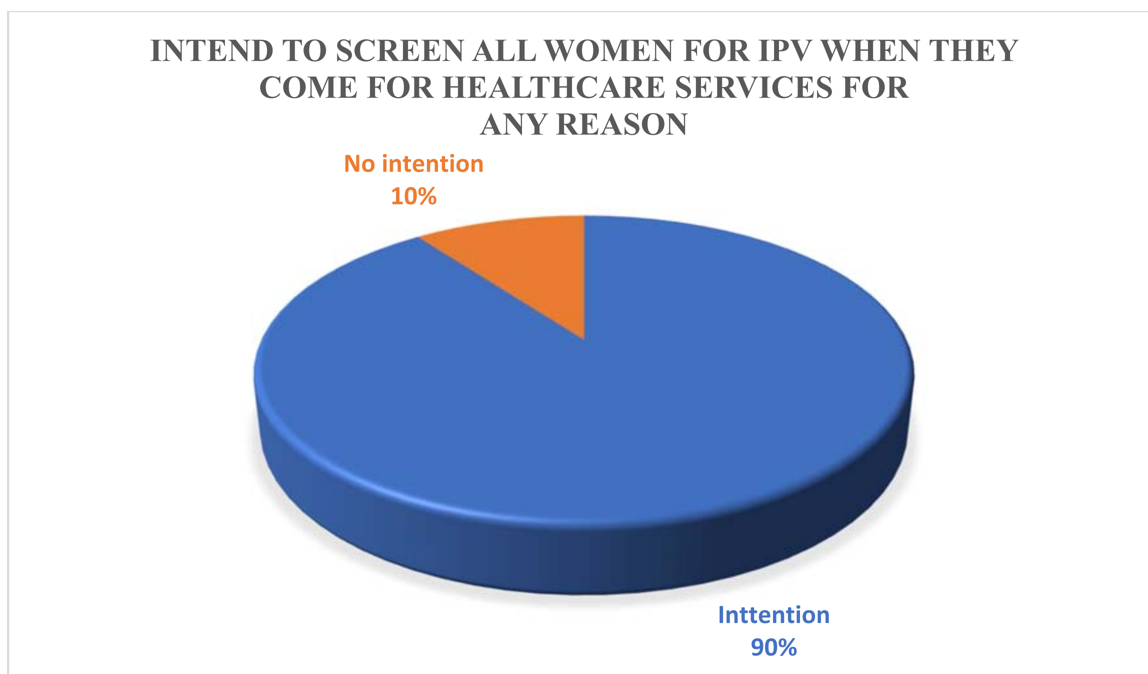


Figure 9. Intention to screen women for IPV

Mean Score of Main Variables

The mean scores of the main independent variables (attitudes, subjective norms, perceived behavioral control towards screening) were between 3.99, 3.79 respectively, and 4.43 (*SD* 0.72-0.74), it is consistent with the level of agreement = agree to extremely agree. See Table 8. In addition, details of each component see Table 9.

Table 8. Mean score of the study main variables

Variables	Mean	SD
Attitude	3.99	0.73
Subjective norm	3.79	0.74
Perceived Behavioral Control	4.43	0.72

Table 9. Mean and standard deviation of attitude, subjective norm, and perceived behavioral control (n=639)

Questions	Mean	SD
Attitude		
ATT-1 Screening women for IPV is a good assessment.	4.41	0.60
ATT-2 Nursing is an important career for screening women for IPV.	4.24	0.69
ATT-3 Screening women for IPV is an intervention that you feel comfortable doing.	3.90	0.78
ATT-4 Screening women for IPV is useful in that it can identify potential risk for women.	4.32	0.57
ATT-5 Screening women for IPV is an opportunity to provide help and offer healthcare services for women who have experienced IPV.	4.40	0.58
ATT-6 Screening women for IPV can help women develop a safety plan.	4.40	0.59
ATT-7 Screening women for IPV can educate women about IPV, which is an important issue for public health and the country.	4.28	0.60
ATT-8 Screening women for IPV can address IPV, which is an important issue for public health and the country.	4.18	0.66
ATT-9 Education from nursing school regarding IPV screening is an important facilitator to prepare you to perform IPV screening for women.	4.20	0.62
ATT-10 Women do not trust you enough as a nursing student to tell you about IPV experiences.*	3.67	0.84

Questions	Mean	SD
ATT-11 Screening women for IPV may make women feel embarrassed.*	3.49	0.93
ATT-12 IPV screening will make women worry about being found out as a victim.*	3.61	0.90
ATT-13 Screening women for IPV takes too much time.*	3.29	0.87
ATT-14 Screening women for IPV may increase the risk of harm to women if it's an inadequate assessment.*	3.48	0.92
Average	**3.99**	**0.73**
Subjective norm		
SUB-1 Nurses in the department strongly support and expect you to perform screening of women for IPV.	3.55	0.75
SUB-2 Teachers in my nursing school strongly support and expect you to perform screening of women for IPV.	3.73	0.75
SUB-3 Other professionals in the department strongly support and expect you to perform screening of women for IPV.	3.68	0.78
SUB-4 Your friends strongly support and expect you to perform screening of women for IPV.	3.60	0.80
SUB-5 Opinions of nurses in the department regarding screening women for IPV are important to your decision to screen the women for IPV.	3.86	0.72

Questions	Mean	SD
SUB-6 Opinions of multi-professionals in the department regarding screening women for IPV are important to your decision to screen women for IPV.	3.92	0.71
SUB-7 Opinions of teachers in your nursing school regarding screening women for IPV are important to your decision to screen women for IPV.	3.93	0.70
SUB-8 Opinions of your friends regarding screening women for IPV are important to your decision to screen women for IPV.	3.76	0.76
SUB-9 Clear and effective hospital policies, guidelines, and orientations regarding IPV screening while practicing nursing are important to your decision to screen women for IPV.	4.13	0.67
Average	**3.79**	**0.74**
Perceived Behavioral Control		
PBC-1 Caring behavior of nurses will facilitate women to disclose IPV experiences.	4.42	0.65
PBC-2 Good relationship between women and nurses will facilitate performing correct IPV screening.	4.44	0.65
PBC-3 IPV training frequently will facilitate performing correct IPV screening.	4.23	0.65
PBC-4 Education from nursing school regarding IPV and IPV screening are enough for you to perform screening women for IPV.	3.74	0.83

Questions	Mean	SD
PBC-5 Private and safety settings will facilitate performing IPV screening.	4.33	0.66
PBC-6 A team approach, including nurses and multi-professionals, can facilitate effective screening of women for IPV.	4.28	0.65
PBC-7 Knowledge and skills regarding IPV screening are required to screen women for IPV.	4.36	0.62
PBC-8 Several resources, including physical and mental resources, will assist in performing screening women for IPV.	4.26	0.60
PBC-9 Other family members being present during the screening can interfere or be a barrier with screening women for IPV.	4.19	0.78
PBC-10 The workload of nurses can affect screening women for IPV.*	3.95	0.87
PBC-11 The number of patients in the clinic can affect the privacy of screening women for IPV.*	3.92	0.82
PBC-12 Limited time for each nursing activity will prevent screening women for IPV.*	3.99	0.75
PBC-13 I am ready to screen women for IPV.	3.63	0.85
Average	**4.43**	**0.72**

*was a reversed item

Results for research question 2

Research question 2: What is the relationship between attitudes toward IPV screening, subjective norms regarding IPV screening, and perceived behavioral controls around IPV screening and intention to screen for IPV and personal experiences with patients who are abused? The independent variable is demographic data (age, gender, GPA, religious, place of living, region of living, experiences of seeing nurse's screening in intimate partner violence, experienced IPV, and experienced of IPV training), and attitudes, subjective norms, and perceived behavioral controls.

Spearman's Rho Correlation between the TPB Components and Intention

The bivariate correlations by Spearman's Rho between TPB components and intention of IPV screening demonstrated a significantly positively moderate correlation. Perceived behavioral control had the highest correlation to intention of IPV screening ($r = 0.46$, $p < 0.01$), followed by attitudes ($r = 0.45$, $p < 0.01$); subjective norms had the lowest correlation to intention ($r = 0.41$, $p < 0.01$). See Table 10.

Table 10. Correlations between TPB components and intention

	Attitude	Subjective norm	Perceived control	Intention
Attitude				
Subj norm	0.52**			
PCB	0.53**	0.53**		
Intention	0.45**	0.41**	0.46**	1

** $p < .001$.

Associations between demographics and intention

There was a significant relationship between participants' demographics and intention of IPV screening (Table 11). Gender, GPA, ever received training regarding IPV (with only having watched a video or participated in discussion regarding IPV significantly associated), having a screening tool at the clinical sites, seeing health professional screening, having experience performing IPV screening, experiencing abuse, and witnessing family abuse were all significantly associated with screening intentions. However, the amount of IPV training was not associated.

Table 11. Associations between demographics and intention

Variables	χ^2	N
Gender	13.31*	637
GPA	361.25	625
Ever trained or discussed IPV	13.05*	636
-Video or discuss	16.80*	210
-Lecture or discuss in classroom	4.52	300
-Training or workshop	3.16	24
-Other	0.89	6
How much training or studying about IPV	5.53	378
There is a screening tool at school	11.02	638
There is screening tool at clinical sites	29.61*	637
Seeing health professional screening at ward	21.43*	638
Experienced screening	27.12*	637
Religion	3.66	638
Place of living	5.42	637

Variables	χ^2	N
Region of hometown	14.66	638
Type of school	8.95	638
Location of nursing school	13.47	638
Experienced abused	9.49*	638
Experienced witness of family abused	8.41*	636

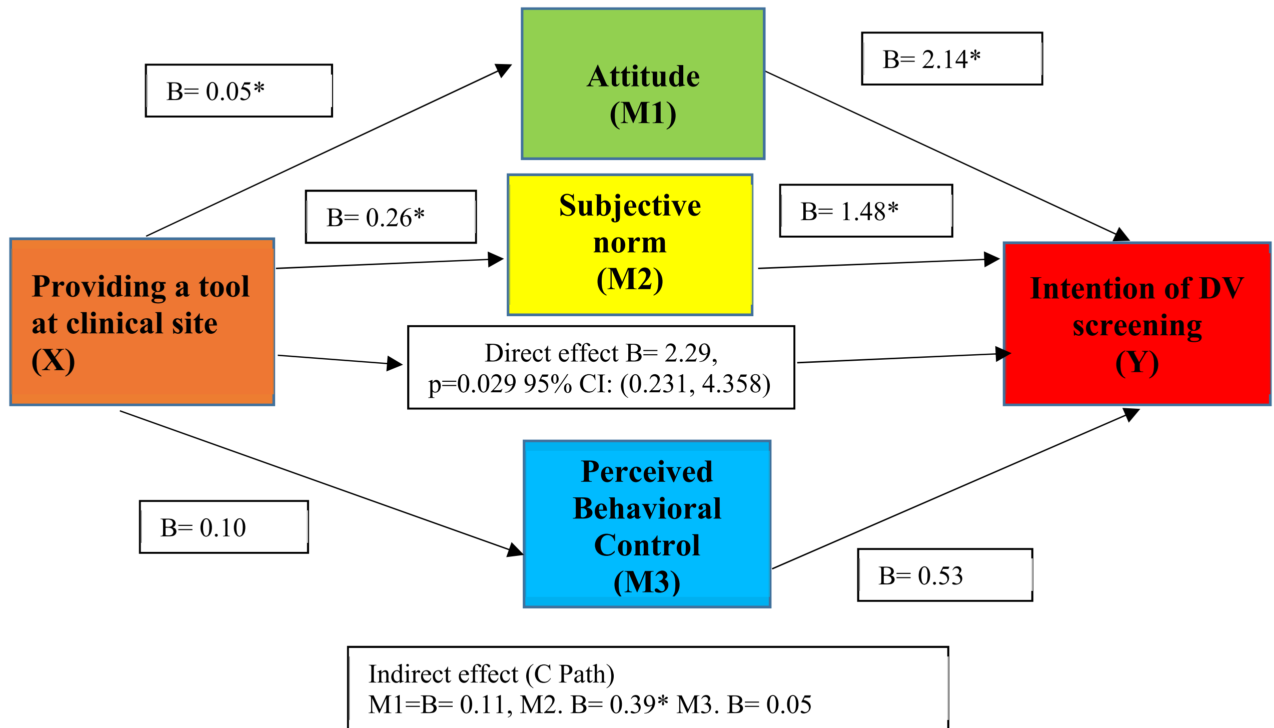
Note. *Chi-square tests and Fisher's Exact Test were used for categorical variables. P<0.05 indicates significant.*

Results for research question 3: How strong was the relationship between participant demographics, level of exposure to IPV training and screening, personal/family experiences of IPV, attitudes, subjective norms, and perceived behavioral controls around IPV screening) and the intention to screen for IPV?

Mediation model

The attitude and subjective norm were mediators of the relationship between having a tool at clinical site and intention to screen, but perceived behavioral control was not a mediator (Figure 10). Only providing a tool at clinical sites was supported as a mediator, indicated by significantly direct and indirect effects. The results indicated that the inclusion of attitude (b= 0.05), subjective norm (b= 0.26), and perceived behavior control (b= 0.01) increased the effect of providing the screening tool at clinical site on intention. These findings indicated that attitude, subjective norm, and perceived behavioral control mediated the influence of intention. The indirect effect was also indicated with 0.39 of effect size.

Figure 10. Unstandardized regression coefficients for the relationships between providing a tool at clinical site and intention by the TPB components as mediators.



P<0.05

Predictors of IPV screening intention

To identify the predictors of screening intention, logistic regression was performed by entering the variables found to be associated to IPV screening in Chi-square test and Fisher's exact Test analysis. In the logistic regression, providing a screening tool at clinical site, attitude, subjective norm predicted intention of IPV screening. Attitude toward intention of screening was the most influential predictor (B=2.14, SE = 0.97, Odds ratio = 8.51, p = 0.02). Subjective norm toward intention of screening was significantly predicted (B=1.48, SE = 0.58, Odds ratio = 4.43, p = 0.01). In addition, even though, providing a screening tool at clinical site was also predicted, the odds ratio of

providing a tool was less than 1 (B=2.29, SE = 1.05, Odds ratio = 0.10, p = 0.02). However, the perceived behavioral control was not a predictor of intention (B= 0.52, SE = 0.59, Odds ratio = 1.69, p = 0.37). The model explained a substantial 31% of the variance in intention. See Table 12.

Table 12. Predictors of intention of screen women for IPV

Predictor	B	SE	Wald	Odds ratio	P	95% confidence
Providing the tool	2.29	1.05	4.75	0.10	0.02*	0.01-0.79
Attitude	2.14	0.97	4.81	8.51	0.02*	1.25-57.60
Subjective norm	1.48	0.58	6.53	4.43	0.01*	1.41-13.89
Perceived Behavioral Control	0.52	0.59	0.78	1.69	0.37	0.52-5.40

P<0.05

a. Pseudo R2 statistics: Cox and Snell: 0.13, Nagelkerke: 0.31
b. Model-fitting information: the model represents a significantly better fit than that with all coefficients set to 0 (X^2= 42.79, p = 0.001)

Research results for question 4: What was the perceptions of IPV screening in nursing education?

The findings from qualitative methods were analyzed from focus groups and individual interviews. There were 56 codes of focus group interviews and 44 codes of individual interviews. The findings were identified by the three components of the Theory of Planned Behavior (TPB): 3 themes of focus groups interviews and 4 themes of individual interviews. See Table 13 and 14.

Findings from focus group interviews

Participant characteristics

48 senior-nursing students from three different types of nursing schools in a province in northeast Thailand were interviewed. There were 38 female and 10 male students. There were three categories that emerged related to nursing students' beliefs of IPV screening, which were attitudes, subjective norms, and perceived behavioral control of IPV screening.

Attitudes of IPV screening

Positive outcomes of screening

Identified survivors

Participants often discussed about the benefits of IPV screening and most of them believed that IPV screening is important and helpful, and that it can identify women who have experienced IPV. A few participants supported the idea that asking about IPV is hard, but it is worth starting a conversation to help women who have experienced IPV. In their view, it is better to do something than nothing. A participant shared of recognizing it is hard to talk to patients about IPV, but deciding to talk; and because of this she could help a survivor to connect the One Stop Crisis Center (OSCC).

> My friend and I asked a pregnant woman, who walked in to the clinic without appointment. We asked her what was going on; she was silent for about 2 mins and cried after that. We let her breathe and asked her again.

> She told us that her husband hit her for years and she just found out that she was pregnant last week. She could not sleep, did not talk to anyone, and had decided to kill herself by trying a lot of paracetamol yesterday. (Female, group 4)

Offer help

Almost all groups explained that offering help to survivors would be a priority in screening. It can help women to get resources that are provided by the hospital, such as OSCC and mental health clinic. If provider does not ask, it is difficult to know what a woman's specific problem is. However, a few participants described that even though there is an OSCC in every hospital, the potential competency of helping is different in terms of resources and multi-professional team that each hospital has.

> I think if a provider asks women or general patients, it means we can help them or we already provided resources to help. Screening is a good intervention between providers and patients; it is a way to refer women to get help from us. (Female, group 2)

Negative outcomes of screening

Women embarrassed

However, some participants mentioned that talking and asking women about IPV is still a sensitive conversation in Thai culture; it is different from other cultures in developed countries where people talk about this issue at large. If providers asked, some

women may think that the provider assumes they have been abused and it would make them ashamed especially if the provider asked them in front of people and if they had experienced sexual abuse or rape.

> It is not easy to ask women for IPV because it seems like a thing that we should not ask women about in public. Women may be angry with us as well. In addition, if they are abused, they might feel really embarrassed and they may be wondering how we know about their situation. (Female, group 5)

Not recognized in nursing work

Most participants agreed that they are not sure whether screening women for IPV is required and recognized for nursing work; however, for nurses, who are trained in IPV, this would be required. They thought that it may be a social work job. A few participants explained that they just asked the cases about IPV with obvious cases, for example, when women walked into the hospital with injuries and told them that they were threatened by or hit by their husbands/partners. On the other hand, health providers, especially nurses, have recognized screening for chronic disease such as diabetic mellitus (DM) and hypertension (HT), but IPV seems not to be recognized very often. As one said, “I believe that IPV is more related to social work more than nursing work; nurses can work on this issue when the social worker asks for help. We did not train for this issue” (Female, group 4)

Subjective norms of IPV screening

Role model of screening

Lack of role model

The majority of participants explained that the cultural environment can motivate them to screen women for IPV. They were not told about this issue when they were at the wards or school. It is not common for students to do any practices in clinical sites without it being allowed by their supervisors. They stated that they saw a few nurses and some instructors being a role model by asking women in IPV, but most of them did not do so. Some participants agreed with and supported that they lacked a role model figure with regards to instructors and preceptors who screen women for IPV. A participant stated that:

> … We did not get orientation and see this is describing tool, so an article should be used a screening tool. In the clinical sites we were in, we just found a few cases that nurses screened. I found it only at the gynecology ward and nurses there showed me where the screening tool that could use, but in other wards, I have not seen it… (Female, group 3)

People's opinions of screening

Ready to follow health team's opinions

All the focus groups raised the issue that can support they screen such as policy and guidelines relate to IPV screening. They explained that students recognize that IPV is

a health issue and they are willing to follow any guidelines relating IPV screening in clinical settings. They think that if instructors or preceptors do not mention anything related to screening women for IPV, students may interpret that it may not be required for students to do it. A male participant said that:

> I know that nursing career is a first career to see patients, screening them for IPV would be significant, but if I screened a woman who has been abused, what should I do next because no one has taught me about how to screen, refer or help. Therefore, as I am a nursing student, I recognize IPV is an important issue and am ready to do and follow the policy of screening, but instructors and nurses should tell about this and teach me. (Male, group 1)

Perceived Behavioral Control

Barriers to screening

Cultural sensitivity

Participants shared a lot about the cultural sensitivity of IPV screening in Thailand. Screening women for IPV would be challenging for a healthcare provider because of how it would be considered by the Thai cultures. Even though IPV is a prevalent issue in Thailand, it is hard for Thai people to disclose to providers about their experience of abuse. Participants stated that Thai wives have been taught that they should share or talk about only good things in family to other people to make their family

beautiful, but keep their silence about bad experiences, especially hitting and fighting by their husbands even if they experience it. A female participant supported that:

> …I honestly can tell that I feel uncomfortable asking my patients about IPV. If I asked, they would think I assumed they have IPV experience, and they would not answer my questions for sure because it is a cultural issue. I feel like that. (Female, group 5)

Not ready, less educated, and lacking training

Even though participants recognized that IPV is a big problem in Thailand and they have to face it as future providers, they feel like they are not ready to deal with the issue and are not well-prepared from nursing school. Participants raised the issue to the group that they feel reluctant to ask women about abused experience because they have not been trained to do so and do not know what questions would be and how to help them. As one said; "They would transfer a case to a nurse or an instructor if they felt like that case would have IPV experience" (Male, group 3)

> It is hard for me to start a conversation with patients related to IPV. I have not gotten used to it and am not trained from school. If I asked, participants would look at me and I would feel embarrassed. It is easy to ask them about diabetes or heart disease. (Female, group 1)

Not required in nursing experience

About half of the participants raised their voices that there is no IPV screening requirement in nursing experiences and that nursing students have to practice within their undergraduate study. The majority of participants agreed that nursing curriculum does not include IPV screening topic, but the topic of IPV is integrated in other classes, such as family and community crisis and drug addiction and violence during pregnancy. This is one of barriers that make students not recognize screening women for IPV. A participant explained that:

> IPV screening is not a clinical requirement in nursing curriculum, so that is why nurse instructors do not address this issue, I believe. But it would be very good if we include it into nursing curriculum and future nursing students will have been learned and trained it. (Female, group 2)

No trust

The trust relationship between women and providers is the one that participants thought it was a barrier to screening. The majority of participants explained that it is difficult for Thai people to explain their abuse experienced or talk about the dark side of a family relationship to someone, who are not trusted; it is a part of Thai culture. Thai women may think that if they explain their abuse experienced to a provider, other people would know as well, it is not private. It would prevent them from talking about or answering anything regarding their family experience to outsiders. A participant noted:

> Without a long and trusting relationship, it is difficult for Thai women to share their abuse experience to healthcare providers they have met one time. No trust and do not believe that providers can help…(Female, group 6)

Do not know screening tool and guidelines

The screening tool and clinical guidelines of screening talked widely in the groups. Participants from all groups shared the same feelings that they do not know the screening tool and guideline of IPV screening. Some of them thought there is an IPV screening tool that hospital or clinic provided for screening, but they do not know how it is used. Participants also mentioned that if hospital would like to promote screening women for IPV, they should get orientation about screening and guideline of screening.

> While I was practicing at the wards and clinics, asking women for IPV was not mentioned widely from providers. I did not get orientation about this practice as well. I just thought if we were told by women about their abused experience, we would refer them to a nurse, who are responsible about this issue, because I do not know about the tool and referral guideline. (Male, group 3)

Facilitators to screening

Trusting relationship

A trusting relationship is a bridge of disclosing the family relationship between women and healthcare providers. Participants believed that a trusting relationship can help women feel like they are not alone; there is someone to talk to and they can ask for

help. Moreover, a few participants explained more details about that; trusting can include privacy, providers' caring behavior, and good communication. As one said, "I believe if our providers can build a trusting relationship to patients, they would tell us all things we ask even abusive relationship" (Female, group 1)

Providing screening tool and guideline

As mentioned earlier, participants do not know about a screening tool and referral guideline. Participants also addressed that if they know about the details of a tool and the process of screening and referring, it may encourage them to screen women for IPV. In addition, some participants confirmed that referral guideline can help them to make sure that if they identify IPV survivors and refer them to resources, they would get help and not get trouble from the systems. One stated, "knowing and understanding about the tool and guidelines of hospital will be helpful and encouraging to me in screening women even I thought it is difficult and sensitive, but it is worth a try" (Female, group 2)

Training

The majority of participants described that training regarding knowledge about IPV and how to screen women effectively was important in encouraging them to decide to screen women for IPV. Participants confirmed that training will help them have more confidence talking with and asking women for IPV as a sensitive talking. Participants also added that training about effective counselling and communication skills will be helpful for them in asking women about IPV.

I think we need to get training about IPV and screening before

practicing with women at the clinics. It will make us feel

comfortable to ask about potential IPV and will make sure we ask

the right things and not harm women. (Female, group 3).

Codes	Sub-categories	Categories
Identified survivors Offer help	Positive outcomes of screening	Attitudes of IPV screening
Women embarrassed Not recognized in nursing work	Negative outcomes of screening	
Lack of role model	Role model of screening	Subjective norms of IPV screening
Ready to follow health team' s opinions	People' opinions of screening	
Cultural sensitivity Not ready, less educated, and lacking training Not required in nursing experience No trust Do not know the screening tool and guidelines	Barriers to screening	Perceived Behavioral Control of IPV screening
Trusting relationship Providing screening tool and guideline Training	Facilitators to screening	

Table 13. Codes, sub-categories, and categories of focus groups (N=48)

Findings from individual interviews with nursing instructors

Participant characteristics

There were nine participants for individual interviews. All of the individual interview participants have ages between 45 and 67 years old and all of them are female nurse educators. They were working at a nursing school under Praboromarajchanok Institute for Health Workforce Development (PIHWD) and a private nursing school. They had between 20 and 35 years of experience as nurse educators. Four themes

emerged from the in-depth interview related to their perceptions: attitudes, subjective norms, perceived behavioral control, and strategies to prepare nursing students regarding IPV screening.

Attitudes of IPV screening

Positive outcomes of screening

Identified survivors

Participants recognized that there are a lot of benefits of screening women for IPV even it is a sensitive issue. It can identify IPV survivors and also help them by introducing resources. A few participants supported that it is a way to build a relationship with women. However, a participant argued that some women would not like to ask them about this issue. A participant mentioned that:

> …When I weighed between asking and not asking about their experience of IPV, I think women may be surprised by the questions at first asking, but if she gets abused and she discloses to us and we could help her, it is worth a try for asking. (Female, private school)

A psychological approach

Assessment to psychological dimension regrading IPV experience is one of nursing roles. Half of the participants stated that one of values of IPV screening was psychological or mental approaches; it is a thing that nurses do not recognize. They may think IPV screening is a social work job. In addition, participants explained that some IPV survivors may come to the hospital with injuries or no injuries, but most of them

would have stress or depression that we would not even know without asking. It is a mental assessment. A few participants agreed that sometimes if we ask it means we care them; they might feel better. A participant stated

> IPV screening is a better way that we can assess psychological dimension of patients, but we just ignore it. I do not know exactly why it is, maybe we focus only on physical and pathological diseases….I think it is time for us to prepare our students for IPV responding, especially asking our patients about their suffering related to their family relationships and their mental health. I think it is the way to reflect our care as holistic nursing. (Female, PIHWD)

Negative outcomes of screening

Women feel embarrassed and insulted

Participants addressed that one negative consequence of screening women for IPV is making women feel like they are the victims and that the community would know about their abuse stories. They would feel embarrassed and insulted if the provider asked them in public, not a private room. However, a participant argued that asking women for IPV might be normal in this period because there are a lot of campaigns that OSCC have done. Some participants discussed that we should assess about the attitude of asking IPV first before asking about how they experience family relationships.

> Thai people may not understand why we ask about their family relationships' experience. They may think we have insulted them and have tried to make them embarrassed. And sometimes it is a stigma for them if we ask. It is very sensitive. (Female, PIHWD)

Subjective norms of IPV screening

People not mentioned

Surrounding people are not mentioned

All the participants explained that even though screening of IPV is very helpful, the "big" people around the head of department at the school or hospital, have not encouraged it or mentioned to do it. More than half of the participants accepted that they do not mention IPV screening to students and they do not have any IPV screening tool provided at the nursing school. A participant stated that:

> We have to agree that we have not done very well for screening women for IPV. Students have not been taught about the issue nor have my colleagues and people around me; when I teach and supervise students, they are not aware of this issue." I think we forgot this issue. (Female, PIHWD)

Lack of support from people

People around and policy have not supported

The majority of participants shared their experiences about how uncomfortable they would be if they led students in screening women for IPV. A screening tool and a referral system would make them give up and be trouble—since there are no tools and policy to support the system. They explained that if they take students to screen women for IPV, they have to let a head nurse and other nurses and colleagues know first. A participant stated that

> …We do not have any guideline or procedure support us if we bring students to ask women for IPV, we need to have a private room and an effectively referral system. I used to bring students to screen a woman, who

> experienced violence one year ago, it was not smooth and the case felt uncomfortable with our system… (Female, private school)

Perceived Behavioral Control of IPV screening

Barriers to screening

Nursing curriculum does not prepare students well

Most participants mentioned a lot about how difficult it was to integrate nursing school and the IPV issue together. The nursing curriculum does not prepare students well with regards to the issue and does not address IPV is a major health issue. It is not a requirement that nursing students have to have experience of screening, it is just optional. A few participants mentioned that it would not be surprising if nursing students would be scared and uncomfortable when they see IPV cases. A participant stated.

> I am not surprised students would tell you that they do not know how to deal with IPV and screening. We did not teach them what we have to do, the blueprint of curriculum did not mention it. We already have a lot of topics that we have to teach students. We should revise and add this topic in our curriculum, for sure. (Female, public school)

Not a culture

All participants discussed about asking women about IPV in Thai culture. They explained that it is difficult, and it is not considered appropriate in Thai culture to ask each other about IPV, if it is not a family member or pretty close friend. However, a

participant suggested that it is good to start conversation about IPV between women and providers; it may be uncomfortable to ask at first, but it will be better if providers have good conversation and tell women why we talk about this topic. One said, “I believe women may not answer us we ask them about IPV. It is not a Thai culture that we ask each other about this sensitive topic even in hospital” (Female, public school)

Private room and workload

Participants also mentioned the things that would make them feel it was difficult or inconvenient to ask patients about IPV. It is a private issue. If we ask a woman at a clinic, including places where three may be strangers around her, she might feel embarrassed. A private room is needed, especially, if a woman comes with her husband or her mother. In addition, half of the participants supported that there are about a hundred patients each day at the clinic; it would take too much time and workload if nurses asked all women about this issue. One of the participants stated that:

> Some women came to hospital with their husbands or children. Their husbands take women to the hospital and wait for them in order to bring them back home. Asking women around the outpatient department or in front of other people (in rural area, they may know each other very well) would prevent women talking about themselves, especially this issue. (Female, public school)

Facilitators to screening

Address IPV and IPV screening into curriculum

All the participants suggested that the nursing curriculum must be adjusted, and most of participants also stated that it is not difficult to address IPV into the curriculum, but they need scoping and description of the subject of IPV. A participant tried to explain that we could add it into the curriculum in our school as a school level, but at the beginning they would have to deal with instructors, who may or may not agree with them on this issue. Participant suggested that it would be impactful if the Thai Nursing Council agreed that IPV and IPV screening should be included into the curriculum, because if they agree, they can send an official letter to the nursing schools and ask them to teach IPV. In addition, a few participants highly recommended that integrating a screening tool with nursing care plan in terms of assessing family relationships.

> We have to make sure students will learn about IPV, add it into nursing curriculum. It is not difficult because we have a curriculum committee if they agree we can make it. I think we can also integrate with psychiatric subjects, family, community, and also obstetric. (Female, private school)

> I think we should make students feel familiar with a screening tool by adding the tool with assessment tools: part of family relationships. However, we have to teach students about the tool before they use it with their patients. (Female, PIHWD school)

Prepare knowledge and training to instructors, nurses, and students

Preparing the instructors, clinical preceptors, and nursing students for IPV and IPV screening are suggested by participants to promote IPV screening. Participants mentioned that knowledge and onsite-training will make providers more confident in screening this sensitive topic as IPV. In addition, a few participants supported that if providers know about the important of screening and negative health consequences for survivors, they would recognize and appreciate IPV screening. A participant stated:

> I have to tell you that I do not have much knowledge about IPV and I am not confident to ask women for IPV. However, if I was educated and trained regarding these, I would know how to manage and deal with survivors. (Female, PIHWD school)

> … I feel like I need to update my knowledge and train about screening and how to approach the victims. I believe if I discuss this issue to students, they will have a lot of questions to me for sure. I have to prepare myself first… (Female, public school)

Providing a screening tool

Half participants mentioned about providing a screening tool for students at schools and clinical sites will promote IPV screening. A few participants accepted that they did not talk about or introduce an IPV screening tool to nursing students because they do not know and have not seen the tool before. They thought that if health settings provide the screening tool, it will make providers and instructors recognize that we have

to screen IPV for women. In addition, participants stated that it will be helpful for nursing students to assess their patients by using the tool as well. A participant stated:

> …If we have a screening tool to teach students and students also see it at the clinics or wards, it would remind them to screen with their patients. It will make students to get used to with the tool before they graduate…(Female, public school)

Trusting relationship

The majority of participants believed that trusting relationship is one of the most important things in disclosing a private issue between providers and patients. A participant also supported that if women trusted providers, they would answer with any questions that we ask; providers will be including nursing students as well. There were many times that nursing students got important information from their patients and it was helpful for treatment. In addition, a participant shared a project at her nursing school, which is called "Simulated Family Program." It is an innovative project that a nursing school prepares students to interact with patients as humans and treat everyone, including patients, like their own families. This project has shown that students are trusted by their patients and have good relationships together.

> …I think trusting relationship between patients and providers is helpful to ask women for IPV. We have a project called "simulated family" It has been going on since 2010; this project is simulating a family between school and community. This project got very good feedback from communities and stakeholders about our alumni that how caring they treat with their patients.

I believe trusting relationship can be a bridge to explore IPV from patients….(Female, public school)

Codes	Sub-Categories	Categories
Identified survivors A psychological approach	Positive outcomes of screening	Attitudes of IPV screening
Women feel embarrassed and insulted	Negative outcomes of screening	
Surrounding people are not mentioned	People not address	Subjective norms of IPV screening
Lack of support from people	Lack of support people	
Nursing curriculum does not prepare students well Private room and workload Not a culture	Barriers to screening	Perceived Behavioral Control of IPV screening
Addressing IPV and IPV screening into curriculum Prepare knowledge and training to instructors, nurses, and students Providing a screening tool Trusting relationship	Facilitators to screening	

Table 14. Codes, sub-categories, and categories of individual interviews (N=9)

Mixed Method findings

The convergent parallel design between quantitative and qualitative methods was used in this study. Independent findings of the quantitative and qualitative strands have been combined and analyzed in this section to answer the mixed-methods question: Do the quantitative measure uphold the prominent themes discovered in the qualitative data? To what extent does the qualitative data contribute to an enhanced interpretation and understanding of the relationships discovered among the quantitative variables? This study used a triangulation approach to mixed-methodology. Triangulation is the use of

more than one approach to research and it is often used in mixed methods research (Heale & Forbes, 2013).

The findings found that overall the instrument measures for quantitative variables upheld the prominent themes discovered in the qualitative data. A cross-tabulating instruments and categories contributed to an enhanced interpretation and understanding of the relationships among the data. See Table 16.

The frequency analysis of IPV screening' s perceptions in qualitative categories (Table 15 and Table 16) identified the number of times a particular IPV screening's perceptions emerged from qualitative categories. Noting the frequency of attributes in categories is beneficial in determining what are considered the key distributions to screen women for IPV. For the focus groups that we interviewed senior-nursing students in qualitative categories, education for nursing school regarding IPV screening (ATT-9) emerged most often (f = 8), followed by screening may make women feel embarrassed (ATT-11) (f=4). For the individual interviews that we interviewed nurse educators, knowledge and skills regarding IPV screening (PBC-7) (f=11), was followed by Good relationships between women and nurses (ATT-2) (f=4).

A cross-tabulation analysis of quantitative measures and qualitative categories of focus groups and interviews compared two types of data. See Table 17. Cross-tabulating instrument measures and categories contributed to an enhanced interpretation and understanding of the relationships among the data. For the attitude component, there were three items that just found only quantitative method, but have not emerged in qualitative method: ATT-3, ATT-7, and ATT-8. Moreover, the mean score of ATT-3 (3.87) is lower

than the average attitude's mean score (3.99). All items of subjective norm from quantitative research covered the emerged categories of qualitative method. In addition, there were four items (PBC-4, PBC-8, PBC-9, PBC-12) of perceived behavioral control in quantitative research did not cover the categories in qualitative research. Furthermore, there were 4 codes that were emerged only in qualitative but could not see in quantitative items: Not require in nursing experience; No trust; Not a culture; and providing a tool. Moreover, even though mean score of perceived behavioral control was high and a lot of codes emerged from this component, the mediation and logistic regression showed that perceived behavioral control is not a predictor and a mediator of intention to screen women for IPV.

A hierarchical categorization of IPV screening was created to achieve a deep understanding of IPV screening expressed by participants of this study. See Figure 11. This hierarchical categorization represented a collection of IPV screening identified through an analysis of survey online, focus group and individual interview data. It was developed by the author with triangulated findings. It is shown that the TPB can be helpful in describing the perceptions of IPV screening.

The understanding gained from this hierarchical categorization is that the intention of IPV screening comes from a combination of attitude, subjective norm, and perceived behavioral control. Under each broad classification were horizontally related to category of IPV screening. In this hierarchy, the categories serve as classifications for the subcategories that were vertically related.

Table 15. Frequency of qualitative (focus groups) and quantitative
IS=identify survivor; OH=offer help; WE=women embarrassing; NC=not recognizes in nursing work; LM=lack of role model; TO=team opinions; CS=Culture sensitivity; NR=not ready; NN=not require in nursing experience; NT=No trust; DT=do not know the tool; TR=trusting relationship; PT=Providing the tool; T=training

Items	IS	OH	WE	NC	LM	TO	CS	NR	NN	NT	DT	TR	PT	T	total
ATT-1	i	i													2
ATT-2				ii											2
ATT-3		i													1
ATT-4	i	i													2
ATT-5		i													1
ATT-6		i													1
ATT-7															
ATT-8															
ATT-9														iiiiiiii	8
ATT-10												ii			2
ATT-11			I				iii								4
ATT-12			i				ii								3
ATT-13															
ATT-14			i												1
SUB-1					i										1
SUB-2					i										1
SUB-3					i										1
SUB-4					i										1
SUB-5						i									1
SUB-6						i									1
SUB-7						i									1
SUB-8						i									1
SUB-9											i		ii		3

Table 15. Frequency of qualitative (Focus groups) and quantitative
IS=identify survivor; OH=offer help; WE=women embarrassing; NC=not recognizes in nursing work; LM=lack of role model; TO=team opinions; CS=Culture sensitivity; NR=not ready; NN=not require in nursing experience; NT=No trust; DT=do not know the tool; TR=trusting relationship; PT=Providing the tool; T=training

Items	IS	OH	WE	NC	LM	TO	CS	NR	NN	NT	DT	TR	PT	T	Total
PBC-1												i			1
PBC-2												i			1
PBC-3														i	1
PBC-4															
PBC-5						i									1
PBC-6						i									1
PBC-7														I	1
PBC-8															
PBC-9															
PBC-10															
PBC-11															
PBC-12															
PBC-13								ii							2

Table 16. Frequency of qualitative (interviews) and quantitative
IS=identify survivor; PA=psychological approach; EI= embarrassing and insulting; PM=people not mentioned; PS=people and policy nor support; CP=curriculum not prepares; RW; private room and workload; NC= not a culture; TC; addressing the tool into nursing curriculum; KT; knowledge and training; PT; providing a tool; TR; trusting relationship

Items	IS	PA	EI	PM	PS	CP	RW	NC	TC	KT	PT	TR	Total
ATT-1		i											1
ATT-2													
ATT-3													
ATT-4	iii												3
ATT-5													
ATT-6		iii											3
ATT-7													
ATT-8													
ATT-9									ii	i			3
ATT-10			ii										2
ATT-11			i										1
ATT-12			i										1
ATT-13							i						1
ATT-14													
SUB-1					i								1
SUB-2					i								1
SUB-3					i								1
SUB-4					i								1

Table 16. Frequency of qualitative (interviews) and quantitative
IS=identify survivor; PA=psychological approach; EI= embarrassing and insulting; PM=people not mentioned; PS=people and policy nor support; CP=curriculum not prepares; RW; private room and workload; NC= not a culture; TC; addressing the tool into nursing curriculum; KT; knowledge and training; PT; providing a tool; TR; trusting relationship

Items	IS	PA	EI	PM	PS	CP	RW	NC	TC	KT	PT	TR	Total
SUB-5				i									1
SUB-6				i									1
SUB-7				i									1
SUB-8				i									1
SUB-9				i							i		2
PBC-1												iii	3
PBC-2												iiii	4
PBC-3										i			1
PBC-4						i							1
PBC-5													
PBC-6					i								1
PBC-7									iiiii	iiiiii			11
PBC-8													
PBC-9											i		1
PBC-10							iii						3
PBC-11							i						1
PBC-12													
PBC-13													

Table 17. A cross-tabulation between qualitative and quantitative research

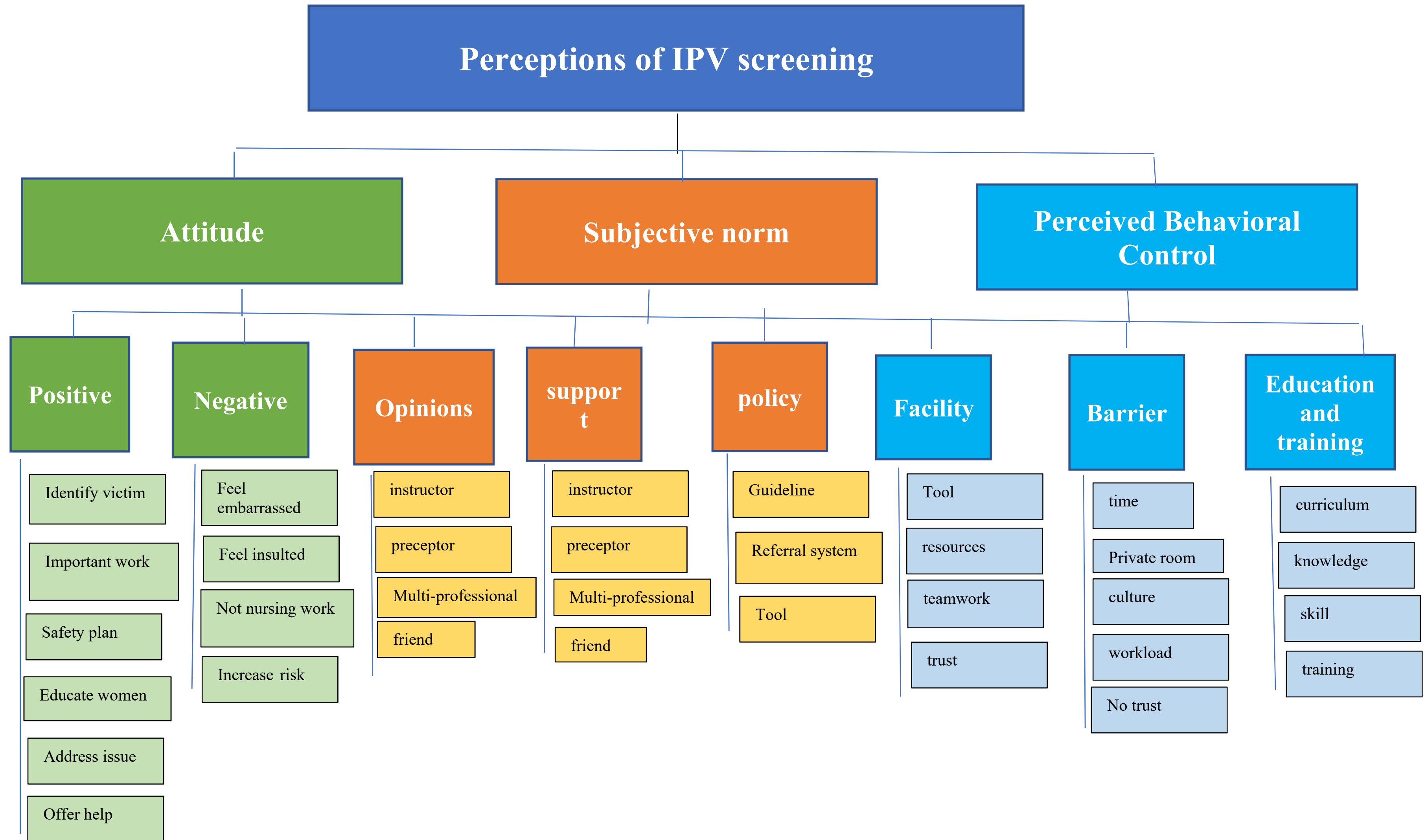
TPB components	QUAL		QUAN	See only in QUAN	See only in QUAL
	Focus group	Interview			
Attitude	Identify survivors Offer help Women embarrassing Not recognize in nursing work	Identify survivors Psychological approach Embarrassing and insulting	Mean score = 3.99 Spearman's Rho correlation =0.45** Mediation= 2.14* Logistic regression: Odds=8.51*	ATT-3-you feel comfortable during screening women for IPV (Mean score 3.87) ATT-7-Screening can educate women for IPV (Mean score 4.27) ATT-8-Screening can address IPV is an important issue (Mean score 4.20)	
Subjective norm	Lack of role model Ready to follow health team' s opinions	People not mentioned People and policy not support	Mean score = 3.79 Spearman's Rho correlation =0.41** Mediation=1.48* Logistic regression: Odds=4.43*		

TPB components	QUAL		QUAN	See only in QUAN	See only in QUAL
	Focus group	Interview			
Perceived Behavioral Control	Cultural sensitivity Not ready, less educating and lack of training Not require in nursing experience No trust Do not know the tool and guideline Trust relationship Providing screening tool and guideline Training	Curriculum not prepares Private room and workload Not a culture Addressing the tool into nursing curriculum Prepare knowledge and training to instructors, nurses, and students Providing a tool Trusting relationship	Mean score = 4.43 Spearman's Rho correlation =0.46** Mediation= 0.53 Logistic regression: Odds=1.69	PBC-8-several resources will assist in perform screening (Mean score 4.26) PBC-12-Limited time for each nursing activity will prevent screening (Mean score 3.97)	Not require in nursing experience No trust Not a culture Providing a tool
Predicting intention			Attitude and subjective norm		
Associated background characteristics to intention			Gender, GPA, ever received training regarding IPV, having a screening tool at the		

TPB components	QUAL		QUAN	See only in QUAN	See only in QUAL
	Focus group	Interview			
			clinical sites, seeing health professional screening, having experience performing IPV screening, experiencing abuse, and witnessing family abuse. P<0.05		

Note. ATT-Attitude, SUB-Subjective norm, PBC-Perceived Behavioral control. IPVSI-NS-Intimate Partner Violence Screening Instrument for Nursing Students, *p<0.005, **p<0.001

Figure 11. Hierarchical Categorization of the IPV screening perceptions among nursing students and nurse educators in Thailand



CHAPTER 5

DISCUSSION

Chapter five discusses the findings of this mixed methods study and integrates them with previous studies. The strengths, limitations, clinical implementations and future studies will be discussed.

This mixed-method study addresses an important gap in scientific knowledge regarding future Thai healthcare providers' exposures to IPV screening and factors related to their intentions to screen women and includes a large, geographically diverse sample of senior nursing students about to enter professional nursing practice. To our knowledge, this study is the first Thai-based study to predict intentions and explore perceptions of IPV screening among senior-nursing students and nurse educators in Thailand by the TPB based on three components: attitude, subjective norm, and perceived behavioral control.

This study found that a vast majority of Thai nursing students (89.84%) described themselves as likely intention to screen women for IPV. This is higher than Natan et al's (2016) which found that 70% of the Israeli nursing students in the study had intention to screen (Natan et al., 2016). However, the backgrounds of participants are different; participants in Natan et al (2016) are nursing students, who completed at least one year of nursing studies; conversely participants in this research were in their last year of nursing program. It may be assumed that participants in this study have exposed to greater amounts of IPV content in their curriculum than those earlier in their studies, e.g., Natan et al (2016), however, this was not the case.

Generally, qualitative findings suggested both nursing students and nurse educators perceived IPV as a critical issue in Thailand. In addition, participants from this study realize that it is time to talk about IPV and promote IPV screening into nursing education. These suggestions are congruent with existing studies that it is important to recognize the need for improving and increasing education and training for nursing professional; additionally, it should be starting with nursing instructors and students (Beccaria et al., 2013; Connor, Nouer, Speck, Mackey, & Tipton, 2013; Tufts, Clements, & Karlowicz, 2009). Nursing education is one of nursing professional challenges in the 21st Century. It is not only necessary to be prepared to address complex health issues every day, but educators have to prepare nurses to be leaders in healthcare (Mannino & Cotter, 2016). Nursing education and service play a vital role in the future of nursing to improve the educational preparation of nursing students today (Mannino & Cotter, 2016).

The mean scores of attitude, subjective norm, and perceived behavioral control regarding IPV screening show that Thai nursing students reported positive attitudes, subjective norms, and perceived behavioral control towards IPV screening. Similarly, qualitative findings suggested participants have good attitudes about IPV screening; they believe that IPV screening can identify survivors and also it is a way of providers to do psychological approach to women. The results are similar to a previous qualitative study which asks medical students about IPV screening (Aluko, Beck, & Howard, 2015). It states that IPV screening could identify survivors and also could potentially offend patients. Furthermore, nurse educator participants in this study support screening women for IPV can be a way to approach women patients holistically. It is an important

information to know that Thai future nurses and nurse educators recognize IPV screening is important and generally support screening.

However, the numbers of participants exposed to IPV training were quite low, as was the amount of training received. Specifically, only 59.2% of participants have ever been exposed to any IPV content within discussions, training, or workshops within undergraduate studies. In addition, less than 1 in 5 senior nursing students (17.7%) had direct experience screening women for IPV. While social desirability may have influenced student responses, the survey was anonymous, and findings generally suggest nursing students may have good intentions regarding IPV and an openness to IPV screening, but their preparation to address IPV in clinical practice is inadequate. These results are congruent with previous studies (Alshammari, McGarry, & Higginbottom, 2018; Doran & Hutchinson, 2017; Natan et al., 2016).

Additionally, the interviews and focus groups with both nursing students and nurse educators in Thailand participants confirmed the quantitative finding that nursing education does not prepare students well for dealing with IPV or promote IPV screening. The participants feel unconfident in dealing with this issue because they have no experience, no knowledge, and they are poorly prepared. These findings are similar to a recent integrated review of literature that nurses do not receive sufficient interactive training about IPV to permit them to deal with, recognize and identify IPV in their future specialized practice (Alshammari, McGarry, & Higginbottom, 2018; Doran & Hutchinson, 2017; Natan et al., 2016). Lack of knowledge and inadequate managing cases of IPV are identified as barriers to responding to IPV in the healthcare sector (Rigol-Cuadra et al., 2015; Usta & Taleb, 2014).

The findings in this study related to intention, while promising, are not entirely congruent with the Thai students' relatively minimal exposures to IPV screening training or resources. While this study did not assess nursing students' actual knowledge, research in other settings with nursing students regarding their perceptions, attitudes, and knowledge of intimate partner violence have suggested many have limited and stereotypical beliefs regarding what constitutes IPV and who perpetrates it, and felt underprepared to address it in clinical practice (Beccaria et al., 2013). This study suggests that it is important to capitalize on Thai nursing students' high level of intentions and provide them with high-quality education and training on IPV prevalence, dynamics, health consequences, and evidence-based intervention, including available community resources, such as Thailand's One-Stop Crisis Centers (OSCC).

The study also indicated that there is a medium-sized significant correlation between students' attitude, subjective norm, and perceived behavioral control, and their intention to screen women for IPV. The result is similar with Natan et al. (2016)'s study. We found that perceived behavioral control was somewhat more highly-correlated than other variables in correlation toward intention, but the difference was not substantial and is overall similar with previous studies (Natan et al., 2016).

Interestingly, we found exposure to IPV training or discussion was associated with screening intention, but the actual number of hours of this exposure was not. In addition, the results show that only watching an IPV video or participating in a discussion was significantly associated with intention of screening, while participating in a training or workshop was not. The results are different from previous study that number hours of training regarding IPV can significantly increase the frequent of IPV screening (Bender,

2016) and also increase clinician training can increase IPV screening (Baig, Ryan, & Rodriguez, 2012). The reason for these findings is not entirely clear, and future research should explore carefully the differential impact of both training modalities and the amount of exposure to training in this population.

Importantly, the results of this current study indicate that only 11% of participants reported their nursing schools provided IPV screening tool for them to screen women for IPV. Additionally, only about 17% reported IPV screening is provided at hospital or community clinics. These results are also confirmed in qualitative interviews. This information can reflect how unready healthcare systems and nursing education are regarding providing facilitation of IPV screening.

However, the situation of IPV screening in Thailand is challenging. It may be also challenging to nursing schools to provide IPV screening tool for nursing students because the tool is not widely used in hospitals and communities as well. Screening tools are provided only in some departments, such as the One Stop Crisis Center (OSCC) and Gynecology department, but other departments such as OPD and ER do not have it; further, to the best of the author's knowledge, there is no standard IPV screening tool that is culturally validated for Thailand. In addition, ER/OPD providers (who function as gatekeepers) would not usually ask patients about their family relationships or abuse. Actually, there is a depressive tool in version 2Q and 9Q (www.dmh.go.th), that Thai providers use to ask patients about their depressive symptoms. If the depressive tool of 2Q is positive, providers will explore 9Q whether there is IPV. Therefore, the results of this study can show the specific gaps of promoting IPV screening and lacking specific IPV screening tool. While Thai providers may be missing some indications for screening

– they are capable of asking their patients about IPV, despite the cultural issues, when this is a policy.

Another interesting result from this study shows that about one in five to six of nursing student participants in online survey have themselves experienced IPV in their lifetime. The results are congruent with previous studies (Çelebioğlu, Akpinar, Küçükoğlu, & Engin, 2010; Ferns & Meerabeau, 2008). Those studies indicate that verbal abuse is the form of violence that nursing students were exposed to the most. These results can imply that IPV is not only a concern for patients or women at the hospitals or communities, but also nursing students who will be the future gatekeeper to screen women or patients for IPV. In addition to supporting Thai nursing students to address IPV in their clinical practice, these students – who are predominantly young women – should be supported to respond to IPV in their own lives as well.

In terms of the role of attitudes and subjective norms as mediators of the relationship between providing a tool at clinical site and intention, some clear patterns were revealed. Of note, we found most of the important factors related to intentions to screen were modifiable; i.e., promoting good attitudes towards screening and exposing nursing students to role models and hands-on practice for screening. Administrators and nurse educators should educate students about the negative health consequences of IPV, the role of advocacy in addressing IPV, and about existing resources, as well as expose them to role models of screening women for IPV. In addition, attitudes of healthcare providers regarding IPV can be associated with providing services and performances of dealing with IPV as well (Yousefnia, Nekuei, & Farajzadegan, 2018).

The theoretical model of TPB predicted 31% of students 'intention to screen women for IPV. The results showed that only attitudes and subjective norms significantly predicted intention of IPV screening. While no other research has looked at these factors related to IPV screening in Thailand, other international research using the TPB model with healthcare providers has indicated attitude and perceived behavioral control are important predictors of predicting healthcare providers' intention toward behavior (i.e.., child abuse reporting; (Feng, Levine, & Neglect, 2005; Young, Jung, & Nam, 2013). Moreover, this study found that attitude was the strongest predictor; similarly, Lee and Kim (2018) found attitude is the strongest predictor of reporting child abuse among emergency nurses in Korea. Conversely, Natan et al (2016) found subjective norms were the most influential predictor of IPV screening among Israeli nursing students. However, a study of physician readiness to manage IPV with 134 physicians and nurses at rural health clinics states knowledge and attitude do not predict IPV screening, but number of hours of training on abuse and organization protocols can significantly increase the frequent of IPV screening (Bender, 2016). The reasons for the patterns of these differences are unclear, but it is important to note that the TPB components do associate significantly with behavioral intention across research studies with future and current nursing students. Nevertheless, according to the result of this study showed that perceived behavioral control not predicted intention, the explanation is still unclear and need to explore more details in the next future studies.

The results found that providing a tool at clinical sites significantly predicted intention of IPV screening, but the odds ratio is less than 1 (0.10), implying that providing a tool is likely predictive of intentions to *not* screen. While these findings are

counterintuitive, only 17.2% of students reported their clinical sites provided a clinical tool for IPV screening, 32.8% reported no provided a screening tool at clinical site, whereas 50% of participants did not know whether the clinical sites provide a screening tool for screening or not. These results may have been recognized that 50% of participants would be real "do not know" about the clinical site provided a clinical tool for IPV screening or not. If so, the nursing instructors and clinical preceptors may create some interventions to help nursing students to know and recognize the screening tool; for example, orientation nursing students for the screening tool and training them how to use the screening tool while they are studying in school and practicing at the clinics.

However, for the next study, we can consider deleting the "do not know" as well. As a general rule, it is best avoid using "do not know" or "no option" response options, it is likely to produce less valid data (Mondak & Davis, 2001). Offering a "do not know" option actually creates a worse problem than it solves by allowing respondents to disengage from the survey (Oppenheim, 2000). Giving the option, some people tend to just select "do not know" to avoid having to think about the answer. When people really don't know, it is okay to ask them to provide their best guess. The best guest will still be more beneficial than a "do not know" response (Mondak & Davis, 2001).

Healthcare providers must recognize that cultural sensitivity is a major concern for women, especially those who live in developing countries, to answer about their own lives regarding IPV (Daniel & Milligan, 2013). Both our qualitative and quantitative findings suggest inquiring about IPV remains a sensitive issue. These findings are similar to previous studies (Beynon, Gutmanis, Tutty, Wathen, & MacMillan, 2012; Daniel & Milligan, 2013; Sohani et al., 2013). However, this can also happen in developed

countries where IPV issues are more frequently and openly discussed. For example, a qualitative Canadian study asked 769 physician and nurses about the barriers of asking IPV; language and culture are included as barriers (Beynon et al., 2012). Even though IPV is a sensitive topic, some studies support that women feel comfortable in answering questions regarding IPV. For instance, a cross-sectional study in the US examined the outcome of IPV screening with using guideline-concordant discussion topics and interventions with 253 women who have aged between 18 and 65 years old (Swailes, Lehman, & McCall-Hosenfeld, 2017). The results show that 58% of women reported very satisfied and 53% reported very comfortable. In addition, an interesting study asks female survivors about what they would like to advise healthcare providers regarding IPV screening (Chang et al., 2005). The female survivors recognize that healthcare providers' asking about IPV is an opportunity for them to raise awareness about IPV and receive information and support rather than a method for identifying IPV.

In addition, it is not surprising that participants mentioned IPV does not exist as an independent topic in the nursing curriculum and it is suggested to add it into the nursing curriculum from participants in both focus groups and individual interviews. It is also supported with an item of perceived behavioral control (PBC-4) that "education from nursing school regarding IPV and IPV screening are enough for you to perform screening women for IPV. The mean score and SD of this item are 3.74 and 0.83 respectively; it is a low score when compared with average score of perceived behavioral control component (4.13). The issue is explored not only nursing education in Thailand, but also around the world, including developed countries, where IPV is not as much of a private matter. For example, Price-Glynn and Missari (2017) examined the conceptualizations of

violence against women in U.S. nursing textbooks between 1995 and 2005. They found that over 40% of generalist textbooks did not mention violence against women. Another study also supports that IPV is not included in nursing curriculum (Lovi, Hurley, & Hutchinson, 2018). It is a mixed-method study in Australia interviewed 18 academics teaching in undergraduate nursing, midwife and paramedicine courses. Results found that there is a paucity of IPV-related content, with curriculum crowding being a major barrier to its inclusion.

A cross-tabulation table from mixed-methods findings also shows that the findings from qualitative method almost cover the 36 items in quantitative based on the TPB. In addition, the information of quantitative statistics also supports all 36 items are at least 3.5 out of 5. It means that participants have good perceptions of IPV screening. It makes researcher better understand how strong information it is. It is also clear that the findings in qualitative study in focus groups (interviewed senior-nursing students) and individual interviews (interviewed nurse educators) are not much different. Their opinions are the same directions that IPV screening is important and we need more facilitators to promote screening such as knowledge and training. Even though perceived behavioral control not significantly predicted intention, there are many themes emerged on perceived behavioral control. In addition, it is interesting that the attitude items of ATT-3, ATT-7, and ATT-8 that are not covered in attitude' s qualitative findings. ATT-3 states that providers feel comfortable during screening women for IPV. This item is congruent with the strong results of qualitative findings regarding negative consequences of screening that women would feel embarrassed in insulted during screening. It can be

implied that it would make providers ignore or scare to ask because it would prevent negative reactions such as embarrassed or uncomfortable from women.

Moreover, the findings of barriers of IPV screening, not a culture and no trusting relationship, emerged in only qualitative method. Furthermore, providing the screening tool is the one that we have found both in focus groups and individual interviews. Providing a tool can be actually addressed and matched in an item of quantitative regarding material and guideline to support screening, but did not mention the tool particularly. Therefore, the interpreting and suggesting from the cross-tabulation table show that we should add the specific words to ask nursing students about their perceptions to IPV screening regarding culture and screening tool.

Strengths of the Study

There are several major strengths of this study. First, this study used mixed-method research by adding the qualitative method to gather rich perceptions of nursing students and nurse educators about IPV screening. It allows author to better understand about participants' perceptions in IPV screening from both sides of collecting data: questionnaires and own words based on the TPB components' explanations. It According to Patton (2002) states that the reflections and own words of participants convey to research of credibility and validity' enhancing and strengthen. Another strength of this study is bringing together between nurse educators and nursing students' perceptions. It will be helpful for nursing administrators to bring the information to develop the nursing curriculum for promoting IPV screening. Furthermore, participant's size and distribution data from survey online make the results of this study stronger and representative. Finally, this study is a first study examined and explored nursing students

and nurse educators regarding IPV and IPV screening in Thailand. This study contributes new and novel findings which should serve as the basis for future research with additional population and various research methods.

This study also contributes new knowledge regarding methodological approaches with this population. Specifically, in the quantitative phase, this study recruited nursing student participants by using an online survey (Facebook and Line applications). We found this approach was successful with this population and fit very well with this study. During the first two months of data collection, this study primarily recruited through the author's professional contacts. We met the minimum sample size, but found most participants were from northeast Thailand and nursing schools under PIHWD (where the author, a nursing school faculty member, is best-connected). Therefore, to reduce the bias of results, we submitted an IRB amendment to recruit more widely via social media and substantially increased the geographic and nursing school diversity in our sample. These social media approaches are congruent with previous studies (Carter-Harris, Ellis, Warrick, & Rawl, 2016; Frandsen, Thow, & Ferguson, 2016; Whitaker, Stevelink, & Fear, 2017). In a recent review of 35 studies, Facebook was found to be a useful and beneficial recruitment tool when compared with traditional methods (print, radio, television, and email) (Whitaker et al., 2017), and with benefits including reduced costs, shorter periods, and improved participant selection in young and hard to reach demographics. To our knowledge, no prior research has recruited Thai nursing students in this fashion; therefore, one contribution to science made by the current study is that an online survey method of recruiting Thai nursing students was efficient and effective at

reaching potential participants, recruited participants quickly, and enhanced the diversity of participants.

Limitations

Even though we were able to recruit from a diverse sample related to nursing school geographic location and types, results are not necessarily generalizable to other different areas, countries, or contexts. Additionally, this study used the constructs of the TPB to predict only the intention; we did not investigate the actual behavior. Furthermore, as the predominance of gender demographic of this study is females, the results would be not referring to participants who identified themselves as male and LGBTQ. Finally, the cross-sectional study design does not lend itself to causal inference and can provide information only for correlation and prediction of variables.

Several limitations are also identified in regard to the qualitative method section. A geographical limitation with a small sample limits the findings from being generalized to nursing students and nurse educators in other provinces and nursing schools. The results from this study are referred from senior-nursing students and nurse educators who have experienced in nursing education at least 10 years. Therefore, the knowledge could not refer to nursing students in other years of nursing program and nurse educators who worked less than 10 years. The categories of results have been followed by the TPB components; even though it is useful to describe and understand the perceptions of participants, it is restricted to the concepts of the TPB components.

Clinical implications and recommendations for future research

As a large number of participants for survey online and validated the information by focus groups and individual interviews, the results of this study can convey to senior nursing students and nurse educators in Thailand regarding their attitudes, subjective norms, perceived behavioral controls, and intentions to screen women for IPV. The results can make suggestions to nurse educators in terms of improving the nursing curriculum by addressing IPV and IPV screening into it. In addition, this research can raise the voices of future nurses to policy makers that it is time to educate healthcare providers about dealing with a health complexity issue as IPV and promote IPV screening.

According to the results show that the small number of exposing or training regarding IPV screening, addressing workshop or training for nursing students about IPV and IPV screening will be required. In addition, it is not only for senior-nursing students, but also “first-,second-, and third-year” of nursing students. Additionally, the results from individual interviews convey that training regarding IPV screening is not only necessary for nursing students, but also instructors and preceptors. Providing the refreshing course about IPV screening for them is required. It will help them have more confidence to teach and supervise nursing students as well. Indeed, regular on-site training and interactive learning opportunities that engage with service users is recommended.

There are a lot of contributing factors associating with intention, including GPA, ever received training regarding IPV (with only having watched a video or participated in discussion regarding IPV significantly associated), having a screening tool at the clinical

sites, seeing health professional screening, having experience performing IPV screening, experiencing abuse, and witnessing family abuse were all significantly associated with screening intentions. Nurse educators can integrate these factors to nursing courses regarding IPV and IPV screening. In addition, nurse educators should evaluate the outcomes of nursing students regarding their attitudes, subjective norms, and perceived behavioral controls to predict intention of IPV screening.

The results from quantitative study show that nursing schools and hospitals do not provide IPV screening tool and additionally nurse educators and preceptors have not addressed about IPV. Therefore, this study would like to address nursing schools should prepare and provide IPV screening tool and nurse instructors and preceptors should more seriously focus on the nursing care plan particularly the part of family relationship for practicum courses. When nursing students present their case studies, it is important to discuss about IPV and results of IPV screening. It will help students to better recognize the negative consequences outcomes of IPV.

It will better understand about preparing of future nurses and new nurses for IPV and IPV screening if we know how readiness of new nurses about IPV screening is. This study is suggesting health policy makers or administrators to explore the knowledge, attitudes, subjective norms, and perceived behavioral control of new nurses who are working between 1-5 years. The results from that study may be helpful for healthcare providers to plan.

The results of mixed-method of this study is recognized that preparing future nurses for dealing with IPV and promoting IPV screening could not be effective if it is

provided just only nursing schools. There has be collaboration with hospital policy and healthcare systems. For example, the research shows that attitude and subjective norm are mediators of the relationship between having an IPV screening tool and intention to screen. If a hospital provides the IPV screening tool, but nursing schools do not teach and increase positive attitude to nursing students or instructors or preceptors are not a role model of screening or a hospital does not have a referral system to support screening. It does not matter. Therefore, it should be working and collaborating together.

Given the paucity of literature in this area, more research is needed to understand how best to promote effective IPV screening and intervention practices by Thai healthcare providers in regard to particular future nurses. This study recommends in particular qualitative and mixed-methods approaches to explore the effects of implementing IPV training into the Thai nursing curriculum is and the characteristics of effective IPV training, including modalities and the amount of exposure. In addition, conducting more research to support the issues relating important of IPV in nursing education is needed. Furthermore, the mediation model may benefit from additional factors. For example, this study found attitude and subjective norm are only mediators of the relationship between providing an IPV screening tool at clinical site and IPV screening intentions. This study suggests future researchers may be able to improve the predictive power of the framework by integrating additional constructs (such as the availability of screening tools and knowledge of IPV). Finally, longitudinal and intervention research to explicate the impact of training and screening practices on IPV on Thai nursing students, practicing providers and IPV survivors are needed.

CONCLUSION

This mixed-methods study has been addressed the important issue of health and a gap between policy and implementation as IPV screening. The results of examining the intentions of IPV screening from survey online explore the value of the main components in the theory of planned behavior (TPB) in understanding and predicting the screening women for IPV of senior-nursing students in Thailand. The results suggest that it is time to consider about adding or integrating domestic violence contents and screening into nursing curriculum, and challenge the policies, guidelines, and healthcare providers to support domestic violence screening. How much of training and how about training interventions are needed to evaluate, and more research regarding IPV and nursing education is definitely needed in Thailand.

In addition, the results from six focus groups with nursing students and nine-individual interviews with nurse educators confirm that nursing students and nurse educators perceived that IPV is a critical issue in Thailand, but it is difficult to identify because of the cultural consideration. They do not feel well-prepared by school in terms of knowledge and training experience. Nurse educators also feel not confident in supervising. In addition, the findings of mixed methods research were helpful to deep understanding of IPV screening expressed by participants.

This study is the first study to specifically examine the intentions and explore the perceptions of IPV in nursing education in Thailand. The findings contribute to improving the nursing curriculum regarding IPV. More research is related to prepare nursing students to deal with IPV issue is required. This study recommends in particular qualitative and mixed-methods approaches to explore the effects of implementing IPV

training into the Thai nursing curriculum is and the characteristics of effective IPV training, including modalities and the amount of exposure. In addition, conducting more research to support the issues relating how important IPV is in nursing education is needed.

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APPENDICES

1. Survey questionnaire
2. Sample size analysis
3. Waiver of documentation of consent
4. Letter of invitation
5. Interview guide
6. IRB

Questionnaire

Intimate Partner Violence Screening Intention (IPVSI-NS)

Healthcare professionals differ in their opinions regarding intimate partner violence (IPV) and IPV screening. This study investigates nursing students' perceptions on IPV and IPV screening. There are no correct or incorrect responses; I am merely interested in your personal opinions. Your answers are completely confidential; only summary statistics are of interest to the investigators. Please read each question carefully and answer it to the best of your ability. The following questions ask you to express your opinions with respect to assessment for IPV when you had clinical practices.

Demographic information (English Version)

1. Age………Year
2. Gender: ……..Male………Female........LGBTQ
3. GPA: ………..< 2.50………2.50-3.00……….3.31-3.50………>3.51
4. Have you ever trained in or discussed IPV?
   a. ……..Yes
   b. ……..No
5. If so, how much training or studying about intimate partner violence issues have you had in nursing school? (apply all)
   a. ……. Watched a video
   b. ……..Attended a lecture or talk
   c. ………Attended a skill-based training or workshop
   d. ………Other (specify)……………………………
6. Estimated total number of hours of IPV training in nursing school
   a. ………..1-5 hours
   b. ……….6-10 hours
   c. ……….11-15 hours
   d. …………More than 15 hours
7. In nursing school, is there an IPV screening form provided to you for screening women for IPV while you practice at hospital or community clinics?
   a. ………. Yes
   b. ………. No
   c. ………..Do not know
8. Is there an IPV screening form in the hospital or community clinic that is provided to you for screening women for IPV?
   a. ……..Yes
   b. ……..No
   c. ……..Do not know

9. Do other health profession screen women for IPV in the hospital or community clinic while you practice?
    a. ……..Yes
    b. ……..No
    c. ……..Do not know
10. While you practice in hospitals or community clinics, have you had experience screening women for IPV?
    a. ………. Yes
    b. ………. No
11. If so, what department or community clinic did you screen at?
    a. ....
12. Religion………. Buddhist…………Muslim…………..Christian…………Other
13. Place of living:……. Rural………Suburb...........Urban
14. Region of living……..South…….North……Northeast…..Central…..East…..West
15. Location of Nursing school ……..South…….North……Northeast…..Central…..East…..West
16. What kind is your nursing school
    a. …………Nursing school under Ministry of Public Health
    b. ……….... Nursing school under Public University
    c. …………Nursing school under Private University
17. Have you ever experienced physical violence, sexual violence, emotional violence, or threats of violence in an intimate partner relationship? …………Yes………..No
18. Have you ever witnessed physical violence, sexual violence, or psychological violence directed towards a family member or friend?

…………..Yes…………No

The questionnaire about Predicting Intention about IPV screening among Nursing Students in Thailand

The answer of each item is Likert Scale as 5 levels of agreement:

a. 5: Strongly agree
b. 4: Agree
c. 3: Neither agree or disagree
d. 2: Disagree
e. 1: Strongly disagree

Item	Level of Agreement				
	5	4	3	2	1
A-1 Screening women for IPV is a good assessment.					
A-2 Nursing is an important career for screening women for IPV.					
A-3 Screening women for IPV is an intervention that you feel comfortable doing.					
A-4 Screening women for IPV is useful in that it can identify potential risk for women.					
A-5 Screening women for IPV is an opportunity to provide help and offer healthcare services for women who have experienced IPV.					
A-6 Screening women for IPV can help women develop a safety plan.					
A-7 Screening women for IPV can educate women about IPV, which is an important issue for public health and the country.					
A-8 Screening women for IPV can address IPV, which is an important issue for public health and the country.					
A-9 Education from nursing school regarding IPV screening is an important facilitator to prepare you to perform IPV screening for women.					

Item	Level of Agreement				
	5	4	3	2	1
A-10 Women do not trust you enough as a nursing student to tell you about IPV experiences.					
A-11 Screening women for IPV may make women feel embarrassed.					
A-12 IPV screening will make women worry about being found out as a victim.					
A-13 Screening women for IPV takes too much time.					
A-14 Screening women for IPV may increase the risk of harm to women if it's an inadequate assessment.					
S-1 Nurses in the department strongly support and expect you to perform screening of women for IPV.					
S-2 Teachers in my nursing school strongly support and expect you to perform screening of women for IPV.					
S-3 Other professionals in the department strongly support and expect you to perform screening of women for IPV.					
S-4 Your friends strongly support and expect you to perform screening of women for IPV.					
S-5 Opinions of nurses in the department regarding screening women for IPV are important to your decision to screen the women for IPV.					
S-6 Opinions of multi-professionals in the department regarding screening women for IPV are important to your decision to screen women for IPV.					
S-7 Opinions of teachers in your nursing school regarding					

Item	Level of Agreement				
	5	4	3	2	1
screening women for IPV are important to your decision to screen women for IPV.					
S-8 Opinions of your friends regarding screening women for IPV are important to your decision to screen women for IPV.					
S-9 Clear and effective hospital policies, guidelines, and orientations regarding IPV screening while practicing nursing are important to your decision to screen women for IPV.					
P-1 Caring behavior of nurses will facilitate women to disclose IPV experiences.					
P-2 Good relationship between women and nurses will facilitate performing correct IPV screening.					
P-3 IPV training frequently will facilitate performing correct IPV screening.					
P-4 Education from nursing school regarding IPV and IPV screening are enough for you to perform screening women for IPV.					
P-5 Private and safety settings will facilitate performing IPV screening.					
P-6 A team approach, including nurses and multi-professionals, can facilitate effective screening of women for IPV.					
P-7 Knowledge and skills regarding IPV screening are required to screen women for IPV.					
P-8 Several resources, including physical and mental resources, will assist in					

Item	Level of Agreement				
	5	4	3	2	1
performing screening women for IPV.					
P-9 Other family members being present during the screening can interfere or be a barrier with screening women for IPV.					
P-10 The workload of nurses can affect screening women for IPV.					
P-11 The number of patients in the clinic can affect the privacy of screening women for IPV.					
P-12 Limited time for each nursing activity will prevent screening women for IPV.					
P-13 I am ready to screen women for IPV.					

1. I intend to screen all women for IPV when they come for healthcare services for any reason.

   1.1………… Intention

   ………..Strongly intentioned

   ………..Somewhat intentioned

   1.2……………No intention

2. Do you have anything that you would like to tell and it does not include above?

……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………
…………………

Question Items	Reverse Scoring	Construct Measured
ATT-2,7,9,10		Outcome Evaluation
ATT-5,6,8,11,12,14	10, 11, 12, 14	Behavioral Belief
ATT-1,3,4,13	13	Attitude direct measure
SUB-4,5,6		Normative belief
SUB-9		Motivation to comply
SUB-1,2,3,7,8		Subjective norm direct measure
PCB-4,5		Perceive Power
PCB-1,2,6,7,8,12	12	Control belief
PCB-3,9,10,11,13	10,11	Perceived behavioral control direct measure

แบบสอบถาม

การทำนายความตั้งใจในการคัดกรองความรุนแรงในครอบครัวของนักศึกษาพยาบาล ประเทศไทย

ส่วนที่ 1 คำจำกัดความ

การคัดกรองความรุนแรงในครอบครัว หมายถึง การประเมิน ค้นหา ความผิดปกติ
สาเหตุของผู้รับบริการที่มีประสบการณ์ หรือ อาจจะนำไปสู่ปัญหาความรุนแรงในครอบครัว
เพื่อช่วยเหลือและให้การส่งต่อที่เหมาะสม
*ในการวิจัยครั้งนี้เป็นการคัดกรองในผู้รับบริการหญิงและจะมีการประเมินทุกครั้งที่มาใช้บริการในสถา
นพยาบาลบริการสุขภาพ*

ความรุนแรงในครอบครัว หมายถึง การกระทำใด ๆของบุคคลในครัวเรือน/ครอบครัว/คู่รัก
โดยมุ่งประสงค์ให้เกิดอันตรายแก่ร่างกาย จิตใจ หรือสุขภาพ
หรือกระทำโดยเจตนาในลักษณะที่น่าจะก่อให้เกิดอันตรายแก่ร่างกาย จิตใจ
หรือสุขภาพของบุคคลในครอบครัว/คู่รัก
หรือบังคับหรือใช้อำนาจครอบงำผิดทำนองคลองธรรมให้บุคคลในครอบครัว/คู่รักต้องกระทำการ
ไม่กระทำการ หรือยอมรับการกระทำอย่างหนึ่งอย่างใดโดยมิชอบ แต่ไม่รวมถึง
การกระทำโดยประมาท

ความรุนแรงทางด้านร่างกาย หมายถึง
การกระทำที่ก่อให้เกิดการบาดเจ็บทางด้านร่างกายโดยวิธีการ
ต่างๆ เช่น การเฆี่ยนตี การเตะ การชกต่อย หรือวิธีอื่นๆ ที่ทำให้ผู้ถูกกระทำได้รับบาดเจ็บทางด้านร่างก
าย เช่น ศีรษะแตก กระดูกหัก เลือดออกภายในฟกช้ำ แผลไฟไหม้ ได้รับสารพิษ

ความรุนแรงทางด้านจิตใจ หมายถึง
พฤติกรรมที่ก่อให้เกิดการทำร้ายทางด้านจิตใจ การควบคุมบังคับบุคคลอื่นอย่างไม่มีเหตุผล ซึ่งการกร
ะทำนั้นทำให้บุคคลที่ถูกกระทำได้รับความอับอาย มีความรู้สึกด้อยค่า หรือลดคุณค่าความเป็นมนุษย์ข
องตนเองลง

ความรุนแรงทางด้านเพศ หมายถึง
การกระทำที่บุคคลมีวัตถุประสงค์ที่จะใช้ในการตอบสนองความต้องการทางเพศของตนเอง หรือใช้ควา
มพยายาม ใช้กำลัง การบังคับขู่เข็ญ
การหลอกล่อ การชักชวน การให้สิ่งตอบแทน ทั้งนี้เพื่อที่จะทำให้ผู้ถูกกระทำยินยอม

นักศึกษาพยาบาล หมายถึง นักศึกษาชั้นปีที่ 4 ที่กำลังศึกษาในหลักสูตรพยาบาลศาสตรบัณฑิต ในประเทศไทย รวมทั้ง กำลังศึกษาในวิทยาลัยพยาบาล หรือ มหาวิทยาลัย ของรัฐหรือเอกชน ในประเทศไทย

ทัศนคติ หมายถึง การประเมินทางบวก ลบ หรือการตัดสินว่าเป็นสิ่งที่ดีหรือเลวของนักศึกษาพยาบาลต่อการคัดกรองความรุนแรงในครอบครัว

การคล้อยตามกลุ่มอ้างอิง หมายถึง การรับรู้ของนักศึกษาพยาบาลว่าบุคคลอื่นที่มีความสำคัญกับตน ต้องการหรือไม่ต้องการให้ตนคัดกรองความรุนแรงในครอบครัว

การรับรู้กับความสามารถในการควบคุมพฤติกรรม หมายถึง การรับรู้ของนักศึกษาพยาบาลว่าเป็นการง่ายหรือยากที่จะคัดกรองความรุนแรงในครอบครัว ซึ่งเป็นการสะท้อนจากประสบการณ์ในอดีตและการคาดคะเนปัจจัยที่เอื้ออำนวยหรือเป็นอุปสรรค

ความตั้งใจ หมายถึง เจตนาหรือความต้องการที่จะพยายามคัดกรองความรุนแรงในครอบครัวในผู้รับบริการหญิง

อาจารย์นิเทศ หมายถึง อาจารย์ประจำของวิทยาลัยพยาบาล และ คณะพยาบาลศาสตร์ ทั้งของภาครัฐและเอกชน ที่ส่งนักศึกษาพยาบาลและได้รับแต่งตั้งให้ทำหน้าที่นิเทศนักศึกษาพยาบาลขณะฝึกปฏิบัติการพยาบาล

พยาบาล หมายถึง พยาบาลวิชาชีพที่ประจำการในสถานบริการสุขภาพที่เป็นแหล่งฝึกการศึกษาภาคปฏิบัติ ของนักศึกษาพยาบาลในหลักสูตรสาขาพยาบาลศาสตร์

ชนบท หมายถึง อาณาบริเวณนอกเขตเมือง เป็นเขตที่มีผู้คนอาศัยอยู่จำนวนไม่มาก ชีวิตความเป็นอยู่ ใกล้ชิดกับธรรมชาติ มีความเป็นอยู่อย่างง่ายๆ กิจกรรมทางเศรษฐกิจขึ้นอยู่กับระบบเกษตรกรรมเป็นสำคัญ

ชุมชนเมือง หมายถึง บริเวณที่มีประชากรอาศัยอยู่รวมกันเป็นจำนวนมาก/ อย่างหนาแน่น เป็นศูนย์กลางของ ความเจริญต่างๆ การคมนาคมสะดวก ผู้คนส่วนใหญ่ประกอบอาชีพอุตสาหกรรม การค้าและการบริการ

ชุมชนกึ่งเมืองกึ่งชนบท หมายถึง ลักษณะความสัมพันธ์ในชุมชนแบบที่เป็นชนบทผสมกับหมู่บ้านหรือเมืองเล็ก มักเป็นสภาพที่พบในชุมชนชนบทที่อยู่ติดกับเขตเมืองเป็นส่วนใหญ่

ส่วนที่ 2 เอกสารชี้แจงและแสดงความยินยอมในการเข้าร่วมวิจัย (THAI VERSION)

ผู้วิจัย: นางสาวทิพย์รัตน์ อุดเมืองเพีย

โครงการวิจัยเลขที่: 2011283HS

เรื่องวิจัย:
การทำนายความตั้งใจในการคัดกรองความรุนแรงในครอบครัวของนักศึกษาพยาบาลในประเทศไทย

1. ผู้วิจัยขอเชิญท่านเข้าร่วมในการวิจัยนี้
2. การเข้าร่วมในการทำวิจัยนี้เป็นการเข้าร่วมแบบอาสาสมัคร
   และถ้าท่านตัดสินใจไม่เข้าร่วมการวิจัยในครั้งนี้จะไม่มีผลเสียใดๆต่อท่าน
   เช่นการได้รับการลงโทษหรือหักคะแนนแต่อย่างใด
3. หากท่านไม่ขัดข้องที่จะเข้าร่วมการศึกษาวิจัยในครั้งนี้ ผู้วิจัย
   ขอเชิญท่านเข้าร่วมในการตอบแบบสอบถามแบบออนไลน์ แบบสอบถามประกอบด้วย 2 ส่วน คือ
   -ส่วนที่3 เป็นข้อมูลทั่วไปและส่วนที่ 4 ทัศคติ กลุ่มบุคคลอ้างอิง และการรับรู้ความสามารถ
   ในการคัดกรองความรุนแรงในครอบครัว
   ท่านจะใช้เวลาในการทำแบบสอบถามทั้งหมดเพียงประมาณ 10-15 นาที
4. วัตถุประสง ของการทำวิจัย
   เพื่อที่จะศึกษาปัจจัยที่มีผลต่อการคัดกรองความรุนแรงในครอบครัวและทำนายความตั้งใจของนักศึ
   กษาพยาบาลในประเทศไทยในการปฏิบัติการพยาบาลเพื่อการคัดกรองความรุนแรงในครอบครัว
5. การดำเนินการวิจัย เป็นการสอบถามนักศึกษาพยาบาลในประเทศไทยประมาณ 500 คน
6. ในการตอบแบบสอบถาม
   ความเสี่ยงทางด้านร่างกายหรือจิตใจที่จะเกิดขึ้นต่อท่านอาจมีบ้างแต่จะน้อยมาก
   เพราะบางคำถามอาจจะทำให้ท่านนึกถึง
   คนไข้หรือกรณีศึกษาที่ท่านเคยดูแลในการฝึกปฏิบัติงานที่ผ่านมา
   ซึ่งอาจทำให้ท่านรู้สึกเศร้าเสียใจหรือหดหู่ใจได้
   ท่านสามารถที่จะเลือกตอบหรือไม่ตอบคำถามข้อใดก็ได้
   และท่านสามารถหยุดที่จะตอบคำถามได้ทุกเมื่อ เมื่อท่านรู้สึกไม่สบายใจ
   เพราะว่าการเข้าร่วมวิจัยในครั้งนี้เป็นแบบสมัครใจ
7. หากท่านสมัครใจที่จะเข้าร่วมการวิจัยในครั้งนี้ ท่านจะไม่ได้รับประโยชน์ใดๆโดยตรง
   ไม่ว่าจะเป็นคะแนนจากการศึกษาพยาบาล
   อย่างไรก็ตามผลประโยชน์จากการที่ท่านเข้าร่วมตอบแบบสอบถามในครั้งนี้

คืออานิสงค์จากผลการวิจัยที่จะสามารถเป็นความรู้
เพื่อพัฒนาระบบบริการพยาบาลและนำไปช่วยเหลือประชาชนได้ในอนาคต

8. หากท่านเลือกที่จะเข้าร่วม ในการตอบแบบสอบถาม ในการศึกษาวิจัยในครั้งนี้
ชื่อของท่านหรือข้อมูลส่วนบุคคลที่สำคัญอื่นๆจะไม่ได้ถูกถาม
เพื่อรักษาความเป็นส่วนตัวและเป็นความลับ
ข้อมูลที่ท่านตอบคำถามจะถูกบันทึกในไฟล์คอมพิวเตอร์
ซึ่งจะมีเฉพาะผู้วิจัยเท่านั้นที่มีรหัสผ่านและเข้าถึงข้อมูลได้
9. การเข้าร่วมวิจัยในครั้งนี้ท่านจะไม่ได้รับค่าตอบแทนใดๆทั้งสิ้น
อย่างไรก็ตามท่านมีสิทธิ์ที่จะร่วมจับสลากในการลุ้นรับ iPad จำนวน 1เครื่องจาก iPad 2
เครื่องที่เตรียมไว้เป็นรางวัลสำหรับผู้เข้าร่วมตอบแบบสอบถาม เมื่อสิ้นสุดการวิจัย
ถ้าท่านสมัครใจที่จะเข้าร่วมการจับสลากในการรับ iPad
ท่านสามารถใส่อีเมลของท่านในช่วงสุดท้ายของแบบสอบถาม
10. หากท่านมีข้อสงสัยหรือไม่สบายใจเกี่ยวกับประเด็นต่างๆหรือเนื้อหาในการวิจัยในครั้งนี้
ท่านสามารถติดต่อ หน่วยงานจริยธรรมการวิจัยในมนุษย์ มหาวิทยาลัยมิสซูรี่
ซึ่งเป็นหน่วยงานที่จะช่วยเหลือและคุ้มครองสิทธิของผู้เข้าร่วมตอบแบบสอบถามในการวิจัย
เบอร์โทรศัพท์คือ (1)(573) 882-3181
11. หากท่านมีข้อสงสัยหรือข้อคำถามเพิ่มเติม ท่านสามารถติดต่อ คุณทิพย์รัตน์ อุดเมืองเพีย ทางอีเมล
tuhk3@mail.missouri.edu ได้ตลอดเวลา

ส่วนที่ 3 ข้อมูลทั่วไปของผู้ตอบแบบสอบถาม

1. อายุ........ปี
2. เพศ:............. ชาย.......หญิง........เพศทางเลือก (เกย์ กระเทย ทอม ดี้ฯลฯ)
3. เกรดเฉลี่ย: ………..
4. ท่านเคยได้เรียนในชั้นเรียน ฟังบรรยาย การพูดคุยอภิปรายหรือการอบรมเกี่ยวกับความรุนแรงในครอบครัวในชั้นเรียนหรือในช่วงฝึกปฏิบัติงานในระยะเวลาที่ท่านเป็นนักศึกษาพยาบาลหรือไม่

    4.1 ……….เคย

    4.2……….ไม่เคย

5. จากคำถามข้อ 4 หากท่านเคยหรือเข้าร่วมการอบรม ฟังการบรรยาย เกี่ยวกับความรุนแรงในครอบครัว ในคณะพยาบาลศาสตร์หรือวิทยาลัยพยาบาลขณะที่ท่านเป็นนักศึกษาพยาบาล การเรียนการสอน การบรรยายที่ท่านเคยเข้าร่วม ลักษณะการสื่อเนื้อหาเพื่อให้เกิดการรับรู้ใช้วิธีการอย่างไร (เลือกตอบได้มากกว่า 1 คำตอบ)

    5.1…….ดูวิดีโอ หรือ แลกเปลี่ยนพูดคุย

    5.2…….บรรยาย และ/หรืออภิปรายในชั้นเรียน

    5.3……..ฝึกอบรม หรือการประชุมเชิงปฏิบัติการ

    5.4……... อื่นๆ (โปรดระบุ)……………………………

6. การเรียนการสอน การอบรมเกี่ยวกับความรุนแรงในครอบครัวที่ท่านเคยเรียน/อบรม จำนวนกี่ชั่วโมง (ท่านสามารถประมาณโดยคร่าวๆเป็นจำนวนชั่วโมง)

    6.1……….น้อยกว่า 1 ชั่วโมง

    6.2………..1-5 ชั่วโมง

    6.3……….6-10 ชั่วโมง

    6.4............11-15 ชั่วโมง

    6.5…………มากกว่า 15 ชั่วโมง

7. ในวิทยาลัยหรือคณะพยาบาลศาสตร์ที่ท่านศึกษาอยู่ มีแบบฟอร์มคัดกรองความรุนแรงในครอบครัวสำหรับการคัดกรองผู้รับบริการหญิงที่ท่านจะใช้ในการฝึกปฏิบัติงานหรือไม่

    7.1 ... .มี

7.2 .. ..ไม่มี

7.3 ………….ไม่ทราบ

8. ในหอผู้ป่วย หรือหน่วยงานที่เป็นแหล่งฝึกปฏิบัติงานของท่าน
   มีแบบฟอร์มสำหรับการคัดกรองความรุนแรงในครอบครัวในผู้รับบริการหญิงหรือไม่

   8.1………….มี

   8.2................ไม่มี

   8.3................ไม่ทราบ

9. ในหอผู้ป่วย หรือหน่วยงานที่เป็นแหล่งฝึกปฏิบัติงานของท่าน
   มีการคัดกรองความรุนแรงในครอบครัวสำหรับผู้รับบริการหญิงที่เข้ารับบริการตรวจหรือรักษาในโรงพยาบาล หรือไม่

   9.1………..มี

   9.2………..ไม่มี

   9.3………..ไม่ทราบ

10. ในระหว่างการฝึกปฏิบัติงานในฐานะการเป็นนักศึกษาพยาบาล
    ท่านเคยมีประสบการณ์ในการคัดกรองความรุนแรงในครอบครัวหรือไม่

    10.1...............เคย

    10.2................ไม่เคย

11. ถ้าท่านเคยมีประสบการณ์ในการคัดกรองความรุนแรงในครอบครัวในระหว่างการฝึกปฏิบัติงาน แผนกหรือหน่วยงานใดที่ท่านเคยมีประสบการณ์ (โปรดระบุ).............................

12. ท่านนับถือศาสนา……..คริสต์......พุทธ......อิสลาม......อื่นๆ (โปรดระบุ)……………

13. ภูมิลำเนาของท่านมีลักษณะ : ....ชุมชนเมือง...........ชุมชนชนบท……………
    ชุมชนกึ่งเมืองกึ่งชนบท................

14. ที่ตั้งของภูมิลำเนาของท่าน:

    14.1............ภาคใต้

    14.2............ภาคเหนือ

    14.3............ภาคตะวันออกเฉียงเหนือ

    14.4............ภาคกลาง

    14.5............ภาคตะวันออก

14.6...........ภาคตะวันตก

15. ท่านศึกษาอยู่ที่วิทยาลัยพยาบาลหรือมหาวิทยาลัย

15.1...............วิทยาลัยพยาบาลสังกัดสถาบันพระบรมราชชนก กระทรวงสาธารณสุข

15.2................คณะพยาบาล ภายใต้มหาวิทยาลัยของรัฐบาล

15.3................คณะพยาบาล ภายใต้มหาวิทยาลัยของเอกชน

16. ภูมิภาคของที่ตั้งของคณะพยาบาลหรือวิทยาลัยพยาบาลที่ท่านกำลังศึกษาอยู่:

16.1...........ภาคใต้

16.2...........ภาคเหนือ

16.3...........ภาคตะวันออกเฉียงเหนือ

16.4...........ภาคกลาง

16.5...........ภาคตะวันออก

16.6...........ภาคตะวันตก

17. ท่านเคยมีประสบการณ์ความรุนแรงด้านร่างกาย ทางเพศ และทางด้านจิตใจกับแฟนหรืออดีตแฟนของท่านหรือไม่

17.1.................เคย

17.2.................ไม่เคย

18. ท่านเคยมีประสบการณ์ความรุนแรงทางด้าน ร่างกาย จิตใจ หรือทางเพศจากสมาชิกในครอบครัวหรือเพื่อนของท่านหรือไม่

16.1............เคย

16.2.............ไม่เคย

แบบสอบถามชุดที่ 3 เป็นแบบสอบถามเกี่ยวกับทัศนคติ กลุ่มบุคคลอ้างอิง และการรับรู้ความสามารถในการคัดกรองความรุนแรงในผู้รับบริการหญิง แบบสอบถามมีทั้งหมด 38 ข้อ คำตอบมีทั้งหมด 5 ระดับ ขอให้ท่านตอบคำถามที่ตรงกับความคิดเห็นของท่านมากที่สุด

5: เห็นด้วยอย่างยิ่ง

4: เห็นด้วย

3: ไม่แน่ใจ

2: ไม่เห็นด้วย

1: ไม่เห็นด้วยอย่างยิ่ง

รายการ	5	4	3	2	1
1.การคัดกรองความรุนแรงในครอบครัวในผู้รับบริการหญิงเป็นกระบวนการประเมินที่ดี					
2.พยาบาลเป็นวิชาชีพที่มีบทบาทสำคัญในการคัดกรองความรุนแรงในครอบครัวในผู้รับบริการหญิง					
3.การคัดกรองความรุนแรงในครอบครัวเป็นกิจกรรมที่ท่านสามารถปฏิบัติได้อย่างง่ายและสะดวกใจ					
4.การคัดกรองความรุนแรงในครอบครัวเป็นกิจกรรมที่มีประโยชน์ ทำให้ท่านสามารถระบุความเสี่ยงความรุนแรง ที่จะก่อให้เกิดปัญหาสุขภาพกับผู้รับบริการที่ท่านกำลังให้การดูแล					
5.การคัดกรองความรุนแรงในครอบครัวเป็นโอกาสที่จะได้ช่วยเหลือและจัดหาการบริการสุขภาพให้แก่ผู้ที่เคยหรืออยู่ในสถานการณ์ที่ได้รับความรุนแรงในครอบครัวได้					
6. การคัดกรองความรุนแรงในครอบครัวสามารถนำมาเป็นข้อมูลในการวางแผนช่วยเหลือผู้ได้รับความรุนแรงให้ได้รับความปลอดภัย					
7.การคัดกรองความรุนแรงในครอบครัวเป็นกิจกรรมที่สามารถให้ความรู้แก่ผู้รับบริการหญิงเรื่องความรุนแรงในครอบครัว					
8. การคัดกรองความรุนแรงในครอบครัว เป็นกิจกรรมที่ช่วยเน้นย้ำและผลักดันให้ปัญหาด้านความรุนแรงในครอบครัวที่เป็นปัญหาสำคัญได้ปรากฏเด่นชัดสู่สาธารณชนและวงการสุขภาพ					
9. การเรียนการสอนในหลักสูตรพยาบาลทั้งภาคทฤษฎีและปฏิบัติเกี่ยวกับความรุนแรงในครอบครัวมีส่วนสำคัญในการส่งเสริมและเตรียมท่านเรื่องการคัดกรองความรุนแรงในครอบครัว					
10.ผู้รับบริการหญิงไม่มั่นใจและไม่เชื่อใจที่จะเปิดเผยเรื่องความรุนแรงในครอบครัวต่อท่านในบทบาทของนักศึกษาพยาบาล					
11. การคัดกรองความรุนแรงในครอบครัวอาจจะทำให้ผู้รับบริการรู้สึกอับอาย					
12.การคัดกรองความรุนแรงในครอบครัวจะทำให้ผู้รับบริการกังวลเป็นอย่างมากถ้าพบว่าเป็นผู้ได้รับความรุนแรง					
13.การคัดกรองความรุนแรงในครอบครัวเป็นการปฏิบัติกิจกรรมที่ใช้เวลานานมาก					
14.การคัดกรองความรุนแรงในครอบครัว อาจเป็นการเพิ่มความเสี่ยงต่อผู้รับบริการได้ ถ้าผู้รับบริการหญิงได้รับการประเมินข้อมูลที่ไม่เพียงพอ และไม่ครอบคลุม					
15.พยาบาลในแหล่งฝึกที่ท่านฝึกปฏิบัติงานสนับสนุนและคาดหวังให้ท่านทำกิจกรรมการคัดกรองความรุนแรงในครอบครัว					

รายการ	5	4	3	2	1
16.อาจารย์ในคณะพยาบาล/วิทยาลัยพยาบาล ที่นิเทศในแหล่งฝึกที่ท่านฝึกปฏิบัติงาน สนับสนุนและคาดหวังให้ท่านทำกิจกรรมการคัดกรองความรุนแรงในครอบครัว					
17.สหสาขาวิชาชีพ (แพทย์ พยาบาล นักสังคมสงเคราะห์ ฯลฯ) ในแหล่งฝึกที่ท่านฝึกปฏิบัติงาน สนับสนุน และคาดหวังให้ท่านทำกิจกรรมการคัดกรองความรุนแรงในครอบครัว					
18.เพื่อนนักศึกษาพยาบาลที่ขึ้นฝึกภาคปฏิบัติที่แหล่งฝึกร่วมกับท่านสนับสนุนและคาดหวังให้ท่านทำกิจกรรม การคัดกรองความรุนแรงในครอบครัว					
19.ความคิดเห็นของพยาบาลในแหล่งฝึกปฏิบัติงานเกี่ยวกับการคัดกรองความรุนแรงในครอบครัวมีความสำคัญต่ อการตัดสินใจของท่านในการคัดกรองความรุนแรงในครอบครัว					
20.ความคิดเห็นของสหสาขาวิชาชีพ (แพทย์ พยาบาล นักสังคมสงเคราะห์ ฯลฯ) ในแหล่งฝึกปฏิบัติงานเกี่ยวกับการคัดกรองความรุนแรงในครอบครัวมีความสำคัญต่อการตัดสินใจของท่านในกา รคัดกรองความรุนแรงในครอบครัว					
21.ความคิดเห็นของอาจารย์นิเทศเกี่ยวกับการคัดกรองความรุนแรงในครอบครัวมีความสำคัญต่อการตัดสินใจขอ งท่านในการคัดกรองความรุนแรงในครอบครัว					
22.ความคิดเห็นของเพื่อนพยาบาลในขณะฝึกปฏิบัติงานเกี่ยวกับการคัดกรองความรุนแรงในครอบครัวมีความสำ คัญต่อการตัดสินใจของท่านในการคัดกรองความรุนแรงในครอบครัว					
23. นโยบาย และแนวทางปฏิบัติที่ชัดเจน ของแหล่งฝึกที่ท่านฝึกปฏิบัติงานเกี่ยวกับการคัดกรองความรุนแรงในครอบครัว มีส่วนสำคัญในการตัดสินใจคัดกรองความรุนแรง					
24.การดูแลที่อ่อนโยนและเป็นมิตรของพยาบาลจะช่วยให้ผู้รับบริการหญิงกล้าที่จะเปิดเผยเรื่องความรุนแรงในค รอบครัวเพิ่มมากขึ้น					
25.สัมพันธภาพความไว้วางใจที่ดีระหว่างพยาบาลและผู้รับบริการหญิงจะทำให้การคัดกรองความรุนแรงในครอ บครัวเป็นไปด้วยความราบรื่นและได้ข้อมูลที่ถูกต้อง					
26.การฝึกอบรมเรื่องการคัดกรองความรุนแรงในครอบครัวที่สม่ำเสมอของท่านจะช่วยเพิ่มประสิทธิภาพในการคั ดกรองความรุนแรง					
27.ท่านคิดว่าการจัดการเรียนการสอนในสถานศึกษาพยาบาลของท่านได้เตรียมท่านอย่างเพียงพอในด้านความรู้แ ละทักษะเรื่องการคัดกรองความรุนแรงในครอบครัวในผู้รับบริการหญิง					
28.สถานที่ที่มิดชิด ปลอดภัย และเป็นส่วนตัวจะช่วยเอื้ออำนวยให้การคัดกรองความรุนแรงในผู้รับบริการหญิงให้มีประสิทธิภาพและได้ข้อมูล ที่ถูกต้อง					
29.การทำงานเป็นทีมที่มีทั้งพยาบาลและสหวิชาชีพจะสามารถช่วยการคัดกรองความรุนแรงในครอบครัวในผู้รับ บริการหญิงให้มีประสิทธิภาพมาก					
30.การคัดกรองความรุนแรงในครอบครัวในผู้รับบริการหญิงที่มีประสิทธิภาพ ผู้คัดกรองต้องมีความรู้และทักษะที่เพียงพอ					
31.แหล่งสนับสนุนช่วยเหลือผู้ที่ได้รับความรุนแรงที่เพียงพอและหลากหลายทั้งทางด้านร่างกายและจิตใจจะช่วย ส่งเสริมการคัดกรองความรุนแรงในครอบครัวในผู้รับบริการหญิง					
32.การที่มีสมาชิกในครอบครัวอยู่ด้วยในระหว่างการคัดกรองความรุนแรงในผู้รับบริการหญิง อาจรบกวน และทำให้ท่านไม่ได้รับข้อมูลที่เป็นจริง หรือเป็นอุปสรรคในขณะซักประวัติ					
33.ภาระงานที่พยาบาลได้รับมอบหมายจำนวนมาก อาจส่งผลกระทบต่อการคัดกรองความรุนแรงในครอบครัว					

รายการ	5	4	3	2	1
34.การมีผู้รับบริการในคลินิกหรือในหอผู้ป่วยจำนวนมากอาจส่งผลกระทบต่อการคัดกรองความรุนแรงในครอบครัวในผู้รับบริการหญิง					
35. เวลาที่จำกัดในการทำกิจกรรมการพยาบาลในแต่ละกิจกรรม เป็นอุปสรรคในการคัดกรองความรุนแรงในครอบครัว					
36. ท่านพร้อมในการคัดกรองความรุนแรงในครอบครัวในผู้รับบริการหญิง					

37.ท่านมีความตั้งใจที่จะคัดกรองความรุนแรงในครอบครัวในผู้รับบริการหญิงที่มาใช้บริการทั้งในโรงพยาบาล หรือแหล่งบริการสุขภาพ เพื่อให้ผู้ได้รับความรุนแรงได้รับการดูแลและช่วยเหลือ

37.1………..ตั้งใจ

37.2………...ไม่ตั้งใจ

38.ท่านมีข้อเสนอแนะหรือข้อคิดเห็นเพิ่มเติมอื่นๆที่ไม่ได้กล่าวถึงในแบบประเมินเ และท่านอยากที่จะบอก เกี่ยวกับการคัดกรองความรุนแรงในครอบครัวในผู้รับบริการหญิง

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Sample size
Logistic Regression Power Analysis

Numeric Results

Power	N	P0	P1	Odds Ratio	R Squared	Alpha	Beta
0.79873	295	0.050	0.100	2.111	0.000	0.05000	0.20127
0.89986	396	0.050	0.100	2.111	0.000	0.05000	0.10014
0.79688	112	0.050	0.150	3.353	0.000	0.05000	0.20312
0.89976	151	0.050	0.150	3.353	0.000	0.05000	0.10024
0.79965	68	0.050	0.200	4.750	0.000	0.05000	0.20035
0.89964	91	0.050	0.200	4.750	0.000	0.05000	0.10036
0.79593	48	0.050	0.250	6.333	0.000	0.05000	0.20407
0.89587	64	0.050	0.250	6.333	0.000	0.05000	0.10413
0.79396	37	0.050	0.300	8.143	0.000	0.05000	0.20604
0.89830	50	0.050	0.300	8.143	0.000	0.05000	0.10170
0.79273	30	0.050	0.350	10.231	0.000	0.05000	0.20727
0.89350	40	0.050	0.350	10.231	0.000	0.05000	0.10650
0.79011	25	0.050	0.400	12.667	0.000	0.05000	0.20989
0.89736	34	0.050	0.400	12.667	0.000	0.05000	0.10264
0.78241	21	0.050	0.450	15.545	0.000	0.05000	0.21759
0.89622	29	0.050	0.450	15.545	0.000	0.05000	0.10378
0.79877	19	0.050	0.500	19.000	0.000	0.05000	0.20123
0.89411	25	0.050	0.500	19.000	0.000	0.05000	0.10589

References

Hsieh, F.Y., Block, D.A., and Larsen, M.D. 1998. 'A Simple Method of Sample Size Calculation for Linear and
Logistic Regression', Statistics in Medicine, Volume 17, pages 1623-1634.

Report Definitions

Power is the probability of rejecting a false null hypothesis. It should be close to one.
N is the size of the sample drawn from the population.
P0 is the response probability at the mean of X.
P1 is the response probability when X is increased to one standard deviation above the mean.
Odds Ratio is the odds ratio when P1 is on top. That is, it is [P1/(1-P1)]/[P0/(1-P0)].
R-Squared is the R2 achieved when X is regressed on the other independent variables in the regression.
Alpha is the probability of rejecting a true null hypothesis.
Beta is the probability of accepting a false null hypothesis.

Summary Statements

A logistic regression of a binary response variable (Y) on a continuous, normally distributed

variable (X) with a sample size of 295 observations achieves 80% power at a 0.05000 significance level to detect a change in Prob(Y=1) from the value of 0.050 at the mean of X to
0.100 when X is increased to one standard deviation above the mean. This change corresponds to
an odds ratio of 2.111.

Sample size
Logistic Regression Power Analysis

Numeric Results

Power	N	P0	P1	Odds Ratio	R Squared	Alpha	Beta
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R-Squared is the R2 achieved when X is regressed on the other independent variables in the regression.
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Beta is the probability of accepting a false null hypothesis.

Summary Statements

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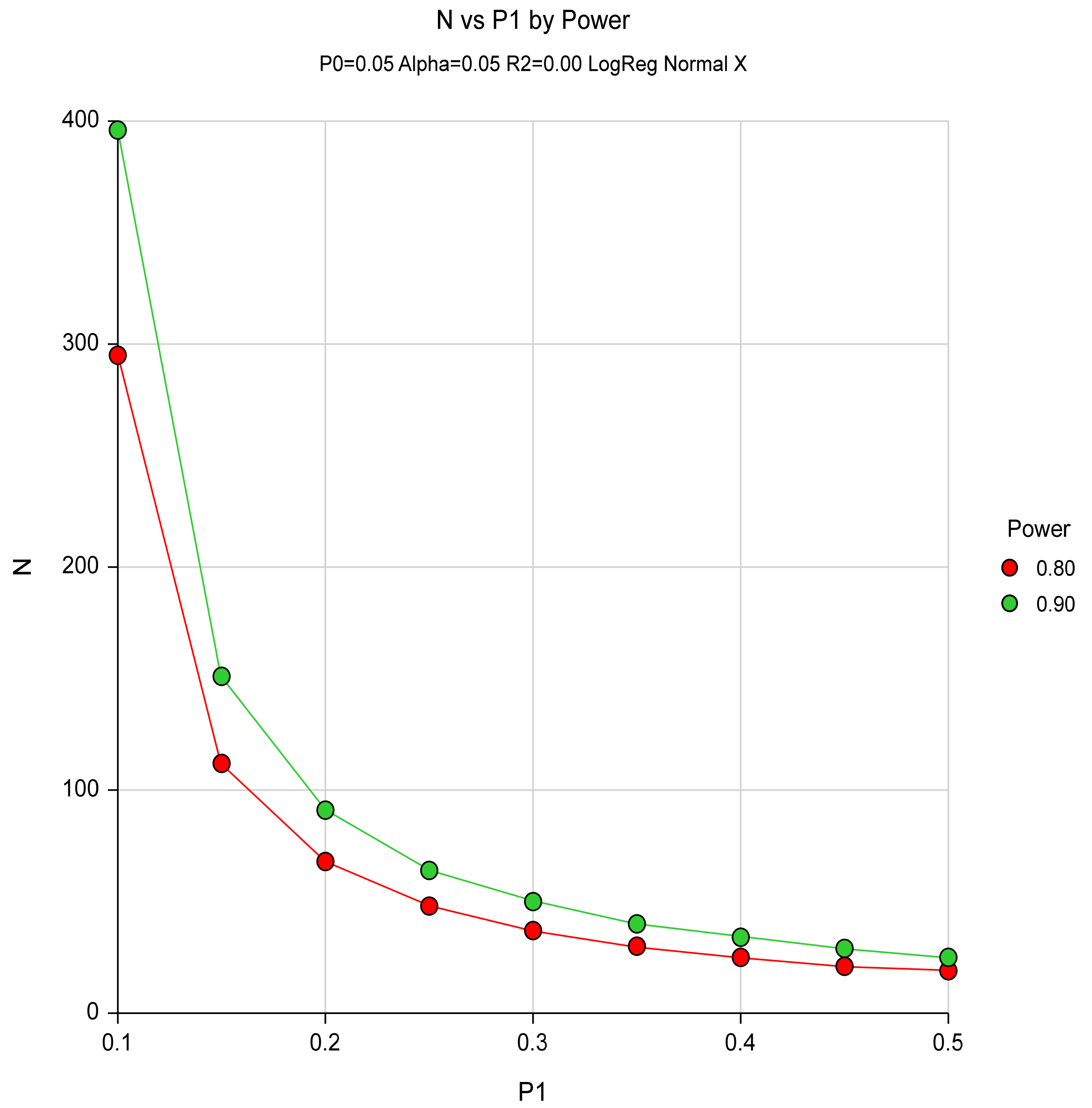
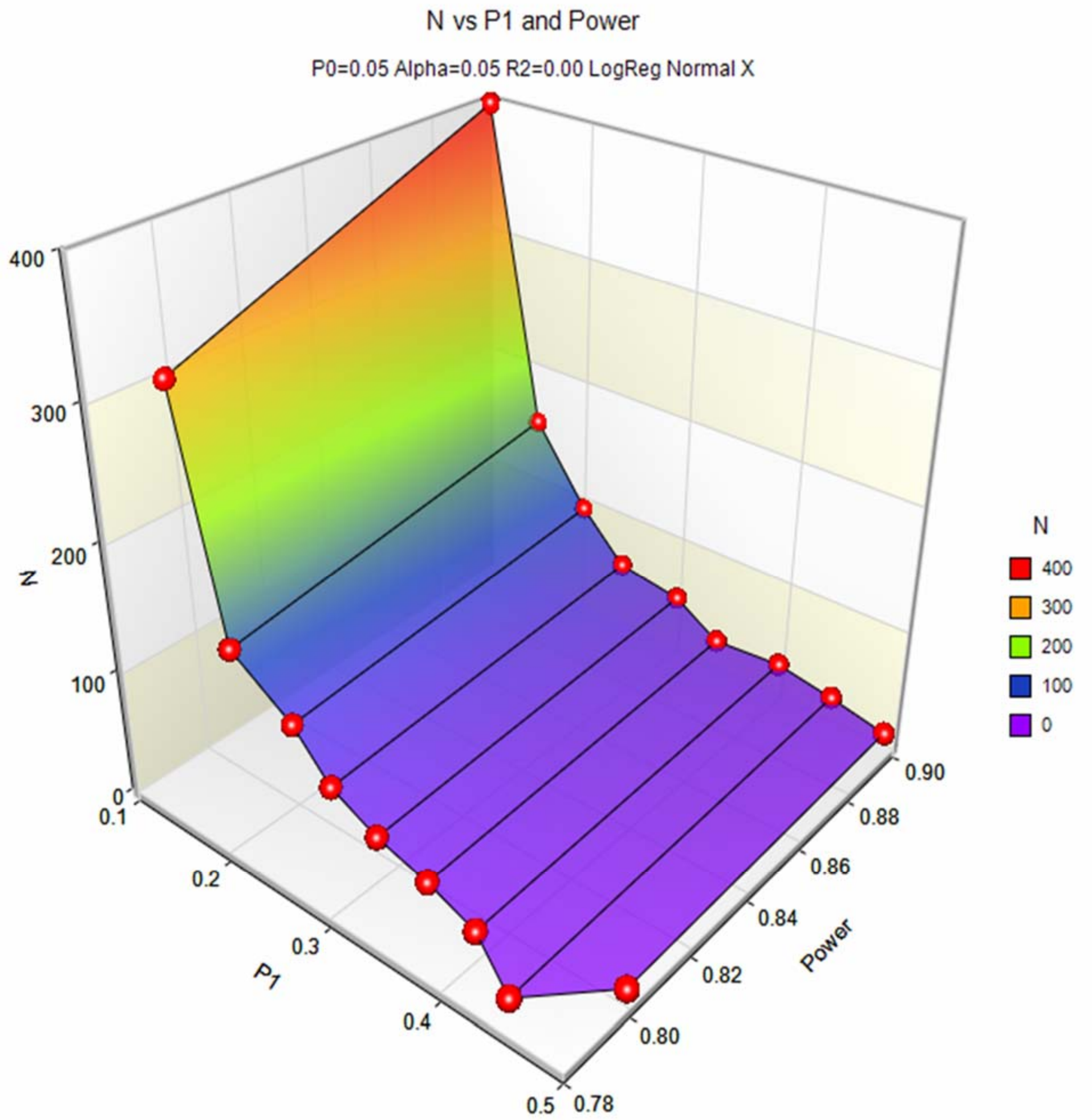
variable (X) with a sample size of 295 observations achieves 80% power at a 0.05000 significance level to detect a change in Prob(Y=1) from the value of 0.050 at the mean of X to
0.100 when X is increased to one standard deviation above the mean. This change corresponds to
an odds ratio of 2.111.

Logistic Regression Power Analysis

Chart Section



Logistic Regression Power Analysis



Waiver of Documentation of Consent

INVESTIGATOR'S NAME: TIPPARAT UDMUANGPIA
PROJECT #2011283 HS

Study Title:

PREDICTING INTENTION ABOUT INTIMATE PARTNER VIOLENCE SCREENING AMONG NURSING STUDENTS IN THAILAND

1. I would like to ask you to take part in a study that involves research.
2. Being in this study is voluntary – it is your choice. If you decide not to be in this study, there will not be any penalty or problems for you
3. For this study, I am asking you to take part in a group discussion or an interview in the Thai language.
4. I am asking you to be in this study because you are a nursing student, nurse or nursing instructor. I want to ask you what you think about intimate partner violence screening and how the ways to prepare nursing students for IPV screening. There are no right or wrong answers to the questions – I am here to learn from you.
5. I am asking up to 30 people to take part in this study.
6. I can withdraw you from the study at any time. I would first explain to you why I was withdrawing you from the study.
7. Risks of being in the study: While you are taking part in the discussion or interview, you may remember or think about abuse of women that you have experienced or seen. That could be upsetting. I will not ask you questions about your own experiences of abuse and you don't have to talk about that if you have those experiences. The study questions are about your professional opinions. You can decide not to answer any question you don't want to answer and you can decide to stop being in the discussion or interview anytime, because being in this study is voluntary.
8. Benefits of the study: If you agree to take part in this study, there are no direct benefits to you. You may expect to benefit from being in the study by knowing that you are contributing to science and future knowledge about how best to help other people.
9. If you choose to participate, I will tape record our group discussion or interview. We will type out the recording to save your words. We will not use your name or identify you when we talk about the study, because your privacy is important to us. All recordings and study information will be kept in a locked cabinet in the researchers' locked office at the University.
10. There are no costs to being in this study.
11. I will compensate you for your time and transportation expenses by providing you with a cash stipend after the focus group or interview ($7 USD). We will also provide refreshments during the focus group or interview.
12. If you have any questions regarding your rights as a participant in this research and/or concerns about the study, or if you feel under any pressure to enroll or to continue to participate in this study, you may contact the University of Missouri Health Sciences

Institutional Review Board (which is a group of people who review the research studies to protect participants' rights) at (573) 882-3181.

13. If you have any problems or questions, you may contact me at tuhk3@mail.missouri.edu
14. I would be happy to answer any questions that you may have.
15. A copy of this script will be given to you to keep.

Waiver of Documentation of Consent in Thai version
เอกสารเพื่อขอยกเว้นการเซ็นต์ยินยอมในการเข้าร่วมการวิจัย

ชื่อหัวหน้าวิจัย: นางสาวทิพย์รัตน์ อุดเมืองเพีย
โครงการเลขที่ #2011283 HS

ชื่อโครงการวิจัย:
การทำนายความตั้งใจในการคัดกรองความรุนแรงในครอบครัวของนักศึกษาพยาบาลในประเทศไทย

1. ผู้วิจัยต้องการที่จะถามท่านในการเข้าร่วมโครงการวิจัยในครั้งนี้
2. การศึกษาวิจัยในครั้งนี้เป็นการเข้าร่วมการวิจัยด้วยความสมัครใจ ถ้าคุณตัดสินใจที่จะไม่เข้าร่วมในการวิจัยในครั้งนี้ จะเป็นการตัดสินใจที่ไม่ส่งผลกระทบกับตัวท่านแต่อย่างไร
3. การวิจัยในครั้งนี้ผู้วิจัยจะถามท่านในการเข้าร่วมการอภิปรายกลุ่มหรือการสัมภาษณ์รายบุคคล
4. ผู้วิจัยถามท่านในการเข้าร่วมวิจัยในครั้งนี้เพราะท่านเป็นอาจารย์พยาบาลหรือนักศึกษาพยาบาล ผู้ที่มีส่วนในการช่วยเหลือและดูแลเรื่องความรุนแรงในครอบครัวและมีส่วนในการออกแบบหลักสูตรพยาบาล ผู้วิจัยต้องการที่จะถามคุณเกี่ยวกับความคิดเห็นเกี่ยวกับการคัดกรองความรุนแรงในครอบครัวและการจัดการเรียนการสอนในหลักสูตรพยาบาลเกี่ยวกับความรุนแรงในครอบครัว ไม่มีผิดและถูกจากคำตอบของท่านในการตอบคำถาม ทางทีมวิจัยต้องการที่จะเรียนรู้จากท่าน เพราะท่านเป็นผู้เชี่ยวชาญในเรื่องนี้
5. งานวิจัยในครั้งนี้จะมีผู้เข้าร่วมประมาณ 30 คน
6. ท่านสามารถที่จะออกจากการเข้าร่วมการพูดคุยได้ตลอดเวลาเมื่อท่านรู้สึกไม่สบายใจที่จะพูดคุย
7. ความเสี่ยงที่อาจจะเกิดขึ้นในการวิจัยครั้งนี้: ขณะที่ท่านพูดคุยในกลุ่มหรือในการสัมภาษณ์รายบุคคล ท่านอาจจะจำเหตุการณ์หรือนึกถึงผู้ที่ได้รับความรุนแรงที่คุณได้เห็นหรือช่วยเหลือ ซึ่งอาจทำให้คุณรู้สึกเสียใจ ทางทีมผู้วิจัยจะไม่ถามคำถามเกี่ยวกับประสบการณ์ของท่านในเรื่องความรุนแรง การศึกษาวิจัยในครั้งนี้จะถามเกี่ยวกับความคิดเห็นในเชิงวิชาชีพซึ่งท่านสามารถที่จะตัดสินใจตอบหรือไม่ตอบก็ได้ และท่านสามารถที่จะหยุดการสนทนาได้ตลอดเวลาเพราะว่าการวิจัยครั้งนี้เป็นการวิจัยแบบสมัครใจ
8. ประโยชน์จากการวิจัย: ถ้าคุณตกลงที่จะเข้าร่วมการวิจัย จะไม่มีผลประโยชน์โดยตรงจากการวิจัยในครั้งนี้ อย่างไรก็ตามคุณอาจจะได้รับความรู้จากการอภิปรายกลุ่มและอาจจะได้ความรู้ในการที่จะช่วยผู้อื่นต่อไปในอนาคต

9. ถ้าท่านเลือกที่จะเข้าร่วมวิจัยในครั้งนี้ ทีมผู้วิจัยจะมีการบันทึกเทปในระหว่างการพูดคุย หลังจากนั้นทางผู้วิจัยจะพิมพ์คำพูดที่ท่านพูดและบันทึกคำพูดของท่าน และหลังจากนั้นทีมผู้วิจัยจะทำลายเทปที่บันทึก ในระหว่างการพิมพ์จะไม่มีการระบุชื่อของท่าน เพราะว่าความเป็นส่วนตัวของท่านเป็นเรื่องที่มีความสำคัญ
10. การวิจัยในครั้งนี้ไม่มีผลประโยชน์หรือกำไรที่จะเกิดขึ้นในการวิจัยแต่อย่างใด
11. ทางทีมผู้วิจัยจะชดเชยค่าเดินทางของท่านในการเข้าร่วมการวิจัย โดยจะจ่ายเงินสดแก่ท่านเป็นจำนวนเงิน 200 บาท
12. มหาวิทยาลัยมิสซูรีไม่มีนโยบาย ในการชดเชยค่าเสียหายแก่ผู้เข้าร่วมวิจัยกรณีที่ท่านได้รับบาดเจ็บจากการร่วมวิจัย ทางมหาวิทยาลัยมิสซูรี่ จะรับผิดชอบในการจัดหาการดูแลด้านการแพทย์ ค่ารักษาพยาบาลสำหรับกรณีที่เกิดการบาดเจ็บจากสาเหตุของความละเลยจากบุคลากรของทางมหาวิทยาลัยมิสซูรี่เอง
13. ถ้าท่านมีปัญหาหรือข้อสงสัยเกี่ยวกับการเข้าร่วมวิจัยในครั้งนี้ ท่านสามารถติดต่อ University of Missouri Health Sciences Institutional Review Board ได้ที่ (573) 888-3181
14. ถ้าคุณมีข้อสงสัยหรือปัญหาอื่นๆ คุณสามารถติดต่อ นางสาวทิพย์รัตน์ อุดเมืองเพีย tuhk3@mail.missouri.edu
15. ผู้วิจัยยินดีที่จะตอบคำถามทุกคำถาม
16. เอกสารชุดนี้จะเป็นเอกสารที่จะมอบให้ท่านเก็บไว้

Demographic measure

1. **Gender:**

__male
__female
__other (LGBTQ)
__prefer not to say

2. **Age**
   _ 20-30 years
   _31-40 years
   _41-50 years
   _51-60 years

3. **Occupation**
   _ Student
   _Nursing instructor

4. **Education**
   _ Bachelor
   _Master
   _Doctoral
   _Other Please identify………

5. **Where are your working or studying?**
   a. **Boromarajonani College of Nursing**
   b. **Public university**
   c. **Private university**

ข้อมูลส่วนบุคคล

1. เพศ

   ....ชาย

   ....หญิง

   ....เพศทางเลือก (เกย์ กระเทย ทอม ดี้)

2. อายุ

   ....20-30 ปี

   ....31-40 ปี

   ....41-50 ปี

   ....51-60 ปี

3. อาชีพ

   ....นักศึกษาพยาบาลชั้นปีที่ 4

   ....อาจารย์พยาบาล/ผู้บริหาร/คณบดี

4. ถ้าเป็นอาจารย์พยาบาล อายุการทำงานในการเป็นอาจารย์พยาบาล

   ....น้อยกว่า 5 ปี

   ....5-10 ปี

   ....11-15 ปี

   ....16-20 ปี

   ....มากกว่า 20 ปี

5. สถานที่ท่านศึกษาหรือทำงาน

   ....วิทยาลัยพยาบาลบรมราชชนนี

   ....มหาวิทยาลัยของรัฐบาล

   ....มหาวิทยาลัยของเอกชน

Sinclair School of Nursing
University of Missouri Health

Tipparat Udmuangpia
PhD candidate
S421 School of Nursing
Columbia, MO 65211
Phone:(573) 529-7039
Fax: (573) 884-4544
tuhk3@mail.missouri.edu

LETTER OF INVITATION

[insert recipient here]

Sa wat dee ka:

GREETINGS FROM OUR RESEARCH TEAM:

1) Associate Professor Dr. Tina Bloom, on faculty at the Sinclair School of Nursing, University of Missouri, in the U.S.
2) Ms. Tipparat Udmuangpia, a nursing instructor at BCNKK and PhD candidate and Dr. Bloom' s doctoral student.

Intimate partner violence (IPV, commonly known as domestic violence) is one of the most common and serious threats to women's health around the world. The title of our research is "Intimate Partner Violence (IPV) in Thailand." We are studying intimate partner violence (IPV) as a women's health issue in Thailand and looking particularly about domestic violence screening. We are researching nursing instructors and senior nursing students' perspectives on IPV screening and women's health. This study has been approved by the Health Sciences Institutional Review Board (IRB) of the University of Missouri (Project #2011283 HS).

Our team will visit Thailand between November 10th and December 5th and conduct a qualitative research study. Your nursing colleges have a lot of important experts and nursing students in this area, and we would like to learn from them.

INVITATION TO PARTICIPATE:
We plan to hold a focus group at [location and time]. We wish to invite you and other personnel to take part in this research.

- People who are eligible to take part are senior nursing students and full-time nursing instructors in Khon Kaen province or nearby, who work with women patients/clients.
- The focus group will last approximately 90 minutes and will be held in the Thai language.
- Participation is confidential, and voluntary.

- Participants will not be asked about their own experiences with violence – rather, we are asking their perspectives and professional opinions about caring for women patients/clients who experience violence.
- Participants will be compensated for their time and transportation expenses by a cash stipend (200 Baht). Refreshments will also be provided.
- The risks of being in this study are minimal. It is possible it may be upsetting to remember or think about abuse of women.
- There are no direct benefits to being in this study.
- Participation in this study will help contribute to science and future knowledge about how best to help Thai women experiencing abuse.
- Participants who are unable to come to the focus group or uncomfortable doing so may contact the research team to arrange an individual interview.

If you have any questions or would like to arrange an individual interview, you may contact Ms. Tipparat Udmuangpia at tuhk3@mail.missouri.edu or 081-392-3911 or Dr. Tina Bloom at bloomt@missouri.edu. Thank you so much for your consideration.

Sincerely,

Tipparat

Tipparat Udmuangpia, PhD candidate

Predicting Intention about Intimate Partner Violence Screening among Nursing Students and nurse educators in Thailand

Overview/reminder: Specific aims is to explore participants' level of exposure to IPV training and screening (including experiences with patients experiencing IPV, experiences of seeing nurses screening for IPV, and exposure to IPV training), own/family experience of IPV, their attitudes, subjective norms, perceived behavioral control regarding IPV screening in healthcare settings, and their intentions to screen for IPV in their own clinical practice.

Focus Group and Individual Interview Guide

1. Is Intimate Partner Violence (IPV) a problem in Thailand?
    a. Is IPV a serious issue? (Why or why not?)
    b. What are the consequences of abuse?
    c. Do you think others in the community see IPV as a problem? Is it talked about?
    d. Who speaks against IPV in your community?
    e. Are there government policies about addressing IPV in Thailand? Is it required?
2. Is IPV related to negative health consequences?
    a. How about getting injuries?
    b. How about mental disorder?
    c. How do we know it is related?
3. What do you think about screening women for IPV?
    a. Did you screen?
    b. Have you seen healthcare providers screening women for IPV?
    c. It should screen all women for IPV?
    d. Have you known IPV screening form at the school or wards?
4. Do you think nursing career is an important career for screening women for IPV?
    a. How is important?
    b. Do nurses screen screening women for IPV in Thailand?
5. What are the barriers of screening women for IPV in Thailand
    a. Healthcare providers, especially nurses, have well prepared for IPV screening?
    b. Do they have screening women for IPV guideline or protocol at the wards?
    c. Do you feel comfortable to screen screening women for IPV?, if not, why?
    d. Have you ever seen IPV screening form at the ward?
6. How nursing school prepare you for IPV screening for women?
    a. Did you take class or workshop?, if so, how was that? How many hours, do you think it is enough?
    b. Do you see IPV screening form that instructors prepared for you to practice?
    c. Do you think preparing you regarding IPV screening is important? Or you can learn it after you graduate?
7. Based on the literature and our preliminary results of asking nursing students regarding IPV screening, the results told us that nursing students have not well-

prepared for IPV screening and they needed while they are studying in nursing school. What do you think about these results?

   a. Do you agree or disagree? Please describe?
   b. If you agree, how we should prepare nursing students for IPV screening?
   c. Do you have any recommendation for nursing curriculum?

8. There are many other results from our preliminary study. For example, it showed that attending the class regarding domestic violence is significant associated with intention of IPV screening, but how many hours of training is not associated. What you think why how many hours of training is not associated?
   a. How many hours should be appropriated for nursing students?
   b. Do you have any suggestions about IPV training for students?
9. If you are a policy maker and can take some classes regarding IPV into nursing curriculum, what should you start for this?
   a. Will you start at the government first?
   b. Will you start at your school first?
   c. How you will convince your colleagues agree with you as including IPV issue in the curriculum?
   d. Do you need some suggestions or feedback information from hospitals or statistics about IPV in Thailand to support and show how important it is to your boss or colleagues?
10. As your nursing instructors or educators, do you have any ideas to put IPV or IPV screening in the nursing curriculum?
   a. It is hard to put it in?
   b. What subjects we should put it in?
   c. Do we should include IPV screening form into mandatory requirement for nursing practicum?
   d. If we will include that what are things or resources that clinical sites should support? Referral system, on-site training?

I invited you all here because you are the experts and we want to learn from you – you are important people in your community and work with women and families.

- Is there anything else I didn't ask you that I should have? Anything else you want to tell us?

Institutional Review Board
University of Missouri-Columbia
FWA Number: 0002876
IRB Registration Numbers: 00000731, 00009014

482 McReynolds Hall
Columbia, MO 65211
573-882-3181
irb@missouri.edu

October 24, 2018

Principal Investigator: Tipparat Udmuangpia
Department: Health & Specialized Libs

Your Amendment Form v.1 to project entitled Predicting Intention about Intimate Partner Violence Screening among Nursing Students in Thailand was reviewed and approved by the MU Institutional Review Board according to the terms and conditions described below:

IRB Project Number	2011283
IRB Review Number	242267
Funding Source	Sigma Theta Tau International
Initial Application Approval Date	April 30, 2018
Approval Date	October 24, 2018
IRB Expiration Date	April 30, 2019
Level of Review	Expedited
Application Status	Approved
Project Status	Active - Open to Enrollment
Risk Level	Minimal Risk
Type of Consent	Consent with Waiver of Documentation
Approved Documents	Consent with waiver of documentation (interview/focus group) Interview/focus group questions Protocol V3 Recruitment Letter

The principal investigator (PI) is responsible for all aspects and conduct of this study. The PI must comply with the following conditions of the approval:

1. No subjects may be involved in any study procedure prior to the IRB approval date or after the expiration date.
2. All unanticipated problems must be reported to the IRB on the Event Report within 5 business days of becoming aware of the problem. Unanticipated problems are defined as events that are unexpected, related or possibly related to the research, and suggests the research places subjects or others at a greater risk of harm than was previously known or recognized. If the unanticipated problem was a death, this is reportable to the IRB within 24 hours on the Death Report.
3. On-site deaths that are not unanticipated problems must be reported within 5 days of awareness on the Death Report, unless the study is such that you have no way of knowing a death has occurred, or an individual dies more than 30 days after s/he has stopped or

completed all study procedures/interventions and required follow-up.

4. All deviations (non-compliance) must be reported to the IRB on the Event Report within 5 business days of becoming aware of the deviation.
5. All changes must be IRB approved prior to implementation unless they are intended to reduce immediate risk. All changes must be submitted on the Amendment Form.
6. All recruitment materials and methods must be approved by the IRB prior to being used.
7. The Continuing Review Report (CRR) must be submitted to the IRB for review and approval at least 30 days prior to the project expiration date. If the study is complete, the Completion/Withdrawal Form may be submitted in lieu of the CRR.
8. Securely maintain all research records for a period of seven years from the project completion date or longer depending on the sponsor's record keeping requirements.
9. Utilize the IRB stamped consent documents and other approved research documents located within the document storage section of eCompliance. These documents are highlighted green.

If you are offering subject payments and would like more information about research participant payments, please click here to view the MU Business Policy and Procedure: http://bppm.missouri.edu/chapter2/2_250.html

If you have any questions, please contact the IRB at 573-882-3181 or irb@missouri.edu.

Thank you,
MU Institutional Review Board

Institutional Review Board
Project Action Summary

Action Date: December 29, 2018 Note: *Approval expired one year after this date.*

Type:
______ New Full Review
__X__ New Expedited Review
______ Continuation Review
______ Modification

Action:
__X__ Approved
______ Approved Pending Modification
______ Not Approved

Project Number: IRB-BCNKK-16-2018

Researcher(s): Miss. Tipparat Udmuangpia

Project Title: Predicting Intention About Intimate Partner Violence Screening Among Nursing Students in Thailand

Modifications Required or Reasons for Non-Approval
None

Supawadee Thaewpia
Chairman of Institutional Review Board
Boromarajonani College of Nursing KhonKaen
Supawadee.t@bcnkk.ac.th

Wacharee Amornrojanavaravutti
Director of BoromarajonaniCollege of Nursing KhonKaen

Vita

Tipparat Udmuangpia was born in September 26, 1983 in Khon Kaen, Thailand. She earned her nursing bachelor in 2006 from Boromarajonnani College of Nursing, Khon Kaen (BCNKK), Thailand to begin her nursing career, and earned her master degree of Caring Science in 2011 from Malardaren University, Sweden. She started her doctoral degree in Nursing in summer 2015, and completed the pursuit in Fall 2019.

Tipparat is a nursing faculty at BCNKK. Tipparat hopes to continue to conduct a research in intimate partner violence (IPV) in Low-and Middle-Income Countries (LMICs), and hope to develop the knowledge and interventions to prevent IPV and help IPV survivors to be safe.