Intimate Partner Violence Screening Among Barbadian Primary Care Professionals: An Exploratory Study of Practitioner Attitudes, Beliefs, Knowledge and Screening Intention

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Intimate Partner Violence Screening Among Barbadian Primary Care Professionals: An Exploratory Study of Practitioner Attitudes, Beliefs, Knowledge and Screening Intention

Janelle K. Bryan, PhD
University of Connecticut, 2020

Intimate Partner Violence (IPV), the most prevalent type of violence against women, has been recognized as a human rights violation by intergovernmental organizations and international law. Due to its physical and psychological sequelae, the World Health Organization has considered IPV a major global public health issue since 1997. Primary care health care professionals (HCPs) are considered especially well-positioned to identify women experiencing IPV, yet screening rates are low. Utilizing the Integrated Behavioral Model (IBM) and Intersectional Feminism as guiding theoretical frames, this mixed method study (qualitative, N = 35; quantitative, N = 176) explored Barbadian HCPs’ attitudes, beliefs and knowledge regarding IPV screening, including personal and professional factors that facilitate or inhibit screening. Future screening intention and past screening behaviors were assessed. Findings from the study indicate that the IBM model explains a significant amount of variance in predicting screening intention, with the IBM construct of self-efficacy being the strongest theoretical predictor of screening intention. Overall, practitioners’ personal experience of physical abuse was the strongest predictor of screening intention. Implications for social work include future IPV research using a community-based participatory research methodology; in terms of practice and education, increasing the number of medical social workers in primary care settings and public health social workers, capitalizing on social work’s person-in-environment perspective to engage systems at multiple levels in addressing IPV. Policy recommendations are to engage in a chronic
disease model of care and trauma-informed practice to empower women experiencing violence in primary care settings.

*Key Words:* Barbados, intimate partner violence, domestic violence screening, primary care practitioners, attitudes, integrated behavioral model
Intimate Partner Violence Screening Among Barbadian Primary Care Professionals:
An Exploratory Study of Practitioner Attitudes, Beliefs, Knowledge and Screening Intention

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A Dissertation
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the Degree of Doctor of Philosophy
at the University of Connecticut
2020
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Janelle K. Bryan

2020
Doctor of Philosophy Dissertation

Intimate Partner Violence Screening Among Barbadian Primary Care Professionals:
An Exploratory Study of Practitioner Attitudes, Beliefs, Knowledge and Screening Intention

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List of Abbreviations

ATSI – Attitudes Toward Survivors of Intimate Partner Violence Survey
CEDAW – Convention on the Elimination of Discrimination Against Women
CSDH – Commission on the Social Determinants of Health
GBV – Gender-based Violence
HCP – Health Care Professional/Practitioner
IBM – Integrated Behavioral Model
IFSW – International Federation of Social Workers
KAB - Providers’ Knowledge, Attitudes, and Beliefs about Domestic Violence Scale
MOFEA – Barbados Ministry of Finance and Economic Affairs
MOH – Barbados Ministry of Health and Wellness
NASW – National Association of Social Workers
NCD – Non-Communicable Disease
OAS – Organization of American States
OHCHR - Office of the High Commissioner on Human Rights
SDOH – Social Determinants of Health
UDHR – Universal Declaration of Human Rights
UN – United Nations
UNDP – United Nations Development Program
UNFPA – United Nations Population Fund
UNGA – United Nations General Assembly
UWI – University of the West Indies
WHO – World Health Organization
CHAPTER ONE: Introduction

“Millie gone to Brazil
Oh Lawd, poor Millie
Millie gone to Brazil
Oh Lawd, poor Millie

Wid the wire wrap round she waist
And the Razor cut up she face
Wid the wire wrap round she waist
And the razor cut up she face.

Millie down in the well
Oh Lawd, poor Millie
Millie down in the well
Oh Lawd, poor Millie

Wid the wire wrap round she waist
And the Razor cut up she face
Wid the wire wrap round she waist
And the razor cut up she face”

~Author Unknown

The upbeat tune of this popular Barbadian folk song from the 1920’s belies the darkness of its lyrics, which are said to be based on a true story. The song’s antagonist, a man known as Bailey, was physically abusive to his common-law wife Millie and ultimately killed her when he learned she was leaving the relationship (Rocha & Alleyne, 2012). Bailey deposited her lacerated, wire-wrapped body in a well, explaining her sudden disappearance to authorities and neighbors by claiming that Millie had gone among the thousands of Barbadians emigrating to Brazil at the time for economic opportunity (Barbados Government Information Service, 2017). This was likely believed until the odor of Millie’s decaying corpse revealed the tragic truth. Nearly 100 years later, the specter of intimate partner violence captured in this song would rise in a way rarely seen in the small island nation.
On a Tuesday night in May, 2013, 64-year old Brenda Belle’s abusive estranged husband Alan would track her to the home of her new partner, chasing them both before “chopping” Brenda to death with a machete (Henry, 2013). Unlike Millie’s covert murder, Brenda’s was committed outside the home where she had taken refuge, in the presence and full view of shocked bystander – none of whom intervened (Stabroek News, 2013). The bystanders that night were not alone in their lack of intervention on Brenda’s behalf. Alan had attacked and stabbed Brenda only a few nights earlier, an incident after which Brenda sought to file a police report. Her effort to do so was impeded as she was informed that a medical report was required for the police to take action (Stabroek News, 2013). Brenda Belle’s case highlights the potentially “life or death” cost of systemic disconnects between the law enforcement and medical fraternities in facilitating and addressing women’s complaints of violence before they escalate.

According to friends of the victim, Brenda was frequently abused by her husband during their 14-year marriage (Stabroek News, 2013), making it highly likely that the stabbing was not the first time that she needed medical attention as a result of her abuse (Devries et al., 2013). Incidents of intimate partner violence (IPV), more commonly referred to as domestic violence in Barbados, rarely exist in isolation, but rather are part of an overall pattern of chronic abusive behavior (UN Women Caribbean, n.d.). Brenda Belle’s death was a major catalyst in the establishment of the Royal Barbados Police Force’s Family Conflict Intervention Unit – an investigative unit to address reports of domestic violence (Kaietur News, 2013; Bailey 2016). There was however, no similar corresponding mechanism implemented in the health sector, despite the apparently pivotal role the attainment of a medical report seemed to play in Belle obtaining action from the police, and the increasingly documented and overwhelmingly negative impact of IPV on women’s health and well-being.
This disparity represents a gap in domestic violence support pathways for women experiencing violence and underscores the need for governments to coordinate the responsiveness of interdependent multi-sector first responders regarding IPV. Such action is necessary not only to reduce fragmentation of the overall continuum of care for victims of violence, but also as part of a social justice framework and prioritization of a public health approach that seeks to enhance the quality of life for all citizens and protect the human rights of vulnerable groups. The present study seeks to understand the Barbadian primary care system’s response to women experiencing violence in their intimate partnerships. Specifically, the study examines Barbadian primary care practitioners’ attitudes, beliefs, knowledge, and screening practices relative to intimate partner violence, using the Integrated Behavioral Model and intersectional feminism as guiding theoretical frames.

**Problem Statement**

Whether occurring publicly or in private, violence against women is a significant problem world-wide. Identified by the World Health Organization (WHO) as a pervasive, priority public health issue and a human rights violation (Garcia-Moreno & Watts, 2011; VanderEnde, Yount, Dynes & Sibley, 2012; WHO, 1997, 2005; 2010; 2017), violence against women is recognized as one of the leading causes of illness and death among women, with intimate partner violence (IPV) being the leading form (El-Mouelhy, 2004; DuPlat-Jones, 2006; Devries et al., 2013; Shavers, 2013; Yaya, Kunnuji & Bishwajit, 2019). According to Deshong and Haynes (2016) exposure to gender-based violence in the Caribbean is among the highest in the world. Debowska and colleagues (2017) for example, found rates of IPV exposure (i.e., experiences of abuse) ranging between 17% and 69%. Such high prevalence is not only indicative of the pervasiveness of violence against women in the context of intimate
relationships, but of the lack of adequate and coordinated institutional responses to such violence, and the maintenance of patriarchal cultural norms and attitudes that undergird the often reported inaction that is tantamount to systemic bystander effect.

Like their counterparts globally and regionally, women in Barbados have been subjected to violence in all its forms. LeFranc and colleagues (2008) reported the increasing incidence of violence-related morbidity and mortality in the English-speaking Caribbean, including Barbados, with IPV perpetrated by men against women being the most prevalent form. The researchers confirmed such violence as a major public health issue, with enduring negative effects on mental and physical health, and on socioeconomic development (LeFranc, Samms-Vaughn, Hambleton, Fox & Brown, 2008). In 2012, the United Nations Human Rights Commissioner cited Barbados for the gravity of domestic violence within the island (United Nations, 2012). According to the most recent country reports on progress toward the Belem Do Para Convention (Organization of American States (OAS), 2017) and Beijing Platform (UN Women, 2019) domestic violence remains a significant concern despite the revamping of the country’s domestic violence law in 2016.

As Brenda Belle’s case illustrated, and most literature on the topic will reflect, the predominant response to the issue in Barbados and the Caribbean as a whole, has been legal reform with an emphasis on the criminal justice system (Clarke, 1998; Spooner, 2009, Bailey, 2016). Despite the overwhelming physical and mental health sequelae resulting from IPV such as higher incidence of reproductive health disorders, and depression (Ellsberg et al., 2008; Allen, 2011; UN Women, 2017), the role of the health care sector has been seen as minimal or tangential in addressing IPV in Barbados (United Nations Population Fund (UNFPA), 2009). The healthcare system is a significantly underutilized avenue of intervention despite the literature
on IPV identifying health care professionals (HCPs) as being critically positioned to screen and potentially intervene on behalf of women experiencing abuse. Such screening and intervention have the potential to contribute to reduced incidence of IPV-related disease, mental health disorders, injury, and mortality (El-Mouelhy, 2004; Tower, 2006; Williston & Lafreniere, 2013; WHO 2016). Kalra, Di Tanna and Garcia-Moreno (2017) note that women experiencing abuse would often prefer to disclose it to their HCP. Numerous studies indicate that despite their strategic position, most HCPs do not perform screenings for IPV (Waalen, Goodwin, Spitz, Petersen & Saltzman, 2000; Tower, 2006; Shavers, 2013; Nyame, Howard, Feder & Trevillion, 2013; Swailes, Lehman & McCall-Hosenfeld, 2017). This has resulted in most victims of IPV “passing silently” through the health care system (Djikanovic, Celik, Simic, Matejic & Cucic, 2010, p.88), since not all indicators of abuse are physically observable, and many victims will not reveal histories of abuse without being asked directly (Tower, 2006, Du Plat-Jones, 2006; UNFPA 2009; Wang, 2016).

Research with HCPs regarding their screening practices has identified several factors which serve as potential barriers and facilitators. These factors can be categorized as personal, professional, institutional and cultural/societal in nature (Sugg & Inui, 1992; Gremillion & Kanof, 1996; Tower, 2006), and correspond to the four nested levels of causality depicted by the WHO’s ecological framework for understanding abuse (Carlson, 1984; Heise, 1998, Krug, Dahlberg, Mercy, Zwi & Lozano, Eds., 2002, WHO, 2010; 2016). The bulk of these and other studies of IPV however, has been limited to high income countries such as the United States and Canada, with few studies conducted in developing countries such as Barbados (Ellsberg & Heise, 2005; Hind & Hind, 2014). Garcia-Moreno and colleagues (2015) note however that significant systemic and personal barriers exist in terms of low- and middle-income countries’ health sector.
response to IPV. The only study to date investigating health care worker attitudes toward IPV in the Caribbean, was conducted in Guyana in 2013 (Mitchell, Parekh, Stephan Russ, Forget & Wright, 2013). While Guyana is culturally identified with the Caribbean it is located in South America and is both considerably larger and poorer than Barbados. Further, the Guyana study was conducted in a tertiary care institution rather than primary care.

**Rationale**

Gender-based violence and mental health are generally given low priority as policy issues in developing countries, (Spooner, 2004; Prince et al., 2007; Columbini et al., 2016). However, as noted by LeFranc et al (2008), these issues impinge on the country’s economic development, as abused women are prevented from maximizing their ability to be productive, contributing members of society (El-Mouelhy, 2004; Mesnard, 2013). Conducting this research in Barbados is of importance as a next step in building upon the United Nations Population Fund’s (UNFPA) study (2009) of the Barbados primary health care system’s response to gender-based violence (GBV) including IPV. While the UNFPA study assessed knowledge and attitudes related to GBV in the primary care setting, data were limited to qualitative interviews with the senior medical officer at each of the eight polyclinics; the study did not include a measure of primary care HCPs’ attitudes, knowledge or screening practices related to IPV. As a result of the study, the UNFPA, recommended the implementation of universal IPV screening in primary care settings. A pilot was consequently launched and HCPs at two of the island’s eight polyclinics received training and implemented the use of an IPV screening tool. The screening process, however, was not universal, but still at the discretion of individual HCPs (E. Ferdinand, MD, personal communication, January 14, 2014). An evaluation of the pilot was conducted, but to date, the report has not been made available to the general public.
Consequently, the current study holds four aims: 1) to examine the extent to which primary care HCPs in Barbados screen women for IPV in their practice; 2) to determine the specific attitudes, beliefs and knowledge of Barbadian primary care HCPs with regard to IPV; 3) to determine whether HCP’s who have received training on IPV have different screening practices from those who do not; and 4) to determine which interplay of personal, professional, institutional or cultural/societal factors have the greatest influence on Barbadian primary care HCPs with regard to participation in or avoidance of IPV screening.

As posited by Schwartz (1961), the social work profession’s role is to facilitate enhanced functioning between systems, regardless of their size. This role includes addressing cultural norms and attitudes that exacerbate gender-based power disparities that are reproduced through dynamic interactions between HCPs and patients. Such interactions implicitly contribute to the risk of continued violence and denial of rights for women (Lazarus-Black, 2008; Mesnard, 2013; United Nations General Assembly (UNGA), 2006). Social work’s commitment to the person-in-environment perspective, client-centered macro-level social change including social justice for marginalized groups, and the advancement of a global human rights agenda, is at the heart of this study.

Encounters with HCPs may prove to be female patients’ only opportunity to disclose abuse and receive assistance (UNFPA, 2009). As such, HCPs’ treatment of these women and the degree to which they screen them for a history of IPV carry implications for disclosures of abuse, women’s feelings of safety and health-seeking behavior (Krug et al., 2002). As a human rights profession (Healy, 2008), social work actively seeks to address injustice in all its forms, particularly as it affects vulnerable and marginalized groups such as women experiencing IPV. An assessment of attitudes, beliefs, knowledge, and their impact on the IPV screening intention
and practices of Barbadian HCPs is a critical first step toward combating cultural approbation and apathy towards IPV in Barbados and the Caribbean.

Chapter Summaries

In Chapter Two, relevant literature will be reviewed across several dimensions to provide context for the present study. First, a rationale for the study that situates social work macro practice historically within a human rights framework, and highlights social work’s long-standing connection to public health, will be provided. This will be accompanied by a brief appraisal of the history and contemporary state of social work in Barbados. These overviews will provide a backdrop for an analysis of IPV as a global, regional, and national human rights issue and public health priority. This analysis will entail an identification of the specifics of the Barbadian milieu as a small island state in the Caribbean, in terms of its infrastructure and social development, progress and challenges in addressing IPV. Attention will also be paid to the relevant sociocultural factors impacting attitudes toward IPV, gender and related policy. This will ultimately set the stage for a delineation of the study’s primary concern: primary health care practitioners’ attitudes, beliefs, knowledge and barriers related to domestic violence screening, to identify individual and institutional challenges to IPV screening in the primary care system. The chapter will conclude with an examination of intersectional feminism as an explanatory theoretical frame for the potential impact of culture, gender, and social class on health care provider screening practices, attitudes and beliefs related to IPV.

Chapter Three will outline the study’s methodology including the research questions and related hypotheses, the research design, procedures, study population and inclusion criteria, operationalization of variables and procedures for data collection and analysis, and study limitations. The chapter will also include a description of the overarching theoretical frame - the
Integrated Behavioral Model - and its relevant concepts and prescribed yet culturally sensitive approach. Chapter Four will report and examine the study’s findings, including descriptive statistics, and the results of tests of reliability for various subscales, bivariate analyses, and regression analyses. Chapter Five will feature a discussion of the findings and the identification of implications for social work practice, research, and education, as well as policy recommendations for the health sector and relevant state agencies. This chapter includes a review of the advantages and disadvantages of a public health approach in addressing IPV in Barbados, and the potential for expanding the role of social work in promoting a cohesive multi-sector approach to addressing IPV.
CHAPTER TWO: Literature Review

“Social justice is a matter of life or death.”

~ CSDH, 2008

As noted in the above quote from the Commission on Social Determinants of Health (CSDH), health-related interventions in a population’s living conditions can make a difference in the quality and length of one’s life. Social work has functioned as a human rights profession even before human rights was articulated by the United Nations in the Universal Declaration of Human Rights in 1948, and in its several subsequent conventions (Healy, 2008). Since its inception, social work has had a strong affinity for public health-related interventions and collaborations to improve the well-being of vulnerable groups. Indeed, as noted by Sable and colleagues (2012), the roots of contemporary public health and those of social work are nearly indistinguishable. It is this history and affinity that provides a strong rationale for the present study. An overview of the origins of social work and its relationship to human rights, and to public health in the context of the United States will be presented. This will be followed by synopsis of the history and present status of social work and public health in Barbados. The main review of the relevant literature on intimate partner violence (IPV) as a human rights and public health concern will be explored within a global and regional context, and in Barbados specifically. The review will then focus on health practitioner screening for IPV, in terms of relevant attitudes, beliefs, barriers and facilitating factors. The chapter will conclude with the application of an intersectional feminist lens in understanding the role of gender, culture, and race/ethnicity as contextual factors for understanding health care practitioner (HCP) perspectives and practices related to IPV screening in Barbados.
Social Work, Human Rights and Public Health: A Historical Perspective

Social work pioneers in the United States, like their counterparts internationally, were at the forefront of the nexus of social work, human rights, and public health. Jane Addams in her work with the settlement houses, immigrants, sanitation, population surveys, anti-war efforts, women’s rights activism and writing, is perhaps the most well-known social work pioneer whose work expressly encompassed these overlapping fields (Healy, 2008; Staub-Bernasconi, 2012). She is joined, however, by many others such as Bertha Capen Reynolds in her work with the rank and file movement, Mary Church-Terrell, E. Franklin Frazier, and Whitney Young who were key figures battling inequality for women and people of color, Frances Perkins who was a key figure in the revolutionary policies of the New Deal, and Antonia Pantoja whose efforts transformed the landscape for bilingual education and community development (Peebles-Wilkins, 1995; NASW Foundation, 2004; Healy, 2008; Browne, 2011; Chaiklin, 2012; Social Welfare History Project, 2012, NASW Foundation, n.d.). In Caribbean countries such as Barbados, social work is rooted in regional traditions of self-help, community development and charity work (Maxwell & Baker, 2012; Rock, 2013). In community development in particular, the English-speaking Caribbean distinguished itself in the years following emancipation. Freed people engaged in grass-roots level organizing and mutual aid to such an extent, that Jamaica was the focus of the UN’s first monograph on community development (Nettleford, 2005; Maxwell & Baker, 2012).

Social Work - A Human Rights Profession

The social work achievements described above resulted from an intentional melding of advocacy, practice and policy efforts based on a commitment by philanthropists and social advocates to addressing inequality. The groundwork for many of these advances was initiated
prior to the formal articulation of human rights in the Universal Declaration of Human Rights (UDHR) after the Second World War (United Nations (UN), 1948). The major referent document for human rights globally, the UDHR outlines the specific rights to which every person is entitled, purely on the basis of their humanity (Healy, 2008). This treaty and subsequent UN Conventions protect and promote rights to life, equality, freedom, and the opportunity for all people to participate in civic and social life (Wronka, 2014). By the time the UDHR was adopted, social work had made many gains on multiple, intersecting fronts: social welfare, civil rights including suffrage and racial justice, as well as rights for women, children, and the economically vulnerable. These accomplishments coupled with the profession’s social justice mission, are the basis upon which social work’s professional associations and scholars assert that social work is a human rights profession, and has been since its founding in the late 1800’s (International Federation of Social Work (IFSW) Europe, n.d.; Healy, 2008; Wronka, 2019; Keeney, Smart, Richards, Harrison, Carrillo & Valentine, 2014; Bent-Goodley, 2015).

While the embodiment of human rights in social work was seen as intrinsic and long-standing, the concept was not codified into professional documents until 1988, when the International Federation of Social Work (IFSW), the profession’s global association, issued its landmark policy paper explicitly stating that social work is a human rights profession, as demonstrated by its most basic guiding principle of valuing the inherent worth of every human being (IFSW Europe, n.d.; Healy, 2008). This was followed by subsequent policy statements, manuals and other guidance on the role of human rights in social work, and social workers’ responsibility to engage in rights-based practice (Keeney et al., 2014), such as the Council on Social Work Education (CSWE) including human rights as a core competency (Wronka, 2019). More recently, the global definition of social work developed by the IFSW and International
Association of Schools of Social Work, stated in part that “Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work” (IFSW, 2014).

Healy (2008) points out the congruence between social work values as expressed in its code of ethics, with the premise of the UDHR, in that both recognize all people as having innate worth and dignity, and regardless of their station in life, social identities, or origins. Social work values expressly charge practitioners with advocating on behalf of those who are marginalized and most vulnerable, and thus accord with the UDHR’s provision for being “free of want” and “promotion of social progress” (UN, 1948; National Association of Social Workers (NASW), 2017). Consequently, the relevance to social work and this study for investigating IPV as a human rights and public health issue derives from the profession’s purpose of addressing social problems from a person-in-environment perspective, with an emphasis on social justice (Morgaine, 2007; McPherson, 2014). This history is clearly reflected both in the United States and in Barbados.

**Social Work Origins - United States**

American social work traces its roots back to the traditions of the Charity Organization Societies (COS), and the Settlement House movement - models imported from England - which took different approaches and roles in addressing social problems. The COS called for individual self-help and became the precursor of modern casework, or micro practice, whereas the Settlement House movement called for environmental change and social reform, and was the progenitor of community-based or macro practice (Healy, 2001). Social work’s rise on both fronts coincided with the dramatic increase in the social ills of the early 20th century following the industrial revolution. Challenges faced included the exploitation and endangerment of
women, children, and minorities (Wenocur and Reisch, 2001). In addition to the era’s work hazards, many lived in slums and tenements which were unsanitary and crowded. These living conditions facilitated a preponderance of public health concerns such as tuberculosis, malnutrition, and high rates of infant, child and adult mortality (Martin and Martin, 1995; Wenocur and Reisch, 2001; Jansson, 2005).

While these conditions are well-documented, what is widely unknown is the way in which they provided the context for social work and public health to begin their parallel development and reciprocal relationship. In 1926, Harry Hopkins, a social worker who along with Frances Perkins was an engineer of President Roosevelt’s’ New Deal, described social work’s influence on public health as visible in the development of every aspect of public health administration in the previous fifty years (Social Welfare History Project, 2012; Ruth & Marshall, 2017). Whereas public health’s historic role centered on reducing the incidence and spread of infectious diseases, social work was known for addressing the “social side of illness” (Shi, Tsai & Kao, 2009; Ruth & Marshall, 2017, p. S237). In hospital settings, early case workers provided psychosocial support to patients, and settlement workers lived among the residents of the communities they served. It was the settlement movement, however, that also sought to mobilize those in the community to affect legislation on their own behalf, armed with careful documentation of the community’s demographics and living conditions. In fact, the major contribution of social work’s macro practice tradition was its introduction of systematic social surveys to study social problems and guide interventions (Axinn and Stern, 2008; Ruth & Marshall, 2017).

One of the most well-known ventures between the two fields, however, was the creation of the Children’s Bureau, which was managed by Julia Lathrop, a social worker. The agency
raised awareness of women’s and children’s issues, among which were high levels of maternal and infant mortality. In Lathrop, the Bureau had a fervent advocate in this area. She believed that the social construction of women’s lives – which entailed preventable circumstances resulting from social, economic, and environmental factors - bore even greater responsibility than medical factors for poor birth outcomes (Ruth & Marshall, 2017). Lathrop’s belief foreshadowed the future of public health, which, with advances in communicable disease control, shifted its focus to health promotion and the social determinants of health (SDOH), placing it even more in line with social work (Shi, Tsai & Kao, 2009; Schild et al., 2012). The SDOH are “the conditions in which people are born, grow, live, work and age” (WHO, 2020). As such, the SDOH reflect the social, political, environmental, and economic structures that shape individual and group experiences of health and illness, through inequities in power and resources due to social stratification. High maternal and infant mortality rates are widely regarded as indicators of overall population health, and prime examples of the impact of social inequality on health (Reidpath & Allotey, 2003; Marmot, 2005). Incidentally, this indicator was also a major impetus for the development of social work and public health in the Caribbean, and Barbados in particular in the years following the Riots of the 1930’s (Rock, 2013).

Social Work Origins – Barbados

Similar to the advent of social work in other parts of the world, health concerns prompted a formalized response to social conditions existing in the Caribbean at the turn of the 20th century (Healy, 2001; Edmonds & Girvan, 1973). The early 1900s saw Barbados as holder of the dubious title of “the most unhealthy place in the British Empire,” with infant mortality rates nearing 50% (Walrond, 2001, p.1). By the 1930’s, despite the early post-emancipation efforts of community development and self-help, living conditions and virtually every measure of social
well-being had deteriorated to untenable proportions (Rock, 2013). These outcomes were due in large part to the island’s oligarchical political structure that disfranchised and exploited the formerly enslaved, and a lack of formalized social assistance combined with parochial administration of aid, and health services. As a result, the working class was particularly impacted (Fletcher, 1992; Maxwell, 2002; Rock, 2013). These social conditions prompted uprisings and riots in Barbados and other West Indian colonies, which in turn prompted a response from the British Crown and set the stage for social change (Maxwell & Baker, 2012; Rock, 2013).

The 1945 Moyne Commission Report was a seminal document and its release a turning point in social welfare in the Caribbean (Edmonds & Girvan, 1973). In response to the overwhelming nature of social problems in the region, Commissioners who were sent from Britain to report on the socio-economic and political conditions in the West Indies recommended an exponential increase in social services provision by government and private charitable efforts. It is worth noting the observation of Maxwell and Baker (2012) that the British Crown opted for service provision rather than economic or social policy reform to combat the structural causes of poverty and other social ills for the predominantly black populace. Barbados’ response to the Moyne Report was one in which the development of social work and public health took place alongside each other.

A department of social welfare was formed in Barbados under the guidance provided by the Colonial Office in 1952, and public health reform began in earnest with the establishment of the first Public Health Center in 1953. A Child Care Committee was established to attend to the infant mortality rate challenges, with social and health services being provided at health and
community centers across the island by the late 1960s (Edmonds & Girvan, 1973; Fraser, 2016a). The 1960s saw major development of the two fields – social work and public health. Social work professionalization initially occurred with the arrival of internationally trained social workers, from places such as the United Kingdom, in the 1940’s to 1950’s. In 1961, however, formalized training of indigenous social workers began with the introduction of a certificate program in social work at the University of the West Indies (UWI) Mona Campus in Jamaica (Maxwell, Williams, Ring & Cambridge, 2003). This certificate program which evolved into a baccalaureate degree program would eventually become the model initially adopted by regional programs such as that in Barbados and Trinidad and Tobago decades later. During this era there was the further expansion of public health facilities in Barbados and in the 1970’s, the polyclinic model of care (akin to US community health centers) was implemented, providing comprehensive primary and public health care to all Barbadians (Fraser, 2016).

In recent years both fields have continued to make strides. Social work training programs across the Caribbean have expanded, with formal undergraduate and graduate social work degree programs having been established at three of the UWI campuses - Mona (Jamaica), St. Augustine (Trinidad and Tobago), and the Cave Hill campus (Barbados). Barbados’ social work degree program was implemented in 1988, and initially followed the certificate model from Jamaica. However, it has since developed into a full program, offering Bachelor’s and Master’s degrees in social work (Rock, 2013). While there is still a strong community development focus in the discipline in the Caribbean, in the period following independence and professionalization, it has had a trajectory similar to that of the United States in terms of a focus on casework and therapeutic interventions for a range of vulnerable populations (Rock & Valtonen, 2002; Nettleford, 2005). Social workers can be found in practice addressing psychosocial issues across
the life-course and engaging a range of client groups including the youth, the elderly, women, and individuals affected by substance abuse and HIV/AIDS. Most social workers are employed in government agencies (Rock, 2013; Ring & Carmichael, 2015). In a social work workforce study conducted in Barbados in 2009, Ring and Carmichael (2015) found that the majority of self-identified social workers (54%) engaged in casework often or always. Respondents also indicated that the activity they participated in least in their work, was advocacy.

In terms of health, Barbados is a regional leader on a number of health indicators and even has a robust medical tourism industry with regional referrals from neighboring countries (Johnston, Crooks, Snyder, Fraser, Labonté & Adams, 2013). Nationally, a strong cadre of public and private health professionals is available to meet the medical needs of the country, in line with international standards. For example, the WHO recommends a minimum of 25 health professionals per 10,000 population, and Barbados had 49 per 10,000 as noted in the most recent Chief Medical Officer’s report (Barbados Ministry of Health and Wellness (MOH), 2015). Despite these advances, contemporary challenges still loom over the social landscape. These include the economic ripple effects of global market activity, environmental concerns such as global warming and natural disasters, poverty, community violence, and of particular interest to this study and the intersection with public health, violence against women (Nettleford, 2005; Maxwell & Baker, 2012; Allen & Maughan, 2016).

In 2001, Walrond, a Barbados medical expert, predicted that health in Barbados in the present century would need to address lifestyle diseases, or non-communicable chronic diseases (NCDs) such as obesity, diabetes and hypertension, as well as the role of gender and interpersonal relationships. This prediction has materialized, with the island reporting alarmingly high rates of chronic diseases (Unwin, Rose, George, Hambleton & Howitt, 2015), and intimate
partner violence (UN News, 2012). This intersection of violence and health is critical to this study and attention to the interplay between the two is critical for the future of women’s health and well-being in Barbados. In 2015, the Ministry of Health conducted a national health study which highlighted the dire nature of NCD’s on the island, and the related high-risk status of women in particular (Unwin et al, 2015).

According to the study, the top five causes of death were chronic NCDs, with 40% of the total population being hypertensive, and 20% of Barbadians living with diabetes (Unwin et al., 2015). In terms of risk factors, the study found that 66% of adults, and 75% of women were overweight. Women were also almost twice as likely as men (43% versus 23%) to be obese. The study ultimately recommended that future emphasis be placed on primary care and the social determinants of health for addressing NCDs. While this is an important beginning, there is evidence that disparities related to gender are not emphasized. This was affirmed by the response to the island’s Beijing +25 report (UN Women, 2019), which notes that the state’s NCD intervention strategies are universal, and do not focus specifically on women. The most recent economic and social report (Barbados Ministry of Finance and Economic Affairs (MOFEA), 2017) indicates that there are domestic violence supports as part of neonatal health for women, but does not elaborate on the nature of those supports. The reality is that the same social factors that shape experiences of violence against women, shape poor health. This experience for women will be described in more detail in the following review of the literature.

**Summary**

In summary, today’s social workers and public health officials in Barbados and elsewhere are tackling issues such as chronic and infectious diseases, human trafficking, and domestic violence, defining them as public health concerns (Sable, Schild & Hipp, 2012). The CSDH’s
first overarching recommendation is to “improve the well-being of girls and women and the circumstances in which their children are born.” (CSDH, 2008, p. 44) To this end, the Closing the Gap in a Generation document they generated (CSDH, 2008), identifies two key social determinants that are most relevant in the context of the present study: health systems, i.e. how the health sector responds to identified challenges; and women and gender equity. A social justice and human rights approach to violence including violence against women, that is, treating it as one of the SDOH, and assessing the health system’s response to it, is a critical component to developing a coordinated, multisectoral response. Social work, with its historic concern for women, its interdisciplinary nature, human rights base, and close alliance with public health, is well-positioned to address this social challenge.

**Literature Review**

**Terminology**

Violence against women, also known as gender-based violence, is an umbrella term for the numerous acts or threats of harm experienced by women and girls whether in public or private (UN, 2017). This includes sexual, psychological, and physical harm, coercion, deprivation of freedom and economic exploitation (UN, 2017). The most prevalent form of violence against women, and the primary screening concern of this study, is intimate partner violence (IPV) between heterosexual partners (Krug et al., 2002; UNGA, 2006; World Health Organization (WHO), 2010; Devries et al., 2013; Shavers, 2013; Yaya, Kunnuiji & Bishwajit, 2019). While IPV affects both people of all genders, the vast majority of IPV victims globally are women (WHO, 2012; Wang, 2016). It is for these reasons that IPV where women are the victims of male partners is the client focus of this study. For the purposes of this study, the WHO’s definition of IPV, which applies to both current and former partners, will be used:
“behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours.” (WHO, 2017). In the gender-based violence literature, IPV is also referred to as domestic violence (Pryke & Thomas, 1998; Carlson & Worden, 2005; Paredes, Roberts, Ruvo & Stuart, 2018). While domestic violence can be an umbrella term itself, referring more broadly to harm or threats of harm between family members, and or members of a household such as couples, children and elders (Dickstein, 1988; Huecker & Smock, 2020), in the context of this study, it will only be used interchangeably with IPV. This will particularly be the case as it relates to the Barbadian context, where “domestic violence” emerged as the most frequent term used by health practitioners to refer to violence between couples, and is used in the country’s legislation on the issue (Spooner, 2004; Barbados Parliament, 2016).

**Intimate Partner Violence and Human Rights**

Violence against women, which includes intimate partner violence (IPV), is formally recognized by the United Nations (UN) as a significant global human rights issue (Krug et al., 2002, UNGA, 2006). Heise and colleagues (1994) note that the international recognition of gender-based violence was precipitated by the convergence of a number of forces, the most influential of which was grass-roots anti-violence activism. It was this agitation from the bottom that underscores its emergence and success despite resistance and apathy from the political elite. Thus, contemporary recognition of women’s rights to be free of violence can be traced to the social movement against domestic violence which began in the 1970s. This was most notable in North American and Europe, but occurred globally, with activism and advocacy converging to effect laws, enforcement practices, services and resources, to protect women locally and nationally from violence (Keck & Sikkink, 1998; Merry, 2006; Morgaine, 2007). A key aspect
of these efforts was the framing of the issue under the premise that “the personal is political” (Hanisch, 2006) in which gender violence was transformed from its perception as an individualistic apolitical act to one which was supported by societal structures of patriarchy and gender inequality (Lehrner & Allen, 2008).

The International Bill of Human Rights is comprised of the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, and the International Covenant on Civil and Political Rights and its two Optional Protocols (Office of the High Commissioner on Human Rights (OHCHR), 1996). The Bill of Rights upholds the rights of all people but focuses on violations of liberties in the public sphere, and on its face, makes no distinction by gender (Thomas & Beasley, 1993, Morgaine, 2007). As noted by Dairiam (2015), these instruments’ failure to expressly reflect the marginalization of women in its apparent equal treatment of inviolable rights, did not take into account men’s privileged access to resources, and women’s disproportionate disadvantage based on their reproductive role, and the sociocultural expectation that women’s social roles would be limited to or primarily focused on caretaking and other activities ascribed to the private domain. Such treatment is a classic example of equality rather than equity, where fairness for all does not take into consideration the pre-existing disparities and marginalization of one group, when juxtaposed to one that is privileged, having the effect of allowing discrimination and stereotyping to continue (Dairiam, 2015).

The UN’s answer to the activism of women’s movements that highlighted this lack of express focus was the 1979 Convention on the Elimination of Discrimination Against Women (CEDAW), which is the only treaty that explicitly addresses inequity between men and women, and establishes women’s rights as human rights (Morgaine, 2007). CEDAW is one of the UN’s most highly ratified instruments, with 187 nation states having taken this step. The convention
serves to hold participating countries accountable to eliminate gender-based discrimination and uphold women’s rights, and includes a rigorous, country-specific progress reporting process for ratifying states (Hall, 2015; Dairiam, 2015).

Despite the adoption and ratification of CEDAW, there was no explicit expression of intimate partner violence being a violation of women’s human rights in the treaty. Through its global mobilization in the 1980’s, the battered women’s movement and other transnational women’s movements were successful in placing violence against women on the international human rights agenda (Merry, 2006, Taylor, 2015). This period saw the codification of IPV as a women’s rights violation with: the CEDAW Committee’s General Recommendation 19 in 1992, which declared CEDAW as being applicable to the elimination of violence against women in public and in private; followed by the UN General Assembly’s 1993 issuance of the Declaration on the Elimination of Violence Against Women which placed upon states the responsibility to prevent violence against women in the public or private spheres. In 1994, a special rapporteur on violence against women, its etiology and effects, was appointed; and the resultant Platform for Action that emanated from the 1995 Fourth World Conference on Women in Beijing delineated gender-based violence and women’s rights as key action areas, with related recommendations for governments, societies and the international community as a whole (Merry, 2006; McQuigg, 2016).

Despite the individualist frame of human rights, such a lens allows violence to be viewed primarily as being rooted in the broader context of structural inequality based on patriarchal cultural and social norms (Merry, 2006). This manifests in social, economic, and political policies promoting gender-based discrimination and power disparities resulting from patriarchy,
with risk of violence resulting from the denial or outright absence of rights for women (Mesnard, 2013; UNGA, 2006).

**Intimate Partner Violence and Public Health**

In addition to being a human rights issue, the World Health Organization (WHO) has identified violence against women as a public health issue, with overwhelming physical and psychological consequences (Beydoun & Beydoun, 2014; WHO, 1997). Under the previously mentioned United Nations conventions and treaties – CEDAW and Belem Do Para - healthcare providers and other service organizations and sectors are obligated to provide comprehensive access to diagnostic, treatment and preventive services as they relate to gender-based violence (Organization of American States (OAS), 2014). Further, the individual actors in each setting play a key role in the provision of such care to ensure positive health outcomes and, affirm a rights-based framework, which deems victims of IPV having the right to healthcare that is comprehensive and responsive (UNFPA, 2009; OAS, 2014). The UNFPA specifically developed a framework which included capacity-building to enable health systems to manage and prevent violence against women by establishing protocols and policies for screening and interventions related to violence against women in all its forms (UNFPA, 2009; WHO, 2016).

To facilitate the work of the health sector and individual HCPs in responding effectively to IPV based on a human rights frame, the state has a leading role to play in protecting women’s rights and challenging the routine occurrence of violence and its acceptance, as normative. Such a role includes providing education initiatives for women who may be experiencing violence, as well as coordinating a multisector response. The response should include institutional backing such as policies and procedures, and training on appropriate, supportive responses for relevant actors from police to health care providers - with whom abused women will interact (Spooner,
2009, WHO, 2016). Such action is a critical consideration given the known, and potential scope of IPV.

The WHO, in its *Multi-Country Study of Violence Against Women*, placed the global prevalence of IPV among women who have ever been in a relationship as ranging from 13% to 71% (Garcia-Moreno, Jansen, Ellsberg, Heise & Watts, 2005, Tran, Nguyen & Fisher, 2016). Given the hidden and underreported nature of IPV, it is likely that the prevalence exceeds these estimates (Wang, 2016). Formal reporting as highlighted in a study of gender-based violence reporting in 24 countries (Palermo, Bleck & Peterman, 2014) found that that a mere 7% of women reported violence to a formal source – with variations by region and country – which suggests that health or police data sources may underestimate actual IPV prevalence by as much as 11 to 128-fold. While the WHO study mentioned above included low and middle income countries, the reporting of gender-based violence in developing countries in particular has not been well-attended in the literature, despite IPV being a global phenomenon (Palermo, Bleck & Peterman, 2014). Increasing rates of disclosure are a critical step to decreasing the health risks associated with IPV (Beydoun & Beydoun, 2014). It is also crucial in reducing mortality, as women are six times more likely than men to be killed by an intimate partner (Stockl et al 2013). In 2017, of all women who were murdered globally, over one-third, or 30,000 women were killed by intimate partners (UN Women, 2017).

Physical injuries and conditions that women experience from violence include bruises, wounds and broken bones, loss of hearing or vision, reproductive health issues and adverse pregnancy outcomes such as miscarriage or low birthweight, sexually transmitted infections, as well as the exacerbation of chronic non communicable diseases (NCDs) such as hypertension and diabetes, through stress (Heise et al., 1994, Rodriguez, Bauer, McLoughlin & Grumbach,
Experiencing IPV is more likely in women presenting with two or more physical conditions or injuries, yet women rarely report violence as the underlying cause for medical visits, unless asked (Bloom & Tavrow, 2018; WHO, 2016).

While the physical effects are more obvious and tend to be incidental, the psychological effects tend to be chronic in nature, and have been described by victims as more devastating (Heise et al., 1994; Libal & Parekh, 2009). Empirical evidence has shown abused women to be at increased, long-term risk of mental health disorders such as depression, anxiety, and post-traumatic stress disorder (PTSD). Of these mental health challenges, PTSD carries the highest risk for suicidal ideation and attempts (El-Mouelhy, 2004; Rose, Trevillion, Woodall, Morgan, Feder & Howard, 2011; Trevillion et al., 2014, Wang 2016). This lends credence to the WHO’s position that there is “no health without mental health” given that psychological disturbance negatively impacts victims’ behaviors related to help-seeking and treatment adherence, as well as the health care provider’s ability to accurately diagnose conditions and provide quality treatment (Prince et al., 2007; WHO, 2018).

Sugg and Inui (1992) note however, that while the majority of prevalence data has been produced from studies of emergency departments, it is believed that the majority of medical visits resulting from IPV are not overtly traumatic. Rather, they result from multiple somatic or chronic complaints, which in turn place primary care providers as strategic actors in screening and offering referrals for intervention for IPV (Sugg & Inui, 1992; Du Plat-Jones, 2006; Beynon, Gutmanis, Tutty, Wathen & MacMillan, 2007). McCall-Hosenfeld (2014) also notes that IPV prevalence in primary care settings is greater than in community-based samples, and that there is
a greater incidence of illness among IPV survivors, giving further credence to the present study’s focus on primary care practices as the most ideal setting for IPV identification and intervention.

In addition to the effects felt directly by victims of abuse, incidence of IPV can burden the entire health care delivery system, and increase costs and medical staff workloads with preventable conditions (Alazmy, Aotaibi, Atwan, Kamel & El-Shazly, 2010; Debowska et al., 2017). Women experiencing IPV frequently visit the primary care provider with some of the previously described illnesses, injuries, and other health complaints that the provider may not attribute to IPV (Bloom & Tavrow, 2018, Kalra, Di Tanna & Garcia-Moreno, 2017). The literature notes that health care utilization rates for women who have experienced IPV are approximately twice that of women who have not, with healthcare utilization for abused women remaining 20% higher than the latter even after the abuse has ended, and as long as 16 years after the abuse ends (Singh, Petersen & Singh, 2014; Hamberger, Rhodes & Brown, 2015; WHO, 2016). While no comprehensive estimate of the socio-economic costs of IPV on the Eastern Caribbean has ever been conducted, a study was conducted in Barbados’ neighboring country of Trinidad and Tobago, which in 2005 estimated the cost of gender-based violence to be about TT$448 million, or US$76 million (Mesnard, 2013). These factors combine to affirm the healthcare system as an ideal avenue for addressing IPV (WHO, 2016).

Gender-based violence and related health concerns, especially mental health, are generally given low priority as policy issues in developing countries (Spooner, 2004, Prince et al., 2007; Columbini et al., 2016). However, if IPV is left unchecked, there are implications beyond the fate of the woman immediately experiencing abuse - such as children, and the larger society. Where there are children in the home, studies from multiple countries have indicated that there is an increased likelihood that boys who witness abuse at home, and experience abuse
themselves, will perpetrate abuse when they are adults (Franklin & Kercher, 2012; Debowska et al, 2017; UN Women, 2017). This intergenerational transmission of violence extends to girls as well in terms of tolerance of abuse in adulthood (Debowska et al., 2017). In their brief on violence against women and children, Sutton and Alvarez (2016) examined levels of acceptance of intimate partner violence in six Caribbean countries, and found that of adults who reported either approving or understanding a man striking his partner for infidelity, 86% reported being physically disciplined during their childhood. In terms of the larger society and state, Le Franc et al (2008) cite an important form of collective or macro-level impact of IPV: the potential damage to a country’s economic development. This results from abused women being unable to maximize their ability to be productive, contributing members of society as a result of injury and illness. Given the deleterious effect of gender-based violence on the country’s economic well-being, a continued threat to women’s safety is simultaneously a threat to national stability, sustainable development, and prosperity (El-Mouelhy, 2004, Mesnard, 2013).

**Intimate Partner Violence in the Caribbean**

The Caribbean region was the earliest region to unanimously ratify the 1979 Convention on the Elimination of Discrimination against Women (CEDAW). This was significant, however, in the years following ratification, many countries in the region had problematic reporting records (Massiah, 2006). While as of 2017, 94% of countries in the region had some degree of legislation prohibiting violence against women, the region is still deemed as the most violent for women (United Nations Development Program (UNDP) & UNWomen, 2017). While the body of knowledge related to interpersonal violence overall has been attended to across a range of fields (Mason & Satchell, 2016) and research on violence against women in the English-speaking Caribbean has grown in the last two decades, there is still a dearth of IPV-related literature on
Caribbean people (Clarke, 1998; DeShong, 2015; Griffith, Negy & Chadee, 2006; Le Franc, et al., 2008; Spooner, 2009; Sutton & Alvarez, 2016). National prevalence data on IPV in the Caribbean is lacking as a result of underreporting, inefficient, inconsistent data collection systems and fragmented external data collection mechanisms (Bailey, 2016; Mesnard, 2013. As such, there is no single report of national data for the region and no mechanism to compare data between countries. Thus, improving data collection on IPV at the national level is a primary challenge for those tasked with developing policy in the Caribbean region (Mesnard, 2013).

There have been efforts in recent years to generate comparative country studies, which provide data on a limited scale (Allen, 2011; UNDP, 2012; Sutton & Alvarez, 2016; Debowska et al., 2017). These studies continue to highlight the potential scope and impact of violence against women in Caribbean society.

Violence in general in the Caribbean is twice the global rate, with available prevalence data indicating IPV rates among Caribbean countries between 20 – 69% (Deshong & Haynes, 2016). Mortality figures indicate that of Caribbean women who are killed at home, between 60 - 78% are killed by a current or former intimate partner, or male relative (Cox, 1997; Jeremiah, Gamache, Hegamin-Younger, 2009). Addressing IPV as a social issue is complicated by the taboo of publicly admitting to either being subject to violence, or a perpetrator. Violence against women has long been a societal norm in Caribbean society. In the Caribbean, the notion of men “disciplining” their women is generally considered part of the assertion of normative male dominance in heterosexual intimate relationships (Jeremiah, et al., 2009). This norm, which supports hegemonic, hierarchical gender relations and sanctions male violence, pervades history, and exists across boundaries of race, ethnicity, and religion (Clarke, 1998; Lazarus-Black 2008; Spooner, 2009). Mason and Satchell (2016) acknowledge a similar confluence of factors,
highlighting the region’s colonial past in trans-Atlantic trade in enslaved Africans. Citing Hutton (1996) the authors note that “violence was the instrument of impregnation, gestation, birth and development of the plantation system” and was the tool through which the enslaved population was regulated, to the point of death, with little if any impunity (Mason & Satchell, 2016, p. 207). Following emancipation however, dichotomous gender hierarchies were established, reflecting the region’s Enlightenment underpinnings, which devalued the private sphere and equated roles associated with it, such as family and the feminine, as inferior. This same value system prized the public, which was equated with the masculine, personhood, and citizenship, all of which were deemed superior. Debowska and colleagues (2017) add that religion plays a significant role in these values, as many self-identify as “very religious,” with faith-based conservative adherence to traditional gender norms justifying male violence and preventing women from reporting it.

Caribbean IPV literature, which has largely come from a sociological and legal perspective, has decried the region’s overreliance on the criminal justice and legal systems, which have yielded limited or indeterminable benefits to women (Clarke, 1998; Spooner, 2009, Bailey, 2016; DeShong & Haynes, 2016). This has been attributed largely to the implementation of these laws being hampered by dominant social norms and cultural attitudes shared by state actors such as the police and health care practitioners, to whom women would go for help. This can be viewed as secondary revictimization, which is prohibited under a UN declaration in a follow-up mechanism to the Belem Do Para convention (OAS, 2014). These points are salient particularly in light of UN conventions’ mandate for comprehensive state responses to violence against women. This mandate challenges these accepted norms. Within a rights-based frame, health professionals, are state actors, and therefore are duty-bearers. As such, their attitudes,
beliefs and institutional supports or lack thereof, play a critical role in their ability to effectively identify and respond to the needs of women experiencing violence (UNFPA, 2009). Thus, state efforts should extend beyond legal reform. For example, they may require the development and implementation of training programs for all of the various sectors with whom IPV affected women will interact, such as health care providers (Spooner, 2009, WHO, 2016).

The Barbadian Context

Geography & Economy

Barbados is the most easterly of the Caribbean islands and one of the region’s smallest countries. With a geographical area of 166 square miles that is home to approximately 280,000 residents as of 2016, Barbados is one of the world’s most densely populated countries (Pan American Health Organization, 2017; MOFEA, 2017). Barbados exchanged its historically agriculturally based economy in sugarcane to one primarily fueled by services including tourism and offshore banking. Consequently, the government’s economic policies focus on attracting international companies, and providing a high degree of regulatory efficiency to facilitate growth of the nation’s private sector (Heritage Foundation, 2012). Such policies enable Barbados, like many other developing countries, to compete in a global market. Tourism is its major industry, and the sector accounts for 40% of GDP overall (Alvarez, Gomes, Schmid & Waithe, 2019). The island has however suffered some macroeconomic fallout since the economic downturn of 2008. Barbados has some of the lowest poverty rates in the Caribbean, according to the most recent national poverty and social conditions study. The Barbados unemployment rate has fluctuated between 9 and 12% between 2015 and 2018 (Barbados Ministry of Labour, 2020; Ministry of Social Care and Constituency Empowerment, 2011). Household poverty rose from 15 to 17% during this period. Extreme poverty, however, fell by half from 6.8% to 3.4%.
**Social Indicators**

Despite its size and challenges, Barbados is considered a regional leader, whose residents enjoy a relatively high standard of living in comparison to both neighboring and other developing countries based on a number of social and economic indicators (Inniss, 2007; Alvarez, et al., 2019). It is considered a middle-income small island developing state and was ranked 56th of 189 countries on the 2019 (data based on CY2018) United Nations Human Development Index, and received a ranking of 55th on the Gender Inequality Index (UNDP, 2019). This ranking places Barbados’ in the “very high human development category” (UNDP, 2019 p. 2), meaning its social indicators are on par with high income countries in such categories as life expectancy, education overall, secondary education for women, low maternal and infant mortality and women in the labor force (Alvarez et al., 2019). This is a direct result of widely available “social protection services” such as universal healthcare and education, which are free. The country’s infrastructure places it 30th of 138 countries – the highest ranking in the region (Alvarez et al., 2019). Women experiencing IPV can utilize such services as crisis hotlines, and counselling through various government agencies. Women also have access to the Barbados Professional Women’s Association’s emergency shelter – the only one on the island. The country as a whole has gained awareness of IPV through the activities of the Bureau of Gender Affairs, the national body responsible for generating and implementing gender-related policies to effect gender equity (UN Women, 2019).

**Human Rights**

With respect to human rights and women’s rights in particular, Barbados has ratified a number of the major international human rights instruments and pledged to uphold international human rights law (OHCHR), 2012), including CEDAW. Domestic violence in Barbados has
been recognized locally as a serious issue by non-governmental organization (NGO) leaders, who, with the aid of local entertainers, corporate partners and the government have established services and organized activities such as public meetings to raise awareness of the issue. Local NGO leaders have adopted international rhetoric, referring to domestic violence as “an invasion of basic human rights” (Austin, 2009a; 2010).

Despite the island’s high standard of living and pledges regarding the various treaties, its reporting records for several of the conventions contain multiple and or extended gaps. For example, the island recently submitted its combined fifth through eighth reports regarding CEDAW in 2017 – the first submission since 2002 (OHCHR, 2017). As such, several the previously highlighted concerns remained. CEDAW had previously cited the island for the pervasiveness of violence against women, including IPV, at all societal levels, which the UN High Commissioner echoed in 2012, urging the island to shore up laws combating discrimination and sexual violence, and for the nation as a whole to change attitudes towards these issues (OHCHR, 2002; 2012; UN News Center, 2012). Additionally, despite the Barbados Constitution’s recognition of women’s right to equality there is no legal prohibition of gender-based discrimination or legislative definition of “discrimination against women” in line with the CEDAW article prohibiting direct and indirect discrimination. CEDAW also cited the limited nature of its Domestic Violence Act as illustrative of deficiencies in the legal codification of convention principles on human rights within the island’s overall legislative and policy infrastructure. (OHCHR, 2002; 2012).

The island’s 2017 Belem Do Para report, according to reviewers, noted that the report submission was incomplete and thus did not provide a basis upon which to make a full determination on the island’s progress (OAS, 2017). The island’s most recent report regarding
the Fourth World Conference of Women, (UN Women, 2019) indicates however, that despite the inconsistencies in its reporting record, and some areas of concern - such as deficiencies in gender-related data, and not having a formal gender policy in place – Barbados has had achievements relative to gender-based violence. Key among these were the establishment and strengthening of the Royal Barbados Police Force’s Family Conflict Intervention Unit, and revisions to the island’s domestic violence law in 2016 (UN Women, 2019).

Response to Domestic Violence

Following the well-publicized domestic violence-related death of Brenda Belle (mentioned in the introduction chapter), and two additional high profile IPV-related deaths in 2013 the Royal Barbados Police Force (RBPF) established its Family Conflict Intervention Unit (FCIU) to investigate domestic violence (RBPF, n.d.). Unit members are not first-responders, but a data collecting, investigative team that also interacts with crisis and other services to coordinate victim services (Bailey, 2016). Since the FCIU’s establishment, there has been increased data collection on IPV. Consequently, we now have statistics which better summarize the extent of the IPV problem in Barbados. Of the 643 cases reported in the unit’s first 18 months of existence, assault was the primary form of violence reported between intimate partners. Police statistics also indicate that 21% of all homicides were IPV-related. As with most police data, there are no universal standards for how data should be collected and recorded, and little ability to disaggregate data (Bailey, 2016).

The 2016 amendment to the 1992 Domestic Violence Act was however, the most consequential achievement in terms of its scope and significance. Barbados’ 1992 Domestic Violence (Protection Orders) Act was the second to be established in the Caribbean region. While it resembled legislation in countries such as the United States, Canada and the United
Kingdom, Barbados’ law differed since it encouraged couples to seek mediation in domestic violence disputes, and only applied to cohabitating married couples (Spooner, 2009). This was problematic given that most intimate relationships in Barbados are “visiting” relationships where both partners are unmarried and do not cohabitate (Spooner, 2004; 2009). While some degree of resistance to the law’s development could be expected, given the island’s colonial history of patriarchy, sexism, and violence against women’s bodies (Beckles, 1998), the level of vitriol expressed by the law’s opponents was remarkable. Legislators deemed it “frightening” that men could now face criminal charges for acts that had long been accepted as normative (Spooner, 2004, p. 123). This affirmed the previously mentioned social norms regarding the level of social acceptance of violence. Popular beliefs such as this represent a major obstacle in addressing domestic violence in Barbados and other English-speaking Caribbean states (Spooner, 2004).

The 2016 amendment filled key gaps and strengthened its 1992 precursor. Key among its provisions were: the law now applied to unmarried couples, including cohabitating and visiting; professional or personal advocates such as social workers, police officers or family members may apply for protection orders on behalf of victims; it mandated police response to every complaint of abuse, regardless of whether or not the victim is the complainant; and it empowered police to immediately issue emergency protection orders (Barbados Parliament, 2016). The law’s revisions however remain predominantly within the realm of law enforcement.

This was further evidenced by the training mentioned by the report being limited to the legal and law enforcement fraternities – police, judges, and magistrates (Beijing+25 Report, 2019). While there is mention of medical care, it is limited, and there is no specific procedure for referrals to healthcare, which is important given the vulnerability of women not just to injury, but
to illnesses such as STIs and HIV (Allen & Maughan, 2016). It is additionally significant given that existing studies of IPV in Barbados have clearly identified IPV as a public health priority.

Prior Research

As exemplified by challenges with police data, a rigorous research agenda is hampered by the relative unavailability of domestic violence data in Barbados, as data collection has been scant and inconsistent (Universal Periodic Review, 2016; Bailey, 2016). There have, however, been studies of IPV in Barbados that illustrate the problem and need for its redress. One of the earliest studies is Johnson’s review of IPV based on hospital records that found most cases of IPV against women were committed by unmarried male partners, (Jordan, 1986 as cited in Bailey, 2016). In 1990, Handwerker (1993) conducted a national population study in Barbados, which combined participant observation and a survey to assess gender power differences between parents and their influence on high-risk sexual behaviors of their children. Using a probability sample of 264 women and 243 men between the ages of 20 and 45, the study estimated that nearly a third of Barbadian women were battered in their adult years, while half of both men and women reported their mothers being beaten (Handwerker, 1993). Heise and colleagues (1994) in their review of research on IPV in 18 developing countries, cited the research of Handwerker, and confirmed such violence as a major public health issue, with enduring negative effects on mental and physical health, and on socioeconomic development. In 2008, in an even larger study, Le Franc, Samms-Vaughn, Hambleton, Fox and Brown assessed psychological aggression and IPV in 15-30 year-olds as part of a study assessing interpersonal violence in Barbados, Jamaica and Trinidad and Tobago. The population-based study used a three-level cluster sampling methodology - participants in households in communities - based on the standard methodology employed by the respective countries’ national statistical services (Le
Franc et al., 2008). The sample consisted of 3,401 respondents, and in Barbados, the response rate was 78%. In terms of victimization of women among the three countries, respondents from Barbados experienced the highest levels of both physical violence (50%) and psychological aggression (70%) in intimate relationships. The most prevalent form of intimate partner violence was found to be the abuse of women by male partners, confirming earlier studies that also found that murder of women was most frequently committed by current or former partners (Le Franc et al., 2008; Heise et al., 1994). Although there is nearly a 15 year gap between the previously mentioned study by Handwerker (1993) and that by Le Franc et al (2008), the incidence of violence in intimate relationships in the Caribbean and Barbados in particular remains staggering from all available reports.

In 2009, the Caribbean Development Research Services, Inc. (CADRES) in conjunction with the Barbados Bureau of Gender Affairs conducted a survey of domestic violence on the island. The survey report has not been published to date. The survey reportedly used a national sample, interviewing individuals from every third house in the country’s 30 constituencies. No total sample information was provided, and researchers used an “estimation” methodology to assess participant’s knowledge of others’ family violence situations, rather their own personal experiences (Immigration and Refugee Board of Canada, 2009). The study found that over one quarter of Barbadians surveyed knew of at least one incident, and the vast majority of incidents (86%) involved a male perpetrator and female victim. The study also highlighted that violations of patriarchal gender norms, for example, of men perceiving that women as “not knowing their place” are often used to rationalize IPV.

Whereas the previous studies established prevalence of IPV to varying degrees, the most pertinent precursor of the present study was an exploratory study of Barbados’ primary care
system’s response to gender-based violence (GBV) including IPV, conducted in 2008. It revealed that no formal protocols for the management of GBV existed. The study also reported that there were no mandates to screen, or to give IPV cases special priority. Rather it was within the HCPs’ discretion to treat cases of IPV as urgent, or routine clinical visits (UNFPA, 2009). The study assessed perceptions of knowledge and attitudes related to GBV in the primary care setting but was limited to qualitative interviews with 16 participants - the medical officers of health and senior health sisters (advanced practice nurses) at the island’s eight polyclinics. As a result of the study, and UNFPA’s recommendation, the national Bureau of Gender affairs issued a Domestic Violence protocol and IPV screening form which were piloted with HCPs at the island’s Black Rock and St. Philip polyclinics (Mesnard, 2013). Screening however was still not universal, and the practice was left to the HCP’s discretion (E. Ferdinand, personal communication, January 14, 2014.) An evaluation of the piloting of the screening protocol was conducted, but to date, the report has not been made publicly available.

Despite the enormous impact of IPV on women’s health, the UNFPA study found that the role of the health care sector was seen as minimal or tangential (UNFPA, 2009). The healthcare system is a significantly underutilized avenue of intervention given that the literature on IPV identifies HCPs as being critically positioned to screen and potentially intervene on behalf of women experiencing abuse - practices with the potential to contribute to reduced incidence of IPV-related disease, mental health disorders, injury and mortality (El-Mouelhy, 2004; Tower, 2006; Williston & Lafreniere, 2013, WHO, 2010; 2016). The current study takes on the task of assessing frontline Barbadian HCPs’ attitudes, beliefs, and knowledge, in both public and private practice settings.
Primary Care HCPs & IPV Screening: Attitudes, Beliefs, Knowledge and Barriers

Primary care HCPs are the focus of this study given that women experiencing IPV will more likely come into contact with these professionals during their lives more often than they will social workers (Colarossi, et al., 2010). According to Williston and Lafreniere (2013) women are as likely to reveal abuse to healthcare providers as they are to police. Further, conducting the study in Barbados is important given that beliefs about IPV are understudied in low- to middle-income countries (Beydoun & Beydoun, 2014; Yount, Halim, Hynes & Hillman, 2010). Many professional health organizations encourage screening to identify IPV patients early enough to lower the burden on these women. Among these are the American College of Obstetricians and Gynecologists and the Centers for Disease Control, which support routine or universal screening (Shavers, 2013). Swailes, Lehman and McCall-Hosenfeld (2017) note that the Institute of Medicine expressly stated that a lack of screening and related intervention represented a gap in care for women experiencing violence, through failure to detect illness and injury due to abuse and prevent related mortality. The institute consequently recommended universal screening for abuse risk in adult women as key to their safety. Other researchers such have affirmed this stance, noting that a lack of detection of abuse, whether in the early or chronic stages, represents a missed opportunity to interrupt the cycle of violence and connect women with supportive services (Bloom & Tavrow, 2018).

Bloom and Tavrow (2018) confirm that screening for IPV leads to greater rates of detection of women experiencing violence in numerous practice settings, including primary care. The authors further indicate that universal screening is deemed potentially advantageous in primary care settings versus emergency or specialty departments given the potential for early detection of occurrences of violence (Bloom & Tavrow, 2018). There is also a growing empirical
base demonstrating positive outcomes for screening, including randomized controlled trials that showed no harm in screening versus not screening (Singh, et al., 2014). These studies show that screening potentially improves health outcomes and reduces violence for women experiencing IPV (McCall-Hosenfeld et al., 2014; Kalra et al., 2017).

Numerous studies indicate that despite their strategic position and the support of screening by relevant policy-making bodies, most HCPs do not screen for IPV (Colarossi et al., 2010; Nyame et al., 2013; Waalen, Goodwin, Spitz, Petersen & Saltzman, 2000; Shavers, 2013; Tower, 2006). Hamberger and Phelan (2006) reported that rates of screening of studies across specialties varied from 1.7% to about 11%, and similar rates were confirmed by O’Doherty and colleagues in their more recent (2015) systematic review. A lack of screening has resulted in most victims of IPV “passing silently” through the health care system since not all indicators of abuse are physically observable (Djikanovic, Celik, Simic, Matejic & Cucic, 2010, p.88), and many victims will not reveal abuse without being asked directly (Du Plat-Jones, 2006; Tower, 2006; UNFPA 2009; Wang, 2016). For those with mental illness, this lack of detection is increased and compounded by the fact that many of them are perceived as perpetrators of violence, when they are actually more likely to be victims of IPV and other forms of violence than the general population (Nyame et al., 2013; Rose et al., 2011; Trevillion et al., 2014).

Sugg and Inui (1992) in their seminal study noted that for HCPs, inquiring about IPV was referred to as “opening Pandora’s box” (p. 3158). This mythological reference indicated a multitude of factors involved in receiving such a disclosure. These factors can be categorized as personal, professional, institutional and cultural/societal in nature (Sugg & Inui, 1992; Gremillion &Kanof, 1996; Tower, 2006), and correspond to the four nested levels of causality depicted by the WHO’s ecological framework for understanding abuse – the individual level
which includes one’s personal history, the micro level which includes one’s personal relationships, the exo or meso level which includes institutions and community or environmental contexts, and the macro level which pertains to societal factors such as social and economic policies (Carlson, 1984; Heise, 1998, Krug, Dahlberg, Mercy, Zwi & Lozano, 2002). A number of qualitative and quantitative studies have been conducted since then to examine factors affecting the IPV screening and intervention practices of physicians, nurses, social workers and other primary care staff in high income countries, such as: the United States (Sugg & Inui, 1992; Rodriguez, Bauer, McLoughlin & Grumbach, 1999; Waalen et al., 2000; Tower, 2006), Canada (Beynon, Gutmanis, Tutty, Wathen & MacMillan, 2012; Gutmanis, Beynon, Tutty, Wathen & MacMillan, 2007); Williston & Lafreniere, 2013), the Middle East, (Alazmy, Alotaibi, Atwan, Kamel & El-Shazly, 2011; Alotabya, Alkandari, Alshmali, Kamel & El-Shazly, 2013; Haj-Yahia, 2013); and the United Kingdom (Du Plat-Jones, 2006; Rose, Trevillion, Woodall, Morgan, Feder & Howard, 2011). Few studies have been conducted in English-speaking developing countries such as Barbados (Ellsberg & Heise, 2005; Hind & Hind, 2014). A likely contributing factor to this gap in the literature is Garcia-Moreno and colleagues’ (2015) assertion that significant systemic and personal barriers exist in terms of low- and middle-income countries’ health sector response to IPV. Only one study of HCP attitudes and screening behavior regarding IPV has been conducted in the Caribbean region (Mitchell, Parekh, Russ, Forget & Wright, 2013). This clinic-based study was conducted in Guyana and consisted of a survey administered to a convenience sample of 363 doctors and nurses at the sole tertiary care hospital in the country.

The previously mentioned studies and others conducted in high income countries reported a number of common factors that impeded HCPs’ screening for IPV. Many of these
factors were summarized in a systematic review by Hamberger and Phelan (2006), which examined physician, patient, and systemic barriers to IPV screening. Many of these factors were confirmed in subsequent studies (Todahl & Walters, 2011; Roush, 2012; Kalra et al., 2017; Swailes, Lehman, McCall-Hosenfeld, 2017). The following is a review of select factors from these studies, which are specifically relevant to practitioners, and assessed in the present study. These are: practitioner knowledge, personal attitudes, perceived relevance of IPV to their professional role, fear of offending patients, perceived time constraints and powerlessness, and past experience with abuse.

Knowledge

A lack of adequate education or training also predominated as a major concern in numerous studies, with more than 60% of providers across specialties indicating that they had not received formal domestic violence training (Du Plat-Jones, 2006; Hamberger & Phelan, 2006; Tower, 2006, Roush, 2012). Of healthcare workers in Mitchell and colleagues’ study (2013), only 7% had any formal IPV training. The literature demonstrates that training is positively related not only to enhanced knowledge and communication skills and attitudes regarding the importance of IPV screening, but to increased rates of screening (Colarossi, Breitbart & Betancourt, 2010; Schoening, Greenwood, McNichols, Heermann & Agrawal, 2003; Bloom & Tavrow, 2018). In a mixed method study of health care workers in a family planning clinic, Colarossi, Breitbart and Betancourt (2010) found that while marginally so, having received training was positively associated with HCP perceptions of the helpfulness of screening. They also observed that providers’ formal training and varying respective job tasks can affect attitudes and perceptions of barriers.
It has been noted that training increases practitioner self-efficacy related to screening (Hamberger & Phelan, 2006; Todahl & Walters, 2011). Todahl and Walters (2011), in their systematic review of 86 quantitative and qualitative studies of universal screening, add some nuance regarding the influence of training. They note that even if providers did have training, not knowing what to do in situations where patients: a) gave an affirmative response to screening questions; or b) deny IPV in the face of obvious indicators, posed a challenge to HCPs inquiring about abuse, along with general provider anxiety about disclosure (Todahl & Walters, 2011). Other research (Colarossi et al., 2010; Waalen et al., 2000; Kalra et al., 2017) has indicated that even where education alone had no significant effect in increasing IPV identification rates, it was significantly related to increased screening when combined with strategies to strengthen institutional support for practitioners (e.g. through formalized policy or having onsite resources such as a social worker). Beynon and colleagues’ (2012) study participants were more explicit in describing institutional support as necessary to raise their confidence to intervene: by providing supportive work environments, training, mentorship, and linkages to community resources. Hamberger, Rhodes and Brown (2015) affirm this position, finding that increases in screening are “dramatic” (p. 87) when institutions utilize a chronic care approach, and designate on-site advocates for women experiencing violence.

In terms of developing countries, Mitchell et al (2013) asserted that the impact of IPV training programs is largely unknown, and they suggest that programs likely need to be modified to take cultural and local attitudes into consideration. Garcia-Moreno et al (2015) also observe that increasing HCP knowledge and skills in identifying abuse is particularly useful in developing countries with low resources, as this enables providers to be supportive by listening to women and making critical referrals to additional support services.
**Personal Attitudes**

According to Flood and Pease (2009) attitudes are an important determinant of violence against women in three spheres: 1) the perpetration of such violence; 2) women’s response to such violence; and 3) community and institutional responses to such violence. It is this third sphere that is the emphasis of this study. HCPs’ treatment of women who have been abused, and the degree to which they actively screen patients for a history of violence have implications for disclosure of abuse and for women’s feelings of safety and health-seeking behavior (Krug et al., 2002). HCPs can exhibit attitudes that may inhibit them from screening for IPV (Hamberger & Phelan, 2006). Colarossi et al (2010) found that some negative attitudes toward screening were not related to the act itself, but to provider perceptions that patients did not act in accordance with their expectations or advice, resulting in HCPs blaming victims either for their abusive situation, or for not doing enough to change it. Todahl and Walters (2011) noted that unfavorable attitudes were linked to a belief that screening was more harmful than beneficial. Some other beliefs which were not conducive to screening included: 1) believing family violence is normative; 2) believing that abuse is not a medical problem; 3) believing that patients accounts of abuse are not verifiable; or 4) believing that the abuse is none of the HCP’s business. (Moore et al., 1998 as cited in Hamberger & Phelan, 2006).

Mitchell and colleagues (2013) examined HCP attitudes in the Guyana study, by presenting three scenarios in which women were beaten: 1) A man is justified in beating his woman/wife when she argues with him; 2) A man is justified in beating his woman/wife when she spends too much time with friends and 3) A man is justified in beating his woman/wife when she is unfaithful. Nearly one-third of participants indicated agreement with presented scenarios in which women were beaten. Favorable attitudes toward IPV in these scenarios were associated
with: age - with older participants (30+) being twice as likely to agree with at least one of the statements, provider type – with nurses being 4 times more likely than physicians to agree with one of the statements; and having had previous training – this group was three times more likely to agree with at least one of the statements. Personal experience with abuse, either as victim or perpetrator, was not associated with agreement with any of the statements (Mitchell et al., 2013).

**Relevance to Practitioner Role**

While a number of studies found that the majority of HCPs did view IPV intervention as part of their professional role (Djikanovic et al., 2010; Williston & Lafreniere, 2013, Kalra et al., 2017), several studies indicated that nearly a quarter of HCPs studied did not consider IPV screening a part of their professional tasks, holding the view that IPV is a social or legal problem, rather than a medical one (Tower, 2006; UNFPA, 2009; Todahl & Walters, 2011; Viera, Dos Santos & Ford, 2012). Providers’ view of screening as irrelevant is thought to be linked to two factors: HCPs’ misinformed perception of the low prevalence of IPV in their practice populations, and the relevance of screening to providers’ specific specialty or practice setting (Gremillion & Kanof, 1996; Hamberger & Phelan, 2006; Sugg & Inui, 1992; Tower, 2006; Todahl & Walters, 2011). A factor related to relevance to practice setting and type is an issue of “competing organizational philosophies” in which patient privacy, which is required for screening is in conflict with family-centered care settings such as obstetrics where women may have children present at the appointment (Hamberger & Phelan, 2006). The Guyana study found that 40% of HCPs were not in favor of screening, with 20% stating it was unhelpful. Nearly half (47%) agreed that privacy related concerns were an issue (Mitchell et al., 2013).
**Fear of Offending Patients**

Providers often cited a fear of offending patients as a barrier to inquiring about IPV (Hamberger & Phelan, 2006; Waalen et al., 2000). This fear was observed in several studies across a number of provider specialties who viewed the line of questioning as an invasion of family privacy and a threat to the provider-patient relationship. More than half of the participants in the Guyanese study cited this as a concern (Mitchell et al., 2013). This reason is contrary to findings from numerous other studies of women regarding their comfort with providers asking about IPV (Hamberger & Phelan, 2006). Zeitler et al (2006) conducted a clinic-based mixed methods study of 645 ethnically diverse young adult and adolescent women and found that the vast majority – 95% - identified HCPs as the most appropriate adult to screen for IPV, and about 90% were in favor of universal screening. This overwhelming support by patients for direct inquiry was also found by Trevillion and colleagues (2014) in their meta-synthesis review of 12 qualitative studies assessing disclosure of abuse in mental health settings.

Despite findings that some women actively hide abuse from their HCP as a result of stigma, or fear of retaliation or having their children removed from the home (Bradbury-Jones, 2014), the overwhelming majority of women (both those experiencing violence and those who are not) have indicated their agreement with the appropriateness of HCPs asking about relationship violence (Todahl & Walters, 2011). Further, HCPs are the party to whom women would overwhelmingly prefer to reveal their abuse, as noted in prior surveys of women who have experienced IPV (Todahl & Walters, 2011; Kalra et al., 2017). Not only does screening permit provider identification of abuse, it allows for women to “see” the abuse themselves, perhaps naming it as such for the first time (Bradbury-Jones, 2014 p. 3063; Garcia-Moreno et al., 2015).
Time Constraints and Powerlessness

Time constraints and feelings of powerlessness or loss of control were seemingly intertwined as HCP concerns for screening. Practitioners feared a positive disclosure of IPV would derail their schedule as well as the remainder of the individual patient encounter itself (Hamberger & Phelan, 2006). Deemed the “tyranny of the time clock,” in Sugg and Inui’s seminal qualitative study (1992, p. 3158), nearly three-quarters of the 38 participants cited time-related pressures as their primary concern relevant to patient’s IPV disclosure. This structural concern relates to HCPs’ agency requirements for productivity, and often high workloads, which might not allow for the in-depth discussion required for taboo subjects such as IPV (Hamberger & Phelan, 2006).

Feelings of powerlessness were expressed by providers who were frustrated with their perceived personal inadequacy to intervene (Rodriguez, 1999; Tower, 2006; Sugg & Inui, 1992). Even where providers received IPV training for example, they did not feel confident about having the communication skills necessary to engage patients on the topic. They felt unable to “fix” the situation, unprepared for strong emotional reactions by patients, and powerless to control what the patient might ultimately choose to do after being referred to services (Hamberger & Phelan, Beynon et al., 2012).

Provider’s Own Experience with IPV

Practitioners’ personal experience with violence has some impact on screening behaviors (Gremillion & Kanof, 1996; Kalra et al., 2017). Regardless of personal abuse history, practitioners may avoid abuse as a result of discomfort with the topic (Gremillion & Kanof, 1996). For some practitioners who have experienced IPV themselves, they may be overwhelmed by the nature of patient accounts of abuse screen (Hamberger & Phelan, 2006). Kalra and
colleagues (2017) note that women experiencing IPV more frequently use health facilities, and more likely than not, will encounter HCPs who do not have a history of abuse themselves. This is important given that without training, for some of these HCPs, may have a poor sense of prevalence of IPV, which is associated with lower rates of screening (Todahl & Walters, 2011).

In summary, successful implementation of policies aimed at healthcare professionals addressing domestic violence is dependent on providers having the knowledge, attitudes, and readiness to respond to IPV (Nyame, Howard, Feder & Trevillion, 2013). The formal responses of professionals and organizations such as those in the health sector are shaped by prevailing societal attitudes, which are influenced by implicit and usually unacknowledged beliefs and values, which are in turn shaped by their respective cultural, political, social and economic systems (Flood & Pease, 2009; Stewart, 2001, Herrero, Rodriguez & Torres, 2016). For example, those who are more condoning or supportive of violence are often less empathetic to women experiencing IPV, tend to blame the victim and are less likely to report cases of violence. Such attitudes are critical in influencing women’s future help-seeking behaviors (Flood & Pease, 2009). Through dynamic interactions, behaviors, and practices reflective of dominant cultural and social norms, values, expectations and beliefs regarding gender roles and expectations are reproduced. This often occurs subtly or invisibly, and in so doing reinforces structural inequality (Stewart, 2001; Lazarus-Black, 2008; Tran, Nguyen & Fisher, 2016).

Theoretical Framework: Intersectional Feminism

A number of theories have been utilized to understand attitudes, beliefs and behaviors related to IPV (Brewster, 2002) on a range of actors. The main theoretical frame for the present study is the Integrated Behavioral Model (IBM). Because of the model’s prescriptive nature and substantive impact on design and implementation of the study, it will be described in the
following chapter describing the study’s methodology. The IBM, however, does not account for variables outside of its central concepts, considering contextual factors, demographics for instance, to be distal. As such, Intersectional Feminist theory will be used as a lens through which to understand the larger social and cultural context and dynamics at play with regard to attitudes regarding gender and IPV in Barbados, as well as the role of HCP’s positionality - based on their membership in multiple social identity groups - and how this influences their attitudes about IPV screening practices.

The predominant conceptual base informing the issue of violence against women in all its forms at a macro level has been feminist theory (Brewster, 2002; McCue, 2007). Feminist theory has been utilized to explain and address the incidence of violence against women in historical, sociological and cultural terms as the exercise of male domination over women, through control and physical, psychological, sexual and economic abuse, contributing directly to women’s unequal social status (Brewster, 2002; Jasinski, 2001; Hanser, 2007; McCue, 2007; McPhail, Busch, Kulkarni & Rice, 2007; Lawson, 2012). Feminist theory and the women’s movement have played an important role in increasing public awareness of violence against women, challenging its relegation to the private sphere and undergirding numerous programmatic, advocacy and legislative efforts to combat the problem (Weldon, 2002; Hanser, 2007; McPhail et al., 2007; McCue, 2007).

Feminism has, however, been criticized since its inception by those in the academy as well as practitioners and others for its unwillingness to acknowledge factors outside of systemic patriarchy as the cause for domestic violence (McPhail et al., 2007). Through the work of feminists of color, lesbian and international feminists, the feminist community has finally given concession to a multiplicity of causal factors motivating incidence of violence against women,
and affecting attitudes toward the phenomenon, including the intersections between gender and other forms of oppression such as racism, classism, and as in the case of Barbados, colonialism (Heise, 1998, McPhail et al., 2007; Sokoloff & Dupont, 2005; Anderson, 1997). Intersectional feminism has as its defining feature, an emphasis on multiple social identities and oppressions, and more than a simplistic reading of culture, which serves to give voice to the marginalized and recognize the unique interplay of social, historical and other contextual factors to women’s experiences of violence (Miller & Garran, 2008; Sokoloff & Dupont, 2005).

**Gender, Culture, Race/Ethnicity**

Cox (1997) notes that the existence of gender bias in Caribbean medical education impacts not only the women who are treated, but extends to related policy and service delivery in general, and as such consideration of the effects of local cultural beliefs and practices on women’s health must be included in the development of effective health policy. The role of gender in determining disclosures of abuse has been consistently significant across numerous studies, with some suggesting that female HCPs across specialties are more likely than males to address IPV as part of their practice (Nyame et al., 2013). Hamberger and Phelan (2006) note that the reasons for variations in disclosure rates may not be as obvious as they appear, and that patients’ increased comfort in disclosing IPV experiences may relate more to behaviors male and female HCP’s display that differentially influence such disclosures. While female HCPs are more likely to be empathetic to victims of abuse and more likely to receive disclosures from patients (Gremillion & Kanof, 1996), they also reported that to receive a disclosure of domestic violence from female patients increased their own feelings of fear, vulnerability and lack of control regarding the potential for violence against their person. This was particularly the case if the provider had personally experienced abuse (Sugg & Inui, 1992, Gremillion & Kanof, 1996;
Tower, 2006; Djikanovic et al., 2010). Male HCP’s were more likely to fear offending the patient by asking questions about IPV (Gremillion & Kanof, 1996; Hamberger & Phelan, 2006).

Nayak, Byrne, Martin and Abraham (2003 as cited in Griffith et al., 2006) found that attitudes of university students toward IPV varied by nationality and gender, with both genders from the United States being less tolerant than those in the comparison countries of Japan, India and Kuwait, and men general were more tolerant of IPV than women. Another study in Kuwait however revealed that while female HCPs were more knowledgeable about IPV, they were also more accepting of abuse “for the right reasons,” i.e. the violation of cultural norms regarding the behavior of women (Alazmy et al., 2011). Griffith, Negy and Chadee (2006) agree that the seriousness ascribed to IPV may differ across cultures. They found that residents of Barbados’ closest geographic neighbor, Trinidad, were more tolerant of IPV than US citizens in their attitudes and less willing to intervene in known situations (Griffith et al., 2006).

Given that unhelpful responses to disclosures of IPV may prevent women from seeking help in the future, it is critical to understand HCPs’ own concepts of power and control as a key way of ensuring proper care (Gremillion & Kanof, 1996; Williston & Lafreniere, 2013). Numerous studies highlight that the detached, objectivity physicians strive for in their clinical training, and the biomedical model’s emphasis on symptoms versus acknowledging possible underlying causes such as IPV as problematic may be a significant barrier to recognizing signs of abuse (Gremillion & Kanof, 1996; Hegarty, 2011; Rose et al., 2011; Trevillion et al., 2014). By failing to screen for IPV, the clinical encounter may contribute to the victim’s cycle of disempowerment and loss of control. Further, the traditional relationship between patient and health care provider may duplicate the power and control dynamics in the victim’s abusive relationship. Thus, patients who are victims of IPV might experience “secondary victimization”
by HCPs who, as a result of insufficient training or perceived lack of preparedness, inflict additional trauma on them (Postmus et al., 2011). In this regard, intersectional feminism is a useful tool in providing insight into the practitioner attitudes and the impact of their social location on their approach to engaging women experiencing violence.

**Conclusion**

Eleanor Roosevelt, a significant contributor to the UDHR, once said: “Where, after all, do universal human rights begin? In small places, close to home... they are the world of the individual person; the neighborhood he lives in; the school or college he attends; the factory, farm, or office where he works. Such are the places where every man, woman, and child seeks equal justice, equal opportunity, equal dignity without discrimination” (Amnesty International UK, 2017). As a human rights profession, social work, with its social justice mission and person-in-environment perspective, is especially committed to client-centered social change on behalf of vulnerable groups. IPV is a major global public health and human rights issue, disproportionately affecting women. Despite this, in the Caribbean and in Barbados specifically, the health sector remains an overlooked resource in addressing IPV as a social problem.

Though critically positioned to intervene by screening, HCPs are unlikely to do so as a result of several personal, professional, institutional, and societal factors. Encounters with HCPs may prove to be the patient’s only opportunity to disclose abuse and receive assistance (UNFPA, 2009). As such, HCPs’ treatment of these women and the degree to which they screen them for a history of IPV carry implications for disclosures of abuse, women’s feelings of safety and health-seeking behavior (Krug et al., 2002). The present study is the first in the island and the region to apply the IBM and intersectional feminism in assessing HCPs’ IPV-related attitudes, beliefs, knowledge, screening intention and past screening behavior. As such, it is an important first step
in protecting women’s rights, promoting policies challenging and eliminating gender inequality, and to engaging relevant sectors such as health in sensitively responding to the needs of abused women.
CHAPTER 3: Methodology

The study was conducted by the student researcher, with assistance from a Bachelor-level social work graduate student from the University of the West Indies -Cave Hill. The research assistant’s duties were to develop the database of private practice primary care practitioners, assembly of survey packets and data entry of completed surveys. The research assistant was trained by the student researcher on each aspect of her duties, and at no time had access to the document which connected potential participants to their unique alphanumeric identifiers, thus preserving confidentiality. The student researcher and research assistant were appropriately trained and certified through the Collaborative Institutional Training Initiative (CITI Program) on research with human subjects. The student researcher’s dissertation advisory committee provided oversight through all phases and aspects of the study.

Integrated Behavioral Model

The present study’s methodology is based primarily on the overarching theoretical frame, the Integrated Behavioral Model (IBM). The IBM is generally considered an extension of Ajzen and Fishbein’s Theories of Reasoned Action and Planned Behavior (TRA/TPB) (Fishbein & Capella, 2006; Fishbein et al., 2001). As such, it shares those theories’ contention that behavioral performance is determined primarily by behavioral intention, or one’s level of commitment or willingness to perform a specific behavior. Unlike TRA/TPB, the IBM does not address outcome evaluations, but rather the underlying beliefs which determine and serve as a proxy for behavioral outcomes (Fishbein & Capella, 2006; Montaño & Kasprzyk, 2008). Empirical data has suggested that there is little variance in terms of behavioral outcomes when underlying beliefs are evaluated and there is agreement among participants, rendering the measuring of outcomes unnecessary (Montaño & Kasprzyk, 2008).
The IBM and the theories from which it draws have been used in hundreds of studies successfully to both explain and predict a broad range of health behaviors such as HIV/STD prevention, cancer screenings, substance use, healthcare professionals’ provision of preventive services. The IBM framework has been developed and modified through empirical work over the past 30 years (Montaño and Taplin, 1991; Fishbein, 1993; Albarracin, Fishbein, Goldestein & de Muchinik, 1997; Morrison, Spencer, & Gillmore, 1998; Bogart, Cecil, & Pinkerton, 2000; Kasprzyk, Montano & Fishbein 2006; Dreibelbis et al., 2013; Branscum & Lora, 2017; Nantha, Haque & Nantha, 2018). The IBM involves a qualitative elicitation process - described later in more detail - which contributes to its empirically supported, cross-cultural applicability. It has been used in over 50 countries, at various levels of development (Fishbein, 2000; Montaño & Kasprzyk, 2008).

According to the IBM, there are three main constructs that determine the central concept of behavioral intention: attitudes, perceived norms, and personal agency. Each of these, in turn, are comprised of two sub-constructs (Fishbein & Capella, 2006; Montaño & Kasprzyk, 2008), as follows:

1) **Attitude** toward a behavior illustrates one’s positive or negative evaluation of performing that specific behavior, and its sub-constructs are “experiential attitudes” and “instrumental attitudes.” Experiential attitudes are one’s emotional reaction to performing the behavior, and instrumental attitudes reflect one’s cognitive beliefs about outcomes associated with performing the behavior (Fishbein & Capella, 2006; Godin & Kok, 1996; Montaño & Kasprzyk, 2008).

2) **Perceived norms** capture the extent to which an individual experiences social pressure or expectations from important individuals or groups to perform a given behavior. A
function of normative beliefs, this construct also brings to bear the influence of strong social identity as a normative influence in some cultures (Bagozzi & Lee, 2002; Montaño & Kasprzyk, 2008; Triandis, 1980). The sub-constructs are “injunctive norms,” or the degree to which important individuals or groups expect performance of a behavior; and “descriptive norms,” or the degree to which these same individuals or groups are believed to be performing the behavior (Fishbein, 2007; Montaño & Kasprzyk, 2008).

3) Finally, personal agency, or one’s exercise of personal influence on one’s own functional capacity and the environmental context, has as its sub-constructs “perceived behavioral control” and “self-efficacy.” Perceived behavioral control refers to the ease or difficulty of performing a specific behavior in light of whether environmental factors lend themselves to such performance. Self-efficacy refers to an individual’s belief in their ability to perform a given behavior in spite of personal or environmental barriers or challenges they may face in doing so, either in terms of personal or environmental factors (Fishbein & Capella, 2006; Montaño & Kasprzyk, 2008).

The IBM assumes that individual characteristics (which can be measured by such demographic variables as gender, age and social class) are indirectly associated with target behaviors through the theory’s constructs and are thus considered external or distal variables (Fishbein & Capella, 2006; Montaño & Kasprzyk, 2008). In the current study identifying differences between subjects is deemed important to understanding the significance of each group’s beliefs regarding IPV screening. It may also allow the student researcher to identify how the determinants of behavioral intention might vary in terms of their impact on the target
behavior for different populations (Fishbein & Capella, 2006; Montaño & Kasprzyk, 2008). Intersectional feminism as described in the previous chapter, is therefore used as a lens through which to view these external factors.

**Research Questions & Hypotheses**

The present study’s first three research questions (RQ) are qualitative and as follows: 

1. **RQ 1**: What are Barbadian HCPs’ attitudes – instrumental and experiential - regarding screening adult female patients for IPV during clinical visits?; 
2. **RQ 2**: What are Barbadian HCPs’ perceived norms - injunctive and descriptive - regarding screening adult female patients for IPV during clinical visits?; 
3. **RQ 3**: What are Barbadian HCPs’ beliefs regarding personal agency - perceived behavioral control and self-efficacy – with regard to screening adult female patients for IPV during clinical visits?;

Research questions four through eight are quantitative. 

4. **RQ 4**: How do Barbadian HCPs’ behavioral intention regarding screening female patients for IPV during clinical visits vary by demographics (age, gender, social class, personal experience as a victim of IPV, provider type, where professional education was completed)? This question has four hypotheses: 
   - **H4.1**: HCPs younger than 30 years old will be more likely to intend to screen adult female patients for IPV than those older than 30; 
   - **H4.2**: Female HCPs will be more likely to intend to screen adult female patients for IPV than male HCPs; 
   - **H4.3**: Irrespective of gender, HCPs with personal experience as a victim of IPV will be more likely to intend to screen female patients for IPV than HCPs with no personal experience of IPV; and 
   - **H4.4**: Nurses will be more likely to intend to screen adult female patients for IPV than physicians. 
5. **RQ 5**: How does the prevalence of self-reported IPV screening behavior among Barbadian HCPs differ by demographics (age, gender, race/ethnicity, personal experience with IPV, provider type, where professional education was
completed)? This question has four hypotheses: \( H_{5.1} \) - HCPs younger than 30 years old will be more likely to have screened adult women for IPV than those older than 30; \( H_{5.2} \) - Female HCPs will be more likely to have screened adult women for IPV than male HCPs; \( H_{5.3} \) – Irrespective of gender, HCPs with personal experience as a victim of IPV will be more likely to have screened women for IPV than HCPs with no personal experience of IPV; \( H_{5.4} \) – Nurses will be more likely to have screened adult women for IPV than physicians.

**RQ 6:** How does the prevalence of self-reported IPV screening behavior among Barbadian HCPs differ by prior participation in the Ministry of Health’s IPV training program? This question has one hypothesis: \( H_{6.1} \) – Barbadian HCPs who have participated in the pilot IPV protocol training will be more likely to screen adult women for IPV than Barbadian HCPs who have not received such training. Research questions 7 and 8 have no hypotheses, but rather explore the theoretical model: **RQ 7:** How well does the IBM explain variance in IPV screening intention in Barbadian HCPs?; **RQ 8:** What constructs in the IBM (Experiential Attitude, Instrumental Attitude, Injunctive Norm, Descriptive Norm, Perceived Control, and Self Efficacy) are most associated with IPV screening intention in Barbadian HCPs?

**Research Design**

The multi-phase mixed-method design (Creswell, Klassen, Clark & Smith, 2011) prescribed by the IBM was utilized in the study. The first phase was the qualitative “elicitation” process which, according to the theory, is key to understanding the underlying belief system that drives individual decision-making processes regarding specific behaviors. Through qualitative interviews, these factors or determinants of behavior are identified for a specific population (Ajzen & Cappella, 2006; Middlestadt et al., 1996). This includes the behavior-specific language used, and participant descriptions of behavioral, normative, and self-efficacy beliefs which they
hold, and are thus relevant to them. From this process, quantitative measures were developed which are specific both to IPV screening behavior, and Barbadian HCPs (Fishbein & Capella, 2006; Middlestadt et al., 1996). Thus, the elicitation phase serves to ground the study in the terminology and perspectives of the target population, not the researcher. The most prominent feature will be the shift in a prioritization of language from the researcher-chosen term IPV, to the participant-preferred term, domestic violence (DV) in the results and discussion chapters.

The second phase was a survey, an established methodology for measuring attitudes, and behaviors in large populations, and exploring hypothesized relationships between multiple variables (Dillman, Smyth & Christian, 2009; Rubin & Babbie, 2011). The self-administered questionnaire was available in hard copy and electronic versions. The overwhelming majority of respondents, however, completed the hard copy administration of the survey. The paper and pencil mode is ideal for HCPs given their professional status and familiarity with ensuring and evaluating quality of care standards. Additionally, self-administered surveys may also be completed at the participant’s convenience and are less time-consuming than other survey administration methods—key advantages for this population.

**Sampling Plan**

The study’s target population is primary care HCPs who provide acute, and routine primary care to females aged 18 years and older. These HCPs included general practitioners, family medicine physicians, obstetrician-gynecologists, dentists, and registered nurses. The most recent data from the Barbados Ministry of Health (2015) indicates that in 2012, there were approximately 582 physicians, 1,215 nurses and 68 dentists of all specialties island-wide. Excluded from the survey are specialty, in-patient and emergency hospital HCPs who would not attend to adult female patients for routine primary care visits. Also excluded are non-licensed
clinical support staff who would not be privy to the type of information to which licensed clinical staff would be. These inclusion/exclusion criteria greatly reduced the total number of HCPs eligible for participation. In order to obtain a sufficient number of responses, data needed to be collected from all eligible respondents supporting a census rather than a probability sample. Nevertheless, the sampling frame did result in some coverage errors (Kerlinger & Lee, 2000). It became clear during the survey administration that there were eligible practitioners who were unable to be included in the study due to their being on sick, vacation or study leave. In the administration of the mailed surveys, several mailings were returned indicating that the practitioner was no longer with the practice or was deceased. Another limitation in terms of coverage was the criteria of contacting practitioners listed in the telephone directory. Most importantly coverage was limited since not all HCPs are listed in the directory, as there are those who do not operate their own practice, but rather serve as substitutes or who work on an as-needed per diem practitioner in private and public settings. The total number of practitioners both private and public, to whom surveys were mailed or delivered, was 375.

The target population of licensed health care professionals was identified from the employee rosters of each of the public polyclinics and the most recent public telephone directory. For the elicitation phase, a convenience sample of HCPs – consisting of private practice physicians and dentists, and nurses and physicians from the polyclinic settings and the Barbados Family Planning Association were identified through the Medical Officers of Health and the student researcher’s professional networks. These samples helped to determine the study population’s salient beliefs about performing IPV screening (Ajzen, 2006; Curtis, Weiler & Ham, 2010; Middlestadt et al., 1998; Sutton et al., 2003). Interviews were conducted at this phase until saturation was reached and no new beliefs were identified.
A power analysis utilizing Cohen’s (1992) table for effect size determined that to perform correlations, a sample size of at least 85 respondents was required to demonstrate a medium effect size ($r = .3$), with an alpha level of .05 and beta set at .80. The other major statistical tests planned by the researcher were regression analyses. One of the generally accepted standards for determining adequate sample for regression analyses is to obtain a sample size of $50 + 8m$ (where $m$ = the number of independent variables). Thus, with the seven major independent variables, a minimum sample size of 106 participants was needed to demonstrate a medium effect size ($R^2 = .15$), with a two-tailed alpha level of .05 and beta set at .80 (Abu-Bader, 2011). The final number of completed surveys – 176 - met these requirements.

**Operationalization of Major Variables**

This study focuses on screening for IPV perpetrated against women in heterosexual relationships, using the WHO’s (2012) definition of IPV. The IBM notes that the behavior in question must be clearly defined, attending to the four elements of: action, target, context, and time (Fishbein & Cappella, 2006). As such, the IBM framework which this research investigated can be described as follows: Barbadian HCPs’ performing (action) IPV screenings (target) during clinical office visits (context) in the next 12 months (time). The major variables arising from the IBM – intention, attitudes, perceived norms, and personal agency – have been conceptually defined previously and are related to the preceding behavioral definition for this study.

“Screening intention” is the major criterion variable and is operationally defined as HCPs’ intention to screen adult women for IPV during clinical office visits during the next 12 months. “Attitudes,” “perceived norms” and “personal agency” are the major predictor variables. Each of these constructs were operationalized as scales with between 4 and 8 questions each.
Ajzen and Fishbein recommend five to six questions each. Based on the criteria used to determine item inclusion (at the elicitation phase; reference), some of the final constructs employed were slightly over (7 – 8) the items. The questions for most constructs had five-point bipolar likert scale response sets, (similar to the anchors from the validated measures to facilitate ease of response).

Two additional major variables “screening behavior” and “IPV training” are not formally a part of the IBM theoretical framework, but the theory calls for their assessment (past behavior, external factors) to fully understand behavioral intention. “Screening behavior” is a predictor variable and is conceptually defined as HCPs’ past assessment of female patients’ IPV risk by directly asking patients about the presence of IPV in their lives. Screening behavior will be operationalized in this study as “Frequency of DV Inquiry” using the “Self-Reported Assessment Behaviors” scale in the Attitudes Toward Survivors of Intimate Partner Violence or “ATSI” instrument (Nicolaidis, 2005). IPV training is also a predictor variable and is conceptually defined as the inclusion of formal IPV content in professional training. IPV training was operationalized in the demographic information section from the ATSI, as completion of IPV-related training in participants’ professional education, continuing education on IPV and specialty or agency-sponsored training. Participants were able to indicate responses of “yes” or “no,” and if “yes,” the number of hours of education received.

**Data Collection.**

The study was conducted with the permission of the Barbados Ministry of Health and Wellness (MOH), and contacts with practitioners included cover letters from the Ministry to leverage authority and legitimacy with the HCPs. The MOH is the central licensing, administrative and regulatory authority for the entire health sector. The relationship between the
MOH and the senior medical staff at the publicly run primary care polyclinics was drawn upon to gain access to HCPs in these settings, which was communicated in contacts with private individual and group primary care practices. Contact and logistics of sharing information regarding the study was tailored according to the request of each medical officer of health. Some were provided with email communications; others were contacted by telephone. Additionally, some contacts were made via in-person meetings. These initial contacts allowed the student researcher to describe the study, its purpose, procedures and potential benefits to both staff and patients, as well as work out the specific logistics of data collection at each study site.

**Phase 1 – Elicitation**

The elicitation process was conducted in January to April 2017 and entailed individually administering a series of semi-structured open-ended questions to the sample to identify salient beliefs (Ajzen, 2006; Middlestadt et al., 1998; Sutton et al., 2003). Salient beliefs, or those which most readily come to mind are identified regarding each of the theoretical constructs – attitudes, normative referents, and control beliefs (Ajzen, 2006; Sutton et al., 2003). Upon screening for eligibility to participate and obtaining consent, the interviews were conducted by the researcher at a location convenient for the participant – usually at the practitioners’ offices. All interviews were digitally recorded with the participants’ permission, and responses were transcribed by the student researcher. Interviews on average lasted approximately 45 minutes. As a token of appreciation for their time, interviewees received BDS $25 (USD $12.50 equivalent) gift cards to Sheraton Mall.

**Phase 1 - Data Analysis.** For research questions one through three, Participant responses to the open-ended interview questions were content analyzed to identify the modal salient beliefs for each IBM construct (Montaño & Kasprzyk, 2008), to answer research questions one through
four. The recorded interviews were not transcribed verbatim, as extraneous speech and non-verbal information was excluded from the transcripts. Halcomb and Davidson (2006) note that verbatim transcription for content analysis, which primarily seeks to identify and quantify common concepts or ideas from qualitative data, is not required. Content analysis, as prescribed by the IBM, is an appropriate analytical method given that the objective in this process is to identify salient rather than latent content (Padgett, 2008).

Ajzen and Fishbein (1980) suggested several alternative approaches to determining which beliefs to include in the final survey: 1) selecting the 10-12 most frequent outcomes; 2) selecting beliefs exceeding a certain frequency (e.g. ‘all beliefs mentioned by 20% of the sample’); 3) selecting “as many beliefs as necessary to account for a certain percentage (e.g. 75%). We adopted Ajzen and Fishbein’s second approach. For this study, all beliefs mentioned by at least 20% of study participants were included and developed as questionnaire items. Transcribed interviews were manually coded, and then entered and coded in NVivo 12 qualitative software. This allowed the student researcher to tabulate the number of participants expressing each salient belief, while referring to the relevant transcripts. The identified beliefs were then used to develop indirect measure items for the final survey instrument (Middlestadt et al., 1998; Sutton et al., 2003).

**Phase 2 – Health Practitioner Survey**

**Validating Measures.** In addition to the indirect measures emerging from the qualitative interviews, validation was sought in the final survey by assessing Barbadian HCPs IPV-related beliefs, knowledge and behavior, using two previously developed instruments— the ATSI and the Providers’ Knowledge, Attitudes, and Beliefs about Domestic Violence Scale or “KAB” (Group Health Cooperative & Harborview Injury Prevention and Research Center, 1997). Because both
scales were developed to measure HCP response to the full range of domestic violence—including against children, elders and other adult members of a household—modifications were made to the instruments, eliminating references to the “Group Health Cooperative,” the previously mentioned other forms of domestic violence, violence between same-sex intimate partners, and interventions with perpetrators of abuse.

Both measures are multidimensional and psychometrically tested. The KAB has greater internal consistency than the ATSI, and has been more extensively tested for content, convergent and discriminant validity (Maiuro et al., 2000; Thompson et al., 2000). The Cronbach’s alpha for the KAB subscales range from 0.73 to 0.91 and 0.88 for the entire scale, and the ATSI’s Cronbach’s alpha ranges from 0.68 to 0.92 (Maiuro et al., 2000; Nicolaidis, Curry & Gerrity, 2005). Four of the KAB’s six factor subscales were used: Perceived Self-Efficacy ($\alpha = 0.73$); System Support ($\alpha = 0.73$); Blame victim ($\alpha = 0.80$); Professional role resistance/fear of offending patient ($\alpha = 0.80$). The Perceived Frequency of Asking scale was similar to the ATSI’s ”self-reported assessment behaviors scale,” which was used instead. The ATSI scale included one more item than the KAB – seven versus six items - and had a similar Cronbach’s alpha to the KAB ($\alpha = 0.91$ and $\alpha = 0.92$ respectively). It also asked for a shorter recall time of past behavior, 30 days versus three months. The KAB’s sixth scale, Victim/Provider safety, was excluded as it referred only to provider encounters and interventions with perpetrators. The KAB also includes two questions regarding the participant’s perception of IPV prevalence. The KAB is mostly scored on a 5-point likert scale, (e.g. 1 = strongly disagree, 5 = strongly agree), with three items scored on a 3-point likert (e.g. 1 = no, 2 = yes, 3 = unsure).

The seven ATSI subscales measure similar constructs: responsibility to assess for IPV ($\alpha = 0.73$); responsibility to counsel regarding IPV ($\alpha = 0.68$); respect for autonomy ($\alpha = 0.70$);
empathy with patients in abusive relationship (α =0.89); barriers to assessing or treating IPV (α =0.79); screening confidence (α =0.82); and self-reported assessment behavior (α =0.92). The self-reported assessment behavior will be referred to from this point on as “Frequency of DV Inquiry” or FDVI for ease of reference. All subscales except ‘screening confidence’ are scored on a five-point likert scale (with 5 indicating strongly agree); the screening confidence scale is scored on a three-point scale. The ATSI’s Knowledge scale (α =0.83) is open-ended and features a scoring system of 0-4, with examples of appropriate and inappropriate responses to each question. The ATSI also features extensive background questions, including: years of experience; where IPV training was obtained; and whether the participant or someone close to them has been personally affected by IPV (Nicolaidis et al., 2005). To obtain a better understanding of practitioners’ experiences with domestic violence, this last question, which originally asked “Have you, a close friend, or a family member personally been affected by domestic violence” was modified and split into five questions. This was due to the double-barreled nature of the question, which made it impossible to determine what party had been abused. The division also accounted for the definition of abuse being used in the study and allowed us to determine if respondents had been abusive to their partners. The question format was inspired by similar questions on abuse experience and perpetration in the Guyana study (Mitchell et al., 2013). Participants were instead asked: “Have you ever been emotionally abused (verbally abused, threatened, controlled) by an intimate partner”; “Have you ever been emotionally abusive (verbally abusive, threatening, controlling) to an intimate partner?”; “Have you ever hit, slapped, kicked or otherwise been physically abusive to an intimate partner?”; “Has an intimate partner ever hit, slapped, kicked or otherwise been physically abusive to you?; and “To your knowledge, has a close friend, or a family member been a victim of domestic
violence? Question threat was minimized by 1) limiting the response set to "yes," "no," and "unsure," for the question on psychological abuse; and 2) limiting the response set to “yes” “no” for the question on physical abuse. Further, questions did not ask participants to describe the abuse in any detail. Additionally, question threat was further tempered by reminding respondents on the information sheet about the voluntary nature of their responses. The finalized draft of the survey consisted of 92 questions.

The questionnaire was subsequently reviewed for readability and flow by two PhD social work peers, and US-based medical and public health professionals in the student researcher’s professional network – a cardiologist, epidemiologist, nurse midwife and an obstetrics nurse. None of these peer reviewers had access to any of the study data. Based on their feedback, questions were revised. After the first revision, the draft survey was reviewed by the student researcher’s dissertation chair. Upon approval, the survey instrument and all related materials necessary to conduct a pilot of the study’s second phase were submitted as an amendment to the IRBs for UConn, the Barbados Ministry of Health, and the University of the West Indies.

**Phase 2 – Pilot Survey.** Upon receipt of the necessary approvals, the survey was piloted with eight Barbadian health professionals – two nurses and two physicians from the public clinics, and two private practice physicians and dentists respectively - for feedback. The pilot participants were a mix of individuals who had been interviewed during the study’s first phase, (two physicians and one dentist), respondents who indicated at the time that they would be interested in participating in the pilot, one respondent, a dentist who self-referred in response to a flyer which was distributed via social media, and one private physician in the student researcher’s professional network. The nurses were referred by the medical officers of health at their respective clinics. The student researcher was present at the completion of all pilot surveys
with one exception; a single respondent completed the pilot survey at home, and subsequently reviewed their experience with the student researcher within two days of completion.

Pilot participants were asked to comment on time needed to complete the survey, clarity of the survey’s layout, clarity and appropriateness of individual questionnaire items for the local context, any challenges related to understanding question instructions and response sets, whether the questions on experiencing and perpetrating abuse made them uncomfortable in any way, and finally, any general comments regarding the survey. Pilot participants reported that the survey took them on average 30 minutes to complete. They found the survey layout, instructions, and response choices to be clear. The overwhelming majority of questions were deemed by pilot respondents to be appropriate for the Barbadian context. One question (“When it comes to domestic violence, it takes two to tango”), presented potential for systematic error, and was removed. Approximately half of the pilot’s respondents indicated either unfamiliarity with the phrase “takes two to tango,” or an incorrect understanding of it.

Respondents considerable feedback in relation to aspects of the survey: Practitioners were confused about the detail with which they were required to report certain kinds of information. Practitioners also indicated being conflicted about giving an opinion because it might change depending on each patient's specific contextual factors (e.g. the types of patients they might empathize with for staying in abusive relationship). They indicated that the responses where they indicated “neither agree nor disagree” were really reflective of the perspective that they “both agreed and disagreed” with the statement depending on the specific situation.

Noting these concerns, we revised the survey in several respects. Introductory language in the survey was added making it clear that details about specific patients were not required. Clarifying language was included in the introduction to the study to emphasize that practitioners
were being asked to respond based on their professional experience, and for their opinion or perspective "in most cases." The instructions for each of the open-ended knowledge question were revised to explicitly reflect that respondents could “list up to 4 responses” to each question, thus making clear that respondents could also list fewer if they could not come up with four items. Demographic questions related to credentials were revised to reflect the titles and degrees of Barbadian practitioners. In order to include dental practitioners, we asked providers where their “professional” training was obtained (instead of where their “medical” training was provided).

General comments from the pilot participants regarding the survey were positive. The nurses commented that simply completing the survey made them more mindful of domestic violence and it helped them to see gaps in, and where they might improve their practice. Regarding the length of the survey, participants noted that while the survey was long, it was comprehensive, and there were no questions that they would remove. None of the respondents indicated that the abuse questions – even the ones that applied directly to their own behavior – made them uncomfortable. Additionally, some respondents indicated their awareness that they could decline to answer questions that made them uncomfortable.

The questionnaire was also reviewed with the student researcher's dissertation committee members (external advisor, theoretical expert, and dissertation chair) to examine and refine existing questions, and add new questions to capture relevant data and to ensure the survey's fidelity to the IBM's (Integrated Behavioral Model) theoretical model. Based on the committee’s feedback, we replaced the question asking participants’ race with a question to gauge providers’ childhood social class, asking “parent’s highest level of schooling.” Social class as a variable allowed for greater potential variance, than race, given that the overwhelming majority of
Barbados’ residents (92%) are of African descent. The impact of social class on screening behaviors and attitudes toward IPV has been examined, but not definitively determined in the literature to date, and as such presents an opportunity for further inquiry (Tower, 2006). A final addition was an open-ended question at the end to capture any respondent feedback about the study itself, or information that may not have been addressed about the topic of domestic violence in the foregoing questions.

The Integrated Behavioral Model requires the behavior of interest to be clearly defined in terms of its target, action, context, and time. Accordingly, each instruction block received the addition of a time component: "think about screening women for domestic violence in your practice in the next 12 months." This period was selected based on practitioner feedback indicating that screening was infrequent; and this time frame also comports with the screening behaviors question from the KAB, which asked about previous screening behavior in the last 12 months. Three new questions were added to reflect and directly measure the IBM's descriptive norm concept, or the degree to which respondents believe that others are performing the behavior in question. Each question focuses on one of the three professional groups under study – doctors, nurses, and dentists – and asks participants how likely it is that each group is screening women for domestic violence in their practice. Finally, one succinct question to reflect and directly measure the IBM's main concept of intention, i.e. the degree to which study participants (providers) intend to perform the behavior in question. Providers were asked how likely it was that they would screen women for domestic violence in their practice in the next 12 months. The response set for these last four additional questions was “Not at all”, “Only slightly”, “Moderately”, “Quite a bit” and “Extremely.” This is consistent with the response set that appeared previously in the questionnaire in items from the KAB. Lastly, typographical and
grammatical errors were corrected, and the finalized questionnaire with all changes incorporated had 96 questions.

**Phase 2 – Final Survey Administration.** The final survey phase of the study was conducted between October 2019 and February 2020 and was based on Dillman et al.’s (2009) tailored design method. Survey packets and related communications were distributed via postal mail for private practitioners, and hand-delivered to the nine polyclinics and Barbados Family Planning Association (BFPA). Contact information for clinic-based practitioners who were not on leave was obtained from each of the Medical Officers of Health at each of the clinics, while private practitioner contact information was retrieved from the 2020 telephone directory and entered into the database. To track survey completion, random alpha-numeric identifiers were assigned to each practitioner. Administration of the survey included four separate contacts: 1) a brief standard pre-notice letter introducing the survey and advising staff of its importance and imminent delivery, and noting that their participation would be greatly appreciated; 2) approximately four days after the first contact, the complete survey packet was delivered; 3) because the survey was hand delivered and responses picked up in person, the student researcher was able to thank and remind each person individually. Thank you/reminder letters were left for those who had not completed the survey approximately a week after their receipt of the survey; 4) another contact occurred approximately three weeks after the delivery of the survey indicating a lack of receipt of the HCPs’ questionnaire and urging them to participate. Participants were offered a replacement questionnaire at their request.

The final survey packet contained: two cover letters, one from the Ministry of Health and Wellness, printed on its letterhead, bearing the signature of the Chief Medical Officer, and one from the student researcher on UConn letterhead; a study information sheet detailing the purpose
and scope of the study, its voluntary nature and their rights, benefits and risks related to participation in as a of the study; the questionnaire with unique identifier; a token incentive of a multifunction (pen, flashlight and stylus) domestic violence (DV) awareness pen; and lastly, a standard size (#10) self-addressed envelope for survey return. The procedure to retrieve completed surveys, varied by clinic setting. In smaller clinic settings, the student researcher arranged with individual practitioners to return the following week after survey distribution to collect completed surveys. Arrangements were made in coordination with the medical officer of health or their designee, the clinic’s Senior Sister or administrative office staff. At four of the larger clinic sites, a locked box – to which only the student researcher had access was placed in a designated administrative office location. A web-based version of the survey was made available via Qualtrics and sent to participants with verified email addresses upon their request, as well as to those who had not responded to the first two contacts with the hard copy questionnaire. Each participant was assigned their own unique link to access the survey, which aided in tracking responses and sending reminders.

**Phase 2 - Data Analysis.** Research questions four through eight were examined through several types of quantitative statistical analysis. Prior to conducting statistical tests, frequencies were run for demographic and other variables to identify incorrect or missing data, and outliers. Variables were also recoded as appropriate and checks were conducted for multicollinearity and homoscedasticity. Descriptive statistics were generated to identify measures of central tendency and standard deviations for the study’s independent and dependent variables. Demographic and potential control variables for analysis include gender, social class, HCP type, credential, specialty, age, years of experience, practice setting, where professional education was completed and personal experience with IPV. Cronbach’s alpha coefficients assessed the reliability of the
various subscales and indirect measures. Bivariate analyses – correlations, and cross-tabulations – were conducted to determine the degree of association between for the various subscales.

For RQ 4 and RQ 5 and their related hypotheses, the predictor variables are demographic variables (age, gender, personal experience of IPV, and HCP type) and the criterion variables are IPV screening intention and IPV screening behavior, respectively. These variables and corresponding analyses will also be used to determine if HCPs’ social identities and positionality influence IPV screening intention and behavior. For RQ 6 and its single hypothesis, the predictor variable is participation in the Ministry of Health’s IPV training program and the criterion variable is IPV screening behavior.

For research questions four through six, chi-square tests of association were conducted to determine the relationship between the several independent variables and the respective dependent variables. For RQ 7 and RQ 8 respectively, predictor variables are the IBM constructs (Attitudes, Perceived norms, Personal Agency) and the criterion variable is IPV screening intention. Multiple regression analyses were conducted for these two research questions. The student researcher treated the dependent variable - IPV screening intention - as continuous for the regression model.

**Protection of Human Subjects.** Prior to conducting the study, and with each subsequent amendment, the student researcher complied with all protocols and filed required paperwork relevant to the Institutional Review Boards for the University of Connecticut, the Barbados Ministry of Health and wellness, and the Barbados National Institutional Review Board at the University of the West Indies – Cave Hill Campus. For the elicitation phase, participants received and signed statements of informed consent, and the voluntary nature of study participation. Study participants’ information remained confidential, with only a unique numeric
identifier used as the means of differentiating individuals, and tracking survey completion. Each identifier corresponded to the name of each participant, the list of which was kept in a password protected document on a password protected computer. For the first phase, upon transcription of the interviews, the key matching the participant’s name with their unique identifier was deleted. Similarly, upon survey return, the unique identifier was matched with the participant’s name, and both were then deleted from the list.

**Data Management.** All interview content was digitally recorded and transcribed by the student researcher, and any potentially identifying information was disguised. The audio files and corresponding transcripts were stored on a password protected laptop to which only the student researcher had access. Quantitative data for the study was analyzed utilizing SPSS version 26, for Windows. Each participant was assigned a unique alphanumeric identifier, and participants’ association with their identifier was known only to the student researcher. Upon receipt of the completed or blank surveys, the participant’s identifier was matched with the name of the participant, after which the individual’s name was deleted from the file.

**Evidence of Scientific Rigor.** Upon transcribing the interviews and performing the content analysis, the student researcher engaged in peer debriefing with members of her advisory committee regarding the selected modal beliefs for inclusion in the quantitative survey. To ensure the survey’s reliability and content validity, a pilot test of the selected modal beliefs related to the indirect measures of the IBM’s constructs was conducted with a small convenience sample, which was then excluded from the final survey. This pilot questionnaire also included the KAB and ATSI measures to evaluate the utility of including them in the final instrument (Ajzen, 2006).
CHAPTER FOUR: Results

As described in the methodology, this mixed method study was conducted in two separate, yet connected phases, the results of which are presented in this chapter. The qualitative elicitation phase was conducted first, and served to identify salient beliefs and attitudes, and ground the study in the language of Barbadian primary care practitioners. The elicitation interview guide is attached at Appendix A. The second phase consisted of a self-administered survey which was distributed to public and private HCPs. The questionnaire, attached at Appendix B, consisted of items developed from the results of the elicitation interviews, and relevant items from the KAB and ATSI instruments assessing HCP attitudes, knowledge, and beliefs regarding intimate partner violence. The findings of the content analysis of interviews will be presented first, following by those from the completed surveys.

Phase 1 – Elicitation

A convenience sample of 35 HCPs participated in the qualitative interviews conducted in the study’s initial phase. Each polyclinic setting was requested to provide two physicians and two nurses and dentists if available. Private practitioners were identified through the researcher’s professional and personal networks. Limited demographic information was collected, as shown in Table 1. The primary characteristic of interest at this phase, as previously noted based on the IBM, was the inclusion of 15-20 members of the respective practitioner groups under study. Of those who participated, there were 15 nurses (RNs and advance practice/public health nurses), 16 physicians, and four dentists. There are only approximately 68 dentists of all types in the country, impacting the number of participants in this group. Four of the physicians and two of the dentists worked in private practice, while all the nurses worked in public settings. In terms of
gender, the sample was predominantly female across the three HCP types, with only five male participants.

Table 1

Elicitation Sample Characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>30</td>
</tr>
<tr>
<td>Men</td>
<td>5</td>
</tr>
<tr>
<td><strong>Practitioner Type:</strong></td>
<td></td>
</tr>
<tr>
<td>Dentist</td>
<td>4</td>
</tr>
<tr>
<td>Nurse</td>
<td>15</td>
</tr>
<tr>
<td>Physician</td>
<td>16</td>
</tr>
<tr>
<td><strong>Practice Setting</strong></td>
<td></td>
</tr>
<tr>
<td>Public</td>
<td>29</td>
</tr>
<tr>
<td>Private</td>
<td>6</td>
</tr>
</tbody>
</table>

After transcription by the student researcher, the interviews were manually coded, and content analyzed. The interviewer also took notes of information provided by the participants that might be used to provide context for more in-depth analysis of the salient data for future study. This included information such as the way in which the clinic operations functioned, and security measures in place at the medical facilities. The interviews were entered into NVivo12 to facilitate accurate tracking of the codes resulting from the content analysis. Content analysis, according to Padgett (2008) is essentially a quantitative mode of analysis applied to qualitative data, which focuses on the number of occurrences of manifest rather than latent themes. This method of analysis is prescribed by the theory for the elicitation process, to identify the most frequently occurring responses of salient beliefs (Ajzen, 2006; Middlestadt et al., 1998; Sutton et al., 2003). The purpose of the elicitation is therefore to identify content areas for inclusion in the
survey, rather than an examination of beliefs as an end in itself. Questions to identify salient instrumental attitudes asked participants their views on the benefits and disadvantages of performing screening, while experiential attitudes asked about positive and negative feelings regarding screening. To identify injunctive norms, participants were asked who would approve or disapprove of them performing screenings. Finally, perceived control and self-efficacy were determined by asking what personal and institutional factors would enable or prohibit HCPs from performing screening. The student researcher engaged in debriefing with two of her committee members during coding and analysis as a means of ensuring rigor (Padget, 2008). Responses given by at least 20% of participants were selected for inclusion in the final survey (Azjen & Fishbein, 1980).

The elicitation phases addressed the present study’s first three research questions (RQ), and the relevant constructs are listed after each question. The first question in the interview guide was not directly linked to any of the three research questions. It served to identify Barbadian practitioners’ preferred or customary terminology used to refer to IPV, which is a requirement of the IBM (Montaño & Kasprzyk, 2008). The descriptive percentages described below are based on N = 35 participants.

Terms for Intimate Partner Violence: When asked how they refer to violence between intimate partners, 74% of participants indicated using the term “domestic violence.” When asked for any other terms they used, 25% responded with “abuse.” As such, the term domestic violence (DV) will be prioritized in describing the findings in this chapter and discussing their meaning and implications in Chapter Five.
**RQ 1**: What are Barbadian HCPs’ attitudes – inductive and experiential - regarding screening adult female patients for IPV during clinical visits?

*Positive Instrumental Attitudes*: When asked about the benefits or advantages of screening, the most frequent responses from participants were that screening: identifies victims and persons at risk (57%); provides an outlet for patients to talk about abuse (48%); helps determine the prevalence of DV (37%); allows help to be offered (31%); improves patient management (28%); and allows for referrals to be made (20%). Table 2 show the modal salient instrumental attitudes.

**Table 2**

*Salient Instrumental Attitudes*

<table>
<thead>
<tr>
<th>Instrumental Attitudes</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Positive</strong></td>
<td></td>
</tr>
<tr>
<td>Identifies victims and persons at risk</td>
<td>57</td>
</tr>
<tr>
<td>Provides an outlet for patients to talk about abuse</td>
<td>48</td>
</tr>
<tr>
<td>Helps determine the prevalence of DV</td>
<td>37</td>
</tr>
<tr>
<td>Allows help to be offered</td>
<td>31</td>
</tr>
<tr>
<td>Improves patient management</td>
<td>28</td>
</tr>
<tr>
<td>Allows for referrals to be made</td>
<td>20</td>
</tr>
<tr>
<td><strong>Negative</strong></td>
<td></td>
</tr>
<tr>
<td>It is time-consuming</td>
<td>37</td>
</tr>
<tr>
<td>Patients may be unwilling to disclose abuse</td>
<td>31</td>
</tr>
<tr>
<td>Patients feel you are “trying to get in their business”</td>
<td>28</td>
</tr>
<tr>
<td>Negative emotional responses to being asked about abuse</td>
<td>23</td>
</tr>
<tr>
<td>Make the abuse situation worse if the partner finds out it was done</td>
<td>20</td>
</tr>
</tbody>
</table>

*Negative Instrumental Attitudes*. When asked about the disadvantages associated with screening, participants most frequently indicated the following as negative outcomes: it is time-consuming (37%); patients may be unwilling to disclose abuse (31%); patients may feel you are “trying to get in their business” (28%); patients may have negative emotional responses to being
asked about abuse (23%); and it may make the abuse situation worse if the patient’s partner finds out it was done (20%).

A follow-up question regarding screening during routine versus acute visits was also asked to determine practitioners’ views regarding routine and universal screening. Participants indicated that routine visits allowed more patients experiencing abuse to be identified (34%), since patients in acute visits will be more likely to prioritize their presenting problem (35%) over disclosures of abuse, unless the presenting problem is abuse-related.

*Positive Experiential Attitudes.* In terms of positive adjectives to describe their feelings regarding screening, participants shared that they felt: helpful (57%); they were empowering the patient (43%); supportive (34%); that they are making a difference (26%); empathy (23%); comfortable (20%); and that it is enlightening with regard to patient care (20%). Salient modal responses for experiential attitudes are shown in Table 3.

**Table 3**

*Salient Experiential Attitudes*

<table>
<thead>
<tr>
<th>Experiential Attitudes</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Positive</strong></td>
<td></td>
</tr>
<tr>
<td>Helpful</td>
<td>57</td>
</tr>
<tr>
<td>They were empowering the patient</td>
<td>43</td>
</tr>
<tr>
<td>Supportive</td>
<td>34</td>
</tr>
<tr>
<td>They are making a difference</td>
<td>26</td>
</tr>
<tr>
<td>Empathy</td>
<td>23</td>
</tr>
<tr>
<td>Comfortable</td>
<td>20</td>
</tr>
<tr>
<td>Enlightening with regard to patient care</td>
<td>20</td>
</tr>
<tr>
<td><strong>Negative</strong></td>
<td></td>
</tr>
<tr>
<td>Emotional</td>
<td>40</td>
</tr>
<tr>
<td>Sad</td>
<td>40</td>
</tr>
<tr>
<td>Angry</td>
<td>37</td>
</tr>
<tr>
<td>Helpless</td>
<td>28</td>
</tr>
<tr>
<td>Fearful for the patient</td>
<td>26</td>
</tr>
<tr>
<td>Depressed</td>
<td>20</td>
</tr>
<tr>
<td>Uncomfortable</td>
<td>20</td>
</tr>
</tbody>
</table>
Negative Experiential Attitudes. Participants indicated that it was easier to identify negative adjectives to describe their feelings regarding screening. They described feeling: emotional (40%); sad (40%); angry (37%); helpless (28%); fearful for the patient (26%); depressed (20%); and uncomfortable (20%).

RQ 2: What are Barbadian HCPs’ perceived norms – injunctive and descriptive - regarding screening adult female patients for IPV during clinical visits?

Injunctive Norms. Responses to the question who would approve or disapprove of practitioners indicated more variation in terms of identifying groups who would approve, than in those who would disapprove. As shown in Table 4, participants indicated that the following groups would approve of screening: ministry of health (68%); colleagues (66%); patients themselves (31%); the SAVE Foundation (domestic violence hotline and advocacy non-governmental organization (NGO); religious groups (28%); women’s groups 26% and the police 23%. Only two responses for “who would disapprove” met the threshold for inclusion. Participants indicated that men perpetrating abuse would disapprove (57%) and “no one” would disapprove (20%).

Table 4

<table>
<thead>
<tr>
<th>Salient Injunctive Norms (Normative referents)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Approve</strong></td>
</tr>
<tr>
<td>Ministry of health</td>
</tr>
<tr>
<td>Colleagues</td>
</tr>
<tr>
<td>Patients themselves</td>
</tr>
<tr>
<td>SAVE Foundation</td>
</tr>
<tr>
<td>Religious groups</td>
</tr>
<tr>
<td>Women’s groups</td>
</tr>
<tr>
<td>Police</td>
</tr>
<tr>
<td><strong>Disapprove</strong></td>
</tr>
<tr>
<td>Men perpetrating DV</td>
</tr>
<tr>
<td>No one</td>
</tr>
</tbody>
</table>
Given that there were only three practitioner types under study, three questions – one per practitioner type – were asked about the likelihood of each group performing screening, to determine descriptive norms. The inclusion of the three questions allowed for practitioners to indicate the degree to which they believed other primary care practitioners – with similar, and different credentials (e.g. physicians compared to physicians, and nurses compared to dentists) were likely to screen women for DV.

**RQ 3: What are Barbadian HCPs’ beliefs regarding personal agency - perceived behavioral control and self-efficacy – with regard to screening adult female patients for IPV during clinical visits?**

*Self-Efficacy and Perceived Control – Positive Factors.* Participants identified the following personal and institutional factors as making it easier to perform screening for DV: training on DV (57%); having privacy during patient visits (45%); having written protocols and policies for DV (40%); having an assessment tool for DV screening (26%); knowing what to do next after a positive screen (23%); and having a dedicated social worker on site (20%). Results for modal salient beliefs for these constructs are presented together in Table 5.

*Self-Efficacy and Perceived Control – Negative Factors.* The following were identified by participants as the factors that make it difficult for them to perform screenings: time constraints (54%); inadequate staffing (37%); partner present at visit (25%); security concerns related to retaliation by partner (23%); lack of staff specifically trained and dedicated to work with DV (20%). Of the factors which would make it easier, or more difficult to perform screenings, the majority were institution-related. Only two items that could be considered personal or self-efficacy were cited by the minimum percentage of participants for inclusion (training and knowing what to do after a positive screen).
Table 5

Salient Beliefs – Self-Efficacy & Perceived Control

<table>
<thead>
<tr>
<th>Enabling</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training on DV</td>
<td>57</td>
</tr>
<tr>
<td>Knowing what to do next after a positive screen</td>
<td>23</td>
</tr>
<tr>
<td>Having privacy during patient visits</td>
<td>45</td>
</tr>
<tr>
<td>Having written protocols and policies for DV</td>
<td>40</td>
</tr>
<tr>
<td>Having an assessment tool for DV screening</td>
<td>26</td>
</tr>
<tr>
<td>Having a dedicated social worker on site</td>
<td>20</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inhibiting</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Time constraints</td>
<td>54</td>
</tr>
<tr>
<td>Inadequate staffing</td>
<td>37</td>
</tr>
<tr>
<td>Partner present at visit</td>
<td>20</td>
</tr>
<tr>
<td>Security concerns related to retaliation by partner</td>
<td>23</td>
</tr>
<tr>
<td>Lack of staff specifically dedicated to work with DV patients</td>
<td>20</td>
</tr>
</tbody>
</table>

Each of the salient modal responses for each construct were rendered as items in the final questionnaire. The instructions for these respective sections stated that they were based on interviews with Barbadian primary care professionals, and asked respondents to indicate the degree to which they agreed or disagreed with each statement. An overarching question was asked, and each indirect measure included as a separate item within the question. For example, “Screening women for domestic violence during office visits is beneficial because: a) it helps determine the prevalence of the problem in the community,” b) It improves patient management. Each item corresponded with a 5-point Likert scale response set from “strongly disagree” to “strongly agree.”

Phase 2: Survey Results

Survey Responses. Of 359 surveys distributed, a total of 176 HCPs completed the self-administered surveys. This represents an overall response rate of 49%. Data were entered into
the Statistical Package for Social Sciences (SPSS) 26 for analysis. When examined by setting type, the response rate was higher for public practitioners at 65% (n = 159), versus private practitioners at 30% (n = 200).

**Item-nonresponse.** The data were cleaned and checked for errors by examining variable descriptives. Incorrect or missing values associated with data entry errors were corrected. Item non-response was accounted for by assigning discrete missing values to questions for which respondents recorded no entry (9, -99), or which they legitimately skipped (-88). Of note are the coding instructions for the ATSI’s “self-reported assessment behaviors” scale, which is a major operational variable, used as a measure of “frequency of DV inquiry, (FDVI)” for the present study. The instructions called for items responded to as “not applicable” to be coded as missing.

According to Dong and Peng (2013), a missing values rate of 15 to 20% is normal for social science research. A missing values analysis was conducted and found that the overwhelming majority of the survey items with numerical responses (92%; n = 167) had a missing value. One item (question 92) was a contingency question with 43% missing values. This item asked respondents to identify the victim, if they indicated in the previous item (question 91) that they knew someone who had experienced DV (“If you answered yes to question 91, please indicate which” followed by a response set of “close friend, family member or both”). Of the total missing value percentage for this item, 40% were legitimate-missing (after responding “no” to question 91) and only 3% were user-missing. Table 6 shows questions with missing values over 20%. Four survey items asked about the venues in which training was received, and each of these items had a corresponding contingency item (asking the number of hours of training for each venue (four items). Only one of the venue questions had a missing value rate above the 20% threshold: the Barbados Ministry of Health training – 22%.
Table 6

*Missing Values > 20% (n = 176)*

<table>
<thead>
<tr>
<th>Item</th>
<th>User Missing</th>
<th>Legitimate Missing</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you answered yes to question 91, please indicate which</td>
<td>3%</td>
<td>40%</td>
</tr>
<tr>
<td><strong>DV training venue:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Barbados Ministry of Health training</td>
<td>22%</td>
<td>-</td>
</tr>
<tr>
<td><strong>DV training # of hours</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional education</td>
<td>38%</td>
<td>53%</td>
</tr>
<tr>
<td>Post-grad or specialty training</td>
<td>38%</td>
<td>55%</td>
</tr>
<tr>
<td>Conferences or continuing education</td>
<td>39%</td>
<td>51%</td>
</tr>
<tr>
<td>Barbados Ministry of Health training</td>
<td>27%</td>
<td>72%</td>
</tr>
<tr>
<td><strong>How many times did you ask about DV when seeing:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injuries (bruises, lacerations, etc.)</td>
<td>1%</td>
<td>36%</td>
</tr>
<tr>
<td>Chronic pelvic pain</td>
<td>1%</td>
<td>34%</td>
</tr>
<tr>
<td>Irritable bowel syndrome</td>
<td>1%</td>
<td>41%</td>
</tr>
<tr>
<td>Headaches</td>
<td>1%</td>
<td>20%</td>
</tr>
<tr>
<td>Depression/anxiety</td>
<td>1%</td>
<td>24%</td>
</tr>
<tr>
<td>Routine health maintenance exam</td>
<td>1%</td>
<td>21%</td>
</tr>
<tr>
<td>Prenatal care</td>
<td>1%</td>
<td>31%</td>
</tr>
</tbody>
</table>

Each of the corresponding contingency items asking the number of hours of training however, recorded the highest total percentage of missing values. These were: professional education at 91% (38% user-missing, and 53% legitimate missing); post-grad or specialty training at 93% (38% user-missing, and 55% legitimate missing); conferences or continuing education at 90% (39% user-missing and 51% legitimate-missing); and Barbados Ministry of health at 99% (27% user-missing and 72% legitimate-missing).

The FDVI items recorded extremely low item-nonresponse. Each item indicated that only 1% of respondents did not provide an answer regarding the conditions presented. Legitimate skip percentages ranged from 20-41%. Given the low proportion of missing values due to
respondents skipping questions deliberately or inadvertently, missing values were excluded pairwise for the study’s bivariate and multivariate analyses. This maximized sample size (Pallant, 2016) and resulted in varying “n” values, based on the type of analysis.

**Sample Demographics.** As detailed in Tables 7 and 8, the sample was predominantly female (76%), with an average age of 47 ($SD = 11.7$). Physicians were the majority practitioner type (46%), and most respondents practiced in a polyclinic or public clinic setting (58%). On average, respondents had been practicing in their respective specialties for 14.7 years ($SD = 11.6$). Forty-two per cent of respondents indicated that their parents had completed a Master’s degree or higher, Nearly three-quarters of HCPs (70%) indicated they had received at least part of their professional training in Barbados, with only 8% indicating that they completed their professional training exclusively in the United Kingdom, Canada or the United States. The remaining 22% completed their professional training in Jamaica and or Trinidad and Tobago.

**Domestic Violence Victimization/Exposure.** As outlined in Table 7, over a third of respondents (36%) indicated personally having been subjected to at least one form of domestic violence by an intimate partner, while 5% were unsure if they had been emotionally abused (verbally threatened or controlled by a partner). Emotional abuse was reported more frequently than physical abuse (33% versus 19%). Not included in the table is that 12% of participants indicated they had ever been emotionally abusive to an intimate partner, while 8% were unsure. Eight percent of respondents indicated that they had been physically abusive.

Over half of respondents (57%) indicated that they knew of a close friend or family member who had been abused, and 13% were unsure. As a percentage of the total sample, 26% of respondents indicated they knew a family member who had been abused, and 16% indicated they knew both a family member and a friend who had experienced abuse.
Table 7

**Descriptive Characteristics (n= 176)**

<table>
<thead>
<tr>
<th>Variable</th>
<th>(%)</th>
<th>(freq.)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>76</td>
<td>133</td>
</tr>
<tr>
<td>Male</td>
<td>22</td>
<td>39</td>
</tr>
<tr>
<td><strong>Parent’s Highest Level of Schooling</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Up to Secondary</td>
<td>22</td>
<td>38</td>
</tr>
<tr>
<td>Post-graduate to Bachelor’s degree</td>
<td>34</td>
<td>59</td>
</tr>
<tr>
<td>Master’s degree and higher</td>
<td>42</td>
<td>73</td>
</tr>
<tr>
<td><strong>Practice Role Practice</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Professionals</td>
<td>42</td>
<td>72</td>
</tr>
<tr>
<td>Physicians</td>
<td>46</td>
<td>81</td>
</tr>
<tr>
<td>Dental Professionals</td>
<td>12</td>
<td>21</td>
</tr>
<tr>
<td><strong>Practice Setting</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public</td>
<td>58</td>
<td>103</td>
</tr>
<tr>
<td>Private Practice</td>
<td>40</td>
<td>71</td>
</tr>
<tr>
<td><strong>Personal Experience with Abuse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotionally Abused</td>
<td>33</td>
<td>58</td>
</tr>
<tr>
<td>Physically Abused</td>
<td>19</td>
<td>34</td>
</tr>
<tr>
<td>Any abuse</td>
<td>36</td>
<td>63</td>
</tr>
<tr>
<td><strong>Knowledge of Abuse Victim</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>57</td>
<td>101</td>
</tr>
<tr>
<td>Unsure</td>
<td>13</td>
<td>23</td>
</tr>
<tr>
<td>Family</td>
<td>26</td>
<td>46</td>
</tr>
<tr>
<td>Close Friend</td>
<td>15</td>
<td>26</td>
</tr>
<tr>
<td>Both</td>
<td>16</td>
<td>28</td>
</tr>
<tr>
<td><strong>DV Training Received</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>During Professional Education</td>
<td>35</td>
<td>62</td>
</tr>
<tr>
<td>During Post-graduate or Specialty Training</td>
<td>26</td>
<td>45</td>
</tr>
<tr>
<td>Conferences or Continuing Education</td>
<td>37</td>
<td>65</td>
</tr>
<tr>
<td>Ministry of Health DV Training</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Any training</td>
<td>59</td>
<td>104</td>
</tr>
</tbody>
</table>
In the subset of respondents who reported knowing someone who had been abused \((n = 101)\), the percentage increases to 46% who knew of a family member being abused, and 28% who knew both a close friend and family member who had experienced abuse.

**Domestic Violence Training:** In terms of DV training, 59% of respondents indicated they had received DV training in at least one of four (4) venues – during their professional education, during their post-graduate or specialty training, at conferences or continuing education courses, and the Barbados Ministry of Health DV training. Most respondents indicated receiving their training through conferences and continuing education (37%), and during their professional education (35%). Table 8 shows that of those who reported the number of DV training hours they had received, those who attended conferences and continuing education completed the largest number of training hours on average, \((M = 9.6, SD = 11.9)\), followed by those who reported completing training as part of their professional education \((M = 5.28, SD = 5.6)\). Most either did not indicate their hours or wrote on the survey that they “don’t remember” how many hours of training they received.

**Table 8**

*Descriptive Characteristics (Cont’d)*

<table>
<thead>
<tr>
<th></th>
<th>(n)</th>
<th>((M))</th>
<th>((SD))</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>166</td>
<td>47.1</td>
<td>11.7</td>
<td>24 - 80</td>
</tr>
<tr>
<td>Years Practicing in Specialty</td>
<td>160</td>
<td>14.7</td>
<td>11.6</td>
<td>1 - 54</td>
</tr>
<tr>
<td><strong>DV Training Hours</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional Education</td>
<td>16</td>
<td>5.28</td>
<td>5.6</td>
<td>1 - 20</td>
</tr>
<tr>
<td>Post-graduate/specialty training</td>
<td>12</td>
<td>5.0</td>
<td>5.5</td>
<td>1 - 20</td>
</tr>
<tr>
<td>Conferences/Continuing Ed.</td>
<td>18</td>
<td>9.6</td>
<td>11.9</td>
<td>2 - 40</td>
</tr>
<tr>
<td>Ministry of Health training</td>
<td>2</td>
<td>3.0</td>
<td>1.4</td>
<td>2 - 4</td>
</tr>
</tbody>
</table>
Identification of DV & DV Management. Several questions in the survey assessed respondents’ opinion of DV prevalence, their own history of identifying DV, and the existence of guidelines within their respective practice settings for managing DV. These are outlined in Table 9.

Table 9

DV Identification and Management (n = 176)

<table>
<thead>
<tr>
<th>Variable</th>
<th>(%)</th>
<th>(freq.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DV in my practice is:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very Rare</td>
<td>8</td>
<td>15</td>
</tr>
<tr>
<td>Rare</td>
<td>48</td>
<td>85</td>
</tr>
<tr>
<td>Somewhat Common</td>
<td>30</td>
<td>52</td>
</tr>
<tr>
<td>Common</td>
<td>9</td>
<td>16</td>
</tr>
<tr>
<td>Very Common</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>DV in the primary care system on the whole is:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very Rare</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Rare</td>
<td>14</td>
<td>24</td>
</tr>
<tr>
<td>Somewhat Common</td>
<td>51</td>
<td>90</td>
</tr>
<tr>
<td>Common</td>
<td>25</td>
<td>44</td>
</tr>
<tr>
<td>Very Common</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Ever identified a patient who was a victim of DV:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>80</td>
<td>140</td>
</tr>
<tr>
<td>No</td>
<td>16</td>
<td>29</td>
</tr>
<tr>
<td>Unsure</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Number of DV victims you identified in the past year:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>33</td>
<td>58</td>
</tr>
<tr>
<td>1-5</td>
<td>55</td>
<td>97</td>
</tr>
<tr>
<td>6-10</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td>11-20</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>&gt;20</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Practice has written guidelines for DV management:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>8</td>
<td>14</td>
</tr>
<tr>
<td>No</td>
<td>70</td>
<td>124</td>
</tr>
<tr>
<td>Unsure</td>
<td>19</td>
<td>34</td>
</tr>
<tr>
<td>Do you think you need more training on DV?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>91</td>
<td>160</td>
</tr>
<tr>
<td>No</td>
<td>5</td>
<td>9</td>
</tr>
</tbody>
</table>
The majority of respondents - 56% - reported DV in their practice as rare or very rare. However, 51% of respondents indicated their belief that DV in the primary care system on the whole is somewhat common, and another 28% said it is common or very common. In terms of their practice experience, 80% of respondents indicated that they had ever identified a patient who was a victim of DV. In the past year, more than half (57%) indicated having identified 1-5 victims, while a 33% had not identified any such patients. Nine per cent of respondents had identified 6 or more patients who experienced DV. Regarding DV management, 70% reported that there were no written guidelines for detection and management of DV in their practice. One survey item that assessed views on universal DV screening (not included in the table above), but which does bear upon management of DV, was “all women should be screened for domestic violence, not just those presenting obvious signs of abuse.” Fifty-five percent of respondents agreed or strongly agreed with this statement. Finally, in response to the question regarding whether they need more training on DV, 91% of respondents said “yes.”

**Dependent Variables**

**Screening Intention**

The major dependent variable for the study and for research question 4, is screening intention. The single 5-point Likert-scale item with anchors “Not at all” to “Extremely,” asked HCPs “How likely are you to screen women for DV in the next 12 months?” As shown below in Table 10, the majority (57%, n = 172) indicated that they would be “moderately” to “extremely” likely to screen women for DV in the next 12 months. For the purpose of analysis, the variable was collapsed into dichotomous groups of “Not at all/Only slightly likely” and “Moderately to Extremely likely” to screen.
Table 10

*Screening Intention (n = 172)*

<table>
<thead>
<tr>
<th>Response Options</th>
<th>%</th>
<th>freq.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Only Slightly</td>
<td>37</td>
<td>64</td>
</tr>
<tr>
<td>Moderately</td>
<td>35</td>
<td>60</td>
</tr>
<tr>
<td>Quite a bit</td>
<td>18</td>
<td>31</td>
</tr>
<tr>
<td>Extremely</td>
<td>4</td>
<td>7</td>
</tr>
</tbody>
</table>

**Frequency of DV Inquiry.**

Frequency of DV Inquiry was assessed using the “self-reported assessment behaviors” scale from the ATSI (Nicolaidis, 2005). The scale consisted of 8 items, asking respondents how often they inquired about the possibility of DV when presented with selected clinical conditions in the past month. One item (coronary artery disease) assessed social desirability bias, and was excluded from the final scores, as were “N/A” responses which were treated as missing, as noted in the beginning of the chapter. As a result, only the responses for those who encountered the conditions in question will be presented in Table 11.

Scale items were summed and divided by the total number of items completed by each respondent, with scores ranging from 1 – 5. Descriptive statistics indicated a mean of 2.2 and a standard deviation of .92. The scale’s reliability was tested, and the Cronbach alpha (α) for the entire scale was determined to be .85, which is a very good level of internal consistency (Nunnally, 1978, Ursachi, Horodnic & Zait, 2015). Tests of normality indicated that the distribution was positively skewed. After square root and logarithm transformations were attempted, however, the distribution remained skewed.
### Table 11

**Frequency of DV Inquiry (FDVI)**

<table>
<thead>
<tr>
<th>Condition</th>
<th>(n)</th>
<th>Never</th>
<th>Seldom</th>
<th>Sometimes</th>
<th>Nearly Always</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injuries (bruises, lacerations, etc.)</td>
<td>111</td>
<td>11%</td>
<td>12%</td>
<td>27%</td>
<td>22%</td>
<td>29%</td>
</tr>
<tr>
<td>Chronic pelvic pain</td>
<td>116</td>
<td>40%</td>
<td>32%</td>
<td>17%</td>
<td>9%</td>
<td>2%</td>
</tr>
<tr>
<td>Irritable bowel syndrome</td>
<td>102</td>
<td>51%</td>
<td>36%</td>
<td>10%</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>Headaches</td>
<td>140</td>
<td>37%</td>
<td>27%</td>
<td>24%</td>
<td>8%</td>
<td>4%</td>
</tr>
<tr>
<td>Depression/anxiety</td>
<td>131</td>
<td>19%</td>
<td>18%</td>
<td>34%</td>
<td>23%</td>
<td>7%</td>
</tr>
<tr>
<td>Routine health exam</td>
<td>137</td>
<td>53%</td>
<td>22%</td>
<td>20%</td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td>Prenatal care</td>
<td>120</td>
<td>45%</td>
<td>28%</td>
<td>18%</td>
<td>6%</td>
<td>5%</td>
</tr>
</tbody>
</table>

α = .85, M = 2.2, SD = .92, Mode = 1

Consequently, the variable was collapsed into an evenly distributed dichotomous variable; the variable compared those above and below the median value for DV inquiry ($M \leq 2.14$ and $M \geq 2.15$). Chi-square tests of independence were conducted to assess the four hypotheses. Given the assumption of association of past screening behavior with behavioral screening intention indicated in the literature, mean scores on the scale were compared to HCPs’ self-reported screening intention.

As shown in Table 11, screening frequency varied by medical condition of the patients seeking healthcare from a provider. Descriptively, the majority of respondents (51%, $n = 111$) asked about DV when encountering injuries nearly always or always, while another 27% asked sometimes. Nearly a third (30%) of HCPs ($n = 131$) reported asking about DV when encountering depression/anxiety nearly always or always, while over a third asked about it sometimes (34%). Three quarters of study participants indicate never or seldom asking about DV in routine health maintenance exams, and nearly three-quarters never or seldom asked about the
possibility of DV in prenatal care. These findings are explored further in addressing our hypotheses in the next section.

Hypothesis Testing

**Research Question 4.** This research question investigated variations in Barbadian HCPs’ screening intention by demographic factors. Specifically, the role of age, gender, experience as a victim of DV, and professional role comprise the four hypotheses that follow. Chi-square tests for independence were performed for each hypothesis to test the association between screening intention and the several demographic variables. Table 12 displays the association outcomes for each hypothesis related to this research question, and the dependent variable, screening intention.

**H4.1:** Younger HCPs (30 years and below) will be more likely to intend to screen women for DV than older HCPs. The original hypothesis was tested, however, given that the sample’s mean and median age were much higher than 30, and there were only 15 participants age 30 or younger, the age variable was collapsed into a dichotomous variable above and below the median age of 47. This grouping was used as the second variable for age. Therefore, we tested two separate age groupings for association with screening intention: 1) Thirty years and below versus those older than 30; and 2) HCPs 47 year and younger, versus those older than 47. The direction of the original hypothesis was maintained, that younger practitioners would be more likely to intend to screen than older HCPs. The chi-square test for independence indicated no significant association between age and screening intention, $\chi^2 (1, n = 164) = .68$, $p = .41$, phi = .06. The test was repeated with the second age grouping and again, no association was found: $\chi^2 (1, n = 164) = .15$, $p = .70$, phi = -.30.
Table 12

**Screening Intention Cross-tabulations**

**Screening Intention**

*How likely are you to screen for DV in the next 12 months?*

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>Not at all/Slightly Likely</th>
<th>Moderately/Extremely Likely</th>
<th>$\chi^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (Hypothesis Grouping)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;=30</td>
<td>164</td>
<td>53%</td>
<td>47%</td>
<td>.68</td>
</tr>
<tr>
<td>30+</td>
<td></td>
<td>42%</td>
<td>58%</td>
<td></td>
</tr>
<tr>
<td><strong>Age (Median)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;=47</td>
<td>164</td>
<td>42%</td>
<td>58%</td>
<td>.15</td>
</tr>
<tr>
<td>48+</td>
<td></td>
<td>45%</td>
<td>55%</td>
<td></td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>170</td>
<td>41%</td>
<td>59%</td>
<td>.69</td>
</tr>
<tr>
<td>Men</td>
<td></td>
<td>49%</td>
<td>51%</td>
<td></td>
</tr>
<tr>
<td><strong>Practitioner Type</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses</td>
<td>148</td>
<td>40%</td>
<td>60%</td>
<td>.04</td>
</tr>
<tr>
<td>Physicians</td>
<td></td>
<td>42%</td>
<td>58%</td>
<td></td>
</tr>
<tr>
<td><strong>Experienced DV (Emotional)</strong></td>
<td>167</td>
<td>41%</td>
<td>59%</td>
<td>.05</td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td>43%</td>
<td>57%</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Experienced DV (Physical)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>167</td>
<td>26%</td>
<td>74%</td>
<td>4.82*</td>
</tr>
<tr>
<td>No</td>
<td></td>
<td>47%</td>
<td>53%</td>
<td></td>
</tr>
<tr>
<td><strong>Frequency of DV Inquiry</strong></td>
<td>144</td>
<td>48%</td>
<td>52%</td>
<td>6.03*</td>
</tr>
<tr>
<td>$M = &lt;=2.14$</td>
<td></td>
<td>28%</td>
<td>72%</td>
<td></td>
</tr>
<tr>
<td>$M = 2.15+$</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ever Identified DV</strong></td>
<td>168</td>
<td>40%</td>
<td>60%</td>
<td>4.08*</td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td>59%</td>
<td>41%</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Victim of either form of DV</strong></td>
<td>170</td>
<td>40%</td>
<td>60%</td>
<td>.434</td>
</tr>
<tr>
<td>Abused</td>
<td></td>
<td>45%</td>
<td>55%</td>
<td></td>
</tr>
<tr>
<td>Not abused</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p<.05, df = 1.*
**H₄.2: Female HCPs will be more likely to intend to screen women for DV than male HCPs.** While women indicated a greater screening intention than men (59% versus 51%), the chi-square test for independence indicated no significant association between gender and screening intention, χ²(1, n = 170) = .69, p = .41, phi = .06.

**H₄.3 – Irrespective of gender, HCPs with personal experience of DV will be more likely to intend to screen women for DV than those with no experience with DV.** Screening intention and experience as a victim of DV were assessed separately for emotional and physical violence. Crosstabs were also calculated for screening intention based on being a victim of either form of violence.

Although reported by a larger number of respondents than physical violence (n = 58 versus n = 34), there was no significant association indicated between emotional violence and screening intention, χ²(1, n = 167) = .05, p = .83, phi = .02. In terms of physical abuse, 74% of those who experienced abuse versus 53% of those who had not, indicated they were moderately to extremely likely to screen women in the next 12 months. This was a significant association at the .05 level, χ²(1, n = 167) = 4.82, p = .03, phi = .17. No association was found for screening intention based on being a victim of either form of violence: χ²(1, n = 170) = .43, p = .51, phi = .05. When gender was factored in (i.e., when crosstabs were stratified by gender), there was no significant difference in screening intention for male HCPs who had been abused versus those who had not. However, among female HCPs, the crosstabulation indicated a significant difference at the .05 level in being moderately to extremely likely to screen women in the next 12 months. Female HCPs who had been physically abused were more likely to intend to screen than Female HCPs who had not been physically abused (74% versus 55%), χ²(1, n = 166) = 3.72, p = .05, phi = .17.
**H4.4** – Nurses will be more likely to intend to screen women for DV than physicians.

The chi-square test for independence assessing the relationship between practitioner role and screening intention found no significant association between the two variables: $\chi^2 (1, n = 148) = .04$, $p = .84$, phi = -.02.

**Past Screening Behavior.** As noted previously, past behavior is seen as a gauge of future behavioral intent according to the IBM, although this relationship is not guaranteed. Consequently, two of the items in the survey assessing past screening behavior were tested for association with screening intention: having ever identified a victim of DV, and the score on the frequency of DV inquiry (FDVI) scale. Both of these items are included above in Table 11 and were found to be significantly associated with screening intention at the .05 level. HCPs who had ever identified a victim of DV were more likely to intend to screen - 60% versus 41% - than those who had not, $\chi^2 (1, n = 168) = 4.08$, $p = .04$, phi = .16. Additionally, HCPs with a score above the median on the FDVI scale were more likely - 72% versus 52% - to intend to screen women for DV in the next 12 months, $\chi^2 (1, n = 144) = 6.03$, $p = .01$, phi = .20.

**Research Question 5.** This research question investigated variations in Barbadian HCPs’ self-reported DV screening behavior (as opposed to screening intention) by demographic factors. As with H4.1, the original hypothesis was tested, despite the sample’s

**H5.1** – Younger HCPs (30 years and below) will be more likely to have screened women for DV than older HCPs. As with H4.1, the original hypothesis was tested, despite the sample’s
mean and median age being higher than 30, and only 15 participants indicating they were age 30 or younger. Age was again collapsed into a second dichotomous variable above and below the median age of 47 and the crosstab was conducted with both age groupings.

**Table 13**

*Frequency of DV Inquiry Scale Crosstabs*

<table>
<thead>
<tr>
<th>“How often have you inquired about DV when seeing any of the [listed] conditions in the past 30 days”</th>
<th>n</th>
<th>( M \leq 2.14 )</th>
<th>( M \geq 2.15+ )</th>
<th>( \chi^2 )</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (Hypothesis Grouping)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;=30</td>
<td>138</td>
<td>53%</td>
<td>47%</td>
<td>.26</td>
</tr>
<tr>
<td>30+</td>
<td></td>
<td>46%</td>
<td>54%</td>
<td></td>
</tr>
<tr>
<td><strong>Age (Median)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;=47</td>
<td>138</td>
<td>55%</td>
<td>45%</td>
<td>4.52*</td>
</tr>
<tr>
<td>48+</td>
<td></td>
<td>37%</td>
<td>63%</td>
<td></td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>143</td>
<td>49%</td>
<td>51%</td>
<td>.12</td>
</tr>
<tr>
<td>Men</td>
<td></td>
<td>46%</td>
<td>54%</td>
<td></td>
</tr>
<tr>
<td><strong>Practitioner Type</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses</td>
<td>129</td>
<td>49%</td>
<td>51%</td>
<td>.80</td>
</tr>
<tr>
<td>Physicians</td>
<td></td>
<td>41%</td>
<td>59%</td>
<td></td>
</tr>
<tr>
<td><strong>Experienced DV (emotional)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>141</td>
<td>48%</td>
<td>52%</td>
<td>.04</td>
</tr>
<tr>
<td>No</td>
<td></td>
<td>46%</td>
<td>54%</td>
<td></td>
</tr>
<tr>
<td><strong>Experienced DV (physical)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>142</td>
<td>48%</td>
<td>52%</td>
<td>.001</td>
</tr>
<tr>
<td>No</td>
<td></td>
<td>49%</td>
<td>51%</td>
<td></td>
</tr>
<tr>
<td><strong>Experienced either form of abuse</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abused</td>
<td>144</td>
<td>50%</td>
<td>50%</td>
<td>.15</td>
</tr>
<tr>
<td>Not abused</td>
<td></td>
<td>47%</td>
<td>53%</td>
<td></td>
</tr>
</tbody>
</table>

*\( p < .05, \ df = 1 \)
The intent of the hypothesis remained the same, that younger practitioners would be more likely to have screened female patients for DV than older HCPs. The chi-square test for independence indicated no significant association between the original age grouping and screening behavior: $\chi^2 (1, n = 138) = .26, p = .61, \phi = .04$. The test was repeated with the second age grouping and a significant relationship was found at the .05 level.

The relationship, however, was in the opposite direction, with those older than the median age of 47 were more likely (63% versus 45%) to have asked about the possibility of DV when encountering selected clinical conditions: $\chi^2 (1, n = 138) = 4.52, p = .03, \phi = .18$. When stratified by gender, a significant association at the .05 level was found among men. Older men were twice as likely as younger men – 70% versus 33% – to have higher past screening scores: $\chi^2 (1, n = 138) = 4.64, p = .03, \phi = .36$.

**H5.2 – Female HCPs will be more likely to have screened women for DV than male HCPs.** While men reported a greater incidence of past screening behavior than women, the chi-square test for independence indicated no significant association between gender and past screening behavior: $\chi^2 (1, n = 143) = .12, p = .73, \phi = -.03$.

**H5.3 – Irrespective of gender, HCPs with personal experience as a victim of DV will be more likely to have screened than those with no experience with DV.** Experience as a victim of domestic violence were assessed separately for emotional and physical violence. Crosstabs were also calculated for past screening behavior based on being a victim of either form of violence. Chi-square tests for independence indicated no significant association for either form of abuse: emotional - $\chi^2 (1, n = 141) = .04, p = .83, \phi = -.02$; physical - $\chi^2 (1, n = 142) = .001, p = .98, \phi = .002$. No association was found for past screening behavior based on being a victim of either form of violence: $\chi^2 (1, n = 144) = .15, p = .70, \phi = -.03$.
**H5.4**– Nurses will be more likely to have screened women for DV than physicians. Although physicians reported higher levels of screening behavior, chi-square tests for independence indicated no significant association between practitioner type and past screening behavior: $\chi^2(1, n = 129) = .80, p = .37, \phi = .08$.

Because the dependent variable for research question 5, Frequency of DV Inquiry (FDVI), is a continuous variable, an independent samples t-test was also computed to compare the mean FDVI scores of each paired group in their respective hypothesis. There was no significant difference in scores for gender, practitioner type, or personally experiencing DV. The only comparison that neared but did not reach statistical significance at the .05 level, was the dichotomous age grouping - <=47, and 48+. Mean scores for younger respondents ($M = 2.08, SD = .88$) and older respondents ($M = 2.36, SD = .93$; $t(127) = -1.7, p = .08$, two-tailed. The magnitude of the differences in the means (mean difference -.27, 95% CI: -.58 to .04) was small (eta squared = .02).

**Research Question 6.** This question explores the difference in prior self-reported screening behavior by participation in the Ministry of Health’s DV training program. This question had one hypothesis as noted below. A chi-square test for independence was performed to test the association between past screening behavior and receipt of DV training. Table 14 shows the findings of the crosstabs computation for this question’s hypothesis.

**H6.1 Barbadian HCPs who have participated in the pilot DV protocol training will be more likely to have screened adult women for DV than Barbadian HCPs who have not received such training.** This hypothesis was modified given that only 10 participants indicated that they had participated in the Ministry of Health training. The hypothesis was expanded to
include HCPs who had completed DV training in any venue, and still posited that those who had received training would be more likely to have reported screening women for domestic violence.

**Table 14**

*DV Training and Past Screening Behavior*

<table>
<thead>
<tr>
<th>Completed DV Training</th>
<th>Frequency of DV Inquiry</th>
<th>$\chi^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trained</td>
<td>$41%$</td>
<td>$59%$</td>
</tr>
<tr>
<td>Not Trained</td>
<td>$59%$</td>
<td>$41%$</td>
</tr>
</tbody>
</table>

$n = 140$, $M = \leq 2.14$, $M = 2.15+$

* $p < .05$, $df = 1$

A new dichotomous variable was created, reflecting either having received training or not, and compared with the dichotomous FDVI variable. The results are shown above in Table 14. Chi-square tests for independence indicated a significant relationship at the .05 level between past screening behavior and receiving DV training: $\chi^2 (1, n = 140) = .439$, $p = .04$, $phi = .18$.

**KAB, ATSI & IBM – Scale Reliability.** Before addressing the final two research questions, an exploration of the subscales in the questionnaire is necessary. Scales from the Providers Knowledge Attitudes and Beliefs or “KAB” (Group Health Cooperative & Harborview Injury Prevention and Research Center, 1997) and the Attitudes Toward Survivors of Intimate Partner Violence or “ATSI” (Nicolaidis, 2005) were included in the questionnaire. These validated instruments featured good to excellent internal consistency, and were used to assess a range of knowledge, attitudes and behaviors not fully captured by the IBM’s constructs. Given that question items from the original instruments which irrelevant to the present study (e.g. questions regarding domestic violence between same sex partners, and regarding the batterer)
were excluded, the scales’ reliability was re-assessed. IBM scales were also assessed for internal consistency reliability, overall distribution, and normality prior to further statistical analysis.

Table 15 below indicates the reliability and descriptive statistics for each subscale in the current study. In their original composition, the Cronbach’s alpha for the KAB subscales range from 0.73 to 0.91, and The ATSI’s Cronbach’s alpha for its subscales ranged from 0.68 to 0.92 (Maiuro et al., 2000; Nicolaidis, Curry & Gerrity, 2005). Each had acceptable internal consistency between α = .60 and α = .86 (Ursachi, Horodnic & Zait, 2015). Only one scale (the subjective norm scale of the IBM) featured a question with a negative item total correlation; this item (which assessed whether perpetrators would approve of DV screening) was removed from scale for further analyses.

Table 15

<table>
<thead>
<tr>
<th>Scales</th>
<th>Total Items</th>
<th>α</th>
<th>n</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>KAB</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perceived Self-Efficacy</td>
<td>5</td>
<td>.75</td>
<td>164</td>
<td>3.43</td>
<td>.62</td>
</tr>
<tr>
<td>Blame Victim</td>
<td>8</td>
<td>.78</td>
<td>170</td>
<td>1.97</td>
<td>.53</td>
</tr>
<tr>
<td>System Support</td>
<td>6</td>
<td>.62</td>
<td>167</td>
<td>3.02</td>
<td>.60</td>
</tr>
<tr>
<td>Professional Role Resistance/Fear of Offending Patient</td>
<td>10</td>
<td>.83</td>
<td>168</td>
<td>2.25</td>
<td>.55</td>
</tr>
<tr>
<td><strong>ATSI</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responsibility to assess for IPV</td>
<td>3</td>
<td>.60</td>
<td>171</td>
<td>3.16</td>
<td>.77</td>
</tr>
<tr>
<td>Responsibility to counsel re: IPV</td>
<td>3</td>
<td>.70</td>
<td>172</td>
<td>4.14</td>
<td>.66</td>
</tr>
<tr>
<td>Respect for Patient Autonomy</td>
<td>2</td>
<td>.60</td>
<td>170</td>
<td>3.61</td>
<td>.92</td>
</tr>
<tr>
<td>Empathy for abused patients</td>
<td>5</td>
<td>.83</td>
<td>170</td>
<td>3.14</td>
<td>.82</td>
</tr>
<tr>
<td>DV Screening Confidence</td>
<td>5</td>
<td>.84</td>
<td>174</td>
<td>2.02</td>
<td>.53</td>
</tr>
<tr>
<td>Perceived Barriers</td>
<td>10</td>
<td>.81</td>
<td>171</td>
<td>3.68</td>
<td>.59</td>
</tr>
<tr>
<td>Knowledge</td>
<td>5</td>
<td>.86</td>
<td>176</td>
<td>2.75</td>
<td>1.18</td>
</tr>
<tr>
<td><strong>IBM</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Instrumental Attitudes</td>
<td>11</td>
<td>.81</td>
<td>169</td>
<td>3.56</td>
<td>.50</td>
</tr>
<tr>
<td>Experiential Attitudes</td>
<td>15</td>
<td>.79</td>
<td>162</td>
<td>3.50</td>
<td>.41</td>
</tr>
<tr>
<td>Injunctive Norms</td>
<td>6</td>
<td>.80</td>
<td>165</td>
<td>3.98</td>
<td>.48</td>
</tr>
<tr>
<td>Descriptive Norms</td>
<td>3</td>
<td>.68</td>
<td>170</td>
<td>2.13</td>
<td>.59</td>
</tr>
<tr>
<td>Perceived Control</td>
<td>12</td>
<td>.68</td>
<td>169</td>
<td>3.41</td>
<td>.43</td>
</tr>
</tbody>
</table>
While the knowledge scale of the ATSI is included, minimal quantitative analyses were run on this measure as the questions are open-ended and coded according to guidance from the instrument’s developer (Nicolaidis, 2005). Respondents received a “score” based on the proximity of their answers to the outlined examples given in the ATSI scoring guide. Full points (4) were awarded for respondents who provided “correct” answers, i.e., when they provided responses inquiring about present or past abuse victimizations, and that included explicit examples of physical or emotional abuse (e.g. hitting, being threatened). Partially correct answers were awarded two points. No points were awarded if questions respondents provided did not educate, when respondents assigned labels to patients (e.g., are “you a victim of abuse”). Of note in the items making up the scale is the lowered mean for the question which asks practitioners how they would screen for violence. Based on the criteria, 45% of respondents received a score of 0, since they provided an incorrect response or no response at all. Where no credit was given, there was a trend of responses that seemed to assess presenting injuries: “how did you get that black eye?” “how long has the abuse been going on?” Another theme that emerged were questions that seemed to build rapport towards asking about DV, such as “How are things going at home?” “Are you happy in your relationship?” These responses align with one of the themes that emerged in the elicitation interviews – that many practitioners indicated that they normally do not ask about abuse unless there is an obvious reason to do so, or if they suspect something is amiss.

While the KAB and ATSI scales were not directly addressed in the study’s research questions, they were included in the study questionnaire as validating measures, and to assess the impact of selected barriers to screening that have been identified in the literature. Tables 16 and 17 show the Pearson product-moment correlations between the scales of the KAB and ATSI, respectively, with the primary dependent variable, screening intention. Preliminary analyses
were conducted to ensure no violations of the assumptions of normality, linearity, and homoscedasticity. Missing values were excluded pairwise.

As shown in Table 16, correlations between the KAB scales and the dependent variable, screening intention, were moderate to strong and reached levels of significance at the $p < .01$ level for three of the four scales. The only exception was the ‘blame victim’ scale which had a small, negative correlation and approached but did not show a significant correlation with screening intention ($r = -14, n = 168; p = .06$). “System support” had a moderate, positive correlation with screening intention ($r = .35, n = 165$). There was a strong negative correlation between “role resistance/fear of offending the patient” and screening intention ($r = -.42, n = 166$).

Table 16

*Pearson Product-moment Correlations: Screening Intention & KAB*

<table>
<thead>
<tr>
<th>Screening Intention</th>
<th>$n$</th>
<th>$r$</th>
</tr>
</thead>
<tbody>
<tr>
<td>System Support</td>
<td>165</td>
<td>.35**</td>
</tr>
<tr>
<td>Blame Victim</td>
<td>168</td>
<td>-.14</td>
</tr>
<tr>
<td>Role Resistance/ Fear of Offending</td>
<td>166</td>
<td>-.42**</td>
</tr>
</tbody>
</table>

** $p < .01$, (2-tailed)**

Table 17 indicates that all but two of the ATSI scales showed small to moderate, but significant correlations with screening intention. The exceptions to this were the “empathy” and “respect for patient autonomy” scales. “Provider responsibility to assess for DV,” and “perceived barriers” were both positively correlated with screening intention ($r = .28, n = 167, p < .01$).
Table 17

*Pearson Product-moment Correlations: Screening Intention & ATSI*

<table>
<thead>
<tr>
<th></th>
<th>$n$</th>
<th>$r$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsibility to Assess for DV</td>
<td>167</td>
<td>.28**</td>
</tr>
<tr>
<td>Perceived Barriers</td>
<td>167</td>
<td>.28**</td>
</tr>
<tr>
<td>DV Screening Confidence</td>
<td>170</td>
<td>.25**</td>
</tr>
<tr>
<td>Responsibility to Counsel re: DV</td>
<td>168</td>
<td>.16*</td>
</tr>
<tr>
<td>Respect for Patient Autonomy</td>
<td>166</td>
<td>.13</td>
</tr>
<tr>
<td>Empathy</td>
<td>166</td>
<td>.11</td>
</tr>
</tbody>
</table>

*p < .05, ** p < .01, (2-tailed)

Because the perceived barriers scale was reverse coded, higher scores indicate lower perceived barriers. “DV screening confidence” was positively correlated with screening intention ($r = .25$, $n = 170$, $p < .01$).

Table 18

*Pearson Product-moment Correlations: Frequency of DV Inquiry & IBM*

<table>
<thead>
<tr>
<th></th>
<th>$n$</th>
<th>$r$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instrumental Attitudes</td>
<td>143</td>
<td>.27**</td>
</tr>
<tr>
<td>Experiential Attitudes</td>
<td>137</td>
<td>.40**</td>
</tr>
<tr>
<td>Injunctive Norms</td>
<td>138</td>
<td>.25**</td>
</tr>
<tr>
<td>Descriptive Norms</td>
<td>144</td>
<td>.13</td>
</tr>
<tr>
<td>Perceived Control</td>
<td>141</td>
<td>.10</td>
</tr>
<tr>
<td>Perceived Self-Efficacy (KAB)</td>
<td>137</td>
<td>.39**</td>
</tr>
</tbody>
</table>

** $p < .01$ (2-tailed)
Table 18 shows the Pearson product-moment correlations between the IBM constructs and the Frequency of DV Inquiry Scale. Four of the constructs indicated small to moderate correlations with FDVI at the $p < .01$ level. The moderate correlation between experiential attitudes and FDVI was highest ($r = .40, n = 137$), followed by perceived self-efficacy ($r = .39, n = 137$).

**RQ 7:** How well does the IBM explain variance in IPV screening intention in Barbadian HCPs? **RQ 8:** What constructs in the IBM (Experiential Attitude, Instrumental Attitude, Injunctive Norm, Descriptive Norm, Perceived Control, and Self Efficacy) are most strongly associated with IPV screening intention in Barbadian HCPs? The final two research questions have no hypotheses but explore the IBM model. A standard multiple regression was conducted to estimate a regression model that best predicts screening intention among primary care HCPs, based on six variables: instrumental attitudes, experiential attitudes, injunctive norm, descriptive norm, perceived control, and perceived self-efficacy. Given that the elicitation interview process did not yield enough questions to measure self-efficacy in a reliable way, the “perceived self-efficacy” scale from the KAB (see Table 15) was added to the model.

Table 19

*Pearson Product-moment Correlations: Screening Intention & IBM Constructs*

<table>
<thead>
<tr>
<th>Scale</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Screening Intention</td>
<td>–</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Instrumental Attitudes</td>
<td>.37**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Experiential Attitudes</td>
<td>.31**</td>
<td>.42**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Descriptive Norms</td>
<td>.21**</td>
<td>.00</td>
<td>.08</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Perceived Control</td>
<td>.16*</td>
<td>.32**</td>
<td>.27**</td>
<td>.01</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Perceived Self-Efficacy</td>
<td>.42**</td>
<td>.50**</td>
<td>.46**</td>
<td>.02</td>
<td>.20**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Injunctive Norms</td>
<td>.26**</td>
<td>.28**</td>
<td>.34**</td>
<td>.08</td>
<td>.28**</td>
<td>.24**</td>
<td></td>
</tr>
</tbody>
</table>

** p < .001, * p < .05 (2-tailed)
Pearson’s product-moment correlations were run with all demographic/background variables to determine any significant association with screening intention beyond that indicated in the crosstabs for research question 4 and related hypotheses. The only two variables which indicated significant correlations with the dependent variable at the p < .05 level were those previously identified as having a significant association through chi-square tests in question 4 (see Table 12). These were: having had DV training from any venue (r = .15, p = .05) and having been physically abused (r = .25, p = .001). These variables were entered as control variables along with FDVI, which, as past behavior, is held to be a predictor by the IBM theory. FDVI was also earlier shown in the chapter through crosstabs to be significantly associated with screening intention, as well as through Pearson’s product moment correlation (r = .27, n = 144, p = .001).

Prior to conducting the regression analyses, preliminary analyses were generated to assess the assumptions of multiple regression (Abu-Bader, 2011; Pallant, 2013). These included descriptive statistics to test normality, linearity, homoscedasticity, multicollinearity, and outliers. Measures of skewness and kurtosis, histograms and Q-Q plots showed the independent variables approaching normality. Additionally, inspection of the both the histogram and normal probability plots of the residuals indicate that the errors were normally distributed. Moreover, inspection of predicted scores against the residuals confirms that the assumption of homoscedasticity was not violated. As shown in Table 19 above, Pearson product-moment correlations were run to assess the level of correlation between the IBM constructs and screening intention. Evaluation of the zero order correlations shows that all the IBM constructs are significantly associated with screening intention. There is also some degree of intercorrelation between the scales.
Nevertheless, model tests - tolerance and VIF values – suggest that these intercorrelations do not cause a problem with multicollinearity.

Table 20 shows the results of the regression model. The three control variables were entered simultaneously into the model at step one, explaining 14% of the variance in screening intention. Having experienced physical violence was a large and significant predictor, accounting for 4% of the variance in the model. Neither of the two remaining control variables – frequency of DV inquiry (p = .44) nor having received DV training (p = .93) were significant after the IBM scales were entered. After entering the six scales at step two, the total variance explained by the model as a whole, including covariates, was 30%, $F (9, 127) = 6.14$, $p < .001$. The six construct variables explained an additional 16% of the variance in screening intention, after controlling for experience with DV, having received DV training, and frequency of DV inquiry (R squared change = .16, $F$ change $(6, 127) = 4.99$, $p <.001$).

Table 20

*Multiple Regression Analysis – Predictors of Screening Intention*

<table>
<thead>
<tr>
<th>Scale</th>
<th>B</th>
<th>Std. Error</th>
<th>$\beta$</th>
<th>$p$</th>
<th>Part Correlation Squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>FDVI</td>
<td>.07</td>
<td>.09</td>
<td>.07</td>
<td>.44</td>
<td>.00</td>
</tr>
<tr>
<td>Experienced DV</td>
<td>.45</td>
<td>.18</td>
<td>.19</td>
<td>.01*</td>
<td>.04</td>
</tr>
<tr>
<td>DV Training</td>
<td>-.13</td>
<td>.16</td>
<td>-.01</td>
<td>.93</td>
<td>.00</td>
</tr>
<tr>
<td>Perceived Self Efficacy</td>
<td>.35</td>
<td>.15</td>
<td>.23</td>
<td>.02*</td>
<td>.03</td>
</tr>
<tr>
<td>Descriptive Norms</td>
<td>.29</td>
<td>.12</td>
<td>.18</td>
<td>.02*</td>
<td>.03</td>
</tr>
<tr>
<td>Instrumental Attitudes</td>
<td>.33</td>
<td>.17</td>
<td>.17</td>
<td>.06</td>
<td>.02</td>
</tr>
<tr>
<td>Injunctive Norms</td>
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<td>Experiential Attitudes</td>
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<td>Perceived Control</td>
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$R = .55$, $R^2 = .30$; $R^2$ Change = .16, $F (6, 127) = 4.99$, $p <.001$
In the final model, two of the IBM constructs were determined to be significant predictors of screening intention. With a beta of .23, (p < .05), perceived self-efficacy was the strongest predictor, followed by descriptive norms with a beta of .18 (p < .05). Instrumental attitudes, with a beta of .17, approached significance (p < .10). The part correlations for each covariate and independent variable were squared to identify the unique variance they contributed to the model. Based on this computation, perceived self-efficacy and descriptive norms each account for 3% of the R square value, and instrumental attitudes account for 2%. None of the remaining constructs – injunctive norms (p = .28), experiential attitudes (p = .52) or perceived control were significant predictors of screening intention after all IVs were entered.

Given the significance level and strength of “experience with DV” as a predictor of screening intention, the responses to the open-ended question “If you or anyone you know has been abused, how has it affected your practice” were also examined. Responses were manually coded and content analyzed, and the most frequently occurring responses tabulated. Of those to whom the question applied (n = 115), n = 34 did not respond; and n = 18 stated that their practice had not been affected. Of those who indicated a positive effect, the most frequent responses were: 1) “increased awareness” of DV (n = 18) – this included awareness of the prevalence of DV, the possibility of DV as a factor impacting patient health, the awareness DV’s often hidden nature, and that anyone could be a victim of DV. A related theme to awareness was “increased vigilance” (n = 5), where participants indicated that they were more observant and alert to patient cues and indicators of violence, and actively looked for them; 2) “increased empathy” for those experiencing violence (n = 16). Related to this theme was participant reports of being “less judgmental” of patients in a violent relationship (n = 5) and “increased sensitivity” in dealing with patients suspected of experiencing DV (n = 4); lastly, participants reported a “commitment
to DV-related care” indicating that they valued screening, educating and counseling as part of good patient management (n = 6).
CHAPTER 5: Discussion

“Communities and countries and ultimately the world, are only as strong as the health of their women.”
~ Michelle Obama

The present study undertook four aims: 1) identify the degree to which primary care HCPs in Barbados screen women for IPV in their practice; 2) determine the attitudes, beliefs, knowledge and screening intention of Barbadian primary care HCPs with regard to IPV; 3) to determine whether HCPs who have received IPV training have different screening practices from those who have not; and 4) to determine which of the Integrated Behavioral Model’s constructs – attitudes, perceived norms, and personal agency - have the greatest influence on Barbadian primary care HCPs’ IPV screening intention. A summary of the key findings for the study’s research questions and related hypotheses supporting these aims will be provided, and discussed in terms of their importance, how they relate to the existing literature on primary care practitioner DV screening, and to the study’s guiding theoretical frames. Future social work research recommendations will be presented, as well as implications for domestic violence policy in healthcare settings, and for social work practice and education in Barbados.

Summary of Key Findings

The present study gave much-needed insight into the factors influencing Barbadian practitioners’ screening behavior and intention related to domestic violence. Analysis of the major dependent variable, screening intention, found nearly two-thirds of Barbadian practitioners expressing moderate to high intention to screen women for domestic violence in the next year. This suggests strong support for domestic violence screening in primary care settings. Research question four, assessing factors influencing screening intention, had two hypotheses out of four supported: practitioners who had personally experienced physical violence, and those who with
past screening behavior (having screened for DV in the past 30 days) were more likely to report positive screening intention. Research question 5, assessing factors influencing past screening behavior, and its related hypothesis that age was negatively associated with screening behavior was not supported. Unexpectedly, we found that age was significantly positively associated with the dependent variable, i.e. older practitioners were more likely to have screened female patients. Research question six had only one hypothesis, and it was supported - completing domestic violence training was significantly associated with past screening behavior. Research questions seven and eight explored the theoretical model and found that IBM constructs were responsible for 30% of the variance in predicting screening intention. The strongest theoretical predictor was perceived self-efficacy, while the strongest predictor of screening intention overall, was having been physically abused. This particular finding is perhaps the greatest takeaway from this study, as it underscores the importance of having those affected by an issue informing the way it is addressed. The implications of these findings will be discussed next, contextualized by several important observations made that are related to screening practices, attitudes and knowledge based on the study’s qualitative and quantitative phases.

**Implications for DV Screening Literature**

Several of the findings from this study affirm the literature on intimate partner violence in primary care settings. This mixed-method study was the first of its kind conducted in Barbados, and the first known to date in the region that has assessed primary care practitioners’ attitudes, beliefs, knowledge, and behaviors related to DV screening. Thus, it contributes to building the knowledge base of the health sector’s response to IPV in low to middle income countries (Ellsberg & Heise, 2005; Hind & Hind, 2014; Garcia-Moreno et al., 2015). In terms of the Barbadian context specifically, the study affirms prior research indicating high rates of exposure
to domestic violence, both directly through personal experience, and indirectly through being acquainted with someone who experienced violence (Handwerker, 1990; LeFranc et al., 2008; Immigration and Refugee Board of Canada, 2009). The finding regarding the role of having experienced personal violence as a predictor of screening intention is a significant contribution to the literature.

**Domestic Violence Screening & Training**

Barbadian practitioners are on par with their counterparts around the world in terms of screening rates but report a much higher rate of training completed. Not surprisingly, Barbadian practitioners report high levels of self-efficacy in relation to screening, and low levels of perceived barriers. The findings from the present study are in accord with the existing literature on training and its relationship to self-efficacy, system support and concerns regarding patient responses to screening (Todahl & Walters, 2011). Completing DV training was not only positively related to screening behavior as found in other studies, (Colarossi, Breitbart & Betancourt, 2010; Schoening, Greenwood, McNichols, Heermann & Agrawal, 2003; Bloom & Tavrow, 2018), but was a significant predictor of it. Barbadian practitioners’ identification of the need for training as the leading personal agency belief was strongly supported in the survey with the overwhelming majority of respondents indicating they felt they needed more training.

**Supportive Attitudes**

Barbadian practitioners expressed many of the concerns of other physicians regarding a lack of confidence regarding communication skills to engage patients. For example, they noted that patients might have strong emotional reactions to being screened for DV, or they may be unable or unwilling to leave the relationship. These responses and patient realities did not however, seem to translate into a sense of powerlessness for Barbadian practitioners as was the
case in other studies (Hamberger & Phelan, 2006; Beynon et al., 2012). Indeed, 87% of respondents actively disagreed, or strongly disagreed with the statement “there is nothing I can do because the patient won’t leave the relationship.” Most Barbadian practitioners, like their counterparts in the literature, are of the view that IPV intervention is part of their role (Djikanovic et al., 2010; Williston & Lafreniere, 2013, Kalra et al., 2017). This is concomitant with low rates of victim-blaming and fear of offending patients. Practitioners’ highest scale scores indicated a strong belief in their responsibility to counsel, and in the beneficial nature of screening, as well as a strong respect for patient autonomy. The practitioner attitudes toward screening which were reported most often in the elicitation interviews were positive. The disadvantages centered on patient reactions to being asked, but overall, practitioners indicated seeing more benefits than disadvantages to screening.

Of particular interest is the salient belief that screening is advantageous because it provides an outlet for patients to talk about abuse, and for practitioners to feel helpful and empowering to the patient. This suggests that Barbadian practitioners have a therapeutic, rather than a traditionally detached or biomedical approach to engaging women experiencing violence (Gremillion & Kanof, 1996; Hegarty, 2011; Rose et al., 2011; Trevillion et al., 2014) This approach supports patients and is particularly helpful in a context like Barbados, where the patient may be unable or unwilling to leave the abusive relationship.

Not only is there only one shelter available on the island, but as noted by Spooner (2009), women experiencing domestic violence in Barbados, and the English-speaking Caribbean mostly desire to de-escalate abusive situations or to obtain respite from the abuse, recourses which would be unusual to the North American observer. Rather than leave the relationship, Barbadian women tend to rely on their religious faith, a) for protection from the abuser, and b) believing it
to be a means to change abusers’ behavior. Providers’ empathic view of screening then provides women victimized by DV with an additional source and degree of support and potential for help as they exercise their agency. Provider empathy also potentially decreases the level of isolation and self-blame experienced by abuse victims (Heise et al., 1994). This suggests a reduced risk of revictimization of patients due to harmful practitioner attitudes. Overall, these data bode well for supporting disclosure of abuse by creating an environment that is conducive to disclosure, and that encourages women to see their provider and by extension the healthcare system, as an avenue through which they can receive help (Krug et al., 2002; Hamberger & Phelan, 2006).

**Time Constraints**

The literature ties time constraints as a barrier to DV screening with practitioners’ sense of powerlessness or loss of control of their schedule and the visit itself. Barbadian practitioners mostly expressed time as a factor similar to the participants in Sugg’s 1992 study, focusing on productivity expectations not allowing them to have the in-depth conversation necessary to address such disclosures. The way practitioners spoke about time constraints did not give the impression that the amount of time needed for attending to patients experiencing DV was an issue in itself. Practitioners’ concern seemed to lie with time as a factor related to the lack of staffing to deal with the volume of patients, particularly in the public settings, rather than an unwillingness to screen for fear of losing control of the encounter.

Time constraints as a barrier was one of the lowest reported disadvantages of screening in the elicitation interviews. However, it was the leading inhibiting belief as an environmental or institutional factor. This suggests that the time needed to screen is viewed as a disadvantageous factor not from a personal or professional resistance to screening itself, but in terms of its potential impact on productivity expectations from an administrative perspective. As one
physician noted in this regard: “that would be a disadvantage to running the clinic, but...if you have a patient, and there's a problem that needs to be addressed, then it shouldn't matter...the length of time. Because each problem has a specific length of time, so if it's a cough or cold, that's like a minute, two minutes. But if it's...a victim of domestic violence, then, that is something that would take longer, so as part of management, more time should be allotted to that patient compared to somebody that just has a cough or cold.” Another physician put it more succinctly by saying “It will be time consuming for us, but it will be an advantage for the community.” This view of time as an institutional concern, particularly as reported by practitioners in public settings, was usually related to a lack of staffing and heavy patient loads. As a result, practitioners reported not broaching the topic of domestic violence unless patients presented with conditions which practitioners connected to DV.

**Parameters for Screening**

According to interview participants, they did not ask patients about abuse unless there was an obvious sign of abuse such as an injury, or suspicion of abuse based on patient behavior or affect that made the practitioner suspect something was wrong. This position was borne out in the first knowledge question in the survey, “how would you screen a woman you are treating for DV?” and in the results from the FDVI asking about screening in relation to presenting conditions. Nearly half of those who answered the knowledge question provided responses which might more accurately be described as “assessment” of DV in terms of onset, frequency, severity and duration, rather than “screening” which seeks to determine if a condition is present.

Further affirmation of this approach is seen with the FDVI findings. In this scale, injuries surpassed all other conditions in terms of practitioners reporting screening always, or nearly always, followed by depression/anxiety. Depression/anxiety was also the condition which
respondents indicated that they asked about DV ‘sometimes.’ Not only does this affirm the reports in the elicitation interviews, but it demonstrates practitioners’ recognition and valuing of mental health, both in terms of overall patient wellness and as an indicator of DV (Prince, 2007). Examination of the FDVI reporting seems to suggest that practitioners are not screening for DV when presented with chronic conditions, or when encountering pregnant women. This may not be the case, as the knowledge question “what would make you suspicious of DV in a patient” featured indicators of the chronic diseases of most concern in Barbados, such as increased blood pressure, and non-compliance with care regimens such as taking prescribed medication. Not screening during pregnancy is also of grave concern, given its support in the literature that indicates that pregnancy is a particularly vulnerable time for women experiencing violence, with violence often escalating (Shah & Shah, 2010; Finnbogadóttir & Dykes, 2016).

This approach of asking about violence primarily in cases of serious or severe physical or psychological harm may also be responsible for the apparent conflation of screening with intervention for DV. By waiting until a visible problem presents, a positive DV identification is being made at a later stage, likely after abuse has escalated. One physician’s statement exemplifies this tendency to see screening and intervention as one and the same: “it might be difficult to get in screenings when you're having a hectic day - time, patient load. When you screen, you need to be prepared to help/guide patients down the path. If you're screening and not prepared to actually follow up with somebody telling you yes, then that puts you at a disadvantage.” This quotation underscores that practitioners want to be able to positively impact the lives of women experiencing DV, rather than just determine if it was occurring. This perspective accords with the literature’s call for helpful responses by practitioners to positive disclosures of DV.
**Personal Experience with DV**

The literature has indicated varying responses by practitioners based on their personal experience with DV (Gremillion & Kanof, 1996; Kalra, et al., 2017). As noted by Tower (2006), the overall impact of such experience is unclear. Perhaps the most consequential decision made by the student researcher for this study was to break up the ATSI’s triple-barreled question inquiring about exposure to DV into five distinct questions. Accordingly, we were able to assess whether the practitioner was ever victimized (and whether the victimization was physical, emotional, or both); we were also able to assess whether the practitioner knew of close friends and or family members who might have been similarly victimized. The role of personal experience with DV variable has emerged in this study quite clearly, with an experience of physical abuse being the most significant predictor of screening intention. While this was singularly interesting, the type of violence that was most impactful was even more so. The literature indicates that women experiencing violence reported emotional violence as being more devastating than physical (Heise et al., 1994). In the present study, more respondents indicated being emotionally abused, yet, unlike physical abuse, emotional abuse was not a significant predictor of screening intention. This finding may be evidence supporting the literature’s contention that those who have been abused might be uncomfortable or overwhelmed by disclosures of abuse, and therefore choose not to engage patients on the topic (Gremillion & Kanof, 1996; Hamberger & Phelan, 2006).

While most respondents had not personally experienced abuse, the majority had been indirectly exposed, through knowing family or friends who had been abused. This personal knowledge, both direct and indirect, is likely the basis upon which Barbadian practitioners are aware of the high prevalence of violence. It is also for many, a main factor impacting how they
approach their practice. Practitioners’ reported heightened awareness and vigilance of DV, along with increased empathy and sensitivity towards these patients, speaks to a patient-centered approach to caring for women experiencing DV. These factors and practitioners’ valuing of DV-related screening and intervention such as counseling, may serve to encourage patient disclosures. They ultimately contribute to good patient management as practitioners are made aware of stressors that may impact women’s health, including those exacerbating underlying conditions such as chronic diseases.

**Perceived DV Prevalence**

The low number of positive identifications of patients experiencing DV may reflect the perception by most practitioners that DV is rarely experienced by patients in their particular practice setting. This perception however, conflicts with the reported perception by a majority of practitioners that DV is somewhat common in the entire primary care system. One potential reason for the seeming disconnect might be that approximately two-thirds of practitioners reported some degree of exposure to abuse, either in terms of their own personal experience, or knowing someone who had been abused. As such, while practitioners are aware of the prevalence from their own experience, institutional factors such as inadequate staffing and large patient volume inhibit their ability to engage with patients around DV, unless it is an urgent medical necessity. This represents a more reactive rather than proactive response, which potentially undermines the health promotion approach espoused by the Ministry of Health. However, salient practitioner beliefs that no one or only perpetrators would disapprove, was underscored by a belief in the national interest and scope of DV as a social problem. As one nurse stated, “I think that most persons would expect that it would be done... but I don’t think there’s really anybody who would disapprove of having the screen done, because, I mean you
want a better Society...and how a person is functioning psychologically affects the kind of society that we live in, so I don't think that there any groups who would object.” One physician stated both points concisely by saying “I think domestic screening should be a national concern. I don’t think anybody should disagree on us getting more information with regards to the number-- how prevalent it is. I don’t think anybody would disagree other than the perpetrators.”

**Theoretical Implications.** The present study was guided by the Integrated Behavioral Model (IBM). The theory’s constructs were shown to predict a substantial amount of the variance in screening intention in Barbadian practitioners, based on the attitudes and beliefs most salient to them, affirming the theory’s cross-cultural applicability. The study also affirmed the IBM’s contention that prior behavior is a predictor of future behavioral intention. In addition, the IBM constructs were found to be congruent with those in the previously validated measures, demonstrating construct validity (Ginty, 2013). Perceived self-efficacy and descriptive norms as the significant predictors align with the results from other aspects of the survey. Self-efficacy as the strongest predictor of screening intention is likely strongly linked to the self-report of more than half of practitioners having received DV training, given that this group demonstrated their willingness to use the training they received to engage patients around DV. Lastly, this valuing of training as a facilitating factor for screening was affirmed by over 90% of practitioners indicating they needed more training on DV. As such, according to the theory, training would be the most beneficial area in which to focus an intervention for practitioners.

Descriptive norms, or the degree to which practitioners believe their colleagues engage in screening, accounted for a similar percentage of the variance in predicting screening intention. This is likely tied again to time. As one physician observed: “How long it may take may be
perceived as ‘keeping back everybody.’” Colleagues and patients waiting frown upon taking a lot of time with one patient especially when there’s a high volume.” In this case, it may be that practitioners believe that if there is uniformity of screening and solidarity in terms of its importance among colleagues, that there will be greater understanding and flexibility should a practitioner be required to take more time with a patient experiencing DV. The IBM considers variables outside of the theory’s constructs, such as demographics and experiences, to be distal. To understand the impact of some of these factors, the theory of intersectional feminism was chosen.

Intersectional Feminism. Intersectionality is concerned with understanding the impact of our several social identities on our life experiences, primarily those related to systems of oppression such as racism and sexism. As such, it has power disparities as a focus and can also be used to understand social locations that are privileged. That the sample was predominantly female may speak to the increased interest in the topic by women, likely given that they are more vulnerable to being victims of domestic violence. The study results also align with the literature that shows that female practitioners screen more than male practitioners (Gremillion & Kanof, 1996; Nyame et al., 2013), however, in the present study these results were not statistically significant. The only demographic variables which were significantly associated with the dependent variables were age and gender.

Age was a significant correlate with screening intention. Irrespective of gender, older practitioners scored higher on the FDVI scale, indicating that they were more likely than younger practitioners to have asked women about DV when seeing selected conditions in the last 30 days. When age was stratified by gender, older men were significantly more likely than younger men to have screened. While both of these variables were hypothesized to be predictors of screening
intention, these specific outcomes were unexpected findings. Younger practitioners were expected to have more progressive attitudes about gender roles and be exposed to more training regarding domestic violence, and women were expected to be more likely to have screened. It can be posited however, that older practitioners, as a generational cohort, have more life and professional experience than younger practitioners. In terms of life experience, older practitioners are likely to be more mature, with spouses and daughters, and increased sensitivity to the harm women might endure from men. In their professional lives, older practitioners are more likely to have had greater exposure to complex or challenging clinical encounters. This exposure is likely to make them less inhibited in broaching difficult or sensitive topics such as domestic violence with patients.

Using an intersectional lens, older male physicians as part of a privileged, dominant group, vested with professional “authority” may also be socialized to expect compliance from patients. This includes answering questions on difficult or sensitive topics such as domestic violence. This might be particularly the case with female patients who have less power both as patients, and as women. However, two factors which are most likely to be influencing this outcome regarding older men, are seniority and practice setting. Male practitioners are significantly more likely to work in private practices and be older than their polyclinic (public health center) counterparts. As such, not only would these HCPs have greater practice experience, they would also be more likely to have seniority and thus more autonomy in their practice settings. In private practice in particular, they would have privacy and be able to take the time necessary to inquire about DV and manage potential emotional reactions by the patient. Younger practitioners in the overwhelmed public system would not only have less privacy, but less time, given expectations regarding their productivity. They would also be likely to have
competing demands for their time with administrative tasks such as committee work in a public multispecialty setting. These demands and power differentials may lead to differences in practitioners’ work behavior and orientation towards those most vulnerable. Support for this conclusion was obtained during the first phase of the study. The student researcher witnessed the stark difference between practice settings and being able to manage time and privacy first-hand during the elicitation interviews. Interviews with all practitioners were scheduled based on their availability. Private practitioners were able to be more flexible and schedule interviews around patient schedules. Consequently, these interviews took place with few if any interruptions. In the public settings, the interviews were again scheduled at the practitioners’ convenience, though it was usually at “slower times” during the day. Each interview in the public settings was interrupted no less than 3 times in an average of 45 minutes of interview time. Interruptions included colleagues needing clarification or direction, patients knocking and opening the door to ask if they were next, and telephone calls.

**Study Limitations.** While the study was based largely on the IBM, the application of the theory was modified given the exploratory nature of the research. Neither the qualitative nor quantitative aspects of the survey included questions regarding the degree of motivation to comply with normative referents. Limitations specific to each phase follow.

Despite the study’s first phase serving primarily to identify and develop survey items for the second phase, it is important to consider the ways in which the researcher as instrument might have influenced the portion of the study. The researcher engaged in reflexivity (Gibbs, 2007) to identify her own potential biases and blind spots that may have impacted the qualitative phase of the study in terms of the interview process and data analysis. These include the researcher’s positionality, and training orientation. The researcher is a Barbadian by birth but
has lived the majority of her life in the United States and is formally trained as a social worker. In terms of positionality, the researcher shares the nationality, gender, and racial background of the majority of participants, but is a lighter-skinned Black woman. As such, the researcher was conscious of the potential role of colorism (a preference for, or favoring of, lighter skin complexions among people of color) and her status as a Barbadian living overseas impacting interactions with participants. On one hand, these factors - lighter complexion and overseas residence - are privileged identities that may have worked in the researcher’s favor, granting access and cooperation. With regard to complexion, a preference for lighter skin tones is based on the vestiges of a colonial past that values whiteness and its approximations even in people who belong to the same marginalized racial group. Regarding overseas residence, privilege here is based on favorable views of the legitimacy of training and research from high-income countries such as the United States. On the other hand, these same privileges may have worked against the researcher, with some participants potentially having viewed these factors unfavorably as entitlement or assumed superiority on the part of the researcher, resulting in participants being less forthcoming in their responses.

As such, the researcher engaged in code-switching as appropriate to build rapport with participants, i.e. using ‘bajan dialect’ to engage with participants, as well as being intentional in observing local cultural norms, such as conservative dress and greetings. The ability to do so was counted as a strength by the researcher. This familiarity with colloquialisms and cultural norms may have been a blind spot, as there may have been views or behaviors that were overlooked for importance because of their familiarity to the researcher within the Barbadian context. As a resident of the United States for her formal training and professional experience in community health centers, the researcher is aware of the predominantly North American perspective she
holds regarding clinic operations. In addition, the researcher’s social work values-based orientation may have been responsible for internal response to some practitioner views and beliefs. While in the minority, these views included those that blamed women for staying in the relationship, and that seemed to impose the practitioner’s belief system on patients, for example, religious views shaping practitioner responses to women disclosed or suspected abuse.

The usage of the study’s qualitative data was constrained by the guiding theoretical frame, which only sought to tabulate the most frequent responses to include in the survey instrument. As such, there may be challenges to transferability, or the degree to which the results may be transferred to other contexts through thick description of the data and purposive sampling (Anney, 2014). Thick description entails a rich, detailed description of all aspects of the qualitative research including the methodology and data collection context, and examples from the data (Houghton, Casey, Shaw & Murphy, 2012; Anney, 2014). While some of this information is present, the data was not utilized to its full potential because of the IBM’s theoretical prescription. There is, however, an opportunity for further, in-depth exploration of the qualitative data. In terms of sampling, while it was purposive in terms of practitioner type, there were no additional demographics readily accessible on the population, limiting the selection of additional purposive criteria.

For its second phase, this study used an exploratory, non-experimental design based on a self-administered survey. As such, it holds all the limitations of non-experimental research such as the lack of randomization, and risk of inappropriate interpretation of findings (Kerlinger & Lee, 2000). Further, causal factors cannot be determined since this is a cross-sectional study. The sensitive nature of the study subject for study participants allowed for the possibility of social desirability bias (Sudman, Bradburn & Wansink, 2004). A number of steps however were taken
to minimize this, including: the self-administered nature of the survey out of the presence of the researcher (Presser & Stinson, 1998); the assignment of a randomized alphanumeric code to each survey and assurances of confidentiality to participants in the survey’s introductory instructions (Larson, 2019); questions that directly assessed social desirability bias (Nederhof, 1985; Larson, 2019).

Although the intention was to conduct a census of all primary care practitioners in the island, this was not feasible given that there was no accessible listing of all members of the target population. This lack of access to such a list also meant that it is also unknown to what extent the sample was representative of the target population in terms of gender, age, etc. To determine this from the telephone listing would have been limited to physicians and dentists, and entailed contacting each practice, which was not feasible. In addition, the results are not generalizable to all HCPs in Barbados, given the inclusion criteria for participation. In terms of the survey response rate, two factors which may have affected survey response were the length of the survey and the timing of its distribution.

At 14 pages in length, the final instrument was extensive, but well-received. Feedback from practitioners who completed the pilot and final survey indicated that they found the survey be long, but comprehensive, and all included items to be relevant. This sentiment was reflected in the low item non-response rate by those who completed and returned surveys, with just a token incentive to thank them for their time. Respondents also indicated that taking the survey made them reflect on DV in their practice and encouraged them to be mindful of how they address it in the future. This suggests that the survey itself was an intervention in promoting awareness and engagement regarding DV. Survey completion averaged 30 minutes, but practitioners were able to complete it at their convenience. In addition, the time required for the
survey was shorter than the qualitative phase of the study which averaged 45 minutes per interview. Given their busy schedules, future surveys of a limited length are likely to engage a greater percentage of HCPs, given the interest demonstrated in the topic by the current sample. This however does not, and should not preclude future qualitative research, as practitioners were very accommodating, and expressed their willingness to participate despite their schedules, as they saw the value of the research to themselves and their patients. Finally, the survey was distributed over a major holiday season, during which time some potential participants were on leave and unavailable.

Despite these limitations, the study’s mixed method design was perhaps its greatest strength by making it culturally relevant. The qualitative elicitation phase allowed the study to be grounded in the language and lived reality of Barbadian health professionals, centering their voices. As such, a substantive portion of the final questionnaire featured items depicting the positive and negative factors affecting DV screening that were most salient to Barbadian HCPs rather than the student researcher. The attitudes, normative referents and facilitating or inhibiting factors that were identified and couched in familiar terms served to make the survey meaningfully reflective of the Barbadian context. In addition, while the elicitation phase was conducted for the specific purpose of identifying survey items, the interview process provided vital contextual information to deepen the researcher’s understanding and interpretation of quantitative findings.

**Directions for Future Social Work Research.** The student researcher found that Barbadian primary care practitioners encountered during all phases of the study were not only very receptive but also accustomed to participating in research activity. They also expressed interest in the topic specifically, and in being apprised of the study’s findings. The Medical
Officers of Health at the polyclinics and the staff of the Ministry of Health and Wellness were also very responsive and accommodating in facilitating the research. This evidence-based orientation by the administrative levels and front-line practitioners present an opportunity for future research with this population and topic area. In addition to further exploring the data from the present study, the following recommendations for future research are proposed.

Responses to a request for feedback on the questionnaire included practitioners expressing that they felt “boxed in” by the closed-ended format of survey research. Future research with practitioners should include interviews and or focus groups with practitioners to solicit more in-depth data on practitioner experiences with domestic violence screening, and attitudes toward domestic violence generally, and patients who have or currently experience it. Such research might be able to identify qualitative differences between the experiences and concerns of physicians who work solely in the polyclinics or private practice settings, and those of public health nurses who work in the community for example.

Given that a major concern of respondents was the ability to ‘help patients,’ by giving them an outlet to talk about the abuse, it would be crucial to identify and evaluate the nature and efficacy of that help. Identifying and understanding the referral mechanisms, pathways, and resources available to and used by primary care practitioners to obtain mental health services for patients is critical to evaluating outcomes for patients. In particular, an examination of the scope and efficacy of social work services available would be of interest.

Future research must also include the population most affected – women who have experienced violence. This group has traditionally been depicted dichotomously as either victims or agents, with their agency reduced to termination of or departure from an abusive relationship (Lazarus-Black, 2001; Dunn & Powell-Williams, 2007). This narrow view of
agency, which emanated from systems such as that of the United States, has been challenged by Connell (1997, p. 118) who redefined agency as “the exercise of any measure of resistance and self-determination used by an abused woman to regain control of her life and in her attempt to stop the abuse she experiences.” As noted by DeShong and Haynes, (2016), involvement of DV survivors in addressing the problem of violence has been largely performative, limited to testimonies given at awareness raising events.

While these do have utility, including survivors meaningfully in the policy development which affects them requires their input to tailor services to their needs. One means of securing this input and engaging this vulnerable population substantively is through community-based participatory research (CBPR) to identify their needs and the barriers they experience in trying to access services, and to identify and draw on the resources and strengths available to them in their communities. Even in the face of ongoing abuse, women demonstrate resilience and employ coping mechanisms and informal support strategies to function in their myriad social roles. These are skills and strengths which can be drawn upon to inform DV-related care and policy (Messing, 2014). This particular methodology would involve survivors of domestic violence and other relevant stakeholders such as HCPs, social workers, nongovernmental organizations, police, and policy makers in government, working together equitably and collaboratively. Such a collaboration would enhance the island’s efforts to address DV, which has largely featured a top-down approach, by meaningfully engaging the community in working towards social change (Tremblay, Martin, McComber, McGregor & Macauley, 2018).

**Implications for DV Policy in Healthcare Settings.** If it has not already, the Ministry of Health should aim to incorporate the relevant recommendations and guidance from the WHO’s Global Plan of Action for addressing interpersonal violence in a collaborative, multisector
manner. The three major areas of need specifically identified by the participants in this study to facilitate DV screening and which should be addressed by the relevant policy-making bodies are: written policies and protocols regarding DV, a screening tool and training. Alvarez and colleagues’ (2017) recommendation to adopt a chronic disease model of care to improve patient care for women experiencing IPV, could potentially combine these pieces cohesively. This approach may be particularly appropriate given the country’s focus on non-communicable chronic diseases, which disproportionately affect women. Chronic care models entail universal screening and routine monitoring, and are inherently interdisciplinary for diseases such as diabetes, allowing for systematic care coordination, and establishment of indicators of wellness for patients. Such an approach includes a case manager or “patient champion” who engages and monitors patients in a way that healthcare practitioners do not. With their assessment and advocacy skills, this would be the ideal position to be occupied by a medical social worker.

In terms of the screening tool, the student researcher interviewed two practitioners who participated in the Ministry of Health and Wellness’ pilot screening program originating from the UNFPA study. Their impression of the screening tool which was piloted was that it was long – several pages – and cumbersome. Given the hectic pace of primary care settings, especially public ones, rapid screening tools with online training guidance available, might be a more efficacious choice. Instruments such as the 3-item Partner Violence Screen (PVS) developed for use in emergency departments, and the five-item Abuse Assessment Screen (AAS) developed for use with pregnant women are two examples of such screening tools. Both have been tested with diverse populations, with the PVS having been tested for use with men as well, and the AAS having been tested internationally in low to middle income countries, and do not entail laborious calculation of risk (Rabin, Jennings, Campbell & Bair-Merrit, 2009).
In terms of training, in addition to training on recognizing DV and engaging patients effectively, practitioners indicated a need for guidance on the resources available for patients in the community, and their legal responsibility regarding disclosures of violence. Interview participants and pilot survey respondents reported that there was no legal mandate to report violence to the police, unless it was sexual assault. At the time of the interviews in 2017, the new DV legislation had been issued approximately a year earlier. Practitioners seemed unaware of the expanded guidelines on individuals who were able to file a complaint, which would ostensibly include them. Training on the new law and required documentation and reporting procedures would be beneficial to practitioners and should be part of mandatory training series for current practitioners, and those in training.

Finally, any new policies and protocols should include a public health awareness campaign. This information can be disseminated via the Barbados Government Information Service, and the government-owned television and radio stations to alert patients to the increased availability of screening. Awareness campaigns might also include making DV literature available in waiting rooms, mounting of posters and or flyers in women’s restrooms with instructions for women experiencing violence to signal their provider or call a hotline if they wish to disclose violence and receive help.

**Implications for Social Work.** Social workers have the potential to make an important contribution as part of an interdisciplinary effort to address domestic violence within the primary care system. Social work’s inherent interdisciplinary nature, its person-in-environment perspective and social justice mission prepares its practitioners to work effectively with client systems of all types. The proposed policy recommendations provide opportunities for social workers to intervene at the micro, mezzo, and macro levels.
Social Work Practice. Given that the HCPs, particularly in public settings have high workloads and related productivity challenges, medical social workers can function at the micro level as dedicated staff to work with at-risk patients, including women experiencing DV. Social workers’ biopsychosocial assessment skills would allow them to assist practitioners by conducting the previously mentioned rapid assessments, or, if the rapid assessments are carried out by HCPs, medical social workers can take the next step and be trained to perform more in-depth risk assessments with clients such as “The Danger Assessment” (Campbell, Webster & Glass, 2008; dangerassessment.org, 2020) which determines women’s risk of lethal harm in their relationships. The tool is intended to be used in partnership with women experiencing violence to encourage empowerment and positive self-determination (Messing, 2014). These assessments lead to interventions at the mezzo level, in which social workers work in tandem with HCPs, can initiate referrals, and act as a liaison between the patient and clinician, police or other community resource. This initiative, using social workers, can be implemented in the polyclinics for women impacted by DV in a way that is similar to how social workers have been employed in these settings to screen persons for HIV. At the macro level, social workers can also ethically draw on the information gleaned from their work with clients and medical and nursing staff to advocate for policy that promotes and protects women’s rights in the healthcare system. The proposed CBPR project presents an opportunity for social workers to engage in policy development at the mezzo and macro levels. Social workers can provide guidance in capacity building and assist in community organizing efforts alongside women and communities affected by violence. This includes work with women’s groups, religious institutions, and grassroots movements such as Life In Leggings, a local movement against street harassment of women and girls, which has grown to include gender-based violence, and become a regional movement.
Social Work Education. To prepare Barbadian social workers with the knowledge to adequately assess and intervene with women experiencing violence in intimate relationships, domestic violence related content must be included in their formal training at the UWI. Relevant undergraduate and graduate courses should specifically address violence against women as a human rights issue, within the context of the social determinants of health. Generalist content at the undergraduate level might consist of courses on women’s issues, family violence, and a concentration in medical social work or women’s studies. At the graduate level, the university might offer a trauma-informed care concentration for clinical-track practitioners, and a dual masters’ in social work and public health for practitioners interested in community and policy work.

A trauma-informed care approach is congruent with social work values and ethics, with its emphasis on the total person, empowerment, a strengths-based perspective and respect for the patient’s right to self-determine (Machttinger, Cuca, Khanna, Rose and Kimberg, 2015). With empathy at its base, trauma-informed care recognizes and acknowledges the impact of trauma such as DV, as well as adverse childhood experiences, on one’s health and behaviors. In addressing trauma, the goal is to provide an environment that is safe and not re-traumatizing to the client (University at Buffalo Institute for Trauma Informed Care, 2020). This approach has been developed into a framework for primary care settings to effectively support and manage the care of women experiencing violence (Machttinger et al., 2015; Taft, Murphy & Creech, 2016; Alvarez, Fedock, Grace & Campbell, 2017). Given that most practitioners reported receiving DV-related training through conferences or continuing education, an opportunity exists for a partnership between the social work programs and medical faculties at UWI to offer a culturally-appropriate certification training on trauma-informed primary care with the SDOH as a
complementary framework. This might take the form of a course for HCPs in training, and a training series for current practitioners. These components reflect the beginning of meaningful systemic change in addressing DV via the healthcare system.

Conclusion

The scale of intimate partner violence as a social justice and public health problem globally is such that there is no country in the world, whether in the global North or South, in which gender-based disparities and violence are not pervasive (Dairiam, 2015). What differs, is each country’s approach to addressing it. Barbados has made significant strides compared to a century ago in terms of efforts to support social well-being and health and is a regional leader on a number of fronts. As noted by Newman and Barrow (2008), the country’s performance on indicators such as the Millennium Development Goals standards for health and education, and its respect for human rights speak to and stem from a responsibility to promote the social welfare of the nation’s citizens. The island, however, faces a challenge in term of several emerging local, regional, and international concerns and threats to social well-being, such as domestic violence, and its public health burden on women, and society. As noted by Rock and Valtonen (2002), a multilevel approach is required to effect social change in response to the emerging social needs of Caribbean populations. Given the importance of women’s roles in the family, community and society, public health and social work responses must center women. In so doing, they must not only attend to medical diagnoses, but work toward alleviating the social risk factors for mental and physical well-being which violate women’s rights and shape their everyday experiences, such as violence. Such an undertaking requires the development and implementation of policies which proceed from rights-based framework, and are culturally relevant (Rock, 2013).
In this vein, the present study set out to determine the attitudes, beliefs, knowledge, behaviors, and future intention of Barbadian primary care practitioners, relative to domestic violence screening. Overall, the study found that Barbadian HCPs engage in screening at levels on par with their counterparts globally, and report more favorable attitudes toward screening than unfavorable ones and view it as part of their role. Barbadian HCPs also report less perceived barriers to screening, low levels of victim-blaming and high respect for patient autonomy. Practitioners also value screening as a therapeutic intervention in itself, giving patients the opportunity to vent regarding the abusive relationship. This is likely in recognition of the shortage of resources such as shelters, and that patients are likely to be unable or unwilling to leave the relationship. Despite these positive attributes, practitioners report that they do not screen routinely for the most part, unless there is some obvious indicator in the patient – physical or emotional – for them to do so. This is the case despite high levels of exposure to violence, both directly and indirectly, and a sense of DV as common in the primary care system. As such, positive identifications are made at late stages after violence has been perpetrated or escalated. This poses a challenge from a patient management and public health perspective, by precluding early detection of violence – past, present, or threatened – as an exacerbating factor for non-communicable chronic diseases, to which Barbadian women are especially at risk.

Barbadian practitioners have received more training than their counterparts and yet identified a nearly universal desire to improve their skills with more training. This underscores their high levels of self-efficacy, the most significant IBM construct predictive of screening intention, and the ideal focus for evidence-based intervention to increase rates of screening. While perceived self-efficacy was the most predictive IBM construct, an experience of physical violence was the strongest predictor of screening intention overall, even above the IBM
constructs. Practitioners reported that exposure to violence impacted their practice by making them more aware and vigilant of DV, more sensitive to patients’ needs and less judgmental of their choice to stay in the relationship. The challenges of time constraints related to health professional staffing shortages amid institutional productivity expectations create an opportunity for social work to partner with health practitioners. Using human rights and SDOH frameworks, social work and public health can partner with women experiencing violence to take a leadership role, in conjunction with other sectors to address the challenge of gender-based violence in a collaborative, holistic manner, within a coordinated continuum of care that is trauma-informed.

Former NASW Chief Executive and public health social worker Elizabeth Clark described public health and social work as “two sides of the same coin,” despite their difference in emphases—social work on intervention and public health on prevention (2013). Both professions share the goals of promoting and reducing health disparities and related risk factors in the social environment, and ultimately promoting overall health and well-being, and social and environmental justice (Sable, Schild & Hipp, 2012). As a human rights profession, social work is on the frontlines of promoting social well-being and protecting the rights and dignity of all, with an emphasis on marginalized groups. Within a rights-based frame, such as the SDOH, violence against women is an affront to women’s rights directly through harm to their person, and indirectly by placing women at increased risk to disparate health and social outcomes. The socially constructed nature of health inequality based on income, gender, race, and other social identities, means that in many cases, morbidity and mortality are amenable to both intervention and prevention (Craig, Bejan & Muskat, 2013). In alignment with social work’s ecological perspective then, a public health approach would serve to emphasize the environmental causes, yet highlight multilevel preventive strategies for multiple individual actors and groups, toward
the end of policy and social change to support victims and decrease the prevalence of violence-related illness and death.

Despite the promise of such collaboration, Barbados’ primary care and social work professionals remain an untapped resource in meeting the needs of women who are being or have been abused. Not only is the healthcare sector considered tangential, but social work is challenged in terms of its perceived professional status, with a lack of jobs for social work graduates. This is the case despite Barbadian social work students being well-prepared in terms of a solidly rights-based curriculum with a local and international focus (Rock, 2013).

Commenting on the mandate set forth by the Global Agenda for Social Work and Social Development, Healy (2017, p. 6) powerfully states that “to be absent is to be irrelevant, at home as well as internationally.” This is a particularly strikingly observation in the case of social workers, who, despite the profession’s rich and intersecting history, are not highly regarded as leaders in the human rights field (Healy, 2017; Ife, 2012; Mapp et al., 2019).

Ife (2012) provides an explanation for this phenomenon, positing the challenge of viewing domestic violence as a human rights violation, as parallel to viewing social work as a human rights profession – both are problematized by being perceived as occupying the private sphere. He notes that human rights are generally construed as existing in the public domain, while violence against women has been relegated to the private. Similarly, social work’s predominant orientation has been direct practice, largely leaving behind the broad social reform efforts of its early years. Ife goes on to say that it is in the private realm where human rights violations are most likely to occur, and be most egregious, specifically citing the experience of women being subjected to gender-based violence as evidence (Ife, 2012). Merry (2006) affirms this and notes that while violence against women has been conceptualized predominantly within
the human rights framework as an individualized problem, many causes of domestic violence have been identified as structural – i.e., involving social, economic, and political policies. However, the problem of violence is not either or, it is both and - both individual and structural. Similarly, Ife’s argument highlights the threat posed by the false dichotomy that is the micro-macro divide that pervades the social work profession. Social work’s professional standing is weakened by a lack of integration of its direct care and social reform facets, which in turn stunts the leadership potential of social work practitioners engaging in interdisciplinary endeavors such as addressing violations of women’s rights. Ife ultimately makes this assertion, noting that the profession needs to bridge this divide by addressing both aspects of social needs simultaneously.

Consequently, a deliberate dual focus is critical for elevating the primacy of domestic violence and social work in the human rights field. By promoting recognition of the structural causes and the individual physical and psychological outcomes associated with domestic violence, a public health approach draws the issue out of the personal or private sphere to that of community and society, which simultaneously contribute to and feel the repercussions of violence. Working with primary care practitioners and public health officials represents an opportunity for social work to articulate and reclaim its public health heritage, as it refocuses on its social justice mandate to address “the causes of the causes” (Marmot, 2005, p. 1105) of health inequality: structural and interpersonal violence experienced by vulnerable groups. The study’s major finding of the role of physical abuse as a major predictor of intention, and these practitioners’ self-report of the how their exposure to abuse affected their practice is a prime example of this. Patients who are in the care of these practitioners benefit from their integrated focus, i.e., the convergence of practitioners’ private experiences positively informing their professional practice, to help and empower those women who may be experiencing violence.
Social workers are very present on the front-lines of addressing inequality wherever it manifests, and with its action orientation, utilizing the professional skills of biopsychosocial assessment, a strengths-based person-in-environment perspective, advocacy and transdisciplinary collaboration (Healy, 2008; Ruth & Marshall, 2017; Sable, Schild & Hipp, 2012). As such, the profession is extremely relevant and well-positioned to perform its most essential function of brokering relationships between systems, and promoting social justice by translating the lived experiences of those they serve, into meaningful policy change (Bent-Goodley, 2015; Healy 2017). By drawing on and strengthening these assets, and pursuing social justice by framing individual problems within a human rights context, social work can effectively maximize its impact by exercising and strengthening its “dual heartbeat” (Ruth & Marshall, 2017, p. S237) of micro and macro practice for the benefit of society in general, with an emphasis on marginalized groups such as women experiencing violence.
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Appendix A

Elicitation Interview Guide

The purpose of this interview is to identify your perspectives around domestic violence (DV) screening in the context of your clinical practice. For this study, domestic violence will be defined as violence between past or present intimate heterosexual partners, and in which women are the victim. Please share the thoughts that immediately come to mind for you in response to the following questions.

1. What terms do you use to refer to such violence? (E.g. Domestic Violence, Intimate Partner Violence, or some other term)

2. Are there any other terms that come to mind to refer to such violence?

I’d like you to think about performing DV screening during clinical office visits in the next 30 days. In your opinion:

3. What are the advantages of performing screenings for domestic violence?
   a. Are there different advantages for routine versus acute visits?

4. What are the disadvantages of performing screenings for domestic violence?
   a. Are there different disadvantages for routine versus acute visits?

5. Is there anything else you associate with performing screenings for domestic violence?

6. What are some positive adjectives that you would use to describe the experience of asking women about their domestic violence history?

7. What are some negative adjectives that you would use to describe the experience of asking women about their domestic violence history?

8. Are there any individuals or groups who would approve of your performing domestic violence screening during clinical office visits in the next 30 days?

9. Are there any individuals or groups who would disapprove of your performing domestic violence screening during clinical office visits in the next 30 days?

10. Are there any other individuals that come to mind when you think performing domestic violence screening during clinical office visits in the next 30 days?
11. What factors or circumstances would enable you to perform domestic violence screening during clinical office visits in the next 30 days?

12. What factors or circumstances would make it difficult for you to perform domestic violence screening during clinical office visits in the next 30 days?

13. Are there any other issues that come to mind when you think about the difficulty or ease of performing domestic violence screening during clinical office visits in the next 30 days?
DOMESTIC VIOLENCE SURVEY FOR PRIMARY HEALTHCARE PRACTITIONERS

For the purpose of this survey, we define domestic violence (DV) as emotional, physical or sexual violence between present or past intimate heterosexual partners, in which women are the victims. Some of the items in this questionnaire refer to DV in general, while other items refer specifically to those who are abused (victims) or the abusers (batterers).

Thank you for taking the time to complete this survey. We are interested in your personal opinion or knowledge related to domestic violence screening, based on your professional experience. Please complete all items and answer truthfully, without regard to what you think we want to hear. We recognize that some items may be answerable in more than one way based on specific contexts – please choose the answer that best represents your opinion “in most cases.”

Survey results will only be released in aggregate, without any identifiers (i.e., your name and information will not be known). Again, thank you!

Primary care providers are asked to do increasingly more for patients in increasingly less time. For each of the statements below, please check (✓) your level of agreement with each statement regarding what should be expected of a primary care provider.

<table>
<thead>
<tr>
<th>The provider’s responsibility includes:</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neither agree nor disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Screening female patients for domestic violence at every routine health maintenance visit.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2. Asking all adult female patients with chronic pain about the possibility of domestic violence.</td>
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<tr>
<td>3. Asking about DV any time an injury is noticed, regardless of the stated cause.</td>
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<tr>
<td>4. Asking about domestic violence at every visit.</td>
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<tr>
<td>5. Making sure a patient gets to a shelter right away if she discloses abuse.</td>
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<tr>
<td>6. Telling a patient that an abusive partner’s behavior is not acceptable.</td>
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<tr>
<td>7. Telling a patient that a particular relationship is harmful to her health.</td>
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<tr>
<td>8. Following up with a patient after making a referral to a domestic violence agency.</td>
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<tr>
<td>9. Telling a patient she needs to leave an abusive relationship</td>
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</tbody>
</table>
Think about DV prevalence and management in your practice. Please check (✓) the response that best represents your experience.

<table>
<thead>
<tr>
<th></th>
<th>Very rare</th>
<th>Rare</th>
<th>Somewhat Common</th>
<th>Common</th>
<th>Very Common</th>
</tr>
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<tbody>
<tr>
<td>10. Domestic violence in my practice is:</td>
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<tr>
<td>11. Domestic violence in the primary care system on the whole is:</td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
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</thead>
<tbody>
<tr>
<td>12. Have you ever identified a patient who was a victim of DV?</td>
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<tr>
<td>13. To your knowledge, does your practice setting have any written guidelines for detection and management of DV?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Have you read your practice setting’s guidelines for detection and management of DV (if applicable)?</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td>15. Rate the usefulness of your practice setting’s written guidelines for detection and management of DV.</td>
<td>Not at all</td>
<td>Only slightly</td>
<td>Moderately</td>
</tr>
<tr>
<td>16. How many victims of domestic violence have you identified in the past year?</td>
<td>0</td>
<td>1—5</td>
<td>6—10</td>
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</tbody>
</table>

Healthcare providers generally find it easier to empathize with some people’s choices than others. Imagine your patient is choosing to remain in an abusive relationship, for each of the patient types listed below. Please check (✓) how easy or difficult it is for you to empathize with their decision to remain in the abusive relationship.

<table>
<thead>
<tr>
<th></th>
<th>Extremely easy</th>
<th>Easy</th>
<th>Neither easy nor difficult</th>
<th>Difficult</th>
<th>Extremely difficult</th>
</tr>
</thead>
<tbody>
<tr>
<td>17. An uneducated, low-income woman who is financially reliant on her partner.</td>
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<tr>
<td>18. An educated middle-class mother of two.</td>
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<tr>
<td>19. A single professional who has a thriving career.</td>
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<tr>
<td>20. A woman with severe depression.</td>
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<tr>
<td>21. A woman with severe physical disabilities.</td>
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</table>
Please check (✓) the response that best represents your experience.

22. How confident do you feel asking about the following topics as part of the medical history?

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Only slightly</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Smoking</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>b. Alcohol use and frequency</td>
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<tr>
<td>c. Emotional abuse</td>
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<td></td>
<td></td>
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<tr>
<td>d. Physical abuse</td>
<td></td>
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<tr>
<td>e. Use/possession of firearms</td>
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</tbody>
</table>

23. How often have you asked a patient about the possibility of DV when you saw any of the following conditions in the last month? (If you have not seen this condition in the past month, check N/A)

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Seldom</th>
<th>Sometimes</th>
<th>Nearly Always</th>
<th>Always</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Injuries (bruises, lacerations, etc.)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>b. Chronic pelvic pain</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>c. Irritable bowel syndrome</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Headaches</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Depression/anxiety</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Coronary artery disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Routine health maintenance exam</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Pre-natal care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
24. Please check (✓) how confident you are in your ability to screen, diagnose, respond, refer and document domestic violence.

<table>
<thead>
<tr>
<th></th>
<th>Not Confident</th>
<th>Somewhat Confident</th>
<th>Very Confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Screen for domestic violence.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>b. Diagnose abuse as a cause of other medical problems.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>c. Respond effectively to a patient who discloses that she is experiencing domestic violence.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>d. Make appropriate referrals to domestic violence agencies at my institution and in the community.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>e. Provide documentation about domestic violence in a patient’s records.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

25. Primary care providers face numerous barriers when it comes to screening for and treating domestic violence (DV). Please check (✓) your level of agreement with each of the following statements.

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neither agree nor disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. I do not have enough time to ask about DV.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>b. I am afraid of offending the patient if I ask about DV.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>c. I find it difficult to get the patient alone if she is accompanied by a partner.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>d. I am afraid that a positive disclosure will take up too much of my time.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>e. I don’t feel like I can help a patient who is in an abusive relationship.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>f. I feel patients who are being abused are unlikely to change their situation.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>g. I feel like I have wasted my time if I make an effort to help an abuse victim, but she stays in the relationship.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>h. I don’t have the resources to deal with a patient who discloses abuse.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>i. I have no place to refer patients who disclose abuse.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>j. I am more interested in dealing with my patients’ medical problems than their relationships.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>
The following questions are based on qualitative interviews conducted with Barbadian primary care health practitioners to understand their knowledge, attitudes and experiences related to domestic violence screening. Please think about screening women for domestic violence in your practice in the next 12 months, and check (✓) the extent to which you agree or disagree with the following statements.

26. Screening women for domestic violence during office visits is beneficial because:

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neither agree nor disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>It helps determine the prevalence of the problem in the community.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td>It improves patient management.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td>It helps to identify victims of abuse and women at risk of being abused.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td>It allows women experiencing abuse to be offered help.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e.</td>
<td>It provides an opportunity to make referrals for women experiencing abuse (e.g. police, counselling).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f.</td>
<td>It provides an outlet for women experiencing domestic violence to talk about the abuse.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

27. Screening women for domestic violence is disadvantageous because:

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neither agree nor disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>It is time-consuming</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td>Patients may be unwilling to disclose abuse.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td>Patients may feel you are “trying to get in their business.”</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td>It may make the abuse situation worse if the partner finds out the screening was done.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e.</td>
<td>Patients may have negative emotional responses to being asked about abuse (e.g. feeling targeted, offended or uncomfortable)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The following questions are based on qualitative interviews conducted with Barbadian primary care health practitioners to understand their knowledge, attitudes and experiences related to domestic violence screening. Please think about screening women for domestic violence in your practice in the next 12 months, and check (✓) the extent to which you agree or disagree with the following statements.

28. Think about conducting domestic violence screening during routine (wellness) versus acute (urgent care) visits as you answer the following:

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neither agree nor disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Routine visits allow more victims to be identified than acute visits</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>b. In an acute visit, patients are more concerned with their urgent health problem than disclosing abuse.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>c. Screening for domestic violence should be a routine part of patient management.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>d. All women should be screened for domestic violence, not just those presenting with obvious signs of abuse.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

29. When screening women for domestic violence, I feel:

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neither agree nor disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. I am empowering my patient</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>b. I am making a difference</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>c. It is enlightening with regard to my patient's care</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>d. Comfortable</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>e. Empathy</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>f. Helpful</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>g. Supportive</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

(Question 29 continues on next page.)
The following questions are based on qualitative interviews conducted with Barbadian primary care health practitioners to understand their knowledge, attitudes and experiences related to domestic violence screening. Please think about screening women for domestic violence in your practice in the next 12 months, and check (✓) the extent to which you agree or disagree with the following statements.

29. (Continued from previous page)
When screening women for domestic violence, I feel:

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neither agree nor disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>h. Angry</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>i. Depressed</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>j. Emotional (disturbed, drained, burdened)</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>k. Fearful for the patient</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>l. Fearful for myself</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>m. Helpless</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>n. Sad</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>o. Uncomfortable</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

30. In your opinion, to what extent would the following groups approve or disapprove of you screening women for domestic violence?

<table>
<thead>
<tr>
<th></th>
<th>Strongly disapprove</th>
<th>Disapprove</th>
<th>Neither approve nor disapprove</th>
<th>Approve</th>
<th>Strongly approve</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Barbados Ministry of Health</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>b. Colleagues (nursing, physician, etc.)</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>c. Religious groups/Faith Communities</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>d. The police</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>e. Patients themselves</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>f. Women's groups</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>g. Men perpetrating abuse</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

31. Do you believe all people would approve of screening?

○ Yes  ○ No
32. In your opinion, how likely is it that physicians in Barbados are screening women for DV in their practice?
   ○ Not at all  ○ Only slightly  ○ Moderately  ○ Quite a bit  ○ Extremely

33. In your opinion, how likely is it that nurses (RNs and Health Sisters) in Barbados are screening women for DV in their practice?
   ○ Not at all  ○ Only slightly  ○ Moderately  ○ Quite a bit  ○ Extremely

34. In your opinion, how likely is it that dentists in Barbados are screening women for DV in their practice?
   ○ Not at all  ○ Only slightly  ○ Moderately  ○ Quite a bit  ○ Extremely

The following questions are based on qualitative interviews conducted with Barbadian primary care health practitioners to understand their knowledge, attitudes and experiences related to domestic violence screening. Please think about screening women for domestic violence in your practice in the next 12 months, and check (✓) the extent to which you agree or disagree with the following statements.

35. The following would enable me to perform screenings for domestic violence:

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neither agree nor disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Having written policies and protocols for DV screening.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>b.</td>
<td>Having an assessment tool for DV screening.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>c.</td>
<td>Knowing what to do next after a positive DV screen.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>d.</td>
<td>Having a follow-through system for women with positive DV screens.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>e.</td>
<td>Having privacy during a patient visit (e.g. confidential space, minimal interruptions).</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>f.</td>
<td>Having training on domestic violence (including how to engage patients effectively).</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>g.</td>
<td>Having a social worker on-site (if applicable to your setting).</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>
36. The following would make it difficult for me to perform screenings for domestic violence:

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neither agree nor disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Time constraints (length of visits, patient volume).</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>b. The partner being present at the visit.</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>c. A lack of adequate staffing.</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>d. A lack of staff specifically trained and dedicated to working with domestic violence victims.</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>e. Security concerns related to retaliation by the abusive partner.</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
</tbody>
</table>

37. How likely are you to screen women for DV in your practice in the next 12 months?

〇 Not at all  〇 Only slightly  〇 Moderately  〇 Quite a bit  〇 Extremely

Please complete the following to the best of your knowledge. List as many responses as you can, up to 4 per question.

38. What questions would you ask a woman that you are treating, to screen for domestic violence?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

39. List up to 4 reasons you may have an increased suspicion about the presence of domestic violence in a woman you are treating.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

40. List up to 4 ways a batterer may control his partner:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
41. List up to 4 ways you can help a patient that you are treating, who has just disclosed to you that she is being abused:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

42. List up to 4 pieces of information that should be documented in the medical records for a patient you are treating, who is experiencing domestic violence:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Please check (✓) the response that best represents your opinion.

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Only slightly</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>43. There are strategies I can use to help victims of DV change their situation.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>44. How useful do you think routine written questions about DV at the time of a physical exam may be in finding potential cases of abuse?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>45. I have ready access to information detailing management of DV cases.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>46. I feel confident that I can make appropriate referrals for abused patients.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>47. I have ready access to medical social workers to assist in the management of DV cases.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>48. I feel that medical social work personnel can help manage DV patients.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>49. I feel that mental health services can meet the needs of my patients.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50. I have ready access to mental health services should my patients need referrals.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Please check (✓) the response that best represents your opinion.

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neither agree nor disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>51. DV tends to become more frequent and severe over time.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>52. Most victims report the abuse to their physicians</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>53. By specifically asking about DV, providers greatly increase their ability to identify victims</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>54. The role of the health care provider is limited in being able to help victims of DV.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>55. A victim must be getting something out of the abusive relationship, or else she would leave.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>56. It is not my place to interfere with how a couple chooses to resolve conflicts.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>57. The victimized patient often does something (consciously or unconsciously) to contribute to the violence.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>58. I don’t have the time to ask about DV in my practice.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>59. I am afraid of offending the patient if I ask about DV.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>60. If I find a patient who is a victim, I don’t know what to do.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>61. There is nothing I can do to help the victim because she is unlikely to leave the relationship.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>62. Asking patients about DV is an invasion of their privacy.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>63. I think that investigating the underlying cause of a patient’s injury is not a part of medical care.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>64. If patients do not reveal abuse to me, then they feel it is none of my business.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>65. It is demeaning to patients to ask them about abuse.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>66. If I ask non-abused patients about DV, they will get very angry.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>67. In many cases, the battering would stop if the victim would quit abusing alcohol.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>68. People are only victims if they choose to be.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>
Please check (✓) the response that best represents your opinion.

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neither agree nor disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>69.</td>
<td>I have patients whose personalities cause them to be abused.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>70.</td>
<td>Women who choose to step out of traditional roles are a major cause of DV.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>71.</td>
<td>Intervening with both batterer &amp; victim would represent a conflict of interest.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>72.</td>
<td>The best approach to questioning about DV is to ask persons at high risk.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>73.</td>
<td>The best approach to questioning about DV is to routinely ask all patients.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>74.</td>
<td>I don’t know how to ask about the possibility of DV.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>75.</td>
<td>The victim’s passive-dependent personality often leads to abuse.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>76.</td>
<td>The victim has often done something to bring about violence in the relationship.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

Please give us a little information about yourself.

77. | What is your gender? |   |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>○</td>
<td>Male</td>
<td>○</td>
</tr>
</tbody>
</table>

78. | What is your age (as of your last birthday)? | yrs |

79. | What is the highest level of schooling completed by your most-educated parent? |   |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>○</td>
<td>None</td>
<td>○</td>
</tr>
<tr>
<td>○</td>
<td>Primary School Certificate</td>
<td>○</td>
</tr>
<tr>
<td>○</td>
<td>Secondary School Diploma</td>
<td>○</td>
</tr>
<tr>
<td>○</td>
<td>Vocational Diploma/Certificate</td>
<td>○</td>
</tr>
<tr>
<td>○</td>
<td>Associate’s Degree</td>
<td>○</td>
</tr>
</tbody>
</table>
80. Please check (✓) the category that best describes your role in your practice.

- Registered Nurse only
- Health Sister/Midwife
- Health Sister/Psychiatric Nurse

- Physician
- Dentist
- Other: ______________________

81. Please check (✓) one of the following to indicate your professional degree.

- Physician – MD
- Physician – MBBS
- Dentist – DMD/DDS

- Health Sister – RN with Advanced Nursing Diploma(s)
- Nurse – RN only

- Other: ______________________

82. If you are a nurse or physician, what is your specialty? (e.g. General Practitioner, Maternal Health, etc.)

______________________________

83. In which country did you receive your medical or dental training?

______________________________

84. In what year did you graduate from your specialty training?

______________________________

85. In what type of practice do you work primarily (more than half of your working hours each week)?

- Polyclinic
- Private Practice

- Public or Private Nonprofit/NGO
- Public or Private For-profit

86. Please check (✓) each venue in which you received training on domestic violence.

<table>
<thead>
<tr>
<th>Venue</th>
<th>Yes</th>
<th>No</th>
<th># of hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>During your professional education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>During your post-graduate or specialty training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At conferences or continuing education courses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Barbados Ministry of Health DV training</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

87. Have you ever been emotionally abused (verbally abused, threatened, controlled) by an intimate partner?

- Yes
- No
- Unsure
88. Have you ever been emotionally abusive (verbally abusive, threatening, controlling) to an intimate partner?

- Yes  - No  - Unsure

89. Have you ever hit, slapped, kicked or otherwise been physically abusive to an intimate partner?

- Yes  - No

90. Has an intimate partner ever hit, slapped, kicked or otherwise been physically abusive to you?

- Yes  - No

91. To your knowledge, has a close friend, or a family member been a victim of domestic violence?

- Yes  - No  - Unsure

92. If you answered “yes” to question 91, please indicate which:

- Close friend  - Family member  - Both

93. If you, or someone close to you has experienced abuse, please offer any comments on how it has affected your practice.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

94. Do you feel you need more training on domestic violence?

- Yes  - No

95. If yes, please list what topics you would like to learn more about.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

96. Do you have any additional comments about the survey, or topic of DV in general? If so, please share below.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

~Thank you for completing this survey!~
DATE: May 30, 2019

TO: Michael Fendrich, Ph.D.
Janelle K. Bryan, Student Investigator
School of Social Work

FROM: Pamela I. Erickson, Ph.D.
Chair, Institutional Review Board
FWA# 00007125

Please refer to the Protocol# in all future correspondence with the IRB.
Funding Source: Investigator Out-of-Pocket

Re-approval Period: From: June 10, 2019 Valid Through: June 9, 2020

“Expiration Date”

The Institutional Review Board (IRB) re-approved this protocol on May 28, 2019. The research presents no more than minimal risk to human subjects and qualifies for expedited approval under category #7: Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

For the phase 2 survey, per 45 CFR 46.117(c)(2), the IRB waived the requirement for the investigator to obtain a signed consent form for the subjects because it found that the research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context.

All investigators at the University of Connecticut are responsible for complying with the attached IRB “Responsibilities of Research Investigators.”

Re-approval: It is the investigator’s responsibility to apply for re-approval of ongoing research at least once yearly, or more often if specified by the IRB. The Re-approval/Completion Form (IRB-2) and other applicable re-approval materials must be submitted one month prior to the expiration date noted above.
**Modifications:** If you wish to change any aspect of this study, such as the procedures, the consent forms, the investigators, or funding source, please submit the changes in writing to the IRB using the Amendment Review Form (IRB-3). All modifications must be reviewed and approved by the IRB **prior to initiation.**

**Audit:** All protocols approved by the IRB may be audited by the Research Compliance Monitor.

*Please keep this letter with your copy of the approved protocol.*

**Attachments:**
1. Validated IRB-2 Re-approval Form
2. Validated Revised Cover Letter (Initial)
3. Validated Cover Letter (Final Contact (Web))
4. Validated Cover Letter (Final Contact)
5. Validated Cover letter (Replacement Questionnaire (Web))
6. Validated Cover Letter (Replacement Questionnaire)
7. Validated Information Sheet
8. Validated Pre-notice Letter
9. Validated Reminder Postcard
10. “Responsibilities of Research Investigators”
IRB No. 161002-B

January 17, 2020

Dr. Janelle Bryan
University of Connecticut
1798 Asylum Avenue
West Hartford CT 06117

Dear Dr. Bryan

Re: Intimate Partner Violence Screening Among Barbadian Health Care Professionals: Applying The Integrated Behavioral Model

Further to our last correspondence of November 04, 2019 I write on behalf of the Cave Hill/Ministry of Health Research Ethics Committee/Institutional Review Board to approve your request for extension of approval for further data collection for one year effective from the date of this letter.

All conditions of the original approval remain in effect. Please remember that we require a written notification of completion when the research is complete.

With best wishes for a very successful research endeavour, I remain,

Yours sincerely,

Michael H. Campbell, Ph.D.
Chair

CC:
Dr. Thea Scantlebury-Manning, Deputy Chair
Graduate Studies
Ms. Kristina Bryant, Office of Research
IRB File
Our Ref: 11P11 Vol. 3

Date: February 20, 2020

Ms. Janelle Bryan
University of Connecticut
School of Social Work
No. 38 Prospect Street
Hartford
CT 06103

Dear Madam,

Continuation/Renewal for Study
‘Intimate Partner Violence Screening Among Barbadian Health Care Professionals: Applying The Integrated Behavioral Model’

Reference is made to your email dated February 18, 2020 with regards to the above captioned subject.

Please be informed that approval has been granted for a continuation/renewal from the Ministry of Health. However, you are reminded that there should be no significant change in the proposal or study design.

Yours faithfully,

Dr. Kenneth S. George
Chief Medical Officer (Agg)
Consent Form for Participation in a Research Study

UCONN
UNIVERSITY OF CONNECTICUT

Principal Investigator: Michael Fendrich, PhD
Student Researcher: Janelle K. Bryan, MSW
Study Title: Intimate Partner Violence Screening Among Barbadian Health Care Professionals: Applying The Integrated Behavioral Model.

Introduction
You are invited to participate in this interview because you are a licensed health professional with a degree in medicine, dentistry or nursing, and you provide acute and/or routine primary care services to women aged 18 and older. The Student Investigator is a doctoral candidate at the University of Connecticut, and is conducting this interview as part of her dissertation. She is interested in exploring primary care health care practitioners' (HCPs) attitudes, knowledge, beliefs and behaviors regarding screening for intimate partner violence (IPV).

Why is this study being done?
The purpose of this research study is to: 1) identify the degree to which primary care HCPs in Barbados screen women for IPV in their practice; 2) determine the attitudes, beliefs, knowledge and screening intention of Barbadian primary care HCPs with regard to IPV; 3) determine whether HCPs who have received IPV training have different screening practices from those who have not received such training.

What are the study procedures? What will I be asked to do?
If you agree to take part in this study, you will be asked to participate in an interview. The interview will take place at a time and location of mutual agreement. Each interview will last approximately 60 minutes. A second interview may be requested if further exploration and explanation is required.

What are the risks or inconveniences of the study?
We believe that the risks presented to you by these interviews are minimal. The Student Investigator will focus on a range of topics related to your views and behaviors as it relates to screening adult female patients for intimate partner violence as part of your practice. This may bring up discussion of previous experiences involving social or emotional conflict. You may choose not to answer any of the questions. A referral list of agencies that may be helpful to you will be provided, upon request. The only inconvenience is the amount of time the interviews take, which should be approximately 1 hour. In order to protect your identity, all identifying information will be removed from all documents and you will be assigned a unique identifier. This consent form, should you choose to sign it and participate in the study, will be kept in a locked file cabinet, accessible only to the Student Investigator, and separate from any transcripts.
or other hard copies of study data. We will do our best to protect the confidentiality of the information we gather from you but we cannot guarantee 100% confidentiality.

What are the benefits of the study?
You may not benefit directly from participating in these interviews. It will be beneficial to the Student Investigator because it will help the interviewer complete her dissertation and may aid her in future research. This research will benefit the Ministry of Health in potentially identifying future areas of focus for training and resource allocation for health care practitioners with regard to the topic of intimate partner violence. The research could also benefit the social work profession and how schools of social work teach new professionals.

Will I receive payment for participation? Are there costs to participate?
There are no costs to you. For your time you will receive a $25 BDS gift card to Sheraton Center.

How will my personal information be protected?

With your permission, the interviews will be audiotaped to obtain complete and accurate information. The Student Investigator will transcribe the tapes and all identifying information will be removed; you will be assigned a unique identifier for the study. Only the PI and Student Investigator will have access to the transcripts. The recordings will be destroyed after they have been transcribed. All electronic files (e.g., database, survey responses, etc.) containing identifiable information will be password protected. Any computer hosting such files will also have password protection to prevent access by unauthorized users. Data that will be shared with others will be coded as described above to help protect your identity. At the conclusion of this study, we will publish our findings. Information will be presented in summary format and you will not be identified in any publications or presentations. Once all the interviews have been analyzed, the key linking the participants to the numeric code will be destroyed. The de-identified interview transcriptions will be kept for at least 3 years after the completion of the study.

You should also know that the UConn Institutional Review Board (IRB) and Research Compliance Services may inspect study records as part of its auditing program, but these reviews will only focus on the researchers and not on your responses or involvement. The IRB is a group of people who review research studies to protect the rights and welfare of research participants.

Can I stop being in the study and what are my rights?
You do not have to be in this study if you do not want to. If you agree to be in the study, but later change your mind, you may drop out at any time. There are no penalties or consequences of any kind if you decide that you do not want to participate.

Whom do I contact if I have questions about the study?
Take as long as you like before you make a decision. We will be happy to answer any question you have about this study. If you have further questions about this project or if you have a research-related problem, you may contact the principal investigator, Dr. Michael Fendrich at (860) 570-9107, or the student researcher, Janelle Bryan at (246) 828-9448. If you have any questions concerning your rights as a research subject, you may contact the University of Connecticut

UCONN IRB
Approved On 11/15/17
Approved Until 11/16/17
Approved By 11/15/17
Institutional Review Board (IRB) at 860-486-8802, or the University of the West Indies at Cave Hill IRB through the Office of Research at (246) 417-4847.

**Documentation of Consent:**

I have read this form and decided that I will participate in the project described above. Its general purposes, the particulars of involvement and possible risks and inconveniences have been explained to my satisfaction. I understand that I can withdraw at any time. My signature also indicates that I have received a copy of this consent form.

<table>
<thead>
<tr>
<th>Participant Signature:</th>
<th>Print Name:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Signature of Person Obtaining Consent</th>
<th>Print Name:</th>
<th>Date:</th>
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<tbody>
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</table>
Information Sheet for Participation in a Research Study

UCONN
UNIVERSITY OF CONNECTICUT

Principal Investigator: Michael Fendrich, Ph.D.
Student Investigator: Janelle K. Bryan, MSW
Study Title: Intimate Partner Violence Screening Among Barbadian Health Care Professionals: Applying The Integrated Behavioral Model.

Introduction
You are invited to participate in this study because you are a licensed health professional with a degree in medicine, dentistry or nursing, and you provide acute and/or routine primary care services to women aged 18 and older. The Student Investigator is a doctoral candidate at the University of Connecticut, conducting this survey as part of her dissertation. She is interested in exploring primary care health care practitioners’ (HCPs) attitudes, knowledge, beliefs and behaviors regarding screening for domestic violence between intimate partners.

Why is this study being done?
The purpose of this research study is to: 1) identify the degree to which primary care HCPs in Barbados screen women for domestic violence in their practice; 2) determine the attitudes, beliefs, and knowledge of Barbadian primary care HCPs with regard to domestic violence; and 3) determine whether HCPs who have received domestic violence training have different screening practices from those who have not received such training.

What are the study procedures? What will I be asked to do?
If you agree to take part in this study, you will be asked to fill out the attached survey. The survey should take about 20 minutes to complete.

What are the risks or inconveniences of the study?
We believe that the risks presented to you by this survey are minimal. The questionnaire will address a range of topics, focusing on your views and experiences related to screening adult female patients for domestic violence as part of your practice. This may bring up previous experiences involving social or emotional conflict. You may choose not to answer any of the questions. A referral list of agencies that may be helpful to you will be provided upon request. The only inconvenience is the amount of time the survey will take to complete. In order to protect your identity, all identifying information will be removed from all documents and you will be assigned a unique identifier. We will do our best to protect the confidentiality of the information we gather from you but we cannot guarantee 100% confidentiality.

What are the benefits of the study?
You may not benefit directly from participating in these interviews. It will be beneficial to the Student Investigator because it will help her complete her dissertation and may aid her in
future research. This research will benefit the Ministry of Health in potentially identifying future areas of focus for training and resource allocation for health care practitioners with regard to the topic of domestic violence. The research could also benefit the social work profession and how schools of social work teach new professionals.

Will I receive payment for participation? Are there costs to participate?
There are no costs to you. As a token of appreciation for your time, a UConn School of Social Work pen is enclosed.

How will my personal information be protected?
Locked boxes for return of hard copy surveys will be placed in a secure administrative area at each polyclinic site, and the contents of each will only be accessible to the Student Investigator. Upon receipt of your completed survey, the data will be entered into a statistical software package for analysis. Surveys will only feature a unique identifier assigned to each participant for the purposes of tracking returned surveys. All electronic files (e.g., database, electronic survey responses, etc.) containing identifiable information will be password protected. Any computer hosting such files will also have password protection to prevent access by unauthorized users. After survey data entered has been entered, the key linking the participant to the numeric identifier will be deleted. This will further protect your information. At the conclusion of this study, we will publish our findings. Information will be presented in summary format and you will not be identified in any publications or presentations. Paper copies of surveys will be kept in a locked cabinet to which only the Student Investigator will have access. Hard copies of the surveys will be retained for five years after the completion of the study.

You should also know that the UConn Institutional Review Board (IRB) and Research Compliance Services or the University of the West Indies-Cave Hill IRB may inspect study records as part of its auditing program, but these reviews will only focus on the researchers and not on your responses or involvement. The IRB is a group of people who review research studies to protect the rights and welfare of research participants.

Can I stop being in the study and what are my rights?
You do not have to be in this study if you do not want to. If you agree to be in the study, but later change your mind, you may drop out at any time. There are no penalties or consequences of any kind if you decide that you do not want to participate.

Whom do I contact if I have questions about the study?
Take as long as you like before you make a decision. We will be happy to answer any question you have about this study. If you have further questions about this project or if you have a research-related problem, you may contact the principal investigator, Michael Fendrich, PhD, at 959-200-3612, or the Student Investigator Janelle Bryan, at 246-828-9448. If you have any questions concerning your rights as a research subject, you may contact the University of Connecticut Institutional Review Board (IRB) at 860-486-8802 or the University of the West Indies-Cave Hill IRB through the Office of Research at 246-417-4847.

Completing and returning the questionnaire constitutes your consent to participate.
Please keep this letter for your records.