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ORIGINAL RESEARCH: EMPIRICAL RESEARCH –
QUALITATIVE

Are we failing to prepare nursing and midwifery students to deal with domestic abuse? Findings from a qualitative study

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Abstract

Aims. To investigate student nurses' and midwives' knowledge, confidence and educational needs regarding recognition and responses to domestic abuse.

Background. Domestic abuse is a serious global problem and has greater, negative effects on long-term health than more obvious diseases, such as diabetes. Nurses and midwives are well-placed to recognize and respond to domestic abuse but many lack confidence in this area. There is firm evidence that training can increase the confidence of Registered Nurses and midwives in responding to domestic abuse. But the issue of undergraduate preparation is significantly under-investigated.

Design. A qualitative study.

Methods. Nursing and midwifery students were recruited using purposive sampling. We facilitated eight focus groups with a total of 55 students (student midwives $N = 32$; student nurses $n = 23$). Data were collected between May–November 2014.

Findings. Students in the study viewed the issue of domestic abuse as important and they possessed sound theoretical knowledge of its nature and consequences. However, they lacked confidence in recognizing and responding to abuse and were concerned about the implications of this for their future practice as registered practitioners. Interactive learning opportunities that engaged with service users and involved experts from practice were viewed as important educational requirements.

Conclusion. Most students in the study felt insufficiently prepared to deal with the issue of domestic abuse. They perceived this as a cyclical state of disempowerment that would impact negatively on their practice and on their own ability to support nursing and midwifery students of the future.

Keywords: domestic abuse, education, empowerment, midwives, nurses, placements, qualitative, student, violence

Why is this research or review needed?

- Domestic abuse is a global issue and it has serious, long-term health and well-being consequences.
- Many nurses and midwives lack confidence in recognizing and responding to domestic abuse.
- How nurses and midwives are prepared to deal with domestic abuse at undergraduate level is significantly under-investigated.

What are the key findings?

- Nursing and midwifery students viewed the issue of domestic abuse as important and they possessed sound theoretical knowledge of its nature and consequences.
- Students lacked confidence in recognizing and responding to abuse and were concerned about the implications of this for their future practice as registered practitioners.
- A cyclical state of disempowerment exists that students perceive will impact negatively on their future practice and on their own ability to support nursing and midwifery students.

How should the findings be used to influence policy/practice/research/education?

- Preparation programmes for nurses and midwives should include the issue of domestic abuse.
- Interactive learning opportunities that engage with service users and integrate expert knowledge are required.
- Further research is needed at national and international levels to investigate how best to prepare nurses, midwives and other health professionals to deal confidently with domestic abuse in practice.

Introduction

Domestic abuse (also referred to as domestic violence or intimate partner violence) is a universal phenomenon that indiscriminately crosses demographic and social boundaries. It is described as the infliction of physical, sexual or mental harm, including coercion or arbitrary deprivation of liberty (World Health Organization (WHO) 2013) or 'Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. The abuse can encompass but is not limited to: psychological, physical, sexual, financial [or] emotional' (Home Office 2012). Such descriptions capture the multiple manifestations of domestic

abuse and the different relationship configurations where it may take place.

Accurate prevalence is difficult to ascertain because domestic abuse tends to be under-reported. But a 10-country study reported that between 15-71% of women had experienced physical or sexual violence by their husband or partner (WHO 2009). In the UK, evidence indicates that over 1.2 million women and 750,000 men in England and Wales experience domestic abuse (National Institute for Health and Care Excellence (NICE) 2014). Domestic abuse has serious, long-term health and well-being consequences. The cumulative impact of mortality and morbidity mean that the health burden contributed by domestic abuse is greater than more commonly accepted public health priorities, such as smoking and obesity (Vos *et al.* 2006, Humphreys *et al.* 2008). It is thus, considered to be a major public health concern (Gutmanis *et al.* 2007, Bacchus *et al.* 2012, Beynon *et al.* 2012). Correspondingly, whereas domestic abuse used to be considered a private matter (Montalvo-Liendo 2009), it is now very much an issue that commands public (health) attention.

Background

Nurses are well-placed to respond to domestic abuse but there is a great deal of evidence that many health professionals – including Registered Nurses (RNs) and midwives – do not know how to assess accurately or respond appropriately to domestic abuse (McCloskey & Grigsby 2005, Lazenbatt *et al.* 2009, Bacchus *et al.* 2012). Education and training have been identified as vital in promoting health professionals' confidence in addressing this issue (Bacchus *et al.* 2003, Feder *et al.* 2011, Beynon *et al.* 2012). Mandatory domestic abuse training is now integrated into many continuing professional development programmes. Additionally, in the UK, NICE (2014) has recommended that training about domestic abuse should be part of undergraduate/pre-qualifying curricula. However, to date, the issue of how nurses and midwives are prepared at undergraduate level to deal with domestic abuse is under-investigated.

Of available studies, Davila (2005) reported that the majority of accredited nursing schools in the USA had failed to integrate violence assessment and intervention into their curricula and as a result, theoretically based educational activities are underdeveloped for baccalaureate nursing students. More recently, again in the USA, Connor and colleagues' (2013) quantitative study measured domestic abuse curriculum content exposure. They found that nursing students who received training on the

issue prior to graduate school had significantly higher perceived preparation and perceived knowledge ratings, than those who had no training (Connor *et al.* 2013). Tufts *et al.* (2009) investigated domestic abuse in relation to nurse educators – suggesting that it is educators who need knowledge and skills regarding domestic abuse to teach students effectively. While such studies provide some insights into the issue, there is a great deal that remains unknown.

As yet we do not fully understand through empirical enquiry, how empowered nursing and midwifery students are (from now on referred to as ‘students’, except where a distinction is required between the two groups) in dealing with domestic abuse and what educational preparation they require to deal confidently and competently with the issue. The study reported in this paper sought to address this gap in knowledge.

Theoretical framework

Theoretically we drew on a model of empowerment proposed by Bradbury-Jones *et al.* (2010): the ‘Spheres of Influence’ model. The model (Figure 1) emphasizes the centrality of knowledge and confidence in determining students’ empowerment in clinical practice. It shows a range of factors that can influence these, including for example, directly related influences such as being recognized as a learner, being part of a team and being respected as a person, having a supportive clinical mentor and a high quality placement, through to broader organizational and political influences. We chose this particular model to theoretically underpin the study because it is empirically grounded in research with nursing students. Its focus on knowledge and confidence aligns with the aims of the study and moreover, it allowed us to take account of the multiplicity of issues that might influence students’ knowledge and confidence and thus their empowerment, regarding recognition and responses to domestic abuse.

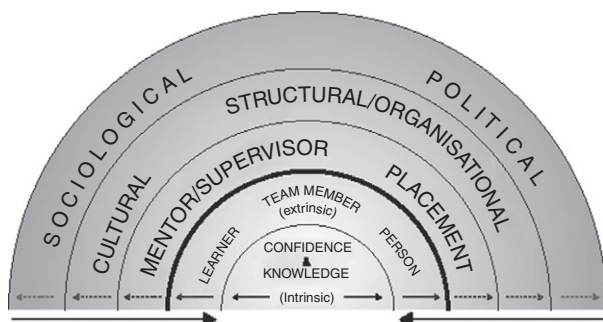


Figure 1 Empowerment of nursing students in clinical practice: spheres of influence.

The study

Aims

The aim was to investigate students’ knowledge, confidence and educational needs regarding recognition and responses to domestic abuse. We sought to answer the following questions:

- Q.1. What do students understand about the nature and manifestations of domestic abuse?
- Q.2 What are students’ experiences of recognising and responding to domestic abuse in clinical practice?
- Q.3. How confident are students in dealing with domestic abuse in clinical practice?
- Q.4. What are the educational needs of students to empower them to deal confidently and competently with domestic abuse?
- Q.5. What are students’ perceptions of the importance and relevance of domestic abuse to their practice?

Design

This was an exploratory study in an area where there is limited evidence and for this reason a qualitative approach was adopted. This is congruent with the Medical Research Council (MRC) (2008) guidance on developing and evaluating complex interventions, where qualitative studies have considerable value in the development phase.

Sample/participants

The study took place in one university in the UK. We aimed for a heterogeneous sample of students to capture a range of perspectives and experiences and to arrive at a full understanding of the issue. Using purposive sampling, we recruited third year students from the Bachelor of Nursing (from adult, mental health and child fields) and Bachelor of Midwifery programmes. Sample size in qualitative research has been a long-standing issue of debate, but as Sandelowski (1995) observed, it is a matter of quality rather than quantity. We planned for a sample of 36 because we considered that this would be sufficient to answer our research question and would ensure sufficient variation in the groups recruited. The inclusion criteria were for students to be in the third (final) year on either of the programmes. The exclusion criteria were students on other educational programmes who were not in the third year. We deliberately recruited final year students because of their extensive

experiential knowledge of student-hood and because we were interested in their perceptions of preparedness for their forthcoming role as professional registrants.

Data collection

Eight focus groups were conducted between May–November 2014. Seven focus groups were audio recorded with the full, written consent of participants and transcribed verbatim. One focus group preferred the researcher to take verbatim notes. We aimed for fluid discussion rather than question and answer format, but to ensure that the focus groups were conducted consistent with the aim of the study, they were organized around a discussion guide (Table 1).

Ethical considerations

Ethics committee approval was obtained from the University Research Ethics Committee, at the selected study site (Ref 14079). The two principal ethical considerations related to: (1) the relative power of the two researchers in relation to the student participants; and (2) the sensitive subject area. To address the first, participants were recruited by an open verbal invitation to participate, accompanied by written information about the project. To overcome potential issues related to coercion, this was via a third party (an academic colleague who was not connected to the study). Prior to the formal start of the focus group, the two researchers explained the purpose of the study and expectations about participation. All students signed a consent form that made explicit their right to exit the focus group at any stage.

In relation to the second ethical issue, Connor *et al.* (2013) reported that 40% of nursing students surveyed had personally experienced some type of domestic abuse. So, there was a considerable chance that some participants in our study may have experienced domestic abuse, resulting in distress and upset. We put in place supportive mechanisms to overcome these, for example, we allowed time at

the end of each focus group for debrief and informal discussion. Also, participant information sheets contained contact information for domestic abuse and child abuse help-lines. Two students did disclose a personal history of abuse during the focus group discussions (participants in some of our previous studies have made similar disclosures). For both students, the abusive relationship had ceased and they were no longer experiencing abuse. However, they were both contacted after the discussion by (CB-J) to ensure that they were emotionally and physically safe.

Data analysis

Data were analysed using thematic content analysis. CB-J undertook an initial analysis independently of KB. The analysis was then shared and the two researchers made some minor moderations to the initial analysis until the final themes were agreed. As indicated in Table 1, we had closely adhered to the research questions in the focus group discussion guide and as a result, we found that the inductively derived themes mapped neatly to our questions, which assisted in the organization and presentation of data.

Analysis of focus group data can be conducted in a similar manner to analysis of other qualitative, self-report data. However, the distinct feature of focus groups, is attention to group dynamics (Kitzinger 2005). For this reason, although some of the data presented in this paper are from individual participants, where possible we have retained strings of discussion to highlight interaction.

Rigour

Evaluating the quality of qualitative research is a contentious issue and some have argued that it is simply a matter of taste (Sandelowski 2014). However, it is important to undertake high quality, rigorous research, irrespective of how others choose to judge it. We attended to rigour in two ways: methodologically and theoretically. Methodologically we drew on Lincoln and Guba (1985) work on trustworthiness. Cognizant of their four criteria of credibility, transferability, dependability and confirmability, we incorporated several strategies into the research design. For example, providing meaningful excerpts of data means that readers can judge the believability or credibility of the findings. Analysing data independently was considered an important measure about dependability and gives us confidence that the findings reflect an ‘accurate’ interpretation of the data. Similarly, although the notion of confirmation in qualitative research is contentious (Ashworth 1993), the two final focus groups were a means of checking that our

Table 1 Focus group discussion guide.

Prompt questions:

- Q.1. What do you understand by the term ‘domestic abuse’?
- Q.2 While on placement, have you encountered any people who have experienced domestic abuse?
- Q.3. How confident do you feel in dealing with domestic abuse in clinical practice?
- Q.4. What do you think is required educationally to equip you to deal confidently and competently with domestic abuse?
- Q.5. How important is it for us to investigate this issue?

interpretation of data aligned with the actual experiences of nursing and midwifery students. In terms of theory, a sound theoretical base in qualitative research has been advocated as an important marker of rigour (Bradbury-Jones *et al.* 2014). So arguably, the model of empowerment used in the study contributed to rigour by providing structure, clarity and strong theoretical and empirical underpinnings.

Findings

Fifty five students took part (representing over-recruitment in relation to our intended sample size of 36). All participants were female; we did not collect data relating to age. In the UK, student nurses chose a 'field' where they subsequently specialize as a Registered Nurse. Along with the 32 student midwives, the 23 student nurses were on the following fields: 16 adult; four child; and three mental health. We had hoped to achieve maximum variation in the sample and we are confident that this was achieved. Composition of the focus groups is shown in Table 2 with a code allocated to each to represent whether it was with student nurses (SN) or student midwives (SM). Findings are presented in response to the research questions. Illustrative excerpts have been selected on account of their typicality to substantiate key findings.

Students' understandings of the nature and manifestations of domestic abuse

In our study, students had a clear awareness of the different manifestations of abuse:

Table 2 Focus group composition.

Student group	Field specific	Code	No. of students
Student midwives	N/A	SM1	10
Student midwives	N/A	SM2	8
Student midwives	N/A	SM3	8
Student midwives	N/A	SM4	6
Student nurses	6 adult & 1 mental health	SN1	7
Student nurses	3 adult & 4 child	SN2	7
Student nurses	2 adult	SN3	2
Student nurses	5 adult & 2 mental health	SN4	7
Total participants			55

[Domestic abuse is] when someone has been either verbally, physically or sexually abused, generally within the home by a member of the family. (SM1)

When people talk about domestic abuse that's kind of the first assumption, it's someone with black eyes, oh I walked into the cupboard again thing. But I think that there are other forms, like financial control or like psychological fear as well. (SN 1)

Student nurses in the second focus group debated the types of abuse and identified some of the typical assumptions surrounding the issue:

Student 1 People just think it's physical don't they? But it's more than that, it's emotional and financial and...

Student 5 I think there is a lot of assumptions when people say domestic violence, you usually think it's a man doing it to a woman, whereas it's like, I think research kind of shows a lot more the other way round now.

Student 2 Oh yeah, 'cause you could just be being controlled, there might not be an element of like physical violence, but you could be being controlled and you might think that's perfectly normal, until someone points out that that's not the way it should be. They might not realize themselves that that's what's happening... (SN2)

It was clear from such discussions, that most students demonstrated sophisticated knowledge of the range and various manifestations of domestic abuse.

Students' experiences of recognising and responding to domestic abuse in clinical practice

Interesting differences were seen in perceptions of exposure between students, with programme and field specific variations. Student midwives were clear about the extent to which they encounter domestic abuse:

Interviewer

Have you encountered women who feel... you've been worried about?

Student 1 Yes.

Student 2 Yes.

Interviewer Yes, all of you?

All Yes. (SM2)

Similarly, nursing students from the child field reflected on their experiences as captured in the following discussion:

In my first year it [my clinical placement] was in quite a deprived area and there were days when literally every single meeting was about domestic violence. Like that was all we did every day was children that were looked after because of present domestic violence or past domestic violence, or the risk of domestic violence. So yeah sometimes it would be all we would do all week. (SN2)

Although many of the students from the adult field also shared experiences of encountering domestic abuse, two students considered that they had never come across it:

I don't think you get to see it in adult field really. Like you don't hear of domestic violence, you don't get to see a police report. I haven't in 3 years...I don't remember seeing it. People hide it don't they? (SN2)

From a practice point of view, during my training I haven't...I don't think I've come across anyone in these situations, but obviously there's always the opportunity that it might arise. (SN1)

Even when students had encountered domestic abuse on placement, their opportunities to engage with the care of those who had experienced it varied considerably:

It gets moved to the specialists. I've spoken to my mentors and they feel a bit like they get deskilled now, because all they do is signpost...and now it's like 'oh I don't know what to do', you know? (SM1)

Student 3 From my experience, as soon as there's like a safeguarding issue or a domestic violence, students weren't allowed to be involved...I think for the family being involved, fair enough, they don't need extra people. But for our learning we don't get provided it, so it's like something that when we're qualified nurses we're expected to do, but we don't get it as students...

Student 6 Yes but it varies though. When I was with health visitors [public health nurses], I always went to the safeguarding and domestic violence things and there was only maybe one when I didn't. Some of them [RNs] are just like: 'Oh no, you can't come'. (SN2)

Students did not consistently describe field placements as providing opportunities to apply their formal knowledge. More often than not, they felt removed from situations when domestic abuse was manifest. As described in the

following section, this contributed to their lack of confidence in responding in practice to this issue.

Students' confidence in dealing with domestic abuse in clinical practice

I think we've had really good lectures on theory around domestic abuse but I don't think we've had such good preparation for practical... especially around if somebody discloses, I don't know...I feel like I am not very well prepared for if it had been disclosed directly to me. (SM2)

In this first illustrative extract, the student confirms lack of opportunity to translate theoretical learning into applied skills for frontline practice. Student nurses in the first focus group were able to expand considerably, on the specific gaps in their knowledge and confidence. The theme of feeling uncertain and ill equipped to respond to situations of domestic abuse in practice was pervasive:

I don't think through the training that we've had massive amounts of teaching on how actually we would deal with it. Because it's one thing someone telling us that they've been involved in domestic violence, but it's another that we actually know how to react and support them in that. And like what kind of referrals that we would need to be doing as well. (SN1)

The student midwives identified similar gaps:

Student 2 They [midwives in practice] assume that we've been learning it in university – had a lecture.

Student 1 The problem is you don't learn that much [about domestic abuse] in university (SM2)

Students were encouraged to think ahead to their impending status as registered practitioners and consider their level of preparedness. One nursing student captured the position well:

It's a tricky one...I am confident in the sense that I am confident that it should be part of the care I deliver. So I have full confidence of it being important... but I am less confident as to what to actually do! SN3

Educational considerations to increase students' confidence and competence in dealing with domestic abuse

Third year students are well-placed to make recommendations about how educational and placement opportunities

might prepare them more fully for responding in practice to domestic abuse:

Student 1 I think maybe a collection of really different stories from really different people [who have experienced domestic abuse], you know people who are really successful and seem to be powerful, strong women who are in a situation. And kind of break the stereotype and have a few... I don't know, just have stories from real people.

Student 4 I think it would be really nice to actually sit like this with people and see them and speak to them. But equally, if that person is not willing to do that, then obviously a written format would give us something, just to refer to. (SN1)

Integration of patients/service users into formal education was firmly recommended by students across the disciplines of nursing and midwifery. As illustrated, students wanted 'solid practical' learning experiences and to engage with real life stories from survivors of domestic abuse. Students' responses to focus group questions clearly indicated that domestic abuse is an unsettling topic and disclosure can prompt fear and panic in students. In the absence of adequate preparation, students are left not knowing how to respond. As indicated in the following excerpt, students struggled to marry up a clear message in policy that safeguarding is the business of all professional groups:

Student 1 I think we could have been trained a little bit better in how to deal with someone disclosing domestic abuse. But can you really prepare for that, I think.

Student 2 I'm wondering whether it would be good, I don't know if it's possible, to get women who have been in that situation to come and talk to us.

Interviewer
Service users?

Student 2 Yes because I'm always terrified of saying the wrong thing, which can prevent you saying anything, you know, you can be a bit hesitant about it. So if you could have a real honest conversation... I know everybody's individual and one service user can't speak for everybody, but it might, as students, give us a bit of confidence about what would feel comfortable with us...

Student 1 And make us more aware of what services are available.

Student 5 Maybe we should be working with social workers? That would be more beneficial. (SM2)

Students' perceptions of the importance and relevance of domestic abuse to their practice

The fact that we over-recruited to this study may serve as an indicator of how students view the issue of domestic abuse. Many said that they had attended the focus group specifically to learn more about the issue. During the discussions, the students highlighted the cyclical nature of lack of educational preparation:

I think it perpetuates itself because if we leave not being prepared, then we're going to feel embarrassed or not sure how to talk to our students about it. And then that's probably why they don't want to talk about it, because they [RNs] feel that 'oh it's this thing that I should know stuff about – but I don't'. (SN2)

We've got to the end nearly [of our programme] and like my biggest concerns are how my training has prepared me – or hasn't prepared me – and the feelings of anxiety that I've got. And so it was productive use of my time to come to something like this [focus group], than to just complain and moan and internalize worries that I might have had about the 3 years that have gone already. (SN1)

Discussion

The 'Spheres of Influence' model (Bradbury-Jones *et al.* 2010) holds that knowledge and confidence are essential elements of student empowerment. Our findings show that students have a good theoretical understanding of the issue of domestic abuse, including the different types and its negative impacts. In fact, they were able to challenge some of the commonly held stereotypes about abuse, for example, that it only occurs among certain groups and contexts (Taylor *et al.* 2013). Most of the midwifery students reported that they had encountered women in practice who had experienced domestic abuse but we were surprised that some of the adult nursing students believed that they had never encountered anyone in practice where domestic abuse was an issue. Given the prevalence of domestic abuse this is highly unlikely and may represent an inability of students to link theory to practice or to pick up on potential clues and indicators of abuse. This points to the need for greater support and education in this area.

Confidence in recognizing and responding to domestic abuse was a pervasive concern for the majority of students

in the study. Many were particularly worried about how to talk about the issue of abuse with patients and service users. The issue of disclosure is a fearful process for people who have been abused (Montalvo-Liendo 2009, Catallo *et al.* 2013), but it is also something feared by many health professionals. Complex assessments need to be made by health professionals in relation to domestic abuse (Davidov & Jack 2014) and previous studies have highlighted how many RNs and midwives lack confidence in dealing with the issue (Taylor *et al.* 2013). Students in the study were concerned about the implications of their lack of preparedness. They described this as cyclical, perceiving that if they remained unprepared as RNs and midwives, they would be unable to suitably support the next generation of students and so on.

The next two concentric layers of the spheres of influence model are concerned with how students are treated in practice as learners, team members and as respected people. These spheres highlight the place of supportive mentors and placements in facilitating students' learning. Some students in our study were able to learn about domestic abuse in practice and were actively engaged in cases where domestic abuse was an issue. However, most lacked such exposure and were excluded from care where domestic abuse was an issue. Although this is invariably to protect individuals and families from yet another person involved with their care, it does present a conundrum. When and where will students ever be able to gain the required experiential knowledge that can assist in translating knowledge into practice?

In our study, students indicated the value of inter-professional learning – a consistent theme in messages from Serious Case Reviews (Brandon *et al.* 2008) is that professionals struggle to work across professional boundaries. The foundation for reciprocal learning could be laid down in undergraduate education, particularly where faculties house multi-professional groupings. In addition to inter-professional learning, students in our study wanted interactive sessions that engage with service users. This is congruent with recent NICE guidelines (2014), where partnership with local specialist domestic abuse services and face-to-face contact are considered to be important considerations for domestic abuse education and training. These can be considered as part of the recommendations for education arising from our study.

The outer layers of the spheres of influence model are concerned with the broader influences on students' knowledge and confidence. The policy context is particularly relevant here. In the context of nursing and midwifery preparation, in the UK where the study was conducted, there are several competences that nursing students need to

achieve to become registered practitioners: these include explicit statements about abuse. The Nursing and Midwifery Council (NMC), states that on entry to the register, all nurses must be able to recognize when a person is at risk and in need of protection and take reasonable steps to protect them from abuse (NMC 2010). Similarly, in relation to midwifery:

To be admitted to the register, student midwives need to demonstrate that they are competent in: 'providing the opportunity to women to disclose domestic abuse and... able to respond appropriately (NMC 2009, p. 44).

The Willis Commission that reported in 2012, was set up to investigate the essential features of pre-registration nursing education in the UK and the types of support for newly registered practitioners that are needed to create a competent and compassionate workforce. The review recommended that nurse education should embed patient safety as its top priority. It also emphasized the imperative for nurses to be provided with the necessary education and skills to equip them for their roles (Willis Commission 2012). Based on the findings of our study, however, we question whether the NMC competences of the recommendations from the Willis Commissions are always achieved.

All students in the study were at the point of registration. The transition from nursing student to practising nurse has been identified as a challenging and stressful time (Missen *et al.* 2014). The student midwives had received some coverage of the issue of domestic abuse as theoretical preparation in university and many had exposure to the issue during clinical practice. But the nursing students had received no educational input into the issue of domestic abuse and most had been excluded from learning opportunities in practice. Connor *et al.* (2013) reported that educational preparation of nursing students regarding domestic abuse is required to enable them to enter the nursing profession with the capacity to directly impact on the care of people with domestic abuse experiences. We agree. But our study highlights a considerable gap in preparation at undergraduate level, particularly for nursing students.

Limitations

There are some theoretical and methodological limitations of the study. Theoretically we drew on a model that was developed from work with nursing students and not midwifery students. Although there are some generic issues of educational preparation that might transcend the disciplinary differences in these two groups, the context of practice is different. This might mean that a model developed from within nursing was unfitting to frame a study that also

involved student midwives. Also, the model was developed in relation to students' empowerment in clinical practice generally – it was not focused on a specific issue. Applying it to explore an issue such as domestic abuse may have therefore been inappropriate. Overall though, while accepting these theoretical limitations, the structure and organization of the model served as a useful framework for the study.

Methodologically, this was a small, study undertaken in one university in the UK. For this reason caution needs to be exercised in over-claiming transferability to other countries and contexts. We know, however, that domestic abuse is an issue that crosses geographical boundaries and it is likely therefore, that students in many countries (and those from disciplines other than nursing and midwifery) will have similar experiences to those included in this study. For these reasons we believe that the findings have transferability internationally.

Conclusion

The study reported in this paper was underpinned theoretically by the 'Spheres of Influence' model; the limitations of which have already been discussed. Overall, however, we found that the model's focus on knowledge and confidence gave direction to the study and ensured that the study was conducted inline with the intended aims. As a result, this small study has generated robust evidence for practice, albeit in need of further exploration.

In terms of education, nursing and midwifery curricula are already squeezed in terms of content. It is impossible to include all health-related issues and there are perennial tensions between what needs to be included; to what extent; and where. All students in this study wanted domestic abuse to be covered in their curricula. The midwifery students had received some educational preparation, but for the nursing students it is evident that domestic abuse had not hit the threshold as an issue to be included in their curriculum. Given the greater health-related impacts of domestic abuse in comparison to some health issues, the argument for including domestic abuse in undergraduate nursing curricula is strong. Regarding implications for research, the small scale nature of this study has been acknowledged. What is required now are larger, national and international studies that build on the findings. These will provide further insights into the educational requirements of students. Extending these to include other health-related disciplines may be useful.

Students in the study appeared to have a thirst for knowledge about domestic abuse and many said that they had

attended the focus group specifically to learn more about the issue. Since undertaking the study, we have begun to integrate coverage of domestic abuse into the nursing curriculum locally. This is a small step in the right direction, but it needs to be more widespread if we are to avoid the culpability of producing future generations of graduates who are ill-prepared to deal with such an important area of nursing practice.

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Conflict of interest

No conflict of interest has been declared by the author(s).

Author contributions

All authors have agreed on the final version and meet at least one of the following criteria [recommended by the IC-MJE (<http://www.icmje.org/recommendations/>)]:

- substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data;
- drafting the article or revising it critically for important intellectual content.

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