UNIVERSITY OF CAPE COAST

ATTITUDE, BEHAVIOUR AND CHALLENGES OF NURSES CARING FOR THE PHYSICALLY ABUSED IN HOSPITALS IN THE SEKONDI-TAKORADI METROPOLIS, GHANA

LOLA MAJEED AIKINS

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BY

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Thesis submitted to the Department of Guidance and Counselling of the Faculty of Educational Foundations, College of Education Studies, University of Cape Coast, in partial fulfillment of the requirements for the award of Master of Philosophy degree in Guidance and Counselling.

JUNE 2022

DECLARATION

Candidate's Declaration

I hereby declare that this thesis is the result of my own original research and that no part of it has been presented for another degree in this university or elsewhere.

Candidate's Signature:.....Date:.....

Name: ……

Supervisor's Declaration

I hereby declare that the preparation and presentation of the thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast.

Supervisor's Signature: .....Date: .....

Name: ……..……..

ABSTRACT

The purpose of this study was to assess the attitude, behaviour and challenges of nurses who take care of the physically abused in selected hospitals in Sekondi-Takoradi Metropolis in Ghana. Specifically, the study examined the differences in the attitude, behaviour and challenges of nurses taking care of the physically abused persons on the basis of their gender, marital status and their work experience. Using purposive and convenient sampling techniques, a sample size of 126 general and mental health nurses from a population of 184 general and mental health nurses from Sekondi-Takoradi Metropolis were selected for the study. Tools used for analysis of the data was frequencies, percentages, mean, standard deviation, independent sample t-test and one-way analysis of variance (ANOVA). The results showed that nurses have positive attitudes towards the physically abused victims irrespective of gender, challenges, marital status and length of work experience. Also, the study found that the behaviour of nurses in general was good. The study recommends that nurses should be trained on their behaviour towards the physically abused especially on how to report abuse cases to domestic violence of victims support unit (DOVVSU) and professional counsellors. Education and training programmes in counselling are to be incorporated in the educational curriculum of nurses' training schools. Also, the government, through the Ministry of Health, should provide policy on screening so that the hospitals can follow protocols on how to screen physically abused victims.

KEY WORDS

Attitudes

Behaviour

Challenges

Nurses

Physical Abuse

Victims of abuse

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DEDICATION

To my dear friend and husband, Rev. Joseph Aikins, my children and my siblings, for their support and encouragement.

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ACRONYMS

A&E	Accident and emergency
CDC	Centers for Disease Control and Prevention
CES	College of Education Studies
CoDE	College of Distance Education
DHS	Demographic and Health Survey
DOVVSU	Domestic Violence Victims Support Unit
EMR	Electronic Medical Records
GBV	Gender Based Violence
GNA	Ghana News Agency
GSS	Ghana Statistical Service
HIV	Human Immune Deficiency Syndrome
IPV	Intimate Partner Violence
MOH	Ministry of Health
NBDVAC	New Brunswick Domestic Violence Awareness Coalition
NGOs	Non-Governmental Organizations
NHIS	National Health Insurance Scheme
NHS	National Health Survey
OPD	Out Patients Department
RWJUHCHPP	Robert Wood Johnson University Hospital Community Health Promotion Program
SOPs	Standard Operating Procedures
SPSS	Statistical Package for Social Studies
UN	United Nations
UNICEF	United Nations International Children's Fund

WHO	World Health Organization
VAWG	Violence Against Women and Girls

CHAPTER ONE

INTRODUCTION

The purpose of this study is to assess the attitude, behaviour and challenges of nurses caring for physically abused victims in selected hospitals in Sekondi-Takoradi Metropolis. Most studies were done on factors affecting clinical nurses' performance and competence. Other research has looked at the link between critical thinking abilities and identity in nurses (Park & Kim, 2009). Others have attempted to raise knowledge of violence and abuse among emergency nurses, as well as their attitudes toward it (cho, Kyeong-Sook &Yang-Sook, 2015). However, these studies did not examine the attitude, behaviour and challenges of the nurses toward the care of physically abused victims. On this account, a yawning gap exist in previous studies which needs to be filled.

Background of the Study

Nursing care behaviour is an act, behaviour, and mannerism enacted by professional nurses that conveys concern, safety, and attention to the patient. The idea of caring behaviour plays a critical role in linking nursing interactions with client experiences, yet it is unclear and challenging for diverse scholars to establish a common interpretation (Oluma & Abadiga, 2020).

Protection, promotion, improvement of health and abilities, avoidance of illness/injury, relief of pain, diagnosis, treatment, and advocacy for individuals, families, and communities are all examples of nursing activities

(American Nurses Association, 2013). Respect, compassion, wisdom, sensitivity, and care should all be displayed by nurses (Rudolfsson & Berggren, 2012). Nursing requires a high level of compassion (Gray, 2008). Caring, according to Finfgeld-Connett (2008), is an interpersonal process marked by competent nursing, interpersonal sensitivity, and close relationships. Nursing includes both technical and medical aspects of care, as well as emotional aspects. Attitudes, behaviors, relationships, acceptance, and variety, according to Brilowski and Wendler (2005), are emotional and technical components of care. Uncaring is the polar opposite of caring. Wiman and Wikblad (2004) described uncaring characteristics as being indifferent, insensitive, cold, and inhuman.

Providing high-quality care entails doing the right thing all the time and enhancing patient, family, and community health outcomes (Uys & Naidoo, 2004). Regrettably, this does not really occur. According to some researchers (Uys & Naidoo, 2004), patients were dissatisfied with the quality of healthcare they received, as well as with insensitive nurses (Wiman & Wikblad, 2004). Other researchers discovered that poor care for specific disorders, including HIV (Van Dyk, 2007) and viral infections (Frazer et al., 2010), was linked to negative attitudes among health workers. Healthcare and patient outcomes require nurses to have a good attitude. Attitudes are "inferred from external visible stimuli" and latent hypothetical traits (Ajzen, 2005). Healthcare personnel attitudes influence behavior, care quality, and health experience (Dias et al., 2012). Negative attitudes have an impact on care for the elderly (Jacelon, 2002) and other disadvantaged patients (Frazer et al., 2010).

The hospital's nursing objective is to provide the best possible nursing care to the residents of the catchment region. On the other hand, clients and external health care consumers have complained about nurses' terrible attitudes. These accusations were publicised in the local press, and a "complaints box" was set up outside the hospital's main door. Nurses at this hospital have been accused of having terrible attitudes and providing inadequate nursing service. The attitudes of nurses needed to be investigated, so that initiatives could be introduced to improve the quality of treatment and solve patient problems (Haskins, Phakathi, Grant, & Horwood, 2014).

Caring is a fundamental and distinct notion in nursing that is defined as human conduct of doing something with, for, to, or as people. It can be presented and done in a way that results in the fulfillment of human needs on a personal level. It denotes a work-oriented, caring, responsible, and affective interaction with others attitude. Nursing care behavior, as well as the nurse's opinion of nursing care behavior, is an act, behaviour, or trait performed by professional nurses to express sympathy, support, and care to patients (Watson, 1979). Mostly in science and art of nursing practice, which encompasses all aspects of providing nursing care to patients, caring is universal as well as central. Caring is a basic attitude and daily life events that occur when a nurse comes into contact with a client and is exhibited throughout actual nursing practices and behaviors. As a result, caring necessitates a nurse's spiritual, moral, personal, and social participation, as well as a dedication to self and others in the community (Watson, 2009). For a better patient outcome, nurses have a professional obligation to provide high-quality nursing care. Nurses' caring behaviors are used to verify all nursing

actions. However, a lack of skilled nursing care causes patients' well-being and health to suffer. As a result, nurses' caring behaviors can have an impact on patient satisfaction and nursing care quality (Suliman, Omer, & Thomas, 2009; Leininger's, 2002).

Caring behaviors include two primary components from a conceptual standpoint. Instrumental behaviors, which are linked to technical and bodily activities, are the first component. The second component is expressive conduct. This involves psychosocial and emotional activities such as providing patients with dedication, conviction, optimism, and emotional compassion (Arthur & Randle, 2007).

According to the World Health Organization (1991), nursing is both an art and a science that requires specific knowledge and skills. Nurses have an incalculable amount of power when working with patients (Hewison, 1995). This power results from a nurse's automatic access to often private and confidential areas of a person's daily life in the course of an assessment and daily work whilst caring for an individual. The relationship between nurses and clients is theorized to be a complementary one (Orem, 1995). The current wave of healthcare marketing has switched from great service to Caring is the trend in this era. Standard Operating Procedures (SOP) or minimal service standards to care with character, which establishes the ideal s of caring as the principles of healthcare. Nursing is based on the principle of High-quality nursing care combined with good caring can influence healthcare quality (Yanis, Ayu, & Nursalam, 2019).

Nursing care is an important part of health care coverage that eases nervousness in patients. Clients' perceptions of nursing care contribute to the

pressure they now have because of medical procedure. This may also be influenced by what they expect medical caregivers to do for them (Nordberg et al., 2010).

Nursing is an important profession that contributes significantly to the care of patients, and their recovery depends on the care that they receive from nurses. Generally, it has been reported that a number of nurses in Ghana have poor attitudes towards their clients. A report from Ghana News Agency, states that some clients and patients that patronize health facilities in the Sekondi-Takoradi Metropolis have expressed displeasure over the continuous disrespect and impunity exhibited by some nurses towards them. They said some nurses speak rudely to them, especially whenever they are seeking health care through the National Health Insurance Scheme (NHIS). This came to light during a stakeholder meeting organized by "Friends of the Nation", an NGO concerned with environmental issues and good governance practices in Sekondi, in an event held at Shama, a suburb of Sekondi-Takoradi Metropolis (GNA, 2016).

In another study at Kwahu Government Hospital, many of the participants had favourable impressions of nurses' attitudes and behaviour, which influenced their hospital attendance, whereas others believed that nurses attitudes toward them drove them to a private institution. They rated as courteous and respectful, and they respond quickly to patients' health care needs. These interactions are still important in the care process because the treatment's success is primarily determined by the patients' opinion of a positive nurse-patient relationship that has been built (Kolan et al., 2021)

In Sekondi-Takoradi, physical abuse is one of the cases that is on the high side at the Outpatient Department. This may be due to the fact that the environmental setting is a blend of industrial, fishing, and institutions. The existence of harbors, clubs, and pubs contributes to their predominant lifestyle. According to OPD records in 2019, the hospitals saw an average of three (3) cases per day. It was discovered that several of the cases were unrecorded. This is due to the unpleasant nature of assault at the hospital, as well as the processes that followed it.

Aggressive behaviour is portrayed as the danger or exercise of physical, mental, as well as enthusiastic damage; that is, any sort of power against someone else with the aim of delivering mischief or practicing force and authority over them (WHO, 2010). Acts of cruelty or other forms of abuse performed by one person against another in a local environment, such as a marriage or living together, are referred to as "aggressive conduct at home." Residential abuse, marital abuse, intimate partner violence (IPV), battering, and familial brutality are all included (Natan, Ari, Bader & Hallak, 2011). An IPV is the use of threats against another lifelong partner or companion by a close companion or accomplice.

Aggressive conduct can occur in both heterosexual and bisexual families and can include abuse against children and adults. Intimate Partner Violence is the most widely recognized type of aggressive behavior against women, with men accounting for the vast majority of perpetrators (95%) and female victims (Abramsky, Watts, Garcia-Moreno, Devries, Kiss, Ellsberg, Henrica, Jansen, & Heise, 2011). Intimate partner violence can take various forms, for example, physical, sexual, and enthusiastic brutality, and it

frequently includes savagery against women committed by their spouses or potentially other close male accomplices (Watts & Zimmerman, 2002).

IPV includes physical brutality such as hits, strikes, kicks, armed attack, murder, and sexual brutality, which are frequently preceded or accompanied by other forms of violence as psychological mistreatment, for example, keeping the casualty from seeing companions, consistent belittlement or embarrassment, terrorizing, or money-related limitations (Watts & Zimmerman, 2002). People who are physically abused are bound to be hospitalised and to utilise outpatient care as opposed to protection care (Usta et al., 2012). Another examination found that among casualties who were killed by their accomplices, 44% were in the trauma centre less than two years before their demises. In an equivalent investigation, 15 patients were in the trauma centre couple of times.

According to the Demographic and health survey (DHS) done in Ghana in 2008, 38.7% of ever married women aged 15 to 49 reported having been physically, psychologically, or sexually abused by a husband or partner at some point in their life. Moreover, a quarter (27.6%) of Ghanaian men said they had been the victim of physical or psychological abuse by their wife or partner (GSSet al., 2009). The fact that women in Ghana live in a patriarchal environment where the man is the head of the household and make all key household choices are one of the main reasons for the high occurrence (IDS et al., 2016).

Physical abuse in Ghana

The Republic of Ghana is situated in the West African sub-region of the Gulf of Guinea. Its overall land area is 238,537 square kilometers, with the Ivory Coast to the west, Burkina Faso to the north, Togo to the east, and the Atlantic Ocean to the south. There are sixteen administrative zones in Ghana: Western south and north, Central, Greater Accra, and Volta, Oti, Eastern, Ashanti, Brong Ahafo, Ahafo, Ahafo East, Northern, Savanna, Northern, Upper East, North East and Upper West. Ghana's populace is around 24 million, as indicated by the 2010 Census (Ghana Statistical Service (GSS 2013). The Ashanti, Eastern, and Greater Accra regions are household to about half of Ghana's population. With only 2% of Ghana's total population, the Upper East is the least inhabited region. Urban areas are home to more than half of the population (GSS, 2013). There are a few ethnic groups that make up Ghana's population. The Akans have the largest group (48%) preceded by the Mole-Dagbani (17%), Ewe (14%), Ga-Dangme (7%), and other ethnic groups (GSS, 2013). According to the 2010 Census, there are 95.2 men for every 100 women. GSS, IDS, and Associate (2016).

As per the National Health Survey (NHS) done in Ghana in 2008, 38.7% of ever-married ladies aged 15 to 49 years reported being subjected to physical, mental, or violent acts at some point in their lives by a spouse or accomplice. Over a quarter (27.6%) of Ghanaians men admitted to being subjected to physical or emotional abuse by their better half or accomplice (GSS et al., 2016).

Ghana has put in a tremendous amount of effort in the course of the most recent three decades to lessen the occurrence of abusive behavior at

home. A portion of the primary investigations on aggressive behavior at home in Africa occurred during the 1990s in Ghana, just as in Tanzania, Uganda and South Africa (Hodgson, 2002; Ofei-Aboagye, 1994b; Watts, Osam & Win, 1995). The efforts of lobbyist groups, which played a large role in the planning and implementation of abusive behavior at home regulations in Ghana, influenced these investigations (Bowman, 2002; Kimuna & Djamba, 2008; Schneider, 2008). Ghana's original enactment endeavors in contrast to abusive behavior at home mirrored the worldwide energy in pushing for ladies' privileges to be perceived as human rights.

Abusive behaviour is a common occurrence in almost all social classes, and it can be found in any gathering. While both men and women can be perpetrators and victims of domestic violence, the majority of cases involve a male perpetrator and a female victim (Casey et al., 2012). According to Pinheiro (2010), 35% of women globally have been physically or sexually mistreated by a personal partner at some point in their lives. According to certain national studies, 70% of women have also experienced physical or sexual abuse from a personal companion at some point in their lives.

The prevalence of physical brutality within local settings has been most noticeable in Africa, with nearly 50% of the continent's nations detailing a period predominance of more than 40%, with the Democratic Republic of the Congo having the highest figure of sixty-four percent (64%) of such cases as of 2007 (Adebayo, 2014). As of the eighth month of 2007, one hundred and sixteen males had been truly abused, according to information available at the Ghana Police Service's Accra Regional Office of the Domestic Violence and Victims Support Unit (DOVVSU).

Ladies in the Ghanaian community are subjected to prejudiced social customs that expose them to their male partner's cruel proclivities. Abused women are more prone than men to disclose violent extremism in practically every country in the world, according to research. In contrast to female victims, male victims are more hesitant to inform others about accomplice abuse. Male survivors of domestic violence report incidents to the cops and other law enforcement organisations in lower numbers than female survivors. The reasons for men's lower proclivity to reporting abusive behaviour at home appear to be rooted in a clarification of the male-centric partnership that confers control and physical prowess solidarity to men.

In this way, male survivors of viciousness are generally criticised and disgraced when such instances of residential maltreatment that they endure in the possession of their female companions are reported. Reported male maltreatment by female life partners is considered "powerless" and incapable of overseeing residential emergency situations (Garrat, 2012). Most male-centric societal orders view males as victims of assault rather than survivors. The one-sidedness of analytical work on abusive conduct at home, which normally investigates men as responsible parties and women as survivors of sexual orientation-based brutality, appears to have discovered further articulation in this cliché perplexity.

At home, men have also been victims of abuse. In a summary report, the Institute of Development Studies (IDS), Ghana Statistical Services (GSS), and Associates analyse the findings of the Domestic Violence in Ghana research report (2016). Domestic violence, whether physical or sexual, affects 35% of women around the world at some point in their lives. Around the

world, 75% of women are subjected to emotional abuse and controlling behavior. As is well known, men are also victims of domestic violence. Domestic violence statistics that are nationally representative are, however, difficult to obtain (IDS et al., 2016).

According to a survey on domestic abuse in 2015, it was reported that 28% of women and 20% of males were abused both physically and emotionally. Domestic violence has immediate and catastrophic implications for those who are affected, including physical injuries, mental health issues, and a general lack of well-being. However, it has long-term, far-reaching consequences, such as persisting inequities between men and women, which impede women and girls' ability to achieve their full potential (IDS et al., 2016).

Domestic abuse survivors suffer poorer long-term physical and mental health, a higher chance of obtaining HIV and other sexually transmitted illnesses, and fewer options for education and employment. They are also prone to having lower educational, income, and productivity levels. As gender inequities become established, the repercussions are not only life-changing for the women and men involved, but also for their families, communities, and wider societies.

This study attempts to examine the Attitude, Behaviour, and Challenges of Nurses caring for physically abused victims in selected Hospitals in the Sekondi-Takoradi Metropolis.

Statement of the Problem

Physical abuse is defined as any intentional act of injuring or injuring another person or thing through physical contact. In most cases, children are

the victims of physical abuse, but adults can also be victims of abuse, such as in cases of domestic violence or workplace intolerance (Giadino, 2014). These physically abused suffer from various forms of injuries ranging from minor bruises to deep lacerations, various degrees of burns, fractures, and sometimes include head injuries that need to be hospitalized for proper and quality care.

The attitude, behaviour, and challenges of nurses caring for the physically abused determine the effectiveness of their care for the abused victims. Poor care of the physically abused can be risky not only to the victims themselves, but also to their immediate relations and peers with whom they interact daily. The continuous neglect of the ever-increasing number of abused patients directly hampers the health of the nation's human resources, which also has implications for productivity and the overall development of the country. In Ghana, statistics show that 33–37% of women have ever experienced domestic violence in the form of intimate partner violence in a relationship (Ghana statistical survey, 2008). Despite intervention in Ghana, including the passage of the Domestic Violence Act 732, it persists. The prevalence remains unacceptably high, with 10–69% of women worldwide being physically assaulted at one point in their lives (Lithur, 2013). According to the statistics available at the Accra Regional Office of the Domestic Violence and Victims Support Unit (DOVVSU) of the Ghana Police Service, as at the eighth month of 2007, one hundred and sixteen men had been physically abused. This means anyone can be physically abused.

Sekondi-Takoradi has also been recording an increasing number of physical abuse/assault cases (527) for the year 2019, according to a report from Ghana Police Service and DOVVSU Sekondi-Takoradi

Metropolis. Hence, most research continues to be focused on other factors, hence the need for current study.

Purpose of the Study

The purpose of the study was to assess the attitude, behaviour and challenges of nurses while taking care of physically abused victims in selected hospitals in the Sekondi-Takoradi Metropolis of Ghana. Precisely, the study sought to:

1. Assess the attitude of nurses towards the physically abused in selected hospitals in the Sekondi-Takoradi Metropolis.
2. Assess the behaviour of nurses towards the physically abused in selected hospitals in the Sekondi-Takoradi Metropolis?
3. Determine the challenges nurses encounter in caring for the physically abused in selected hospitals in the Sekondi-Takoradi Metropolis?
4. Determine the differences between male and female nurses in their attitude towards physically abused victims.
5. Determine the differences between male and female nurses in their behaviour towards physically abused victims.
6. Determine the differences between male and female nurses in the challenges they encounter in caring for physically abused victims.
7. Determine the attitudinal differences among the nurses' care of the physically abused based on marital status.
8. Determine the differences on the basis of length of work experience in the attitudes of nurses towards the care of the physically abused victims.

Research Questions

The following Research Questions were posed to guide the conduct of the study:

1. What is the attitude of nurses towards the physically abused in hospitals in the Sekondi-Takoradi Metropolis?
2. What is the behaviour of nurses towards the physically abused in the hospitals in the Sekondi-Takoradi Metropolis?
3. What challenges do nurses encounter in caring for the physically abused in the hospitals in the Sekondi-Takoradi Metropolis?

Research Hypotheses

The following Research Hypotheses were tested to further guide the conduct of the study:

$H_0$1: There is no statistically significant difference between male and female nurses in their attitude towards physically abused victims.

H_A1: There is statistically significant difference between male and female nurses in their *attitude* towards physically abused victims

$H_0$2: There is no statistically significant difference between male and female nurses in their *behaviour* towards physically abused victims

H_A2: There is statistically significant difference between male and female nurses in their behaviour towards physically abused victims

$H_0$3: There is no statistically significant difference between male and female nurses in the challenges they encounter in caring for physically abused victims.

H_A3: There is statistically significant difference between male and female nurses in the challenges they encounter in caring for physically abused victims

$H_0$4: There is no statistically significant difference based on marital status in the attitude of nurses towards the care of the physically abused victims.

H_A4: There is a statistically significant difference base on marital status in the attitude of nurses towards the care of the physically abused victims

$H_0$5: There is no statistically significant difference based on work experience in the attitude of nurses towards the care of the physically abused victims.

H_A5: There is a statistically significant difference, on the basis of work experience in the attitudes of nurses towards the care of the physically abused victims.

Significance of the Study

It is expected that the study may be of great significance to the nurses because it has the potential to identify the nurses' degree of challenges to overall abuse and violence. The study may help the researcher and government and non-governmental bodies in advocating and protecting the interests and welfare of victims of physical abuse. Also, findings from the study may help hospital managers improve nurses' performance and competence towards the care of physically abused victims through advocacy interventions. The findings from this study may again assist in the development of counselling interventions geared towards improving nurses' professional quality and clinical performance and competence. Finally, this study may become a reference point for future research through the use of its outcome data as the literature for such research.

Delimitation of the Study

The study was delimited to:

1. General and mental health nurses in some selected hospitals in Sekondi- Takoradi metropolis in the Western Region. The study was further delimited to physically abused victims.
2. Selected hospitals including Effia-Nkwanta General hospital, Takoradi hospital and Essikado hospital.

Limitations of the study

1. The subjective nature of the close-ended questionnaire items, which required the respondents to express their views on the attitude, behaviour, and challenges of physically abused victims in their area of operation, was a hindrance. Participants may provide false information to mask their true intentions due to the sensitive nature of the topic. They would therefore be well educated and engaged on the need to give true information so as to give a true reflection of the work.
2. There might be an issue of selective bias due to the shift duty roster of the hospital staff. This might reduce the sample size, which will make it difficult to generalize the outcome of the study. The administrator would be present at a meeting prior to the visit to communicate with staff and obtain their permission to be present on the days of data collection.

Definition of terms

Nursing

It is the act of giving wholistic care to the individual who has been physically abused to promote and restore health.

Caring

The behaviour directed at the abused victim to satisfy his or her health needs

Health care

It is the service provided by the nurse to the victims of abuse.

Quality of Care

The desire and expected outcome for the client as a result of the service rendered to them.

Patient

They are the physically abused victims who are have received or are receiving treatment.

Attitude

Nurses' perception of assault which has an impact on their (nurses') behaviour.

Behaviour

The way the nurses act towards the physically abused victims in the course of their engagement with them.

Physical abuse

They are individuals who suffer from various forms of injuries ranging from minor to serious lacerations and fractures from other people (perpetrators).

Organization of the Study

The research is divided into five chapters. The first chapter which is the introduction of the study covered the background to the study, statement of the problem, purpose of the study, research questions, hypothesis, significance of the study, delimitations of the study, limitations of the study, definition of terms and organization of the study. Chapter two is about literature reviews which includes theoretical framework, conceptual framework and empirical

review. Chapter three describes the research design, the study area, population, sampling procedures, data collection instruments, data collection procedures and data processing and analysis. The fourth chapter presents the results and discussions and chapter five gives the gives an overview of the entire study which are the summary of the findings, conclusions, and recommendations.

CHAPTER TWO

LITERATURE REVIEW

Introduction

The purpose of this study was to assess the attitude, behaviour, and challenges of nurses caring for the physically abused in hospitals in the Sekondi-Takoradi Metropolis of Ghana. It starts with the conceptual framework that underpins this study, followed by psychological theories addressing the rationale behind the care of physical abuse victims by nurses. This is followed by the empirical framework of the study, which looks at existing literature on the themes. The attitudes and behaviours of nursing staff toward the abused, nurses' challenges towards the physically abused, marital status, and length of work experience in relation to the gender of the nurses' model training programmes for dealing with physical abuse will all be investigated.

Theoretical Framework

Counselling Theories

A variety of psychological hypotheses have been proposed to identify the rationale behind the care of physical abuse by nurses. Some of these are social learning systems theory and resilience theory.

Social Learning Theory

Social learning hypothesis keeps up that, people pick up social conduct by watching and mimicking others (Bandura, 1989). Model impersonation is the most important aspect of how people learn. The progression of language,

animosity, and good dynamic are all examples of this mechanism. According to the theory, as youngsters grow older, they receive criticism from their peers about their own conduct, causing them to build standards for making decisions about their behaviour and seek out role models that follow these principles (Bandura, 1989).

Most learning theories assume that an individual must have direct experience in order to learn. According to the social learning theory, a large portion of learning occurs through observation: watching other people and determining what happens to them. Learning is often a social process, and other individuals, especially significant others, provide compelling examples as role models for how to think, feel, and act (Engler, 2014).

Social learning theory is largely based on the work of Albert Bandura (2001), who mapped out a perspective on learning that includes consideration of personal characteristics of the learner, behavioural patterns, and the environment. Role modelling is the central concept of the social learning theory. Some highly impressive role-model work in the field of nursing A more experienced nurse who demonstrates desirable professional attitudes and behaviour sometimes serves as a mentor for a less experienced nurse (Engler, 2014). Research indicates that role models with high status and competence are more likely to be observed, although the learner's own characteristics may be a more significant determiner of attention.

The basic principles of this theory are;

- Focus on role models, the reinforcement that a model has received, the social environment and the self-regulating processes within the learner.

- The role of the teacher is to act as a very good role model, to use effective role model in teaching that are rewarded for their behaviour.

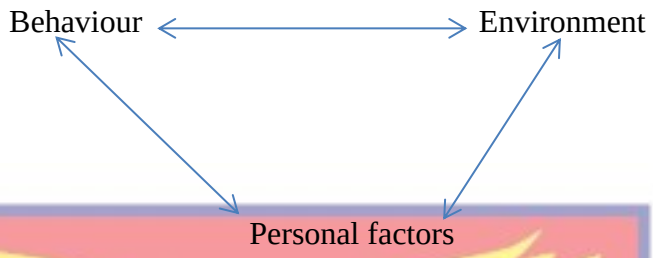

Figure 1: Bandura's behaviour model

According to Bandura (2001), the environment influences behaviour. Personal factors influence behaviour and vice versa, and environmental factors influence behaviour and vice versa. He advocates that the interplay of these elements regulates human behaviour. The environment in which the nurses find themselves and their thoughts influences what they do or how they behave towards their clients.

Resilience Theory

The theory was developed by Norman Garmezy, a developmental psychologist and clinician. Resilience is well-defined as the capability to cope with hard times, obstacles, and disasters, and it is vital for a successful leader. The hypothesis establishes a link between a leader's job stress and their ability to remain steadfast in the face of difficulty (Ackerman & Maslin-Ostrowski, 2002). The theory of "thriving" signifies an individual's ability to grow and perform beyond his or her own unique level of operation, even when confronted with difficult situations on a regular basis (O'Leary, 1998). Per the concept, one's reaction to pain is influenced by the meaning attributed to the pain, one's self-awareness, age, and developmental stage; genetic and mental resources; personal strengths and potentials; and social, cultural, and

economic circumstances (Nishikawa, 2006). Resilience helps the victim who is faced with stressful events and intimidation to bounce back. It helps the nurse to recover from the difficulties that have taken a toll on her.

Resilience Theory argues that the important is how we deal with the difficulties rather than the nature of adversities.

Within their clinical practice, all health professionals experience several stressors, including time constraints, workload, multiple tasks, and emotional concerns (McCann, Beddoe, McCormick, Huggard, Carole, Adamson & Huggard, 2013). Workplace stress can have a detrimental effect on health workers' physical and emotional well-being, leading to exhaustion and, in some circumstances, traumatic stress syndrome. These results can have an impact on health professionals' overall well-being as well as their capacity to perform effectively. As a result, it is critical to take proactive measures. Creating resilience-promoting environments in the health professions can be investigated as a way to reduce negative stress effects in health professionals while increasing good results (McCann et al., 2013).

Time pressures, workload, various tasks, and emotional concerns are all factors that contribute to stress in the health and helping professions (Lambert et al., 2004; Lim, Hepworth, & Bogossian, 2011). Frequent occupational environmental stress connected with human pain and anguish can have an impact on health workers' physical and emotional well-being, leading to burnout and, in some circumstances, traumatic stress-like symptoms (Stamm, 2010). These negative stress effects can have an influence not only on health professionals' well-being, but also on their ability to provide effective treatment to others (Barnett, Baker, Elman, & Schoener, 2007).

As a result, it is critical to take preventative measures. Developing and supporting resilient ecosystems and individuals within the health profession is emerging as a technique to reduce negative stress effects in health workers while increasing good ones (McCann et al., 2013).

Its role in positive organizational behavior

Other research has looked at resilience, along with optimism and hope, as one of many coping positive psychological resources. "The study and use of positively oriented human resource qualities and psychological capacities that can be tested, developed, and effectively managed for performance improvement in today's workplace," according to Luthans (2002).

Resilience Theory in Social Work

Resilience theory has grown in importance in the field of social work in recent decades, particularly when it comes to children. The essential significance of community interactions in both academic professions, as well as the key social work idea that individuals should assume responsibility for one another's wellbeing, are some of the reasons for this (International Federation of Social Workers, 2014). The premise that identifying resilience - building elements can help at risk clients (Green et al., 2004) is one of the key drives for additional resilience theory research in social work contexts. Increasing their skills and increasing their health assisting them in overcoming adversity and navigating life's challenges increasing their ability to thrive and grow.

The following are some of the most important concerns facing social workers:

- Identifying protective variables and incorporating them into intervention planning.

- Using practical applications to improve individual clients', societies', and communities' capacity and strength.
- Understanding how social work policy and services can help or hurt people's well-being and alleviate social and economic inequity (Mandie, 2015).

Social work strategies for building client resilience

Green et al. (2004) looked into the tactics and abilities that social worker used to help their clients become more resilient. Among them were the following: when dealing with adversity or traumatic situations, providing clients with safety and requirements; for example, conversing gently with concerned individual and reminding them of their capacities and ability to get through their problems. Listening being present and honest, and learning from people's tales while understanding their grief are all important skills to have. Promoting interpersonal bonds, affiliations and connections among members of a group or society. Encourage them to see themselves as valuable contributors to society. Modeling resilient behaviour, such as how to deal with stress at work in a healthy way.

Resilience in nursing and health

Some nurse researchers have explored resilience as a concept (Ahern et al., 2006; Olsson et al., 2003), but treating resilience as a concept does not enable the development of a caregiving and supportive framework that might enhance nursing. According to Ahern et al. (2006), the importance of healthcare providers in preserving or regaining the mental health of their patients who are facing adversity is underappreciated. Many concepts that have been found to improve resilience in the management of chronic illness or

the course of disability have been independently incorporated into nursing theory. One notable exception is Haase and her colleagues' lengthy research program, which examined resilience as a concept, constructed a resilience instrument (Haase et al., 1999), presented a mid-range theory (Haase & Peterson, 2015), and conducted additional quantitative testing (Haase et al., 2017). Haase's research focused on teenage cancer patients and looked into topics like spirituality, family communication and cohesiveness social support and information demands. The Adolescent Resilience Model (Haase, 2004) was developed to guide interventions for adolescents with cancer. From Haase's work, a consensus statement (Nelson et al., 2004) and interventions were developed and applied using The Adolescent Resilience Model to improve care for adolescents with cancer and their families (Haase, 2004). Haase's contribution to our understanding of resilience is extraordinary, but it is targeted exclusively at adolescent oncology.

Conceptual Framework

Causes of Physical Abuse

The most frequently acknowledged reasons for physical mistreatment of people have been identified, according to Mash and Wolfe:

- Many harmful and careless guardians have had insufficient exposure to healthy parental models and supports.
- There is typically a higher level of anxiety in the family situation.
- Information-handling annoyances can lead to abused caregivers misinterpreting or mislabeling their children's behavior, resulting in improper responses.

- There is often a lack of awareness or understanding of formatively fitting desires (Mash & Wolfe, 2010).

Other risk factors that increase the likelihood of physical abuse includes;

- Drug abuse
- Stress, fatigue and dissatisfaction
- History of violence
- Psychological and physical impairments.

Prevalence of Physical Abuse

Pregnant Women

Physical maltreatment influences a critical minority of pregnant ladies and is related with pressure, absence of help and a partner with a drinking issue. Ladies whose accomplice tended to drink too much were 3.4 occasions (95%) bound to have been mishandled than ladies whose accomplice did not tend to drink too much (Muhajarine & D' Arcy,1999)

Incarcerated Women

In an examination among 150 members (18–59) year old detained ladies in a most extreme security setting. The reason for this examination was not to connect exploitation encounters to specific kinds of criminal practices, but instead to recognize the commonness of these encounters in this populace. The announced predominance and seriousness of 6 kinds of brutality were talked about: (1) extreme physical savagery by parental figures, (2) youngster sexual attack, (3) extreme physical animosity and (4) assault by private accomplices in adulthood, and (5) physical and (6) sexual viciousness by outsiders or colleagues. Discoveries propose that viciousness over the life expectancy for ladies imprisoned in everybody of a most extreme security jail

is unavoidable and serious (Browne, Miller, & Maguin, 1999). In this New York State maximum security women's prison 94 percent of the women had suffered serious physical or sexual abuse at some point in their lives. Eighty-two percent of the women had been assaulted as children, and seventy-five percent of the women had been abused by an adult romantic partner. Not only was there a high prevalence of abuse, but it was also severe and cumulative over the course of the women's lives (Browne et al., 1999).

Adolescent

Physical Abuse Across High School Students Prevalence and Correlation with Other Health Behaviors was directed among twenty-five schools in Oregon in a school-based review of pupils in grades 9 through 12. 31.5 percent of the 1957 respondents said they had ever been seriously mistreated, with females (34.6 percent) being more likely than males (28.0 percent) to have been mistreated. In the preceding week, 3.7 percent of understudies were genuinely abused, 7.8 percent in the previous month, and 16.3 percent in the previous year. According to multivariate models, understudies who had been seriously mistreated in the preceding year were almost as likely as those who had never been truly mistreated to participate in a variety of high-risk behaviours (David et al., 2005).

Maltreatment against males is pervasive and males are defrauded as clients in human services. Reaction ratio was half (N=2924). Lifetime encounters of psychological mistreatment were accounted for by 16.7%, physical maltreatment by 48.9%, sexual maltreatment by 4.5% and maltreatment in medicinal services by 7.3% (Swahnberg, Davidsson- Simmons, Hearn, &Wijma, 2012).

An aggregate of 2,807 men announced household misuse arguments against their spouses a year ago as against 3,143 the earlier year. Likewise, around 13,465 ladies additionally detailed abusive behavior at home arguments against their mates a year ago as against 15,207 the earlier year (DOVVSU, 2013).

Elderly

Elder abuse is frequent, according to evidence acquired from an inquiry undertaken in the United States. Adults aged 60 and older were asked regarding enthusiastic, physical, sexual, and financial abuse, as well as potential disdain, in an arbitrary public example (defined as a recognized need for assistance that no one was successfully attending to). 5777 people were polled, and the results were analyzed. One-year pervasiveness was 4.6% for psychological mistreatment, 1.6% for physical maltreatment, 0.6% for sexual maltreatment, 5.1% for expected disregard, and 5.2% for current budgetary maltreatment by a relative. In the past year, one out of every ten respondents reported enthusiastic, physical, or sexual abuse, as well as likely disrespect.

Model Training Programmes for Healthcare Professional in the Management of Physical Abuse

It is critical for healthcare workers to acquire education about the dynamics of abuse, screening tools, and referral sources in order to take advantage of the unique chance to address physically abused patients within the healthcare system (Trevillion, Agnew-Davies, & Howard, 2011). For healthcare practitioners to have a greater chance of identifying and recording physical abuse and assisting victims with accessing the assistance and support

they need, education, supportive policies, and intervention protocols must be in place (Du Plat-Jones, 2006).

Due to low levels of routine screening, primary care physicians are missing opportunities to recognize and intervene in domestic abuse (Rodriguez et al., 1999). Domestic abuse protocols, training, screening, and reporting policies differ by state. In 46 of the 50 states, there are no laws requiring healthcare providers to screen for domestic violence. Thirty-three states have no laws requiring domestic violence training for any occupation. In New Jersey, there is no law mandating healthcare providers to screen their patients for physical abuse, nor is there any necessity for healthcare providers to undertake physical abuse training. In order to sufficiently modify clinical practice in respect to physically abused, structural modifications, regular in-service education, institutional regulations, and physician training are all required (Rodriguez et al., 1999).

Despite the lack of state legislation and policy requiring healthcare workers to be educated about intimate partner abuse, research has shown that screening and education are important to assist them obtain the necessary abilities. According to twenty peer-reviewed quantitative research, 43-85% of female patients support universal screening for physical abuse (Ramsay, Richardson, Carter, Davidson, & Feder, 2002).

The Robert Wood Johnson University Hospital Community Health Promotion Program (RWJUH CHPP), in collaboration with the New Brunswick Domestic Violence Awareness Coalition (NBDVAC) and Anna Trautwein, RNC, of Saint Peter's University Hospital (SPUH), created a toolkit to educate healthcare providers in New Jersey while also addressing the

frustrations and barriers they face. This is supported by a generous donation from the Verizon Foundation, which has made domestic violence prevention a top priority. 330 healthcare personnel, including nurses, physicians, social workers, and medical students, were educated to spot domestic abuse, screen patients, and refer them to community resources between June 2012 and June 2013. This training model was developed before the US Preventative Services Task Force released a recommendation in January 2013 for primary care practitioners to screen women of reproductive age (ages 14 to 46) for physical abuse and send those who test positive to programs or support services (Moyer, 2013).

The Domestic Violence and the Role of the Healthcare Provider conference is designed to give healthcare practitioners with the knowledge and resources they need to provide assistance to battered women, as well as to help them feel more comfortable screening all of their patients. Healthcare providers are educated about the dynamics of abusive relationships and the clinical symptoms of abuse during the three-hour training sessions, which are vital in addressing personal hurdles they may have when treating victims. The facilitators go over clinical and mental health signs and symptoms of abuse. (VAWC, 2013). Furthermore, healthcare providers are trained that victims frequently present as people who are unconcerned about their health. Survivors may appear to put off getting medical help, travel to the emergency room frequently, have several healthcare providers, and have an ashamed, strange, and evasive manner (McCloskey, Williams, Lichter, Gerber, Ganz, & Sege, 2007). Since nearly one-fifth of women who were physically abused in the previous year had partners who interfered with their healthcare, and more

than half of women with an interfering partner were abused in the previous year, healthcare providers are also trained to be aware of signs in the partner that may confirm suspicions of abuse of the patient, such as a partner's insistence on attending every appointment, healthcare providers are also trained to be aware of signs in the partner that may confirm suspicions of abuse of the patient (McCloskey et al., 2007). These acts in a patient's partner could be a sign of coercive control and a way to keep information from coming out (Trevillion et al., 2011).

Healthcare professionals are taught how to properly screen patients for physical abuse. They've been taught how to ask questions in a variety of ways, including direct, indirect, and framing queries (Trevillion et al., 2011). It is critical for doctors to cultivate a caring and trusting relationship with their patients in order to create a safe atmosphere for victims to complain and seek help (Bradbury-Jones et al., 2011). The quality of the connection might either promote or discourage a victim from seeking help (Bradbury-Jones et al., 2011). Even if they choose to stay with the abuser, healthcare providers are encouraged to respect and protect the patient's right to autonomy. Regardless of whether the victim is in or out of the relationship, the Domestic Violence and the Role of the Healthcare Provider model program constantly reminds healthcare professionals that their primary goal is to increase the victim's safety and reduce the victim's isolation (Trevillion et al., 2011).

Patients have a better chance of developing trust and rapport with their healthcare practitioner if they are screened on a regular basis. It also conveys that domestic abuse is abhorrent and that the medical community is working to address the problem. Screening frequently occurs during the “wrong” portion

of the cycle of violence, according to healthcare practitioners (Trautwein, 2012). After the violence has occurred and the physical indicators of abuse are visible, most health providers screen. In effort to atone for his sins, the abuser will frequently apologize and offer promises of reform. Because the abuse has temporarily stopped, the victim may hope their partner will change, disclosure is unlikely at this point. When the victim is in the tension-building phase of the relationship, before the violence occurs, when the victim is anticipating the abuse, screening should be done. Screening during this phase may lead to additional disclosure because the victim is often afraid of the next abuse occurrence. During the tension-building stage of the relationship, victims are more likely to see healthcare practitioners for routine or chronic problems (Tautwein, 2012). As a result, healthcare providers are recommended to assess survivors on a regular basis, regardless of the presence of signs, in order to contact them when they are most likely to accept aid.

Role-playing is used to help healthcare providers feel more comfortable with screening. The activity reinforced what they had learned about the dynamics of abusive relationships and screening strategies, according to feedback from the post-training evaluations.

The need of understanding reporting regulations and procedures is instilled in healthcare providers. State-by-state reporting requirements differ. While domestic violence isn't needed to be reported in New Jersey, injuries caused by a firearm, destructive device, bomb, or weapon must be reported right away (Durborow et al., 2010). If children, the disabled, or the elderly are being physical abused, regular detailing is essential. In Ohio, failing to report genuine harm is considered a crime, and doctors must note known or

suspected true manhandled patients in their notes (Durborow et al., 2010). Health providers are encouraged to use the "Tell before You Ask" strategy, which means that they should tell patients on what they are required to disclose before gathering information about cases that have been legitimately mistreated.

All social insurance experts ought to know about the components of security arranging, and ought to have the option to examine these components with their patients. Training on security arranging is particularly significant for providers answering to law implementation. Notifying the public would not remove casualties from dangerous situations, but it could increase the patient's risk. Guardians of victims are faced with the difficult task of leaving their children, and relatives with their victimizer (Bair-Merrit, 2010). Providers are taught that the patient's autonomy is critical, and that they should focus on encouraging patients to make decisions on their own time and in their own way, but they should also be aware of what they are required to report by law, which varies by state.

Members are encouraged to provide follow-up care and assistance to patients who divulge maltreatment they have witnessed, where appropriate and consented to by the patient (Du Plat-Jones, 2006). By giving assets and archiving maltreatment in an outline, medicinal services providers can turn into a partner to the patient. Providers ought to never constrain manhandled ladies to leave. Rather, they have to offer clients choices and assets. Compelling clients to surrender get them over to feel lacking indeed, in the event that they are not prepared or trust it's anything but a sheltered time for them to do as such. Ladies have stated that they do not reveal information

about their feelings of well-being for themselves or their children. Forcing patients to leave a connection might cause embarrassment and possibly increase the patient's separation, as they may feel uneasy continuing to see that provider if they continue in the relationship. Medical service providers must understand that leaving a harmful relationship is a cycle, not an event, and that the risk often increases when a victim leaves her victimizer, because misuse is about the victimizer maintaining power and control. Abusive behavior in the home is frequently absurd. At the point when the casualty leaves, the victimizer frequently raises his/her strategies so as to recapture control or rebuff the person in question (McCloskey et al., 2002).

Medicinal services providers are reminded that aggressive behaviour is common in all societies and that it is critical to regard every patient's exceptional social foundation. Providers are urged to go to classes on social competency and to find out about assets that are accessible for settlers and ladies of different identities and societies. Language and social barriers are a barrier for mistreated women, therefore providers are reminded that the New Jersey aggressive behaviour at home hotline has a "language line" where they may interact with survivors who speak any language. There are also specific resources available in select areas for survivors with a certain social background, such as Manavi, which assists South Asian women in the New Brunswick, New Jersey area (Kramer et al., 2004).

The Mexican immigrant population in New Brunswick is the largest subgroup of the Latino and Hispanic population, and research has shown that Mexican migrant women suffer more severe mistreatment over longer periods

of time than Anglo women (Hancock, 2007). Providers must develop social competency in order to effectively support people who have been abused.

Procedures in Handling Cases of Physical Abuse

Gender-Based Violence (GBV) Prevention and Response Rules illustrate the need for enabled multi-sectoral and between authority intercessions in controlling sex-based viciousness (United Nations, 2008). Initially, an organized strategy must be built up by the interagency group to guarantee execution of the base anticipation and reaction mediations by every single applicable entertainer. The strategy ought to incorporate an arrangement for creating Standard Operating Procedures (SOPs). Furthermore, singular associations will set up their own inner strategy and procedural direction with respect to their association's GBV exercises and projects (United Nations, 2008).

Standard Operating Procedures (SOP) are explicit methods and understandings among associations that mirror the strategy and individual associations' jobs and duties. Accordingly, SOPs are partner archives that help the GBV strategy. Advancement of SOPs is a cycle that must include every applicable entertainer. The way toward creating SOPs is as significant as the last SOP item. It connects the entirety of the pertinent entertainers and includes cooperation, between hierarchical and between sectoral exchange, network interest, arrangement, and accordingly expands all members' comprehension of how to forestall and react to sex-based brutality (United Nations, 2008). The SOP layout gives a system to tending to moral and security contemplations and accomplishing lucidity on core values for issues

identifying with secrecy, regarding the desires of the survivor, and acting to the greatest advantage of a casualty.

Delegates being equal and local gatherings taking an interest all the while and referenced in the report show by method of mark that they are in concurrence with the substance of the archive and that they focus on teaming up and planning, just as reconsidering the record dependent on assessment results. As to the core values, all activities are required to: Comprehend and hold fast to the moral and security proposals in the World Health Organization (2005), archive; Lengthen the fullest collaboration and help to one another in forestalling and reacting to GBV with involvement of circumstance investigation and appraisal data to stay away from duplication and amplify a common comprehension of the circumstance; Establish and keep up deliberately organized multi-sectoral and between hierarchical intercessions for GBV anticipation and reaction; Engage the network completely in comprehension and advancing sex balance and force relations that ensure and regard the privileges of ladies and young ladies; Ensure equivalent and dynamic cooperation by ladies and men, young ladies and young men in surveying, arranging, actualizing, checking, and assessing programs through the orderly utilization of participatory techniques; Incorporate and standard GBV mediations into all projects and all segments.

All personnel and volunteers participating in the prevention and response to GBV, including interpreters, should understand and sign a Code of Conduct to guarantee personal responsibility at all times or a comparable report outlining identical standards of direct action (United Nation, 2008). Without doubt, the key ideals for dealing with individual survivors of GBV

are solely focused on improving the well-being of the victims. As a result, it expects the following to be reliable: Ensure the person in question's and her family's well-being on a regular basis, Acknowledge the classification of the influenced person(s) and their relatives on a consistent basis. Only share important and beneficial data together to support the survivor if the client gives her informed and express consent, such as referring to administrations. Every piece of written information about casualties must be kept in a secured file. Respect the person in question, the survivor's decisions, rights, and nobility, and hold meetings in restricted settings (United Nation, 2008).

The rule endorses in advance that, for women casualties, there is the need to consistently attempt to direct meetings and assessments with female personnel, as well as interpreters. For men casualties ready to demonstrate inclinations, it is ideal to inquire as to whether he favors a man or a lady to direct the meeting. On account of little youngsters, female staff is generally the most ideal decision. Employees must treat one another with courtesy and keep a non-judgmental demeanor. Personnel should not make fun of the victim or show no respect for her way of life, relatives, or circumstances; they must maintain restraint and only investigate if the casualty refuses to talk about her experience (for instance, the status of the virginity of the casualty is not applicable and ought not be examined). It's critical not to make the casualty repeat the story in many sessions, and to avoid segregation in all interactions with casualties and aid arrangements. The above ethics should be applied to youngsters, remembering their entitlement to take an interest for choices that will influence them. In the event that a choice is taken for the benefit of the

youngster, the eventual benefits of the kid will be the abrogating guide and the fitting methodology ought to be following (United Nations, 2008).

For a far-reaching paradigm of care, support, and anticipation of sexual and sex-based barbarism, various systems exist. One of these structures supports the following techniques: Medical administration of sexual brutality at the stage of first interaction with victims; mental counseling of assault victims; delicate approaches to overseeing child sexual violence victims (of both genders), and the empowering and empowering introduction by men who are victims; criminological fact collection (at the health facility during clinical administration and also at the police station). It additionally recommends solid connections among police and wellbeing office to empower occurrences to be alluded in either heading so that, whenever wanted, An arraignment can be started; police-initiated indictments are continued by the legal executive; and new or enhanced network-based countermeasure solutions can be established that are applicable and suited for the environment and are immediately connected to the nearest clinical/police structure (WHO, 2003; Population Council, sub-Saharan Africa, 2008).

There is a need to develop norms for detecting and reporting cases of aggressive conduct at home to appropriate authorities, as well as early identification and management screening approaches these conventions should be designed in consultation with spousal abuse experts. (UNICEF Research Center, 2000).

There is fear that victims' enhanced treatment may impose more harm on victims who disclose misconduct (Kim & Motsei, 2002). Clients who reveal misuse must be managed in terms of security and privacy, and any testing

procedure must be performed in a sense of psychological safety manner. As a result, consoling survivors and assuring their long-term well-being require protection and confidentiality. In dealing with cases of violence towards children, sensitive approaches to supervising child savagery overcomers (of both genders) should be energized (Kenya Ministry of Health, 2004).

Ghana perceives physical maltreatment as an infringement of the basic freedoms of its residents. In light of the danger of physical maltreatment, the Domestic Violence Act (2007, Act 732) was instituted. The Act plots modalities for taking care of abusive behaviour at home cases. In announcing abusive behaviour, a survivor of aggressive behaviour or any individual with data about aggressive behaviour may record a grumbling about aggressive behaviour at home with the police. An individual from the casualties' family or the casualties' companion may likewise record a grievance to the police in the interest of the casualty where the casualty is in any capacity whatsoever unfit to document a protest by and by. Experts, for example, social laborers or post trial agents, health awareness providers, individuals from security administrations, writers and basic liberties activists will likewise record a grumbling about aggressive behaviour at home where the intercession is in light of a legitimate concern for the person in question. At last, as per the Domestic Violence Act, 2007 segment 6, a perished individual's agent or a relative of the expired family or someone else skillful to speak to the expired may record a grievance where an individual who could have been a complainant under the Act has kicked the bucket. Regardless, a youngster cannot disclose a situation of viciousness against him or her to the police on

his or her own. The people described above will assist a child in preparing a report (DOVVSU, 2011).

Addressing the Needs of the Physically Abused

The safety and well-being of victims of physical abuse should be at the forefront of legal frameworks, such as Ghana's Domestic Violence Act. It is critical that precautions are taken to ensure that the casualty is not left without appropriate assurance and is not re-managed. If physical viciousness interruptions are to be effective in reducing and deflecting violence, survivors of physical abuse have both immediate and long-term needs that must be satisfied. In the fight against viciousness, the needs of victims for safety, protection, training, material and financial assistance, directing, and restoration or reintegration are critical.

Wellbeing requires a basic requirement in the life of casualties of viciousness. The social insurance framework is all around to recognize casualties who have been manhandled and elude them to different administrations. The truth, nonetheless, is that a long way from assuming a hands-on job, the social insurance framework has ordinarily been apathetic to casualties particularly ladies experiencing residential abuse. Absence of admittance to wellbeing administrations is a basic restriction to clinical assessment for casualties encountering abusive behaviour. Preparing for medicinal services providers is important to control them on the early screening and recognizable proof of especially casualties who are encountering aggressive behaviour. Such preparing, likely, ought to be acclimatized into existing preparing programs as opposed to be made as withdrawn projects (UNICEF Innocent Research Center, 2000).

In Ghana, the development of a Victims of Domestic Violence Support Fund with roughly five purposes is a crucial mechanism for the compelling use of the Domestic Violence Act, (2007). Willful promises to the Fund from persons, associations, and the reserved sector; monies affirmed by Parliament for installment into the Fund; and funds from some other source authorized by the Minister in charge of Finance have all been clearly demonstrated as sources of cash for the Fund (Domestic Violence Act 2007, Section 29).

Section 8 of the Domestic Violence Act (2007) clearly expresses the needs of victims of abusive behaviour at home, as well as how they are to be met. Giving the individual in question a clinical framework and, if necessary, transporting the casualty to a clinical office are all examples of police assistance to a casualty. A casualty of abusive behaviour at home who is helped by the police to get clinical therapy is qualified with the expectation of complimentary clinical treatment from the State. A victim of aggressive behaviour may be eligible for free therapeutic treatment in the event of a crisis or a dangerous situation, pending a protest to the police and the filing of a report. When fully implemented, this agreement will be a benefit to Ghana in terms of satisfying the needs of survivors of domestic violence. In any event, it's important to note that, despite Ghana's great laws; substantial challenges arise when they're applied.

Monetary guide for aggressive behaviour at home casualties who are reliant on culprits for their requirements are basic to diminishing weakness to viciousness. According to the Office of the Head of State (2004), Spain's Organic Act on Integrated Measures Against Gender Based Violence, special assistance is provided to survivors of sex savagery who lack financial means,

when their age, general lack of master abilities, and social circumstances are a barrier to significantly refining their employability. In such issues, casualties may link focused-on activity program focused on their expert inclusion. This assistance, which will be scaled according to the person's age and family commitments, is primarily designed to provide them with a base resource salary that will allow them to live free of their assailant.

As per Ghana's Domestic Violence Act, (2007) the primary goal for the foundation of the aggressive behavior at home reserve is to give fundamental material or money related help to casualties of abusive behavior at home. Notwithstanding, Ghana's National Domestic Violence Policy and National Plan of Action (2008), showed that a significant number of the rational needs of casualties of misuse were scarcely met.

Cover and related administrations are another important prerequisite for most survivors of viciousness. According to the Minnesota House of Representatives Research Department (2007), at the time of arrest, a peace officer is required to inform a victim of residential maltreatment whether a haven or other administrations are available in the network, as well as to inform the victim of their legal rights and remedies. The official must provide the victim with a notification that includes the asset posting, as well as the phone number for the zone abused women's asylum.

Mistreated women's safe houses and services are subsidized by a variety of fines imposed by the courts in order to ensure long-term funding. Courts are required to collect fines under the criminal code and to distribute seventy percent (70%) of each statutory minimum fine to a local casualty aid program that provides various sorts of assistance in the district where the

violation occurred (Minnesota House of Representatives Research Department, 2007).

Given that safe houses are costly, NGOs in creating nations are unable to give asylum to casualties, and spotlight rather on giving legitimate guidance, mental and social help. This is a zone where civil and common governments is expected to give feasible, present moment and long haul covers, referral administrations to different areas (wellbeing, equity, and police) and help with related needs, for example, lodging, work, and kid care. Progressively, governments are making such help administrations in organization with NGOs as a component of an incorporated reaction to aggressive behaviour at home (UNICEF Innocent Research Center, 2000).

Supporting casualties rebuild their lives and confidence, has been a specific focal point of NGO endeavors. Many embrace a strengthening approach for ladies through training, lawful proficiency, and financial confidence programs inside haven homes to assist ladies with assuming responsibility for their own lives and individual security. Such projects additionally give directing and an association with existing systems of ladies. Obviously whenever casualties have the chance to cooperate with others encountering similar issues, they can get away from their confinement, disgrace and dread, and can modify their lives at a quicker pace (UNICEF Innocent Research Center, 2000).

In Ghana, the Domestic Violence Fund has two goals: to construct open havens for victims of aggressive conduct at home in government-controlled areas and locales, and to prepare/limit the work of people involved

in the establishment of safe homes, recovery, and reintegration personally (Domestic Violence Act 2007, Section 29 and 30).

Nonetheless, Ghana's (2010) National Plan of Action for Orphans and Defenseless Youngsters, archives just a single government possessed asylum in Ghana situated in Accra for the arrangement of sanctuary and recovery administrations to youngster casualties of misuse since 2003, it has been in operation. Thus, Ghana's (2008) National Domestic Violence Policy and National Plan of Action demonstrated that as of now, just scarcely any NGOs (two to be specific the Ark Foundation and WISE) are driving the path in the arrangement of safe house administrations to battered ladies. With these, the quandary of grown-up survivors of aggressive behavior at home needing cover administrations in Ghana could be impossible to say.

Directing has long been acknowledged as an important factor in accelerating the recovery process, which is highly customized and can extend for years (Campbell et al., 2004). There is a need for guidance in order to regulate the psychosocial measures of cruelty in terms of casualties. In cases involving genuine cycles, advising also plans for casualties for the equity framework. The need for guidance is not limited to the individual in question: family members and associates may also be affected and require assistance (Kilonzo, 2003).

Residential Mistreatment Counseling and Educational Packages help to relieve the impacts of viciousness. As indicated by the Minnesota House of Representatives Research Department (2007), If a court stays the inconvenience or execution of a sentence for a domestic abuse offense while the wrongdoer awaits the outcome of the post-trial process, the court must

request that the guilty party participate in and successfully complete a domestic abuse guiding system or instructive program as a condition of the stayed sentence. The norms for household misuse advising and instructive projects must involve wrongdoers and manhandling gatherings to go to at least (24) meetings or (36) hours of programming, except if a post-trial supervisor has suggested less meetings. Said administrations must be given in a gathering setting, except if the wrongdoer or manhandling gathering would be improper in such a situation. There must be discrete meetings for men and women members. The program must have a methodical approach that prohibits program staff from offering or implying marriage or couple mentoring until the wrongdoer or mishandling party has completed the program and the staff understandably accepts that the viciousness, terrorizing, and pressure have stopped, and the victim feels safe enough to take an interest (Minnesota Research Department, 2007).

As a result of the preceding discussion, survivors of brutality must be provided with legal, clinical, financial, and mental assistance, as well as clinical referrals as necessary. Networks and promoting groups of people for aggressive conduct at home casualties, which include both police and social insurance providers, as well as advising administrations, must be considered (United Nation Populated Fund, 2003).

In the event that abusive behaviour is to be viably tended to, it is essential to meet a significant need which is the requirement for proper instruction on aggressive behaviour related issues. Ghana's National Domestic Violence Policy and National Plan of Action (2008), which aims to eradicate domestic violence, calls for coordination from the government through

Parliament, Ministries, Departments, and Agencies, as well as civil society organizations such as NGOs, professional associations, faith-based organizations, traditional authorities, and local communities and development partners.

The Ministry of Women and Children's Affairs (MOWAC) is accused of the obligation of generally speaking coordination of the DV Act. Under MOWAC, the Department of Women, Department of Children and the Domestic Violence Secretariat are entrusted to effectively take part in sharpening and training programs on aggressive behavior at home just as lead research on abusive behavior at home related issues in Ghana.

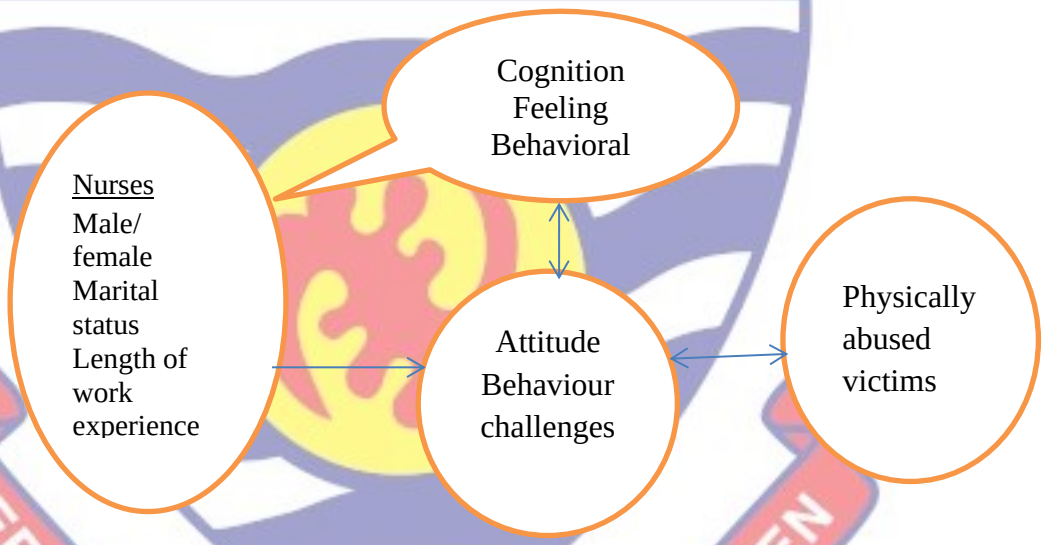

Figure 2: Conceptual model for nurses caring for physically abused victims.

This framework tends to shed more light on the link between the nurses' care and the physically abused victims. The attitude, behaviour, and challenges of nurses have an impact on the health care seeking and quality of life of abused victims. Positive attitude and favourable behaviour lead to quality care, while negative attitude and unfavourable behaviour lead to poor and ineffective care. The effect of poor attitudes, behaviour and challenges does not only affect the abused victim but also the family and the nation. It is

vital for nurses to have a positive attitude and good behavior towards the care of abused victims if good quality is provided. Apart from the nurses' attitude, behaviour, and challenges, it is also assumed that demographic characteristics such as the length of work experience, marital status, and gender of these nurses can have an effect on the care of the physically abused victims. The cognition, feelings, and behavior responses of the nurses interact to determine the type of care they will give to the abused victims.

Empirical Review

Overview of Physical Abuse

Physically abused victims experience physical and mental repercussions that last far longer than the destructive event or even the abusive relationship. Physical abuse can have long-term consequences for a victim's health and well-being (Chrisler & Ferguson, 2006). Casualties may continue to experience physical side effects such as low vitality, helpless rest, cerebral pains, hyper-vigilance, weakness, torment, bad dreams, hustling hearts, and decreased invulnerability (Chrisler & Ferguson, 2006). Many abusers are left with the physical consequences of an explicitly delivered illness, which can cause urinary tract infections, cervical cancer, barrenness, and in some circumstances, fatality (Chrisler & Ferguson, 2006; Letourneau et al., 1999; Usta et al., 2012). Manhandled women frequently feel compelled to stop doing everything, have a persistent fear of intimacy, and believe they are unfit to confide in men (Chrisler & Ferguson, 2006).

Attorneys, clinicians, medical attendants, social specialists, government assistance laborers, and other experts are vital participants in restricting brutality. There is a need to develop norms for detecting and

reporting cases of aggressive conduct at home to appropriate authorities, as well as early identification and management screening approaches. These conventions should be designed in consultation with spousal abuse experts. (UNICEF Research Center, 2000). Ghana perceives physical maltreatment as an infringement on the basic freedoms of its residents. In light of the danger of physical maltreatment, the Domestic Violence Act (2007, Act 732) was instituted.

Survivors of abuse have an impact on almost every aspect of their lives, including their physical well-being, emotional well-being, work, relationships with loved ones, possible substance abuse or maltreatment, and education, and the effects are likely to last well beyond the period in which they are mistreated (Sprague et al., 2012). According to the Centers for Disease Control and Prevention (CDC), female survivors of truly mishandled have a complex pervasiveness of long-term medical issues, for example, diabetes, incessant agony, difficulty sleeping, and asthma (CDC, 2011). In an investigation, it was discovered that 69.7% of the casualties who reacted detailed at least one medical issue (Kramer, Lorenzon, & Mueller, 2004). Individuals who have been abused are also more vulnerable to health and wellness issues, such as coronary disease, diabetes, back pain, strokes, psychological instability, and other common judgments (Bergman and Brismar, 1991; Stark & Flitcraft, 1995). Manhandled individuals experience more medical issues than non-manhandled individuals (McCloskey, Lichter, Williams, Gerber & Gantz, 2006). Furthermore, these conditions occur more frequently and with greater severity in casualties than in non-manhandled individuals (Dolezal, McCollum, & Callahan, 2009).

The CDC estimates that 4,450,807 women are trapped by their accomplices every year in the United States and are burdened with wounds running from abrasions and wounds to broken bones, projectile injuries, blade wounds, and death (Chrisler & Ferguson, 2006). In New Jersey, there were over 70,000 aggressive behaviours at home in 2011, with 26% of abusive behaviours at home resulting in injury (Chrisler & Ferguson, 2006).At this point, victims of genuinely manhandled are well on their way to witnessing savagery or witnessing an increase in both the frequency and severity of brutality during pregnancy (Chrisler & Ferguson, 2006; Du Plat-Jones, 2006; Usta, Antoun, Ambuel, and Khawaja, 2012; Trevillion, Agnew-Davies, & Howard, 2010).Pregnant victims are more likely to experience failed labors, premature births, and fetal wounds, and pregnant women are more likely to be killed by their accomplices than to die for any other reason (Du Plat-Jones, 2006; Trevillion, Agnew-Davies & Howard, 2010; Usta, Antoun, Ambuel & Khawaja, 2012).

Pregnancy shows that private accomplice brutality directed at pregnant ladies prompts low birth weight babies, a genuine medical issue for an infant that can have deep-rooted results (Sullivan, Bryant, Robertson, Abel, Chang & Caughey, 2006). Abusive behaviour has also been linked to fewer premature births (Usta et al., 2012).

Casualties may continue to experience significant manifestations, for example, low vitality, helpless rest, migraines, hyper-cautiousness, weakness, torment, bad dreams, racing hearts, and decreased workplace safety (Chrisler & Ferguson, 2006). Many abusers are left with the physical consequences of an openly communicated disease, which can result in urinary tract diseases,

cervical malignant growth, barrenness, and, in some cases, death (Chrisler & Ferguson, 2006; Letourneau et al., 1999; Usta et al., 2012).

Nurses' Attitudes towards Abused

The literature offers many definitions of attitudes. According to the Longman Dictionary of the English Language (1992), an attitude is a way of feeling about something, especially as it influences one's behaviour. A similar definition is offered by the Collins English Dictionary (1995). Groenman et al. (1998) identify the development of attitudes as being central to the socialisation process in which norms and values are individually learned. The process of nursing is no exception, developing its own individual attitudes towards the care of clients in the Accidents & Emergency department.

Nurses, like other health care providers, frequently assign blame for an illness or injury based on their own personal knowledge and attitudes (Iphofen & Poland 1998). A moral evaluation of victims is often made. Grief and Elliot (1994) unearthed this phenomenon when they explored the concept of "ranking" particular patients according to their illnesses or injuries. In a descriptive survey, Grief and Elliot reported that 66 percent of nurse respondents disliked caring for "regular customers" of the emergency department.

Battered women have a pattern of multiple attendances at Accidents & Emergency, and being regular users of the department, plus creating feelings of anger and frustration in the reviewing nurses, does not place them in a very favourable position for continuing support by Accidents & Emergency staff. Hodgson (1997), in analysing attitudes towards HIV and AIDS, reveals that a natural state of "moral entropy" occurs through fear, lack of knowledge, and

lack of support. Van Wissen & Woodman (1994) employed an exploratory qualitative approach using focus groups to discover a somewhat similar result. However, the contentious nature of the issue caused many respondents to feel uncomfortable disclosing personal views in front of colleagues. It is possible that a similar result could emerge if the contentious issue of battered women is raised using a similar research methodology.

Northouse (1997), in illustrating the process of nurse–client communication, highlights the essential nature of attitudes, values, and personal experiences in the unique process of human interaction. This supports Sbaih (1998) in highlighting the complex process of client assessment in the A & E department, whereby personal attitudes have a part to play in the formation of an individual personality. However, it's vital to remember that attitudes can shift without warning (Tiffing et al., 1999) and that attitudes don't always predict behaviour (Kent, 1996). The perspectives of the attendants to patients who have been manhandled have been the subject of a few investigations. Meetings and polls directed to attendants and by and large emergency clinics (Ramons, Bancrofjt, & Skrimshirae, 1975; O'brien, & Stollk, 1977) have indicated that both staff groups share an undecided mentality. Yet, medical attendants will in general, be more thoughtful and understanding. Both Goldney and Botrill (1980) and Ghodse (1978) discovered a substantial lack of sympathy toward physically mistreated patients, particularly among the workers who had the most contact with them. Suokas and Lonnqvist (1989) discovered that mentalities were generally negative among trauma centre personnel and best among serious consideration staff among workers working in various areas of the crisis division. Ghodse

looked at the perspectives of trauma centre medical caretakers and emergency vehicle workers and found that, among clinic-based staff, attendants had the best mentalities. Studies which incorporate faculty working in the mental health offices propose that specialists show more sympathy than other clinical staff (Hawtonk, Marsack, & Fago, 1981).

Among mental medical caretakers and therapists, Ramons (1980) discovered attendants to be less tolerating, less thoughtful, and less prepared to help than specialists. General doctors communicated a more negative view than attendants (paying little heed to their territory of claim to fame) or therapists, though nurture in the overall clinic was more thoughtful than their nursing associates at the mental clinic (Ramons, 1980). The nursing profession evolved from a simple task to a recognised profession over many years of effort. Nurses' attitudes towards their profession have been exposed for decades. To varying degrees, research is being conducted all over the world. In a study of 346 nurses in Saudi Arabia, it was discovered that 33.2 percent of them had a positive attitude towards nursing. Since the early 1950s, when Allport's intergroup interaction theory was published, social and educational scientists have maintained that attitudes have a significant impact on an individual's actual conduct (Ajzen, 2005). To understand, predict, and influence the behaviours of nurses dealing with this population, it is critical to determine nurses' attitudes and behaviours toward physically abused patients, as well as the characteristics that correspond with such attitudes (Ajzen, 2005).

A study conducted in Ghana showed that, majority of respondents (85.7%) believe that the nurses are rude, whereas majority of respondents (75%) say that the nurses at the hospital are not hardworking or respectful.

Patients are pretentious when it comes to showing sickness, according to the majority of respondents (38.4%) and patients are impolite when they visit the health institution (Nyarko & Kahwa, 2020).

Research by Dapaah (2016), reveals that health workers providing these services, with the exception of a few, generally showed positive attitudes and behaviours towards clients during clinical encounter. Health workers warmly received clients to the facilities, addressing clients with courtesy, advising clients on a wide range of issues, sometimes supporting clients financially, and comfortably interacting with them. This is contrary to the findings of most studies in the literature that health workers often do not communicate and relate to these patients well.

In many Sub-Saharan African countries, including Ghana, there have been concerns about the way and manner some health workers relate to and communicate with patients in health facilities. Health workers, particularly nurses, sometimes do not treat patients or clients well. Some nurses are rude and harsh towards patients and health workers often give immediate and high-quality treatment to patients they know.

For instance, in a study conducted in Nigeria found that a significant number of health Professionals show discriminatory attitudes and engage in unethical behavior towards patients with HIV/AIDS (Reisetal, Reis, Heisler, & Amowitz, 2005). This description is certainly the case as was also found by Jewkes, Abrahams, and Myo (1998) in their study on nurses in South Africa. The authors indicated that some pregnant women expressed reservations of delivering in the hospital due to previous experiences of being shouted at, beaten or neglected by nurses. According to the study findings, although some

nurses agreed with the reservations of the pregnant women, they attributed the practices to many factors. These were organizational issues, professional concerns, including perceptions that staff were themselves abused by patients, a perceived need to assert control over the environment and patients, social sanctioning of coercive strategies including punitive actions, and an underpinning ideology of patient ignorance and inferiority as further observed by Jewkes et al. (1998).

A report by Godwill Arthur-Mensah of Ghana News Agency (GNA, 2016), state that some clients and patients that patronize health facilities in the Sekondi-Takoradi Metropolis, have expressed displeasure over continuous disrespect and impunity exhibited by some nurses towards them. They (patients) said some nurses speak rudely to them, especially whenever they are seeking health care through the National Health Insurance Scheme (NHIS) This came to light during a stakeholder meeting organized by Friends of the Nation, an NGO concerned with environmental issues and good governance practices in Sekondi.

Wright (1993) highlights a potential misconception by nurses in dealing with abused women which may stem from either their own denial, thus 'this could never happen to me 'phenomenon. As stated previously, the sequel of these feelings and attitudes can be destructive and lead to the abused woman experiencing secondary victimization by the uninformed nurse (Hattendorf & Tollerud, 1997).

Behaviour of nurses in the care of physically abused victim

The nursing Code of Conduct obliges nurses to inform appropriate persons or authorities if they perceive an individual to be unsafe or in jeopardy

(A Bord Altranais, 2000). However, specific to violence, if a nurse or health professional is told by a victim the source or cause of her injuries, the health professional legally does not have to report an incident of abuse unless the extent of injury constitutes a 'serious offence' (Blake, 1997).

In the study by Campbell et al. (1994), of 74 abused victims, half the women suffered negative experiences. They stated that staffs were mainly concerned with the physical injury sustained rather than attempting to discover the history and true cause of the trauma. Little attention was given to emotional support of women.

Campbell et al. (1994) also highlighted that there is an inconsistency in the referrals of abused victim to other services, the majority not being referred at all. In reviewing the literature, several themes have thus emerged which may explain the discrepancy that appears to exist in the detection, management and screening of potentially abused victim in the A & E department by nurses. All victims according to Peckover (1998), find it understandably difficult to raise the issue of them being abused. Psychological, physical and emotional barriers are reasons highlighted by Alpert (1995) and are also contributing factors in preventing abused victims from disclosing their abuse and seeking help (O'Reilly, 1998). For this reason, many victims prefer to be asked by the nurses rather than bring up the subject themselves.

Nurses, according to Travelbee (1979) are after all individual human beings and personally vulnerable. Many are faced with increasing technological and patient demands placing undeniable stress upon the individual nurse (Douglas, 1993).

Healthcare experts have a one of a kind chances to address physical manhandled by recognizing casualties, offering backing and referrals to network organizations and can assume a significant job in tending to the issue of personal accomplice savagery (Kirst, Zhang, Young, Marshall, O'Campo & Ahmad, 2012). Casualties present to a wide assortment of social insurance callings, for example, trauma centre doctors, orthopedic or injury specialists, family doctors, and experts in obstetrics and gynecology Sprague et al. (2012). Also, because of their steady patient contact, human services experts are exceptionally situated to steadily and secretly screen patients for casualties Hamberger et al. (2004). Since social insurance experts are frequently "the main line reaction" for some individuals who experience abusive behavior at home, it is imperative to have training, arrangements and conventions set up so they can distinguish, record physical manhandled and help casualties with getting the administrations and backing they need (Du Plat-Jones, 2006).

Shockingly, social insurance experts face individual boundaries, work related hindrances and patient-related obstructions that may ruin their capacity to viably distinguish and help survivors of personal accomplice savagery (Allen et al., 2007; Kirst et al., 2012; Sprague et al., 2012; Tower, 2003). Furthermore, the elements of physical mishandled are mind boggling, and it is regularly hard to see how it presents inside patients. A patient may give off an impression of being rebellious and unreliable when actually her accomplice is keeping her from going to her planned arrangements on the off chance that he cannot accompany her (Du Plat-Jones, 2006; Trevillion, Agnew-Davies & Howard, 2011). Patients may likewise give constant and persevering substantial grumblings and have helpless reaction to standard treatment

techniques. Physical manhandled can be a shrouded chance factor or contributing element for some ladies' medical issues; however, it is frequently unidentified because of the different obstructions at play inside the human services setting (Du Plat-Jones, 2006).

Many victims of abuse or violence seek care for physical injuries, and the nurse is likely to examine the victims of abuse or violence, as well and have professional responsibility to report the incident. Nurses are the first to make contact with patients. The nurse should have the knowledge and abilities of emergency care as well as evaluate the precise circumstances of the outpatients, and determine cases of physical abuse and injury (Sekula, 2005).

Challenges of nurses in the care of physically abused victims

According to studies, time limits, a lack of assets and backing, a lack of referral sources, and a lack of adequate screening methodology are challenging that health care experts may face. (Allen et al., 2007; Hamberger et al., 2004; Sprague et al., 2012; Tower, 2003; Trevillion, Agnew-Davies & Howard, 2011; Usta et al., 2012; Usta et al., 2012). Moreover, over 68% of health care coverage need information, instruction and preparing about how to distinguish, screen and elude patients encountering genuinely manhandled (Hamberger et al., 2004). The general steady nature of a social insurance association, the presence of clear and thorough approaches encompassing screening patients for mishandling, just as arrangements for alluding and interceding for patients who reveal, additionally fundamentally impacts experts' capacity and eagerness to screen (Allen et al., 2007). As of late, numerous medicinal services offices have been pushing in the direction of using Electronic Medical Records (EMR) frameworks to report and follow

persistent records. Unless a request is made to the designer to include a body map, such a framework does not take into account the account of casualties' accounts to be recorded and may exclude an unmistakable guide of the casualty's body with which to record wounds. This could create another significant barrier to recognizing casualties (Trautwein et al., 2012).

It is possible that education of nurses could prove beneficial in promoting a more positive attitude towards detecting and managing abused victims. The literature suggests that there is a dearth of knowledge about all facets of domestic violence and victim maltreatment. In Hong Kong, Chung et al. (1996) performed a survey of 400 Accident and Emergency nurses. Surprisingly, 94 percent of nurses said they had no formal training in dealing with domestic abuse. Unsurprisingly, 86.2 percent of respondents said their understanding was insufficient to deal competently with the problem. Ingram (1994) mentioned a lack of nurse education, awareness, and training.

The obvious value of education in this arena undoubtedly speaks for itself. Educating nurses about partner abuse has, according to Bokunewicz and Carman-Copel (1992), been effective in altering nurses' attitudes and behaviour in dealing with victim abuse. Given the limitations of an evaluative pilot study involving only 18 nurses, this area warrants further research. McLeer and Anwar (1989), in a conclusive large-scale study, retrospectively reviewed medical records of 771 female trauma victims and established a rise of 25% in the identification of woman abuse solely due to the use of an actual protocol which nurses were educated about and currently using. Such protocols include the use of a screening question universally administered by the nurse in triage assessment, which in the study by Grunfeld et al. (1994)

resulted in a positive response rate of 6% of the two hundred and fifty women studied.

Woodtli and Breslin (1996) surveyed the implications of domestic violence for nursing teachers. The respondents themselves questioned their own ability to provide appropriate knowledge and skills to nursing students. This was an honest response with urgent relevance to nurse educators in Ireland who have known the predominance of Catholicism and the associated reverence and privacy attributed to Irish relationships and marriage (Bowen, 1998).

In Canada, many nurse educators are aware of and have engaged themselves in the spectra of abuse, educating themselves and others (Hoff & Ross, 1995). An interesting point to note is that an agency in Minnesota, Womankind Incorporated, which encourages, support systems for battered women, has initiated a programme which includes a nurse education training package in identifying battered women (Hadley, 2003). Nurses tend to have a tough time learning how to recognize victims of abuse.

Lack of time is a factor identified by nurses, which ultimately affects the care and management of the abused victims. It is also frequently cited as a barrier to effective detection of woman battering in the A & E department (Jezierski, 1999). Byrne (1997) unearths this common theme on interviewing 400 pre hospital workers, including nurses, and may explain a common perception felt by the general public that A & E nurses are predominantly task centered.

The sad fact is that nurses are often so busy with the large volume of patients that they must prioritize what items or tasks are the most urgent;

resuscitation of patients is of course a priority and must be attended to first. Ingram (1994) notes in his study of the literature that tackling the issue of abuse against female could possibly open a "can of worms" that emergency personnel are not able to handle due to time constraints. A & E nurses describe their workload as a juggling act in Sbaih's (1998) paper. The extent to which a patient is assessed is determined not just by time constraints, but also by the nurse, the setting, and the patient (Sbaih,1998). This serves to highlight not only the complexity of a battered woman's situation, but also the complexity of the environment she presents to and the individual nurse she encounters in A & E. An interesting concept requiring future research is whether staffing levels affect the frequency of detection of battered women. Given the nature of a busy A & E department, it is surprising that any potentially physically abused clients are screened at all.

An internal irony also exists within nursing which further hinders the effectiveness of communication between nurse and victim (Hagell, 1989). Historically, and also according to Hagell (1989), a patriarchal society traditionally present in hospitals has through time, successfully suppressed this predominantly female profession. The female nurse by her profession is also stereotyped into an eternally receptive perpetually caring mode (Smith, 1993). Nurses, according to Travelbee (1979) are individual human beings and personally vulnerable. Many are faced with increasing technological and patient demands placing undeniable stress upon the individual nurse (Douglas, 1993).

According to Flanagan (1997) circumstances currently make nurses' work an even more difficult task and fear of failure is an ever-present shadow

in the increasingly consumerist litigation conscious society we live in today (Benner & Wrubel 1989). Kralik et al. (1997), observed nurses to be either engaged or detached when caring for patients or communicating with them. During the course of their training, nurses learn unwritten rules from watching senior staff in the management of patients. Adhering to 'the rules' of nursing work is where competence in nursing is obtained (Sbaih, 1997), but adherence to such 'rules' does not appear to allow nurses the opportunity to adequately review potentially abused victims. It is also difficult to imagine how battered women can expect a universal supportive response on presenting in the hospital when such different approaches exist.

McWilliams and McKiernan (1995), on interviewing a convenient sample of consultants and senior nurses, discovered that many staff are actually uncomfortable with the whole issue of domestic violence. One reason for this could be the fact that an abused woman is presenting to a Profession which is predominantly female, and is understandably disturbed at the actual concept of violence towards a woman. Hotch et al. (1996), in a cross-sectional national survey of 198 hospitals discovered similar feelings of inadequacy and discomfort in dealing with the issue.

This discomfort could result in altered awareness of the gravity of the problem of domestic abuse, which in itself is a difficult arena (Byrne & Heyman, 1997). Altered perceptions can emerge from different areas of an individual's life. Some nurses have unresolved feelings towards a battered woman, believing that she may have 'asked for it' or is deserving of punishment. This paradigm most often stems from nurses who have not been

exposed to the truths of woman battering and thus possess little theoretical understanding of the situation (Davison, 1997).

Marital status and length of experience of nurses in relation to their attitudes

A study by Cherniss (1986), found out that job satisfaction increases with tenure of service. Nurses who have spent 5-10 years in service enjoyed more satisfaction than those with less than five years. In the same vein, those who have served for more than 10 years were more satisfied than those with 5-10 years tenure of office. It can then be deduced that experience on a job reduces the level of stress, and then enhances the satisfaction that is derived from the job. This is in line with the findings of Cherniss (1986), in a research carried out on young professionals that are new on the job (between 1-10 years) found out that most of them expressed extreme frustration, apathy, worries, tiredness and job dissatisfaction. All the demographic variables (marital status, sex, and tenure of service) measured have significant effect on job satisfaction of the respondent. The roles which demographic characteristics play in job satisfaction cannot be overemphasized. It therefore implies that variables must be taken into consideration while designing plans and strategies aimed at improving job satisfaction of workers in their workplace environment (pp. 21).

In a study conducted in Nigerian Federal Health institute on influence of sex, marital status and tenure of service on job stress and job satisfaction of health workers, the result indicated that, all the demographic variables (marital status, sex, and tenure of service) measured have significant effect on job satisfaction of the respondents (Olatunji & Mokuolu, 2014).

In their study, Olatunji and Mokuolu (2014), examined the perception of actual and ideal ethical climate type among 95 nurses working in the internal medicine wards of one central hospital in the state of Israel. We also examined whether nurses' demographic characteristics influence that perception and if a relationship between perceptions of an actual and an ideal ethical climate type influences nurses' job satisfaction. A questionnaire composed of three sub questionnaires was administered and the responses analyzed using multiple linear regressions, analysis of variance and Pearson's correlation coefficient. The results demonstrated that demographic characteristics (such as: gender, job tenure and level of education) partially influence the perception of an ideal ethical climate. Incongruence in perceptions of 'caring' and 'independence' climate types indicated a decline in nurses' job satisfaction, while perception of actual 'caring' and 'service' climates positively influenced all aspects of job satisfaction. We recommend constructing training programs emphasizing the ethics of nursing practice and also to help lead nurses to clarify an ethical framework and guide nursing staff in dealing with ethical dilemmas (Olatunji & Mokuolu, 2014).

Chapter Summary

It is obvious from the writing that the issue of physical abuse, understated, is measurably upsetting, influencing a huge extent on the planet. Nurses need to get engaged with the avoidance and treatment of physical abuse, a general wellbeing quandary. Having a sound information base of the commonness (family wellbeing dangers identified with aggressive behaviour at home), markers, and referral assets is vital. To mediate in abusive behaviour at home requires arranged intercessions. By inquiring on a regular basis, the

nurses may be able to address aggressive behaviour at early stage before it becomes a problem.

The job of the nurse is critical with respect to screening and thinking about abused casualties. The nurses by their inclination and position in could without much of a stretch guide the abused casualty introducing to the office. In any case, as featured, numerous elements may forestall medical providers carrying out their responsibility viably. These elements go from a situational to an individual level inside the circle of the hospital. Unmistakably more exploration is fundamental to additionally characterize the sketched-out issues. At exactly that point will the nursing calling be in a genuine situation to deliberately handle this touchy issue which reasonably could influence any of us.

As a result, this study aims to fill this research vacuum by analyzing the behavior, attitude, and challenges of Nurses caring for physically abused victims in Hospitals in the Sekondi-Takoradi Metropolis.

CHAPTER THREE

RESEARCH METHODS

Introduction

The purpose of this study is to assess the attitude, behaviour and challenges of nurses caring for the physically abused victims in hospitals in Sekondi-Takoradi Metropolis of Ghana. This chapter outlines the methodology and research tools that were used to generate data for the study. It entails the description of the research design, study area, population of the study, sampling procedure, data collection instruments, data collection procedure and data processing and analysis.

Research Design

A cross-sectional descriptive survey was adopted. A descriptive survey's purpose was to draw conclusions about some population characteristics based on the sample size (Jewkes et al., 2000). I adopted a quantitative research approach. The findings from the sample under study will more precisely reflect the broader population from which the sample was selected, which is an advantage of quantitative research (Scott & Johnson, 2009). It's also used to quantify the issue by creating numerical data that may be turned into useful statistics. Since I was working with a larger sample size of 126 people and wanted to quantify the variables, this quantitative method was a good fit. It enabled the researcher to quantify attitudes, opinions, actions, and other identified factors. Again, it helped generalise results from a larger sample group.

Study Area

The study was conducted in Sekondi-Takoradi metropolis, with two hospitals selected in Sekondi and one from Takoradi. This was because all the hospitals selected have similar characteristics. Sekondi-Takoradi is one of the districts in Western Region with its capital in Sekondi. The population is about 23.5 percent of the total population of the region which is 2,376,021 (GSS, 2010). Sekondi-Takoradi has 4 main public hospitals. This study was based on three of them with a total population of general and mental health nurses as at the time of this study were 184 excluding other categories. The nurses were ranked from staff nurse to the deputy director of nursing services.

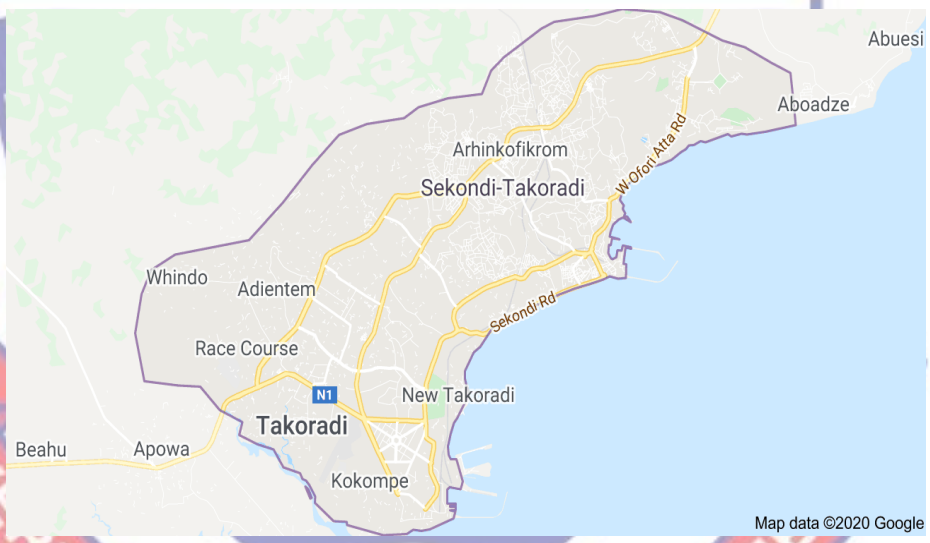

Figure 3: Map of Sekondi-Takoradi Metropolis

Population

The target population of 184 for the study comprised all the general and mental health nurses in selected hospital in the Sekondi/Takoradi Metropolis in the Western Region of Ghana. A statistical report obtained from the Metropolitan Health Directorate in June, 2017, indicates that the selected hospitals in the Metropolis have a total of 184 nurses as shown on the table (1)

below, making up the target population (MOH, 2017), and an accessible population of 126 respondents.

Table 1- *Distribution of Respondents by hospital*

Hospital	**Male**	**Female**	**Total**	**Selected Respondents**
Effia Nkwanta	10	59	69	47
Takoradi	8	53	61	42
Essikado	8	46	54	37
Total	**26**	**158**	**184**	**126**

Source: Annual Health Facilities Census 2017 for Sekondi/Takoradi Metro (MOH, 2017).

Sampling Procedure

Using Yamane's formula (1967), the sample size was determined using the formula $n= N/1+Ne^2$ where "e" is the sampling error (0.05). N is the Target population of 184. Yamane's method produces a sample size of 126 for a population of 184.

As a result, the study's sample consists of 126 nurses drawn from the three health institutions which was purposively selected. Both probability and non-probability sampling methods were employed. Thus, stratified random sampling and simple random sampling, then purposive sampling. Since the hospitals in the Metropolis do not have equal number of nurses, the researcher used a purposive sampling method to select the population from the metropolis. Also, a stratified sampling method was used to put them into strata. That is, Effia Nkwanta Hospital 47, Takoradi Hospital 42 and Essikado Hospital 37. Again, the researcher used a simple random sampling (Lottery method) to select the required numbers from the various strata. First, the total

figures from the various hospitals were collated and the names designated for the two groups written separately on and are represented males by M and females by F.

Data Collection Instrument

The study used four instruments to gather the data. The questionnaire was adopted. The first instrument was the demographic data, the second instrument was the nurses' attitude towards the physically abused, the third instrument was the behaviour of nurses towards the physically abused, the fourth instrument was challenges encountered by nurses towards the care of the physically abused. These therefore formed the sections in the questionnaire.

The questions on the survey were all close-ended. The close-ended category's five-point Likert-type scale was rated strongly agree (5), agree (4), neutral (3) disagree (2), and strongly disagree (1), and used as options for respondents to tick their choices to statements on nurses' attitudes and behavior toward the physically abused and the demographic characteristics that influence nurses' attitudes and behavior toward the physically abused. Section A had nine items, section B had seven items, section C had seventeen items, and section D had five items.

A questionnaire was used as the data collection tool. The general and mental health nurses were asked to fill out the survey. The questions were divided into four categories: A, B, C, and D.

i. Respondents' personal information, such as academic and professional qualifications, job experience, and current position in the Ghana Health Service, were collected in Section 'A.' This section has nine questions.

ii. Items in Section 'B' looked at nurses' attitudes about care for physically abused patients.

iii. Section 'C' had behaviour of nurses towards caring for physically abused victims.

iv. Section 'D' detailed the difficulties they experienced when caring for the abused. These sections used a five-point Likert scale ranging from strongly agree (weighted five points) to strongly disagree (weighted 1 point). The questionnaire's structure is outlined in Appendix D.

Pre-Testing of Instruments

Instrumentation testing the researcher was able to detect the instruments' flaws related to ambiguous phrasing through pilot testing. It also allowed the researcher to figure out how long it would take for people to respond to the questionnaire. It was necessary to determine whether the instructions that accompanied the items were clear enough to assist respondents through the questionnaire as correctly as feasible. To ensure the instrument's reliability and validity, it was pre-tested. The tool was pre-tested on 20 nurses at the Ewim Polyclinic in the Central Region of Ghana's Cape Coast Metropolis. The metropolis was chosen because it has many of the same metropolitan features as the metropolis in terms of regional hospitals with a larger staff population, qualified health professionals, and suitable infrastructure. During the investigation, the questionnaire was individually administered and collected. Fraenkel & Wallen (2000), proposed that the Cronbach's Alpha co-efficient, a measure of reliability, was the minimum acceptable level for statistical analysis. The instrument was chosen for the investigation based on this hypothesis.

Data Co llection Procedure

The researcher contacted the Director of the College of Distance Education (CoDE) of the University of Cape Coast for introductory letter that introduced the researcher to the prospective respondents (see appendix C for a copy of the letter). Due to unreliability of the postal system and the fact that the selected hospitals were easily accessible, duplicates of the questionnaire were delivered to the respondents in the various identified hospitals by hand. Upon previous arrangement with the hospital administrator of each identified hospital, the researcher visited the facility during break to contact the respondents, updated them on the purpose of the study and conducted the study. The responses were then divided into several topics, which became the study questions.

Ethical Consideration

The Ethical Committees of College of Education Studies (CES) University of Cape Coast and the three selected hospitals gave their approval for the study. After the purpose of the study was explained to all of the participants, the health personnel and clients at the respective institutions gave their agreement to participate. Respondents could withdraw their participation at any moment during the study. Respondents' human rights breaches were reduced as a result of this. The study was also conducted in accordance with the standards of data confidentiality and person anonymity. The copies of the questionnaire were left with respondents with each enclosed in an envelope to ensure privacy, to be submitted to the hospital administrators after completion in one of the hospitals. The copies of the questionnaire were collected personally by the researcher from Effia Nkwanta regional hospital and most of

the questionnaire took not less than two weeks before they were retrieved. Whiles respondents in two other hospitals were assisted to answer the questionnaires with the help of three trained research assistants at Essikado Hospital and Takoradi Hospital.

Data Processing and Analysis

Following the data collection in the field, the researcher checked the number of instruments received to see if the required number had been received. To evaluate data, the statistical package for social sciences (SPSS) was used. Research questions one, two and three, which was to assess the attitude, behaviour and challenges in the care of the physically abused was analyzed using frequencies, percentages, mean and standard deviation. whiles the statistical tool used for the hypothesis one, two and three, the researcher employed independent sample t-test to compare the means of two independent groups in order to determine whether there is statistical evidence that the associated population means are statistically significantly different. One Way Analysis of Variance (ANOVA) was used for hypothesis four and five. This is to compare the means of three or more independent variables.

The result was presented in tables for discussion.

Summary

A descriptive survey was used for the study to assess the attitude, behaviour and challenges of nurses in three selected hospitals in Sekondi-Takoradi metropolis of Ghana. Using a structured questionnaire, data was collected by convenience sampling, analyzed using frequency distribution tables, independent sample t-test and One-Way Analysis of Variance (ANOVA). The instrument was validated on 20 nurses at Ewim polyclinic

before using it for the actual study. The subjective nature of the questionnaire which required the respondents to air out their views on the attitude, behaviour and challenges about physically abused victims in their area of operation was a limitation as participant may give false information not reflecting the reality on the ground due to sensitive nature of the topic. The shifting duty with the hospital system leading to selective bias was a limitation.

CHAPTER FOUR

RESULTS AND DISCUSSION

Introduction

The purpose of the study was to assess the attitudes, behaviour and challenges of nurses while taking care of physically abused victims in selected hospitals in the Sekondi-Takoradi Metropolis. The study examined the statistical differences between male and female, marital status and work experience of the nurses on their attitude behaviour and the challenges encountered by nurses in caring for the physically abused victims. This chapter presents the information obtained and discusses the findings of the study. Detailed descriptions and discussions of the results were interpreted, and the results were related to existing research findings and theories. This chapter presents an in-depth analysis and discussion of the results of the study using frequency tables, independent t-sample tests, and One-Way Analysis of Variance (ANOVA). These are in relation to the objectives and hypotheses of the study, presented in the form of tables and figures.

Demographic Characteristics

The demographic attributes of the respondents are presented in table 2. This covers the gender, marital status and the length of work experience of the respondents.

Table 2- *Demographic data of respondents*

Item	Frequency (F)	Percentage (%)
Gender		
Male	28	22
Female	98	78
Marital Status		
Married	62	49
Divorce	4	3
Single	60	48
Length of years of Experience		
1 – 5	68	54
6 - 10	36	29
11 – 15	15	12
16 – 20	3	2
21 – 25	3	2
25+	1	1

Source: Field Survey (2019).

Table 2 shows the background characteristics of the respondents in the study. It shows that a significant proportion of the nurses (98%) were females, while 22% were males. This may be due to societal perceptions that nursing is a female-oriented role. This has been a major factor in the low numbers of men in the nursing field and continues to exert pressure on those in the nursing field today (Kirk, 2013). 49% of the nurses were married with 3% divorced, and 48% single. 54% have 1–5 years of work experience, 29% have 6–10 years of work experience, 12% have 11–15 years of work experience, 2% have

16–20 years of work experience, and 2% and 1% have 21–25 years and 25 years plus of work experience respectively.

Research Questions and Hypothesis

This uses mean and standard deviation to analyse the results of the three study questions, whereas an independent t-test and analysis of variance (ANOVA) were used to explore questions 4, 5, 6, and 7, 8 respectively.

Research Question 1

Table 3- *Attitude of male and female nurses toward abused victims*

Gender	**Male**		**Female**	
	Mean	**Std. Dev.**	**Mean**	**Std. Dev.**
4. The Hospital gets physically abused clients	3.79	1.07	3.82	1.08
5. The Hospital has a leader or unit who deals with the physically abused clients	2.71	1.36	3.21	1.12
6. Some of the abusers are stressed and therefore uses it on their wives	3.00	1.41	3.19	1.22
7. Nurses are to report cases of physically abused to the DOVVSU	3.18	1.39	3.17	1.28
8. Cases are referred to counselors when needed	4.00	1.09	3.52	1.25
9. There is the need to counsel the victim	4.12	1.23	4.36	0.71
10. There is the need to counsel the perpetrators	3.96	1.17	4.30	1.99

Source: Field Survey (2019).

In addressing the first research question in Table 3, it shows that both male and female nurses have a good and positive attitude toward the physically abused. There is no difference between the mean of males (3.79) and that of females (3.81) as regards the physically abused reporting cases. This means that both male and female nurses agree that clients use the hospital. However, the difference between the mean of male nurses (2.71) compared to female nurses (3.21) with regards to the hospital having a leader or a unit to deal with the physically abused clients is that female nurses agree more than male nurses do. Regarding stress leading to abuse, the male nurses are neutral (mean 3) as are the female nurses (3.19). The nurses are neutral about the issues of stress causing physical abuse. However, male nurses agree (mean 4) more than female nurses (mean 3.52) that cases are reported to the counsellors.

The overall mean of male nurses' (3.54) attitudes towards the physically abused is high as that of female nurses' (3.66). There is no gender-specific differences with regards to total attitude. This really means that nurses have generally good attitudes towards physically abused patients. This may be due to the social learning theory and social system theory having an influence on both nurses. According to the theories, individuals are influenced by their interactions in society and the people with whom they are constantly in contact. Their most noteworthy prize was the patients' improvement and being released from the emergency clinic.

To achieve these requires an exceptional individual with extraordinary qualities (Chokwe & Wright, 2012). Medical attendants need to have an inspirational mentality towards patients and patient consideration. Wellbeing

laborers' perspectives influence conduct, the nature of care, and wellbeing results (Dias et al., 2012).

This investigation affirms what the Domestic Violence Victims Support Unit (DOVVSU) told the exploration group during interviews in Ghana that it had handled a few cases revealed by men and young men because of the inspirational perspectives of attendants towards the genuinely mishandled (DOVVSU, 2011).

At the universal level, comparable proof is accounted for in IDS et al. (2015); Dias, Gama, Cargaleiro, and Martins, (2012) that nurses have patient and positive attitude towards patients. However, this study contradicts that of Grief and Elliot (1994), Hodgson (1997); Iphofen and Poland (1998) that nurses, like other health professionals, often attribute blame for an illness or injury according to their own personal knowledge and attitudes. Grief and Elliot discovered that 66 percent of the nurse respondents disliked caring for 'regular users' of the emergency department. Hodgson (1997), in analyzing attitudes towards HIV and AIDS reveals that a natural state of 'moral entropy' occurs through fear, lack of knowledge and lack of support. Van Wissen and Woodman (1994), employed an exploratory qualitative approach using focus groups to discover a somewhat similar result. However, the contentious nature of the issue caused many respondents to feel uncomfortable disclosing personal views in front of colleagues.

Research Question 2

Table 4- *The behavior of male and female nurses towards the abused victims*

Gender	Male		Female	
	Mean	**Std. Dev.**	**Mean**	**Std. Dev.**
11. As a nurse, I receive Physically abused victims well	4.29	0.66	4.18	0.78
12. As a nurse, I examine Physically abused clients for injuries	4.18	0.82	4.05	0.90
13. As a nurse, I do not report abuse so as not to make the abuser angry	2.84	1.25	2.84	1.15
14. As a nurse, I find it easy to identify physically abused clients.	3.18	1.22	3.27	1.17
15. As a nurse, I always report on physically abused cases.	3.18	1.28	3.09	1.16
16. As a nurse, I report on victims if they are children	3.00	1.19	2.85	1.19
17. As a nurse, I report on victims if they are mostly Women	3.46	1.23	3.06	1.32
18. As a nurse, I report on victims if they are mostly Men	3.29	1.12	2.99	1.15
19. As a nurse, I report on victims if they are mostly Elderly	4.04	1.10	3.78	1.01
20. I report on victims if they are mostly Physically impaired.	3.93	0.94	3.37	1.10
21. I advocate for physically abused client.	2.57	0.92	2.48	1.10
22. As a nurse, I apply my training on how to care for the physically abused.	4.21	0.96	3.90	1.12
23. I always take part in hospital training on physically abused.	4.18	0.95	3.74	1.19
24. As a nurse, I give enough time to listening to physically abused victims.	2.32	1.02	2.27	1.03
25. As a nurse, I always ask abusers the number of occurrences of abuse.	2.54	1.04	2.51	1.00
26. As a nurse, I ask victims' families if they always aware of the abuse.	2.14	0.65	2.32	0.89
27. As a nurse, I follow up on physically abused cases	3.96	1.00	3.81	1.07

Source: Field Survey (2019).

There are several behaviours that are listed in the literature. But this study concentrates on a few of them including receiving abused victims, reporting abuse, and other listed in the first column in Table 4. From Table 4, first row, both male (mean 4.29) and female nurses (4.18) agree that the physically abused are well received. Also, both males (mean 4.18) and female (mean 4.05) nurses agree that physically abused clients are examined for injuries. Sometimes victims are mostly elderly, nurses should have training on how to care for the physically abused, and nurses follow up on physically abused cases are all behaviors both nurses agree to and there is, therefore, no difference between male and female. Both male nurses (mean 3.93) and female nurses (mean 3.37) agree that reported victims are mostly physically impaired but male nurses are more than female nurse.

From the fifth row to the 10th row of Table 3, both male and female nurses are neutral regarding gender disparity and social position in reporting abused cases. This implies that both nurses do not agree or disagree to the fact that gender, social standing, age, and other factors does not determine whether one will report abuses. The overall mean of male nurses (3.37) behaviour is high towards the physically abused as well as that of female nurses (3.21). Research Article on Attitudes and Behaviours of Health Workers and the Use of HIV/AIDS Health Care Services by Dapaah (2016), reveals that health workers providing these services, with the exception of a few, generally showed positive behaviors towards clients during clinical encounters. Health workers warmly received clients to the hospitals, addressing clients with courtesy, advising clients on a wide range of issues, sometimes supporting clients financially, and comfortably interacting with them. This is contrary to

the findings of most studies in the literature that health workers often do not communicate and relate to these patients well (Dapaah, 2016).

In the study by Campbell et al. (1994), of 74 abused victims, half the women suffered negative experiences. They stated that staffs were mainly concerned with the physical injury sustained rather than attempting to discover the history and true cause of the trauma. Little attention was given to emotional support of women.

Campbell et al. (1994) also highlighted that there is an inconsistency in the referrals of abused victim to other services, the majority not being referred at all. In reviewing the literature, several themes have thus emerged which may explain the discrepancy that appears to exist in the detection, management and screening of potentially abused victim in the A & E department by nurses. All victims according to Peckover (2003), find it understandably difficult to raise the issue of them being abused. Nurses, according to Travelbee (1979) are after all individual human beings and personally vulnerable. Many are faced with increasing technological and patient demands placing undeniable stress upon the individual nurse (Douglas, 1993).

Research Question 3

Table 5- *Nurses challenges in caring for the abused victims*

Gender	Male		Female	
	Mean	Std. Dev.	Mean	Std. Dev.
28. There is time constraint in collecting proper history and complaint from victims	3.46	1.07	3.56	1.18
29. Client is always unwilling to give information on the causes of the assault	3.04	1.37	3.21	1.13
30. There is a challenge with culture and language	3.14	1.30	3.15	1.14
31. Lack of knowledge in identifying, screening and educating victims	3.18	1.31	3.07	1.18
32. Lack of policy by the institution in screening victims	3.21	1.17	3.42	1.09

Source: Field Survey (2019).

Table 5 illustrates the comparison of male and female nurses' total challenges in caring for the physically abused. Both male (mean 3.46) and female (mean 3.57) nurses agree that there are time constraints in collecting proper history and complaint from victims. Again, the nurses admit that there are when it comes cultural and language differences with mean 3.14 for male and mean 3.15. The overall mean for male and female is adjudged high above

the cut-off point which was 3. This means in caring for these physically abused victims, nurses encounter some degree of challenges.

Regardless of the difficult setting of absence of strategy by the organization, staff deficiencies, absence of equipment, absence of the board backing, and customers ready to give data, their exercises of treating the customers are not bargained. Their most prominent prize was the patients' improvement and being out of medical clinic. Nursing is genuinely requesting, and nurture need to shape connections inside a delicate and regularly clamorous setting while at the same time maintaining the moral codes of the calling (Smith et al., 2014).

The finding of the investigation affirms the overall assumed that even though there are challenges in treating patients, the troubles cannot forestall legitimate consideration medical attendants can give. In spite of different examinations that find that, among nurses, a hazardous observation exists that ambush and dangers from patients are "simply part of the activity" and happen in view of patients' conditions. Brutality from patients and guests is regularly connected with significant delay times, absence of data, swarming, receipt of terrible news, stress, and helpless adapting abilities (Hackethall, 2016, Casey, 2017). Nurses and other social insurance laborers frequently don't report difficulties, episodes of patient or potentially guest hostility and savagery because of dread of reprisal from their managers and code of morals. Because many people who encounter IPV turn to healthcare professionals for help, it's critical to have education, policies, and protocols in place so that they can recognize and document episodes of IPV and help victims get the assistance and support they need (Chrisler & Ferguson, 2006). Unfortunately, healthcare

workers encounter a variety of personal, professional, and patient-related obstacles that might make it difficult for them to properly identify and support victims (CDC, 2011).

Hypothesis Testing

Hypothesis 1

H_O1: There is no statistically significant difference between male and female nurses in their attitude towards the care of the physically abused victims.

H_A1: There is statistically significant difference between male and female nurses in their attitude towards the care of the physically abused victims.

Table 6- *Result of independent sample t-test on attitude and gender*

Variable	Gender	N	Mean	SD	t-value	df	Sig.
Attitude Scale	Male	28	3.54	0.81	-0.801	124	0.424
	Female	98	3.65	0.64			

Source: Field Survey (2019) (F = 2.713, Sig. = 0.102)

The results of the Levene's test of homogeneity indicated that equal variance assumed. Hence, this assumption of homogeneity was not violated.

From table 6, independent sample t- test was conducted to compare the means of the study variable. The females (mean 3.6) appears to have more favourable attitude compared to the males (mean 3.54), however the differences in mean is not significant. Significant value 0.424> 0.05 (α-value) 2-tailed, therefore there is no statistically significant difference in the attitude of male and female nurses in the care of physically abused victims. Therefore, we fail to reject null hypothesis. There is no gender disparity in the attitude of nurses in this

study. It appears both male and female have favourable attitude. The result of this study is contrary to a study conducted by Amara (2020), patients reported that male nurses are respectful, considerate, good listener, unbiased, and supportive.

Hypothesis 2

H_O2: There is no statistically significant difference between male and female nurses in their behaviour towards the care of the physically abused victims.

H_A2: There is a statistically significant difference between male and female nurses in their behaviour towards the care of the physically abused victims.

Table 7- *Result of independent sample t-test on behaviour and gender*

Variable	Gender	N	Mean	SD	t-value	Df	Sig. value
Behaviour Scale	male	28	3.36	0.52	1.577	124	0.117
	female	98	3.20	0.45			

Source: Field Survey (2019) (F = 2.463, Sig. = 119)

The results of the Levene's test of homogeneity indicated that equal variance assumed. Hence, this assumption of homogeneity was not violated. From table 7, the males (mean=3.36) appears to have more positive behaviour compared to the females (mean=3.20) however the differences in mean is not significant. Significant value 0.117> 0.05 (α-value) 2-tailed, therefore there is no statistically significant difference in the behaviour of male and female nurses in the care of physically abused victims. Both male and female have positive behaviour, hence we fail to reject null hypothesis. Even though some

patient might like the service of male nurses than that of female nurses because their expectation about them is good, this study proved that there is no gender difference in their nursing care. Patients expect five specific loving behaviors from male nurses who care for them, according to these studies. It implies that patients have unique expectations for effective nursing care from their male nurses. Male nurses might encourage these actions in their patients to improve their relationships (Amara, 2020).

Hypothesis 3

H_O3: There is no statistically significant difference between male and female nurses in the challenges they encounter in caring for physically abused victims.

H_A3: There is a statistically significant difference between male and female nurses in the challenges they encounter in caring for physically abused victims.

Table 8- *Result of independent sample t-test on challenges and gender*

Variable	Gender	N	Mean	SD	t-value	Df	Sig. value
Challenge Scale	Male	28	3.2071	.65202	-.539	124	0.591
	Female	98	3.2857	.68864			

Source: Field Survey (2019) (F = 0.136, Sig. = 0.713)

The results of the Levene's test of homogeneity indicated that equal variance assumed. Hence, this assumption of homogeneity was not violated. From table 8, it appears that, the females (mean 3.28) encounter more challenges as compared to the males (mean 3.20), however the differences in mean is not significant. Significant value 0.591> 0.05 (α-value), therefore there is no statistically significant difference in the challenges they

encountered in the care of physically abused victims. Both nurses encounter challenges. A support for the result is that, according to Byrne (1997), generally nurses are predominantly task-centered hence they have time constraint which ultimately affect the care and management of the abused victims.

Hypothesis 4

H$_O$4: There is no statistically significant difference between marital status and attitude of nurses towards the care of the physically abused victims.

H$_A$4: There is a statistically significant difference between marital status and attitude of nurses towards the care of the physically abused victims.

Table 9- *Result of ANOVA on attitude and marital status*

Variable	Group	N	Mean	SD	F-value	Df	Sig. value
Attitude Scale	Married	62	3.60	0.72	0.772	2(123)	0.464
	Divorce	4	3.29	0.72			
	Single	60	3.68	0.64			

Source: Field Survey (2019) F(2, 123) = 0.922, Sig. = 0.401

The results of the Levene's test of homogeneity indicated that equal variance assumed. Hence, this assumption of homogeneity was not violated. From table 9, One-Way Analysis of variance (ANOVA) was conducted. The singles (mean 3.68) appears to have positive attitude compared to married group (mean 3.60) and divorce (mean 3.29), however the differences in their means are not significant. Significant value 0.464 > 0.05 (α-value) 2 -tailed, therefore there is no statistically significant difference based on marital status

in the attitude of nurses towards the care of physically abused victims. This is contrary to a study conducted at the Nigerian Federal Health Institute on the influence of sex, marital status, and tenure of service on job stress and job satisfaction of health workers. The result indicated that all the demographic variables (marital status, sex, and tenure of service) measured have a significant effect on job satisfaction of the respondents (Olatunji & Mokuolu, 2014).

Hypothesis 5

$H_0 5$: There is no statistically significant difference between work experience and attitude of nurses towards the care of the physically abused victims.

$H_A 5$: There is a statistically significant difference between work experience and attitudes of nurses towards the care of the physically abused victims.

Table 10- *Result of ANOVA on attitude and work experience*

Variable	Group	N	Mean	SD	F-value	Df	Sig. value
	1-5yrs	68	3.66	0.72			
	6-10yrs	36	3.69	0.58			
Attitude	11-15yrs	15	3.41	0.66	1.944	5(120)	0.092
	16-20yrs	3	3.29	0.38			
	21-25yrs	3	4.00	0.86			
	25+yrs	1	2.00	.			

Source: Field Survey (2019) F (4, 120) = 0.629 = Sig. = 0.643

The results of the Levene's test of homogeneity indicated that equal variance assumed. Hence, this assumption of homogeneity was not violated. From table 10, there are differences in mean among the nurses based on work experience. However, Significant value 0.092>0.05 (α-value), therefore there is no statistically significant difference on the basis of work experience in the attitudes of nurses in the care of physically abused victims. Therefore, we fail to reject the null hypothesis.

A study by Cherniss (1986), found out that job satisfaction increases with tenure of service. Nurses who have spent 5-10 years in service enjoyed more satisfaction than those with less than five years. In the same vein, those who have served for more than 10 years were more satisfied than those with 5-10 years tenure of office. It can then be deduced that experience on a job reduces the level of stress, and then enhances the satisfaction that is derived from the job.

Job satisfaction, performance and attitude are interrelated with each other. It was found that employees' attitudes toward satisfaction are indicators to solidarity between members and management. More experienced nurses are found to be committed (Knoop 1995). This is contrary to the result of the hypothesis which reveals that irrespective the length of experience, nurses appear to have favorable attitude.

Summary

From tables 6, 7, 8, 9 and 10 using independent sample t-test statistics for 6, 7, 8 and table 9 and 10 for one-way ANOVA, all the significant values were greater than α value 0.05. Hence, we fail to reject null hypothesis H_0. There is no statistically significant difference between gender and attitude,

gender and behaviour, gender and challenges nurses encounter, marital status and attitudes, and work experience and attitude of nurse in the care of physically abused victims.

The finding of the study confirms the general notion that though there are difficulties in treating patients, the difficulties cannot prevent proper care nurses can give. With the exception of a few, health personnel offering these services had generally positive attitudes and behaviours toward clients throughout clinical contacts. Clients are greeted cordially at the facilities, with health personnel treating them with civility, counselling them on a wide range of concerns, occasionally financially assisting them, and socializing with them in a relaxed manner. This contradicts the findings of most research in the literature, which show that health care providers frequently fail to communicate with and relate to these patients (Dapaah, 2016).

Counselling Implications

Social learning theory is largely based on the work of Albert Bandura (2001), who mapped out a perspective on learning that includes consideration of personal characteristics of the learner, behaviour patterns and the environment. According to the social learning theory, an individual learns through the influences of the environment on the mind. Most learning theories assume the individual need not have direct experience to learn. According to the social learning theory, much of learning occurs by observation watching other people and determining what happens to them. Learning is often a social process, and other individual, especially significant others, provide compelling examples as role models for how to think, feel and act. Social learning theory

is one of the learning theories that considers the function of the environment in shaping responses through interaction with the learner's cognitive skills.

The central aspect of this theory is the focus on the internal aspects rather than external aspects. Regarding the focus of this theory on the social aspects of learning. Some of it counseling implications are:

1. Social learning theory can be applied to nursing education, to address psychosocial problems, and to maximize the use of support groups. For example, research shows that managers who understand their roles and responsibilities in promoting a positive work environment improves learning, competence, and satisfaction; dissatisfaction, on the other hand, has a detrimental effect and is a major cause of staff turnover (Kane-Urrabazois, 2006), very suitable for teaching and using this theory can be helpful in a group environment.
2. Application of the theory in the nursing training colleges would mold students, behaviour so that they become competent and skilled on the job while in school and after graduation. According to McKenna (1995), nursing educators should play a similar function as a professional model, transferring their excitement and interest in the nursing profession to students and preparing them to perform their professional abilities.
3. One of the most significant components of nursing, that a new student should learn is the professional role which can be accomplished by allowing the students to observe professional nursing activities. The students would not only observe the nurses' performance, but also, the relationship between nurses, patient and other members of the caring

team. (Basavanthappa, 2003). As a result, their attitudes practice and concurrent skills and procedures are established.

4. Ghana Health Service/ Ministry of Health needs to hire more professional counsellors so that counselling is included in the nursing curriculum. Teaching new behaviours and abilities encouraging and persuading previously taught behaviours, attracting learner's attention, eliciting strong and emotional responses, or decreasing the influence of deterrents are all examples of how counselling can be used.
5. Regular use of theories by health professionals would give a clear reasoning, educational activities, proper interactions with clients' management, employee training, continuing education and health promotion programs, especially in the current health care structure. In most countries, nurses are in charge of the design, execution, and procedures for promoting health training.
6. Role modeling and mentorship is a central concept of the theory. As an example, a more experienced nurse who demonstrates desirable professional attitudes and behaviors sometimes is used as a mentor for a less experienced nurse. Research indicates that nurse managers' attitudes and actions, ensuring safety, integrating knowledge with practice, sharing feelings, challenging staff nurses and students, and their competence and willingness to provide guidance to others influence the outcomes of the clinical supervision process (Berggren & Severinsson, 2006). In the social learning model, the nurse tries to motivate employees to develop self-regulated behavior. Behavioral standards are the key to self-regulatory behavior and are best

established by instruction, experiencing consequences growing out of behavior, and observing models engaging in self-evaluative behavior.

7. Social learning theory would help to design and plan for more effective health promotion programs by utilizing theories of behaviour change. The motivation of employees to make behavior changes can be enhanced by raising their awareness of the problem, engaging clients in the process of goal setting, and making self-satisfaction conditional on a certain level of performance
8. In nursing education, this approach can be used to learn new behaviors and abilities, reinforce previously learned behaviors, and engage learners' attention. The instructor's position as a role model for the students is critical, not only for executing the procedures, but also for teaching the students how to communicate with patients and medical team partners, as well as how to follow ethical norms (Spiegler & Guevremont, 2009).
9. Apart from the profession of the person, knowledge about the learning process, it is largely associated with the everyday life of the people too. Learning theories can be used individually, group-wise or at a community level, not only for understanding and learning new things, but also for problem solving, changing the health habits, constructive communication, control emotions and affecting behavior development (Nelson, 2007).

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Introduction

The purpose of the study was to assess the attitude, behaviour and challenges of nurses whiles taking care of physically abused victims in hospitals in the Sekondi-Takoradi Metropolitan in Ghana. Specifically, the study examined the statistical difference between gender, marital status and work experience of nurses on the bases of attitude, behaviour and challenges towards the physically abused. Accordingly, the study was guided by five hypotheses. This chapter captured the summary of findings that were made from the study. It goes on to provide conclusions made from the study and thereafter gives recommendations to various stakeholders in society based on the findings and conclusions. The chapter ends with limitations of the study and also gave directions for further research on the topic.

Summary of the Research Process

The main objective for conducting the study was to assess the attitude, behaviour, and challenges in caring for physically abused victims Sekondi-Takoradi metropolis of Ghana. Research questions that guided the study were:

1. What is the attitude of nurses towards the physically abused in hospitals in the Sekondi-Takoradi Metropolis?
2. What is the behaviour of nurses towards the physically abused in the hospitals in the Sekondi-Takoradi Metropolis?

3. What challenges do nurses encounter in caring for the physically abused in the hospitals in the Sekondi-Takoradi Metropolis?

The following Research Hypotheses were tested to further guide the conduct of the study:

$H_0$1: There is no statistically significant difference between male and female nurses in their attitude towards physically abused victims.

H_A1: There is statistically significant difference between male and female nurses in their *attitude* towards physically abused victims

$H_0$2: There is no statistically significant difference between male and female nurses in their *behaviour* towards physically abused victims

H_A2: There is statistically significant difference between male and female nurses in their behaviour towards physically abused victims

$H_0$3: There is no statistically significant difference between male and female nurses in the challenges they encounter in caring for physically abused victims.

H_A3: There is statistically significant difference between male and female nurses in the challenges they encounter in caring for physically abused victims

$H_0$4: There is no statistically significant difference based on marital status in the attitude of nurses towards the care of the physically abused victims.

H_A4: There is a statistically significant difference base on marital status in the attitude of nurses towards the care of the physically abused victims

$H_0$5: There is no statistically significant difference based on work experience in the attitude of nurses towards the care of the physically abused victims.

H_A5: There is a statistically significant difference, on the basis of work experience in the attitudes of nurses towards the care of the physically abused victims.

The study was also guided by a couple of pieces of literature on the attitudes and behaviour of nurses, challenges, and marital status in relation to the attitudes. Others focused on violence and abusive behaviors, as well as the role of health care providers in dealing with physical abuse. Following, the empirical framework of the study was the explanation of the conceptual framework that underpinned it. A number of psychological and counselling theories, such as the social learning theory and the resilience theory, were used.

A descriptive survey was used to explore the problem. The target population for the study comprised all the general and mental health nurses in a selected hospital in the Sekondi-Takoradi metropolis in the Western Region of Ghana, which was 184. Three hospitals were selected purposively A sample of 126 was selected for the study. All 126 nurses responded to the questionnaires adopted and modified by the researcher. There was a 100% return rate.

All the respondents provided the needed pieces of information through a questionnaire consisting of two main sections. The first section consisted of the biographic data of the respondents. In the second section, items were designed to find out the nurses' attitudes, behaviors, and the challenges they encounter in caring for the physically abused victims.

The instrument was pre-tested on 20 nurses in the Ewim Polyclinic in Cape Coast Metropolis in the Central Region of Ghana before it was used to

collect the actual data for the study. The metropolis was selected because it shares lots of similar urban characteristics in terms of having regional hospitals with a larger staff population, quality health professionals, and adequate facilities. The questionnaire was personally administered with three other trained assistants and collected during the research. Descriptive and inferential statistics were the main tools for the analyses. Thus, means, standard deviation, percentages, independent sample t-test, and one-way ANOVA analysis were used, respectively.

Summary of Key Findings

The main findings that emerged from the study were as follows:

1. Nurses in general appeared to have favourable attitudes towards the physically abused victims.
2. In general, nurses have good behaviour toward the physically abused.
3. The nurses face some difficulties when caring for the physically abused. Every nurse faces challenges in the management and caring for the physically abused. However, some challenges, such as challenges with culture and language and lack of policy by the institution in screening victims, are more prevalent among general nurses than mental health nurses.
4. There was no statistically significant difference between male and female nurses in their attitude toward the care of the physically abused victims.
5. There was no statistically significant difference between male and female nurses in their behaviour toward the care of the physically abused victims.

6. There was no statistically significant difference between male and female nurses in their challenges they encounter in caring for physically abused victims.
7. There was no statistically significant difference based on marital status in the attitude of nurses towards the in care of physically abused victims.
8. There was no statistically significant difference based on the basis of length of work experience in the attitude of nurses towards the care of physically abused victims.

Conclusions

From the findings of the study, a number of conclusions have been drawn.

- Nursing as a profession is built on sympathy and caring for people.
- It can also be concluded that, no gender gap in terms of attitude, behaviour, and demographic characteristics of nurses in the care of the physically abused.
- Again, it was concluded that, generally nurses have some challenges with culture and language.
- Finally, there was lack of policy by the institutions in screening victims.

Recommendations

I recommend that:

- Effective support programmes be designed to assist nurses in various work places. This can be done with the support of hospital managers liaising with professional counsellors to regularly visit and educate the nurses.
- This information should be factored into the establishment of post assault programs. Greater emphasis should be paid to the care and support nurses provide to those who have been assaulted while performing their professional tasks.
- Nurses should be informed that referring victims to counsellors and reporting physically abused people to DOVVSU are very helpful.
- Education and training programmes on counselling are to be incorporated into the preparation of nurses. This could help nurses counsel the physically abused well.
- The government, through the ministry of health, should ensure that nurses are posted to communities where they understand and can speak the language of the people and also provide policy so that the institution can screen victims to reduce the challenges nurses face, especially among general nurses.

Suggestions for Further Research

Future studies can consider similar analysis by investigating the physically abused victims themselves to analysis the attitude, behavior, and the challenges of nurses in treating and caring for them. This will help to find the true attitudes, behavior, and challenges of the nurses. Again, future

research could consider higher sample size and include private hospitals to get clearer views of the attitudes and behaviour of nurses towards the physically abuse.

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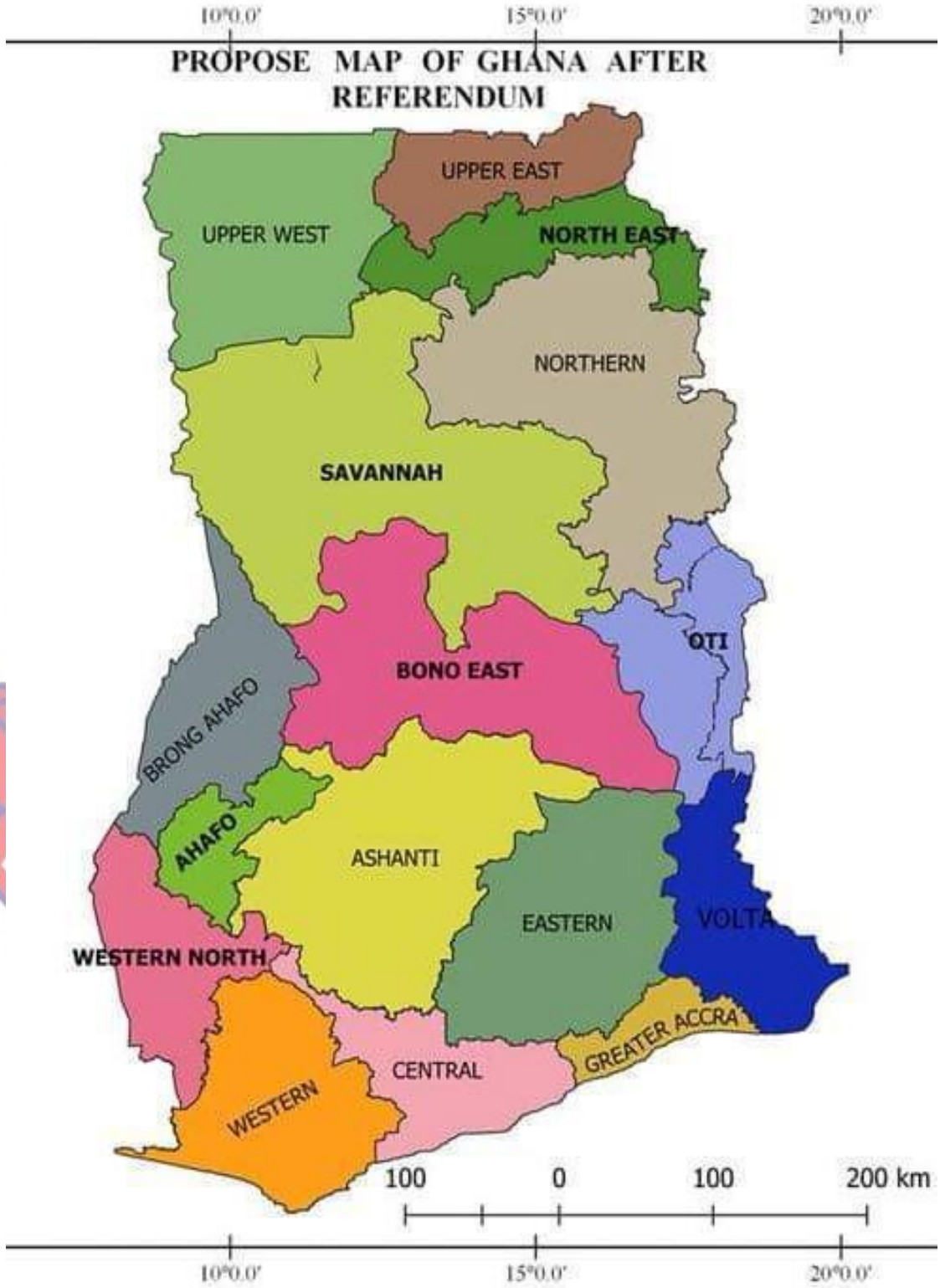
APPENDICES

APPENDIX A: MAP OF GHANA



APPENDIX B: QUESTIONNAIRE FOR NURSES

Dear Sir/Madam,

This questionnaire is intended to elicit information that will form the basis for appraising the extent of nurses' attitude, behavior and challenges they face in the care of physically abused victims. Your candid opinion is highly welcome.

You are assured of confidentiality of any information so given.

SECTION A: Personal Data

Please tick [ ] or fill the blank space where appropriate

1. Gender Male [ ] Female [ ]
2. Marital Status
   - I. Married [ ]
   - II. Divorce [ ]
   - III. Single [ ]
   - IV. Widow /Widower [ ]
3. Indicate your Clinical Experience from the following list below
   - I. 1 – 5 years [ ]
   - II. 6 – 10 years [ ]
   - III. 11 – 15 years [ ]
   - IV. 16 – 20 years [ ]
   - V. 21 – 25 years [ ]
   - VI. 25 years and above [ ]

SECTION B: General Nursing Issues

Indicate the responses closest to your view by ticking (√) the appropriate column for each item in terms of magnitude or priority. Strongly agree (SA), Agree (A), Neutral (N), Disagree (D), Strongly disagree (SD).

My attitude as a nurse towards physically abused victims

	QUESTIONS	SA	A	N	D	SD
4.	The Hospital gets too many physically abused clients					
5.	The Hospital should have a leader or unit who deals with the physically abused clients					
6.	Some of the perpetrators are stressed and visit their anger on their spouses					
7.	Nurses should report cases of physically abused to the DOVVSU					
8.	Nurses should referred cases to counselors when needed					
9.	There is the need to counsel the victims of physical abuse					
10.	There is the need to counsel perpetrators of physical abuse					

My behavior as a nurse towards the physically abused

	QUESTIONS	SA	A	N	D	SD
11.	As a nurse, I receive physically abused victims well					
12.	As a nurse, I examine physically abused clients for injuries.					
13.	As a nurse, I do not report abuse so as not to make the abuser angry					
14.	As a nurse, I find it easy to identify physically abused clients					
15.	As a nurse, I always report on physically abused cases.					

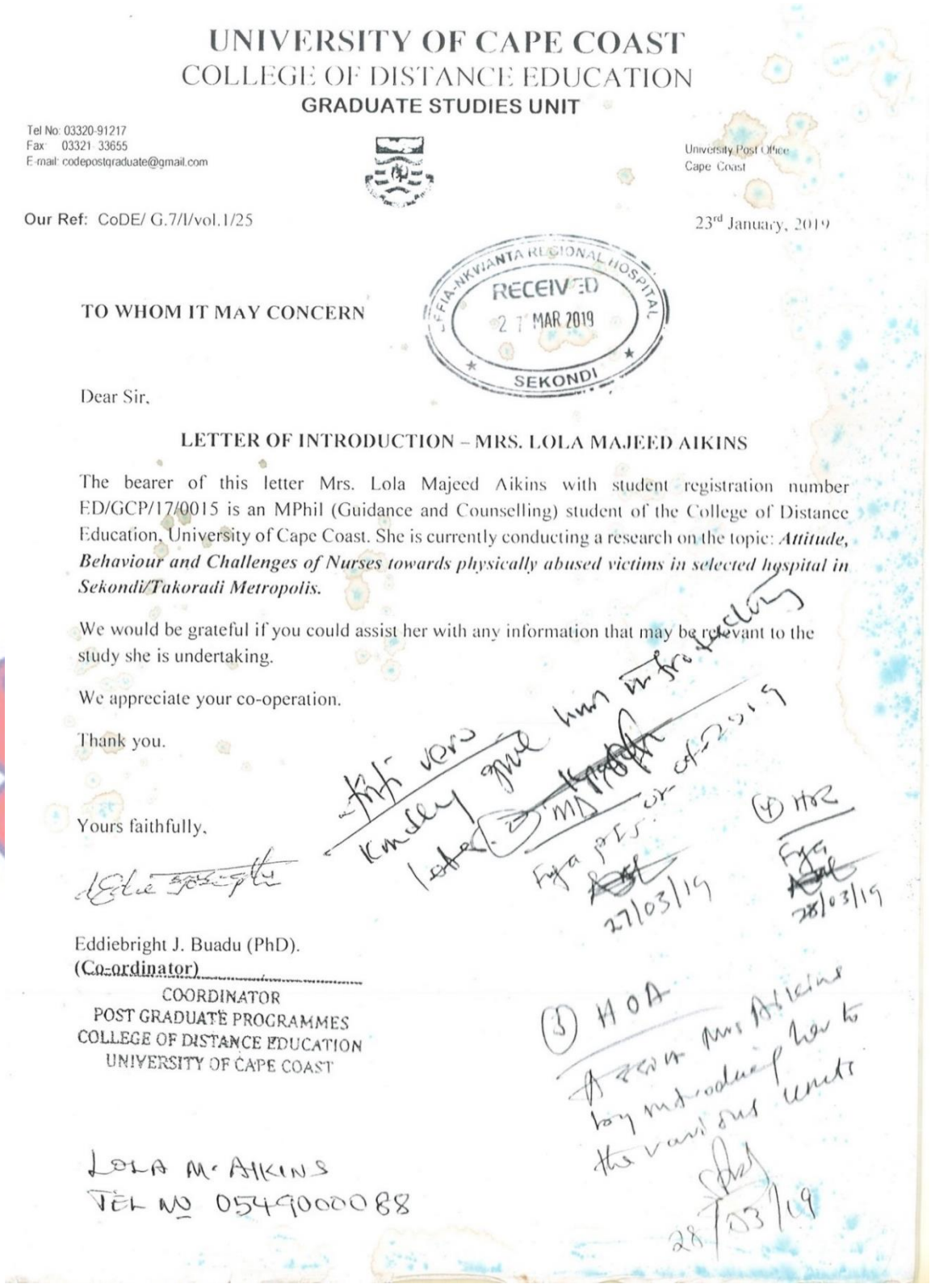
16.	As a nurse, I report on victims if they are children					
17.	I report on victims if they are mostly women					
18	As a nurse, I report on victims if they are mostly Men					
19	As a nurse, I report on victims if they are mostly Elderly					
20	Reported victims are mostly Physically impaired					
21	I advocate for physically abused clients.					
22	As a nurses, I apply my training on how to care for the physically abused.					
23	I always take part in facility training on physically abused victims.					
24	As a nurses, I give enough time to listening to physically abused victims.					
25	As a nurses I always ask abusers the number of occurrences of abuse.					
26	As a nurse, I ask victims' families if they are always aware of the abuse					
27	As a nurse, I follow up on physically abused cases.					

Nurses challenges in caring for the physically abused

	QUESTIONS	SA	A	N	D	SD
28	There is time constraint in collecting proper history and complaint from victims					
29	Client is always not willing to give information on the causes of the assault.					
30	There is a challenge with culture and language					
31	Lack of knowledge in identifying, screening and educating victims.					
32	Lack of policy by the institution in screening victims.					

APPENDIX C

INTRODUCTORY LETTERS



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TO WHOM IT MAY CONCERN

Dear Sir,

LETTER OF INTRODUCTION – MRS. LOLA MAJEED AIKINS

The bearer of this letter Mrs. Lola Majeed Aikins with student registration number ED/GCP/17/0015 is an MPhil (Guidance and Counselling) student of the College of Distance Education, University of Cape Coast. She is currently conducting a research on the topic: *Attitude, Behaviour and Challenges of Nurses towards physically abused victims in selected hospital in Sekondi/Takoradi Metropolis.*

We would be grateful if you could assist her with any information that may be relevant to the study she is undertaking.

We appreciate your co-operation.

Thank you.

Yours faithfully,

Eddiebright J. Buadu (PhD).
(Co-ordinator)
COORDINATOR
POST GRADUATE PROGRAMMES
COLLEGE OF DISTANCE EDUCATION
UNIVERSITY OF CAPE COAST

LOLA M. AIKINS
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Your Ref: DGC/L.2/VOL.1/177

25th March, 2022

The Regional Commander
Ghana Police Service
Sekondi-Takoradi
Western Region

LETTER OF INTRODUCTION

We introduce to you, Lola Majeed Aikins a student pursuing an M.Phil. Programme in Guidance and Counselling at the Department of Guidance and Counselling of the University of Cape Coast. As a requirement, she is to submit a Thesis on the topic: ***"Attitude, Behaviour and Challenges of Nurses Caring for Physically Abused in Selected hospitals in Sekondi-Takoradi Metropolis, Ghana".*** We are by this letter affirming that, the information she will obtain from your Institution will be solely used for academic purposes.

We would be most grateful if you could provide her the necessary assistance.

Thank you.

Dr. Stephen Doh Fia
HEAD OF DEPARTMENT

APPENDIX D

ETHICAL CLEARANCE

UNIVERSITY OF CAPE COAST
COLLEGE OF EDUCATION STUDIES
ETHICAL REVIEW BOARD

UNIVERSITY POST OFFICE
CAPE COAST, GHANA

Our Ref: CES-ERB/ucc.edu/v4/20-78

Your Ref: .....

Date: 12th March, 2020

Dear Sir/Madam,

ETHICAL REQUIREMENTS CLEARANCE FOR RESEARCH STUDY

The bearer, Lola Majeed Aikins, Reg. No. ED/GCE/17/0015 is a M.Phil. / ~~Ph.D.~~ student in the Department of Guidance and Counselling in the College of Education Studies University of Cape Coast, Cape Coast, Ghana. ~~He/~~ She wishes to undertake a research study on the topic:

Attitude, behaviour and challenges of nurses caring for the physically abused in selected hospitals in the Sekondi-Takoradi Metropolis

The Ethical Review Board (ERB) of the College of Education Studies (CES) has assessed ~~his~~/her proposal and confirm that the proposal satisfies the College's ethical requirements for the conduct of the study.

In view of the above, the researcher has been cleared and given approval to commence ~~his~~/her study. The ERB would be grateful if you would give ~~him~~/her the necessary assistance to facilitate the conduct of the said research.

Thank you.
Yours faithfully,

Prof. Linda Dzama Forde
(Secretary, CES-ERB)

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