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RECOGNIZING AND TREATING VICTIMS OF DOMESTIC VIOLENCE IN HEALTH CARE SETTINGS

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Comparison of perceived barriers in responding to domestic violence between health care professionals

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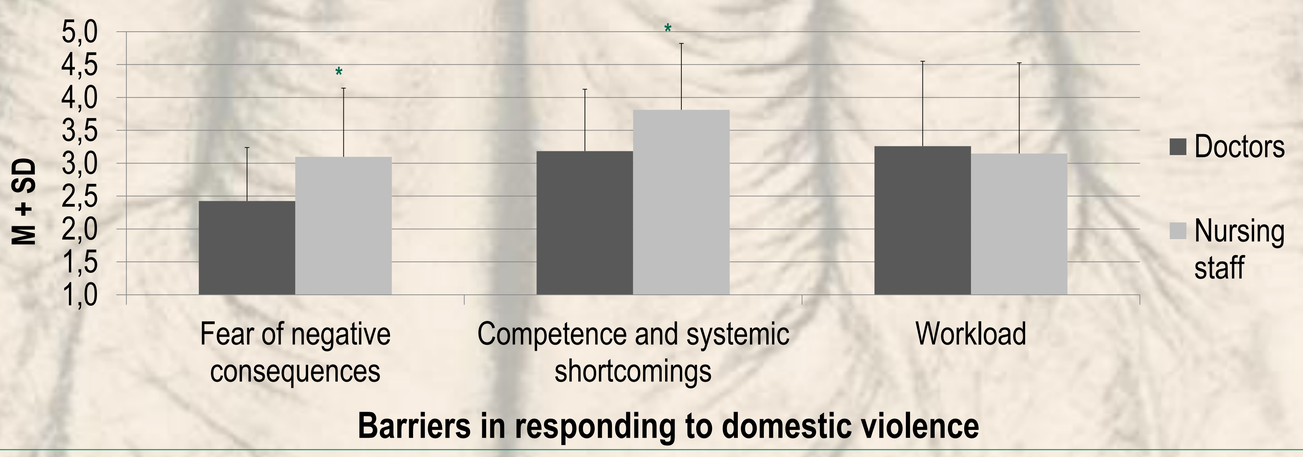
Background: For victims of domestic violence, health care settings often represent the first and usually most accessible contact with institutions, which can help dealing with their situation[1], therefore health care professionals have an important role in recognizing and treating victims of domestic violence[2]. In spite of that many cases of domestic violence remain unrecognized[3], it has even been reported that health care professionals recognise only 1 out of 20 victims of domestic violence[4]. Effective identification of victims is often compromised by different barriers which health care professionals encounter daily, such as systemic barriers, barriers arising from work characteristics[5] and also barriers referring to lack of knowledge and competences in the area of domestic violence[6].

Aim: The aim of the present study was to compare two groups of health care professionals (doctors and nursing staff) who already encountered domestic violence in perceived barriers in responding to domestic violence.

Methods: In a broader study of the project Recognizing and treating victims of domestic violence in health care settings: Guidelines and training for health professionals 488 participants were included. Self-assessment Questionnaire on recognition and treatment of domestic violence for health care professionals, developed as a part of a project, was used. Sample of a present study consisted of 259 health care professionals ($N_{doctors(d)}$ = 171, $N_{nursing\ staff(ns)}$ = 88) who already encountered domestic violence at their work and responded to all items in the questionnaire regarding barriers. Barriers part of the questionnaire consists of 10 items in 3 subscales: fear of negative consequences (Cronbach's α = 0.78), competence and systemic shortcomings (α = 0.81), and workload (α = 0.96). Participants provided their response on a five-point scale (1 – I completely disagree, 5 – I completely agree). Due to some deviations from normality bootstrap was performed for statistical inference. Chosen criterion level of analyses was 5 %.

Results: Statistically significant differences of perceived barriers between doctors and nursing staff were observed on the two subscales of barriers. The ns reported higher means than d on the fear of negative consequences subscale (M_{ns} = 3.10, SD_{ns} = 1.05; M_d = 2.43, SD_d = 0.81), *t*(142,5)= -5.257, p = 0.000, 95 % IZ [-0.923, -0.419], and on the competence and system shortcomings subscale (M_{ns} = 3.81, SD_{ns} = 1.01; M_d = 3.18, SD_d = 0.94), *t*(257)= -4.970, p = 0.000 , 95 % IZ [-0.877, -0.379]. There were no differences in scores on the perceived workload subscale when comparing the two groups (M_{ns} = 3.15, SD_{ns} = 1.38; M_d = 3.26, SD_d = 1.29; *t*(257)= 0,649, p = 0.517, 95 % IZ [-0.229, 0.454]).



Conclusions: When examining perceived barriers that make it more difficult to respond to victims of domestic violence, nursing staff reported more fear of negative consequences and also more competence and systemic shortcomings than doctors did. One possible explanation could include the occupational hierarchy of health care in which those with biomedical diagnostic skills (i.e. doctors) are privileged[7] which might be linked with nursing staff feeling inferior even when it comes to dealing with victims of domestic violence.

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