

Are Psychiatric Nurses More Vulnerable to Domestic Violence Compared with Nurses from Other Specialties?

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Abstract Women, especially working women, suffer from domestic or intimate partner violence worldwide. Nurses are no exception. The study aim was to compare the magnitude of domestic violence and its effects among psychiatry nurses compared with nurses from other specialties. This cross-sectional comparative study was conducted on 120 psychiatric nurses from in Abbasiya Mental Hospital and 120 nurses in other specialties from El-zaitoon hospital. Data were collected using a self-administered questionnaire with the HITS (Hurt, Insult, Threaten, Scream) Scale for exposure to domestic violence, and the Women's Experience with Battering (WEB) scale to assess the meanings women attribute to their exposure to domestic violence. The fieldwork lasted from April to June 2017. The nurses in the two groups had comparable demographic characteristics. More nurses in the psychiatry group were not sharing in home expenses ($p=0.01$), had independent house ($p<0.001$), had their work affecting home needs ($p=0.03$), and marital relations ($p=0.04$), and were asked to leave work by husband ($p=0.03$). The psychiatry nurses had significantly lower mean and median HITS scores ($p=0.007$). More psychiatry nurses reported thinking of leaving work as a consequence of domestic violence ($p=0.001$). In multivariate analysis, the independent positive predictors of the HITS score were the nurse age at marriage, husband age, sharing in home expenses, working overtime, and the work having a negative effect on marital life, while, the negative predictors were being a psychiatric nurse, age, and living in an independent house. For the effects score, the independent positive predictors were being a psychiatric nurse, having children, work having a negative effect on marital life, in addition to the HITS score, whereas the negative predictors were the income and working for need. In conclusion, the psychiatric nurses are less vulnerable to domestic violence, compared with other specialties; however, the impact of this violence is more severe among them, with a higher tendency to leave the work for this. The work environment, particularly in psychiatry should be improved with more flexible schedules and less hours of overtime work. More intervention research is suggested to assess the effectiveness of various approaches to deal with domestic violence.

Keywords: *psychiatric nurses, domestic violence, intimate partner violence*

Cite This Article: Evon S. Shokre, and Nagwa A. Souilm, "Are Psychiatric Nurses More Vulnerable to Domestic Violence Compared with Nurses from Other Specialties?" *American Journal of Nursing Research*, vol. 5, no. 6 (2017): 226-234. doi: 10.12691/ajnr-5-6-5.

1. Introduction

Domestic or intimate partner violence is a universal problem affecting women worldwide [1]. Statistics estimate that 40% of women are abused by their husbands or intimate partner [2]. However, the rates vary among countries, with lower estimates in the Western world in comparison to the east [3]. This has been attributed to differences in cultural norms and values, where some societies are more tolerable of such abuse under the context that it is the right of the husband to punish his wife [4,5]. Efforts have been exerted to decrease the rates of domestic violence, but the outcomes are sub-optimal [6].

Research identified a number of factors significantly influencing women's exposure to domestic or intimate partner violence. These include certain personal variables

such as the woman's age, age at marriage and its length, having children and their numbers and gender, and the type of residence [7,8]. From these, it is deduced that less educated women living at lower socioeconomic levels are more vulnerable to such violence [9,10]. On the other hand, highly educated women are less vulnerable to domestic violence because they have skills and resources to prevent violent behaviors [11]. Other factors are related to husband. Thus, research showed that the perpetrator husbands are more dominant and have more control over their wives [12,13].

Working women seem to be more susceptible to domestic violence [14] despite the assumption that economically independent women might have feeling of more security from such abuse [15]. Woman's work can lead to a poor-quality relationship with her husband, or social undermining, which can enhance conflicts and induce violence [16]. The problem is accentuated when

the work of the woman encroaches on her family needs due to more working hours and overtime work and unsuitable job schedules [17,18].

The nature of the work in the nursing profession can lead to family-work conflicts, thus exposing them to a high possibility of domestic violence. The situation is aggravated by the high prevalence of workplace violence among nurses in general [19], and psychiatric nurses in particular [20]. However, there is a paucity of research on domestic violence among nurses [21].

1.1. Aim of the Study

The study aim was to compare the magnitude of domestic violence and its effects among psychiatry nurses compared with nurses from other specialties. It was hypothesized that the nurses in the psychiatry specialty are less prone to domestic violence compared with those working in other specialties.

2. Subjects and Methods

2.1. Design and Setting

This cross-sectional comparative study was conducted in Abbasiya Mental Hospital and El-zaitoon Specialized Hospital. Abbasiya Mental Hospital is the most important mental institution in Egypt and the Middle East, built in 1883. Eighteen mental hospitals across Egypt are connected to it. Approximately 1500 patients attend the hospital every month. The hospital considers rehabilitation to be the most important stage for any patient. El-zaitoon Specialized Hospital is a 100-bed capacity hospital, with a new extension to increase capacity to 190 beds. It serves a large mix of patients.

2.2. Subjects

The study involved two different samples for comparison of domestic violence, one consisting of psychiatric nurses (from Abbasiya hospital), and the other of nurses from different other specialties (from El-zaitoon hospital). All the nurses working in the study settings were eligible for inclusion in the study samples if fulfilling the criteria of being married either currently or previously, and having a work experience of at least one year in the current specialty. The sample was calculated to detect a difference in the mean score of HITS between the two groups or samples with a moderate effect size (0.4) according to [22]. It turned to be 115 per group at 95% level of confidence, 80% power, and accounting for 15% non-response. The nurses were recruited consecutively in each group according to the set criteria.

2.3. Data Collection Tool

The researchers prepared a self-administered questionnaire for data collection. It comprised a part for demographic, job, socioeconomic, and health characteristics of the nurse. It also asked about the consequences of domestic violence. The second part consisted of the HITS (Hurt, Insult, Threaten, Scream) Scale developed by [23] to

screen for exposure to domestic violence. It has four questions asking about how often does partner physically hurt, insult, threatened with physical harm, and screamed or cursed at respondent. The responses are on a 5-point Likert scale ranging from "never" to "frequently." These are scored from 1 to 5 so that the total scale score ranges between 5 and 20. A total score of 10 or more is considered as diagnostic of exposure to domestic violence. The authors reported high reliability and validity of the scale. Moreover, the present study tested reliability of the HITS scale revealed a Cronbach alpha coefficient of 0.923.

The last part of the self-administered questionnaire consisted the Women's Experience with Battering (WEB) scale developed and validated by [24] to assess the meanings women attribute to their exposure to domestic violence. The scale has ten items checked on a 6-point Likert scale ranging from "strongly agree" to "strongly disagree." Examples of these items are "He makes me feel unsafe even in my own home," "I hide the truth from others because I am afraid not to," "He can scare me without laying a hand on me," etc. The responses are scored from "6" to "1" respectively, with a higher score implying a more severe domestic violence effect on respondent. The total sum of the ten items ranges between 10 and 60. A total score of 20 or higher indicates high domestic violence effects. The tool reliability and validity were previously reported [25]. The reliability of the WEB scale in the present study was high with Cronbach alpha coefficient of 0.966.

2.4. Pilot Study

A pilot study was conducted out about 10% of the calculated sample size. Since no changes were needed in the data collection tools, the pilot sample was included in the main study sample.

2.5. Study Maneuver

After acquiring official permissions to conduct the study, the researchers started the process of recruitment of the nurses in the two groups or sample (psychiatry and other specialties). Eligible ones were invited to participate after getting a full explanation of the study aim and procedures. Those who gave their verbal consent to participate were given the data collection form and instructed in its filling it in. Every nurse filled the form individually and in privacy during the work time according to the work circumstances. The filling of the form took an average of 15 minutes. The data collection work was done twice weekly. The fieldwork lasted from April to June 2017.

2.6. Administrative and Ethical Issues

The study protocol was approved by the research and ethics committee in the Faculty of Nursing, Fayoum University and Faculty of Nursing, South Valley University. An agreement to conduct the study was obtained from the hospital director. The Helsinki Declaration principles of ethics in research were followed. A verbal informed consent was taken from each nurse after clarification of the study aim, and informing her about her rights to refuse

or withdraw. The researchers ensured the anonymity and confidentiality of any information gained.

2.7. Statistical Analysis

Data entry and statistical analysis were done using SPSS 20.0 statistical software package. Data were presented using descriptive statistics in the form of frequencies and percentages for qualitative variables, and means and standard deviations. Cronbach alpha coefficient was calculated to assess the reliability of the scales through their internal consistency. Quantitative continuous data were compared using the non-parametric Mann-Whitney test. Qualitative categorical variables were compared using chi-square test. Whenever the expected values in one or more of the cells in a 2x2 tables was less than 5, Fisher exact test was used instead. In larger than 2x2 cross-tables, no test could be applied whenever the expected value in 10% or more of the cells was less than 5. Spearman rank correlation was used for assessment of the inter- relationships among quantitative variables and ranked ones. In order to identify the independent predictors of the HITS and WEB scores, multiple linear regression analysis was used and analysis of variance for

the full regression models done. Statistical significance was considered at p-value <0.05.

3. Results

Table 1 indicates that the samples of nurses in the two study groups, psychiatry and other specialties, had comparable demographic characteristics. The differences of statistical significance were in nurse’s age (p=0.04), age at marriage (p=0.007), and husband education (p=0.04). However, the differences in the mean age and age at marriage were very small, two years and one year, respectively. Although less psychiatric nurses were divorced/widow, the difference did not reach statistical significance (p=0.08).

As regards job, the great majority of the nurses in the two groups had a diploma degree, with a staff nurse position, worked overtime and for financial needs as illustrated in Table 2. Significantly higher percentages of the nurses in the psychiatry group were not sharing in home expenses (p=0.01), had independent house (p<0.001), had their work affecting home needs (p=0.03), and marital relations (p=0.04), and were asked to leave work by husband (p=0.03).

Table 1. Demographic characteristics of nurses in the two study groups

| | Specialty | | | | X ² test | p-value |
|--------------------|--------------------|------|---------------|------|---------------------|---------|
| | Psychiatry (n=115) | | Other (n=115) | | | |
| | No. | % | No. | % | | |
| Age: | | | | | | |
| <30 | 37 | 32.2 | 28 | 24.3 | 1.82 | 0.40 |
| 30- | 51 | 44.3 | 55 | 47.8 | | |
| 40+ | 27 | 23.5 | 32 | 27.8 | | |
| Range | 23.0-59.0 | | 23.0-50.0 | | U=4.05 | 0.04* |
| Mean±SD | 33.9±7.2 | | 36.0±7.2 | | | |
| Median | 33.0 | | 35.0 | | | |
| Marital status: | | | | | | |
| Married | 107 | 93.0 | 99 | 86.1 | 2.98 | 0.08 |
| Divorced/widow | 8 | 7.0 | 16 | 13.9 | | |
| Age at marriage: | | | | | | |
| Range | 18.0-28.0 | | 19.0-26.0 | | U=7.21 | 0.007* |
| Mean±SD | 22.7±2.6 | | 23.9±3.1 | | | |
| Median | 23.0 | | 23.0 | | | |
| Years of marriage: | | | | | | |
| Range | 0.0-30.0 | | 0.0-27.0 | | U=0.00 | 0.97 |
| Mean±SD | 11.1±6.8 | | 11.2±7.6 | | | |
| Median | 12.0 | | 12.0 | | | |
| Husband age: | | | | | | |
| <30 | 14 | 12.2 | 17 | 14.8 | 4.71 | 0.09 |
| 30- | 41 | 35.7 | 26 | 22.6 | | |
| 40+ | 60 | 52.2 | 72 | 62.6 | | |
| Range | 24.0-65.0 | | 24.0-57.0 | | U=1.54 | 0.21 |
| Mean±SD | 38.9±8.0 | | 40.4±8.1 | | | |
| Median | 40.0 | | 40.0 | | | |
| Husband education: | | | | | | |
| Illiterate | 11 | 9.6 | 14 | 12.2 | 8.10 | 0.04* |
| Basic | 26 | 22.6 | 38 | 33.0 | | |
| Intermediate | 56 | 48.7 | 54 | 47.0 | | |
| University | 22 | 19.1 | 9 | 7.8 | | |
| Husband job: | | | | | | |
| Employee | 46 | 40.0 | 24 | 20.9 | -- | -- |
| Worker | 67 | 58.3 | 87 | 75.7 | | |
| Unemployed | 2 | 1.7 | 4 | 3.5 | | |
| Have children: | | | | | | |
| No | 10 | 8.7 | 15 | 13.0 | 1.12 | 0.29 |
| Yes | 105 | 91.3 | 100 | 87.0 | | |

(*) Statistically significant at p<0.05

(U) Mann Whitney test

(--) Test result not valid.

Table 2. Job and socio-economic characteristics of nurses in the two study groups

| | Specialty | | | | X ² test | p-value |
|---|-----------------------|------|------------------|------|---------------------|---------|
| | Psychiatry (n=115) | | Other (n=115) | | | |
| | No. | % | No. | % | | |
| Nursing qualification: | | | | | | |
| Diploma | 111 | 96.5 | 110 | 95.7 | Fisher | 1.00 |
| Bachelor | 4 | 3.5 | 5 | 4.3 | | |
| Job position: | | | | | | |
| Manager | 20 | 17.4 | 13 | 11.3 | 1.73 | 0.19 |
| Staff nurse | 95 | 82.6 | 102 | 88.7 | | |
| Work overtime: | | | | | | |
| No | 31 | 27.0 | 23 | 20.0 | 1.55 | 0.21 |
| Yes | 84 | 73.0 | 92 | 80.0 | | |
| Work for financial need: | | | | | | |
| No | 20 | 17.4 | 28 | 24.3 | 1.68 | 0.19 |
| Yes | 95 | 82.6 | 87 | 75.7 | | |
| Income: | | | | | | |
| Insufficient | 64 | 55.7 | 60 | 52.2 | 0.28 | 0.60 |
| Sufficient | 51 | 44.3 | 55 | 47.8 | | |
| Share in home expenses: | | | | | | |
| No | 25 | 21.7 | 9 | 7.8 | 8.84 | 0.01* |
| In part | 23 | 20.0 | 27 | 23.5 | | |
| Totally | 67 | 58.3 | 79 | 68.7 | | |
| Have independent house: | | | | | | |
| No | 16 | 13.9 | 39 | 33.9 | 12.64 | <0.001* |
| Yes | 99 | 86.1 | 76 | 66.1 | | |
| Work affects home needs: | | | | | | |
| No | 27 | 23.5 | 42 | 36.5 | 4.66 | 0.03* |
| Yes | 88 | 76.5 | 73 | 63.5 | | |
| Work negatively affects marital relation: | | | | | | |
| No | 33 | 28.7 | 48 | 41.7 | 4.29 | 0.04* |
| Yes | 82 | 71.3 | 67 | 58.3 | | |
| Husband satisfaction with work: | | | | | | |
| Dissatisfied | 25 | 21.7 | 26 | 22.6 | 3.00 | 0.22 |
| Uncertain | 49 | 42.6 | 37 | 32.2 | | |
| Satisfied | 41 | 35.7 | 52 | 45.2 | | |
| Husband asked to leave work: | | | | | | |
| No | 35 | 30.4 | 51 | 44.3 | 4.75 | 0.03* |
| Yes | 80 | 69.6 | 64 | 55.7 | | |

(*) Statistically significant at $p < 0.05$.

As indicated in Table 3, slightly more than one-fourth of the nurses in the two study groups had chronic diseases, and a few were having disabilities. The majority of both samples had recurrent physical problems. Meanwhile, higher percentages of the nurses in the other specialties had frequent emergency room visits and history of pre-term labor, and the differences were statistically significant, $p=0.04$ and $p=0.01$, respectively.

Concerning exposure to domestic violence, Table 4 demonstrates slightly more than a half (54.8%) of the psychiatry nurses had high exposure according to HITS scale compared to 63.5% of the nurses from other specialties, and they had a significantly lower mean and median scores ($p=0.007$). As for the domestic violence effects, as assessed by the Women's Experience with Battering Scale, the table indicates no statistically significant between the two samples. The table also shows that the most commonly reported consequences of domestic violence in the two samples were family disruption and having long leaves. Meanwhile, significantly more psychiatry nurses reported thinking of

leaving work as a consequence of domestic violence ($p=0.001$).

Table 5 points to statistically significant strong positive correlations between nurses' scores of HITS and effects of domestic violence in each of the two samples. The income has a negative correlation to both scores in the two samples. Negative correlations were found between each of the two scores and the age at marriage in the psychiatry nurses sample, and husband level of education in the sample of nurses from other specialties. Moreover, in this latter sample, the nurse age and the number of children had negative correlations with the HITS score.

In the multivariate analysis (Table 6), the independent positive predictors of the HITS score were the nurse age at marriage, husband age, sharing in home expenses, working overtime, and the work having a negative effect on marital life. Meanwhile, the negative predictors were being a psychiatric nurse, age, and living in an independent house, although psychiatric nursing was of borderline significance ($p=0.067$). The model explains 30% of the variation in the HITS score.

Table 3. Health characteristics of nurses in the two study groups

| | Specialty | | | | X ² test | p-value |
|--|-----------------------|------|------------------|------|---------------------|---------|
| | Psychiatry (n=115) | | Other (n=115) | | | |
| | No. | % | No. | % | | |
| Have chronic disease: | | | | | | |
| No | 83 | 72.2 | 83 | 72.2 | 0.00 | 1.00 |
| Yes | 32 | 27.8 | 32 | 27.8 | | |
| Have disability: | | | | | | |
| No | 108 | 93.9 | 110 | 95.7 | 0.35 | 0.55 |
| Yes | 7 | 6.1 | 5 | 4.3 | | |
| Home accidents with delayed treatment: | | | | | | |
| No | 56 | 48.7 | 64 | 55.7 | 1.12 | 0.29 |
| Yes | 59 | 51.3 | 51 | 44.3 | | |
| Recurrent physical problems: | | | | | | |
| No | 27 | 23.5 | 31 | 27.0 | 0.37 | 0.54 |
| Yes | 88 | 76.5 | 84 | 73.0 | | |
| Recurrent psychological problems: | | | | | | |
| No | 61 | 53.0 | 56 | 48.7 | 0.43 | 0.51 |
| Yes | 54 | 47.0 | 59 | 51.3 | | |
| Frequent emergency room visits: | | | | | | |
| No | 101 | 87.8 | 89 | 77.4 | 4.36 | 0.04* |
| Yes | 14 | 12.2 | 26 | 22.6 | | |
| Recurrent injuries (head/neck): | | | | | | |
| No | 99 | 86.1 | 104 | 90.4 | 1.05 | 0.31 |
| Yes | 16 | 13.9 | 11 | 9.6 | | |
| Preterm labor: | | | | | | |
| No | 102 | 88.7 | 87 | 75.7 | 6.68 | 0.01* |
| Yes | 13 | 11.3 | 28 | 24.3 | | |

(*) Statistically significant at p<0.05.

Table 4. Exposure to domestic violence and its effects and consequences among nurses in the two study groups

| | Specialty | | | | X ² test | p-value |
|---|-----------------------|------|------------------|------|---------------------|---------|
| | Psychiatry (n=115) | | Other (n=115) | | | |
| | No. | % | No. | % | | |
| Hurt, Insult, Threaten, Scream (HITS) score: | | | | | | |
| Low (<10) | 52 | 45.2 | 41 | 35.7 | 2.18 | 0.14 |
| High (10+) | 63 | 54.8 | 74 | 64.3 | | |
| Range | 4.0-20.0 | | 4.0-19.0 | | U=7.20 | 0.007* |
| Mean±SD | 9.6±4.0 | | 11.1±3.8 | | | |
| Median | 11.00 | | 12.00 | | | |
| Violence effects (Women's Experience with Battering Scale) score: | | | | | | |
| Low | 48 | 41.7 | 42 | 36.5 | 0.66 | 0.42 |
| High | 67 | 58.3 | 73 | 63.5 | | |
| Range | 10.0-60.0 | | 10.0-60.0 | | U=0.02 | 0.88 |
| Mean±SD | 34.0±16.6 | | 34.6±15.1 | | | |
| Median | 39.00 | | 36.00 | | | |
| Consequences of violence from husband: | | | | | | |
| Family disruption | 38 | 33.0 | 44 | 38.3 | 0.68 | 0.41 |
| Have long leaves | 36 | 31.3 | 45 | 39.1 | 1.54 | 0.21 |
| Quitting home | 28 | 24.3 | 33 | 28.7 | 0.56 | 0.46 |
| Think of leaving work | 17 | 14.8 | 3 | 2.6 | 10.73 | 0.001* |
| Separation | 15 | 13.0 | 23 | 20.0 | 2.02 | 0.16 |
| Psychological problems | 14 | 12.2 | 14 | 12.2 | 0.00 | 1.00 |
| Physical problems | 13 | 11.3 | 15 | 13.0 | 0.16 | 0.69 |
| Divorce | 7 | 6.1 | 10 | 8.7 | 0.57 | 0.45 |
| Bad reputation | 7 | 6.1 | 3 | 2.6 | 1.67 | 0.20 |
| Physical disability | 2 | 1.7 | 5 | 4.3 | Fisher | 0.45 |

(*) Statistically significant at p<0.05

(U) Mann Whitney test.

Table 5. Correlation between nurses' exposure to domestic violence and its effects and their characteristics

| | Spearman's rank correlation coefficient | | | |
|--------------------------------|---|---------|---------------------------|---------|
| | Psychiatry (n=115) | | Non-psychiatry (n=115) | |
| | HITS | Effects | HITS | Effects |
| Effects score | .747** | | .800** | |
| Personal characteristics: | | | | |
| Age | -0.04 | -0.13 | 0.10 | 0.06 |
| Qualification | 0.03 | 0.06 | -.194* | -0.09 |
| Age at marriage | -.213* | -.299** | 0.16 | 0.02 |
| Marriage duration | -0.02 | -0.07 | -0.01 | 0.00 |
| No. of children | -0.04 | -0.02 | -.254* | -0.11 |
| Husband age | 0.08 | -0.04 | 0.16 | 0.17 |
| Husband education | -0.16 | -.204* | -.430** | -.206* |
| Crowding index | 0.01 | 0.03 | 0.11 | .184* |
| Income | -.197* | -.398** | -.456** | -.492** |
| Husband satisfaction with work | -0.03 | -0.12 | -0.08 | -0.10 |

(*) Statistically significant at $p < 0.05$ (**) Statistically significant at $p < 0.01$.**Table 6. Best fitting multiple linear regression model for the HITS and effects scores**

| | Unstandardized Coefficients | | Standardized Coefficients | t-test | p-value | 95% Confidence Interval for B | |
|--|-----------------------------|------------|---------------------------|--------|---------|-------------------------------|-------|
| | B | Std. Error | | | | Lower | Upper |
| HITS score | | | | | | | |
| Constant | 1.06 | 2.98 | | 0.354 | 0.724 | -4.83 | 6.94 |
| Psychiatric nursing | -0.91 | 0.50 | -0.12 | 1.839 | 0.067 | -1.89 | 0.07 |
| Age | -0.23 | 0.07 | -0.40 | 3.392 | 0.001 | -0.36 | -0.10 |
| Age at marriage | 0.23 | 0.10 | 0.17 | 2.220 | 0.028 | 0.03 | 0.43 |
| Husband age | 0.19 | 0.06 | 0.36 | 3.103 | 0.002 | 0.07 | 0.30 |
| Independent house | -1.59 | 0.67 | -0.17 | 2.360 | 0.019 | -2.91 | -0.26 |
| Share in home expenses | 1.05 | 0.33 | 0.20 | 3.174 | 0.002 | 0.40 | 1.71 |
| Work overtime | 1.92 | 0.64 | 0.20 | 2.982 | 0.003 | 0.65 | 3.19 |
| Work -ve effect on marital life | 2.47 | 0.59 | 0.29 | 4.215 | <0.001 | 1.31 | 3.62 |
| r-square=0.30 Model ANOVA: F=11.70, $p < 0.001$ | | | | | | | |
| Variables entered and excluded: marriage duration, have children, qualification, income, job position, work for need, husband job, husband satisfied with work, chronic disease | | | | | | | |
| Effects score | | | | | | | |
| Constant | 11.529 | 3.630 | | 3.176 | 0.002 | 4.37 | 18.69 |
| Psychiatric nursing | 3.29 | 1.37 | 0.11 | 2.407 | 0.017 | 0.59 | 5.98 |
| Have children | 1.37 | 0.70 | 0.08 | 1.975 | 0.049 | 0.00 | 2.75 |
| Income | -6.64 | 1.42 | -0.21 | 4.690 | <0.001 | -9.43 | -3.85 |
| Work -ve effect on marital life | 3.59 | 1.55 | 0.11 | 2.323 | 0.021 | 0.54 | 6.64 |
| Work for need | -3.93 | 1.89 | -0.09 | 2.081 | 0.039 | -7.66 | -0.21 |
| HITS score | 2.80 | 0.19 | 0.71 | 14.988 | <0.001 | 2.43 | 3.17 |
| r-square=0.64 Model ANOVA: F=60.71, $p < 0.001$ | | | | | | | |
| Variables entered and excluded: age, marriage age and duration, qualification, job position, husband age and education, overtime work, husband satisfied with work, chronic disease, independent house, share in home expenses | | | | | | | |

As regards the model for the effects score, the same table indicates that the independent positive predictors of this score were being a psychiatric nurse, having children, work having a negative effect on marital life, in addition to the HITS score. Conversely, the negative predictors were the income and working for need. The model explains 64% of the variation in the effects score.

4. Discussion

The present study indicates that the exposure to domestic violence is high among nurses, whether in

psychiatric nursing or in other specialties. However, psychiatric nurses seem to have a lower exposure to domestic violence, although the effect of such violence is higher among them. The findings thus lead to acceptance of the set research hypothesis.

According to the present study findings, the HITS score was significantly lower among psychiatry nurses compared with the nurses in other specialties. Moreover, working in psychiatric nursing was identified as an independent negative predictor of the HITS score in multivariate analysis [23], although of borderline significance that could be attributed to the sample size. The findings could be explained by the higher ability psychiatric

nurses have in managing crises and conflicts, a skill they gained through study and daily practice. Therefore, they might be more skillful in solving domestic clashes or disagreements, and thus prevent the occurrence of violence or aggression. In agreement with this, [26] clarified that the health professionals working in psychiatry are more knowledgeable of the risk factors of domestic violence and its sequels, and of the means to prevent and manage it safely.

On the other hand, the results of the present study demonstrated that working in psychiatry nursing was an independent positive predictor of the WEB score of effects of domestic violence. Hence, although psychiatric nurses seem to be less prone to domestic violence, they are more vulnerable to its effects. This might be explained by that the exposure to domestic violence among psychiatric nurses indicates her failure to prevent it through the use of appropriate skills of dealing with conflict. This feeling of failure could augment the effect of domestic violence on them. Moreover, the non-preventability of such domestic violence often implies a more austere violence, with consequently more severe effects. Additionally, they might lack the benefit of talking about their domestic violence with health professionals due to embarrassment being their colleagues. Such beneficial effect of disclosure of abuse has been demonstrated in a systematic review [27]. Nonetheless, a study in Iran concluded that the factors underlying the experience of the various effects of domestic violence remain under-studied [28].

The present study also demonstrated a significant strong positive correlation between nurses' scores of HITS and effects of domestic violence (WEB) in each of the two samples. Thus, a higher exposure to domestic violence is associated with more severe effects on the victim. Moreover, the HITS score was identified as a significant independent positive predictor of the WEB score. The findings are quite plausible, since the woman exposed to more than one type of violence (Hurt, Insult, Threatening, Screaming) is more likely to suffer from its effects. In congruence with this, a recent study in the United States reported an association between the severity of violence and victim's perceptions of its impacts [29].

Apart from the role of nursing specialty in the exposure to domestic violence, the present study identified factors that could increase or decrease the vulnerability to such exposure. Thus, the nurse older age and her living in an independent house seem to protect her from domestic violence, which quite plausible, as advancing age in professionals is associated with higher work prestige and less job stress, which may decrease the likelihood of acquired with advancing age. In line with this, a study in Sweden reported lower domestic violence with increasing woman age [30]. Moreover, the presence of in-laws in the same house could foster and complicate marital conflicts as demonstrated in a study in India [31]. However, and in disagreement with this, other studies found a protective role of the extended family compared with the nuclear family living in independent residence, and this was attributed to the possibility of social support in the former situation [32,33].

Conversely, the current study revealed that the nurse sharing in home expenses and working overtime hours is more vulnerable to exposure to domestic violence,

and this is explained by the fact that her work might have a negative impact on her marital life. Moreover, her sharing in home expenses might intensify her feelings of shared dominance, and could inversely lead to a feeling of lower authority and power among her husband. Such situation would certainly foster marital clashes and lead to domestic violence. In line with this, a study in Philippines [34] found that a dominant role of woman in household finances is associated with a more severe domestic violence due to the disequilibrium in gender roles and family dynamics.

As regards the factors influencing the nurse's perception of the effects of domestic violence, apart from the nursing specialty, the present study demonstrated that having children was an intensifying factor. This is expected since domestic violence in the presence of children is humiliating to the mother, and it increases her negative feelings. The finding is in congruence with those of a study in turkey [35]. Moreover, the presence of children could be her only reason to stay, and thus it adds to her suffering. This could even have a negative impact on maternal bond as reported by [36] in a study in Brazil, and on mothers' parenting styles as demonstrated by [37] in a study in the Netherlands.

On the other hand, the current study revealed that a higher income nurse is less likely to suffer from the effects of domestic violence. This could be attributed to that she does not feel financially dependent on her husband, a sensation that may alleviate her suffering from such violence. In agreement with this, studies of the correlates of intimate partner violence in the demonstrated that a low income is an important factor significantly associated with suffering from such abuse [15,38].

Concerning the consequences of domestic violence, the current study results showed that family disruption and having long leaves were the most commonly reported. Similar effects of intimate partner violence were reported in a study in Hong Kong [39]. Meanwhile, the psychiatry nurses not only had long leaves, but also had a significantly higher tendency to leave their jobs as a sequel of their exposure to domestic violence. This might be explained by the finding that their work had significantly more negative impacts on their family life given the nature of their work, and were more asked to quit work by their husbands. This factor was in fact identified as a positive predictor of their exposure to domestic violence. Quitting work is more likely when the woman's job does not pay enough for saving, which is the only factor that underlies husband's satisfaction with her work as shown in a study in Kenya [40].

5. Conclusion and Recommendations

The psychiatric nurses are less vulnerable to domestic violence, compared with those in other specialties; however, the impact of this violence is more severe among them, with a higher tendency to leave the work for this. Certain job factors foster the occurrence and effects of domestic violence. Thus, the work environment of nurses, particularly in psychiatry should be improved with more flexible schedules and less hours of overtime work. Moreover, they need training in how to prevent and

deal with behaviors that lead to domestic violence. More intervention research is suggested to assess the effectiveness of various approaches to deal with domestic violence.

Acknowledgements

All thanks and appreciation for all nurses who shared in making this work complete and valuable.

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