Encounter experience of head nurses with domestic violence victims and some problems in domestic violence victim support system in Japan: a questionnaire survey

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Encounter experience of head nurses with domestic violence victims and some problems in domestic violence victim support system in Japan: a questionnaire survey

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Abstract

PURPOSE: This study aimed to verify the actual state against the domestic violence (DV) victims in medical facilities. **METHODS**: A questionnaire survey to the head nurses of general hospital around Japan was carried out in 2005. The questionnaire was designed to assess the attitudes, knowledge, beliefs, and clinical practice of the nurses in managing DV cases. The answers were analyzed especially focusing on encounter experience with DV victims and the changes of a way of dealing with them at hospital after the enforcement of the DV Prevention Law in 2001. **RESULTS**: Sixty-eight nurses participated and the response rate was 34%. Approximately a half of the head nurses had encounter experience with DV victims. The cases identified as DV have gradually increased at the medical facilities in recent years. However many nurses were not satisfied with current DV victim support system and subconsciously required the accurate and latest information about DV issue. **CONCLUSION**: The DV Prevention Law has become effective in some regards. However, many head nurses have difficulty how to deal with DV victim and require more information about the DV. To promote the contribution in the DV victim support system and to improve the education system about DV issue, more positive role of medical staffs, including nurses, against DV issue should be stipulated legally.

Keywords: DV, DV Prevention Law, victim support system, nurse, medical facilities

Introduction

In 2001 "Law for the Prevention of Spousal Violence and the Protection of Victims" was enforced. It was the first law to prevent women against domestic violence (DV) in Japan and partially amended in 2004 and 2007. The law is generally referred to as the "DV Prevention Law". Some nationwide surveys, however, indicated that the support system for DV victims has not been established yet[1-4]. The DV Prevention Law includes the article that if physicians or other medical personnel, in the course of their duties, detect individuals who they consider to have suffered injuries or medical conditions resulting from spousal violence, they may notify them to a Spousal Violence Counseling and Support Center (SV Center) or police officer. It is just a nonbinding target. We showed in 2004 that few medical staffs who detected the DV victim notified SV Center or the police[5].

In Japan, nursing activities to patients in the hospital ward tend to be profoundly influenced by the intention of the head nurse. We therefore conducted a questionnaire survey to the head nurses of general hospital to verify the actual state against the DV victims in medical facilities. The answers were analyzed especially focusing on encounter experience with DV victims and the changes of a way of dealing with them at hospital after the enforcement of the DV Prevention Law.

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Methods

Sample and survey method

The data for this article were obtained from a questionnaire survey by mail. Twenty general hospitals with more than one hundred beds were randomly selected around Japan and 200 questionnaire sheets (10 per hospital) with the explanation of the purpose of research were sent to the directors of nursing service department. Subjects of the survey were the head nurses and the answers were written in a self-administered procedure with anonymity. Then the sheets were sent back to the authors. Survey period was from 1 October to 31 December in 2005.

Questionnaire design and data analysis

The questionnaire was designed to assess the attitudes, knowledge, beliefs, and clinical practice of the head nurses in identifying and/or managing DV cases. At the beginning of the blank form, the demographic information (gender, age, facility type, years of practice, etc.) were arranged to describe. The question items were our original instruments for DV survey[6]. To know the nurses' behavior to DV issue quantitatively and qualitatively, the questionnaire was combined a selection method amongst some options, and a fill-in blank form with free texts to the question. The questions closely involving this article were as follows: (1) Did you have encounter experience with DV victim or suspect in hospital? (2) When did you have first encounter with DV victim? (3) Have you ever been consulted by the DV victim or family member? What were the contents of consultation of DV case? (5) Did you have difficulty at the attendance to DV victims? What were the contents of difficulty at that time? (6) Do you need more information about DV victim support system? (7) How do you think about the current DV victim support system? (8) What is inadequate in the current support system? (9) Has the nursing practice to DV issue been changed after the enforcement of the DV Prevention Law?

The data aggregation and a chi-square test were performed using a computer software SPSS 11.0J.

Definition of terms

The term "spousal violence" was defined in the DV Prevention Law that the violence toward the body or words and deeds by one spouse that cause comparable psychological harm to the other. Although the encounter experience with DV victim is assumed in a variety of situations, it is predefined in the question sheet as the nurses' own awareness, including suspicion, that the patient has been subjected to DV. Depending on cases, it may be sensed with physical damage without the complaint of victim or become clearer by the confession of family member.

Ethical treatment

This survey was undertaken within an approval of the bioethics committee of the Graduate School of the Medical and Dental Sciences, Kagoshima University. Throughout the survey, privacy protection was carried out strictly.

Results

Thirteen hospitals (2 national, 7 public, and 4 others) cooperated with the survey and 68 head nurses participated. The

Table 1. Basic attributes of the head nurses studied (n=68).

Gender		Years of age (Mean=49.3)	
Male	1(1.5%)	30–39	3(4.4%)
Female	67(98.5%)	40–49	26(38.2%)
Region		50–59	36(52.9%)
Hokkaido	15(22.1%)	60+	1(1.5%)
Honshu	32(47.1%)	Missing	2(3.0%)
Shikoku	10(14.7%)	Years of nursing practice (Mean=27.4)	
Kyushu	11(16.2%)	−10	1(1.5%)
Facility type		11–20	8(11.8%)
National hospital	12(17.6%)	21–30	37(54.4%)
Public hospital	32(47.1%)	31+	21(30.9%)
Others	24(35.3%)	Missing	1(1.5%)

response rate was 34.0%. Basic attributes of the participants were listed in Table 1.

Thirty-three head nurses (48.5%) had encounter experience with DV victims (Table 2). Elapsed time from the first encounter was within 6 years in 81.8% at the time of survey (Table 2). Of the nurses who had encountered with DV victims, 30.3% were consulted on DV directly by victims and 15.2 % were asked for certain advice indirectly by family member (Table 3). Among the contents of consultation, physical abuse was the most complaint, and emotional abuse was the second. Furthermore we asked those nurses (n=33) whether they had been confused at the first attendance to DV victim. Twenty-one nurses (63.6%) disclosed that they had difficulty how to deal with DV victim at that time. Details of difficulty described by 21 nurses were picked out and shown in Table 4. Many nurses were puzzled to deal with not only a victim but also the family and the assailant.

Regarding the social system involving the DV issue, 92.6% of the nurses required more concrete information and 83.8% felt dissatisfied with current victim support system (Table 5). Inadequacies pointed out by the head nurses were noted in Table 6. Representative examples of answer were unclearness of administrative agency for DV support and insufficiency of current education system against the DV issue for the medical and co-medical staffs. We statistically assessed the relationship between the encounter experience with DV victim and the change in nursing practice against DV

Table 2. Encounter experience of head nurses with DV victims and elapsed time from the first encounter.

Encounter experience (n=68)	
Yes	33 (48.5%)
No	35 (51.5%)
Elapsed time (n=33)	
Less than 1 years	9 (27.3%)
1–2 years	10 (30.3%)
3–4 years	4 (12.1%)
5–6 years	4 (12.1%)
6–9 years	1 (3.0%)
More than 10 years	5 (15.2%)

Table 3. Manner of being consulted and contents of consultation.

Manner of consultation (n=33)	
Directly consulted	10 (30.3%)
Indirectly consulted	5 (15.2%)
Never consulted	14 (42.4%)
Others	3 (9.1%)
Missing	1 (3.0%)
Contents of consultation (n=29)	
Physical abuse	15 (51.7%)
Emotional abuse	9 (31.0%)
Child abuse	2 (6.9%)
Abuse from family	1 (3.4%)
Social violence	1 (3.4%)
Others	1 (3.4%)

Table 4. Difficulty at the attendance to DV victims described by 21 nurses. Multiple answers were allowed.

How to deal with a DV victim	8
How to deal with family	7
How to attend an assailant	7
Insufficient DV support system in hospital	7
Insufficient expert knowledge	6
Shortage of human resources	6
Insufficient network of DV support system	5
Busyness with other routine work	4
Lack of specialist and specialized agency	4
Risk for medical stuffs	4
Risk for DV victim	3
Dealing way with the victim's child	3
Feeling of powerlessness	3
Lack of consultation service	2
Lack of corresponding time	2
Legal limitation	1
Poverty of DV victim	1
Violation of victim's privacy	1
Others	4

Table 5. Head nurses' recognition about the current DV victim support system. (n=68)

Do you need more information about DV victim support system?	
Yes	63 (92.6%)
No	1 (1.5%)
Others	4 (5.9%)
How do you think about the current DV victim support system?	
Sufficient	2 (2.9%)
Slightly insufficient	26 (38.2%)
Insufficient	31 (45.6%)
Uncomprehending	9 (13.2%)

Table 6. Inadequacy of DV support system that head nurses pointed out. Multiple answers were allowed.

Unclearness of administrative agency for DV support	36
Insufficiency of education about DV	28
Lack of ability of medical stuff toward DV victim	25
Lack of shelter for DV victim	24
Shortage of enlightenment campaign on DV prevention	22
Anxiety about correspondence of police	20
Lack of supporter against DV	18
Lack of cooperation against DV	18
Lack of financial help	11
Deficiency of social relation	11
Lack of person who understands DV well	10
Anxiety about correspondence of specialist	7
Defectiveness of the law	6
Others	1

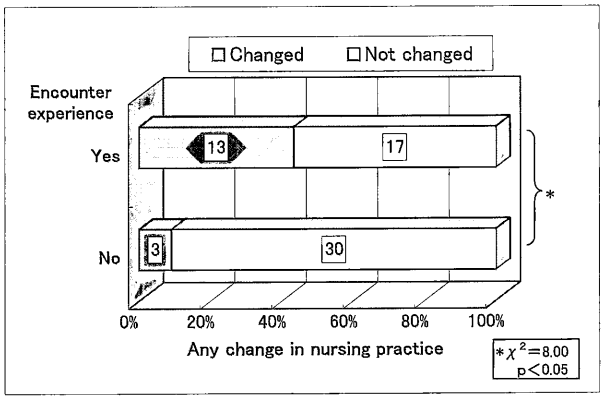

Fig. 1 Head nurses' encounter experience with DV victim and change in nursing practice to DV issue after the enforcement of the DV Prevention Law. A chi-square test (*) revealed that encounter experience has close relationship with change in nursing practice.

issue after the enforcement of the DV Prevention Law (Fig.1). A qui-square test revealed a significant association between them at the 95% confidence interval ($X^2 = 8.00$ with Yates' correction, P=0.046, 2 d.f.).

Discussion

In our survey, approximately half of the head nurses of general hospital had encounter experience with DV victim. The percentage was higher than that of the common nurses in Kagoshima City surveyed in 2003[6]. Eighty percent and more of the first encounter were within 6 years. These facts indicate that the cases identified as DV have gradually increased at the medical facilities in recent years. Fig. 1 shows that the encounter experience with DV victim influences on the nursing practice after the enforcement of the DV Prevention Law. Accordingly, we consider that the Low has become effective in some regards.

About half of the DV victims in Japan are physically damaged to be treated in hospitals[7]. Thus a medical facility is one of the front lines that the DV is detected. The DV Prevention Law requires an endeavor of medical staff to notify the DV matter to the SV Center or police, and to provide patients with information on the use of SV Center, etc. However, the notification of DV case to the SV Center or police remains few. Most of head nurses have not been accustomed in managing DV victims and/or their family members. In addition, many head nurses are not satisfied with current DV support system in Japan, and need more information about DV issue. As mentioned above, the activity of the medical staffs against DV is very limited and problems continue to exist.

Fig. 1 suggests that the contact with actual case of DV will cause a good change of nursing practice. However, the manner how to deal with DV victim is not fully systemized. It is shown as the confusion of the head nurse facing a DV victim. Toward the early detection and treatment of DV victim, the systematic education about DV issue is necessary for all medical staffs. In the nursing school, it should be adopted as a part of the curriculum. For the working nurses, the workshop or training course about DV issue should be increased both inside and outside the hospital. Required contents of the education are at least the comprehension of the DV Prevention Law, the knowledge to cooperate with other concerned organizations, and the dealing manner of DV victim.

Despite the profession likely to detect the DV evidence, the role of medical staffs in the DV Prevention Law is not duty-bound. To promote the DV education of all medical staffs, more positive role in the DV victim support system should be stipulated legally.

Conclusion

The DV Prevention Law has become effective in some regards for the detection of DV victim at medical facilities. However, the notification of DV case to the SV Center or police remains few. Many head nurses have difficulty how to deal with DV victim and require more information about the DV. To promote the contribution in the DV victim support

system and to improve the education system about DV issue, more positive role of medical staffs, including nurses, against DV issue should be stipulated legally.

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