



RECOGNIZING AND TREATING VICTIMS OF DOMESTIC VIOLENCE  
IN HEALTH CARE SETTINGS

# COPING WITH DOMESTIC VIOLENCE: EXPERIENCES OF VICTIMS IN THE HEALTH CARE SETTING

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# PUBLIC HEALTH AND DOMESTIC VIOLENCE

- Role of the public health community in reducing violence and mitigating its consequences
- From the 1970s – domestic violence put on the global health agenda (WHO), policy documents
- Major effect of domestic violence on mental and physical health
- Role of health workers in recognition and treatment of domestic violence

# ROLE OF THE HEALTH CARE SECTOR

- Focus on prevention
- Using a scientific approach to domestic violence as a base to create and implement policies
- Potential to initiate and contribute to multidisciplinary and multisectoral efforts
- Role in assuring the availability of services for victims and in reducing the effect, severity and duration of psychological injuries and physical disabilities for victims of domestic violence
- (Feder et al. 2006, Plichta, 2007, Usta et al., 2012, Robinson and Splisbury, 2008)

# HEALTH CONSEQUENCES OF DOMESTIC VIOLENCE FOR VICTIMS OF DOMESTIC VIOLENCE

- Negative evaluations of physical and mental health
- **Somatisation** of psychological problems as a result of exposure to stress, fear, threats and humiliation of the perpetrator – headaches, increased blood pressure, cardiovascular diseases
- Alcohol consumption and medication taking
- Recognising the dynamic of domestic violence >
  - Reluctance of victims to discuss the reasons for need of health care –

Spontaneous reporting rare (national study in Slovenia – 1 in 20 victims, Leskošek et al. 2010)

- COMPLEXITY OF DOMESTIC VIOLENCE

# BACKGROUND OF THE STUDY

- Slovenia:
- Domestic violence prevention act – 2008 – intersectoral approach to domestic violence
- - issue: Guidelines for treating victims of domestic violence in health care settings (2015) – problem of implementation (doctors vs. Nursing) - low reporting of domestic violence by health care workers, low participation in multidisciplinary (intersectoral) teams for treatment of domestic violence cases

## AIM OF THE STUDY

- preliminary, exploratory study: experiences of victims of domestic violence in the health care settings, barriers and obstacles to recognition and treatment
- questionnaire for victims of domestic violence (N=120)
- 30 expert interviews with professional involved in domestic violence work (NGO's, social workers, women's shelters, health workers – social workers, home care nurses, doctors – different medical specialisations)

- 65% of respondents have been in contact with the health sector regarding their experience of domestic violence
- taking into account indirect consequences of domestic violence – psychological violence – recognition and persecution of perpetrators!
- first points of contact – social work and police, health sector to a lesser extent
- Within the health sector, family medicine doctors/general practitioners most often the first point of contact

# WHY WAS THERE NO CONTACT WITH THE HEALTH CARE SECTOR?

- Health workers cannot help me
- Not a problem I could discuss with health workers
- Previous bad experiences with communication with health workers
- Health workers not interested in domestic violence
- Lack of time
- Restricted access to health care by the perpetrator



## EXPERIENCES OF VICTIMS

- **Most common – emotional aspects:** HCP didn't judge them
- HCP believed them – 43,3 %
- HCP respected their privacy – 42,5 %
- HCP listened to victims – 40,8 %
- **Least common – Cooperation and information:**
- HCP gave me enough information about other sources of help – 21,7 %
- HCP helped me react to DV – 21,7 %
- HCP took care of my current safety – 17,5 %
- HCPs cooperated with other institutions dealing with DV – 17,5 %

# EXPERT INTERVIEWS

- To a large extent corroborated the findings of the quantitative exploratory study of domestic violence victims
- Lack of cooperation and institutional cooperation and lack of a proactive approach to domestic violence among health care workers
  - recognised as an important part of domestic violence treatment and prevention
- - lack of knowledge on domestic violence dynamics – domestic violence perceived as a conflict not abuse of power – stereotypes!
- - assumptions about the family and gender roles within the family

- Discrepancy between official domestic violence statistics and the state »on the field«- issue of underreporting – rural areas with specific social, economic and cultural characteristics
- Lack of health care services for victims of domestic violence (especially with regard to mental health services) and especially a lack of systematic programmes for perpetrators
- Addressing the obvious symptoms, health consequences – prescription of antidepressants, tranquilisers
- Violence inflicted upon health and other professional workers, presence of perpetrator during the medical encounter

## ADDITIONAL ASPECT – VULNERABLE GROUPS!

- migrants, ethnic minorities: culturally incompetent treatment, access to health care, communication issues – language and symbolic, cultural, social capital, poor social networks – health disparities
- Marriage migrants as especially vulnerable (children, issue of formal status)
- harmful practices and the issue of culture (e.g. forced marriages among the Roma, tolerance for domestic violence among the community and among the professional workers)

# OLDER PEOPLE AND DOMESTIC VIOLENCE

- stress of the caretaker as a legitimization of domestic violence among the elderly
- Neglect as a form of domestic violence!
- Mutual intersections between factors and acknowledgment of complexity of domestic violence

# IMPLICATIONS OF FINDINGS

- Importance of psychological violence
- Possible gender differences – inclusion of men into studies
- In-depth studies into victims' experiences – sensitivity of topic, giving socially desired answers
- Need for an intersectoral approach

Thank you for your attention!



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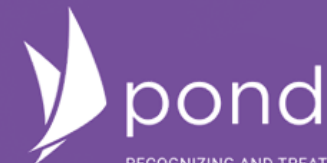
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Medical Chamber of Slovenia



EMMA Institution,  
the Centre for helping victims of violence



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