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DOMESTIC VIOLENCE AMONG FEMALE NURSES: PREVALENCE, EFFECTS, AND UNDERLYING FACTORS

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ABSTRACT

Violence against women is a considerable worldwide problem with huge economic and social costs. There is a paucity of research investigating the problem in the nursing profession. The study aim was to measure the magnitude of domestic violence among female nurses, and determine the underlying factors.

Methods: This cross-sectional analytic study was conducted in two general hospitals (A and B) on a consecutive sample on 324 female nurses. A self-administered questionnaire including the Women Abuse Screening Tool (WAST) and the Women's Experience with Battering (WEB) scale was used in data collection.

Results: Female nurses' age ranged between 23 and 59 years, mostly diploma female nurses (86.1%). Exposure to domestic violence was found among 50.6% of them, and 59.6% had high violence effects. Only 21.9% previously reported husband violence. While the work of the nurse was the third in rank as a cause of domestic violence.

In conclusion, female nurses have a high prevalence of domestic violence, with significant impact on their psych. In addition to personal factors as age and husband education, certain work-related factors may contribute to this violence such as overtime and shift work. The study recommends educational programs to increase female nurses' awareness about domestic violence and the appropriate measures for prevention and management. Further research is proposed to examine the effect of such educational interventions on the prevalence of domestic violence among female nurses.

Keywords: Domestic violence, Female nurses, WAST, WEB

INTRODUCTION

Violence against women is universal regardless of culture, ethnicity, orientation, or socioeconomic class. It has been estimated that, worldwide, one in three women is exposed to domestic or intimate partner violence (Sprague *et al.,* 2015). It can take place at work, home, or in public places. Violence at home is known as domestic or intimate partner violence or abuse. This constitutes a considerable worldwide problem with huge economic and social costs (Spangaro, 2017). However, there are wide discrepancies among studies of the prevalence of domestic violence, which could be related to difference in study settings and communities, in addition to the use of different data collection tools that may not be sensitive to cultural variations (Kalokhe *et al.,* 2017). Thus, the prevalence rates vary from 4% or lower in high-income countries to 40% or more in low-income ones (Heise and Kotsadam, 2015).

Domestic violence is a public health problem that needs solutions at the population level through influencing the environments and conditions in which people live and work (Armstead *et al.,* 2017). Female nurses have a key role in such programs for the identification of domestic violence victims during their provision of care in various healthcare settings (Ali *et al.,* 2016). Nonetheless, no optimal methods of screening and identification of the factors affecting domestic violence has been identified (Ahmad *et al.,* 2016).

Although health care providers, including female nurses, are thought to be knowledgeable of the problem of domestic violence in order to be able to deal with

such cases, research showed many misconceptions among them about intimate partner violence, and lack of knowledge about its causes, prevention, and management (Torralbas-Fernández and Calcerrada-Gutiérrez, 2016). Hence, it is important for female nurses to comprehend the factors underlying domestic violence and its effects on women's health. So there is a need to addressed this problem in nursing schools' curricula (Crombie *et al.,* 2016; Doran and Hutchinson, 2016).

A cluster of factors has been implicated to underlie the occurrence of domestic violence or abuse. Among the most important of these factors are those of employment and related economic and financial factors. Thus, unemployment and economic hardship were found to increase such abuse (Schneider *et al.,* 2016). Additionally, research demonstrated that domestic violence is prevalent not only among the poor, but also among poor nations regardless of individual economic status (Sabina, 2013). Moreover, factors related to the type of work, its revenue, and its effect on family life needs were demonstrated as risk factors leading to domestic abuse (Yount *et al.,* 2014; Muthengi *et al.,* 2016). Nonetheless, there was paucity of research investigating the problem of domestic violence in the nursing profession.

Aim of the study

The study aim was to measure the magnitude of domestic violence among female nurses, and determine the underlying factors.

SUBJECTS AND METHODS

Design and setting: This cross-sectional analytic study was conducted in two general hospitals (A and B).

Subjects: All married female nurses working in the study settings were eligible for inclusion in the study sample with no inclusion or exclusion criteria. The sample size was calculated to estimate a prevalence rate of 50% or higher at 95% level of confidence with 5% absolute precision. Using the OpenEpi software program for sample size determination of a single proportion with finite population correction, the required sample size was 278. This was increased to 324 to account for an expected non-response rate of about 15%. A consecutive sampling technique was used in recruiting the required sample.

Data collection tool: A self-administered questionnaire form was used in data collection. It included a section for the socio-demographic data such as age, marital status, marriage age and duration, children, age of husband, education, and job status, in addition to questions about the socioeconomic state such as housing condition, income, sharing in home expenses, etc. The section also asked about work such as nursing qualification, job position, department, shift work, husband satisfaction with her job, etc. Lastly, there were questions about chronic diseases and disabilities among respondents and their families, in addition to queries about events suggesting exposure to violence such as recurrent head/neck injuries, frequent emergency room visits, preterm labor, etc.

The self-administered questionnaire included two scales for assessment of the exposure to violence and for its effects. The first was the Women Abuse Screening Tool (WAST). This 7-item tool was developed and validated by Brown *et al.,* (1996) to screen for exposure to domestic abuse. The first two items assessed the degree of tension in marital relations and difficulties in solving problems. The remaining five items elicit information about exposure to abuse such as feeling low in arguing with husband, and exposure to physical and psychological violence. The responses were on a 3-point Likert scale from "never" to "often." These were scored from "3" to "1" respectively. The scores are summed so that a higher score indicates more exposure to domestic abuse or violence. For categorical analysis, a cutoff point "14" was used to indicate high exposure since it corresponds to "often" exposure to a least one of the types of abuse.

The questionnaire also involved a scale for measuring the effects of domestic abuse, namely the Women's Experience with Battering (WEB) scale. This 10-item questions tool was developed and validated by Smith *et al.,* (1995) to assess the meanings of abuse for the women attached to their exposure to violence. It has questions such as "I feel ashamed of the things he does to me," "I feel like I am programmed to react in a certain way to him," "I feel like he keeps me like a prisoner," etc. The responses are on a 6-point Likert scale ranging from "strongly agree" to "strongly disagree," scored respectively from "6" to "1". The scores are summed so

that a higher score indicates a more severe effect of the domestic violence on woman. For categorical analysis, a woman was considered having high effects of domestic violence if the total WEB score was 20 or higher.

The last section of the questionnaire solicited respondent's opinions about the causes underlying domestic abuse as well as its consequences. It also asked about the action taken by the battered wife, whether she officially reported such events, and the reasons why wives do not report exposure to domestic violence.

The tool was vigorously revised by experts Prof. Dr. Nevien Moustafa, Siham Girgis. The two scales used are valid ones. A pilot study was carried out on approximately 10% of the study sample. Based on its findings, the tool was finalized. The scales showed high reliability with Cronbach alpha coefficient 0.902 for the WAST scale and 0.968 for the WEB scale.

Fieldwork: Permissions were obtained through official channels from the Directors of the hospitals, after explanation of the aim and methods for data collection. Data was collected during the period from August to September 2016. The researcher met with the female nurses individually, explained the aim of the study, and invited them to participate. Those who gave their verbal consent were handed the data collection form along with instructions to fill it. It took on average 10-15 minutes for each participant to fill the form. The researcher was present all the time for answering any queries. The filled up form was collected and revised to ensure completeness. The work was done two days per week.

All principles of ethics in research were applied according to Helsinki Declaration. An oral consent was obtained from each nurse after explaining the purpose of the study, as well as the rights to refuse or withdraw. The confidentiality of any obtained information was ensured.

Statistical analysis: Data entry and statistical analysis were done using SPSS 20.0 statistical software package. Cronbach alpha coefficient was calculated to assess the reliability of the scales through their internal consistency. 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 scores of exposure to domestic violence and its effects, multiple linear regression analysis was used, and analysis of variance for the full regression models was performed. Statistical significance was considered at p-value <0.05.

RESULTS

The study sample consisted of 324 female nurses whose age ranged between 23 and 59 years (Table 1). The majority were currently married (89.8%), and had children (89.8%). The medians of their age at marriage and of its duration were 23.0 and 12.0 years respectively. Their husbands' ages ranged between 24 and 65 years, with slightly less than half of them (44.1%) having intermediate education. More than half of the female nurses reported having sufficient income (57.4%), and the majority shared in home expenses either totally (62.3%) or in part (24.7%).

Table 1: Socio-demographic characteristics of female nurses in the study sample (n=324)

	Frequency	Percent
Age:		
<30	90	27.8
30-	148	45.7
40+	86	26.5
Range	23.0 -59.0	
Mean±SD	35.0±7.0	
Median	34.0	
Marital status:		
Married	291	89.8
Divorced/widow	33	10.2
Age at marriage:		
Range	18.0 -30.0	
Mean±SD	23.5±2.9	
Median	23.0	
Years of marriage:		
Range	<1.0 -30.0	
Mean±SD	11.1±6.9	
Median	12.0	
Husband age:		
<30	42	13.0
30-	111	34.3
40+	171	52.8
Range	24.0 -65.0	

Mean±SD	39.4±7.8	
Median	40.00	
Husband education:		
Illiterate	28	8.6
Basic	68	21.0
Intermediate	143	44.1
University	85	26.2
Husband job status:		
Unemployed	6	1.9
Working	318	98.1
Have children	291	89.8
Have independent house	265	81.8
Get help at home	106	32.7
Have sufficient income	186	57.4
Share in home expenses:		
No	42	13.0
In part	80	24.7
Total	202	62.3

As regards female nurses' job characteristics, Table 2 shows that the majority were diploma female nurses (86.1%), with staff nurse position (73.8%). Slightly more than one-third of the sample was from the psychiatry department (36.4%) while the lowest percentage was from intensive care units (4.9%). More than half of the female nurses worked in shifts, worked overtime, and were working for financial needs. They also reported negative effects of their work on home needs and marital relations. Only 39.5% of them stated that their husbands were satisfied with their work.

Table 2: Job characteristics of female nurses in the study sample (n=324)

	Frequency	Percent
Nursing qualification:		
Diploma	279	86.1
Bachelor	45	13.9
Job position:		
Head nurse	85	26.2
Staff nurse	239	73.8
Department:		
Psychiatry	118	36.4
Administration	71	21.9
Medical/pediatric	64	19.8
Emergency	36	11.1
Surgical/Ob-Gyne	19	5.9
Intensive care	16	4.9
Work in shits	204	63.0
Work overtime	242	74.7
Work for financial need	246	75.9
Work affects home needs	214	66.0
Work negatively affects marital relation	192	59.3
Husband asked for leaving work	196	60.5
Husband satisfaction with her work:		
Dissatisfied	52	16.0
Uncertain	144	44.4
Satisfied	128	39.5

Table 3 demonstrates that about one-fourth of the female nurses were having chronic diseases (24.7%), and fewer ones had disabilities (4.6%). Concerning the events suggesting exposure to domestic violence, the most commonly reported were the recurrent physical (71.3%) and psychological (48.5%) problems, and home accidents with delayed treatment (42.3%). Meanwhile, more than one-tenth reported frequent emergency room visits and recurrent injuries of the head and neck.

Table 3: Health characteristics of female nurses in the study sample (n=324)

	Frequency	Percent
Have chronic disease	80	24.7
Have disability	15	4.6
Husband has chronic disease	59	18.2
Husband has disability	40	12.3
Child has chronic disease	33	10.2
Child has disability	20	6.2
Events suggesting exposure to domestic violence:		
Recurrent physical problems	231	71.3
Recurrent psychological problems	157	48.5
Home accidents with delayed treatment	137	42.3
Preterm labor	59	18.2
Frequent emergency room visits	45	13.9
Recurrent injuries (head/neck)	38	11.7

As illustrated in Table 4, slightly more than a half of the female nurses had high exposure to domestic violence (50.6%), and a higher percentage (59.6%) had higher violence effects according to the Women's Experience with Battering Scale.Only 21.9% previously reported husband violence, but only 28.2% got a good response after their notification, and among 35.2% of them the problem was resolved.

Table 5 shows that the wife work came third in rank as a cause of domestic violence, followed by life stressors and family conflicts. Meanwhile, few female nurses reported neglecting of housework (6.5%) and of self (6.5%) as causes for domestic violence. The action

Table 4: Exposure to domestic violence and its effects and related actions among female nurses in the study sample (n=324)

	Frequency	Percent
Women Abuse Screening Tool (WAST) score:		
Low (<14)	160	49.4
High (14+)	164	50.6
Range	7.0-21.0	
Mean±SD	13.3±3.6	
Median	14.00	
Women's Experience with Battering (WEB) scale score:		
Low	131	40.4
High	193	59.6
Range	10.0-60.0	
Mean±SD	34.2±16.3	
Median	36.0	
Previously notified about husband violence	71	21.9
Response (n=71):		
None	20	28.2
Partial	31	43.7
Good	20	28.2
End result (n=71):		
Problem solved	25	35.2
No change	26	36.6
Problem increased	20	28.2

taken in case of exposure to domestic violence was mostly negotiation (45.4%), or resorting family issues (35.5%). Conversely, the least reported actions were aggression (11.4%) and resorting to law (9.0%). As for the consequences of domestic violence, the most common was family disruption (34.6%). However, about one-third of the female nurses reported taking long leave (31.8%), and 7.7% reported leaving work as possible consequences. The table also shows that two-thirds of the female nurses mentioned that the main cause of not taking action against domestic violence was to keep peace in the family. In the meantime, 2 (0.6%) female nurses stated that it was the husband's right to confer violence upon the wife.

Table 5: Opinions about domestic violence and its causes and effects among female nurses in the study sample (n=324)

	Frequency	Percent
Causes of violence from husband:		
Life stressors	185	57.1
Family conflicts	113	34.9
Wife work	91	28.1
Jealousy	85	26.2
Children raising	78	24.1
Financial	64	19.8
Neglect of housework	41	12.7
Neglect of self	21	6.5
Other	12	3.7
Action taken:		
Nothing	61	18.8
Negotiation	147	45.4
Resort to family	115	35.5
Resort to friends	39	12.0
Aggression	37	11.4
Resort to law	29	9.0
Consequences of violence from husband:		
Family disruption	112	34.6
Long leave	103	31.8
Quitting	95	29.3
Separation	47	14.5
Physical problems	45	13.9
Psychological problems	37	11.4
Divorce	26	8.0
Leaving work	25	7.7
Bad reputation	16	4.9
Physical disability	9	2.8
Causes of wives not taking action against violence from husband:		
Keep family	218	67.3
Fear from divorce	115	35.5
Children	101	31.2
No other place to live	80	24.7
Fear for reputation	49	15.1
No other financial support	18	5.6
Fear from husband	16	4.9
Financial restrictions	6	1.9
It is a husband's right	2	0.6

Table 6: Correlation matrix of coping scale domains scores

	Spearman's rank correlation coefficient	
	WAST	WEB
WEB	0.747**	
Age	0.039	0.062
Qualification	-0.118*	-0.052
Age at marriage	-0.129*	-0.160**
Marriage duration	0.011	0.079
Number of children	-0.117*	0.001
Husband age	0.132*	0.148**
Husband education	-0.309**	-0.128*
Crowding index	0.052	-0.003
Extent of share in home expenses	0.330**	0.228**
Husband satisfaction with work	-0.145**	-0.106

(*) Statistically significant at p<0.05,
(**) Statistically significant at p<0.01

Table 6 illustrates the presence of a strong positive statistically significant correlation between the scores of exposure to domestic violence (WAST) and its effects (r=0.747). Conversely, the exposure score was negatively correlated to nurse level of qualification, age at marriage, number of children, husband education, and husband satisfaction with her work, but positively correlated to husband age. As for the effects score, it was negatively correlated to the age at marriage and husband education, and positively correlated to husband age and extent of share in home expenses.

In multivariate analysis (Table 7), the statistically significant independent predictors of the score of exposure to domestic violence (WAST) were the divorced/widow status, husband age, sharing home expenses, working overtime, having disability or husband having disability. Conversely, the negative predictors were nurse age, having children, husband education, and husband satisfaction with her work. The model explains 40% of the variation in this score.

Table 7: Best fitting multiple linear regression model for the WAST and WEB scores

	Unstandardized Coefficients		Standardized Coefficients	*t*-test	*p*-value	95% Confidence Interval for B	
	B	Std. Error				Lower	Upper
WAST score							
Constant	11.86	1.53		7.759	<0.001	8.85	14.87
Age	-0.15	0.05	-0.28	-2.843	0.005	-0.25	-0.04
Divorced/widow	3.65	0.65	0.27	5.635	<0.001	2.37	4.92
Have children	-0.62	0.20	-0.17	-3.194	0.002	-1.01	-0.24
Husband age	0.14	0.05	0.28	2.955	0.003	0.05	0.23
Husband education	-0.94	0.19	-0.25	-4.885	<0.001	-1.32	-0.56
Share in home expenses	0.84	0.26	0.17	3.263	0.001	0.33	1.35
Work overtime	2.00	0.40	0.24	4.960	<0.001	1.21	2.79
Husband satisfied with work	-0.49	0.24	-0.10	-2.002	0.046	-0.97	-0.01
Has disability	2.44	0.79	0.15	3.096	0.002	0.89	3.99
Husband disabled	1.14	0.53	0.10	2.139	0.033	0.09	2.20
r-square=0.40 Model ANOVA: F=1 8.37, p<0.001 Variables entered and excluded: marriage age and duration, qualification, job position, shift work, independent house, get help at home, chronic disease							
WEB score							
Constant	32.01	11.21		2.856	0.005	9.95	54.07
Divorced/widow	15.19	3.46	0.24	4.395	<0.001	8.39	21.99
Age at marriage	-1.04	0.30	-0.19	-3.444	0.001	-1.64	-0.45
Husband age	0.36	0.12	0.16	3.048	0.003	0.13	0.59
Independent house	-6.87	2.62	-0.15	-2.618	0.009	-12.04	-1.70
Get help at home	-4.80	1.82	-0.14	-2.633	0.009	-8.40	-1.21
Share in home expenses	3.11	1.19	0.13	2.615	0.009	0.77	5.45
Staff nurse position	-4.20	2.02	-0.12	-2.074	0.039	-8.19	-0.21
Work shifts	8.59	1.92	0.26	4.481	<0.001	4.82	12.36
Husband disabled	10.56	2.71	0.20	3.894	<0.001	5.22	15.90
r-square=0.26 Model ANOVA: F=1 2.42, p<0.001 Variables entered and excluded: age, marriage duration, qualification, husband education, have children, overtime work, husband satisfied with work, chronic disease, disability							

As regards the score of the effects of violence, the table demonstrated that the statistically significant independent predictors were the divorced/widow status, husband age, sharing in home expenses, working shifts, and husband having disability. On the other hand, the negative predictors were nurse age at marriage, living in an independent house, getting help at home, and having a staff nurse position. The model explains 26% of the variation in this score.

DISCUSSION

Domestic violence or intimate partner violence is a worldwide problem affecting at least one-fourth of women (White *et al.,* 2017). The present study results demonstrate a high prevalence of domestic violence among female nurses, reaching around a half of the sample, with considerable effects on battered ones. This is influenced by the socio-demographic characteristics as well as their job and work conditions.

The current study sample covered a wide age range spanning from early twenties to late fifties, and a similar wide range of marriage duration extending from 1 to 30 years, which would allow the identification of age and marriage years on the prevalence of domestic abuse. The sample also included a variety of working conditions such as the qualification, job position, shift and overtime work, and various socioeconomic conditions in order to assess the influence of these factors on domestic violence occurrence and effects. In fact, the study findings demonstrated significant associations between these factors and domestic violence.

According to the current study findings, the prevalence of exposure to domestic violence was high, reaching about half of the sample. This rate is higher compared with similar previous studies. Thus, in Turkey, Selek *et al.,* (2012) reported a rate of 22.7% domestic violence among female nurses. Similarly, in a study among female nurses in the United States, the rates of exposure to domestic physical and sexual abuse were 22.0% and 10.0% respectively. More recently, Sharma and Vatsa (2014) found that 36.3% of Indian female nurses were exposed to physical and/or sexual domestic violence. The discrepancy with our rate could be attributed to differences in the settings with related norms and cultures, as well as in the data collection tools used. Thus, the rates identified in the current study are close to those reported in an Egyptian study carried out in Alexandria but on women and not on female nurses, where the rates ranged between 41.3% and 60.0% for women in urban and squatter areas (Guimei *et al.,* 2012). The close similarity with our figures is certainly related to the common values, norms, and cultural characteristics in the Egyptian community.

The present study has also investigated the impact of domestic violence exposure on victimized female nurses. The findings indicate that approximately two-thirds of them experienced considerable effects of such abuse. Thus this lead to a feeling of shame and belittlement, leading to worries and distress. In line with this, a study in Malaysia identified domestic violence as an important predictor of depression (Kader Maideen *et al.,* 2014). The high impact among female nurses could be attributed to the untoward consequences of domestic violence being themselves involved in its diagnosis, prevention, and management. In this respect, Bradbury-Jones *et al.,* (2017) emphasized that female nurses have a significant role in screening women for domestic violence and abuse, and in their referral to specialized services, as well as in their counseling and empowerment.

As regards the factors influencing exposure to domestic violence among the present study female nurses, the multivariate analysis identified two sets of factors, namely personal and work-related. The personal protective factors were the older nurse age, having children, and a higher husband education, whereas the risky ones were being divorced or widow status, aged husband, and having disability or husband having disability. All these factors seem plausible since they respectively influence marital life positively and negatively. In agreement with this, a study in the United States showed that female nurses' age and having children had significant independent associations with their exposure to either domestic violence or domestic abuse (Bracken *et al.,* 2010). Similar factors were also identified in the study in Alexandria, Egypt (Guimei *et al.,* 2012). Moreover, and in agreement with the current study, Costa *et al.,* (2016), in a multicenter study in Europe, demonstrated a negative association between husband education and domestic violence.

Concerning the work-related factors influencing female nurses' exposure to domestic violence, the

present study identified that working overtime and sharing home expenses were risk factors, whereas the husband satisfaction with nurse's work was the only protective factor. The overtime work, although it could be a source of extra-income, it could lead to neglect of family duties, which is one of the causes underlying domestic violence. As for sharing in home expenses, it could be a source of family conflicts if the woman gives her husband the impression that she is supporting him or his family financially. This factor is of major importance in communities where the male authority over female is prominent as in our community. A similar finding was reported in a study of domestic violence in Minia, Egypt (Yount *et al.,* 2014), and in Norway (Heise and Kotsadam., 2015).

The current study has also identified protective factors like living in an independent house, and getting help at home. These two factors may alleviate the impact of violence since they allow the couple to solve their conflicts with no external interferences, and getting help in home chores may help in coping. It was also found that being in a position of head nurse might increase the effects of domestic violence, which could be attributed to the higher job status that may accentuate the feelings of being hurt at home while having a prestigious status at work. In agreement with this, a study in Florida, United States, demonstrated a significant relation between wife's concerns about work and career and her exposure to domestic violence (Copp *et al.,* 2016).

According to the present study findings, nurse's work was not reported as the main cause underlying domestic violence, but it secondary to life stressors and family conflicts. This could be explained by the need of economic support from wife in our community. In fact, more than three-fourth of the female nurses in the study sample reported working for financial needs. However, taking long leaves or even thinking of quitting work was among the possible consequences of domestic violence. In congruence with this, a study in the United States revealed the negative impact of domestic violence on women' job stability (Adams *et al.,* 2012).

As regards the management of domestic conflict, the most common approaches were negotiation and seeking family help, while taking more extreme actions as counter-aggression or resorting to legal actions was much less according to the reports. This, as mentioned by a majority, was for keeping the family, which is important as a cultural norm in our community. However, another possible reason for not resorting to legal actions was due to the unfavorable outcome. In fact, of those few female nurses who reported taking such action, only about one-third mentioned that the problem was solved with a good outcome. In agreement with this present study finding, Sharma and Vatsa (2014) reported that only 16.7% of female nurses exposed to domestic violence in India took a positive action, and this low reporting rate was attributed to similar reasons as in the present study. Moreover, Selek *et al.,* (2012) found that none of the female nurses exposed to domestic violence in Turkey took a legal step. Meanwhile, a study in Brazil demonstrated that women reported exposure to domestic violence only when they reached beyond their limits of tolerance (Albuquerque Netto *et al.,* 2015).

Interestingly, two of the female nurses in the present study stated that it was the husband's right to batter his wife, which may reflect a misconception deeply rooted in rural communities. This could also be a reason for not taking any action or reporting such abuse. Moreover, the influence of the society and media could also affect the way victimized women deal with their exposure to domestic violence. In congruence with this, Lloyd and Ramon (2017) found that the approaches of the media to the problem of domestic violence are often biased against women, with tendency for blaming the victim. Such situations would make victimized women more reluctant to report such exposures. On the same line, a study on nursing students in Australia (Doran and Hutchinson, 2016) found that most of them had misconceptions of domestic violence, with stereotypical attitudes of blaming the victim, and considering such violence as a normal happening.

CONCLUSION AND RECOMMENDATIONS

In conclusion, the female nurses in the study settings have a high prevalence of domestic violence, with significant impact on their psyche. In addition to personal factors as age and husband education, certain work-related factors may contribute to this violence such as overtime and shift work, as well as husband's satisfaction with wife's work. Most female nurses do not take a proper action to manage their exposure to violence. In view of

these findings, the study recommends educational programs to increase female nurses' awareness about domestic violence and the appropriate measures for prevention and management. The work conditions that may increase the risk of violence should be addressed. Misconceptions such as the tolerance of domestic violence on the grounds that it is a husband's right, need to be corrected. Further research is proposed to examine the effect of such educational interventions on the prevalence of domestic violence among female nurses.

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