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RESEARCH ARTICLE

KNOWLEDGE, VIEWS AND ATTITUDES OF HEALTHCARE PROFESSIONALS TOWARDS THE VARIOUS FORMS OF DOMESTIC VIOLENCE

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Abstract

Background: Healthcare professionals play a critical role in the detection, clinical management, and psychosocial support of individuals affected by domestic violence. This study sought to examine the extent of healthcare professionals' level of knowledge, perspectives, and attitudes toward domestic violence.

Method and Material: A cross-sectional study was conducted involving 150 healthcare professionals from all departments of a General Hospital in Greece, utilizing the RADAR questionnaire and the self-report instrument developed by Nicolaidis.

Results: Totally, 38% of participants reported that they know exactly what actions they should take when they come into contact with a victim of abuse and 68.7% of them consider that the identification of domestic violence victims falls within their competence. Also, 58% of the participants claimed that they are not given relevant training and information on how to properly recognize and help domestic violence victims. The most important barriers faced by healthcare professionals when investigating or providing care to people who have been abused are the difficulty in isolating the patient (31.4%), fear of offending the patient when asking questions (31.3%), and lack of sufficient time to investigate patients for violence (28.6%). Age was positively correlated with domestic violence victims' recognition (r=0.201, p=0.013).

Conclusions: The role of healthcare professionals in the identification and management of patients who have fallen victim to domestic violence is of crucial importance. However, it seems that healthcare professionals remain in need of further education about the strategies that could be followed in order to support domestic violence victims.

Keywords: Violence, domestic violence, healthcare professionals, hospital patients, support structures.

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INTRODUCTION

In the last decade, global policies have focused their attention on the urgent need to address incidents of domestic violence. This "problem", as it is characteristically referred to in literature, requires a complex intersectoral approach, so that the health system can promptly identify and effectively support affected families. The World Health Organization (WHO) has emphasized the critical role of an effective health system in reducing the widespread harm of domestic violence.[1]

Domestic violence has high prevalence and significant impact on the health and well-being of women, men, children, wider family networks and society in general. It is estimated that globally, one in three women worldwide experiences physical or sexual violence, most often perpetrated by an intimate partner. In the European Union (EU), it has been shown that 1 in 3 women (or 61 million out of 185 million) have experienced physical or sexual violence, or both, from the age of 15.[2] According to the European Institute for Gender Equality, in 2021 Greece ranked last among the EU Member States in terms of gender equality, with the ranking remaining relatively stable over the past decade.[3]

Healthcare professionals, due to their frequent contact with the public and the primary care services they provide, are in a unique position to be able to recognize and address incidents of domestic violence. Their role is crucial, as initial contact with victims can determine both the initiation of treatment and the extent of psychological support provided.[4] Based on our knowledge, this is the first study conducted in Greece addressing domestic violence from the perspective of healthcare professionals.

The research gap addressed by this study lies in the limited data and lack of focused research on how healthcare professionals in Greece perceive, understand, and manage domestic violence cases. While international studies have extensively examined the role of healthcare systems in tackling domestic violence, Greece has remained under-researched, particularly from the perspective of healthcare professionals themselves. This gap is even more significant considering Greece's consistently low ranking in gender equality within the EU, suggesting systemic challenges that may influence healthcare professionals' ability to respond to such incidents effectively.

Unlike broader EU or global studies, this research delves into the unique sociocultural and systemic factors shaping Greek healthcare professionals' knowledge, attitudes, and responses to domestic violence. While many prior studies have focused on victims or policy frameworks, this study shifts the focus to healthcare providers as an instrumental group in the early detection, support, and intervention in cases of domestic violence. Given the fact that domestic violence is a phenomenon that continuously increases and has a serious impact on the victims, the study aimed to explore the level of knowledge, views and attitudes of healthcare professionals regarding the major issue of domestic violence and the role they have in the management of such incidents.

METHODOLOGY

Design

The study is cross-sectional.

Participants

The recruitment of participants was conducted through an on-site, department-based approach within a large public hospital in the Region of Western Macedonia, Greece. The researchers directly visited various hospital departments, aiming to ensure broad representation among different healthcare roles, including physicians, nurses, healthcare assistants, and other clinical professionals. Administrative employees, technical staff, and healthcare professionals who declined participation were excluded from the study.

During these visits, the researchers distributed self-administered questionnaires to all eligible healthcare professionals. The face-to-face distribution method allowed the researchers to briefly explain the study's purpose, ensure clarity in the questionnaire's content, and address any immediate concerns or questions. This approach aimed to increase engagement and encourage participation. Despite this effort, from a total pool of 444 eligible healthcare professionals, 150 individuals chose to participate, resulting in a response rate of 33.78%.

Data collection

Data collection was done by two instruments. The first instrument used was a screening tool, named RADAR. The RADAR tool

is a structured screening guide designed to help healthcare professionals identify and manage cases of domestic violence. It's built around five key steps, represented by the acronym:

R (Routinely screen female patients): Encourages healthcare professionals to consistently incorporate domestic violence screening as part of routine care, regardless of whether there are visible signs of abuse. This step helps normalize the practice and reduces the stigma for patients.

A (Ask direct questions): Emphasizes the importance of asking clear, direct, and compassionate questions about potential abuse. For example, questions like "Has anyone at home ever hurt you?" or "Do you feel safe in your current relationship?" are recommended.

D (Document your findings): Instructs healthcare professionals to record any signs of abuse, both physical and behavioral, as well as patients' responses. This documentation is crucial not only for the continuity of care but also for potential legal use, should the patient pursue protection or justice.

A (Assess patient safety): Guides healthcare professionals in evaluating the immediate safety of the patient, exploring whether they face urgent danger and whether they have a safe place to go.

R (Review options and referrals): Supports clinicians in providing resources, including counseling, shelters, and social services. This step helps ensure that patients are aware of the available support and can make informed decisions about their next steps.

In the context of this study, the RADAR tool was integrated into the questionnaire provided to healthcare professionals. It served two main purposes. The questionnaire investigated how frequently and effectively healthcare professionals used each component of RADAR in their daily practice. For example, participants were asked whether they routinely screened patients, what types of questions they typically asked, and how often they documented findings or provided referrals. A significant part of the data collection explored perceived barriers to using the RADAR tool, such as time constraints, fear of offending patients, lack of confidence in handling disclosures, or unawareness of available support services. The R.A.D.A.R. acronym was developed by the Massachusetts Medical Society and has been used to a number of countries worldwide.[5]

We also used the questionnaire of Nicolaidis et al. (2005) which includes 32 questions and explores six different areas of domestic violence, a) the attitudes of healthcare professionals towards domestic violence victims, within the framework of their responsibilities, b) the degree of understanding of healthcare professionals of the situation of the domestic violence victims, c) the obstacles faced by healthcare professionals when investigating or providing care to domestic violence victims, d) the ability of healthcare professionals to diagnose, respond, refer and document incidents of domestic violence, e) the investigation of domestic violence in interviews of "pathological" situations and f) personal attitudes and therapeutic views regarding domestic violence. It has been used in Greek population. The Cronbach a was found 0.813 showing advanced reliability of the questionnaire.[6]

Ethical issues

Ethical Guidelines for Educational Research underpinned the approaches adopted; The Scientific Committee of the Hospital approved the study (22/19-03-2024). Verbal and written informed consent was obtained from all study participants.

Statistical analysis

The IBM SPSS v.26.0 statistical software package was used to analyze the data. Descriptive statistical analysis focused on recording frequencies and percentages, because all variables were categorical. The normality of the data was checked with the Kolmogorov Smirnov test. Then, a t-test (comparison of 2 variables with each other) and one-way Anova analysis (comparison of more than 2 variables with each other) were performed for those variables that follow a normal distribution and a Mann Whitney test (comparison of 2 variables with each other) and Kruskal Wallis test (comparison of more than 2 variables with each other) for those variables that do not follow a normal distribution. The significance level was set at 5%.[7]

RESULTS

The demographic and employment data of the participants are presented in Table 1.

The study revealed key insights into healthcare professionals' knowledge, attitudes, and perceived responsibilities regarding domestic violence. An overwhelming 95.3% of participants reported confidence in recognizing incidents of violence against women. Regarding attitudes and responsibilities, 43.3% of participants expressed a neutral or cautious stance on whether they know how to act when encountering a victim, 68.67% acknowledged that identifying domestic violence victims falls within their professional duties and 42.7% felt their work environment maintains a neutral attitude toward handling abuse cases.

Furthermore, 58% of participants disagreed with the statement that they receive adequate training or information on recognizing and assisting victims of domestic abuse. About screening practices, 40% of participants opposed routine domestic violence screening for female patients during regular check-ups, and 42% agreed they should inquire about domestic violence after any trauma, regardless of the patient's stated reason for the visit.

About 1 of 3 of participants believed they should facilitate immediate shelter or care home placement for victims, and 73.4% felt responsible for offering counseling and informing victims that their partner's violent behavior is unacceptable. Finally, participants identified several barriers to investigating and caring for domestic violence victims and especially lack of time (28.6%), fear of offending the victim (31.3%), difficulty isolating victims from perpetrators (31.4%), lack of self-confidence (13.3%), lack of knowledge (22.7%) on how to assist victims and absence of referral services (13.3%) (table 2).

Moreover, 32.7% of participants stated that when, during their work, they determined that the patient who came in was a potential victim of abuse, they made sure to provide him/her with information on how he/she could contact the appropriate local counseling service or services dealing with incidents of abuse, while 24% of participants initially sought to assess the severity of the patient's condition and 18.7% to record his/her observations in the patient's file/health record. On the contrary, 4% of them did not take any action, showing indifference (Figure 1).

The study uncovered significant variations in healthcare professionals' ability to empathize with victims' decisions to remain in violent relationships, influenced by the victim's personal and socioeconomic background. Specifically, 40% of participants found it easy to understand why a woman with low educational and economic status, financially dependent on her partner, might stay in an abusive relationship. About a fifty five percentage of participants found it hard to understand when the victim was a middle-class, well-educated mother of two children and 67.3% struggled to comprehend why a single, career-focused professional woman would remain in such a situation. Additional, 59.3% of participants found it difficult to empathize with an educated homosexual woman staying in an abusive relationship, 43.3% expressed difficulty understanding the decision of a woman suffering from severe depression to stay with an abusive partner, 60.7% struggled to understand the choice of a man with a stable income to stay in an abusive relationship, 42% and 44.7% found it hard to empathize with women and men with severe physical disabilities, respectively, who remained in violent relationships. The attitudes of the participants are presented in Table 3.

The study revealed key insights into how healthcare professionals respond to suspected or identified domestic violence cases. A percentage of 52.7 of participants reported that they had not identified any domestic violence victims among hospital patients in the past 6 months and 31.3% admitted they took no action even after recognizing a patient as a potential victim of abuse. Regarding, actions taken by participants, among those who did act, 27.3% conducted health assessments (screening) on the victim, 19.3% referred the patient to a more appropriate support service, and 16.7% informed the victim about local counseling services or crisis response hotlines. An amount of 57.3% of participants chose to notify the hospital social worker when they identified a domestic violence victim, and 28.7% of participants did not provide any service referral to the victim, highlighting a potential gap in care continuity.

The results found statistically significant differences between nurses and physicians. Nurses were more likely to fear they might offend patients when asking about domestic violence (2.92±1.1 vs. 2.28±0.7, p=0.005), reported greater difficulty isolating patients from accompanying partners (2.91±1.1 vs.

2.40±1.1, p=0.033), and were more inclined to believe that questioning patients about domestic violence could infringe on privacy and human rights (2.55±0.9 vs. 2.04±0.9, p=0.014). The correlations are presented in Table 5.

Age was positively correlated with the identification of domestic violence victims (r=0.201, p=0.013).

DISCUSSION

In this study, it was found that 61.3% of professionals are able to recognize an incident of domestic violence, which indicates they possess the necessary knowledge and experience to identify a patient who may be a victim of abuse. This aligns with findings from Nigeria, where two-thirds of healthcare professionals in a teaching hospital demonstrated sufficient knowledge of domestic violence.[9]

However, only 32.7% of participants in this study advised victims on how to contact local counseling services or other support mechanisms. This highlights a gap between recognizing abuse and actively guiding victims towards available resources. Encouragingly, many healthcare professionals acknowledged their role in combating abuse and expressed positive views about their ability to support victims and influence social perceptions of violence. Nevertheless, a portion of professionals reported discomfort initiating conversations about intimate partner violence, reflecting potential gaps in education or self-confidence. Similar trends were observed in studies by Ramsey et al.[10] and Baraldi et al.[11], which advocate for expanding the role of healthcare professionals in identifying domestic violence and connecting victims with supportive services.

The findings of Dwivedi et al.[12] further support this perspective, emphasizing that healthcare professionals' attitudes and perceptions significantly influence how they treat and support victims. Education emerges as a transformative factor, capable of reshaping healthcare professionals' views and enhancing their ability to support domestic violence victims effectively.

Regarding inquiry methods, this study found that only one-third of respondents would directly ask patients about domestic violence.9 This contrasts with findings from Western countries, where the majority of healthcare professionals adopt a direct questioning approach when addressing domestic violence.[10,11,13,14]

This study found that healthcare professionals maintain a neutral and cautious attitude regarding whether they know how to act when encountering a victim of abuse, which suggests the existence of uncertainty among professionals, which can be attributed to either insufficient training or experience. In this line, the participants themselves claimed that they are not provided with training on how to identify domestic violence victims, as well as on how to manage them, while one in ten were those who claimed to have received training. Research from Divakar et al.[15] revealed that approximately 80% of healthcare professionals had never received training on managing domestic violence cases, reinforcing the need of structured educational programs. An observational study found that about half of domestic violence victims had mental health issues and most of them had recurrent presentations to the emergency department.[16] Another study reported that most domestic violence victims were females and were affected to the head and neck region.[17] These studies emphasizes the seriousness of identifying victims of domestic violence by frontline health workers.

Papadakaki's study highlights the importance of creating training opportunities, establishing interdisciplinary protocols, and adopting diagnostic tools to support clinical decisions and improve effectiveness in primary healthcare settings.[8] This aligns with the present study's finding that many professionals reported a lack of training on identifying and managing domestic violence cases.

Additionally, while chronic pain can be an indicator of abuse, only one to three respondents in this study reported screening patients with unexplained chronic pain for domestic violence. In a study from Nigeria, less than a third of the respondents believed that unexplained chronic pain and substance abuse were both indicative of an abused victim.[9] This contrasts sharply with findings from London, where 91.5% of respondents recognized frequent injuries as a potential sign of abuse.[11] Cultural differences likely contribute to this variation, indicating a need for localized training that accounts for contextual nuances.

A significant concern identified in this study is that screening for

domestic violence may be time-consuming or potentially risk offending patients. This highlights the necessity of developing discreet, respectful inquiry techniques that safeguard patient dignity and privacy. Furthermore, the challenge of isolating patients when they are accompanied underscores the importance of having designated private spaces for sensitive discussions.

Age appeared positively correlated with recognizing domestic violence victims, with older participants more confident in their ability to identify abuse cases. However, the literature lacks a detailed exploration of factors enhancing recognition skills, focusing instead on overall preparedness. This gap suggests a need for further research to determine which competencies and experiences improve recognition abilities.[1,18]

The study also found that healthcare professionals' status influences their ability to recognize domestic violence incidents quickly and accurately. This finding echoes Notko et al.'s research, which demonstrated that professional roles shape perceptions of domestic violence based on core tasks, institutional practices, and organizational structures. Strengthening interprofessional collaboration is crucial for enhancing identification and management efforts.[19]

Recommendations for Practice

Healthcare professionals can improve their ability to recognize, support, and guide domestic violence victims, ultimately contributing to a more compassionate and effective healthcare response. It can be achieved by developing comprehensive, context-specific training modules focusing on recognizing and managing domestic violence cases. This should include practical communication strategies to address discomfort around initiating conversations. Also, interprofessional teamwork within healthcare units must be promoted in order to ensure varied perspectives contribute to a holistic understanding of domestic violence cases. It is very important to implement clear, culturally sensitive guidelines for screening patients, including those with chronic pain, to ensure consistent identification efforts. There is a necessity for designing secure, private areas within healthcare facilities for confidential discussions to be held so as protect patient privacy. Finally, strengthen connections between hospitals and local support services will streamline referrals and ensure victims receive continuous care and assistance.

Limitations of the study

The main limitation of the study is the low response rate of the participants (33.78%) and as a result it is very difficult to generalize the results. Another limitation is that data collection was done with questionnaire. The participants may give subjective answers due the fact that the researcher who was responsible for data collection worked at the same hospital.

CONCLUSIONS

The role of healthcare professionals in the identification and management of domestic violence victims is crucial. Both the understanding and attitude of healthcare professionals towards recognizing domestic violence victims was found to be lacking. Neither hospital had protocols that documented the management of domestic violence victims. However, it does not appear that due attention has been given by the scientific and research community to the education and training of healthcare professionals, depending on their specialty (doctors, nurses, social workers, etc.) and the department in which they work in health units, as well as the strategies that could be followed to support domestic violence victims.

The findings of the study can serve as a foundation for educational programs, policy adjustments, and practical guidelines to empower Greek healthcare professionals to handle domestic violence cases more effectively.

REFERENCES

1. Skaine R. Violence Against Women Act. Abus an Encycl Causes, Consequences, Treat. 2015;304–6.
2. European Union Agency for Fundamental Rights. Violence against women: an EU-wide survey. Main results. Publ Off Eur Union, 2014 [Internet]. 2024; Available from: https://fra.europa.eu/sites/default/files/fra_uploads/fra-2014-vaw-survey-main-results-apr14_en.pdf
3. The European Institute for Gender Equality. Combating coercive control and psychological violence against women in the EU Member States. 2022. Available from:

https://eige.europa.eu/publications-resources/publications/combating-coercive-control-and-psychological-violence-against-women-eu-member-states?language_content_entity=en

4. Montesanti S, Goveas D, Bali K, Campbell S. Exploring Factors Shaping Primary Health Care Readiness to Respond to Family Violence: Findings from a Rapid Evidence Assessment. J Fam Violence. 2023.
5. R.A.D.A.R. Cards - an adult screening tool for domestic violence intervention. Available at: https://www.multiplyingconnections.org/store/radar-cards-adult-screening-tool-domestic-violence-intervention
6. Nicolaidis C, Raymaker DM, Ashkenazy E, McDonald KE, Dern S, Baggs AEV, et al. "Respect the way i need to communicate with you": Healthcare experiences of adults on the autism spectrum. Autism. 2015;19(7):824–31.
7. George D, Mallery P. IBM SPSS Statistics 26 Step by Step: A Simple Guide and Reference (16th ed.). Routledge, 2019.
8. Papadakaki M. The involvement of primary care services in the management of intimate partner violence and the improvement of quality of care. Crete; 2013.
9. Aworinde O, Fijabiyi M, Ayinde M, Aliu-Ayinde M, Adekunle A, Adeyemi A. Knowledge and attitude of health care providers towards the identification and management of domestic violence victims. PAMJ-One Health. 2024 Apr 26;13(20).
10. Baraldi PAC, de Almeida AM, Perdoná G, Vieira EM, Dos Santos MA. Perception and Attitudes of Physicians and Nurses about Violence against Women. Nurs Res Pract. 2013;2013:785025.
11. Ramsay J, Rutterford C, Gregory A, Dunne D, Sharp D. Domestic violence: knowledge, attitudes, and clinical practice of selected UK primary healthcare clinicians. Br J Gen Pract. 2012;62(602):e647-e655.
12. Dwivedi YK, Kshetri N, Hughes L, Rana NP, Baabdullah AM, Kar AK, et al. Exploring the Darkverse: A Multi-Perspective Analysis of the Negative Societal Impacts of the Metaverse. Inf Syst Front. 2023;25(5):2071–114.
13. Vieira EM, Dos Santos MA, Ford NJ. Seizing an Opportunity to Help—Knowledge and Attitudes of Doctors and Nurses Towards Women Victimized by Intimate Partner Violence in Brazil. Health Care for Women International. 2012;33(3):228-249.
14. Ramsay J, Richardson J, Carter YH, Davidson LL, Feder G. Should health professionals screen women for domestic violence? Systematic review. BMJ. 2002;325(7359):314.
15. Divakar U, Nazeha N, Posadzki P, Jarbrink K, Bajpai R, Ho AHY, et al. Digital education of health professionals on the management of domestic violence: Systematic review and meta-analysis by the digital health education collaboration. J Med Internet Res. 2019;21(5):e13868.
16. Ghafournia N, Healey SJR. Identifying domestic violence and sexual assault presentations at a regional Australian hospital emergency department: Comparative analysis of domestic violence and sexual assault cases. Womens Health (Lond). 2022;18:17455057221103992.
17. Chew KS, Wong SSL, Siew KL, Kandasamy V. Unmasking domestic violence: Examining victim and perpetrator characteristics and injury patterns in Kuching, Sarawak. Med J Malaysia. 2024;79(2):128-132.
18. Renner LM, Wang Q, Logeais ME, Clark CJ. Health Care Providers' Readiness to Identify and Respond to Intimate Partner Violence. J Interpers Violence. 2021;36(19–20):9507–34.
19. Notko M, Husso M, Piippo S, Fagerlund M, Houtsonen J. Intervening in domestic violence: interprofessional collaboration among social and health care professionals and the police. J Interprof Care. 2022;36(1):15–23.

ANNEX

TABLE 1. Demographic and employment data of the participants.

Variable		N	%
Gender	Male	31	20.7
	Female	119	79.3
Age(years)	Under 32	14	9.4
	33-45	46	30.7
	46-55	64	42.7
	Over 55	26	17.4
Marital Status	Single	30	20.0
	Married	100	66.7
	Divorced/Widower	20	13.4
Education level	Secondary School	37	24.7
	University/College	74	49.3
	Master/Phd	39	26
Professional status position	Healthcare assistants	22	14.7
	Nurses	80	53.3
	Head nurses	8	5.3
	Physicians	20	13.3
	Physicians` Directors	5	3.3
	Other healthcare professionals	15	10.0
Experience, years	0-5	20	13.3
	6-10	18	12.0
	11-15	23	15.3
	16-20	26	17.3
	Over 20	63	42.0
Shift work	Yes	105	70.0

TABLE 2. Knowledge, attitudes and opinions of healthcare professionals on the management of incidents of violence.

	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
Knowledge about managing incidents of domestic violence					
Knowledge of the actions that need to be taken	14%	-	43.3%	38%	4.7%
The identification of victims is competence of healthcare professionals.	50.7%	18%	23.3%	6.7%	1.3%
Support for dealing with incidents of abuse	35.3%	4%	42.7%	15.3%	2.7%
Education and information on the identification of domestic violence victims	38.7%	19.3%	26.7%	12.7%	2.7%
Views on the duties of healthcare professionals regarding domestic violence					
Duties of healthcare professionals - continuous patient monitoring	30.7%	9.3%	28%	20.7%	11.3%
Screening patients with chronic pain for domestic violence	21.3%	6%	34.7%	28%	10%
Questioning the patient about domestic violence	14.7%	5.3%	20.7%	42%	17.3%
Questioning domestic violence at each visit	33.3%	12.7%	38%	10%	6%
Care for domestic violence victims	6.7%	3.3%	26%	37.3%	26.7%
Counseling support by healthcare professionals	5.3%	4%	17.3%	34.7%	38.7%
Providing information on the effects of violence on mental health	3.3%	4.7%	9.3%	39.3%	43.3%
Monitoring the progress of the victim of domestic violence	16%	4%	25.3%	34.7%	20%
Informing domestic violence victims	6%	4.7%	18.7%	30%	40.7%
Obstacles in investigating or providing care to people who have been abused					
Lack of sufficient time to investigate patients for violence	32.7%	12%	26.7%	23.3%	5.3%
Fear of offending a patient during Question formulation	34%	10%	24.7%	29.3%	2%
Difficulty in isolating the patient	29.3%	12%	27.3%	26.7%	4.7%
Expenditure of valuable time in case of testimony	46.7%	21.3%	24%	6%	2%
Feeling of providing assistance to a victim of violence	42%	17.3%	27.3%	10%	3.3%
Change in the status of a patient victim of domestic violence	37.3%	14.7%	25.3%	21.3%	1.3%
Lost time in providing assistance to domestic violence victims	46%	25.3%	19.3%	8.7%	0.7%
Means and knowledge for managing the testimony of a victim of domestic violence	31.3%	12%	34%	16%	6.7%
Non-existence services for referring a victim of violence	46%	20%	20.7%	12%	1.3%
Mainly interested in health and not personal issues	43.3%	20%	26%	9.3%	1.3%

TABLE 3. Attitudes of healthcare professionals on issues of domestic violence.

	Very Difficult	Difficult	I do not Know	Easy	Very Easy
A woman with low educational and economic status	20.7%	20%	19.3%	30%	10%
An educated middle-class woman, mother of two children	32.7%	22.7%	26%	13.3%	5.3%
A single/non-professional with a successful career	32%	35.3%	16%	15.3%	1.3%
An educated homosexual	29.3%	30%	26%	10.7%	4%
A woman with severe depression	23.3%	20%	24.7%	23.3%	8.7%
A married man with a stable income	34%	26.7%	20%	14.7%	4.7%
A woman with severe physical disabilities	21.3%	20.7%	25.3%	21.3%	11.3%
A man with severe physical disabilities	22%	22.7%	23.3%	22%	10%

TABLE 5. Attitudes of healthcare professionals on issues of domestic violence.

	Nurses	Physicians	p-value
I am afraid I will offend the patient if I ask him/her about domestic violence. (1=Strongly disagree, 5=Strongly agree)	2.92±1.1	2.28±0.7	0.005
I find it difficult to isolate the patient when he/she is accompanied by his/her partner. (1=Strongly disagree, 5=Strongly agree)	2.91±1.1	2.40±1.1	0.033
Asking a patient about the possibility of domestic violence is an invasion of his/her privacy and human rights. (1=Strongly disagree, 5=Strongly agree)	2.55±0.9	2.04±0.9	0.014

FIGURE 1. Participant`s actions for detecting patient abuse.