Journal of Gender-Based Violence • vol xx • no xx • 1–17 • © Centre for Gender and Violence Research
University of Bristol 2020 • Print ISSN 2398-6808 • Online ISSN 2398-6816
https://doi.org/10.1332/239868020X15924187662218

article

Hospital responses to staff who have experienced domestic and family violence: a qualitative study with survivor staff and hospital managers

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Health professionals play a critical role in responding to the health consequences of domestic and family violence (DFV). However, health professional women themselves experience high rates of DFV and there is scant evidence underpinning hospital workplace responses. The aim of this Australian research was to explore the views of survivor health professional women and their managers about the role of the hospital workplace in responding to survivor staff. A 'combined methodological approach' encompassed open-ended survey questions to survivor health professionals about workplace experiences and support needs. Managers participated in an interview about the employment response. Thematic analysis of survivor staff (*n*=93) and manager (*n*=18) data identified three themes: (a) *Understand that DFV affects staff*, (b) *Support for staff is essential* and (c) *Challenges of establishing a safe workplace*. Survivors wanted understanding about how trauma had affected them, and managers recognised that staff were exposed to potentially triggering patient narratives of abuse. Both groups believed that formal resources and support were essential, including managers trained to respond sensitively to disclosures of DFV. However, challenges to creating an environment where staff felt emotionally and physically safe were identified. A trauma and violence informed hospital response could promote recovery for survivor staff ***and*** patients.

Key words intimate partner violence • domestic violence • hospitals • health professionals • managers

Key messages

- A supportive hospital organisational response to survivor staff has three main components: (1) awareness-raising and understanding that domestic and family violence (DFV) affects staff at hospitals, not just their patients; (2) multifaceted support that is not disclosure dependent; and (3) promotion of staff safety.
- Developing a trauma and violence informed culture towards both hospital patients and staff could provide the infrastructure for a safe and supportive workplace response to staff DFV.

To cite this article: McLindon, E., Humphreys, C. and Hegarty, K. (2020) Hospital responses to staff who have experienced domestic and family violence: a qualitative study with survivor staff and hospital managers, *Journal of Gender-Based Violence*, vol xx, no xx, 1–17,
DOI: 10.1332/239868020X15924187662218

Background

Prevalence and impact of domestic and family violence for health professionals

Domestic and family violence (DFV) is a common and chronic issue affecting Australian women, with health consequences leading to an over representation of survivors attending hospital services, who have mostly female staff (Campbell, 2002; Australian Bureau of Statistics, 2016). DFV is defined by the World Health Organization as 'any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in that relationship' (Krug et al, 2002). DFV abusive behaviours may be perpetrated by a partner or family member, and one such behaviour is child witnessing (World Health Organization, 2012). The term 'survivor' refers to someone who has experienced DFV (Elliott et al, 2005). This term is used in recognition of the strength and resilience of people with lived experience of DFV (Bond et al, 2018). Globally, 30% of women are affected; while the national Australian prevalence is 25% (Garcîa-Moreno et al, 2005; Cox, 2012). Women experiencing DFV access healthcare services more frequently than women without a history of DFV, and best practice with survivors includes a multifaceted bio-psychosocial response (Rivas et al, 2015).

Health professionals are increasingly recognised as being at the frontline of responding to violence and trauma in the family (Garcîa-Moreno et al, 2015). A recent Australian study found the lifetime prevalence of DFV against a group of 471 women nurses, doctors and allied health professionals was 45.3%; higher than the prevalence in the general community, while lower than in a clinical sample of women accessing primary care (McLindon et al, 2018). Some research has suggested that personal exposure to DFV may affect health professionals' readiness for DFV clinical care with survivor patients, acting as a barrier for some survivor staff and an enabler and motivator for others (Mezey et al, 2003; Beynon et al, 2012). An analysis of the association between health professionals' personal experiences of DFV and their clinical care of survivor patients found that survivor health professionals were more likely than their non-abused peers to have accessed professional DFV training, hold more sensitive and informed attitudes about DFV survivors and to have recently provided DFV information to their patients (McLindon et al, 2019). However, while DFV may be an enabler of good clinical practice, there are other impacts for survivor health professionals at work, including the risk of vicarious trauma from bearing witness to the traumatic narratives of patients (McCann and Pearlman, 1990; Gates and Gillespie, 2008; Goldblatt, 2009).

Employment and workplace support for survivors

Although employment can be an asset for survivors, DFV can negatively impact upon it and there is limited research about how survivor employees want their workplace to support them. While employment may afford social support, financial resources and

increased exit options out of violence (Falk et al, 2001; Rothman et al, 2007; Blustein, 2008; Felblinger and Gates, 2008; Pollack et al, 2010), DFV can also contribute to job instability and problems at work which are, in turn, associated with depression and anxiety (Adams et al, 2013).

Research suggests that employers may have limited awareness about DFV experienced by employees, despite there being substantial costs to the organisation (Commonwealth of Australia, 2009). Mismatches between the type of support survivor employees want from their workplace, and that which they actually receive, are common (Swanberg et al, 2005; Swanberg et al, 2007; Yragui et al, 2012; Laharnar et al, 2015; Glass et al, 2016). Of the research about how workplaces can support survivor staff, most has focused on the perceived helpfulness of support and resources offered after disclosure, with mixed results (Samuel et al, 2011; Yragui et al, 2012; Laharnar et al, 2015; Glass et al, 2016; Kulkarni and Ross, 2016; MacGregor et al, 2016). In their Canadian study of 2,831 survivors (mostly employed in education), MacGregor et al (2016) found that survivors who had disclosed DFV generally perceived the support they had received as helpful, particularly having a 'listening ear', paid time off, assistance with safety planning and referral. By contrast, Kulkarni and Ross (2016) in their United States study of 500 employees in private business found that survivor employees perceived the workplace as less supportive and accommodating regarding DFV than did their non-abused peers.

How do hospitals respond to survivor staff?

Hospitals are unique workplaces since, in addition to survivor staff perhaps being overrepresented, they are often female-dominated, and the work of health professional employees necessarily exposes them to vicarious trauma and not uncommonly occupational violence from patients and visitors (Gates and Gillespie, 2008, Pich et al, 2017, Shakespeare-Finch and Daley, 2017, Shea et al, 2017). While all health professionals are at risk of vicarious trauma in their job identifying and responding to survivor patients, research suggests that vicarious trauma reactions may be heightened if the health professional has lived experience of DFV (McCann and Pearlman, 1990; Bell et al, 2003). As a site of employment, hospitals have not been investigated about their response to survivor staff (Garcîa-Moreno et al, 2015). An extensive review of the international literature located only one study with 3,611 health and education union members (response rate ~4.6%) (McFerran, 2011). The study investigated impacts and outcomes of discussing DFV at work for the 30% of survivors who had experienced lifetime DFV (5% in the last 12 months). Since the professional background of participants was not separated in the findings, the study does not provide specific outcomes for different employment settings. However, overall nearly half of the participants reported that DFV had sometimes affected their capacity to get to work, with 15% affected while at work (McFerran, 2011). Half (48%) of survivors had disclosed DFV to their supervisor, although only 10% found that helpful (McFerran, 2011). As a result of discussing DFV with someone at work, most survivors found that either nothing changed or the outcome was negative, with paid leave the main form of assistance offered (19%) (McFerran, 2011).

An additional gap in the literature is the hospital managers' views of their workplace's role in responding to employees who have experienced DFV. The authors were unable to locate any studies on this topic, despite some research in non-healthcare fields

having previously identified the positive impact management can have in supporting staff (Swanberg et al, 2007; Glass et al, 2016; MacGregor et al, 2016). There would appear to be a gap in the literature about how hospital workplaces should respond to DFV affected employees from the perspectives of both survivor staff and hospital managers who administer and supervise hospital workplaces. To address this gap, the aim of this research was to explore: (i) *What support needs do survivor health professionals have of their hospital workplace?* and (ii) *What are the views of hospital managers about the role of the workplace in responding to staff survivors?*

Methods

This study utilised what Halcomb (2019) refers to as a 'combined approach' to research. This theoretical approach incorporates both quantitative and qualitative methods to collect data towards one aim. Using a combined methodological approach, qualitative and quantitative data were applied to answer different research questions. This was a large project about the prevalence (McLindon et al, 2018), impacts (McLindon et al, 2019) and implications of DFV against health professional women. Results of the quantitative data have been published elsewhere (McLindon et al, 2018; 2019). This article presents findings from the qualitative data about implications. Preliminary outcomes of the quantitative data with survivor health professionals formed the basis of the first interview question to managers and this was the extent of the interaction between the two data sets until the analysis phase (McLindon et al, 2018).

Study design, setting and participants

Qualitative survey data from survivor health professionals

Health professionals at a major Australian tertiary maternity hospital participated in a questionnaire about DFV prevalence, impacts and experiences at their workplace (McLindon et al, 2018; 2019). This hospital was selected as the research site as the first author was employed as a health professional there and the hospital fully supported staff participation in the study. The hospital was engaged in strengthening their response towards survivor patients, however, it had not begun addressing the issue of survivor staff. Methods are described elsewhere (McLindon et al, 2018; 2019). Briefly, an electronic and paper cross-sectional survey of all clinical health professionals was conducted between August and December 2013 (McLindon et al, 2018). The survey was developed by a team of DFV clinicians and researchers and it went through a pilot phase with health professionals, including survivors. Staff survivors were female nurses, midwives, doctors and allied health professionals who had experienced DFV and were employed in a maternity hospital setting. DFV victimisation included: self-reported family violence during childhood and/or 12-month or intimate partner violence since the age of sixteen measured using the Composite Abuse Scale (Hegarty and Bush, 2002; McLindon et al, 2018). This article reports the qualitative data from open-ended survey questions about the role of the hospital workplace. A survey method was chosen, rather than an alternative (for example, interviews, focus groups), because of the sensitive nature of the research topic (Braun and Clark, 2013). It was theorised that an anonymous survey would likely result in more comfortable

and candid participation and a broader range of views (Braun and Clark, 2013). Staff survivor participants are identified via a number within the results.

Interviews with hospital managers

Face-to-face individual and group interviews were conducted with individuals in a position of leadership either at the hospital, an employee assistance programme (EAP) or union (hereafter uniformly referred to as 'managers') between April and June 2014. Group interviews were offered to employees in the same team, for example, human resources (HR) and the EAP. Recruitment was based on purposive sampling to obtain a wide range of views so that individuals at different levels of management and across every department at the hospital were represented. Eighteen managers participated in an individual or group interview (11 individual, seven in one of two group interviews). Interviews began with the interviewer providing a brief summary of the results of a prior DFV prevalence study, which showed that DFV commonly affected health professionals (McLindon et al, 2018). Managers were then asked what they thought the role of a hospital workplace should be in responding to staff survivors. The interviews were semi-structured, and open-ended questions explored what the hospital workplace was doing well/could improve on and the components of an effective response, including a case example prompt. Individual and group interviews lasted between 30 minutes to an hour in length and were audio recorded with consent before being transcribed verbatim and imported into NVivo (Version 11) (QSR International Pty Ltd, 2018). Manager participants are identified via a pseudonym within the results.

Data analysis

Data was analysed following the phases of thematic analysis specified by Braun and Clarke (2006). EM became familiar with the data, generating initial codes from the staff survivor and manager data separately, followed by open coding to generate concepts for both groups. While a coding frame was not used, EM, CH and KH were involved in double coding extracts of data in an active and reflexive process, reflecting those who were involved (Clarke and Braun, 2014). From here, the strategy for analysis varied based on the different methods of data collection.

Responses to open-ended questions by staff survivors ranged from a short sentence to several paragraphs in length, thus in-depth analysis was not always possible and the coding strategy was, in that case, predominantly descriptive (Braun and Clark, 2013; Kulkarni and Ross, 2016). For the manager interview data, a more detailed analysis could occur, and after creating a coding scheme, an inductive approach was undertaken to explore themes, engendering meaning and implications. Upon conclusion of the separate analysis of the two sets of data, the themes and subthemes were brought together to understand connections and distinctions between them. An iterative process with all authors ensued; the themes were checked to understand their fit with the coded extracts and the entire data set, developing a thematic map. In keeping with a common convention when representing prevalence in thematic analysis, a quantified measure (that is, an exact number) of the staff survivor and manager participants who contributed to a particular theme is not provided (Braun and Clarke, 2006). Rather, the proportion is indicated where it is deemed helpful for the reader. The data presented in this article was selected from the original sample to illustrate a theme, and to ensure quotes represented different participants. To limit

the potential for bias in the selection of data for presentation, EM critically examined the perspective she brought to data analysis and met with CH and KH to review and agree (Critical Appraisal Skills Programme, 2018). EM, CH and KH agreed on the distinctions between each theme and reviewed the overall narrative of the analysis. Finally, all authors were involved in naming each theme (Braun and Clarke, 2006).

Ethics approval

Ethics approval was granted by both the recruiting hospital and the university Human Research and Ethics Committees (Ethics ID: 1339986).

Results

Survivor health professional characteristics

There were 471 health professional women employed at the tertiary hospital who participated in the survey, and of these, 212 (45.2%) had experienced DFV (McLindon et al, 2018). Of the survivor health professionals, 93 (43.8%) answered one or more of the open-ended survey questions about their workplace support needs. These responses are the focus of this article. Most of the staff survivors were nurse or midwives (63/93, 67.7%), aged between 30 and 59 years (80/93, 86.0%), with ten or more years of professional experience (63/93, 73.1%). For nearly a quarter of the staff survivors (21/93, 22.6%), intimate partner violence was a current issue in their life (last 12 months), and a third (29/93, 31.2%) had a history of multiple relationships where violence had occurred, self-reporting *both* intimate partner and family violence. Staff survivors described a range of DFV impacts on their lifetime employment, the most common being a physical or psychological injury that had affected them at work (60.8%).

Manager characteristics

Eighteen managers (14 female and four male) participated in an individual (n=11) or group interview (n=7) about the role of the hospital workplace in responding to DFV in the lives of staff. All but two of the managers approached agreed to participate and interviewees represented ~40% of clinical managers at the hospital. Manager participants were employed in the role of 'manager', 'director' or 'executive' within the hospital (n=15), EAP (n=2), or union setting (n=1).

Three distinct themes were constructed from analysis of the survivor staff and manager participant data: (a) *Understand that DFV affects staff*, (b) *Support for staff is essential*, and (c) *Challenges of establishing a safe workplace*.

Understand that DFV affects staff

In this theme, staff survivors reflected upon some of the ways that DFV had affected them in their professional role, and managers shared their perception of the challenges for survivors in the workplace. Some staff survivors described having felt alone in their experience of DFV and thought that breaking the silence and acknowledging that DFV affects health professionals, not just their patients, might send a message of support and hope against shame to other survivors. One survivor nurse suggested that she would support a survivor colleague by, 'reminding them that what they are

experiencing doesn't make them an outcast and there are others out there who may be going through the same thing' (Staff Survivor 505). Speaking about awareness raising throughout her hospital, a survivor nurse said:

> I would like to see more openness about the number of current staff impacted by violence as I believe that would go some way to dispel many of the myths of family violence, e.g. it doesn't happen, if it was me I would just leave etc. It is so much more complex than that!! (Staff Survivor 521)

Unknowingly affirming the staff survivors who had made the same suggestion before them, some managers also spoke about building awareness that DFV affects staff in the hospital. These managers thought this was critical step towards encouraging survivors to seek support:

> It's a topic that has a perceived stigma attached […] if there were a few staff with the courage to start to disclose that could be a really powerful impact and help create awareness that it's okay to seek support. (Carol)

Staff survivors spoke about the impact DFV had had on their professional practice. Some credited it with improving their clinical skills, including motivating them to work 'with an understanding of trauma and its impact on people' (Staff Survivor 341). One staff survivor believed her experience gave her greater empathy for her colleagues experiencing diverse challenges:

> As someone who has experienced and survived domestic violence, I am actually very 'grateful' […] as I hope that it has given me a greater level of empathy for team members experiencing this or other challenges. (Staff Survivor 521)

More commonly however, survivors spoke about the difficult aspects of working within a hospital environment after DFV. This included being unable to function at normal capacity and finding aspects of the hospital environment a trigger to feelings of distress. For example, an allied health professional experiencing current DFV spoke about acting self-protectively to avoid traumatic memories being triggered:

> [I want] Time to debrief after talking to a woman who has disclosed a domestic or sexual violence issue, so I am not left worrying about the person. I deliberately avoided a [DFV] work presentation, afraid of the issues it might bring up for me. I did not want to think about them, especially the worst domestic violence and sexual violence of past relationships and as a child. There would be no one to talk to if I did become upset so I'd probably have to bottle it up and this could exacerbate my depression. (Staff Survivor 258)

Most of the staff survivors wanted their workplace to be a more supportive, flexible and understanding environment, 'So [survivors] are not in fear of losing their jobs as a result of what they might be experiencing' (Staff Survivor 461). Staff survivors wanted, 'Understanding if not firing on all cylinders at work sometimes' (Staff Survivor

80), and policy which, 'acknowledges this experience for staff – an important step in recognising and validating experience' (Staff Survivor 341).

Some managers spoke about challenges which they anticipated survivors might experience in talking about DFV, including feeling ashamed, fear of people being judgemental, and negative ramifications caused by evaluations about a survivor's capacity to do their work. As one manager said,

> Doctors are often very reluctant to admit depression, anxiety […]there's a professional potential for impairment in their career progression because if they report mental health issues, then we may or may not be obliged to report them to [the Australian Health Practitioner Regulation Agency], and in turn, if they perceive that hanging over their heads they may decline reporting. (Paul)

The choice of doctors not to disclose psychological health issues at work because of concern about career impairment is likely to be felt more broadly, including by other health professionals. This worry could pose a significant risk to a workplace environment where survivors feel able to seek DFV support, such as leave for appointments and role flexibility, which could be critical to wellbeing and ongoing employment. This type of culture also risks perpetuating the confidentiality matters that staff survivors raised, presenting a barrier to DFV support even if it were made available.

Support for staff is essential

The majority of staff survivors and managers thought that hospitals should have a planned support response for staff with a history of, or current DFV. They suggested equipping managers to respond, providing access to people with whom survivors could talk, flexibility in the workplace, and resources including DFV leave. Most managers and survivors thought that an environment of understanding and acknowledgement of the importance of staff wellbeing and safety was critical. Managers thought that to realise this, cultural change would be required.

The first and second most frequently cited aspects of a supportive workplace response were encouraging managers, HR and EAP staff to respond to survivors in a compassionate, confidential and informed way, building a culture of understanding, empathy and awareness in the workplace:

> Training/appointment of managers who are understanding and skilled with this issue to make it easier for staff to approach managers for help and equip managers/staff to recognise signs of DFV. (Staff Survivor 73)

The importance that staff survivors placed on managers and other key professionals being skilled to respond to disclosures by staff was illustrated in the difference between how managers and staff survivors conceptualised DFV leave. While most managers believed that leave was an important resource (not available at the time of the research), more survivors than not identified unease about DFV leave. Survivor staff's primary concern was that to access leave would require disclosure to somebody in authority who might not respond with sensitivity and discretion. As one survivor midwife said:

> Extra leave for DFV would mean that work would become aware of a person's situation and that is most often the last thing a person wants. It's easier to call in sick with nil stigma associated with such leave. (Staff Survivor 257)

To advance a culture where the wellbeing of staff, not just patients, is considered critical, many managers and some staff survivors thought cultural change was required. It was suggested that this be underpinned by an 'ideological policy position higher than Human Resources' (Anthony), prioritised by leadership and expressed through policy. Some survivors and managers thought that the ethos against bringing personal issues into the workplace should be challenged. As Louise said:

> Every organisation I've ever worked in has always been about the patients' experience and not about people in the workforce. So, I can't imagine that it wouldn't require a cultural shift […] I think that it needs to be explicit within the occupational health and safety discussions – whether it's policies, procedures, et cetera.

Many staff survivors wanted counsellors and other professionals, rather than their managers, human resource staff or EAP staff made available to talk about DFV. Other onsite resources were advocated for, including supervision, mentors and people with whom to debrief. These resources were suggested to mediate against the secondary trauma faced by all health professionals, as well as the negative impacts for staff survivors that could be triggered by a patient's narrative of abuse: 'I have tried to bring this up with Human Resources on many occasions but have fallen on deaf ears. I believe we need to have on-site counsellors who we can speak with at a personal and professional level' (Staff Survivor 148). Managers, however, rarely suggested this type of support.

More than half of managers thought that they individually, and as an organisation, had a 'duty of care' (Sarah) to provide DFV specific support to staff. In referencing clinical care of survivor patients as core business for the hospital, some managers were concerned that staff who required workload flexibility, or needed time off, could not always be accommodated. Some managers spoke about the sensitive nature of discussing DFV and the magnitude of competing clinical and other demands which hospitals are tasked with addressing that would get in the way of meeting a survivors' needs. Other managers queried whether it was feasible or even necessary to single out DFV as a specific area of staff support, suggesting that it be incorporated into a broader staff wellbeing or mental health programme:

> Would we write a guideline for everything that could happen in someone's life or is it more about skilling our managers to be able to respond to whatever people might come to them with or disclose to them? (Carol)

While managers and staff survivors both believed in the importance of a sensitive workplace response, many staff survivors had had experiences at work that were not safe, and managers too, raised this as a significant challenge to establishing a DFV-supportive environment.

Challenges of establishing a safe workplace

In the two earlier themes survivors called for understanding and confidentiality, and managers suggested a more supportive response. However, this would seem to be dependent upon a workplace being safe. In this theme, challenges to establishing workplace safety were explored. Survivors and managers spoke about safety in a nuanced way: including the absence of workplace abuse and harassment the risk of secondary trauma and emotional safety to feel comfortable to disclose DFV.

More than half of the staff survivors reported that their hospital workplace had, at times, been made unsafe because of bullying or harassment by colleagues, or abuse from patients and hospital visitors. Speaking of having experienced multiple threats to her safety, one staff survivor said:

> I have been physically threatened with 'Cut my throat' and 'I'll follow you to your car'. I have been bitten; had a bedside table rammed into my back and been choked by patients […] I have been called all sorts of things […] I have been yelled at by partners of women because I asked questions and because of waiting periods, etc and I have been verbally abused and bullied by my colleagues. (Staff Survivor 148)

This survivor was experiencing current violence by an intimate partner and disclosed a history of family violence as a child. Another staff survivor expressed how workplace bullying can, 'trigger memories/situations of past domestic violence. At times this workplace is like being in a domestic violent relationship' (Staff Survivor 482). This survivor's experience was of her home life made unsafe because of violent behaviour, compounded by an abusive workplace environment. Speaking about the importance of safety, and acknowledging that people are affected by their experience, one manager said:

> I think every workplace has a duty of care to ensure that the workplace is safe. Any organisation's employees bring themselves to work with their total being and that includes what's happened in your personal life. This can impact you, your productivity, your relationships and your level of safety in the workplace. (Judy)

Some managers referred to secondary DFV exposure through survivor patients, which one manager termed 'double jeopardy' (Helen). These managers identified hospitals as unique and potentially triggering workplaces where staff are routinely exposed to secondary DFV in their patients' lives when assessing a patient's history or providing clinical interventions:

> We're a workplace that is going to expose people to patients who have experienced violence. In really plain terms – it's like an occupational hazard. It is a risk here and it might aggravate pre-existing issues […] [better responding to this] it's really important. (Carol)

Some managers suggested that DFV staff support should be a specific issue planned for by the hospital. More than a quarter of managers had professional experience of supporting staff survivors either as their manager or colleague. They spoke about

bearing witness to the ways physical and psychological injuries can impact a survivor at work and acknowledged the importance of survivors' feeling secure in their employment, not just for financial stability, but as a safe environment outside their home: 'Work is a very important part of keeping that person functioning […]it's part of rehab, it's part of their self-respect, self-esteem, financial' (Michelle). Some managers emphasised that an understanding, supportive and safe working environment for staff may, in turn, impact the hospital environment for patients:

> We need the people in our workplace to feel that they can give the best of themselves, both for their own fulfilment, and for the welfare of the organisation, which is a proxy for the patients that we look after. (Anthony)

Discussion

This research contributes to a gap in the literature: how hospital employers can support staff survivors of DFV (MacGregor et al, 2016). Survivors and managers suggested that everyone in the organisation should understand that staff may be affected by DFV, onsite and external support was considered critical, and challenges (including emotional and physical safety) should be confronted. Three themes were created from the two different groups of participants, (a) *Understand that DFV affects staff*, (b) *Support for staff is essential*, and (c) *Challenges of establishing a safe workplace*.

Despite the managers not being aware of the themes raised by staff survivors at the outset of their interviews, their ideas were generally supportive of, and consistent with those of survivor staff. This finding differs from previous research that found employers and survivors to be mismatched on the topic of DFV support needs (Yragui et al, 2012). The two areas where survivors and managers were most aligned were: suggestions for how the workplace could support survivor staff, and the importance of ensuring a safe workplace. This topic is important to mitigate the risk of a disparity between the type of support which survivors identify they need from their workplace and that which they are actually offered. Research suggests that this could be a vital component of trauma recovery (Pollack et al, 2010; Yragui et al, 2012).

Our findings confirm previous research regarding how employers can show support to staff survivors, including through schedule flexibility (Swanberg et al, 2007; Glass et al, 2016), workplace policies (Glass et al, 2016), the availability of someone with whom to talk (Kulkarni and Ross, 2016), raising awareness about staff survivors in the workplace (Glass et al, 2016), and working to dispel fear of negative outcomes in response to disclosure (Laharnar et al, 2015). The managers in our study cited DFV leave as a critical aspect of workplace support. Many survivors, however, expressed concerns about confidentiality and how they would be responded to if leave was disclosure dependent. These findings sit alongside those of McFerran (2011) who found that for participants who had disclosed their most recent episode of DFV to someone at work, the most common assistance offered was paid leave which was often not the only type of support that a survivor needed. The remaining participants in that study named privacy concerns as their chief reason for not disclosing DFV at work (McFerran, 2011).

More than half of the survivors in our study had felt unsafe in their workplace because of harassment by colleagues and a culture of silence about mental health problems highlighting the challenge to establishing workplace support for DFV.

Beyond the struggle of gathering commitment and resources from within an organisation, cultural issues can pose barriers to employees feeling safe to access DFV support (British Medical Association, 2019).

The location of the survivors' employment was not incidental in this study. Hospitals are critical sites for research on this topic because in addition to the risk of being a primary survivor of DFV, all health professionals' work exposes them to secondary trauma (Sinclair et al, 2017). The survivors in this study were all working in an environment where they were identifying and responding to violence against predominantly pregnant women and their children; emotionally demanding work that was emphasised by several participants (Mollart et al, 2009). Health professionals routinely hear the traumatic stories of patients (Gates and Gillespie, 2008). Over time, this can result in a secondary or vicarious trauma response (McCann and Pearlman, 1990). The term 'vicarious trauma' describes the accumulation of stress or problematic reactions experienced by clinicians, researchers and others who witness to other people's stories and images of abuse (McCann and Pearlman, 1990; Kulkarni et al, 2013). This type of a reaction may be hastened or heightened if the health professional has their own trauma history, which is not uncommon (Jenkins et al, 2011; Newcomb et al, 2015). Additionally, health professionals face a daily risk of abuse from their patients and harassment from their colleagues (Walsh, 2014; Shea et al, 2017). Although this study was limited in its focus to one hospital in Australia, these findings may contribute to wider efforts aimed at improving workplace support for hospital staff affected by DFV.

Limitations

One limitation of this study was the focus on a particular group of survivor employees (health professionals), and a specific type of workplace (a hospital), which may restrict the learnings being applied in other settings. Another limitation included the collection of qualitative data through open-ended survey questions which may have affected the depth of the survivor data. This study included two different participant groups, and two methods of data collection, which might be viewed by some as a limitation because of the potentially divergent paradigms and the risk of not attending enough to context (Barbour, 1998). However, method and data source triangulation can also contribute to deeper understanding because they arise from different perspectives, reinforming the study's thesis (Carter et al, 2014). Another strength was the health professional background of EM who administered the survey and conducted the interviews. As a hospital social worker employed at the research site, participants may have felt enhanced trust and exhibited greater openness (Braun and Clark, 2013). Finally, a strength of this study was the rigorous data analysis, which included investigator triangulation (Carter et al, 2014).

Summary and implications

The themes raised by survivor health professionals and their managers about how hospitals can respond to staff affected by DFV indicate the potential of a trauma and violence informed organisational approach towards patients *and* staff (Ponic et al, 2016). While trauma and violence informed practice has advanced strongly in relation to service users of mental health and human service systems in Australia (Quadara,

2015) and overseas (Hopper et al, 2010), to date it has not been conceptualised for general hospitals. A 'strengths-based' framework, trauma and violence informed care guides the organisation and behaviour of the entire system in which it is implemented, so that every interaction aims to promote recovery (Elliott et al, 2005; Hopper et al, 2010). Trauma and violence informed organisations understand the centralising influence that trauma can have in people's lives, prioritise psychological and physical safety, including through addressing secondary or vicarious trauma, and respond to the diverse and sometimes complex needs of survivors with a focus on rebuilding a sense of control (Harms, 2015). Developing a trauma and violence informed culture in hospitals may encourage a more empowering and health-promoting organisation for both health professional staff and their patients (Bloom, 1997; Cocozza et al, 2005).

Conflict of interest

The authors declare that they have no conflicts of interest.

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