

Recognising and Responding to Domestic Violence and Abuse: The Role of Community Nurses

INTRODUCTION

Domestic violence and abuse (DVA) is defined by the UK Home Office (2013) as ‘Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who, are or have been, intimate partners or family members, regardless of gender or sexuality. The abuse can encompass, but is not limited to, the following types of abuse: psychological, physical, sexual, financial [or] emotional’. The World Health Organization (WHO) (2013) describes it as the infliction of physical, sexual or mental harm, including coercion or arbitrary deprivation of liberty. Both these definitions highlight some important points. Domestic violence and abuse encompasses a range of behaviours and the word ‘violence’ can sometimes be misleading because of its physical connotations. A great deal of DVA is characterised by controlling, coercive behaviours and emotional abuse that do not involve physical violence (see for example, Stark, 2007; Katz, 2016). In recognition of the seriousness of control and coercion, such behaviours are now considered an offence in the UK under the Serious Crime Act (Home Office 2015). It is important to note that almost all physical violence is accompanied by emotional abuse, coercion and control.

THE EXTENT OF THE PROBLEM

Domestic violence and abuse is a difficult problem to assess regarding prevalence because it is under-reported but it is estimated that almost one third (30%) of all women who have been in a relationship have experienced physical and/or sexual violence by their intimate partner (WHO 2013). The UK Office for National Statistics (ONS 2015) reporting on data from the

2013/2014 Crime Survey for England and Wales (CSEW, previously known as the British Crime Survey), that 8.5% of women and 4.5% of men experienced abuse in the last year, equating to an estimated 1.4 million female victims and 700,000 male victims. This means that women are almost twice as likely as men to experience DVA. Women do abuse men (Flinck & Paavilainen 2010) but DVA perpetrated by men against women forms the most violent and the most repeated form of DVA.

As reflected in the earlier definition, DVA occurs in different relationships, irrespective of gender or sexuality (Home Office 2012). “Lesbian and bisexual women experience IPV at a similar rate to women in general (1 in 4) although a third of this is associated with male perpetrators (Hunt and Fish, 2008). Compared with 17% of men in general, 49% of gay and bisexual men have experienced at least one incident of DVA since the age of 16” (NICE, 2014, p.27). Overall, DVA can be expressed as a gendered issue due to the significance of DVA perpetrated by men against women. This is why this article tends to focus on women. However, it is important to recognise that the configuration of a relationship is not in itself a risk factor – there are however, other associated risks.

RISK FACTORS

There are no straight-forward linear causes of DVA, but there are a number of well-documented risk factors and associations. Mental health problems and drug and alcohol misuse are closely related to DVA and their combined relationship is referred to as ‘The Toxic Trio’ (Co-ordinated Action against Domestic Abuse (CAADA) (2014). In their investigation of the effect of DVA on children, CAADA reported a clear co-occurrence of the toxic trio risk factors, with nearly a third of mothers and fathers in families experiencing DVA, disclosing either mental health problems, substance misuse, or both. This does not

imply an inevitable association between these three elements, but it is helpful to be aware of their tendency to co-existence in many cases of DVA.

Pregnancy is a risky time for DVA and Van Parys and colleagues' (2014) reported that one fifth (20.4%) of the women who took part in their study in Belgium experienced some form of DVA in the 12 months before and/or during pregnancy. Pregnant women experience a range of abuse and violence such as the behaviours described in the introduction. Perhaps the most shameful assault is that directed at the foetus itself; kicks to the abdomen are not uncommon. Unsurprisingly, DVA is linked to adverse foetal outcomes including premature birth, low birth weight, stillbirth, perinatal foetal injury and death (O'Reilly et al. 2010). Disability is a risk factor for all types of abuse, including child abuse. More than half of disabled women have experienced some form of domestic abuse and they are at particular risk of severe physical violence (Brownridge 2006). Disabled women can face particular forms of impairment related abuse, such as partners withholding assistive devices or refusing to provide basic care (Breckenridge et al 2014).

Age is an interesting issue in relation to DVA. The Home Office definition presented earlier refers to people aged over 16. This lower age limit was lowered from previous definitions in recognition that young people are at relatively high risk of DVA. There are no upper limits and on the other end of the age spectrum, older people experience DVA too (McGarry et al 2011; Stöckl and Penhale, 2015). It can be useful to conceptualise DVA as something that can happen to anyone irrespective of age, gender, socioeconomic status, nationality or ethnicity. That said, there are certain circumstances and contexts that place a person temporarily or permanently at risk. So the endemic issue of violence against women across the world means that in comparison to men, womanhood is an inherent risk factor. The relatively transient state of pregnancy might render a woman susceptible to certain types of abusive behaviour at that time, particularly directed at the unborn child. Overall it is

important to remain alert to prejudgements that might lead us to believe that DVA only happens to certain people. It doesn't. But levels of risk and manifestations of DVA vary considerably.

CONSEQUENCES FOR WOMEN AND CHILDREN

The relationship between DVA and poor health is well recognised and it is known to result in compromised health over the life-course (Symes et al. 2014). Its negative impact on health is greater than other more obvious threats, such as smoking or diabetes and it now ranks as a major public health problem (Bacchus et al. 2012). The negative health effects can be linked back to the risk factors described in the previous section: DVA is a cause of physical injury (Campbell 2002), complications of pregnancy (Bacchus et al 2004), and mental health and addiction problems (Lazenbatt et al 2009). Some women who experience DVA end their own lives (Devries et al 2011), and two women in the UK are killed every week by a current or former partner (Hester 2009).

There is no doubt that adversity in childhood is harmful and there is strong evidence that harm often remains through to adulthood. Many children live in a home where DVA is an issue and it is recognised that living in such an environment is harmful to children's social, emotional and physical development (Buckley et al., 2007). In their investigation, CAADA (2014) found that two thirds (62%) of the children exposed to DVA were directly harmed (most often physically), or emotionally abused or neglected. They reported that children living with DVA suffered multiple physical and mental health consequences as a result: over half (52%) had behavioural problems, over a third (39%) had difficulties adjusting at school and nearly two thirds (60%) felt responsible or to blame for negative events. A study in the US involving 300 abused women and their children reported that children who live in homes where DVA is occurring grow up learning that violence is an acceptable way of resolving

conflict (Blair et al. 2015). The findings showed that the effects of exposure to DVA were not the same between girls and boys. Boys were significantly more likely to display externalising behaviour such as aggression and hostility, with potential influence on their own future intimate relationships. The Royal College of Psychiatrists have produced a really helpful factsheet for parents, teachers and anyone who works with young people. Readers may find it a useful resource. It lays out the effects that DVA can have on children and offers advice about how to avoid these problems. See:

<http://www.chimat.org.uk/resource/view.aspx?RID=223567&src=pimh>

In this section the consequences of DVA for women and children have been discussed. Statistically they make for an unhappy read. However, it is important to keep in mind the issue of resilience. There is a whole body of literature on resilience, with theories and empirical evidence explaining and reporting how many individuals overcome the harm caused by being abused. In the context of DVA, a balanced perspective is helpful. This means acknowledging the negative and often long-term effects on women and children on one hand, while avoiding determinism (harm is not inevitable). Early intervention is key however if long term effects of DVA are to be ameliorated – this is where the role of community nurses is key (DoH, 2013).

ROLE OF COMMUNITY NURSES

There are many strategies that can be adopted to address risk factors for DVA and “promote protective factors across the life course” (DoH, 2013, p.3). The primary prevention of DVA is of key importance and Dennis (2014) has described ways in which health visitors may get involved in primary prevention activities. Community nurses also have a crucial role in recognising and responding to women who have experienced DVA (Dennis, 2014) and while

many are competent and confident to do so, some are less so (Bradbury-Jones et al. 2014). There is an increasing amount of research that seeks to understand why this is the case, but the underlying reason seems to be fear of having what has been termed ‘difficult conversations’ about DVA (Bradbury-Jones 2015). The fearful element is based on concerns about causing offence by broaching such an emotive subject. However, most women (whether experiencing DVA or not) are not offended when asked about DVA and in fact, most want to be asked (Taylor et al. 2013).

It might seem a little contradictory that while many women want the issue of DVA to be discussed, abused women tend to deny their experiences when asked. It often takes a number of times of being asked before a woman has the confidence to disclose. This can be a little confusing. The main reason is that DVA is surrounded by secrecy, stigma and shame (Ahmad et al. 2009). The impact of DVA on children has already been explored and women are concerned about having their children removed from them (Peckover 2003). Also, fear of further abuse prevents many women from disclosing (Robinson & Spilsbury 2008).

However, it is still important for community nurses to be prepared to ask about DVA and this ought not to be a mere one-off event. Where possible, raising the issue sensitively on a number of occasions is helpful. NICE (2014) describe this as being ‘a routine part of good clinical practice’ (p.12). The DoH (2013) advises on the importance of ensuring it is safe to ask, noting:

- Consider the environment:

- Is it appropriate to ask?

- Is it safe to ask?

- Never ask in the presence of another family member, friend, or child over the age of two years

- Create the opportunity to ask about DVA
- Where required use an appropriate professional interpreter (never a family member).

Talking openly (but safely) about DVA provides an indication that it is an issue to be discussed. Many women experience coercive, controlling and emotional forms of abuse that they do not readily identify as being DVA – they deal with it as part of their life. Overall there are multiple benefits to community nurses talking safely about DVA: it creates an environment in which women can begin to see the abusive nature of their relationships; it makes it less of a taboo subject; it opens opportunity for disclosure and subsequent safety planning.

RESPONDING TO DISCLOSURE

Understanding the processes for responding to disclosure of DVA is crucial. A helpful starting point is acknowledgement that disclosure in itself does not necessarily equate to a woman leaving the abusive relationship. In the same way as it takes most women several times of being asked about DVA before disclosure takes place, leaving the relationship often takes multiple attempts. Even when women leave, many return. There is not a straightforward link between asking-disclosing-leaving. ‘Why doesn't she just leave?’ is over-simplification and there are multiple, complex reasons why the only choice for a woman is to stay (Bradbury-Jones 2015). Homelessness and refuge are not appealing options. Additionally, most women know that abuse does not end on exiting a relationship – post-separation is in fact an extremely high risk time for women and children (Nikupeteri, Tervonen & Laitinen, 2015). So remaining in an abusive relationship is not an irrational phenomenon. The role of

community nurses in this context is to respect women's choices and work with her in safety planning for herself and her children.

Insert figure 1

Eventually, many women do make the decision to exit the abusive relationship and community nurses can offer crucial support at this time. In the UK there are clear reporting duties for vulnerable children and adults (Department of Health (DoH) 2013, HM Government 2015) and immediate danger to a woman or her children requires an emergency response. Children's safety needs to be a priority and where children are present within a DVA situation a child protection concern should be raised.

In their assessments, community nurses in the UK may find the DASH Risk Identification Checklist helpful (<http://www.dashriskchecklist.co.uk/>) and also the Barnados Risk Assessment Matrix (http://www.londonscb.gov.uk/domestic_violence/). Many will also be familiar with the Identification and Referral to Improve Safety (IRIS) programme (<http://www.irisdomesticviolence.org.uk/iris/>). This is a general practice-based DVA training support and referral programme with an enhanced referral pathway to specialist DVA services. IRIS is a collaboration between primary care and third sector organisations specialising in DVA, such as Women's Aid. In the UK there are clear referral pathways for DVA and the NICE guidelines on DVA (2014) provide a simple, yet helpful illustration (Figure 1). Community nurses need to be familiar with the DVA pathways relevant to their own clinical areas and their own Trust DVA policy but most will be based on a similar model to Figure 1. As with all referral, consent and documentation are important, but there needs to be careful consideration of both safety and confidentiality especially when documenting in personal records as suggested in Figure 1.

SUPERVISION, SUPPORT AND TRAINING

The emotive element of DVA has been discussed in this article. Dealing with the issue has been shown to be associated with a range of emotions among community nurses, including fear, distress and frustration (Taylor et al 2013). It is important therefore that community nurses take care of themselves and each other emotionally. One way to achieve this is through access to robust systems of supervision. This needs to offer support to community nurses in dealing with DVA among patients, clients and families. But it also needs to take into account that many nurses are themselves living with DVA. Sensitivity, compassion and protection of each other are as important for community nurses, as it is for the women with whom they work.

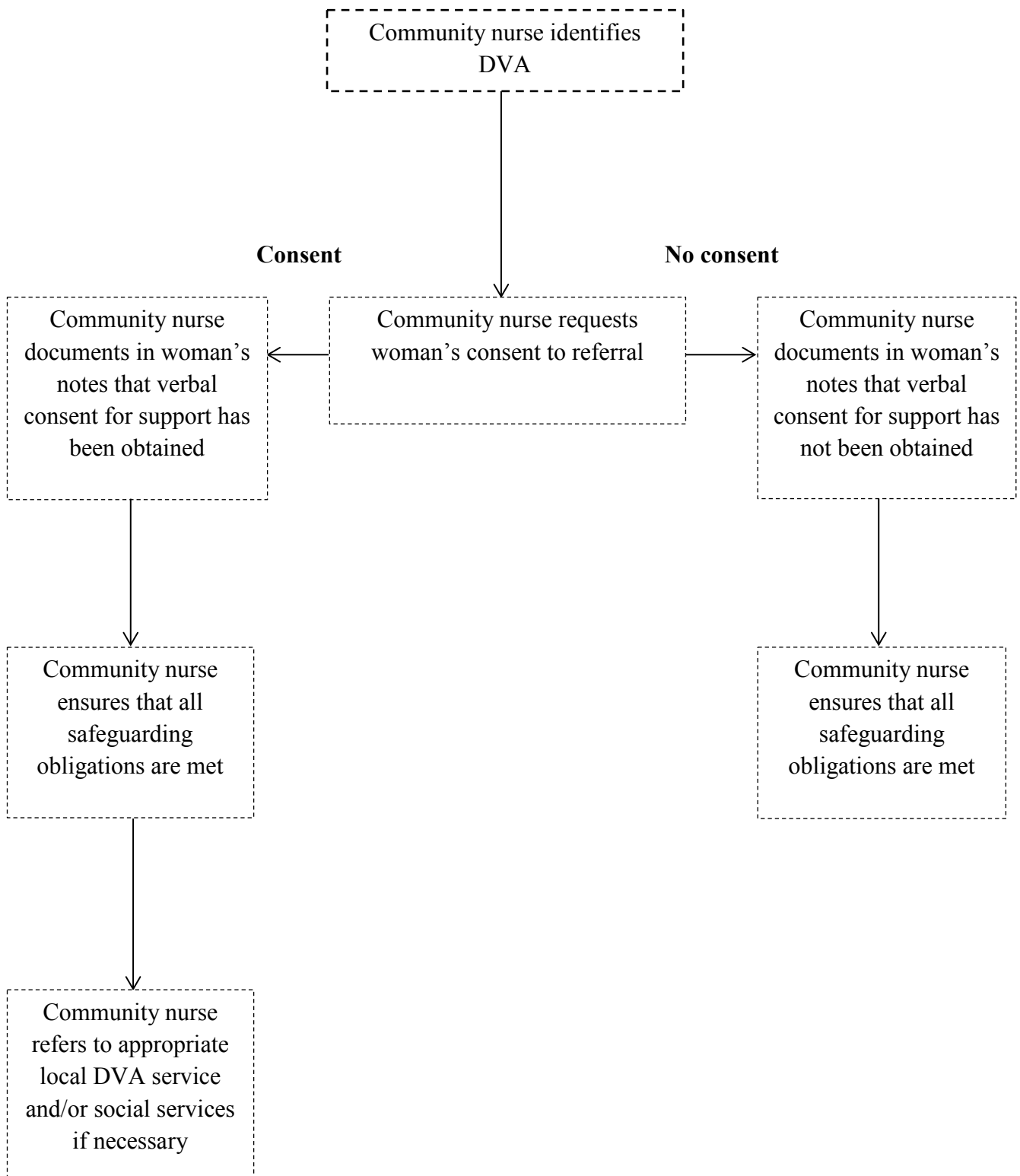
Education and training are vital in promoting community nurses' confidence in recognising and responding to DVA. Many Health Trusts and Boards in the UK have lead health professionals who provide guidance and training around DVA issues. However, although some community nurses have access to regular, high quality DVA training, provision is patchy. A message for providers of community nurse services is in the significant benefit of such training. For community nurses who do not have access to formal DVA training programmes (or to supplement the learning of those who do) further information for community practitioners to keep up to date about DVA can be found at <https://www.gov.uk/guidance/domestic-violence-and-abuse>

SUMMARY

There are three key messages for community nurses in this article. Firstly in relation to recognition, do not be afraid to discuss the issue of DVA. It is unlikely to cause offence if

undertaken sensitively and safely and it will demonstrate confidence in addressing the issue in which women will trust. Secondly regarding response, sometimes the only helpful response to disclosure of DVA is acceptance that for now that is all that a woman can deal with. But the act of disclosure can begin a pathway of safety planning for both the woman and her child(ren). Figure 1 refers to 'safeguarding obligations' and these are relevant in all cases of DVA that involve children or where a woman is in immediate danger. Lastly, there is nothing mystical about recognising and responding to DVA. It requires sound clinical judgements, communication competences and referral knowhow. These are at the heart of all nursing practice and in these, most community nurses excel.

Figure 1: Referral Pathway for DVA (Adapted from NICE 2014)



CPD questions (please go to www.communitypractitioner.com/CPD to submit your answers)

1. Domestic violence and abuse encompasses a range of behaviours which include/including:
 - a) Physical and sexual abuse
 - b) Psychological abuse
 - c) Controlling, coercive and emotional abuse
 - d) **All of the above**

2. What is the prevalence of DVA for women and men according to the 2013/2014 Crime Survey for England Wales?
 - a) 11.5 % of women and 7% of men
 - b) **8.5% of women and 4.5% of men**
 - c) 7% of women and 3% of men
 - d) 6% of women and 3.5% of men

3. Which negative health outcomes are associated with DVA?
 - a) Physical injury
 - b) Complications of pregnancy
 - c) Mental health and addiction problems
 - d) **All of the above**

4. DVA is something that can happen to anyone irrespective of age, gender, socioeconomic status, nationality or ethnicity.
 - a) **True**
 - b) False

5. What age group of young people is referred to in the Home Office (2013) definition of DVA?
 - a) **16 years**
 - b) 17 years
 - c) 18 years
 - d) 21 years

- 6) Which of the following statements is incorrect when responding to disclosure about DVA?
 - a) Ensure the safety needs of the woman and child(ren)

- b) Be kind, sensitive and non-judgmental.
 - c) Do not validate what is happening to the individual.
 - d) Ensure that all safeguarding obligations are met.
- 7) Is the following statement true or false: Lesbian and bisexual women experience IPV at a similar rate to women in general (1 in 4) although a third of this is associated with male perpetrators
- a) True
 - b) False
- 8) Which of the following relating to DVA is false?
- a) The relationship between DVA and poor health may result in compromised health outcomes over the life-course.
 - b) Some women who experience DVA end their own lives.
 - c) The severity of DVA is not linked to health outcomes.
 - d) Leaving an abusive partner is an extremely high risk time.
- 9) Which of the following relating to DVA and pregnancy is false?
- a) DVA may start or intensify during pregnancy
 - b) DVA is linked to poor foetal outcomes including premature birth, low birth weight and perinatal foetal injury.
 - c) DVA can result in stillbirth and death.
 - d) Pregnancy related violence is rarely directed at the unborn child. DVA.
10. Which of the following statements relating to the community nurse role in relation to responding to DVA is false?
- a) A safety assessment should consider both risk and protective factors.
 - b) Training is unlikely to impact positively on nurses' confidence in dealing with DVA.
 - c) Education and training are vital in promoting community nurses' confidence in recognising and responding to DVA.
 - d) Risk factors may be assessed using the CAADA-DASH Risk Identification Checklist

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