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Nurses recognition of domestic violence and abuse.

Introduction

This paper aims to review the literature on and discuss nurses' recognition of domestic violence abuse (DVA) and explore the implications for mental health nursing practice. DVA is a significant public health issue worldwide and a violation against human rights though the World Health Organisation (WHO) (2016a) focuses only on women as victims/survivors within intimate relationships (WHO, 2016a). The WHO defines violence against women as:

> "any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life." (WHO, 2016a: online)

For the purpose of this paper, we adopt the UK Home Office definition as this offers a broader conceptualisation as it defines DVA 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: psychological; physical; sexual; financial; emotional." (Home Office, 2013: online)

As such, the Home Office proffers a gender-neutral understanding of DVA and whilst it is acknowledged that women are statistically more likely to experience serious harm or even death within domestic settings (Walby & Allen, 2004), it is also useful to acknowledge that anyone, regardless of gender or sexuality, can be a victim/survivor. Hereafter, within this paper will use the term 'survivor', in accordance with discourses of empowerment for those experiencing DVA whatever their gender (Gupta, 2014) and we reject the common term 'victim' which can have a pathologising tendency (Rogers, 2013).

Background: Prevalence and impact of domestic violence and abuse

The UK's Crown Prosecution Service indicates that any person regardless of gender, ethnicity, sexuality, age, disability, immigration status, religion, belief system and socio-economic background can experience DVA. Statistics do not necessarily reflect this diversity, but do indicate the widespread nature of DVA as in the UK it is estimated that 2.1 million people experience some form of DVA each year: 1.4 million women (8.5% of the population) and 700,000 men (4.5% of the population) (Office for National Statistics [ONS], 2015). On a worldwide scale, on average, 30% of women have experienced physical and/or sexual violence and abuse in the context of an intimate relationship rising to between 60 and 68% in lower income regions, and that 35% of women have experienced either physical and/or sexual intimate partner violence or sexual violence outside of an intimate relationship (WHO, 2013).

Mostly the available prevalence data, as well as the majority of discourse, reflects DVA as a social problem which is 'asymmetrical' in the context of gender relations (Stark, 2006, 2007; Anderson, 2009); in other words, DVA is experienced disproportionately by women and perpetrated predominantly by men. Indeed, as noted above, the most recent data reports that it is almost twice as common for women to experience any one variant of DVA as it is for men (Office for National Statistics [ONS], 2015). Donovan & Hester (2014) claim that this supports the perpetuation of a 'public story' of DVA; that DVA is a problem of heterosexual men's physical violence against heterosexual women.

Yet the need to recognise that domestic abuse can be found across all communities is essential if we are to address the costs to both individuals and society. There is a growing body of work which presents a challenge to the 'public story' as it illuminates DVA as a problem where both women and men can be survivors *and* perpetrators and where DVA is experienced by people who identify as trans/non-binary gender and/or who may be in a same-

sex relationship (Hines & Douglas, 2010; Hester et al., 2012; Donovan & Hester, 2014; Rogers, 2013, 2016a).

There are other groups of marginalised people for whom the experience of DVA is 'hidden', and problematic in terms of the barriers to identification and reporting. For example, people with learning disabilities are reportedly more susceptible to abusive relationships as they do not receive adequate sex education or lack the knowledge of what is appropriate within a relationship (McCarthy, 2017). People from black and minority ethnic communities face additional barriers to accessing services particularly if their abuse experiences incorporate 'honour-based' action or forced marriage, as women in particular can be viewed negatively as passive recipients of cultural control (Gill, 2013). Similarly, identification of older people's experiences of DVA can be obscured by views about elder abuse (which does not necessary recognise the gender-based attributes of DVA), or beliefs about traditional gender roles and practices which normalise behaviours (Rogers, 2016b).

Overall, however, it is difficult to measure the prevalence of DVA in any community as often the nature of abuse means that people do not necessarily recognise it themselves and therefore do not report it for the prolonged, ongoing and sustained process of abuse that it is (Donovan et al. 2006; Brown & Herman, 2015). Moreover, people can be reluctant or unable to report DVA. If those who experience abuse do not recognise it, practitioners, including nurses, need to be particularly vigilant in this regard. Moreover, the latest version of HM Government's (2016: 12) strategy to 'End Violence Against Women and Girls' states that tackling violence against women and girls is 'everyone's business' including all private and public sector agencies as well as the wider public.

Risk factors for DVA are the same as risk factors for mental disorder which makes recognition very complex; mental health service users are more likely to experience DVA

(Oram et al, 2017), and people who experience DVA are more likely to have social, behavioural and health-related conditions. These include chronic pain, respiratory and musculoskeletal conditions, cardiovascular disorders, diabetes, gastrointestinal symptoms, sleep disturbances, suicidal ideation, self-harm, eating disorder, dependence on alcohol and substances, depression, post-traumatic stress disorder (PTSD) and anxiety (Campbell, 2002; Hegarty, 2011; Warshaw et al, 2013). However, focusing on mental illness diagnosis distracts and undermines the effects of DVA experiences (Oram et al, 2017). The severity and frequency of DVA can correlate directly with the severity of symptomatology that appears during and/or following abusive incidents (Dillon et al, 2013). Survivors often experience other psychological and behavioural changes such as feelings of shock, confusion, fear, isolation, despair and with feelings of a loss of connection with one's own sense of self and with reality (Warshaw et al, 2013).

In economic terms, the cost of DVA to healthcare provision has been calculated at £1.73 billion with mental health costs estimated to be an additional £176 million (Walby, 2009). Given the identified impacts with regards to healthcare provision (that is, the economic burden and the health problems experienced by survivors) there are clear implications for Health Care Practitioners (HCPs) who may be the first point of contact. This is recognised within the DVA sector as in 2016 a report published by SafeLives, a UK-based national charity dedicated to ending DVA, argued persuasively that all hospitals should have DVA specialists. However, even where these might exist nurses appear to be failing to recognise DVA as the reason for the symptoms and health issues presented to them (Hegarty, 2011; Bagman & Donovan, 2016). This means that the opportunity to intervene as a provider of help and support and assist with both the symptomatology and social aspects of DVA is lost. Nurses appear to be ill-equipped and, at times, reluctant to enquire about DVA in those they

treat, despite much professional and legislative guidance advising to the contrary (Hegarty, 2011; National Institute for Clinical Excellence (NICE), 2014; Bagman & Donovan, 2016).

The Nursing & Midwifery Council's code of practice (NMC 2015) states that nurses should respect and uphold human rights putting the interests of people using services first, making care and safety a priority and recognizing, assessing and responding to physical, social and psychological needs. Therefore, this review aims to address the question: How can nurses recognise domestic violence and abuse?

Nurses' recognition of DVA

References for the review were identified by searching the databases CINAHL, Medline, ASSIA and PsychINFO (2002-2017). Synonyms were identified and combined using Boolean operators as shown in table 1. The searches were conducted in Feb-March 2016 and updated in July 2017.

Table 1 Combined terms for search

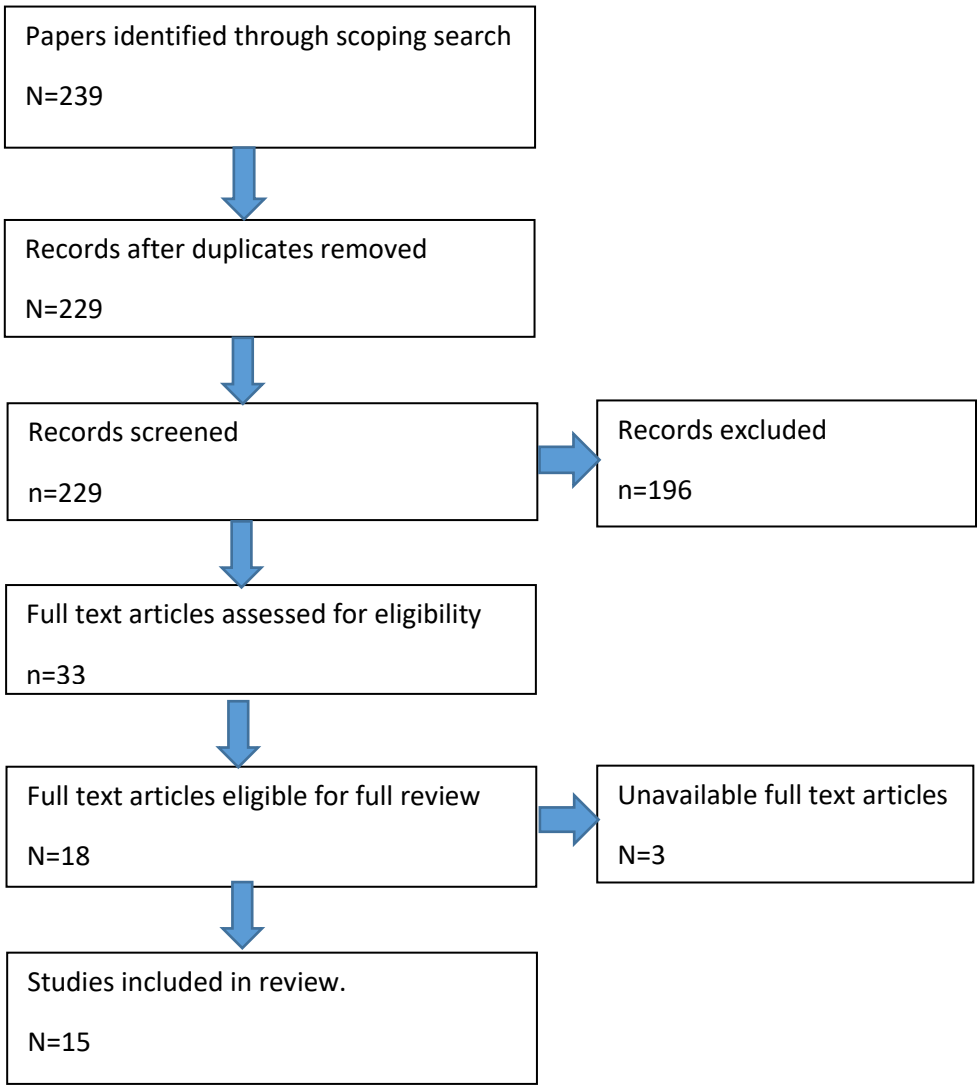
DVA	**and**	**Recognition**	**And**	**Nursing**
Domestic violence		recogni*		nurs*
Or		Or		
Domestic abuse		identif*		
Or		Or		
intimate partner violence		assess*		

Fifteen papers were identified and subject to full review. The prisma diagram shown in figure 1 shows the selection process.

Apart from the need for a specific focus on nurses recognition of domestic abuse and violence as defined by the search terminology, the inclusion criteria required that they be in the English language, were peer reviewed research and focused on adults. A date limit of

2011-2017 was applied to locate the most up to date research. All papers located through this process were included in the review. The excluded papers did not explicitly fit the inclusion and none were excluded on the basis of a quality assessment. The critical appraisal skills programme (CASP) qualitative checklist & cohort study checklists (2013) were used to inform the review of the research.

Figure 1 Prisma diagram showing study selection process



Although the central interest in this paper is mental health nursing, the generic concept nurs* was used as the scoping search revealed that there were only two research papers focused on

mental health settings and DVA (Nyame et al 2013; Arkins et al 2016). However, the studies located mostly involved multidisciplinary groups within primary care (3), obstetrics & gynaecology/midwifery (2), general hospital & emergency depts. (6) and health and social care professionals (3). Therefore, this literature focussing on multidisciplinary health care practitioners (HCPs) will be reviewed followed by a discussion of the implications for mental health nursing practice.

Themes were identified by using data extraction tables to compare findings across all studies. As these had some overlap, they are presented here as: education, training and organisational support, and, screening, inquiry and the therapeutic relationship, with an additional category (given the original aim of the review) 'mental health settings'.

Education, training and organisational support

Husso et al (2012) identified four key themes explaining how HCPs view DVA;

- practical, where there was no time and nurses did not know where to refer,
- medical, where it was seen as a social issue and not a nurses role,
- psychological, where the issue was avoided and,
- individualistic, where it was viewed as an individual's problem.

These were compounded by confusion as to whose role it is to intervene (Husso et al, 2012; Williston & Lafreniere, 2013) and by the complexity of survivors who commonly conceal their experiences (Litherland, 2012; Bradbury-Jones et al, 2014). However, training for HCPs builds knowledge and improves attitudes resulting in the confidence to recognise DVA and provide appropriate information (Leppäkoski et al, 2015; Litherland, 2012; McGarry & Nairn, 2014; Sundborg et al, 2012). Interprofessional education is suggested as best practice as this enables greater knowledge and awareness of DVA but also enhances knowledge and understanding of the different disciplinary roles in working together towards better recognition of DVA (Leppäkoski et al, 2015). Any form of educational activity and improvement of recognition of DVA however, is not achieved without organisational support

which promotes responsible practices (Husso et al, 2012; Ritchie et al, 2013; McGarry & Nairn, 2014). This support can be through local policy and guidelines, having a nurse specialist or inter-agency working across localities (Leppäkoski et al, 2015; Litherland, 2012; McGarry & Nairn, 2014; Sundborg et al, 2012). McGarry & Nairn (2014) found that the presence of a DVA specialist nurse improved access to information for patients and nurses, improved general confidence, reduced fear and enabled follow up and supervision.

Screening, inquiry and the therapeutic relationship

Screening cannot happen without training but training alone is insufficient for better recognition or enhancing practice (Ritchie et al, 2013; LoGiudice, 2015). In a qualitative secondary analysis of HCPs in primary care, Bradbury Jones et al (2014) identified a framework for highlighting the processes in health care regarding DVA where;

1. Both the HCP and the patient recognise DVA,
2. The HCP recognises DVA but the patient does not,
3. Neither the HCP nor patient recognise it,
4. The patient recognises it but the HCP does not.

However, even where nurses have the skills to identify DVA (Sundborg et al, 2012) medical care is often prioritised in order to avoid screening despite suspicions (Al Natour, 2014). Lack of time, resources, knowledge, clear responsibility or the organisational culture means that recognition of DVA is avoided in favour of other priorities or pressures (Litherland, 2012; McGarry & Nairn, 2014; Natan et al, 2012; Husso et al, 2012; Bradbury-Jones et al, 2014; LoGiudice, 2015; Al Natour, 2016). Bradbury-Jones et al (2014) investigated the nature of DVA awareness and recognition in 29 primary healthcare staff and 14 female survivors. The study found that the women wanted to be asked about DVA, and suggested that it is the responsibility of HCPs to create an environment and therapeutic relationship in which such issues can be openly discussed. This requires skills and experience, and it has been found that the more experience or prepared staff are for identifying and screening for

DVA the more likely they are to recognise and screen for it in future (Lawoko et al, 2011; Natan et al, 2012; Bradbury-Jones, 2014).

LoGiudice (2015) questions whether nurses should employ routine screening or screen on suspicion, debating whether the use of screening is appropriate without first having built up a therapeutic, trusting relationship with a patient. Williston & Lafreniere (2013) found that nurses felt that screening was fraught with risks to both the patient and HCP. Uncertainty, unfamiliarity and the inability to 'fix' the problem all served as barriers to screening as did the belief that as it was a social problem, not a nurse's responsibility.

Mental health setting

Only two of the research papers were focused on mental health settings, Arkins et al (2006) systematic review of screening tools available and one research paper exploring screening and responses (Nyame et al, 2013). Nyame et al (2013) conducted a cross-sectional survey of 81 psychiatrists and 50 community mental health nurses (MHN) in London. Universal screening was found to be low (15%) but it had identified one case of DVA in the previous six months. The psychiatrists were more likely than MHN to provide information to service users but MHN were more likely to undertake assessment and management of DVA. High proportions of participants had inadequate knowledge of services available. Given that people with mental health problems are more likely to be survivors of DVA and vice versa (Howard et al, 2013), mental health services have a major role to play (Oram et al 2017) which has important implications for mental health nurses.

Implications for mental health nursing practice

There is clearly a dearth of research evidence regarding recognition of DVA in mental health settings. The research reviewed in this article regarding recognition of DVA by HCPs suggests that a) inquiry or screening cannot happen without education and b) education will

not increase screening unless this is strengthened by organisational support. The only paper specifically focused on the organisational approach evaluates the role of DVA nurse specialists suggesting that it gives nurses confidence to inquire about DVA knowing people would receive follow-up care. This is important as the literature suggests that though nurses do recognise DVA, where this occurs they often feel powerless and anxious, unable to screen or inquire due to awareness of the lack of available follow-up support (Natan et al, 2012; Husso et al, 2012). This anxiety may explain why nurses miss the social, behavioural and psychological signs of DVA, as well as the presenting risks (such as inconsistent accounts, overprotective partners, flinching on touch, avoidant of physical contact; see NICE 2014) and instead tend to medicalise the presenting symptoms (Natan et al, 2012; Husso et al, 2012; Catallo et al, 2012). Whether this is true for MHN is unknown though perhaps the psychosocial nature of MHN has potential for better recognition. Certainly identification, prevention and treatment of the consequences of DVA needs to be more efficient in mental health services and staff must guard against victim blaming and disempowering attitudes (Oram et al 2017). Although Agenda (2016) recommend routine inquiry by services encountering women in poverty (who have more risk), organisational endorsement and planning is needed (Williams & Paul, 2008), as routine screening is potentially unethical and harmful if follow up support services are unavailable or staff are not appropriately trained (Litherland, 2012, Reeves, 2012; WHO, 2013, NICE 2014).

One of the barriers for nurses was that they perceived themselves as healers and problem solvers, wanting to 'fix' problems, and 'curing' DVA was not achievable (Williston & Lafreniere, 2013, p825). This is not the same for MHN whose role is focused on person centred interventions within therapeutic relationships, creating 'safe places of positive asylum and give expert professional help to those in mental distress and their families' (Butterworth & Shaw, 2017, p7). If as Bradbury-Jones & Taylor (2013) suggest, inquiry about DVA can

only happen when HCP create therapeutic relationships in which such issues can be openly discussed then MHN are in a good position to achieve this. A good therapeutic relationship can minimise distress and maximise autonomy, which is particularly helpful as disclosures by patients are more readily made when they do not feel hurried or pressured in some way (Reeves, 2012).

Moreover, Reeves (2012) review of trauma-informed care for survivors of physical, sexual and domestic abuse found that screening aids can assist MHN to recognise past *and* present trauma and abuse. Similar to the findings in the review, Reeves (2012) found that people who had experienced trauma preferred healthcare professionals to ask them about it and not to have to disclose it themselves. But staff need to be trained and have access to trauma informed interventions (WHO, 2013; NICE, 2014). Nevertheless, some service users may disclose their experiences spontaneously, and in accordance with the NMC code (2015) nurses much take all reasonable steps to protect people who are at risk from neglect or abuse. How a MHN responds to disclosure is of key importance as feeling comfortable with the environment and confidence in staff is essential for good outcomes following disclosure (Robinson & Spilsbury, 2008; Bradbury-Jones et al 2011). Enabling change involves the key skills of patience, bearing witness to the story, respect for the person, enabling feelings of safety and implementing appropriate relationship boundaries whilst maintaining human warmth (Williams & Paul, 2008) Williston & Lafreniere (2013: 825) note how a 'delicate, flexible and reflexive approach is needed' in addition to accessible screening tools (accessibility to appropriate tools was found to be a barrier to recognition) (Arkins, et al 2016). As yet, however, there are no evidence-based tools that can be used effectively in mental health settings as existing psychometric tools have not been tested in these environments (Arkins et al, 2016). Best practice guidance for gender informed care on acute mental health wards (Williams & Paul, 2008) indicates that understanding gender inequality

and the harm it can do to mental health is essential and multidisciplinary teams must be willing to address this as part of mental health recovery. Although there appears to be no information on how well these guidelines have been implemented in the ten years since publication, the RCN has recently updated it guidance and made support resources available for nurses at https://www.rcn.org.uk/clinical-topics/domestic-violence-and-abuse .

Limitations of the review

The search was limited to research papers only in four health and social care databases. Therefore evidence from grey literature or other sources is not included. Searches covered only the last fifteen years, 2002-2017. Literature published in journals other than English language was not included which limits access to other international evidence.

Conclusion

The disparities in service provision for supporting survivors is an international problem (Litherland, 2012; Husso et al, 2012; Leppäkoski et al., 2015; LoGiudice, 2015). Healthcare services should train HCP to ask people they treat about DVA, ensuring that staff tailor support to meet people's needs, offer specialist advice, advocacy and support as part of a comprehensive referral pathway if an enquiry leads to disclosure of domestic abuse (NICE, 2014). Such activity needs to be supported by organisational policies procedures and guidelines (Bradbury-Jones & Taylor, 2013: 43). MHN are in a good position to develop this area of practice, but their current ability to recognise DVA and provide appropriate interventions needs to be explored more fully in research, particularly in relation to the organisational support which can enable this.

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