What causes domestic abuse and how can nurses effectively support abused women?

One in four women will experience domestic abuse in their lifetime. Nurses can help them cope by offering support, empathy and understanding.

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Domestic abuse is a significant public health problem in the UK, primarily perpetrated against women. Nurses can play a vital role in identifying patients who have experienced abuse, and in offering them emotional, psychological and practical support.

This article explores the causes of domestic abuse and nurses role in caring for those affected. It emphasises the need for enhanced nurse education and awareness to enable nurses to provide holistic care for women.

INTRODUCTION

Domestic abuse – the molestation of a person in the home or family environment – is a widespread problem, primarily experienced by women. Research suggests that one in four women in the UK will experience a form of domestic abuse in their lifetime (Bynorth, 2008; Walby and Allen, 2004), irrespective of race, sexual orientation, class, age and disability (Jones, 2006; Smith, 2003a). This is despite the government’s attitude of zero tolerance to violence in society, especially in the home.

The literature on domestic abuse tends to concentrate mainly on physical abuse. However, emotionally and psychologically abusive behaviours are equally damaging and used systematically as a means of control (Walker, 2006). Understanding the causes of domestic abuse provides insight into why women are particularly vulnerable to violence in society, especially in the home.

This article examines how those who experience domestic abuse can take steps to resolve their situation, and how the health service, particularly nurses, can help them. As the overwhelming majority of domestic abuse is perpetrated against women, this article focuses on their experiences of abuse.

WHAT IS DOMESTIC ABUSE?

The definition of domestic abuse determines how it is considered in academia and society (McHugh and Frieze, 2006). The British government defines it as: “Any incident of threatening behaviour, violence or abuse physical, psychological, sexual or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality” (Taket, 2004). This acknowledges the nature and complexity of domestic abuse, unlike the terms “spouse abuse” and “domestic violence”, which exclude those not in a marital relationship and suggest it is limited to brute force (McHugh and Frieze, 2006).

A British crime survey was undertaken by Walby and Allen (2004) to provide further insight into domestic abuse. They gathered data from 22,463 men and women aged 16-59 from a range of social backgrounds and found that domestic abuse incorporates physical violence, often accompanied by rape. Among the abused, 23% had been sexually assaulted by their partner.

These actions take place in the home, a setting traditionally viewed as a refuge, which becomes the site of terror. The feelings of fear and shock at suffering abuse in the home lead to isolation and shame. Yet, in some cultures, men’s sexual needs are fulfilled with no concern for women; some teenage boys in the UK believe that rape does not exist within the marital home (Lowenstein, 2005).

Other forms of abuse

Emotional and psychological abuse are described as threats of abandonment or harm, deprivation of contact, humiliation, verbal abuse and isolation. The eventual isolation is a large part of the control exerted by abusers and is what holds the relationship together (Walker, 2006). Once abused women become isolated, they have no one to verify that their relationship is not normal and they believe they are responsible (Women’s Aid, 2007).

Although World Health Organization research implied that the effects of physical violence are more harmful (Krug et al, 2002), psychological and emotional forms produce greater shame and lasting effects and leave those affected feeling disbelieved (Heath, 2003). Researchers must, therefore, be careful in how they conceptualise domestic abuse, as they can implicitly inform health professionals’ judgements.

Economic abuse involves the theft, fraud or exploitation of property and inheritance (Walby and Allen, 2004). At a more basic level, some women are forced to rely on their partner for money to feed and clothe themselves (Amiel and Heath, 2003).

Power and control

Researchers consider abusive behaviour to be a form of domination through the expression of power and control (Krauss, 2006; McHugh and Frieze, 2006). Domestic abuse differs from other relationship tensions in that incidents have a cyclical pattern (Walker, 2006). The deliberate pattern of abuse can be compared with that of prisoners of war, where abuse inflicted
against captured troops was not randomly performed but used definitively to weaken them physically and mentally (Mechanic, 2004). Unlike prisoners, however, people experiencing domestic abuse feel they have somehow provoked it (Heath, 2003).

Various models illustrate how this pattern of behaviour takes place, such as the cycle of violence (Fig 1) and the power and control wheel (National Victim Assistance Academy, 2002). These show that incidents are not random and escalate repetitively as the relationship navigates the cycle (National Victim Assistance Academy, 2002).

Inside both wheels are the behaviours or tactics used to gain and maintain control. The cycle of violence restricts victims to stages through which they will progress, but fails to appreciate that each relationship is different. This, however, is reflected in the power and control wheel, as it allows for fluidity between behaviours and acknowledges that not all must be present.

Western culture emphasises individuality and, as such, those who suffer domestic abuse can be blamed when they do not leave (Dunn and Powell-Williams, 2007). The power and control wheel emphasises that victims of abuse are trapped by social and psychological barriers. Dutton and Goodman (2005) highlighted that victims feel powerless to avoid or influence outcomes – this is not a reflection of their own weakness, however, but the interconnected behaviours that subtly build on one another and restrict choices.

CAUSES OF ABUSE

Biological and evolutionary perspectives consider males more likely to exhibit violent and aggressive behaviour because they are responding to their natural biological functions (Smith, 2003b). Domestic abuse is then viewed as a pathological phenomenon shown by men with abnormal testosterone levels, a problem they were born with (Smith, 2003b). This explanation fails to account for the other subtle emotional and psychological actions used to control and manipulate (Women’s Aid, 2007).

On the other hand, Perry (2000) argued that men learn early in childhood to become abusive and to accept abuse as normal when they watch aggressive and domineering behaviour in their family. Arguments are a part of relationships; while the use of verbal and psychological abuse to belittle and demean is unacceptable to some, it is part of life for others (Women’s Aid, 2007). In this way, interacting with a partner in a threatening and disrespectful manner is a result of the environment these men have been brought up in and is part of their culture (Perry, 2000).

In a study of male students, White and Smith (2004) found those with a childhood history of observing domestic abuse in their family showed higher rates of abuse towards women in early adulthood, which steadily increased. This is supported by Herrenkohl et al (2007), who found that males who had witnessed and grown up around domestic abuse had learnt aggression before the age of 15 and were at risk of committing criminally violent acts against women by the age of 21.

Both studies used a longitudinal design, which allows them to measure how participants’ behaviours changed over time. This design also highlights other variables that are constant throughout and could have an effect on behaviour. While the family setting is important, Herrenkohl et al (2007) found that poverty and unemployment were also regular variables in abusive participants.

Unfortunately, neither team attempted to explain how their findings could be applied to women who have witnessed abuse in childhood. On the other hand, Herrera and McCloskey (2001) highlighted that only women who have been sexually abused are more likely to commit domestic abuse themselves. This suggests there is an inherent gender difference behind domestic abuse.

The gender issue

Gender is seen as an important concept in understanding domestic abuse (Krauss, 2006). While sex is biologically determined, gender is socially constructed through social, behavioural and psychological characteristics that are deemed appropriate for either males or females (Fernandez, 2006).

In a patriarchal society, male characteristics are based on being more powerful than females and commanding more resources and respect than them – an image against which men measure themselves (Fernandez, 2006). People who have little power often overuse violence and threats, which would support the notion that men lash out at women they can no longer control or support financially (Jewkes et al, 2002). One suggestion is that lifestyles and relationships are less stable as a result of changing socioeconomic status, which increases confrontation (Lowenstein, 2005).

While it could be argued that men and women from higher socioeconomic groups are less likely to experience domestic abuse, Moe (2007) noted that many residents in a domestic violence shelter were highly educated and had successful careers before being abused. Notably, these were not women trapped by their own ignorance; they described instances in which abuse had prevented them from finding or staying in work and using their wages to establish independence and safety (Moe, 2007).

The media has an enormous influence on culture and it could be argued that it reinforces patriarchal stereotypes. Krauss (2006) found that exposure to media violence positively correlates with rates of adult violence.

Feminist theory

Feminist theorists consider violence to have been legitimised for some time within religion and law (Hanmer, 2003). Domestic abuse is seen as typifying the violent culture of society, and it can be argued that men have quickly learned that the powerful structures of religion and law will do little to stop their actions (Sandis, 2006).

A common theme in literature is that abuse is private matter and should be dealt with in the home (Jones, 2006), which is unsurprising considering the ways society has considered women historically (Sandis, 2006). For example, it was not illegal to use violence against one’s wife in the UK until 1891 (Hanmer, 2003). Heath (2003) said the main catalysts for abuse are money, jealousy, housework, friends and children. These suggest that abusive incidents reinforce women’s traditional role in a patriarchal society, implying it is still considered acceptable in modern times to wield power in an abusive manner (Fernandez, 2006).

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FIG 1. THE CYCLE OF VIOLENCE

Source: adapted from Walker (2006)
If we are to find a way of reducing domestic violence, then society as a whole must reconsider how it perceives the rights of women (McHugh and Frieze, 2006).

**Nurses’ Role**

Although domestic abuse was previously considered a social problem and an issue for social care professionals, the government now considers it a healthcare issue. Lavis et al (2005) argued that it could be medicalised by considering it from a health perspective. They said that when women are advised to leave an abusive relationship and do not, they are perceived as ignoring the advice of professionals and of not wanting to escape from the abuse. However, practitioners often give advice that ignores the lack of employment opportunities, as well as the difficulties of living with children in poverty, alone and in danger of stalking and threats. Interestingly, Lavis et al (2005) failed to consider domestic abuse to be a public health problem, guided by the principles of prevention that do not rely solely on medical expertise (NHS Scotland, 2003). Nurses are moving away from a medical model of care towards a biopsychosocial one, in which knowledge of the social and psychological aspects of healthcare considered important as the pathological factors underpinning wellbeing (Naidoo and Willis, 2000).

**Nursing knowledge**

Nursing knowledge can help identify abuse, as nurses’ holistic approach to care means they consider patients’ health and illness as a product of their environment, including their significant others (Fawcett, 2000). This encourages nurses to investigate the underlying causes of ill health. However, many health professionals feel that, if patients are experiencing domestic abuse and desperately need help, they will ask for it (Elliott et al, 2002). In fact, the literature highlights that the barriers are too great and women must be asked directly if they have ever, or are experiencing, domestic abuse (Taket, 2004).

Questioning women who present with indicators of abuse forms the basis of selective screening (Phelan, 2007) (Table 1). However, this relies on health professionals being able to link injuries to abuse, leaving significant room for error. For this reason routine screening, in which all women are questioned about abuse, is more often advocated (Phelan, 2007). This can be implemented in many ways—women could be asked in all settings from acute to primary care, or all those in a specific setting, such as gynaecology, A&E, general practice or the home. These areas cover a number of nursing roles, but there is a lack of specific recommendations in order to implement this for each branch of nursing in research and government reports.

### Routine screening

Peckover’s (2003) qualitative study looked at the experiences of women who had suffered domestic abuse and the care they had received from their health visitors. The women looked back at their situation as a desperate time, filled with a longing to tell someone their story. This suggests routine screening is more effective as it identifies vulnerable people who would have remained undetected using selective screening.

In studies by Lutenbacher et al (2003) and Petersen et al (2003), using the same retrospective design, participants welcomed routine screening. Nonetheless, nurses are reluctant to ask patients about domestic abuse (Doane and Varcoe, 2005). This is unsurprising, especially as government recommendations (NHS Scotland, 2003) involve only a bullet point box with prototype questions, which should not be the extent of preparation in caring for people with such complex problems. Guided by questions, nurses automatically become detached, and the encounter is seen as an opportunity to identify, label and diagnose patients (Doane and Varcoe, 2005).

By developing trust, nurses can understand patients’ needs on their own terms, and by listening, they can pick up clues about particular concerns, keeping the assessment process patient centred. In this way, nurses do not allow themselves or the questions to determine what is significant about domestic abuse (Doane and Varcoe, 2005).

Often it is the more confident practitioners who are able to follow patients’ cues, and education is identified as the factor that most affects confidence levels (Doane and Varcoe, 2005). Hinderliter et al (2003) found that optimal confidence depends on both pre and post registration education, but domestic abuse awareness training does not

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**TABLE 1. INDICATORS OF DOMESTIC ABUSE**

<table>
<thead>
<tr>
<th>Physical</th>
<th>Psychological/emotional</th>
<th>Behavioural</th>
</tr>
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<tbody>
<tr>
<td>Stress related ailments – headaches, irritable bowel syndrome</td>
<td>Depression/anxiety/panic attacks</td>
<td>Fearful, evasive, ashamed, embarrassed</td>
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<tr>
<td>Sexually transmitted infections, vaginal infections</td>
<td>Post traumatic stress disorder – sleep problems, nightmares, tension, fluctuations in mood, feelings of guilt, fear when approaching the place or situations that hold memories of the incident</td>
<td>Use of alcohol and drugs</td>
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<tr>
<td>Chronic pelvic pain, urinary tract infections, pain on intercourse</td>
<td>Self harm</td>
<td>Eating disorders</td>
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<tr>
<td>Miscarriages</td>
<td>Attempted suicide</td>
<td>Frequent use of pain medications</td>
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<tr>
<td>Termination/still births</td>
<td></td>
<td>Presenting with vague symptoms</td>
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<tr>
<td>Low birth weight babies</td>
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<tr>
<td>Fractures to foot</td>
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<tr>
<td>Bruises on body, particularly breasts and abdomen</td>
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<td></td>
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<tr>
<td>Injury to face and neck</td>
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<tr>
<td>Multiple injuries in different stages of healing</td>
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<td></td>
</tr>
<tr>
<td>Burns</td>
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<td></td>
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<tr>
<td>Bilateral injuries</td>
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Sources: adapted from Johansen et al (2006); Taket (2004); Campbell (2002)
exist in the pre-registration curriculum and, in practice, is at the discretion of health boards (Davidson et al, 2000).

**Empathic care**

Generally there is a lack of continuity of care for women experiencing domestic abuse, as there are no definite structures in place to ensure equal standards. Hinderliter et al (2003) found that even with pre and post registration education, there were still barriers for nurses in terms of raising the issue. They suggested this was because nurses perceived abused women to be different from themselves; those unaffected by domestic abuse might look simplistically at the situation and question why women put up with it. But care involves showing empathy and understanding, and working to improve self-esteem. Women need to be able to talk to someone who can give them unconditional positive regard (Doane and Varcoe, 2005).

Hinderliter et al’s (2003) study suggested that, when women return to their abuser, nurses can chastise them and consider them responsible for any subsequent damage to their health. This is counterproductive and contravenes the ethical principles of respect and dignity (British Association for Counselling and Psychotherapy, 2008). In order to properly support women, nurses must be open, connecting and believe they are not different from their patients (Doane and Varcoe, 2005).

**CONCLUSION**

This article has explored the causes of domestic abuse and nurses’ role in ensuring victims are able to access the services they need. Nurses are involved in caring for women who suffer from abuse, and their role is to help prevent and protect them from further maltreatment by offering support, understanding and empathetic care. If nurses can convey that they want to help, women will feel that they have a source of support and are not totally isolated.

**REFERENCES**


British Association for Counselling and Psychotherapy (2008) Ethical Framework for Good Practice in Counselling and Psychotherapy. tinyurl.com/ethical-frame


