How to address domestic violence and abuse

In this article...
- The nature, scope and impact of domestic violence and abuse
- The role of nurses in reducing harm from DVA
- The importance of making every patient contact count

DVA has a considerable impact on health; it is known to result in compromised health over one’s lifetime (Symes et al, 2014). People subjected to DVA often experience acute and life-threatening trauma, as well as post-traumatic mental illness (Ozcan et al, 2014; Devries et al, 2011). Nurses in all settings can play an important role in reducing the ill effects of DVA by detecting it and referring those experiencing abuse to specialist services. This article reviews nurses’ role in dealing with DVA, offers guidance on how to respond to it effectively and safely, and highlights the importance of making every patient contact count in addressing this issue (Public Health England, 2016). It also discusses the impact of DVA on health and wellbeing, how to recognise DVA, and what to do if DVA is suspected or if a patient discloses that there is a problem.

The article addresses four key areas that nurses need to think about in order to deal with DVA: the nature, scope and impact of domestic violence and abuse; the role of nurses in reducing harm from DVA; the importance of making every patient contact count; and the need to prioritise the safety of vulnerable adults and children.

Author
Caroline Bradbury-Jones is reader in nursing at the University of Birmingham; Maria Clark is lecturer in nursing at the University of Birmingham.

Abstract

Domestic violence and abuse (DVA) is widespread and has serious, long-term negative effects on health and wellbeing. These vary depending on the nature of the abuse, but usually encompass anxiety and depression. Each interaction with patients is an opportunity to assess for DVA, and it is vital that nurses know how to do this competently. This article discusses why DVA is such a significant health issue, explores health assessment and safety planning in relation to DVA, and suggests what nurses should do if a patient discloses a problem related to DVA.

It is estimated that, worldwide, almost one-third (30%) of all women who have been in a relationship have experienced physical and/or sexual violence inflicted by their partner (World Health Organization, 2013). The UK Office for National Statistics (2015) reports that the most common types of domestic violence and abuse (DVA) are non-sexual partner abuse (22%), stalking (21%) and sexual assault (20%). They report that women are twice as likely as men to have experienced DVA: in 2015/16 8.5% of women (an estimated 1.4 million) and 4.5% of men (700,000) in England and Wales had experienced abuse. It is important to recognise, however, that DVA can occur between partners irrespective of gender or sexuality (Bradbury-Jones et al, 2014).
Nursing Practice

Review

with DVA effectively. The term DVA is used because it is in line with the terminology widely employed in relevant policy in the UK (National Institute for Health and Care Excellence, 2014).

The impact of DVA on health and wellbeing

DVA can take the form of abuse by a partner or another family member, sexual assault or stalking. It can be described as the infliction of physical, sexual or mental harm, including coercion and arbitrary deprivation of liberty (WHO, 2013). The violent and abusive behaviours occur between those aged 16 or over who are or have been intimate partners or family members (Home Office 2012). Most nurses understand that DVA occurs in many forms and that it often combines physical, sexual, emotional and financial aspects (Taylor et al, 2013), but it is important that they recognise their own role in detecting and addressing it, and bear it in mind during every patient contact.

Risk factors

Women are at increased risk of DVA during the perinatal period; pregnant women are particularly at risk of first-time incidence of abuse or of escalating abuse (Seng and Taylor, 2015). One-fifth (20.4%) of women who participated in a Belgian study experienced some form of DVA in the 12 months before and/or during pregnancy (Van Parys et al, 2014). DVA is also linked to serious adverse foetal outcomes including prematurity birth, low birthweight, stillbirth, perinatal foetal injury and death (O’Reilly et al, 2010).

Disability is also a risk factor; Breckenridge et al (2014) reported that disabled women face particular forms of abuse, such as partners withholding assistive devices or refusing to provide basic care.

Impact on children

Many children live in a home where DVA occurs, and living in such an environment is recognised as harmful to their wellbeing: this harm is often long-lasting (Buckley et al, 2007). The National Society for the Prevention of Cruelty to Children (2016) suggests that a child who witnesses DVA may:

- Become aggressive;
- Display antisocial behaviour;
- Suffer from depression or anxiety;
- Do less well at school than other children, because of the difficulties at home or the disruption caused by moving to and between refuges.

DVA is, therefore, a significant health issue not only for those who experience it directly, but also for any children living in a home where it is occurring. When DVA occurs or is suspected in a situation where children are involved, it is a safeguarding issue.

Who experiences DVA?

Although DVA is disproportionately perpetrated by men against women, this is not always the case; anyone can perpetrate or experience it, so it is crucial to keep an open mind and a non-judgemental stance, and to ensure practice is non-discriminatory (Feder et al, 2011; Murray, 2008; Keeling and Bairch, 2004). Any patient, irrespective of age, gender, sexuality and socioeconomic status, may experience DVA (NICE, 2014), so it is important to bear in mind that many patients whom nurses come into contact with will have experienced, or will be experiencing, DVA.

Integrating DVA assessment into routine care

Clinical assessments are a fundamental aspect of nursing care, and awareness of the indicators and signs of DVA enables nurses to use these assessments as an opportunity to look for signs of DVA. For example, a routine physical examination may reveal physical signs indicating that a patient may have experienced personal assault or intimate (genital) injury; a patient may have difficulty walking, sitting, standing or lying down, depending on the type of injury sustained.

Another sign that should ring an alarm bell is a controlling partner or relative, who may be reluctant to let you see the patient alone or not let the patient speak or make decisions, even when capable of doing so. Patients with a history of frequently seeking medical care for vague or unusual complaints may be trying to make contact and somehow ‘tell’ someone there is something wrong (NICE, 2014).

Box 1 lists questions that can be used to encourage patients to reflect on whether they might be experiencing DVA; replying ‘yes’ to any of these could indicate that they are in an abusive relationship. The questions can also help nurses formulate their own questions about DVA for use in assessments.

Patients often go to great lengths to hide DVA (Bradbury-Jones et al, 2014). They do this for a number of reasons (Rose et al, 2011):

- They experience compounding anxiety, confusion and other mental health difficulties, including fear of being judged;

Boxes

**BOX 1. QUESTIONS FOR PATIENTS AROUND DVA**

- Has your partner tried to keep you from seeing your friends or family?
- Has your partner prevented you from continuing or starting a college course, or from going to work?
- Does your partner constantly check up on you or follow you?
- Does your partner unjustly accuse you of flirting or of having affairs?
- Does your partner constantly belittle or humiliate you, or regularly criticise or insult you in front of other people?
- Are you ever scared of your partner?
- Have you ever changed your behaviour because you were afraid of what your partner might say or do to you?
- Has your partner ever deliberately destroyed any of your possessions?
- Has your partner ever hurt or threatened you or your children?
- Has your partner ever kept you short of money so you were unable to buy food and other necessary items for yourself or your children?
- Has your partner ever forced you to do something that you really didn’t want to do, including sexually?

Source: Adapted from NHS Choices, 2016

> They are worried about having their children removed;
> They are afraid of the consequences of disclosure, such as being subjected to further abuse.

Again, it is necessary to keep an open mind about the possibility of DVA and integrate it into all patient assessments: there may or may not be signs, such as mental distress or general ill-health.

Creating opportunities to discuss DVA

As discussed above, most patients will not spontaneously disclose that they are experiencing DVA, and even when asked about it, most will deny that there is anything wrong happening in their lives (Payne and Wermeling, 2009; Murray, 2008). However, raising it as part of routine care lets them know that the issue is not taboo and that nurses are both willing to help and confident in dealing with it. It makes it all right to broach the subject, sending a signal that the patient can talk openly with a nurse about DVA.

Taylor et al (2013) found that some nurses assumed that women were upset or...
Preserving safety
If a patient discloses DVA or you suspect it might be happening, but there is no immediate threat or danger, then the patient can be signposted to local resources – many clinical areas have posters and leaflets with contact details of local support groups – or national organisations such as Women’s Aid (www.womensaid.org.uk) or Refuge (www.refuge.org.uk). These two organisations jointly run the 24-hour National Domestic Violence Freephone Helpline (0808 2000 247, www.nationaldomesticviolencehelpline.org.uk), which can be a useful source of information and support. Support and advice for men experiencing DVA is available from mensadviceline.org.uk (0808 801 0327), while Refuge also offers advice (bit.ly/RefugeMen). As with other aspects of addressing DVA, care should be taken when providing telephone numbers or leaflets and cards regarding support services; if the perpetrator finds them, this may expose the patient to further abuse.

Disclosure of DVA does not necessarily mean referral to specialist DVA services. Some patients might not wish the disclosure process to go any further, so clinical judgement should be exercised when deciding whether or not to respect this wish, particularly if children are involved. Nurses have an ethical duty of care and may need to make difficult decisions about sharing patient information in a crisis situation.

Local safeguarding guidance on preserving patients’ right to confidentiality should be followed, but nurses need to be able to recognise when concerns about patient, family or public safety may supersede the patient’s right to confidentiality. In an emergency, it is crucial to act swiftly to identify and protect those most at risk of harm, act as the patient’s advocate and prioritise the safety of vulnerable adults and children. It may be necessary to refer the case to a more senior person or designated nurse or to specialist services. So, accurate record keeping is crucial to ensure all relevant details are passed on and to provide evidence if necessary for legal or safeguarding processes.

Separation from the abusive partner does not necessarily equate to safety; the post-separation period is, in fact, an extremely high-risk time for women and children (Nikupeteri et al, 2015). Part of nurses’ role after disclosure is to assess the respective risks involved if the patient exits or remains in the abusive relationship, and be able to address either scenario.

DVA rarely presents a stand-alone risk to patients and is often accompanied by compounding issues, such as mental health problems and substance misuse. This calls for cross-sector collaboration. NICE (2014) produced guidance for multi-agency working to reduce the ill effects associated with DVA. The Nursing and Midwifery Council code (2015) suggests nurses should work more closely with patients and other disciplines and/or agencies to make good clinical decisions for individual and family health. It highlights the issue of missed clinical opportunities to promote collaborative care in safeguarding children and adults from life-threatening abuse, both in institutional and domestic informal care contexts. Therefore, nurses must seek out and apply local safeguarding advice and refer to the appropriate agencies for follow-up care.

Collaborative whole-system approaches are more likely to reduce the

### TABLE 1. NURSES’ ROLE IN DEALING WITH DVA

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<thead>
<tr>
<th>Understanding DVA and its impact on health and wellbeing</th>
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<tbody>
<tr>
<td>Be aware of the different forms of DVA and of its considerable impact on health</td>
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<tr>
<td>Remember that anyone can be a victim of DVA regardless of age, gender, sexuality and socioeconomic status</td>
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<tr>
<td>Keep an open mind and avoid making judgements based on stereotypes</td>
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<tr>
<td>Bear in mind that DVA also affects children who witness it</td>
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<tr>
<th>Integrating DVA assessment into routine care</th>
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<tr>
<td>Be aware of the signs of DVA, whether physical, emotional or psychological</td>
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<td>Look out for these signs during clinical assessments</td>
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<tr>
<td>Remember that, in many patients, there will be no visible signs of DVA</td>
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<tr>
<td>Bear in mind that many patients will be reluctant to disclose or talk about DVA</td>
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<th>Creating opportunities to discuss DVA with patients</th>
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<tr>
<td>Be prepared to discuss DVA as part of routine care</td>
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<td>Signal to your patients that it is all right to talk about DVA and that you are willing and able to help</td>
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<tr>
<td>Make sure you discuss DVA sensitively and in a safe environment</td>
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<td>If necessary, create an opportunity to see the patient alone</td>
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<th>Preserving patient and family safety, preserving oneself</th>
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<tr>
<td>Signpost patients to available resources (in non-urgent cases)</td>
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<td>Put in place safety planning where needed</td>
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<td>Take prompt action if a patient or child is at immediate risk</td>
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<td>Seek out and follow local safeguarding guidance</td>
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<tr>
<td>Use your clinical judgement to balance patient confidentiality against the safety of all involved</td>
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<tr>
<td>Refer to a more senior person or delegated nurse if necessary</td>
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<tr>
<td>Collaborate with other disciplines and/or agencies</td>
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<tr>
<td>Seek supervision and peer support to maintain your own wellbeing</td>
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insulted when asked about DVA. However, there is evidence that women are not offended (Bradbury-Jones et al, 2014) and that they expect to be asked about incidents and patterns of abuse. While screening for DVA is not recommended because there is insufficient evidence that it is effective as an intervention (Spiby, 2013), asking about it is recommended and ‘should be a routine part of good clinical practice’ (NICE, 2014).

Bradbury-Jones et al (2016) suggest a practice-based framework for nurses to undertake what they term ‘crucial conversations’ about abuse. These conversations involve nurses talking with patients about the difficult and sensitive issue of DVA. However, it is crucial that conversations around DVA take place in an appropriate and safe environment. It would never be appropriate to discuss the issue in the presence of the patient’s partner, and it may be necessary to create an opportunity to see the patient alone before raising the issue. Taking a patient discreetly to one side can be one way of creating a safe space for discussion.
likelihood of harm from DVA, but professional barriers and resistance to change may impede progress. Turner et al (2015) found that training programmes on DVA for health and social care professionals (including nurses) improved participants’ knowledge, attitudes and clinical competence for up to a year after delivery. Access to specialist DVA practitioners, interactive discussions and booster sessions were key to the success of these programmes, which provided a means of overcoming professional resistance to engaging in DVA interventions.

Practitioners’ safety and wellbeing

Addressing DVA is associated with emotional labour (Taylor and Bradbury-Jones, 2011). The NSPCC (2013) warns that vicarious trauma, compassion fatigue and burnout are considerable threats, and argues that if the emotional consequences of this work are not mitigated, professionals’ wellbeing and ability to work effectively will be affected. There is an argument that to empower others they first have to be empowered themselves. In striving to support abused patients, nurses must first keep themselves safe emotionally; self-care is vital. One way to manage vicarious trauma is through rigorous supervision and peer support (NSPCC, 2013). Clinical supervision may offer peer support and ‘restorative practice’ opportunities to help nurses build their capacity and resilience (Wallbank, 2013).

Conclusion

All nurses have an important role in addressing DVA. Table 1 sums up some key aspects of this role. Nurses need to recognise the prevalence of DVA and be more knowledgeable and aware of its presentation. DVA is not always physically visible or immediately life-threatening, but clinical assessment may reveal wider patterns of abuse or detect a patient’s vulnerability to escalating or compounding violence. DVA assessment must be incorporated into ‘top-to-toe’, routine health assessment in general and specialist nursing practice. If patients disclose DVA, steps need to be taken to preserve the safety of the individual and other family members, particularly children.

Engaging patients in crucial conversations about their health and wellbeing is a fundamental aspect of nursing practice. To do this well, nurses need to strengthen their ability to undertake sensitive conversations while working proactively and collaboratively with other agencies, in order to optimise the safety of patients and families entrusted to their care. Nurses need to make every contact with patients count in the general effort to reduce harm from DVA. NT

References


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