## Domestic violence: responding to the needs of patients

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### Summary

Victims of domestic violence have increased contact with healthcare services, but may not always be identified as experiencing abuse. Guidelines advocate that healthcare professionals should enquire about abuse and receive training on how to respond appropriately to any disclosures. This article examines how improved identification and response to domestic violence by healthcare staff can improve care for patients.

### Authors

Kylee Trevillion, researcher in women's mental health, Institute of Psychiatry, King's College London; Roxane Agnew-Davies, clinical psychologist and director of Domestic Violence Training Ltd, Surbiton, Surrey; and Louise Michele Howard, professor in women’s mental health and head of section of women’s mental health, Institute of Psychiatry, King’s College London. Email: kylee.trevillion@kcl.ac.uk

### Keywords

Domestic violence, intimate partner violence, patient welfare, risk assessment

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### Aims and intended learning outcomes

The aim of this article is to assist nurses in identifying and responding effectively to domestic violence. The article recognises the trauma experienced by some patients and focuses on key skills that professionals can develop to address patients’ needs. After reading this article and completing the time out activities you should be able to:

- Recognise the physical, sexual and psychological effects of domestic violence.
- Identify potential barriers to an effective response to domestic violence and consider ways to overcome them.
- Offer key messages in response to patient disclosures and conduct a simple risk analysis towards helping develop safety plans.
- Identify pathways of support for patients who are experiencing domestic violence.

### Introduction

The Royal College of Nursing (RCN) (2000) guidance on domestic violence states that, for nurses to meet the needs of women who have been abused, they should receive appropriate education and become knowledgeable about sources of referral. In 2003, the RCN established the Women’s Mental Health Group, with the aim of promoting and supporting gender-sensitive mental health nursing. One of the key principles put forward by the group is that women receive support from staff who are competent in identifying signs of abuse and who have the ability to assess and prioritise patients’ safety. These recommendations have been developed in response to increasing evidence of the high prevalence of domestic violence incidents among health service users.

The intimate relationship between the perpetrator and recipient means that the violence is often more frequent and severe than other forms of victimisation (Kropp et al 2005). Findings from the British Crime Survey estimate that around 3,500,000 people experience domestic violence in England and Wales per year, and that two women a week are killed by a partner or ex-partner (Nicholas et al 2005).
When examining gender differences in incidents of abuse, evidence suggests that women are more likely to experience frequent and severe assaults and report greater fear for their lives compared with men (Finney 2006, Howard et al 2010a). Around 89% of people who are subjected to four or more domestic violence assaults are women (Nicholas et al 2005). Women are sexually assaulted by a partner approximately seven times more often than men (Povey et al 2008). Furthermore, 40% of females are killed by their partner or ex-partner, compared with 7% for males (Povey 2005). Despite gender differences, it is important to note that men also experience domestic violence and both men and women should have access to appropriate support.

### Time out 1

How would you define domestic violence? Discuss this with a colleague and identify all the behaviours that you would characterise as being abusive.

### Time out 2

Which of the following are warning signs that a patient may have been abused by his or her partner? Tick all that apply.
- Chronic unexplained pain.
- Post-traumatic stress disorder.
- Substance abuse.
- Frequent injuries.
- Depression.
- Anxiety.

### Defining domestic violence

Although there is no universally agreed definition of domestic violence, it is generally accepted as the use of coercive control within an intimate or family relationship (Stark and Flitcraft 1996). The Home Office (2006) defined domestic violence as ‘any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality’.

### Physical abuse

Abuse of this nature includes behaviours such as:
- Hitting, pushing or kicking.
- Burning.
- Throwing objects.
- Stabbing or shooting.
- Sleep deprivation.

### Sexual abuse

This type of abuse is characterised by behaviours such as:
- Rape.
- Forced prostitution and pornography.
- Cutting or disfiguring of genitalia.
- Refusal to practise safe sex.
- Refusal to adhere to religious prohibitions.

It is estimated that between 10% and 14% of married women have experienced forced sex by an intimate partner (Martin et al 2007).

### Emotional or psychological abuse

Psychological abuse includes controlling or dominant behaviours and humiliation or degradation of the victim. Individuals tend to experience both poor physical and mental health. Abuse can take the form of verbal and non-verbal behaviours such as:
- Unremitting criticism.
- Threats of harm.
- Emotional blackmail.
- Enforcement of petty rules.
- Neglectful behaviours such as ignoring signs of distress and pleas for comfort, or prolonged refusal to communicate.

Perpetrators may seek to prevent those who are being abused from gaining employment and restrict their social activities. Stalking behaviours – defined as repeated and malicious following, harassment or threats – are also common, and victims are at increased risk of being stalked following separation (Melton 2007). Within a healthcare setting, the insistence of a partner, parent or carer to attend every healthcare appointment, be present at all
Domestic violence may be associated with a range of physical injuries, including fractures, contusions, lacerations, and maxillofacial and ocular injuries (Campbell 2002, Besant-Matthews 2006, Sheridan and Nash 2007). Injury following choking and strangulation is also commonly reported, along with internal injuries (Campbell 2002). Research suggests that physical abuse is a major cause of injury among women, with between 19% and 55% reporting some form of violent injury in their lifetime (Ellsberg et al 2008). Gynaecological problems are the longest lasting and largest physical health difference between women who are physically abused and those who are not (Ellsberg et al 2008). Problems include recurring pelvic pain and sexually transmitted infections, and human immunodeficiency virus (Jewkes et al 2002). Adverse pregnancy outcomes are also associated with domestic violence, including placental separation, fetal fractures, miscarriage and premature labour. The most serious outcome is the death of the mother or fetus (Jejeebhoy 1998, Parsons and Harper 1999).

Domestic violence is associated with numerous psychological consequences, including anxiety, depression, post-traumatic stress disorder and self-harming behaviours (Golding 1999, Boyle et al 2004). It may lead to the development of mental health problems and exacerbate existing illnesses (Golding 1999, Howard et al 2010b). Research shows that mental health problems increase with greater exposure to violence and reduce when violence ceases (Golding 1999). Box 1 outlines a variety of physical and psychological effects of domestic violence.

There are no distinct patterns of injury that reliably predict domestic violence (Boyle et al 2004). One of the most significant predictors therefore is repeated attendance at healthcare services (Fanslow et al 1998). Victims of domestic violence have increased contact with healthcare services compared with the general population (MacMillan et al 2006). Research estimates that 41% of people in contact with general practices, at least one in five people in contact with emergency services and up to six in ten psychiatric inpatients have experienced domestic violence (Feder et al 2009, Howard et al 2010b).

Responding to domestic violence

Despite increased service use, healthcare professionals often fail to identify victims of domestic violence. This finding is noteworthy because patients may not have direct contact with any other services or may experience difficulties accessing help, for example language barriers. International research suggests staff working
queried whether identification of domestic violence was part of their role (Rose et al 2010) (Figure 1).

However, guidance from the Department of Health (DH) (2004) advocates routine enquiry and recommends that healthcare professionals receive training on how to approach the subject and respond to patient experiences of abuse.

Healthcare professionals’ concerns about time constraints and competing demands hindering enquiry should be considered in light of findings that suggest people experiencing domestic violence present more frequently to healthcare services than the general population (MacMillan et al 2006). Therefore, if healthcare professionals incorporate time to explore patients’ experiences of abuse they may reduce the need for further visits.

Professional barriers to enquiry

Interviews with healthcare professionals working in a variety of settings identified that a lack of confidence and expertise in dealing with domestic violence, fears about offending patients and workload priorities often act as barriers to enquiry (Agar et al 2002, Minsky-Kelly et al 2005). The authors’ research with mental health professionals reported similar findings and some professionals queried whether identification of domestic violence was part of their role (Rose et al 2010) (Figure 1).

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Patient barriers to disclosure

In contrast to healthcare professionals’ concerns about broaching the subject of domestic violence, patients report feeling comfortable with questioning and suggest that enquiry often assists disclosure (Feder et al 2006, Rose et al 2010).

The authors found in their research that all patients, irrespective of whether they had experienced abuse, found enquiry to be

![FIGURE 1](https://via.placeholder.com/150)

**FIGURE 1**

Professional barriers to enquiry of domestic violence

- Personal discomfort with the topic
- Lack of confidence in approaching the subject
- Too complex an issue
- Domestic violence not a priority
- Importance of engagement between client and professional
- Limited opportunity for enquiry
- Presence of partner
- Time constraints
- Competing demands
- Questioning if there is evidence that asking is helpful
- Lack of knowledge/expertise about domestic violence
- Enquiry not part of their role
- No indication of violence
- Focus on symptoms
- Dominance of the medical model
- Gender
- Culture
- Fear of consequences
- Fear of retraumatisation
- Fear of offending

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acceptable (Rose et al 2010). Similar views have been expressed among most patients in contact with primary healthcare and maternity services (Bacchus et al 2002, Ramsay et al 2002).

As previously mentioned, patients may find it difficult to disclose abuse in the absence of direct questioning from healthcare professionals. Barriers identified by patients include fear of further violence if the perpetrator becomes aware of the disclosure, shame and embarrassment and fear that children may be removed from their care (Figure 2) (Feder et al 2006, Rose et al 2010). Research by the authors found that patients may also find it difficult to identify their experience of abuse, as perpetrators seek to deny and cover up the violence. Some patients also stated that because of the traumatic nature of their experiences they put the abuse to the ‘back of their mind’ (Rose et al 2010). In these instances, a discussion about domestic violence can be vital in raising patients’ awareness of abuse and may also help healthcare professionals address any trauma.

Addressing barriers to provide an effective response

Healthcare professionals can help patients overcome barriers to disclosure by employing simple techniques that seek to challenge self-blaming behaviours and feelings of shame. By creating a supportive therapeutic relationship with the patient they can encourage disclosure (Rose et al 2010). One of the key ways in which healthcare professionals can encourage patient disclosure is through direct enquiry (Freund et al 1996). However, enquiry alone is not sufficient to improve patient outcomes (Ramsay et al 2002). Enquiry can lead to adverse consequences for patients if clinicians are not adequately trained about domestic violence. Healthcare professionals should be trained to enquire about abuse in a sensitive and safe manner and identify clear pathways of referral (Box 2). Recent DH (2010) guidance highlights the importance of education and training in raising healthcare professionals’ awareness about the health implications of domestic violence and ensuring that patients are appropriately referred.
**Assisting enquiry about domestic violence**

Key phrases that introduce the topic of enquiry about domestic violence can be readily incorporated into clinical meetings and can be used to challenge feelings of embarrassment. Introducing the subject of abuse may make patients aware that healthcare professionals are willing to explore this area and reduce feelings of shame, embarrassment and self-blame (Rose et al 2010). Box 3 identifies some key phrases for enquiry.

To improve cross-cultural communication healthcare professionals should employ non-psychological terms when asking about experiences of abuse. The LEARN model (Berlin and Fowkes 1983) also outlines strategies of good practice, including:

- Listen to the patient’s perspective.
- Explain and share your own view.
- Acknowledge differences and similarities between the two views.
- Recommend a specialist immigration support service where appropriate.
- Never accept culture as an excuse for domestic violence. Everyone deserves the right to be safe in their own home.

Healthcare professionals can alleviate patients’ concerns about the repercussions of a disclosure by assuring them that discussions will remain confidential and not be reported back to the perpetrator. They can challenge self-blaming attitudes among patients by explaining that the perpetrator is solely responsible for any abuse or violence and that the patient is not to blame (Box 4). These techniques can demonstrate to patients that healthcare professionals are responsive to their experiences and can allow individuals to explore the trauma associated with abuse, without fear of being blamed.

Interviews with patients experiencing domestic violence have reported the positive value of discussions with healthcare professionals, which explore the link between violence and poor health outcomes (Rose et al 2010). However, many patients report that the dominance of the medical model results in healthcare professionals focusing predominantly on diagnosing and treating symptoms and overlooking underlying factors that contribute to the individual’s current presentation (Humphreys and Thiara 2003, Rose et al 2010). Some have warned that an overriding focus on symptomatology can run the risk of medicalising the trauma and consequently may exacerbate feelings of self-blame (Humphreys and Thiara 2003). Therefore, supportive and non-judgemental responses to disclosures are crucial in ensuring that patients feel safe to discuss their experiences. By offering information about domestic violence services, healthcare professionals can educate patients about available options and empower them to take control of the situation.

**BOX 2**

**Key considerations for ensuring patient safety**

- Always see patients alone when discussing potential experiences of abuse. It is not safe to enquire in the presence of partners and family members, who may be the perpetrators or report back to the perpetrator.
- If patients require translation services, professionally trained interpreters should be used, not family members or friends who may monitor the conversations to ensure a disclosure is not made.
- Do not try to force disclosure. Patients might not be ready to disclose during a first meeting, but repeated enquiry allows them the opportunity to disclose when they are ready.
- Do not provide patients with any written information to take home unless it is safe for them to do so, as the perpetrator may find this information.
- Conduct a simple safety assessment to determine level of risk to patients.
- Have information available for patients to identify sources of support and help them make confidential contact with services if desired, for example allow them access to a private room with telephone facilities.

**BOX 3**

**Key phrases for enquiry**

- Are you ever afraid at home?
- Has your partner ever hit you?
- Do you ever feel you have to go along with sex to keep the peace, or does your partner refuse to take no for an answer?
- We know that one in four women experience domestic violence and that it affects their physical and mental health. Has anyone hurt or frightened you at home?

**BOX 4**

**Key phrases for responding to disclosures**

- I am willing to listen and glad that you told me.
- The perpetrator is responsible for his or her actions; the abuse is not your fault.
- There is help available that I can help you access.
- What do you need?
Safety
Ensuring the safety of patients experiencing domestic violence is always a priority and healthcare professionals need to ask if it is safe for patients to return home (Box 5). Full recovery can only occur when the person’s safety is assured. However, professional support is important at any stage, and should never be withheld. When managing the safety of patients, healthcare professionals should focus on increasing the victims’ choices and provide support to promote safety.

Documentation
As discussed earlier, healthcare professionals may not always document patient disclosures of abuse. However, documentation can help to protect victims and their children, particularly if the violence leads to court reports being filed.

Time out 3
Plan a sentence that you could say in response to a person who has experienced domestic violence and makes the following statements:
› ‘I cannot leave.’
› ‘I should stay for the sake of the children.’
› ‘I provoked him, I deserved it.’
› ‘It’s his childhood, he grew up in a violent home.’
› ‘Why me? I just go from one abusive relationship to another.’

Time out 4
Read the scenario below and consider what kind of information you would document about this patient’s experience of abuse:
You have seen Gemma, a 46-year-old white British woman who has been married for 26 years and has two children. She attends the appointment alone and asks how long the session will last, as she needs to call her husband to tell him when she will return home. Gemma tells you that she is feeling increasingly depressed and spends the majority of her days in bed. She has bruising on her arms and when you ask where the bruising has come from she says that sometimes her husband becomes heavy-handed when he has been drinking.

Writing down the information given by a patient about domestic violence is an important aspect of treatment, because:
› It shows that the healthcare professional listened and takes domestic violence seriously.
› These records can protect victims by helping them access legal rights.
› The healthcare professional’s duty of care may be met if there is a domestic homicide review, which is required by the Domestic Violence, Crime and Victims Act 2004.
› Notes may play a crucial role in ensuring the victim’s safety. Many housing agencies will accept a woman’s application to be re-housed safely if she can produce evidence from a healthcare professional.
› It may help the individual to access welfare rights, now or in the future.

When documenting disclosures of domestic violence, healthcare professionals should note any injuries or symptoms observed and describe factual information provided. It is also worthwhile to report answers to questions in the patient’s own words and make a record of any actions taken, such as details of a referral.

Identifying pathways of referral
Following identification and documentation of domestic violence, professionals should explore...
with patients various sources of support. Good practice guidelines (DH 2010) recommend that professionals make themselves aware of local and national domestic violence services and pass this information on to patients.

**Conclusion**

Healthcare professionals can support the needs of patients subjected to domestic violence by implementing three key steps: ask, record and respond. Healthcare professionals can encourage patient disclosures, and alleviate feelings of shame, self-blame and isolation, by creating a supportive and non-judgemental environment that is open to discussing the nature and effect of abuse. By documenting disclosures, professionals show patients that they take incidents of domestic violence seriously and these records can be used to secure access to legal assistance, support housing and resettlement.

**References**


learning zone domestic violence

claims. If healthcare professionals are able to provide patients with information on domestic violence services and other sources of support they can reduce patients’ risk of harm and improve their physical and psychological wellbeing NS

USEFUL RESOURCES

- Refuge www.refuge.org.uk
- Women’s Aid www.womensaid.org.uk
- Men’s Advice Line www.mensadvice-line.org.uk
- Mankind Initiative www.mankind.org.uk

Time out 6

Now that you have completed the article, you might like to write a practice profile. Guidelines to help you are on page 60.


