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Responding to intimate partner violence in health care settings

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Abstract

Intimate partner violence is a significant health and social care issue. Nurses, midwives and other health care professionals, by virtue of their role, are more likely to come in contact with victims of IPV especially those seeking health care services to manage the impact of intimate partner violence. Therefore, they can play a very useful role in identifying and managing intimate partner violence by providing person centred care to victims of intimate partner violence. It is important for nurses, midwives and other health care professionals to understand the complex phenomenon of intimate partner violence. This article provides an overview of intimate partner violence, its forms, presentation and impact on the physical and psychological health of the victim. Factors also explored that may help or hinder nurses and other health care professionals' ability to identify, respond and appropriately manage IPV victims in health care settings.

Responding to intimate partner violence in health care settings

Aims and Intended Learning Outcomes

This article explores intimate partner violence (IPV), its impact on the physical and psychological health of the victim, its presentation and management in health care settings. The article will also explore factors that may help or hinder nurses and other health care professionals' ability to identify, respond and appropriately manage IPV victims in health care settings. More specifically, after reading this article and completing the timeout activities, you should be able to:

- Define intimate partner violence (IPV) and identify various forms of IPV.
- Describe the impact or effects of IPV on victims and their families.
- Discuss the complexity of possible presentations of IPV across a range of clinical environments.
- Understand the factors that may impact on the ability and safety to disclose IPV and how these may be addressed.
- Identify the possible actions that may occur as a result of a disclosure of IPV.

Introduction

Domestic violence and abuse (DVA) is defined as 'any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse among those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality' (United Kingdom Home Office, 2013). This definition also encompasses acts of 'honour' based violence, female genital mutilation (FGM) [cutting] and forced marriage. DVA is a complex issue and can manifest itself in several forms including child abuse, elder abuse and intimate

partner violence (IPV). IPV remains one of the most prevalent forms of DVA and one that health care professionals, including nurses and midwives, may encounter regularly. Therefore, nurses and midwives need to develop their knowledge and awareness about IPV. In fact, IPV is associated with child abuse and can be masked and presented as elder abuse later in life (McGarry, Simpson, & Mansour, 2010). It is well established that IPV affects a significant number of individuals and families worldwide and intersects cultural, religious, gender and ethnic boundaries. It can occur in marital, cohabiting, heterosexual as well as same sex relationships (Baker, Buick, Kim, Moniz, & Nava, 2013; Ali, Dhingra, & McGarry, 2016b), as demonstrated by the data from the Crime Survey of England and Wales (CSEW) in Figure 1 (Office for National Statistics, 2015).

Insert Figure 1

Historically, IPV was considered to be perpetrated by men against women; however, there is a growing recognition that women can also perpetrate IPV against their male or female intimate partners (Capaldi, Kim, & Shortt, 2007; Hines & Douglas, 2013). Nevertheless, the number of women victims of IPV, sustaining serious injuries (Caldwell, Swan, & Woodbrown, 2012; Howarth, Feder, Howard, Agnew-Davies, & Feder, 2013) or losing their lives is much higher than men (Hamberger & Larsen, 2015). Men, as current intimate partners or ex-partner, remain the most common perpetrators of IPV. On the other hand, men are more likely to experience violence by strangers or acquaintances. There are many different terms that have been used to refer to IPV and you will find it useful to reflect on your awareness and understanding of different terms used to describe IPV over past few decades.

Complete activity one

Form of IPV

IPV may result in physical, psychological and sexual harm to the victim and may manifest in several forms, including physical assault, sexual coercion, psychological abuse and controlling behaviours (World Health Organisation, 2014). Examples of physical IPV include beating, kicking, slapping, pushing, shoving, dragging, biting, stabbing, scratching, hitting with or without a weapon, nursing, choking, threatening or using a gun, knife or any other weapon to cause physical suffering to the victim (García-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005; Ali, McGarry, & Dhingra, 2016a). Psychological IPV, on the other hand, refers to use of behaviours to insult and control an intimate partner. Examples of psychological IPV may include criticising, name calling, blackmailing, blaming, threatening to beat victim or their children, restricting victim's movement, stalking, restricting access to health and social care, family and friends, humiliating and belittling the victim in public or private (Follingstad & DeHart, 2000; WHO, 2002). Sexual IPV can take the form of forcing sexual acts, coercing a partner into sexual acts, making unwanted sexual comments, forcing a partner to perform or engage in sexual acts that they find unacceptable, degrading or humiliating (García-Moreno et al., 2005). A specific characteristic of IPV is the presence of coercive control that has been attempted to define specifically more recently. In fact, coercive control is now a reportable offence involving various acts designed to make a person subordinate by isolating them, depriving them of support and independence, exploiting their resources and capacities for personal gain, criticising and/or regulating their everyday behaviour (United Kingdom Home Office, 2013).

Available research evidence suggests that IPV victims may experience various forms of violence simultaneously. For instance, physical IPV often occurs with sexual and emotional IPV. A multi country study conducted by the World Health Organization (WHO) (García-

Moreno et al., 2005) revealed that 23-56% of women reported experiencing physical as well as sexual IPV at the same time. Similarly, another study (Bott, Guedes, Goodwin, & Mendoza, 2012) using data collected for Demographic Health Survey (DHS) from12 Latin American and Caribbean countries revealed that 61-93% of the women reported physical as well emotional abuse during the past year (at the time of data collection).

Complete activity two

Prevalence of IPV

It is now recognised that IPV is prevalent in all communities, ethnic and religious groups across the world (van der Wath, van Wyk, & Janse van Rensburg, 2013). Despite this, knowing actual global and even the national prevalence of IPV is extremely difficult due to various reasons including, for example, under reporting, inconsistent definitions and a lack of epidemiological or exploratory studies (Wong & Mellor, 2014). In the UK, according to the reports of the CSEW, approximately 30% of women and 17% of men between the ages of 16 and 59 experience IPV (Office for National Statistics, 2015). International evidence suggests that every third woman experiences IPV at some point in their life and that IPV prevalence ranges from 25% to 37% across various WHO regions (Wathen, MacGregor, & MacQuarrie, 2016).

Reporting the prevalence of IPV during pregnancy varies and according to the WHO (García-Moreno et al., 2005) ranges between 1% in Japan city to 28% in Peru province. Analysis of DHS survey data from 19 countries reported a prevalence of IPV during pregnancy, ranging from 2% in Australia, Cambodia, Denmark, and Philippines to 13.5% in Uganda (Devries et al., 2010). Another systematic review of studies from Africa reported a prevalence of IPV during pregnancy, ranging from 2-57% (Shamu, Abrahams, Temmerman, Musekiwa, & Zarowsky, 2011). However, evidence also suggests that higher rates of IPV are reported in health care settings (World Health Organisation, 2013) as the victims may require health care

services as a result of IPV experiences. This indirectly highlights the need for health care professionals and especially nurses and midwives to understand IPV, its various forms and presentation to enable them to respond to their patients' needs effectively.

Complete activity three

Impact /side effects of IPV

IPV is associated with serious psychological as well as physical side effects on not only the victim, but others in the family such as children. According to World Health Organization (2013), there are three key mechanisms and pathways that can explain side effects or health impact of IPV (Figure 2). Approximately 42% of women who experience physical or sexual IPV sustain injuries as a result (World Health Organisation, 2013).

The examples of minor physical effects may include cuts, punctures, bruises and bites. Severe injuries may result in permanent disability (e.g. loss of limb, hearing loss, damage to teeth). Victims of violence report higher rates of poor health, compromised ability to walk, pain, vaginal discharge, loss of memory and dizziness and self-harm compared to those who do not (Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008; Vung, Ostergren, & Krantz, 2009). Other examples of the impact of sexual IPV include unwanted pregnancy, miscarriage, sexually transmitted infections (STI) and other gynaecological problems (Casique & Furegato, 2006; Black, 2011).

Psychological effects of IPV may include fear, depression, low self-esteem, anxiety disorders, depression, headaches, obsessive-compulsive disorder, post-traumatic stress disorder, low self-esteem, disassociation, sleep disorders, shame, guilt, self-mutilation, drug and alcohol abuse and eating disorders. Psychological consequences may also manifest through psychosomatic symptoms, sexual dysfunction and eating problems (Plichta & Falik, 2001; Romito, Molzan Turan, & De Marchi, 2005). In addition, IPV can have fatal consequences for victims resulting

from homicide or suicide (Black, 2011). It is important to note that consequences related to mental health and substance abuse may be a direct result of any of the three mechanisms resulting in increased health risks. However, "mental health problems and substance use are not necessarily a precondition for subsequent health effects, and will not always lie in the pathway to adverse health" (World Health Organisation, 2013, p. 8). Similar side effects are reported by victims of female perpetrated violence (with exception to gynaecological symptoms) or those in a same sex relationship.

Complete activity four

IPV Recognition in Health Care Settings

Healthcare professionals, especially nurses and midwives working in any health care settings, can play a crucial role in identification, prevention and management of IPV (NICE, 2014) as they may regularly encounter IPV victims, who visit health care settings (Houry et al., 2008). Women victims of physical abuse are more likely to use health care settings such as mental health, emergency department, hospital outpatient, primary care, pharmacy, and specialty services (Bonomi, Anderson, Rivara, & Thompson, 2009; García-Moreno et al., 2015). Nurses are integral to the health care workforce in these settings and may have most frequent and prolong contact with such patients. They need to have sufficient understanding of IPV, its presentation, its impact on victims and others. This may help them distinguish between injuries resulting from IPV or other causes and provide person centred, sensitive and empathetic care to IPV victims.

Nurses, midwives and other health care professionals are not always prepared to deal with IPV victims (Sundborg, Saleh-Stattin, Wandell, & Tornkvist, 2012). Nurses, midwives and other health care professionals are not always empathetic and may blame the victim for abuse (Yam, 2000). Victims also feel that health care professionals do not show concern, and miss

opportunities to ask about IPV during health care encounters (Yam, 2000) even when IPV is obvious (Bradley, Smith, Long, & O'Dowd, 2002). On the other hand, it has been suggested that nurses, midwives, and health care professionals should routinely screen (Houry et al., 2008) for at least all suspected victims of IPV (Waalen, Goodwin, Spitz, Petersen, & Saltzman, 2000). There is no consensus about screening – although there is routine screening in some areas e.g. maternal health.

Complete activity five

In addition to lack of knowledge and understanding of IPV, there are many barriers to appropriate identification, detection and management of IPV in health care settings (Hugl-Wajek, et al.,Hugl-Wajek, Cairo, Shah, & McCreary, 2012). For instance, physicians, nurses, midwives and other health care professionals may not be confident and prepared to deal with victims of IPV (Gerbert et al., 2002; Gutmanis, Beynon, Tutty, WathenC, & MacMillan, 2007; Hugl-Wajek et al., 2012). A recent review of available evidence (Ali, in press) suggests that factors affecting IPV identification and management can be divided into three categories:

- Victims ability to disclose IPV
- Practitioner ability to explore IPV
- Workplace/ organisational support

Victims' Ability to Disclose IPV

There are many factors affecting an IPV victim's ability to disclose IPV. To be able to disclose IPV experiences, a victim need to be able to recognise and acknowledge their experiences of IPV. Not recognising IPV is often the biggest barrier in disclosing IPV to nurses, midwife or other healthcare professionals. Accessing a health care service due to the impact of IPV can be very challenging as victims may experience feelings of shame, embarrassment,

helplessness and hopelessness. It may not be easy for a victim to disclose their experiences of abuse to health care professionals who may appear to be very busy and rushed. Such disclosure becomes even more difficult if the patient (victim) is accompanied by the perpetrator, their family member and children. In addition, health care settings where provision of privacy is often difficult, adds to the complexities of the situation (Kramer, Lorenzon, & Mueller, 2004). One such setting is the Emergency Department where availability of time and provision of privacy can be extremely difficult (McGarry & Nairn, 2015). However, other settings may also have specific challenges. For instance, it may equally be difficult to disclose IPV in one's own home during a nurse, midwife, lady health visitor or health care professionals visit due to the presence of other family members or partner (perpetrator). Not knowing whom to ask for help or whether health care professionals could help may also have an impact on the victim's ability to disclose their IPV experiences. Many victims may also fear perceived negative consequences (such as my children will be taken away by social services). Spending time with the client to develop rapport and trust may help the patient/victim become more comfortable with their nurse or other care provider and consequently may facilitate IPV disclosure. In addition, provision of appropriate and private environment and respecting patients/victim's autonomy, and decisions may help in improving patients' confidence to disclose their IPV experiences (Ali et al., 2016a).

Practitioner's ability to explore/ probe

There are many factors affecting the practitioners' (nurse, midwife, health care professional) ability to identify and explore IPV. An understanding and knowledge of IPV, its manifestations and complexities is necessary for nurses, midwives and other health care professionals. A lack of knowledge and understanding of this acts as a hurdle to the identification of IPV(Al-Natour, Qandil, & Gillespie, 2016). Another important aspect is personal attitudes, views and perspective of health care professionals, including nurses and

midwives 'about IPV and its causes (Ramsden & Bonner, 2002; Gutmanis et al., 2007; Ramsay et al., 2012). Awareness of personal attitudes and views about IPV may help practitioners deal with their patients (victims as well as perpetrators) in a non-judgmental manner. Lack of attentiveness and lack of empathy that may act as barriers to IPV identification, detection and management in health care settings (Bradley et al., 2002; Ramsden & Bonner, 2002; Kramer et al., 2004; Ramsay et al., 2012). The practitioner's ability to spend time with the patient/victim and to develop trust and rapport is important as this enables victims to open up and disclose their IPV experiences. In addition, knowledge and awareness of referral pathways to other agencies and organisation working to support IPV victims is essential. Considering this, providing appropriate education and training to enable practitioners' ability to ask appropriate questions to identify IPV competently and confidently is crucial (Ritchie, Nelson, & Wills, 2009; Ramsay et al., 2012).

Workplace/organisational support

In addition to patient/victim and health care professionals related factors, there are some organisational or workplace related factors that affect IPV identification, detection and management practices of nurses, midwives and other health care professionals in their respective organisations (Al-Natour, Gillespie, Felblinger, & Wang, 2014; Al-Natour et al., 2016). These include lack of private space to facilitate IPV disclosure (Ramsden & Bonner, 2002; Ritchie et al., 2009), lack of time (Ramsay et al., 2012), and a lack of out of hours services (Ramsden & Bonner, 2002). Policies describing the role of practitioners including doctors, nurses, midwives in relation to identification and management of IPV cases are required. In addition, practitioners' awareness about such policies and expectations of their role is also necessary. Ensuring appropriate provision of conducive and private environment for the victim/ patients where they feel safe and comfortable in disclosing their IPV experiences

without a fear of being subjected to prejudice, patronising and or pressurising behaviour can be extremely useful.

Nurses' responsibilities

In terms of professional accountability, all registered nurses in the UK have a professional duty to "takes all reasonable steps to protect people who are vulnerable or at risk of harm, neglect or abuse" (Nursing and Midwifery Council, 2015). However, in addition to the general responsibility of nurses to promote the highest standards of care and to act as an advocate for patients and clients in their care, in 2014, the National Institute for Health and care Excellence (NICE) published NICE Domestic Violence and Abuse guidance. This guidance highlighted the important role of health and allied health care professionals in the effective management and support of those who had experienced IPV (NICE, 2014). This professional mandate was further strengthened through the NICE Domestic Violence and Abuse Quality Standard that was published in February 2016. The NICE quality standards (NICE, 2016) are developed in order to provide clear guidance and indictors for quality improvement for individuals and organisations. The NICE Domestic Violence and Abuse Quality Standard have a number of key recommendations and these include the provision of education and training in the recognition of IPV, responding appropriately to disclosure of abuse, knowledge and ability to use specialist services and referral pathways. Individual practitioners (such as nurses, midwives and other health care professionals) and health care organisations should comply with NICE guidelines and quality standards to ensure provision of best possible care to their patients and to contribute to identifying, managing and preventing IPV. Box 1 provides references to these resources and it will be useful for the readers to familiarize themselves with NICE guidelines and quality standards.

Complete activity six and seven

Nurses, midwives and other health care professionals can play an important role in identifying, managing and preventing IPV. They need to understand IPV, its presentation, impact and factors affecting the identification, detection and management of IPV in health care settings. We recognise that IPV is both complex in presentation and potentially challenging in practice. It is anticipated that through reading this article and undertaking the suggested activities that nurses and other health care professionals will have a greater understanding of IPV and identify key areas where they may need to develop their skills and knowledge further, to support the victims of IPV who present in healthcare contexts.

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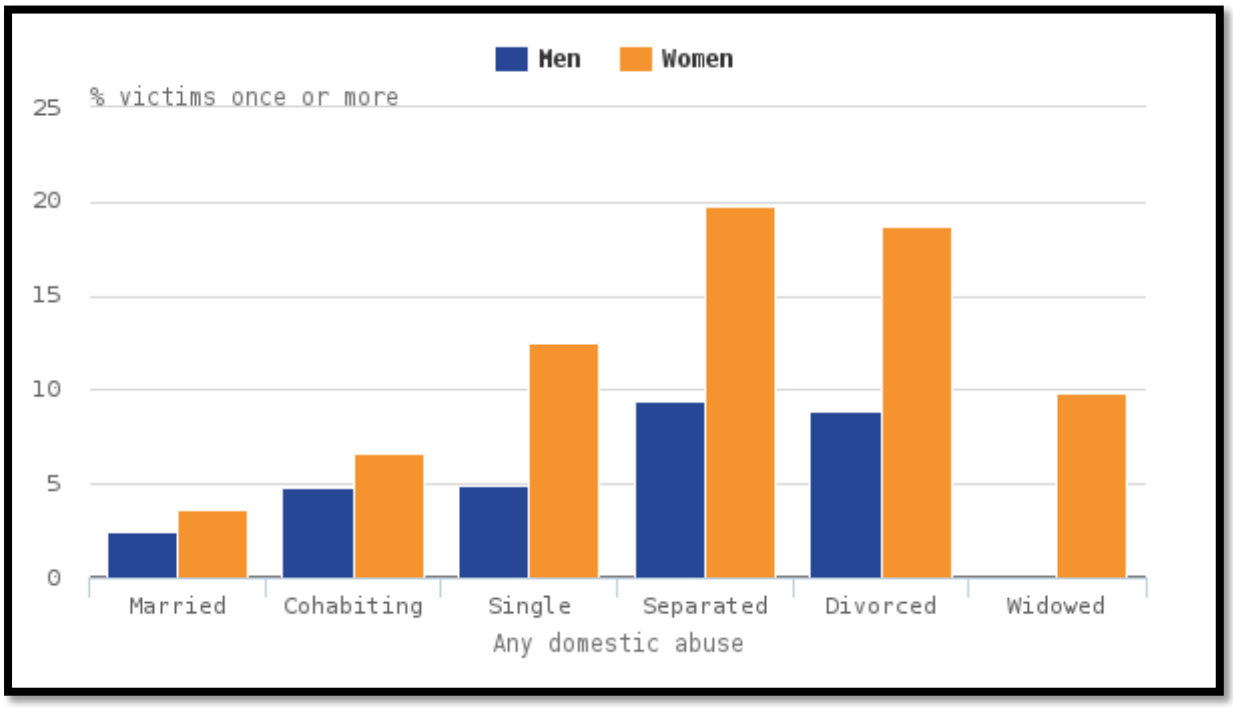

Figure one: Percentage of adults aged 16 to 59 who were victims of domestic abuse in the last year, by marital status and sex, year ending March 2015 (Crime Survey for England and Wales , 2015)

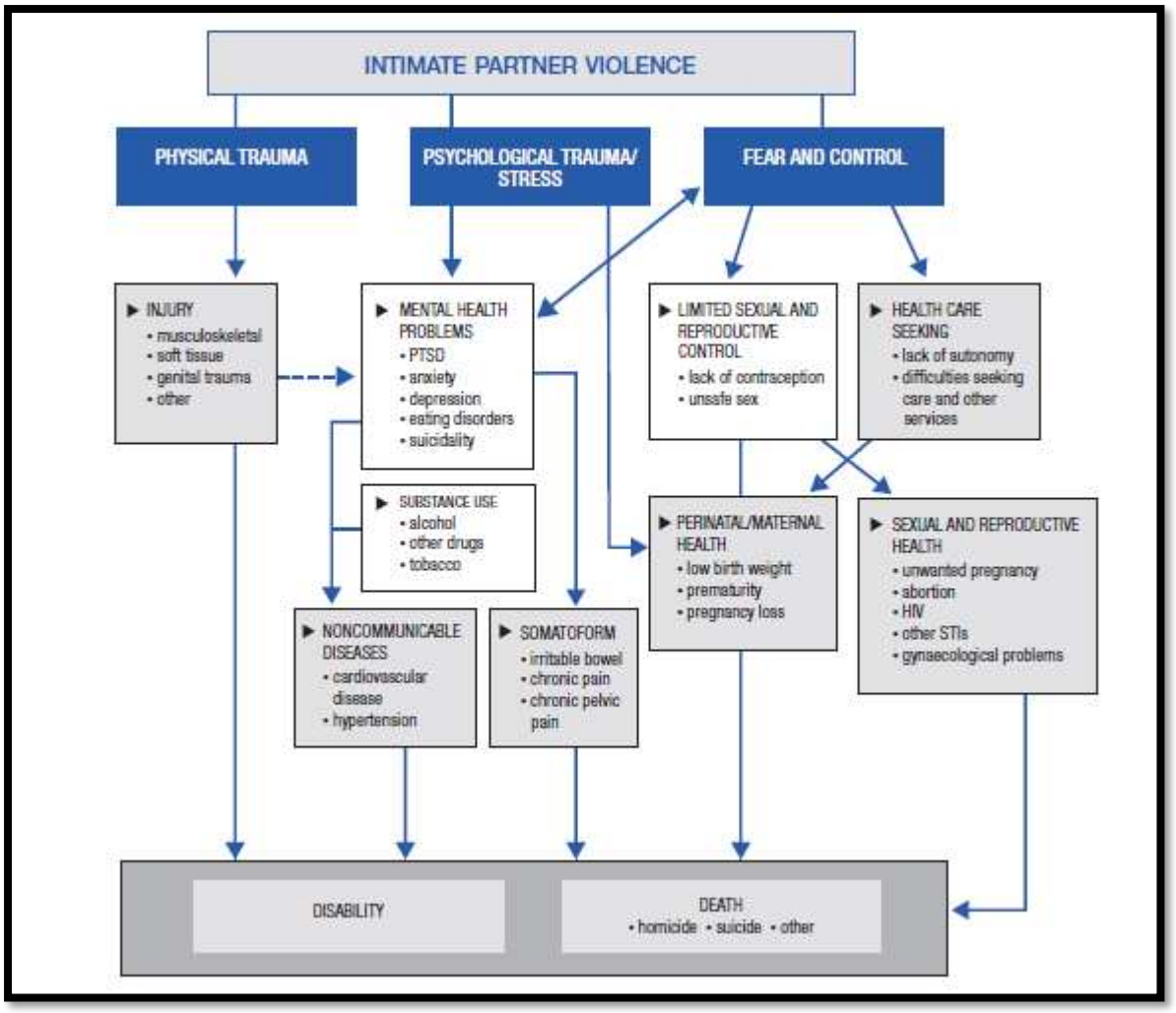

Figure 2. Pathways and health effects on intimate partner violence

Box One: Useful resources

Domestic violence and abuse NICE quality standard [QS116] (2016) https://www.nice.org.uk/guidance/qs116

Domestic violence and abuse: multi-agency working NICE guidelines [PH50] (2014) https://www.nice.org.uk/Guidance/PH50

Nursing and Midwifery Council. (2015) The Code https://www.nmc.org.uk/standards/code

Activity One: Are you aware of other terms that have been used to describe intimate partner violence in past three decades? How might the different use of terminology impact on professionals responses to IPV?

Activity Two: Reflect on your practice experience over the past year. Do you remember any particular encounter with a patient or client who disclosed IPV? It may be useful to write about that experience 200-300 words. If you haven't encountered such a situation you may wish to reflect on your working environment and if you feel that it facilitates disclosure of IPV – for example, are there any issues surrounding privacy.

Activity Three: Consider the different ways in which IPV may be experienced by a victim. Consider how patients/clients may present in your area of practice – for example, mental health or primary care contexts.

Activity Four: What role do nurses, midwives and other health care professionals play with regards to identification, management and prevention of IPV? Reflect on your views using 200-300 words.

Activity Five: Reflecting on the example in activity two, think of the factors that have or would affect/ affected your or other nurses / midwives and health care professionals' ability to identify and respond to IPV victims.

Activity Six: Please access the NMC code, NICE website and Quality Standard. Reflect on your own area of practice and consider the ways in which the guidance within the Quality Standard can be developed within your own workplace or the ways in which particular mechanisms are already in position:

Activity Seven: Consider what you have learnt through reading this article and undertaking the activities. Consider what else you need to know. You may wish to start to develop an action plan or explore the resources and further reading provided in this article.